# ‘The Birth I Want’

## Negotiating the Ideal and the Practical in Natural Birth

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## Abstract

This thesis explores the disjunction between a public, moralised discourse of natural birth and women's own more complex narratives of practical decision making and lived experience. I focus on women's negotiations of these two dimensions, which I term 'the work of birth', which includes the planning, preparation and practice in which some women are involved during their pregnancies. I argue that this work can be considered an ethical self-formation in which women work on the self in order to construct and present a particular subjectivity - of the good and responsible mother.

I address questions which are not adequately answered in the sociology of childbirth literature, including how and why some women become involved in natural birth groups; why they consider investing time and money in antenatal education as a good thing to do; and why they report the need to practice for a natural birth. I approach their natural birth practices as things of 'value' or 'matter' (Bender and Taves 2012), as their search for meaning-making within a particular embodied event. As such, I argue that theoretical approaches from both cultural sociology and religious studies, including theories of lived religion and of ritual, can shed new light on the meanings and motivations of these practices.

The thesis draws on analysis of primary materials, on observation of different antenatal groups and on over 40 interviews with pregnant women, new mothers, midwives and antenatal teachers, all of whom were involved in natural birth practices including Hypnobirth, home birth and using the services of a doula. I analyse the ideal of natural birth within the women's own narratives in order to understand the concept of the 'natural' in this particular context; what do women mean when they use this term and what work does it do here? I argue that the natural is not in a simple dichotomy with a medicalised birth and is not just the content of a particular type of birth but rather is intricately connected to the perception of choice, of having 'the birth I want'. I analyse the ideal in connection with the non-ideal or the 'profane'. Central to this is the constructed 'other' who does not do birth 'right', which reveals a changing location of expertise not only away from the medical establishment towards the birthing woman but also away from the midwife and towards the doula and other 'birth workers'.

The interview narratives reveal a process of negotiation between the ideal birth and women's own practical considerations, including her embodied experiences (or lack thereof in first pregnancies) and her relationships with significant others (including her partner, baby and the expert). This negotiation takes the form of 'work'; of planning, preparation and practice for the ideal birth through the physical, mental and emotional working on the self. I suggest that this bears parallels to a western spiritual legacy of work on the self and shares its understandings of self-in-relation. As a result, I argue that the work should not be seen as a narcissistic pursuit of individualism, nor a futile practice which sets women up for failure. Rather, it can be seen as an expression of lived and embodied ethics, of attempting to make the best possible decisions in light of individual and relational circumstances within a plethora of choices in the field of consumption and a strong moral discourse in the public sphere. Through the performance of particular choices and practices, some women seek to demonstrate their good and responsible motherhood, regardless of whether the ideal birth is attained.

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## Chapter One - Natural Birth in Context

In October 2011, BBC Breakfast News included a segment on new NICE guidelines which would make it easier for women to choose an elective caesarean under NHS care.[1] Joining the two presenters for a five-minute discussion were an independent midwife, Virginia, holding her newest baby grandson on her lap, and an elective caesarean advocate, Pauline. As could be expected, these two women presented the extremes of this polarised debate. Pauline began with something of a potted history of backlashes against pain relief in labour quoting the Biblical phrase, 'in sorrow you shall bring forth children', as part of the reasoning behind this. She went on to suggest that, 'fortunately we are now at a stage when women don't have to go through natural labour'. Evidently riled by this, Virginia cut across Pauline to say, 'well we don't have to get pregnant in the normal way either do we, we could all go for IVF. We don't have to go to the loo even, we could have a colostomy bag'. She went on:

> The fact is, normal birth is what women are designed to do. Women are meant to give birth. What messages are we giving to our daughters and the women of tomorrow - that our bodies fail us? Women are amazing and you cannot judge and measure this feeling of empowerment that women get when they give birth naturally. That cannot be measured by any statistician.

Pauline replied to this, 'but safety outcomes can be and I'm more interested in those than I am in an ideological view of birth'. Virginia said, 'but birth is ideological'.

I began my fieldwork a few months later, observing different antenatal preparation courses and interviewing women who self-identified as interested in 'natural birth', expecting to find these themes of natural birth as ideological, as empowering and as what women are meant to do, repeated in the classes and the interviews. Whilst this was certainly an underlying assumption of some of the classes, particularly in the Hypnobirthing course,[2] the interview data was not so straightforward. Although the women I interviewed had responded to my flyers or social media posts for participants in a 'natural birth study', and had written initial contacting emails explaining their interests in, and experiences of,

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[1] NICE guidelines CG132, published November 2011 - https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance#planned-cs. NICE (the National Institute for Health and Care Excellence) provides 'evidence based guidance' which is used by the NHS (National Health Service) in the UK.

[2] Hypnobirthing is a 'birth education programme' which teaches self-hypnosis for labour and is most associated with the work of Marie Mongan (although there are now other teachers/courses in the UK too). My fieldwork was of the 'Mongan Method'.

natural birth, in the actual interviews they were often reluctant to position themselves so directly as hoping for, or having had, a natural birth and sometimes found the idea of natural birth itself hard to articulate. The result of this was two-fold; a greater ease with articulating what was not a natural birth, and hence with what they did not want in their birth experiences, combined with a great deal of practicality in discussing their birth desires and experiences - both pre-emptively in the sense that pregnant women placed great emphasis on 'keeping their options open', and in post-hoc rationalisations for their decision-making.

Jane, for example, had invested a lot of time and money, not to mention emotional and physical preparation, in her second pregnancy and birth. Following a first birth experience in which her son was born in hospital with a ventouse delivery[3] and she struggled with breastfeeding and with socialising after his birth, she decided to have her daughter at home, in water. As she felt that she had received little preparation, knowledge or support from the NHS[4] during her first pregnancy and birth and afterwards, she decided to look elsewhere for support. She paid for both an NCT course,[5] in order to build an alternative support network, and a Hypnobirthing course in order to prepare her for birth. She attended antenatal yoga classes and paid for numerous alternative treatments including massage and reflexology. She also sought some private counselling in order to resolve the issues around her negative experience of breastfeeding and an early miscarriage.

Jane's daughter was born on the day we had initially arranged an interview - at home, in water, using Hypnobirthing techniques, as planned. When I interviewed Jane a few months later, I asked whether she thought Hypnobirthing was a natural way to give birth? Despite

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[3] A 'vacuum-assisted vaginal delivery' in which the baby is born with the aid of a suction cup.

[4] The NHS is the National Health Service in the UK. It was founded in 1948 on the principle of healthcare for all and is free at the point of use. It is funded by taxation and has been rated as one of the most impressive healthcare systems worldwide. In 2015/16 it employed more than 1.5 million people, had a budget of over £116 billion and dealt with over one million people every 36 hours - https://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx. In general, UK citizens place a high moral value on the NHS; the (incorrect) claim that the NHS would receive £350million a week if the UK left the EU is considered a significant factor in the Leave campaign winning the Brexit vote - http://www.bbc.co.uk/news/uk-politics-eu-referendum-36574526.
Sociologist of religion, Linda Woodhead, has suggested that the NHS could be considered a new religion in the UK in that it provides the care from 'cradle to grave' previously provided by the Churches (talk at the Feminist Review on 16/6/2011).

[5] The NCT (National Childbirth Trust) is the UK's largest parenting charity which provides support for parents in the first 1,000 days (from the start of pregnancy up to the child's second birthday).

having said earlier in the interview that Hypnobirthing 'was like I'd been let into a secret about how it should be', in answer to this question, she replied

> I'd watched Hypnobirthing videos, seen women give birth without screaming which is what I did with my first and that was quite nice, it looked like a nicer way to give birth, to not be in as much pain and… the thought of having a less painful birth looked a nicer way of doing it… but it wasn't that I as much, 'I want a natural birth', it just looked like a nicer birth if I could. But I didn't look at it as, 'I'm gonna stay here at all costs, I don't want to go in'. I was looking at, 'I want to stay at home for as long as I can' and then I did everything I could to help me do that.

Despite the 'ideal' birth being achieved, Jane still did not label this as a 'natural' birth being more content to describe her birth choices and experiences in more practical terms, as 'home birth' and as 'Hypnobirth', as well as being motivated by practicality - it was just a pursuit of 'a less painful birth' and a 'nicer birth'. That a home water birth was considered potentially less painful than a hospital birth with pharmaceutical pain relief does suggest a commitment to a particular birthing ideology, however.

Virginia and Jane's different presentations of the same type of birth (one that has as little medical intervention during labour as possible, including limited or no pain relief, and that ideally takes place in the home) represent two ends of a spectrum of ideological to practical approaches to natural birth. In reality of course, most women move along this spectrum in discussing their birth choices and experiences, and the negotiation of these two poles has come to be the focus of this thesis. I focus on what women do during their pregnancies - their planning, preparation and practices, or 'work', encapsulated in Jane's statement, 'I did everything I could to help me with that' - as their means of negotiating their adherence to an ideal form of birth with their own individual, practical considerations and lived experiences including their embodied knowledge and the influence of their social networks.

This thesis explores the everyday experience of trying to balance an ideal[6] with one's own practical circumstances within the extraordinary (in the most literal sense of the term) context of pregnancy and childbirth. It asks, how do we understand a particular situation (in this case childbirth) where there is a discrepancy between a public moralised discourse and everyday practices which are influenced by, and contribute to, this moralised discourse

[6] See Chapter Two for more on the concept of the ideal.

and yet are arguably more influenced by practical concerns especially embodied, biographical experience and knowledge, as well as the influence of a social network? My focus is on how symbolic meanings and lived experience are negotiated through practices, in this case, how women make choices and prepare for their births. I focus specifically on the ideal of 'natural' birth and consider what natural birth means to the women interviewed.

It is perhaps worth pausing here for a moment to state the key ideas and practices of natural birth as popularly understood in the medical-natural dichotomy. The concept of natural birth has a long history which is influenced by both a western spiritual legacy of understandings of self and holism, as well as twentieth century understandings of health, individualism and responsibility. This history will be discussed later in the chapter. At this point, it is important to note that a natural birth can be generally defined as a spontaneous vaginal birth without medical intervention. In this understanding, routine medical interventions such as induction of labour; assisted delivery including forceps and ventouse; and caesarean section are excluded. Other medical procedures occupy more of a 'grey' area and may or may not be included in definitions of natural birth, including 'stretch and sweep' as a less invasive means of inducing labour; artificial rupture of membranes in order to speed labour; pain relief including epidural, pethidine and gas and air; episiotomy (a surgical cut to enlarge the vagina); artificial third stage of labour (an injection to speed delivery of the placenta), as well as screening during pregnancy such as blood tests and ultrasounds. The general definition corresponds with the NHS use of the term 'normal birth' which is 'vaginal birth without the use of technology of medical interventions. This excludes the onset of labour using induction methods, pain management such as epidural or spinal anaesthetic, and the use of forceps or ventouse'.[7] In both popular and midwifery understandings, natural or normal births occur more often in a midwife-led birth unit, whether this be part of a hospital or a stand alone centre or, ideally, in the home; birthing in a labour ward usually entails at least one of the routine medical interventions listed above. The ideal natural birth is one in which only midwives assist and a (male) medical doctor does not enter the room. The birthing room is calm, relaxed, dark and quiet.

[7] http://betterbirths.rcm.org.uk/resources/read/defining-normal-births

It must be recognised that for some women, the ideal birth is a highly medicalised one represented by elective caesarean and strong pain relief but, unsurprisingly, these women did not respond to my call for participants in a 'natural birth study'. My interest in natural birth and reasons for selecting it as an object of study are manifold and are explored further in Chapter Three, but for now it is important to note that natural birth is a particular site of normative moral claims as the form of birth that is encouraged at a policy level and by the medical establishment, ostensibly as best for mother and baby, but also as the least costly form of birth for the NHS.[8] Natural birth is hence something of a 'benchmark' ideal with which many women engage even if it is not the particular form of birth they want. Two further caveats should be added here. First, I retained the older term 'natural' birth in preference to 'normal' birth for various reasons including that anecdotal evidence suggested that lay women still use the term natural birth over normal; I wanted to position my project as non-medical and this was a useful signifier; and I wanted to explore the concept of the natural as having sacred/moral significance. Second, despite popular presentations, there is no such thing as an organised, coherent 'natural birth movement'. Instead, natural birth is comprised of various practices and teachers, which may or may not integrate with one another. Different teachers will be discussed later in this chapter and the practices of natural birth are the focus of this thesis. Even the term 'groups' must be interpreted loosely as not all of the women interviewed were involved in organised groups (although the majority were involved in social media discussion groups).

In 2005, the UK's Royal College of Midwives (RCM) launched the 'Campaign for normal birth', a 'dedicated programme of activities…promoting and enabling normal birth and improving childbirth experiences for both women and midwives'.[9] This campaign evolved from an earlier initiative called the 'Virtual institute for birth', and was intended as a 5-10 year plan. Nevertheless, when the project evolved again into the 'Better Births Initiative',[10] (a process which began in 2014 but was not announced until 2017),[11] sections of the press and some members of the Conservative government hailed this as the end of midwives

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[8] In 2017, a caesarean section was said to cost the NHS around £1,700 and a normal delivery £750 - https://www.theguardian.com/lifeandstyle/2017/jan/21/how-risky-are-caesarean-births

[9] https://www.rcm.org.uk/news-views-and-analysis/analysis/the-big-push-for-normal-birth

[10] http://betterbirths.rcm.org.uk

[11] http://theconversation.com/why-uk-midwives-stopped-the-campaign-for-normal-birth-82779

forcing women into natural births, which would help decrease neonatal mortality rates.[12] A contributing factor in their (misinformed) celebrations was the 2015 publication of 'The Report of the Morecambe Bay Investigation'.[13] This distressing report outlines a catalogue of errors which led to the unnecessary deaths of at least three mothers and sixteen babies. Part of the problem, the report states, 'was a growing move amongst midwives to pursue normal childbirth "at any cost"' (Kirkup 2015: 7). That this is a common practice amongst midwives across the NHS has been strongly debated, and denied, in midwifery circles.

These debates are circulating in a context in which there is a shortage of 3,500 NHS midwives, according to Royal College of Midwives predictions,[14] contributing to a pressurised and stressful working environment. As of January 2018, there were 21,900 midwives working in the NHS, an increase of around 1,600 since 2010. A newly qualified midwife's salary starts at just over £21,000 per year; a senior or managerial role can pay between £30,000 and £40,000 per year.[15] However, recent surveys and media articles suggest that this is not an altogether happy profession - in line with the huge dissatisfaction of NHS workers in general. A seven year pay cap for NHS workers will only end in 2018 in a service which is struggling financially amid ever increasing patient demand. A 2015 NHS staff survey reported that 46 per cent of midwives had suffered work-related stress in the previous 12 months.[16] A 2017 RCM survey reported that 61 per cent of midwives were considering leaving the profession in the next one to two years, 91 per cent felt that there were not enough staff to complete jobs properly and 98 per cent felt that their organisations relied on the 'goodwill' of midwives.[17] A 2016 RCM survey reported that 33 per cent of midwives are in their 50s and 60s and that young people are not joining the profession

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[12] For instance, http://www.telegraph.co.uk/news/2017/08/12/midwives-agree-drop-normal-births-campaign-makes-women-feel/

[13] This was an 'independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at The University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013.'

[14] https://www.rcm.org.uk/news-views-and-analysis/news/'eliminate-the-midwifery-shortage'. See also https://fullfact.org/health/shortage-midwives/

[15] https://www.prospects.ac.uk/job-profiles/midwife

[16] https://www.rcm.org.uk/news-views-and-analysis/news/stress-affects-almost-50-of-englands-midwives

[17] https://www.rcm.org.uk/news-views-and-analysis/news/rcm-survey-reveals-midwives'-feelings-towards-pay

partly because of the eradication of student bursaries.[18] Furthermore, reports of bullying within midwifery are prevalent. The 2015 NHS staff survey reported that 32 per cent of midwives had experienced bullying, abuse or harassment from NHS staff in the previous 12 months. The RCM recognises this as an endemic problem and, in 2014, launched an online 'anti-bullying toolkit', in association with the Royal College of Obstetricians and Gynaecologists. Current media articles and Facebook support groups suggest that this has not yet eased the problem.

Midwives dissatisfied with NHS working conditions have previously had the option of practising as self-employed 'independent midwives' in the private health sector. They generally care for women in the women's homes but can also accompany women into hospital should they choose a hospital birth or a medical indication in labour requires transfer. Many join 'Independent Midwives UK' (IMUK), a membership organisation founded in 1985, to offer women greater choice than that provided by the 'paternalistic, medical model' of midwifery care.[19] Independent midwives consider themselves to be experts in normal birth. Independent midwives, who number only a few hundred in the UK, are registered to practice through the Nursing and Midwifery Council (NMC) who provide their indemnity insurance. However, various legal challenges over the past seven years culminated in a judicial review in December 2017, won by the NMC, who will no longer provide the requisite insurance for independent midwives to practice.[20] Independent midwifery in the UK now faces an uncertain future. Through promoting themselves as custodians of normal birth, independent midwives tend to be chosen by women who subscribe to ideas of the 'natural', 'normal', 'holistic' model of midwifery care for various reasons, including a negative first birth experience and/or being placed in a 'high risk' birth category by the NHS - including for older age, obesity, or previous caesarean - thus restricting their choices. Three of the women I interviewed had chosen independent midwives, and I also interviewed four independent midwives. Other women whom I interviewed spoke of independent midwifery as the 'ideal' but felt that it was either too expensive or that it was not something they should have to pay for as the NHS should

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[18] https://www.rcm.org.uk/sites/default/files/SoMS%20Report%202016_New%20Design_lowres.pdf

[19] http://www.imuk.org.uk/about/our-history/

[20] http://www.imuk.org.uk/news/message-to-our-supporters/

provide the same quality of care. Care from an IMUK midwife through pregnancy, birth and postnatally, costs between £2,000 and £5,000.[21]

The 'Better Births Initiative' moves away from the terminology of 'normal' birth recognising it as a term laden with value judgements, but its aims closely match those of the earlier campaign. The campaign still aims to increase 'normal' birth rates in the UK. In 2017, the normal birth rate in the UK was somewhere between 40 per cent and 60 per cent.[22] The caesarean section rate was around 26 per cent (split roughly evenly between emergency and elective sections), instrumental delivery (forceps or ventouse) rate was between 10 and 15 per cent and the episiotomy rate was around 20 per cent (Chapman and Charles 2018). 29.4 per cent of women were induced and around 35 per cent had an epidural. In statistical terms then, 'normal' or 'natural' birth remains the norm. Yet this is not the 'ideal' birth that my informants strove towards. In 2017, around 88 per cent of women gave birth in hospital obstetric units or 'labour wards'. Just 2.1 per cent of women gave birth at home in 2016, a slight decrease from the period 2012-2015 when it remained constant at 2.3 per cent.[23] In contrast, in my sample of 43 participants, over half (24) had planned a home birth, and 15 had had a home birth (34.8 per cent). This was the most common practice which unified my sample: 17 women had an involvement with Hypnobirthing, either as a teacher or course attendee; fifteen were involved in pregnancy yoga classes; and six women attended NCT courses. All of the women I interviewed, self-selected on the basis of their interest in 'natural birth' and their participation in online or physical natural birth groups, had prepared or were preparing for an ideal, natural birth with common elements, although they were emphasised to different extents, including a birth that was as pain-relief free as possible, not induced and in a calm and relaxed birth environment. The women I interviewed had invested time, money, emotions and more in

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[21] http://www.imuk.org.uk/families/faqs/#paymen

[22] The RCM March 2016 Survey Report, 'Interventions in Normal Labour and Birth', suggests that there is no consistency in measuring and reporting normal birth rates across different trusts. Seven trusts were surveyed, reporting a 65 per cent rate of normal birth, but according to the definition used in the survey, only 22 per cent of women experienced a normal labour and birth. https://www.rcm.org.uk/sites/default/files/Labour%20Interventions%20Report%20A4%2020pp%202016_3.pdf

[23] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2016

achieving a particular type of birth - one which aligned with a ‘normal’ birth but was largely outside of the mainstream, medical context.

**The Construction of Natural Birth**

Below I give a history of birth with a focus on theoretical understandings of the ‘natural’ and on connections with religious views, which are integral to, but are not always drawn out in, popular presentations of a history of birth. I place the ‘natural’ as it relates to natural birth, within a specific historical and social context, sharing foundational concepts with the holistic milieu and with other moral communities around the natural. The place of such communities in contemporary consumer culture and the connections between a concept of the natural and an individual’s perceived responsibility of choice is discussed. I discuss first the ways in which birth has been medicalised and professionalised in Western European countries over the past few centuries. This sets the context in which natural birth first developed as a coherent approach to birth in the UK in the early twentieth century. I then trace its development from a patriarchal, colonialist and middle to upper-class concern, to its reclamation by white second wave feminists to symbolise something quite different. With the influence of second wave feminism, natural birth became (for some) a symbol of female emancipation from male medical control as opposed to a form of birth considered appropriate for middle-class mothers of the empire. The work of both natural birth pioneers and contemporary teachers, including those drawn upon by my participants, are discussed within this context. Second wave feminist understandings of natural birth remain predominant amongst some of my interviewees and in both popular birth and midwifery literature. Finally, I discuss the social situation around birth in the contemporary UK. Drawing on Charles Taylor’s (1989, 1991) writings on the subjective turn, Ulrich Beck and Elisabeth Beck-Gernsheim’s (1992, 1995, 2002) writings on risk and individualisation, and Nikolas Rose's (2001) discussion of contemporary biopolitics, I discuss the context in which a huge premium is placed on taking responsibility for personal health. Personal responsibility and choice are encouraged in government policy for all areas of health, including pregnancy and birth. In the next section, in which I discuss some of the existing sociological literature on birth, I suggest that the current situation is usually described with a focus on the policing and regulation of pregnant and birthing women. I suggest an approach, which is developed further in the following chapter, which focuses

more on women's agency, creativity and meaning-making in their pregnancy and birth practices as a form of lived ethics.

### *The Medicalisation and Professionalisation of Birth*

Whilst birth has never been 'natural', that is pre-social or pre-cultural, the history of birth in the West is a story of increasing medicalisation. In the West, historically, women have not usually been left to birth alone but instead have sought the support of other women, whether relatives, friends or a village wise woman, who acted as midwife amongst other things. The term 'midwife' is an old English term meaning 'with woman'. In France, midwives were known as 'sage femmes' or 'wise women'. The association of midwives with village wise women was particularly popularised after the 1973 publication of *Witches, Midwives and Nurses* by feminist scholars, Barbara Ehrenreich and Deirdre English. However, the historian Edward Shorter (1997: 48) reminds us, 'people today have a romanticised and generally false picture of the typical birth in traditional times'. He goes on, 'it is untrue that people regarded birth as a "natural process" and abstained from intervention. The typical mother was in fact harassed by meddlers and officious interveners from the moment she realised she was pregnant until she finally received her ritual "cleansing" a month after giving birth' (1997: 48-49). Midwives and 'meddlers' used various techniques and tools to assist with birth such that birth has never been non-technological. But the forms of technology utilised - and those utilising them - have changed over time in line with the increasing technologisation of medicine.

The history of midwifery, like that of medicine in general, is inherently connected to the religious institutions of the societies in which it developed. Numerous scholars of religion (Mellor and Shilling 1997, Szerszynski 2005, McGuire 2008) point towards the Protestant Reformation as marking a movement away from embodied forms of religion and a separation of health and healing from the religious realm. This entailed that relationships with the transcendent became mental, internal and individual rather than physical and communal, and nature became a realm to be mastered, paving the way for the development of biomedicine. But the established churches still sought to regulate health and healing, whether traditional folk practices or the emerging field of biomedicine. Shorter (1997: 40-41) traces the way in which midwifery in Europe was regulated from the 13th century

onwards, first by the Roman Catholic Church, then by the medical establishment and then by government. In the 13th century, a primary concern of the Church was that midwives were able to administer the sacrament of baptism to babies who would not survive. In various European countries, midwives swore oaths before the national Church to perform this service as well as to help the women in their care (sometimes excluding Jewish women) (Shorter 1997: 41). Christian understandings of pain in childbirth as a consequence of Eve's sin have also determined pain relief options. In the Middle Ages, women and their midwives had been put to death for seeking to ease pain in labour through folk remedies (Cassidy 2007: 85). James Simpson, who pioneered the use of chloroform as an anaesthetic in labour in the mid-19th century, faced criticisms from the Church in Scotland, which he sought to counter with his own religious arguments, including that God did not condone suffering and that the Hebrew word for 'sorrow' could also be translated as 'to work' (Cassidy 2007: 85). This argument was repeated by Grantly Dick-Read a century later. The use of chloroform only gained widespread acceptance when it was used by Queen Victoria, head of the Church of England, for the delivery of her eighth child in 1853 (Cassidy 2007: 90). Jennie Bristow (2013) links the gradual acceptance of chloroform with a generalised sense of progress and optimism in the nineteenth century.

From around the sixteenth century onwards, male medical doctors sought to displace female midwives from the realm of birth which they had managed for hundreds of years. But it was not the case that birthing women were unwilling victims in this process of medicalisation, as some feminist texts suggest. The fashions of birthing were largely driven by the practices of upper class women; once they had popularised a practice it filtered down to the lower classes and became desirable. Upper class women began to choose male doctors as birth attendants, rather than traditional female midwives, in the view that male doctors represented progress and education. The notion of progress is a subjective one however; the medical profession made strides in developing new tools and techniques, but often the use of these initially entailed an increased risk of injury or death for mother and newborn. For instance, the use of forceps by male surgeons was popularised in the UK in the seventeenth century. Some surgeons used this new tool for all the births they attended, sometimes before the baby had even begun to descend through the birth canal, leading to

injuries for both mother and baby (Cassidy 2007: 168-172, Shorter 1997: 151-6).[24] It also saw the establishment of the first 'lying-in hospitals', in which poor and destitute women could find a place to birth and some support, but in reality also became guinea-pigs for doctors' new tools and techniques. Such hospitals had high maternal and neonatal mortality rate due to the rise in puerperal fever (uterine infections following birth), caused by doctors' internal examinations and use of instruments without sterilisation or even clean hands, often coming straight from autopsies to deliveries. Puerperal fever was not so common under midwifery care as midwives did not perform such frequent internal examinations, instrumental births or autopsies. Nevertheless, throughout the nineteenth century, the male medical profession went to concerted efforts to destroy the female practice of midwifery. The nineteenth century midwife in popular culture was that of the untrained drunkard, epitomised in Charles Dickens' 1844 portrayal of 'Sarah Gamp' in Martin Chuzzlewhit.

The technologisation of the Industrial Revolution was not unanimously considered as progress, however. Eighteenth and nineteenth century movements which rejected industrialism marked the beginnings of the romanticisation of the natural, in which 'nature' took on new meanings, as well as new uses as places of 'contemplative retreat', spaces for leisure and recreation, and places to be 'appropriated visually' in landscape paintings. Nature itself became sublime and a physical space in which to 'find oneself' (Szerszynski 2005: 103). The Romantic ideal was to be 'in' nature with nature represented 'as a realm of purity and moral power in contrast to the instrumental, technological world of modern society'(Szerszynski 2005: 102). Catherine Albanese (1990, 2002), in her studies of nineteenth century nature religions, argues that even as the fields of science and technology came to prominence and biomedicine gained its hegemony, there co-existed healing systems which drew on nature as a healing source; 'Nature became the great healing symbol' (1990: 122). Nineteenth century Christian and 'irregular' physiologists (those who drew directly on natural healing systems) understood health as a state of harmony with nature's immutable laws; 'Nature was everywhere the norm and disease was rebellion against it, a consequence resulting from a violation of Nature's laws' (1990: 130). As a

[24] Shorter (1997: 153-4) also argues that in the first half of the twentieth century in the UK, the high number of labouring women being transferred to hospital with the designation FFO (failed forceps outside), due to doctor incompetence and impatience, contributed to the move away from home birth and towards hospital.

result, it was assumed that those who lived closest to nature would be in the best health, an idea central to the Transcendental movement and the later homesteading movement. Health was seen as the natural state of the body, illness was the result of a violation of these laws and hence was the individual's own responsibility. However, as Becky Mansfield (2008: 1085) rightly points out, proponents of natural birth do not promote a Romantic ideal of a return to nature but rather a specific interpretation of a nature-society relationship.

In the nineteenth century, a number of midwives sought to counter the male takeover of midwifery and the negative portrayal of midwives in popular culture through the development of their own professional organisations. In 1881, a London-based midwife, Zepherina Veitch, and her colleagues, established the 'Matron's Aid' or 'Trained Midwives Registration Society', the forerunner of what is today the 'Royal College of Midwives'. In the face of opposition from doctors, who were challenged by the prospect of professional women performing the same service for lower fees, the Society campaigned for the proper registration of midwives. In 1902 the first 'Midwives' Act for England and Wales' was passed. 'This established the Central Midwives' Board, which governed the training and practice of midwives and made it illegal for any unqualified person to act as a midwife',[25] as well as the process of supervision of midwives, which continues to this day.

Women in the early twentieth century could thus choose to pay for the services of either a professionally trained female midwife or a male medical doctor. In either case, the huge majority of births took place within the home. This was to change over the course of the century. For many first-wave feminists of this period, equality for women entailed a search for the eradication of pain in childbirth. A pain-relief method that originated in Germany and became popular, particularly in America, was that of 'twilight sleep', in which labouring women were injected with a combination of the amnesiac scopolamine with morphine (Cassidy 2007: 91). This did not eradicate pain - and indeed the heavily drugged women were tied down for birth - but rather women's memories of pain. Upper class American women travelled to birth clinics in Germany to experience such births and then campaigned for such methods upon their return to America, forming the 'National Twilight Sleep Association' (Bristow 2013: np). A heavily drugged hospital birth became the norm in America from the 1930s onwards. Twilight sleep was not so popular in the UK, although

[25] https://www.rcm.org.uk/sites/default/files/History%20of%20the%20RCM.pdf

the ‘National Birthday Trust Fund’ was founded in 1928 to campaign for the provision of analgesia in childbirth, amongst other things.[26]

Whilst ‘twilight sleep’ was not so popular in the UK, the 1930s saw a move towards hospital births here as in the USA. Shorter (1997: 139) attributes this to a shift in doctor’s emphasis from mother to baby; ‘in the 1930s the doctors shifted their own concern from keeping the mother alive and undamaged to producing a healthy baby’. Hospital was seen as the best place in which to do this. In 1946, the year that Aneurin Bevan’s ‘National Health Service Act’ was published, around half of births took place in hospitals in the UK. This Act set out ‘a duty for the Minister of Health’ to ‘promote the establishment’ of a ‘comprehensive health service’ to improve the ‘physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness’. Furthermore, ‘The services provided shall be free of charge’.[27] Two years later, in 1948, the NHS was established. This marked a turning point in maternity care in the UK, with women and children the greatest beneficiaries of the NHS, with the sharp decline of maternal and neonatal mortality rates (Davis 2013). The NHS today creates a unique context for pregnant and birthing women in the UK, who know that they will receive good, free care. Bristow (2013) suggests that it is the safety of birth in the contemporary UK that allows nature to be romanticised. Angela Davis (2013) writes, however, that there was never a ‘clear plan for maternity services’ and there were a number of successive inquiries and reports which each time sought to increase the target numbers of hospital births. The Cranbrook Report of 1959 set a target of 70 per cent of all births in hospital, whilst the Peel Report of 1970 set a target for 100 per cent hospital birth. The ‘Reducing the Risk’ report of 1977 repeated that all women should birth in hospital because ‘Even if a woman is “low-risk” and likely to have a normal birth, one cannot be sure it is normal until it is over’ (Davis 2013: np). Between 1963 and 1975, Davis writes, hospital births in the UK increased from just over 68 per cent to 95 per cent.

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[26] http://www.aim25.ac.uk/cgi-bin/vcdf/detail?coll_id=10802&inst_id=7&nv1=search&nv2= In later years, this charity became focused on medical research into specific maternity related topics and in the 1990s it became the charity, Wellbeing of Women - https://www.wellbeingofwomen.org.uk

[27] http://nhstimeline.nuffieldtrust.org.uk/?gclid=CjwKCAiAtdDTBRArEiwAPT4y-9q93De94TGePUXDZADWEYgVxzVeUG2Gj8YFXBk9i1mrqH_jM8ZSLxoC-6EQAvD_BwE

***The Origins of Natural Birth: A Middle Class Concern***

At the same time that the NHS was being established and many women were choosing hospital births, an alternative movement of 'natural' birth was developing. Ornella Moscucci (2003: 168) traces the origins of 'natural childbirth' to a 'physical and mental hygiene' approach to pregnancy which developed in Britain between the two world wars, although understandings of nature developed during the previous two centuries could also arguably be seen to provide a longer context for this. The pioneer of this approach was British obstetrician, Grantly Dick-Read (1890-1959). His first book, *Natural Childbirth* (1933) outlined what he termed the 'Fear Tension Pain Syndrome' in which he argued that 'civilised' women's fear of childbirth caused pain in birth. Drawing on his experience of assisting a labouring woman in the slums of Whitechapel, London, give birth with no pain, he argued that 'civilised women' have become conditioned to fear birth which subsequently causes tension in their bodies and hence a real experience of pain. Like James Simpson before him, he underlined this with a religious argument, stating that fear of birth has arisen from the purposeful mistranslation of the word 'labour' in the Bible to mean pain and suffering rather than rewarding hard work and toil. This incorrect understanding has filtered down through the medical establishment to the wider population. Dick-Read argued, in contrast, that the mother with her newborn is closest to divinity, and that God could not intend birth, the fulfilment of a woman's life, to cause pain. The pain of birth is hence a cultural response and not an inherent, physical property of birth. As Moscucci (2003: 170) states, 'Dick-Read believed that childbirth revealed God's presence in the universe'. The majority of *Natural Childbirth* details his letters to, and conversations with, religious scholars around Biblical terminology, in his attempts to convince them of his own viewpoint. He sought to eradicate the fear of birth, which directly corresponds with the level of (presumably Christian) civilisation in his argument, through a celebration of motherhood.

There are numerous elements at play in Dick-Read's understanding of natural birth, including the ideal of the pre-civilised woman who births without pain, but the central element is the sacrality of the mother whose life is fulfilled through motherhood, including birth. Whilst Dick-Read's 'Fear Tension Pain Syndrome' is the basis of the majority of natural birth teachings in the contemporary UK, including both Hypnobirthing and NCT, the religious argument of the link between divinity and motherhood has been lost. Whilst

Dick-Read was mentioned in the Hypnobirthing classes I attended and by many of my participants, the women did not seem to be aware of the religious element of his work or of his essentialised views of women and mothers. However, such essentialised views formed the context in which Dick-Read wrote. Moscucci (2003: 168-9) links the development of 'natural childbirth' with the rise of reform eugenics, in which, from the late nineteenth century onwards, various health reformers and organisations sought to encourage middle-class women of 'good stock' to have more children. Part of this campaign was to encourage such women - who might otherwise be influenced by the emergent first-wave feminist movement - to once again view motherhood and domestic life as worthwhile.

Feminist theorists of class, such as Beverley Skeggs (2003) and Stephanie Lawler (2008), have noted that the category middle class arose in the nineteenth century as a distinct grouping different from both the aristocracy and working-classes. This relational classification system, dependent on marking difference from people seen to belong to other classes, centred partly on women's sexuality. Skeggs (2003: 3-4) describes the process through which 'Victorian male reformers' desires to categorise (and hence contain) women's sexuality, especially the figure of the prostitute, gave rise to classification systems in Australia and Ireland, for instance. 'The production of sexuality was therefore very much a class product', Skeggs writes (2003: 4). Related to this, the concept of 'respectability' was a 'central mechanism through which the concept class emerged' (Skeggs 1997: 2), as were notions of hygiene. Middle-class respectable individuals were defined against the lower-class 'masses' devoid of respectability, hygiene and hence moral authority. Skeggs (2003: 4) notes that 'hygiene was one of the earliest discourses to combine and condense class, race, gender and sexuality'. Race, like class, is also a socially constructed and relational category, as will be discussed further below.

Dick-Read's story of the birthing woman in the 'slums' of Whitechapel reveals this fascination with the sexuality of the lower-classes which is then 'sanitised' or made respectable into an appropriate teaching for the middle-classes. For it is the middle-class woman who must maintain the respectability of the middle-class family through her sexuality and mothering duties. Women 'had to incorporate the proof of "class" within their persons' (Lawler 2008: 257). 'Dick-Read sought to appeal to the middle classes' sense of social responsibility and persuade them to have more children. Women should

drop their claims to emancipation and return to their "natural" role as child rearers and homemakers', Moscucci writes (2003: 171). The intersections of class, gender and (to a lesser extent) race will be emphasised throughout this thesis, for the historical entanglement of natural birth and middle-classness suggests that the 'good' and 'responsible' mother, who is performed through natural birth, will be a white, middle class one.

Dick-Read's ideas were developed in his second book *Childbirth Without Fear* (1942). Whilst his ideas did not gain acceptance amongst the medical community, they found a popular audience. In 1956, Prunella Briance placed adverts in *The Times* and the *Daily Telegraph,* seeking other women interested in the ideas of Dick-Read to establish an organisation for the promotion of 'natural' birth.[28] This marked the beginning of the 'Natural Childbirth Association' which later became the National Childbirth Trust (NCT).[29] The initial campaign 'associated natural childbirth with such values as religious morality, improving the race, reinforcing family life and re-establishing the Empire' (Moscucci 2003: 171). The NCT has distanced itself from such conservative views and current teachers and clients are often not aware of this controversial history. Some elements of natural birth remain consistent however, not least the idea that natural is best and that this is, for various reasons which will be discussed throughout this thesis, a decidedly middle class concern.

### *Second Wave Feminism and the Reclamation of the Natural*

During the 1970s, the concept of 'natural childbirth' was reclaimed by feminists and was reinterpreted away from an inherently anti-feminist concept to one which challenged male, medical authority and control over women's bodies. As Bristow (2013: np) notes, 'The translation of the natural birth movement into a feminist cause in the 1970s was indeed remarkable, given its essentialist roots'. Moscucci (2003: 172) suggests that this is because

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[28] Briance discovered the ideas of Dick-Read when pregnant with her second child. She suffered a still-birth with this child and was convinced that this was 'the result of mishandling by medical staff during the labour' (Moorhead 1996: 2).

[29] The Association for Improvements in the Maternity Services (AIMS) was similarly established a few years later, in 1960, when founder and president, Sally Willington, 'wrote to a national newspaper describing her distressing antenatal and birth experience'. https://aims.org.uk

ideas of natural childbirth have not been static over time but are ‘at bottom a tool for thinking about the state of health and illness in society in general’. The category of the ‘natural’ took on new meanings in the counter-culture of the 1960s and 1970s, albeit drawing on the longer legacy outlined earlier in this chapter.

White second wave feminists such as Betty Friedan (1963), Adrienne Rich (1976), Barbara Katz Rothman (1982) and Arlie Hochschild (1983) in the USA and Ann Oakley (1974) in the UK, drew on the earlier work of Simone de Beauvoir (1949) who argued that the socio-cultural constructions of women’s embodied reproductive roles of menstruation, pregnancy and lactation tied them to the domestic and private sphere, entailing that they have been considered ‘other’ and the ‘second sex’ in patriarchal western societies. Second wave feminism was influenced by, and contributed to, numerous areas of societal change from the 1960s onwards including the emergent environmental movement (for example, Rachel Carson’s *Silent Spring* 1962) and the sexual liberation movement (beginning with the arrival of the contraceptive pill onto the market in 1960). However, it had a more complex relationship with the civil rights movement in America, following the uneasy relationship that black and white feminists had during first wave feminism. From its inception in the 1960s, second wave feminism was critiqued by black feminists and women of colour in the USA. Black feminists, including the contributors to Toni Cade Bambara’s edited collection *The Black Woman* (1970), those involved in the Combahee River Collective (1977), Angela Davis (1981), bell hooks (1981, 1984), Audre Lorde (1984) and Patricia Hill Collins (1986, 1989), argued that second wave feminism was a white middle-class perspective which ignored the life experiences of poor black women. hooks (1981: 14) suggests that black women were not initially involved in the women’s movement of the 1960s as race was considered ‘the only relevant label of identification’; unlike black female activists of the 19th century, such as Sojourner Truth, who emphasised the interconnectedness of race and gender in lived experience. Both 19th and 20th century black activists recognised, however, that black women were ‘dually victimised by racist and sexist oppression’ (hooks 1981: 20). They were made invisible in both anti-racist movements, where black men predominated, and feminist movements, where white women predominated; they were ‘marginalized in both arenas’ (Collins 1986: 15). Both black men and white women ‘can act as oppressor or be oppressed’; they have both ‘led liberation movements that favour their interests and support the continued oppression of

other groups' (hooks 1984: 16). Black women, on the other hand, have no '"other" that we can exploit or oppress' (hooks 1984: 16). Collins (1986: 20) describes this situation in which black women have been 'assigned the inferior half of several dualities, and this placement has been central to their continued domination'. hooks (1981: 28) writes of her 'disturbance' with 'white women's liberationists' insistence that race and sex were two separate issues', as her 'life experience' had shown that the 'two issues were inseparable'. She suggests (1981: 24) that because of these issues, black female activists either allied themselves to the black patriarchy or began their own black feminist groups. The focus of black feminist groups was hence on the inseparability of race, class, gender and sexuality.

In a later work, *Feminist Theory: From Margin to Center*, hooks (1984: 2) argues that white second wave feminism, represented in the work of Friedan, was concerned only with the 'specific problems and dilemmas of leisure-class white housewives'. White feminists attempts to universalise their experiences to the lives of all women was further evidence of their race and class privilege. Their prioritising of gender reflected a lack of understanding of issues of race and class (hooks 1984: 15). hooks suggests that the privileged position of being able to employ black domestic workers allowed white feminists of the 1960s to pursue women's liberation in the form of equal careers with men, including in academia. She writes (1984: 2) that Friedan neglected the fact that around one-third of women were already in the work place and Collins (1986: 14) notes that 'In 1940, almost 60 per cent of employed Afro-American women were domestics'. Ula Taylor (1998: 249) explains that 'The economic realities of most African American women dictated that they had to work outside the home. And her underpaid, too often exploited labour power provided the means to liberate White women'.

The life experiences of poor and black women were ignored in white, middle-class women's calls for equal access to 'careers'. Their writings thus say nothing of the experiences of poor women who have to work from economic necessity and the familial relations this then entails. The American stereotype of the black 'mammy', who has a loving relationship with her white employers children but does not have time to care for her own, initially went unchallenged in feminist writings. Further stereotypes confounded issues of race, class, gender and sexuality, such as the figure of 'Sapphire', the angry black wife, or 'Jezebel', the promiscuous, sexual black woman. Stereotypes of black women,

dating from the slavery era's simultaneous use of and fear of black people's sexuality, portrayed them as either asexual, strong mothers or as sexually promiscuous, dangerous and hence in need of social control, including through restricted access to reproductive health care. Such stereotypes were 'distorted renderings of those aspects of Black female behaviour seen as most threatening to white patriarchy' (Collins 1986: 17).

The primary concerns of white and black feminists in the 1960s and 1970s were hence different. White second wave feminisms were engaged in the critique of patriarchal religions, whereas black feminists found support in their churches (Collins 1989: 762). White feminist critics of religion included women who called for a rejection of all religious traditions as inherently patriarchal; women who sought to remain within Abrahamic traditions but reinterpreted them in a quest for gender equality (such as Mary Daly 1974, Rosemary Radford Ruether 1974); and those who developed the Goddess Spirituality movement which sought to sacralise that which had been profaned in Abrahamic traditions, including the female body, bodily fluids, sex and women's capacity to birth and lactate (such as Griffin 1978, Daly 1979, Christ and Plaskow 1979, Starhawk 1979). The last movement in particular, as part of the 'radical feminism' within the second wave movement, celebrated a particular interpretation of the natural as a sacred form; women's bodies as part of 'nature' were inherently seen as sacred and powerful. It was radical feminism which focused on the celebration of women's bodies as different from men's, as capable of birthing without male assistance, and as a source of empowerment, which was to have the most direct impact on midwifery and on women's understandings of pregnancy and birth.

Radical feminists argued that the patriarchal system had created a situation in which gender was defined by the pre-existing category of sex, which meant that women were primarily defined - and oppressed - by their embodied experiences, especially around reproduction. Responses then were either to reject the reproductive role or to reclaim it as a natural and empowering process which had been taken over by patriarchy. The second response became the focus of the white women's health movement, epitomised in The Boston Women's Health Book Collective and their book, *Our Bodies Ourselves*, published in 1971 in America and 1978 in the UK. This claimed that the medical profession was part of the patriarchal system which sought to control and oppress women by regulating their

bodies, by reconstructing natural processes as health problems which needed surveillance and treatment. Women should take back responsibility for their own health, it suggested, leading to an empowered position. The natural birth movement and especially radical midwifery which developed at this time, supported these views. Groups such as the Association of Radical Midwives founded in 1976,[30] critiqued medicalised birth as being integral to the patriarchal system, as a means of oppressing women by taking away their ability to give birth themselves through limiting their movement whilst in labour and through the use of instruments and drugs. This denied women the possibility of a potentially empowering experience, it was argued.

Whilst black feminists shared concerns with the white women's health movement, especially around access to abortion and contraception, the issues of race and class added further dimensions. Black feminists in the USA, most notably Dorothy Roberts (1997), articulated their experiences of 'reproductive oppression' stemming from the historical legacy of slavery in which they had no legal control over their own bodies, including their reproductive capacity, making them targets for experiments in the newly-developed field of gynaecology and, later, contraception (Ross 2017: 289). Oppression continued during segregation in the form of restriction of access to health and reproductive care for black women. Prohibited from attending white medical centres, black women in the American South relied on black 'granny' midwives for their reproductive health care, until they were outlawed in the 1950s-70s (Ross 2017: 289). Once they could access white medical services, post-civil rights, black women still found their rights and options curtailed by their economic positions and the general culture of white supremacy in which black bodies were criminalised. Black women in the American prison system, for instance, have experienced forced abortions and sterilisations (Ross 2017: 294-5), as have Native American women. Loretta J. Ross (2017: 299) describes the process in which 'coercive reproductive policies signal the government's transition from overt sterilization before the 1980s into covert and coercive policies' into the present. Such concerns led to the mobilisation of black women's health organisations in the early 1980s, including the National Black Women's Health Project, which later became Black Women's Health Imperative.[31] Such organisations sought to address the inequality of white and black

[30] Known as ARM - the same acronym as used for 'Artificial Rupture of Membranes', a popular means of speeding labour.

[31] https://www.bwhi.org/

women's health outcomes, rather than focusing on the more specific concerns of some white feminists, such as approaches to birth.

In the early 1990s, black feminists working within health and social justice movements coined the term ‘reproductive justice’, incorporating both a theory and praxis, to address the ‘intersectional oppressions of white supremacy, misogyny, and neoliberalism’ (Ross 2017: 290). Reproductive justice combines reproductive rights with social justice in order to expose the structural and economic constraints on women of colour to either have or not have children and on how to parent (Ross and Solinger 2017: 9). Reproductive justice activists ‘scrutinize all public policies to comprehensively analyze systemic reproductive restraints to consider unexpected connections that affect childbearing and parenting’, including issues of immigration, criminalization, racial profiling, the welfare system, educational opportunities and more (Ross 2017: 292). It hence posits itself as a wider movement than that of ‘pro-choice’ which is concerned primarily with abortion rights. Reproductive justice recognises ‘that the control, regulation, and stigmatization of female fertility, bodies, and sexuality are connected to the regulation of communities that are themselves based on race, class, gender, sexuality, and nationality’ (Silliman et al. 2004: 4). The notion of choice, so central to the white women's health movement and natural birth in particular, is here complicated through an emphasis on ‘the constraints within which women of color navigate their reproductive lives and organizing’ (Silliman et al. 2004: 5). Reproductive justice writers emphasise that the right not to have children is inextricably linked to the right to have children (Silliman et al. 2004: 4). They seek to expose ‘coercive population control’, both in explicit forms, such as sterilization programmes prior to the 1980s, or more implicit forms such as the curtailing of women's fertility through economic policies - family caps on public benefits being one such example (Silliman et al. 2004: 8). For women of colour, who are not granted the neoliberal tradition of rights, the choice of whether or not to have a child, let alone how to birth that child, is not so straightforward as for the privileged white women who are the focus of this thesis. Silliman et al. (2004: 11) suggest that white health activists ‘have been unable to see how what may be reproductive freedom for them is reproductive tyranny for others’. Reproductive justice posits the granting of full human rights to black women as its goal. It is only a human rights framework which can bridge the gap between legal rights and the economic resources needed to access them (Silliman et al. 2004: 17). It is only a human rights framework

which can allow for ‘safe and dignified fertility management, childbirth, and parenting’ (Ross and Solinger 2017: 10). The movement of health organisations, both black and white, towards a human rights framework, will be discussed further in Chapter Five.

Many white pregnant and birthing women in western societies in the 1970s and 80s were caught in a situation in which they held second wave feminist ideals (as well as perhaps those of environmental concern and progressive spiritualities) and yet had no autonomy or dignity as soon as they entered the hospital to birth. As a result, these decades were the time of the greatest polarisation between medical and natural models of childbirth. UK government policy stated that all women should birth in hospitals, which simultaneously introduced more and more routine medical interventions from shaving, enemas and episiotomies as standard for all births to an increase in induction and instrumental deliveries. All women were expected to desire pharmaceutical pain relief and, by 1970, 97 per cent of women in the UK were using analgesia (Moorhead 1996: 34). Ultrasounds and antenatal testing such as blood screening were becoming more and more routine making the foetus, rather than the mother, the focus of pregnancy. And yet this situation was increasingly challenged by radical feminists, consumer groups and by the numerous natural birth teachers active at this time.

In the UK, the NCT took on board radical feminist ideas, teaching them to individual women in antenatal classes and campaigning on government policies which contradicted them, campaigning for home births and against induction, for instance (Moorhead 1996: 52). Influential teachers and authors of the 1970s and 80s (some of whom will be discussed further below) include NCT board member and anthropologist Sheila Kitzinger; her student and fellow NCT teacher, Janet Balaskas; Frederick Leboyer; and Michel Odent. Balaskas pioneered the Active Birth Movement in the 1980s, encouraging women to be active and upright for labour and to practice yoga during pregnancy. Later in the 1980s, she pioneered the practice of water birth in the UK, already popularised in France by Odent. She found an ally in fellow South African, obstetrician Yehudi Gordon, who allowed women taught by Balaskas to practice Active Birth at the Royal Free Hospital in London where he was based. The hospital authorities however banned the practice in 1981, and Balaskas and Gordon, with the help of Kitzinger, Odent and the NCT, organised a public protest on London’s Hampstead Heath. Five thousand people attended and the practice was

reinstated. Joanna Moorhead (1996: 73) states that this was the first such large scale public protest in the UK which 'united women and midwives in a common cause'. It was not the last public event which this group of natural birth pioneers was to organise. In 1982, Balaskas organised an Active Birth conference which attracted three thousand people (Moorhead 1996: 73) and in 1987, Balaskas, Kitzinger, Beverley Beech of AIMS and Melody Weig of Independent Midwives UK, organised the 'International Home Birth Conference' in Wembley which attracted two thousand participants from seventeen countries (Moorhead 1996: 79).[32]

The 1970s hence saw an explosion of natural birth teachers, with their associated books and programmes, and they remain some of the most influential teachers today. As they form the basis of my fieldwork, both in terms of the classes I observed, and the books which my participants read, it is worth discussing them at some length in this introductory chapter. It is also worth noting that amongst natural birth practitioners, there exist variations in the degree to which the ideas and practices of natural birth are explicitly linked to a religious position. Variations can also be found in the extent to which the natural is explicitly linked to a wider, ecological lifestyle with its underlying ideas of salvation of self and society. Some natural birth authors and practitioners link natural birth with a move towards 'living lightly on the earth'; others frame natural birth as an existential question, a consideration of the legacy passed on to future generations.

The first position is most associated with the teachings of Californian 'spiritual midwife', yoga teacher and environmental activist, Jeannine Parvati Baker (d. 2005), who coined the term 'birthkeeper' in order to express the idea of healing the Earth through healing birth. She described herself as 'a spiritual midwife whose main tools are my faith in the naturalness of birth, my healing hands and word medicine'.[33] She is also widely attributed with popularising the practice of 'freebirth' in the USA, that is birthing without any form of medical assistance, based on the idea that medical assistance in the most intimate and

[32] Other public protests have included those in support of female obstetrician, Wendy Savage, suspended from practice in 1985 for alleged incompetence in five caesarean cases but championed as upholding women's rights by refusing to perform caesarean's too early; the 2010 'Reclaiming Birth Rally' in support of the Albany Midwifery Practice whose contract was terminated by King's College Hospital NHS Foundation Trust on grounds of 'patient safety', which the practice contested; and the 2013 rally in support for Independent Midwives, which I attended as part of the research for this thesis.

[33] http://www.yoni.com/motherf/handsthatheal.shtml

sexual event of birth is a form of violence.[34] She argued that birth is a natural and spiritual rite of passage which should be a 'conscious' journey undertaken by the couple, from pre-conception to conception, pregnancy, birth and beyond. This teaching was described as both a 'journey to the sources of healing' and an unlearning of the dominant technocratic model of birth.

Parvati Baker began her birth teachings in the mid-1970s and was active until her death in 2005. Her ideas have been taken up by many other midwives and birth practitioners around the world, particularly amongst those who describe themselves as 'spiritual' or 'shamanic' practitioners, such as independent midwife, Emily Fuller, in the UK[35] and Veronika Robinson, founder of the Mother Magazine. Robinson has written, 'The Mother magazine is well-known as a supporter of vaginal birth, free from the hands of obstetricians and doctors. We believe babies should be born, not delivered. Peace on Earth begins at birth'.[36] Jane Hardwicke Collings, is an Australian midwife who has founded the School of Shamanic Womancraft, based on a philosophy of understanding and appreciating 'the interconnectedness of all life' and a belief 'that by reclaiming the power, magic and healing potential of the cycles of Nature, a renewed sense of balance and wellbeing can be restored to the Earth and her people'.[37] Like Parvati Baker, one of her mentors, she links 'healing birth and healing the Earth'.[38]

A more common position taken within the natural birth milieu is to frame the issue of natural birth as a legacy for future generations. This is a position taken either explicitly or more implicitly by some of the natural birth 'pioneers' including Grantly Dick-Read, Michel Odent, Ina May Gaskin and Janet Balaskas, as well as more recent teachers such as Marie Mongan (1989, 1992, 2009), Gowri Motha (2004) and Katherine Graves (2012).

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[34] She actually defines free birth as 'a delivery free of MANipulation and medical control' (capitalisation in the original). http://www.yoni.com/motherf/handsthatheal.shtml

[35] http://www.thefullermidwife.com/about--testimonials.html

[36] https://veronikarobinson.com

[37] http://schoolofshamanicwomancraft.com/vision-statement/

[38] Whilst Parvati Baker was not mentioned by my research participants, one woman was in touch with the School of Shamanic Midwifery, as it was then called. Amy, an older mother of a 2 year old son, sought advice from them on facing her birth fears - see Chapter Six for a description. But, like my other research participants, she did not connect these practices with a wider position of 'living lightly on the earth'.

Within the writings of these authors, the natural is interpreted in different ways. Ina May Gaskin, author of *Spiritual Midwifery* (1975), is another natural birth proponent whose understanding of the natural has a religious element. Ina May and her partner Stephen founded the spiritual intentional community, The Farm, in Tennessee in 1971. Natural birth was, and remains, a major teaching of the community. The Farm Midwifery Center, run by members of the community who are qualified midwives, claims to teach 'the art and science of spiritual midwifery'[39] and holds workshops open to those outside the community. For the Gaskins, natural birth was one of the foundational concepts of their community, in the belief that the form of birth they practiced - at home and with the loving couple as the focus - would create a happier, healthier, more 'sane' society. As Dick-Read's writings essentialised the mother, Ina May's (as she is referred to by her followers) essentialised the heteronormative couple. Spiritual midwifery was developed at a time when fathers were not present for births in hospital and its key argument is that the couple should birth the baby together by using the same 'love energy' that created the baby, including kissing, hugging and fondling throughout labour. *Spiritual Midwifery,* comprised mostly of women's testimonies of happy and successful births at The Farm, uses the language of 1970s spirituality, with claims that birth was 'psychedelic', 'telepathic', 'tantric' and more. But it also includes admonitions to birthing women from the Farm midwives to be more loving to their husbands and to not make a fuss. The key component of the Gaskins' ideal of natural birth is hence the heteronormative couple, an aspect which was neglected when my research participants referenced her work.

The Gaskins and other authors frame natural birth as an existential question, a consideration of the legacy that should be passed on to future generations, as evidenced in the Gaskin's creation of a community in which to live out their teachings. They argue that how a woman gives birth is significant for future generations and hence for civilisation itself. If babies are not birthed in the family context, with the release of natural hormones, in joy and free from pain, and instead the mother and baby are drugged, are scared and disempowered, they cannot bond and there is potential for long term damage. This position is perhaps most associated with the work of French obstetrician, Michel Odent. Having worked in and managed maternity units in French hospitals from the early 1960s to the mid 1980s, Odent became interested in the impact of the birthing environment on women's

[39] http://midwiferyworkshops.org

birthing experiences and outcomes, particularly in relation to their ability to release the 'love hormone', oxytocin. In over 15 books published in English since the 1980s, Odent argues that the natural release - or not - of oxytocin by a mother whilst giving birth has an impact on the child's long term physical and mental health, and hence on her children's children and so on into future generations. He has established the Primal Health Research Database[40] which 'specialises in studies that explore correlations between what happens during the primal period (fetal life, the perinatal period and the year following birth) and what happens later on in life in terms of health and personality traits' (Odent 2011: 9).[41] He argues that the long term effects of the use of synthetic oxytocin, one of the most common medical interventions in childbirth, are not known and could potentially have a damaging effect on the health of later generations. In *Childbirth in the Age of Plastics* (2011), he asks 'Is the capacity to effectively release oxytocin depleted from generation to generation, as a result of several aspects of modern life, particularly medicalised birth? This is a vital question for the future of civilisation, since the oxytocin system is involved in sociability, capacity to love, and potential for aggression' (2011: 4-5).

Odent (2011: 110) concludes *Childbirth in the Age of Plastics* with an epilogue called 'Childbirth in the Land of Utopia' in which women give birth 'thanks to the release of a "cocktail of love hormones"', without the need for assisted deliveries and with lower rates of c-section.[42] For Odent then, it is the birth environment which is crucial in a 'natural' birth. Natural childbirth is one in which the birth environment is optimal for the release of oxytocin, including a dark, intimate room, with few people present - just a midwife knitting in the corner so as not to disturb the birthing woman and, controversially in the contemporary period, the father not present. Odent is also credited with other foundational natural birth ideals such as water birth and skin-to-skin bonding between mother and baby immediately after birth. Whilst Odent is considered by many proponents to be a pioneer of natural birth, including by many of my research participants, he actually has a rather

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[40] www.primalhealthresearch.com

[41] It should be noted that I am not interested here in the 'truth' - or falsity - of Odent's argument - indeed I am not qualified to analyse the medical data. I am interested purely in his arguments as ideology and in how they are taken up by proponents of natural birth.

[42] Odent argues that the pre-labour elective caesarean is an incredibly safe operation and should always be the choice over a long, drawn-out vaginal delivery which ends in medical assistance in the form of a ventouse or forceps delivery. These latter forms of childbirth have the highest indicators for long term damage to the health of mother and child, he argues.

ambiguous relation to any form of organised 'natural birth movement' arguing that it misunderstands some of the medical data. And whilst he has written the foreword to the 2004 edition of *Childbirth Without Fear*, in which he states that if Dick-Read's ideas had been accepted in the 1940s, 'there would have been a different history of childbirth' (Odent 2004: vii), the Spiritual Midwifery and Hypnobirthing ideal of the heteronormative couple at the centre of birth, does not fit with his own philosophy in which midwifery and birth is a female realm. Nevertheless, Odent's ideas have strongly influenced the natural birth milieu to the extent that his ideas around birth environment form some of its foundational concepts.

Janet Balaskas, founder of Active Birth, uses the term natural birth in her books and classes. Balaskas founded Active Birth as an act of resistance against the increasing medicalisation of birth in the 1970s. The history section of the Active Birth website states that 'When she founded the Active Birth Movement, Janet made it her life's work to spread the message that "nature knows best"'.[43] Balaskas used the term natural birth throughout the two hour class I observed. She stated that whilst we might not get a natural birth, 'we may as well start with what our body knows and that is natural birth'.[44] For Balaskas, a natural birth is an active birth in which the woman is free to move to any position she desires during labour and birth, in which she is empowered and in control and is not 'actively managed' by (male) medical professionals to labour in the lithotomy position, with her feet in stirrups and with such procedures as induction and episiotomy routinely performed. Natural, active birth, is equated with giving birth in an upright position: standing, kneeling, on all fours or, the most ideal position, squatting, which is described as the 'natural, physiological position' (Balaskas 1989: 14) that is used most often throughout history and across cultures. During the class I observed, Balaskas referred to the positions as 'grandmother knowledge', suggesting a timeless, female, embodied knowledge. Practising yoga during pregnancy, Balaskas argues, prepares the body for labour because it is a relearning of natural body positions which contemporary westerners no longer practise because of our sedentary lifestyles. Yoga, and Active Birth itself, is hence a reconnection with our 'natural' past. For Balaskas and other pregnancy yoga teachers, the sacred form of the natural is instantiated in the pregnant and birthing body.

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[43] http://activebirthcentre.com/janet-balaskas-story-active-birth-movement/

[44] Quotation from field notes.

Hypnobirthing is another natural birth programme which draws on the philosophy of Grantly Dick-Read. Hypnobirthing was pioneered by the American hypnotherapist Marie Mongan (known as Mickey), whose book *Hypnobirthing: A Celebration of Life* was first published in 1989. The Hypnobirthing Institute was founded the same year. Mongan (2009: xi) describes Hypnobirthing as a programme of 'natural birthing' and as a 'rebirth' of a philosophy of birth which existed thousands of years ago and was 'captured' by Grantly Dick-Read who, according to Mongan, is a 'prophet' who 'returned to women their rightful gift of truly natural childbirth'. She describes Hypnobirthing as a 'celebration' of childbirth and as a 'natural expression of life'. Mongan follows Dick-Read's teaching in arguing that the Fear Tension Pain syndrome is a barrier to a 'good' birth. Hypnobirthing seeks to eradicate fear through a positive birthing philosophy and through a set of skills which can reduce pain by helping the woman stay calm and focused and hence allowing 'natural birthing instincts' to take over. A key aspect of the teachings is creating a positive mindset towards pregnancy and birth by reframing the language of birth; medical terms such as contractions, pushing, waters breaking and dilation are all rejected and replaced with 'softer' terms such as surges, nudging and membranes releasing. Not listening to any negative birth stories or watching television programmes which show birth in a highly medicalised and potentially frightening context is recommended.

Hypnobirthing makes numerous references to 'natural birthing instincts' and 'letting go' and 'allowing the body to take over'. However, it is primarily a 'mind over matter' approach with its focus on techniques for self-improvement, especially through positive affirmations and visualisations, and its teachings around releasing fears and negative thoughts and emotions before birth. The aim of the teachings is to create a calm state of mind in order to let the body take over and birth the baby; but the birthing woman can only be calm if she has learnt and practised the Hypnobirthing techniques, it is suggested.[45]

Hypnobirthing encourages a dichotomous view in drawing on the foundational concept of a history of medicalised birth in which authority and power are claimed to have been taken away from birthing women and midwives by the male medical profession. It claims

[45] The practices of Hypnobirthing, and indeed the concept of practice itself, will be further discussed throughout the thesis.

authenticity through age, through claims of a return to teaching childbirth as it should be, or as it has been practiced throughout time. There are some religious elements to Mongan's teaching, not least because she claims that Hypnobirthing engages with the 'emotional and spiritual needs of birthing women' (Mongan 2009: xii). Mongan accepts Dick-Read's view of the history of birth in relation to control by the Church through the Church's definition of labour. In *HypnoBirthing* (2009) she makes brief reference to God as the creator of the process of birth and of women's bodies and their design to birth, but she makes many more references to Nature as designer or creator. Mongan (2009: 159) also accepts Odent's ideas on the importance of the birth environment, writing that 'The birth environment should have the same respect and calm as a place of worship. Great or humble, the decorum and protocol surrounding the birth of each and every baby should be conducted in a manner of reverence'.

Hypnobirthing, NCT and Active Birth, or other forms of pregnancy yoga, remain some of the most popular private antenatal courses in the contemporary UK and were the practices in which my participants were involved. The influence of second wave feminist ideas around women's bodies as natural and as strong and competent to birth remain foundational concepts. However, more recent ideas around patient choice and responsibility can also be seen at play. The NCT is a prime example of a movement which has moved from its origins in promoting 'natural' birth to a consumer organisation which outlines parents' choices. My participants, involved in such groups, were simultaneously influenced by second wave feminist understandings of the 'natural' and the key themes of wider contemporary health care, namely choice and responsibility. It is to the rise of these themes that I now turn.

### *Modern Health, Choice and Responsibility*

Charles Taylor (1989, 1991) has argued that contemporary culture is characterised by a 'subjective turn' in which sources of authority are drawn from within ourselves rather than external sources such as national or religious institutions, or even the family. Taylor maps a change in the sources of moral visions in contemporary western societies, away from a theistic moral source towards 'inner nature' as a moral source. He identifies the rise of 'scientific' and 'technological' understandings of nature and self in the eighteenth century,

as well as the opposition to these understandings propounded by both the Romantic Movement and the philosophy of Deism, as views which have shaped modern western culture and our images of the self and moral ideals (1989: 234). These differing views of nature and self have given rise to three major facets of modern identity, according to Taylor (1989: x): inwardness - 'the sense of ourselves as being with inner depths, and the connected notion that we are "selves"'; the 'affirmation of ordinary life' and; 'the expressivist notion of nature as an inner moral source'.

Paul Heelas and Linda Woodhead (2005: 2-5), following Taylor, propose the 'subjectivitization thesis', arguing that 'the massive subjective turn of modern culture' has become 'the defining cultural development of modern western culture' and can be seen in all areas of life from education, health, work, consumption and leisure. The subjective turn entails a movement away from 'life lived in terms of external or "objective" roles, duties and obligations' (including 'life-as religions') and 'a turn towards life lived by reference to one's own subjective experiences (relational as much as individualistic)' (including 'subjective-life spiritualities') (Heelas and Woodhead 2005: 2). A 'wellbeing culture' encompasses child-centred education and patient-centred healthcare, amongst other things. The holistic milieu, comprised of 'subjective-life spiritualities', is part of this wider culture but is more intensive and is more explicitly spiritual. It caters for those who want to go deeper than the general subjective culture, they argue or, put differently, the wider culture primes some people for entry into the holistic milieu (2005: 83-4 and 88). The most popular activities in both the holistic milieu and the wider culture, Heelas and Woodhead (2005: 89) argue, are yoga, massage, aromatherapy, homeopathy and reflexology, all of which are central to natural approaches to pregnancy and birth. Woodhead (2012b) has argued that it is through the popularity of CAM (Complementary and Alternative Medicine), that religion has re-entered the world of healthcare. Woodhead (2012b: 21) writes that, 'Prior to the advent of the modern state', healing was 'offered chiefly by religious providers'. The creation of the NHS in 1948 largely 'erased' this 'wider programme of social healthcare' provided by religious institutions and volunteers. But the eradication of religion from healthcare was short-lived as the 1970s saw 'an explosion' of CAM practices which, since the turn of the millennium, have been accessed by around a third of the adult UK population. Religion has thus returned 'to healthcare under the market regime', in a move largely driven by 'consumer capitalism' (2012b: 21).

A process comparable to the 'subjective turn' has been noted by Beck and Beck-Gernsheim (1992, 1995, 2002) in their many writings on risk and individualisation. Beck and Beck-Gernsheim argue that contemporary western societies are characterised by the pursuit of 'a life of one's own'. 'The ethic of individual self-fulfilment and achievement is the most powerful current in modern society' (2002: 22). However, they place more emphasis than Taylor and Heelas and Woodhead on the societally constructed sense of moral pressure to fulfil one's potential which is produced through the socio-economic conditions of post-industrial societies. Like these other authors, however, they note that the individualism of contemporary culture is not a self-in-isolation (as some have claimed, such as, Bruce 2002, Carrette and King 2004) but in relationship. Beck and Beck-Gernsheim further suggest that women face the discrepancy between living 'a life of one's own' and 'living live for others', to a greater extent than men, as women are still the primary carers in society - of their families and in paid-employment. Heelas and Woodhead and others (including Houtman and Aupers 2008, Sointu and Woodhead 2008), have drawn on this argument to account for the predominance of women in the holistic milieu. Eeva Sointu and Linda Woodhead (2008: 265) suggest that participation in the holistic milieu goes some way towards resolving the discrepancy as it validates three areas of contemporary femininity: the body and emotions; self-worth and well-being; and intimate relationships.

Beck and Beck-Gernsheim (2002) describe an 'institutionalised individualism' in which we experience this move to individualism collectively. They see potential positive aspects of this form of individualism; 'these new "we" orientations are creating something like a co-operative or altruistic individualism. Thinking of oneself and living for others, once considered a contradiction in terms, is revealed as an internal connection' (2002: 28). However, they also suggest that this reveals how we are 'self-*in*sufficient and increasingly tied to others' (2002: xxi) (emphasis in original). In terms of contemporary understandings of health, a not so positive picture is painted.

The characteristics of the modern self, Beck and Beck-Gernsheim suggest, include the pursuit of an 'elective biography' through constant activity, experiment and reflexivity. This 'goes hand in hand with forms of self-responsibility' (2002: 24). A failed biography - including illness - is a personal failure, contributing to fear, 'even in the externally wealthy

middle layers of society' (2002: 24). Beck and Beck-Gernsheim (2002: 139) propose that 'health' and 'responsibility' are 'two basic values of the individualised society'. In post-industrial societies with competitive labour markets, it is the individual's responsibility to stay fit and healthy in order to participate. Individualism is key to neoliberal healthcare policies in contemporary western societies. Sue McGregor (2001: 84), critiquing such policies, argues that 'neoliberalists eliminate the concept of the public good and the community and replace it with individual and family responsibility'. Beck and Beck-Gernsheim (2002: 141) argue that the modern 'health project' has two linked aspects: health as a 'pressure to perform' and health as 'a secular expectation of salvation'. In secularised societies, they argue (2002: 140), 'health, too, is not so much a gift from God as a task and achievement of the responsible citizen, who must protect and look after it or face the consequences'. Health has acquired 'a new meaning and a higher value' (2002: 141).

Other authors, such as Nikolas Rose (2001), Ilpo Helén (2004), Silja Samerski (2009) and Deborah Lupton (2013), have focused on the ways in which the success and predominance of the biomedical worldview has altered the very 'politics of life itself' (Rose 2001). Rose (2001) traces the history of governmental concern over public health from the 19th century 'neo-hygienist' movement, (which was largely concerned with the moral habits of the poor, as discussed above) and the eugenics movement, which sought to control reproduction. Rose and Samerski both argue that the rise of genetics, and genetic screening in particular, can be seen as part of the legacy of these two 19th century movements, moving from the 'prevention of abnormal people' to 'the creation of products that satisfy individual preferences' (Samerski 2009: 746). Furthermore, they argue that contemporary biomedicine is governed by 'risk politics', by 'control and experimentation' (Helén 2004: 28), and by the prevention of ill health. It is 'formally based on the idea of the moral autonomy of the individual, represented by the principles of informed consent' and choice (Helén 2004: 39). In reality the situation is more complex as the compulsion to choose is a 'new constraint' (Samerski 2009: 742).

Public health focuses in particular on those individuals and groups who are deemed to be at risk of developing certain diseases or falling ill in some way, based on population statistics and genealogy. Pregnant women are particularly targeted through genetic screening

programmes. In the contemporary neoliberal age, the concern for public health has expounded whilst similarly being privatised such that private health care and insurance policies abound, and biotech companies, medical research councils and ethics committees are as powerful as the government in this field. This has created a situation in which the state promotes and governs public health care whilst simultaneously abdicating responsibility 'for securing individuals against the consequences of illness and accident' (Rose 2001: 6). It is the responsibility of each individual, as Beck and Beck-Gernsheim argue, to ensure their optimum health. As Samerski notes (2009: 743), however, 'what can be chosen in reality is not health itself but service options that promise to reduce health risks and enhance future well-being'.

Contemporary biomedicine creates particular power relations and a particular subjectivity, for 'individuals allocated to a high-risk group' must 'conduct their lives under the shadow of medical authority if they are to be "responsible"' (Rose 2001: 11). However, he suggests, this has been internalised by the population. As Deborah Lupton (2013: 146) writes, 'It is clear that many aspects of people's lives are influenced by their awareness of risk and the responsibilities involved with avoiding risks'. Rose (2001: 17) suggests that an alliance has been 'formed between political aspirations for a healthy population and personal aspirations to be well'. The 'personal aspiration to be well' has entailed that the body has become the focus of 'work on the self' (Rose 2001: 18). Rose terms this process as 'ethopolitics' - 'the self-techniques by which human beings should judge themselves and act upon themselves to makes themselves better than they are' (Rose 2001: 18). This understanding of self-cultivation, particularly in relation to genetic testing in pregnancy, will be returned to below. Throughout the thesis I offer a different perspective on self-cultivation, arguing that whilst it might be inescapable it can be framed positively by practitioners as they work on themselves and towards an ideal.

Just as nineteenth century movements linked individual health with salvation, this linkage has continued in contemporary biomedicine. As Meredith McGuire (2008: 136) has written of modern biomedicine, 'health has become a salient model for salvation'. McGuire (2008: 136) argues that biomedicine places a 'strong emphasis on mastery and control over the body' and thus places the onus of responsibility for health on the individual. She writes that 'Contemporary Western societies promote particularly high expectations of individual

health', creating 'the widespread presumption that optimum health is, in principle, achievable' (2008: 136). Optimum health requires the individual to eat right, exercise, manage stress, avoid dangerous activities and consume the appropriate products and services. This view co-exists with an almost contradictory situation in which it has come to be accepted that 'experts are the only appropriate persons to treat all human bodily or emotional experiences' (2008: 136). Health has become linked with ideas of this-worldly salvation, with ideas of the possibility of a life free from illness if lived in the right way - that is aligned with nature's laws in the nineteenth century and through the consumption of the right products and services in the twenty-first century. Within the field of natural birth, a central idea is that mother and baby will be happier and healthier if they birth 'as nature intended'. The onus of responsibility is on the mother to provide this optimum state, not only for herself but also for her child and for the legacy of future generations.

Reflecting these societal changes and the success of consumer groups such as the NCT and the natural birth pioneers discussed above, maternity policy from the 1980s onwards has become more and more 'woman-centred', focused on choice, continuity of care, and a desire to increase women's satisfaction of their pregnancy and birth experiences. In the late 1980s, the NCT began to forge links with the establishment of which it had previously been critical. It developed links first with the Royal College of Midwives and then with the Health Visitors Association (Moorhead 1996: 81). Whilst this could be seen as marking its success as a campaigning group, it also entailed a movement away from its natural birth roots and radical edge to become the UK's largest parenting charity which provides support and information to all parents whatever their birthing, parenting and feeding choices. However, due to the freedom of individual NCT teachers to devise their own courses, there exists variation in the degree to which the natural becomes a normative position in the antenatal classes. It is perhaps this which allows different critics to simultaneously argue that the NCT has lost its natural birth roots (the argument made by some Hypnobirthing teachers in relation to NCT) whilst others argue that the NCT is a clique of natural birthers who pressurise other women into sharing their viewpoint through feelings of guilt and inadequacy (an argument made in opinion pieces in the media from time to time).[46] The NCT plays a major role in influencing government policy. The

[46] For example, https://www.spectator.co.uk/2015/10/new-mothers-deserve-something-better-than-nct-classes/#

Winterton Report of 1992 advocated change in maternity services, placing midwives at the centre of maternity care for the first time in many years, and seeking to improve three 'c's': choice, continuity and control for women. It stated that 'low-risk' women need not see an obstetrician and their care could be managed by midwives. An Expert Maternity Group was established which, in 1993, published a report, *Changing Childbirth*, the recommendations of which became government policy in 1994. Maureen Porter (2000) has written that these changes were consumer-driven, with pressure for the changes coming from the consumer movement (primarily NCT), feminist groups and radical midwives. She writes, 'In its recommendations for *Changing Childbirth*, the British government seems to have been swayed by the predominantly middle class voices of the consumer groups from which it took evidence' (2000: 190). Porter voiced doubt that midwives would be able to manage the policy recommendations due to structural limitations. Bristow (2013) too notes a more insidious side to the move to 'woman-centred care'. She argues that the 'notion of equivalence' between home birth and hospital birth that has emerged from the 1970s onwards, has meant that ideas of the 'superiority' of 'natural childbirth' has become normalised to the extent that women desiring elective caesareans or epidurals are often denied them, and that there are financial motivations behind this. Recommendations for natural birth gloss over 'how much they hurt', she writes (2013: np).

That the 1994 recommendations were not fully implemented is born out in their repetition in subsequent reports and reviews. Subsequent policy papers, such as *Choosing Health* (2004) further substantiated the New Labour policy of prioritisation of 'patient choice' in all aspects of healthcare, not just maternity services. Sarah Holloway and Helena Pimlott-Wilson (2014: 96) argue that the Labour government's time in office (1997-2010) was characterised by a general rhetoric of 'rights and responsibilities'. Charlotte Faircloth (2013) suggests that *Choosing Health* marked a move towards the responsibility of 'informed choice' being placed on the client-consumer. Health became understood 'as something individuals should be enabled to choose, through educational programs facilitating alteration of their behaviour' (Faircloth 2013: 43). She goes on, 'Healthy lifestyles become an expression of engagement with a particular political regime and a form of self-expression for the responsible citizen - a responsibility heightened in the case of mothers charged with maintaining the health of their children' (2013: 43). The 2012/13 *Choice Framework* explained that 'the NHS is changing, to give you more choices about

your healthcare'.[47] Government policy today defines public health as 'about helping people to stay healthy, and protecting them from threats to their health. The government wants everyone to be able to make healthier choices, regardless of their circumstances, and to minimise the risk and impact of illness'.[48] The suggestion is that if people make the correct choices they are more likely to have good health.

*Maternity Matters* (2007) built on the importance of choice suggesting that women should have choice in four areas of maternity care: how to access maternity care; choice of type of antenatal care; choice of place of birth (depending on circumstances); and choice of place of postnatal care. These themes were repeated in *National Maternity Review: Better Births* (2016). Here the emphasis was on 'personal care', on women being able to make their own choices and for these choices to be managed rather than opposed; as well as on 'continuity of carer' with women seeing the same team of four to six midwives throughout their care. However, it also makes clear that with the increased control that women are being offered 'comes a responsibility to accept that personal health and fitness are integral to safe and fulfilling childbearing'.[49] Choice is the recurring theme in the government desire to improve maternity services (and indeed all health services) through increasing women's satisfaction with their experiences. Not only have these promises of choice and continuity of care still not been realised but furthermore, remaining implicit in these reports and reviews is the consequence that with choice comes a burden of responsibility to research and make correct choices, in this case not only for oneself but for one's child. The radical feminist desire for women to reclaim responsibility for their health and their bodies may then have been realised, but it has arguably led to unforeseen anxieties, perceptions of risk, and of a lack of support which women with the necessary social and financial resources seek to remedy through a reliance on the private sector. The importance placed on 'birth workers' and the eroding authority of NHS midwives is a recurring theme in this thesis.

In this section, I have set out the social and cultural context of natural birth. I have traced the origins of birth support from the realm of female midwives governed by churches to

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[47] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216981/2012-13-Choice-Framework.pdf

[48] https://www.gov.uk/government/topics/public-health

[49] https://www.rcm.org.uk/sites/default/files/Maternity%20Review%20Summary%202016.pdf

the increasing medicalisation (and masculinisation) of birth and its professionalisation by both male medical doctors and female midwives in an attempt to provide a viable alternative to that offered by men. I have discussed the promotion of natural birth by male medical doctors in the early twentieth century as the form of birth appropriate to middle-class women who should accept birth and motherhood as their sacred role; to the reclamation of natural birth as an act of female emancipation by second wave feminists. Discussing the writings of natural birth pioneers and contemporary teachers in this context, I suggest that the current ideas of natural birth which my participants described are a result of this legacy as well as of contemporary government policy which emphasises personal choice and responsibility.

Below I argue that some current sociological literature on pregnancy and birth focuses on contemporary government policy and its impact on women to the exclusion of other social forces such as the historical legacy outlined. Some existing literature also excludes individual women's voices. A macro-level focus can hide the importance of lived experiences which include the role of embodied practices, relationships, and morals and values in women's lives. It is these areas which are my focus.

**Critical Perspectives on the Meanings and Significance of Natural Birth**

Having provided an overview of developments in natural birth in a wider social and historical context, it is important to situate this thesis in the context of current academic literature on the meanings and uses of natural birth approaches, as well as on wider forms of contemporary construction of the morally responsible parent (as natural birth is an example of this construction). I argue that whilst there are a number of sensitive accounts of women's decisions around natural birth, attachment parenting and breastfeeding, in general the question of why some women choose natural birth is not adequately addressed in the existing literature. I suggest that some feminist texts which seek to refute second wave, radical feminism, take a 'hermeneutics of suspicion' approach (Ricouer 1970) with the implication that natural birthers are experiencing 'false consciousness' and are doomed to failure and feelings of guilt. Other work, such as that within the new field of parenting culture studies (PCS), has chosen to focus on structures over agency and so does not always focus on individual women's choices and practices. I argue that PCS can be

usefully extended through the inclusion of literature from other disciplines (namely religious studies and anthropology) which has a focus on the role of morals and values, embodied practices and meaningful relationships in individuals' attempts to construct ethical lives. I first describe literature on the construction of the 'natural' as a moral force, not only in birth but in parenting more widely, as well as in spiritual and consumption-based communities. I then turn to a focus on PCS literature and writings from sociology which suggest a hermeneutics of suspicion approach. I end this section with a summary of how my theoretical approach differs from those outlined.

### *The Meaning of the 'Natural' and Existing Studies of Natural Birth*

In this thesis, I complicate the medical-natural dichotomy in order to explore the differences, ambiguities and tensions in understandings of the natural. I draw here on a number of authors who have written about the natural as a moral source and motivating factor with regard to natural birth (Davis-Floyd 1992, Klassen 2001, MacDonald 2007), mothering (Bobel 2002) and breastfeeding (Faircloth 2011, 2013, 2015). These ethnographies provide data which is closest to my own and are of great influence in this thesis, especially in their sensitive analysis of women's lived experiences in order to interrogate what the natural means in their different but related fields of analysis. These authors argue that the natural is inherently connected to a perceived responsibility of choice and to a working on the self.

Both Chris Bobel (2002) and Charlotte Faircloth (2013) describe the 'natural' in natural mothering and extended breastfeeding as an embodied, authoritative force which creates a normative reality and guides choices, creating a commitment to a right way to practice. Natural mothering, with its practices of home birth, extended breastfeeding, alternative medicine, ecologically sound products and homeschooling, is a form of ethical and simple living, Bobel (2002) argues, which is perceived as close to nature and the 'natural' order or state of humanity. The 'paradox' of natural mothering, as in the title of Bobel's book, refers to the fact that the women she studied framed their practices and decisions in a language of choice whilst at the same time suggesting that, as nature is an authoritative force in their lives, they had little choice as to how to parent; natural mothering became the only option as it was revealed as the right way to parent, through the women's embodied, experiential,

self-knowledge. The natural is an authoritative force that is based in the body; it is an embodied knowledge, based on intuition, and was justified by both Bobel's and Faircloth's participants as 'it just feels right'. Faircloth (2011, 2013) identifies three forms of the natural which interplay in women's breastfeeding accounts, and which are similar to understandings of the natural revealed in my interview narratives. These are: ideas of 'evolutionary and ecologically appropriate care', of 'scientifically best' care and as instinctive or intuitive care, captured in the phrase, it just feels 'right in my heart' (2011 and Faircloth et al. 2013: 121). She argues that it is the natural which is 'a moral grounding for action' in breastfeeding accounts, with ideas of the natural drawing on both 'an evolutionary "hominid blueprint" of care, as well as an ecological perspective on social life more broadly' (Faircloth 2015: 1). She argues that women in the UK who practice extended breastfeeding embrace the concept of the natural, seeing it as 'desirable, even mandatory, to "get in touch with nature"' (2015: 1), in a legacy of the Romantic movement outlined above.[50]

Similarly, within the narratives of midwives and clients practising in Ontario, Canada, Margaret MacDonald (2007: 2) argues that nature is one of three 'foundational concepts', along with 'tradition' and 'home', which provide 'cultural weight' in that they 'inform the identities and practices of midwives themselves as well as the embodied experiences of women in their care'. All three foundational concepts are portrayed as either ahistorical or rooted in the past, with timelessness and/or age strategically used to convey authority and authenticity. However, in reality, each is continuously reinterpreted. The natural, MacDonald argues, incorporates other concepts including informed choice, trust in the midwife-client relationship, and emotional or intuitive knowledge, as also described by Bobel and Faircloth. Pamela Klassen (2001) too, in her analysis of American women who choose home birth for religious reasons, argues that references to 'intuition and instinct' figured prominently in women's metaphors of birth. She argues that in contrast to the dominant biomedical metaphor of the birthing woman as machine, the home birthing women she interviewed used primary metaphors of birth as an 'animal act', as activating 'feminine instincts and wisdom' located in their bodies, and as a 'God-designed process' (Klassen 2001: 141). Whilst these metaphors have different interconnections of

[50] Interestingly, she argues that this is not the case in France where, because of the different trajectory of the feminist movement, and the influence of Enlightenment ideals, the natural is 'considered as something to escape, subordinate and resist' (2015: 1).

ideas of nature, the body, power and religious beliefs, Klassen (2001: 170) suggests that the 'natural' is always 'conceived of as an unquestionable good'. She writes that 'understanding the diversity of ways that the word "natural" is used to manifest a birthing ideal shows the power that a desire to be natural holds in guiding women's birthing choices' (2001: 170).

Becky Mansfield (2008) agrees with MacDonald's claim that the 'natural' in natural birth does not simply represent a desire to return to an idealised past, but is rather continuously interpreted in the present. Mansfield argues, through the analysis of popular advice books for pregnant women, that the 'natural' in natural birth is created through specific social practices. Three types of social practices 'allow natural childbirth to be natural': 'activity during birth'; 'preparation before birth'; and 'social support' (Mansfield 2008: 1084). The natural is hence eminently social, she argues. I extend Mansfield's analysis through a focus on women's own reports of birth practices and preparation. Mansfield's focus remains on a literary level, as does Sallie Han's (2013) ethnography of 'ordinary pregnancy' in the contemporary US. Han (2013: 5) focuses on the 'everyday experiences' of an 'ordinary pregnancy', through a focus on the practices of 'reading advice books, talking to the belly, seeing the "baby" at the twenty week sonogram, provisioning the house and nursery, and receiving and giving gifts at baby showers'. Han hence focuses on the themes of literacy and consumption. She uses the idea of pregnancy as a literacy event to focus on women's meaning-making and to move away from the academic focus on the policing of pregnant women (2013: 31). Whilst Han's focus is on pregnancy and not on preparations for a particular birth - natural or otherwise - it has similar intentions to my own. Mansfield and Han's analyses can both be extended through a focus on women's embodied practices and preparations for birth.

Thomson et al.'s *Making Modern Mothers* (2011) focuses on women's birth choices in the contemporary UK context. Whilst it is sensitive to lived experiences it has little focus on embodied practices. It addresses questions of what first-time motherhood means to women in the contemporary UK, how it changes their identities, and how this differs according to age, including intergenerational chains within the same families (2011: 283). Thomson et al. (2011: 13) argue that age is a key distinguishing feature of contemporary motherhood with mothers falling into one of three categories which share similarities of ideas,

behaviour and taste: young mothers (aged under 25), who discussed motherhood as the end of their own childhood; a middle group (aged 25-34, the most common age for first time motherhood), who discussed motherhood in terms of 'effective biographical planning'; and older mothers (aged over 35), who discussed motherhood as 'the last gasp of fertility'. Information, services and products - the 'cultural discourses' of birth - are geared towards the middle group, the authors argue, with the younger and older mothers sometimes feeling excluded from services. My informants fall across the middle and older categories of motherhood, bearing in mind that they were not all first time mothers, and are united more in their critique of the medicalisation of pregnancy and birth than in their age. Whilst *Making Modern Mothers* provides insightful analysis of narratives of conception, embodied experiences of pregnancy at work and commodities, amongst other things, I also find it lacking in several respects. Thomson et al. (2011: 241) argue that 'Regardless of age, women tended to aspire to a birth that was "as natural as possible"', but do not adequately explore what this means to the women in their sample, nor how they make preparations for this form of birth. Indeed, their focus on birth preparation is restricted to cognitive activities, on 'information gathering' through books, magazines and websites. Whilst I certainly agree with, and build upon their statement, that 'Engaging with experts, taking advice and building a personal knowledge base can be seen as part of the work of motherhood' (2011: 16), I argue that cognitive work, or training of the mind, forms only one half of the preparation for birth in which women interested in natural birth engage. Thomson et al. make no mention of physical preparations for birth in the form of antenatal classes attended, exercise and diet, for instance, and the importance of the 'training of the body' is something I emphasise in this thesis. I argue that a more holistic analysis of birth preparation can shed deeper light on the meanings of natural birth practices to women in the contemporary UK.

There has not yet been an in-depth study of why many women in the contemporary UK desire a natural birth and how they engage in preparations for such a birth. I certainly agree with Thomson et al. (2011: 244) that many first time mother's 'anticipatory accounts of birth planning were characterised by flexibility and uncertainty', although less so with their statement that risk awareness led to 'a willingness to entrust one's own safety and that of the child to the "experts"' (2011: 244). My thesis, in contrast to Thomson et al. (2011), includes both first-time and second or subsequent time mothers. I show that whilst the

narratives of first-time mothers are often characterised by 'flexibility and uncertainty', this is less the case for second-time mothers who have the advantage of embodied experience and so, amongst the women I interviewed at least, have a stronger commitment to an 'ideal' natural birth. But even amongst the first-time mothers in my sample who had participated in antenatal education such as Hypnobirthing, there was a reluctance to consider the medical establishment as always the 'experts' in mother and baby's safety, characterised by the rejection of some recommended medical procedures.

An adherence to an 'ideal' of natural birth amongst my sample is a point of difference to Thomson et al.'s. It is also a point of difference to the work of Kirstie Coxon (2012, 2013, 2015), who has written numerous articles on women's intended places of birth using data from the Birthplace in England Research Programme.[51] Coxon and colleagues have analysed why around 90 per cent of women in the contemporary UK give birth on labour wards despite alternative places of birth (home birth and midwifery led units) being encouraged in government policy. They argue that this is partly because of the historical association between hospital birth and safety, and 'the heightened perception of risk' (Coxon et al. 2013: 5) in contemporary western societies. They suggest that whilst first-time mothers are more open to the idea of alternative places of birth, those expecting second or subsequent babies tend to favour hospital births (Coxon et al. 2013: 7) and that for the majority of women who favour hospital birth, medical intervention is seen in a positive light. They also argue that women who had a positive birth experience, regardless of place of birth, opt for the same place of birth in future pregnancies (Coxon et al. 2015). However, they do recognise that some women become opposed to hospital births and my data sheds further light on this small aspect of their sample. In contrast to Coxon's findings, some of the women I interviewed progressively moved away from 'mainstream' medical birth throughout their birthing biographies. The inclusion of both first and subsequent-time mothers in my sample, and the close analysis of the construction of difference between births in the interview narratives, provides further insight as to the nature of commitment to natural birth; namely that it is frequently developed in second

[51] 'The Birthplace national cohort study was designed to answer questions about the risks and benefits of giving birth in different settings, focusing in particular on birth outcomes in healthy women with straightforward pregnancies who are at "low risk" of complications'. More information is available on the website https://www.npeu.ox.ac.uk/birthplace.

pregnancies as a marker of difference to the first birth and as a signifier of how birth 'ought to be'.

I also draw on ethnographies of other movements centred around the natural as a moral force, such as modern homesteading in America (Gould 2005) and conscious capitalism (Emerich 2007, 2008, 2011). Interconnections between nature, the self, the body and health are central to these movements. Both Rebecca Kneale Gould and Monica Emerich stress the extent to which an engagement with the natural entails a particular form of working on the self. Gould (2005: 8) explores how homesteaders' constructions of nature are equally constructions of the self, arguing that 'getting close to nature' is often as much about cultivating the self, sometimes in spite of nature. The ritual actions of homesteading[52] serve to construct and maintain the alternative lifestyle through a cultivation of the self which is in relationship to nature. And whilst there are ambiguities and ambivalences in this relationship, 'nature comes to have an authority that is indisputable. "Nature" suggests that new structures of time, work and play are "more appropriate"…. "Nature" dictates that technology is "bad" (or "good") or that certain food, herbs, and physical regimes are "healthy" (because they are "natural")' (Gould 2005: 219).

Similarly, within the 'conscious capitalism' of Lifestyles of Health and Sustainability (LOHAS),[53] which Emerich describes, the discourse surrounding nature and natural is normative and taken-for-granted and yet there is ambiguity surrounding the terms and hence room for different interpretations; from matter as sacred, to nature having its own essence, to nature as wise teacher. Emerich (2008: 6) defines conscious capitalism as a 'spirituality of sustainability' which is underpinned by the understanding of nature as an interlocking whole. At its most basic level, she writes, LOHAS promotes natural as healthy and unnatural as unhealthy. On closer analysis, the term natural refers to 'an ideal state of human and planetary health' (Emerich 2008: 7) and living naturally and sustainably 'has both ordinary and extraordinary meanings and values'; ordinary in its link with consumption and extraordinary in its linkage with ideas of salvation. Neither the ordinary

[52] The concept of ritual actions will be explored further in Chapter Six.

[53] The term LOHAS was coined in 2000 by a media organisation called Natural Business Communications, where Emerich was employed as a research director at the time, 'as a way to link diverse products geared towards holistic health and sustainable living practices', from 'organic foods, energy-efficient appliances, and solar panels, as well as alternative medicine, yoga tapes and eco-tourism' (2007: 2).

link with consumption nor the extraordinary link with salvation are new phenomena, as suggested throughout this chapter. Albanese (1990: 123) states that nineteenth century healing movements found expression not only in individual acts of healing but in 'the life-style injunctions and admonitions that, in effect, formed an ethical system for everyday life - to walk the path of "prevention" that, at least theoretically, led to fewer and fewer celebrations of the ritual of cure'. Similarly, within LOHAS, the only way to 'heal the world' is through interconnectedness and holism in which the three sites of 'the self, the social world and the natural world' (Emerich 2008: 8) are reconnected. The disconnection of the three sites is believed to lead not only to various states of un-health but to 'the erosion of the vital force of existence, a moral and ethical code of how one should be in the world' (Emerich 2008: 8). I consider the practices of natural birth as an ethical path throughout this thesis.

### *Parenting Culture Studies and Intensive Motherhood*

My study of natural birth in the contemporary UK can be situated within the wider debate about contemporary parenting, exemplified in the newly emergent and influential field of 'parenting culture studies' (PCS). PCS, most associated with the work of Ellie Lee, Charlotte Faircloth, Jennie Bristow and Jan Macvarish, who have all been based at the University of Kent at some point in their careers, draws on Frank Furedi's work on 'parental determinism' (2001) and Sharon Hay's work on 'intensive motherhood' (1996) in an interdisciplinary project 'to understand better the roots and trajectory of parental determinism' (Lee et al. 2014: 3). It focuses on the social structures and cultural norms surrounding parenting in the contemporary UK. It intentionally utilises the term 'parenting' over 'mothering' in order to signify both that the work of fathers should not be neglected[54] and that the development of the term parenting as a verb, since the 1950s, has specific connotations of a particular skill set which must be learnt from experts and which is therefore always lacking in some way when engaged in by 'ordinary' parents. PCS provides analysis of the cultural construction of parenting, critiquing it through an emphasis on its negative connotations, its assumption of a deficit. It criticises the situation

[54] Whilst recognising that parenting does in fact remain gendered work with women undertaking a greater proportion than men. In this sense, it has a more critical edge than the move from 'motherhood' (as a patriarchal institution) to 'mothering' (a woman's relationships to her children) amongst feminist authors such as Andrea O'Reilly (2004) following Adrienne Rich (1976).

in contemporary western cultures in which childhood is safer than ever and yet parents are deemed to be both solely responsible and yet inadequate in caring for their children, an idea taken from Frank Furedi's concept of 'parental determinism' outlined in *Paranoid Parenting* (2001). Following Furedi, PCS authors argue that current governmental policy, influenced by both 'risk consciousness' and particular interpretations of neuroscience which argue that parents are responsible for the very core of the child's being, their brain development, and hence of their socioeconomic status as adults, has led to continual surveillance and monitoring of parents. This surveillance is also internalised by parents in their construction of accountability strategies and identity work to legitimate their parenting choices (Lee et al. 2014: 2-3). 'Parental determinism' and its adoption in social policy has changed the act of parenting in recent years, it is argued (Faircloth et al. 2013: 122). Whilst the work of PCS is invaluable in describing the context of parenting in the contemporary UK, its focus on interpretations of policy issues, such as feeding babies, drinking during pregnancy, teenage pregnancy and more, and its political argument that parenting 'should be properly shared by all adults' (Lee et al. 2014: 3) means that a focus on women's embodied, ordinary experiences, and their capacity for creative agency, is not a focus in the more general and theoretical writings of PCS.[55] Work which attends to creative agency and ordinary experiences can add useful nuance to PCS.

Sharon Hays' *The Cultural Contradictions of Motherhood* (1996) was perhaps the first text - and remains one of the most influential - to outline the new and now predominant middle class parenting style of 'intensive motherhood', in which mothers take primary responsibility for child raising and subjugate their own desires to the perceived needs of the child. Hays and subsequent authors (including Faircloth 2013, Lee et al. 2014, Macvarish 2016) argue that intensive motherhood has become the mainstream parenting norm in western societies. The practices of natural birth, partly characterised by participation in private antenatal education programmes, is consistent with intensive motherhood. Women involved in natural birth seek to demonstrate their responsible motherhood through researching their options and acting on them. Natural birth requires a great deal of preparation and practice on the part of the mother in the assertion that natural birth does not always come 'naturally' but, paradoxically, must be learnt through classes,

[55]This, of course, is not true of the ethnographies which form a part of PCS, such as Faircloth's study of breastfeeding practices (2013).

books, videos and online discussions.[56] It is a gendered practice. Writings on intensive motherhood and the subsequent field of parenting culture studies thus form the backdrop to my study.

Hays (1996: x) describes the situation in the USA, which is also applicable to other western societies including the UK, in which the 'contemporary cultural model of socially appropriate mothering takes the form of an ideology of intensive mothering. The ideology of intensive mothering is a gendered model that advises mothers to expend a tremendous amount of time, energy and money in raising their children'. The 'cultural contradictions' are that this 'ideology' has arisen at a time when more mothers are engaged in the work force and so practically have less time and energy to spend with their children; and that most behaviour is guided by a logic of 'self-interested gain', whilst motherhood seems to be guided by 'unselfish nurturing' (Hays 1996: x). Rather than accepting a reduction in time for their children, however, mothers are instead spending more time with their children and 'intensifying' this time in terms of the type and breadth of activities in which they engage together. This can lead to an unworkable and exhausting situation in which the mother's needs and desires are relegated to that of the child's. This situation has become 'naturalised' however, such that intensive motherhood is not subject to any market place 'logic' but is rather deemed to be natural, necessary and even sacred, guided by the 'priceless child' (Hays 1996: 8, drawing on Zelizer 1985). Whilst this situation contributes to the subordination of women, with the ideology of intensive mothering ultimately benefitting 'not only men, but also capitalism and the modern state' (1996: 18), it has arisen in opposition to the logic of capitalism in which everyone is encouraged to be motivated by the selfish pursuit of individualist goals. Intensive mothering, on the other hand, naturalises the sacrifice of the self for an 'other'. Through this work of motherhood, Hays suggests, some mothers find personal fulfilment and a new primary identity.

Numerous authors have built upon Hays' theory. Cameron Lynne Macdonald (2010) for instance, has considered the role of intensive motherhood in mother and nanny/au pair relationships in the USA. She suggests that intensive motherhood guides middle-class American mothers who work full time to the extent that they experience '"blanket

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[56] Whilst the majority of antenatal groups are attended by couples, it is primarily the mother who works towards a particular form of birth through training the mind and body in particular ways. Hence it is mothers who are the focus of this thesis.

accountability", the sense that they are responsible for everything that happens in their children's daily lives, regardless of who provides the actual care' (Macdonald 2010: 13). The paradox of hiring someone to fulfil the role of at-home-mother ('shadow mothers') whilst they also desire to be that mother, translates into micro-management of the nanny or au pair's working lives to the extent that seemingly banal activities, such as television watching and phone use, are monitored and restricted. Furthermore, 'blanket accountability' is gendered; even women working full time still took on more childcare than fathers, in Macdonald's sample. Annette Lareau (2011) has continued a similar line of analysis in *Unequal Childhoods* in which she uses the term 'concerted cultivation' to refer to middle-class parents' efforts to ensure that their children retain class privilege. The cultivation of children's cognitive and social skills through extra-curricular activities; through parent-supervised and structured play; and through parent-child discussions and negotiations, are key to this. Working-class parents, on the other hand, 'facilitate the accomplishment of natural growth' (Lareau 2011: 3) in their children, whereby their children have more free time but much clearer boundaries around adult-child relationships; children are expected to follow adults' directives. Social institutions and professional advice supports 'concerted cultivation' rather than 'natural growth' meaning that middle-class children are socially advantaged through parenting. Furthermore, middle-class parenting techniques are more subject to change, partly in line with professional advice, than working-class techniques which remain more consistent over time, according to Lareau (2011: 4-5).[57]

PCS authors draw on feminist theorists of class such as Lareau (2011), Skeggs (1997, 2003) and Lawler (2005, 2008), who in turn build upon Pierre Bourdieu's writings on class (1984). Bourdieu conceptualised class not simply as a material/ economic state but as a relational one governed by flows of power. Class is characterised by struggle and competition over 'capital' which is not equally distributed and of which there are four forms: economic (such as wealth), cultural (including education), social (networks, group memberships) and symbolic (capital when it becomes legitimated) (Skeggs 2003: 16-17).

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[57] However, Lareau takes some issue with Hays arguing that Hays focuses on attitudes over and above behaviours accounting for her finding of a 'shared commitment to "intensive mothering"'. Lareau argues that the class differences she describes are behaviours. She writes, 'If I looked at attitudes, I saw fewer differences; for example, all exhibited the desire to be a good mother and to have their children grow and thrive. The differences I found, however, were in how parents *enacted* their versions of what it meant to be a good parent' (2011: 386 n5).

Class is hence ‘not a given’ nor static but is rather dynamic, in a state of ‘continual production’ (Skeggs 2003: 3) through the political work of judgement, distinction and moral evaluation. Through this work, group-boundaries are policed and maintained with some necessarily excluded and placed into different classes. ‘Class is always made by and in the interests of those who have access to power’ (Skeggs 2003: 3), who then consider their power and privilege as ‘natural’, ‘legitimate’ and ‘ascribed’ (Skeggs 2003) rather than something that is ‘achieved’ or as an ‘accident of birth’ (Skeggs and Loveday 2012). Class is about the interests of particular groups and about their relationships with others.

Feminist theorists have focused on the embodied and affective dimensions of the lived experience of class, as well as the ambiguities and anxieties this lived experience generates. Skeggs (1997) for instance, has called for a renewed focus on class as ‘a major feature of subjectivity’, as central to self-formation. Lawler (2005: 800) writes of ‘classed subjectivities’, conveying the notion that class is considered ‘a set of personality characteristics’. Class is both a material category and a symbolic one of personal attributes (Lawler 2008: 256). Working-class people, Lawler writes (2005: 800), are othered not through their poverty but through their ‘assumed lack of knowledge and taste’. The middle-classes, on the other hand, have ‘solidified into an identity that has come to silently occupy a “normal” ground’ (Lawler 2008: 247). Middle-class dispositions have become ‘naturalized’ such that ‘middle-class culture’, including ‘intelligence, taste, good childcare practices and so on’, is ‘configured as real culture’ (Lawler 2005: 803). In other words, the middle-classes have appropriated ‘culture’ and its linkages to morality (Lawler 2008: 247).

Feminist theorists of class have tended to focus on working-class people. Skeggs for instance, has focused on the ways in which white working-class women ‘become respectable' (1997) and how working-class people have reinterpreted the notion of respect in New Labour’s Respect Agenda (with Vik Loveday 2012). In both cases, her focus is on how those who are accorded no value reinterpret notions and categories to ascribe alternative systems of value to themselves. The working-class people she studies are ‘constantly aware of the judgements of real and imaginary others’ (1997: 3). However, both Skeggs (2003) and Lawler (2008) have also written of the importance of studying the middle-classes as the category with a predominance of ‘value’ through ‘access and entitlement to resources’ (Skeggs 2003: 25). Lawler (2008: 248) states that it is because of

'this hegemonic centrality, this privileged normality' that 'attention to the middle classes is crucial'. The 'intensive motherhood' practices studied by PCS authors and others can be seen as part of this middle-class culture and hence middle-class women are the focus of this thesis. Themes of judgement and othering of different birth practices are central to natural birth and are discussed in Chapter Four.

Whilst the issue of class is central to much of the work within PCS, the issue of race has, to date, remained more implicit.[58] Authors who became associated with 'critical whiteness studies', such as Ruth Frankenberg (1993) and Vron Ware and Les Back (2001), have argued that race, like class, is a socially constructed category - whiteness is a 'purely relational construct' (Ware and Back 2001: 5). This is not to say that race is not 'real', with 'tangible and complex impacts on individuals' but that it is 'linked to relations of power and processes of struggle, and whose meaning changes over time' (Frankenberg 1993: 11). The category 'whiteness' has gone 'unnamed' and 'unmarked' (Frankenberg 1993: 1) such that it is the unspoken norm, including within academia, much like the category middle-class. This unspokenness 'is itself an effect of its dominance' (Frankenberg 1993: 6). Frankenberg, influenced by the arguments of black feminists critiquing the racism of second wave feminism, sought to name and expose the social construction of whiteness. In *White Women, Race Matters* Frankenberg (1993: 1) considers how 'race shapes white women's lives', arguing that the category 'whiteness' bestows a 'structural advantage of race privilege'. 'To speak of whiteness', she writes (1993: 6), 'is to assign *everyone* a place in the relations of racism' (emphasis in original). It is to understand how the white, western self is constructed in relation to 'a range of cultural and racial Others', in the historical legacy of colonialism (Frankenberg 1993: 17). Ware and Back, in *Out of Whiteness: Color, Politics and Culture*, write that (2001: 2) 'our main aim in writing about whiteness is not to describe it, but to work for its abolition'. They take issue with work that simply exposes the category whiteness without the more radical impulse to 'actively seek to disrupt existing racial frameworks' (2001: 6). Critics such as Kehinde Andrews (2016: 438) have argued, however, that the 'transformative potential' of critical whiteness studies is limited. This is because it is based on the assumption that through the exposure of whiteness, racism can be overcome with rational dialogue. Andrews argues (2016: 435) instead that

[58] This issue will be addressed in a panel at the conference of the Canadian Sociological Association, June 2019: 'What's missing from Parenting Culture Studies? The racial politics of contemporary parenting discourse'.

whiteness is so rooted in the social structure as to be beyond any form of 'rational engagement'. It is a form of 'psychosis', defined by its 'inability to see reality in any way other than the distorted view it creates' (2016: 439). Racism can only be defeated when the social conditions which construct whiteness are destroyed (2016: 446). Furthermore, he suggests (2016: 438) that critical whiteness studies is only a new perspective to those who read mainly white authors and that its impetus is lost when it 'gets incorporated into the neo-liberal architecture of the university'.

These authors emphasise how race is intertwined with other socially constructed categories including class, gender and sexuality - an argument which has been made by black feminists since at least the abolitionist movement of 1830-1865 (Taylor 1998: 235-6). The criticisms of second wave feminism made by black American feminists in the 1970s and 1980s focused on white women's neglect of black women's lived experiences of the interconnection of race, class, gender and sexuality. Black women were oppressed because of their race, their gender and their class as poor (largely domestic) workers. Black feminist arguments also provided the impetus for what became known as 'intersectionality studies'. Patricia Hill Collins and Sirma Bilge (2016: 64 and 81) argue that such studies did not begin with the coining of the term by African-American legal scholar, Kimberlé Crenshaw in 1991, as most academic histories would have it, but rather that the core ideas of intersectionality were developed by black feminists in the 1960s and 1970s, particularly in the work of those involved in the Combahee River Collective (1977). Collins and Bilge (2016: 2) suggest that intersectionality

> is a way of understanding and analyzing the complexity in the world…people's lives and the organization of power in a given society are better understood as being shaped not by a single axis of social division, be it race or gender or class, but by many axes that work together and influence each other.

Intersectionality is the foundational theory of 'reproductive justice', the term coined by black female health activists in the 1990s, to call for equal access to health care for black and minority women in the USA. The statement, 'Black Women on Universal Health Care Reform' (1994), called for 'universal coverage and equal access to health services', 'comprehensiveness' and 'protection from discrimination' (Ross 2017: 306-7). Reproductive justice activists argue that the culture of white supremacy in the USA is built upon, and contributes to, the control of black women's reproductive work. 'Reproductive justice is rooted in the belief that systemic inequality has always shaped people's decision

making around childbearing and parenting, particularly vulnerable women' (Ross 2017: 291). The solution is a human rights framework in which black women gain their full human rights and equality with others. Activists such as Loretta J. Ross take inspiration from the Combahee statement (1977), 'to be recognized as human, levelly human, is enough' (Ross 2017: 287). Black activists in the USA are perhaps unlikely to be engaged in the white, middle-class project of intensive motherhood and natural birth.

As noted throughout this thesis, gender, middle-classness and whiteness are all intertwined in natural birth, both historically and in the contemporary period. Not only are participants predominantly drawn from these categories but natural birth is constructed through difference with others. The implicit racism of second wave feminism remains through both a universalising of women and a romanticisation of 'primitive' peoples. This will be discussed further in Chapter Four.

PCS authors focusing on the UK context have argued that these processes of intensive motherhood and concerted cultivation begin with conception, or sometimes even earlier (as Katharine Dow (2013) notes with regard to women planning parenthood in Scotland). Macvarish (2016), for instance, argues that neuroparenting is a new social policy (albeit based on earlier psychological attachment theories) to create 'good' parents who cognitively and socially stimulate their children in the first few years of life, based on the presumption that the 'first years last forever'. PCS texts point to the social and governmental pressures to perform this form of culturally sanctioned middle-class parenting. UK governmental policies to encourage, or even force, lower-income families to engage in this form of parenting - with no regard for an alternative logic at play in lower-class parenting strategies (Gillies 2007, Lareau 2011, Perrier 2012) - are evidenced in such policies as Sure Start Centres and new parenting courses such as CANparent (Macvarish 2016).[59] Neuroparenting encourages such activities as singing and talking to the baby whilst in utero, and continuing this stimulation of the newborn through other sensory practices such as touch and baby massage. Hypnobirthing and pregnancy yoga techniques

[59] Although Holloway and Pimlott-Wilson (2014) argue that, in their sample at least, lower-class parents did embrace middle-class parenting ideals as aspirational, meaning that there were not significantly different middle and lower-class parenting techniques. They argue for analysis of 'local mothering cultures' alongside analysis of class difference.

of bonding with the baby through talking, touch and mentally communicating are in line with this mode of thinking.

The performance of this predominant middle-class form of parenting demonstrates one is a 'good' and 'responsible' parent. Faircloth (2013) suggests that the internalisation of predominant forms of middle-class parenting as the best and correct way to raise children is evidenced in its use in mothers' 'accountability strategies'. In Faircloth's study (2013), mothers account for their extended breastfeeding practice by claiming that it is simultaneously both 'natural' and 'scientifically' proven to be best for baby, as well as being guided by instinct. They thus argue that they are doing the best and most responsible thing for their child in choosing to breastfeed to 'full term'.[60] Similarly Meredith Nash (2012) argues that through the performance of exercise and maintaining an appropriate weight and body image throughout pregnancy, Australian mothers are demonstrating their 'good' and 'responsible' motherhood. Their 'fit' bodies suggest that they are 'fit' to mother (Nash 2012: 196).

Other authors have expanded PCS by complicating the relationships between 'good', middle-class parenting and the predominance of the academic focus on intensive mothering and concerted cultivation. Tracey Jensen (2013), for instance, has focused on the classed viewing practices of different child raising programmes, such as *Supernanny*, and what this reveals about judgements of 'good' and 'bad' mothering in the contemporary UK. She focuses on how parents interact with pedagogy, examining how the relationship is made meaningful and how this meaning becomes central to identity. She argues that it is through negotiations with pedagogy 'that parents produce versions of themselves as "choosing to become" specific kinds of parents and attach themselves to particular forms of moral value' (Jensen 2013: 51).

Maud Perrier (2012) too has sought to complicate the equation of middle class and 'good' motherhood through a focus on middle-class women's 'ambivalent feelings' about intensive mothering and concerted cultivation. She examines the 'internal struggles doing mothering generated for middle-class mothers' moral selves' (Perrier 2012: 659). She argues that in her sample, only one middle-class mother demonstrated practices which

[60] That is, when the child themselves chooses to stop breastfeeding.

could be considered ‘concerted cultivation’ - that is, scheduling enough extra-curricular enrichment activities to fill all of her child’s free time. Perrier suggests that Lareau’s ‘concerted cultivation’ argument leaves out the ‘moral significance’ of childrearing strategies (2012: 664). I expand this argument further throughout this thesis by suggesting that moral norms, embodied practices and relationships are integral to understanding women’s participation in natural birth as an ethical path and a search for meaning in their pregnancies and births.

Similarly, Thomson et al. in the conclusion to *Making Modern Mothers* (2011: 280), state that they hope their data has presented a ‘more mundane, ambiguous and balanced’ picture than that of ‘disapproving and disappointed grandmothers’, ‘paranoid parents’ and ‘intensive mothering’. They go on to state that, ‘new parenthood is a highly privatising moment where individuals, couples and families see themselves as having heightened responsibility for their destinies’ (2011: 280). This ‘heightened responsibility’ is an inevitable and perhaps constant consequence of bringing new life into the world but, PCS authors argue, is felt more keenly in contemporary western societies than at other times in history.

The political context of neoliberalism, in which individual responsibility is one of the defining characteristics, has contributed to the intensification of a sense of responsibility in the fields of both health and parenting. This is nowhere more evident than in the field of pre-natal genetic testing. Scholars such as Silja Samerski (2009) focusing on Germany, and Ilpo Helén (2004) focusing on Finland, have provided a feminist critique of such genetic testing, arguing that it is an imposition of choice and responsibility which can only produce anxiety. It is an ‘existential responsibility’ which is ‘characterized not by reflexivity but by anxiety’ (Helén 2004: 40). The plethora of antenatal screening programmes which are offered to pregnant women, who must then make their own choices as to which, if any, to have, is not empowering, but rather disabling, Samerski suggests (2009: 735). Helén argues (2004: 38) that women do not only have an ‘opportunity to make a choice’ but are compelled to do so. Personal choice becomes the only way of ‘living these anxieties’ (Helén 2004: 45). The ‘inevitable side effect’ of ‘informed choice’, Samerski suggests (2009: 736), is ‘paralyzing contradictions’, burdening women with ‘impossible decisions’. These impossible decisions can lead to a stasis, she suggests, a sense that one's

fate is already sealed. It changes the pregnant woman's subjectivity from a state of expectation to one of anxiety and foreboding, and it foregrounds the health and well-being of the foetus over that of the mother (Lupton 2012: 160-161). It creates 'risk anxiety' amplified by the knowledge that a risk designation is 'not a diagnosis but a calculated probability' (2009: 740). It can 'predict nothing about an individual woman', but rather places her in a 'statistical category based on one characteristic' (2009: 751). It is for this reason that 'doctors hand decisions over to their patients' (2009: 740). But this new form of self-determination is a 'social engineering technique'; it 'has to be facilitated by experts and mediated by technoscience' and thus 'makes women powerless while holding them responsible' (Samerski 2009: 744). Helén (2004: 30) describes this as an 'ethical split' in which medical authority assumes technical responsibility whilst leaving 'the choice, that is, the ethical responsibility' to individual women. Furthermore, the ability to make informed choices through research partly relies on social and educational capital which is unequal across social classes. This can lead to class-based anxieties, for instance particular middle class anxieties which arise from trying to fulfil expectations of choice and responsibility (Perrier 2012).

The texts discussed above provide useful analysis of the cultural and social situation of pregnancy, birth and parenting in the contemporary UK. However they do not address questions of how this situation translates to or encourages the pursuit of a particular form of natural birth. The processes of self-cultivation which Samerski (2009) and others describe with regard to pre-natal genetic testing are different to those I describe with regard to the pursuit of a particular form of birth. Whilst contemporary neoliberal biomedicine, outlined in this chapter, inevitably forms the context of my study, I focus on the ways in which my participants challenge this culture (for instance, for some, rejecting pre-natal genetic screening, medical authority and hospital care more generally, and prioritising their own embodied experiences and intuition) whilst simultaneously being embedded within it and the possibilities if offers (for example building alternative networks of 'experts' from beyond the 'technical', medical field, independently chosen and paid for). Pregnant women in the UK and other western societies today have no choice but to make their own decisions and embody responsibility; however the women I interviewed framed this self-cultivation positively, placing value on their 'work of birth'. This thesis questions the blanket critique of choice and responsibility offered by some scholars, such as Samerski

(2009), to call for additional perspectives. As Lupton (2013: 147) has argued with regard to the 'reflexivity theory' of writers such as Beck and Giddens, such theories of risk emphasise engagement with expert knowledge whilst downplaying lay knowledge, relationships with other non-experts and embodied experiences. I suggest that whilst we should not reject the general critique of neoliberal biomedicine, we should also be aware of the possibilities it offers for women to build their own communities, support networks and embodied expertise which they perceive as liberating, even whilst we recognise the structural constraints and cultural context around their decision-making.

### *Natural Birth and the Hermeneutics of Suspicion*

Some authors writing on natural birth - and particularly journalists in the mainstream media - interrogate natural birth from a hermeneutics of suspicion approach, in which it is assumed that desire for a natural birth is a form of 'false consciousness', and an unobtainable, unrealistic goal which sets women up to fail and hence is ultimately oppressive. Some PCS authors imply this position. For example, Bristow's 2013 opinion piece on 'the politics of childbirth',[61] begins in support of two recent media articles by science journalist Linda Geddes and anthropologist and TV presenter Alice Roberts respectively, who both voiced 'frustration at the way that women's choice in childbirth tends to be assumed to run in one direction alone - that is, the choice to have less medical intervention, rather than more' (Bristow 2013: np). Bristow implicitly critiques the 'notion of equivalence' between home and hospital birth on which current maternity services stand, stating that 'Health policymakers (were) put on the defensive by the barrage of complaints about obstetric care' throughout the 1970s and 80s. She goes on to write that 'the ideas around "natural childbirth" that were influential in bringing about this situation have also contributed to new restrictions on women's choices during birth and afterwards, and in many ways arguably compromise care'. She cites financial reasons for encouraging home birth and a lack of information and awareness about the pain of childbirth as evidence of this. While there are valid criticisms made of natural birth, the condemnatory tone taken towards its practitioners implicitly here and more explicitly in media articles, does nothing to illuminate why some women desire natural birth *despite* these problematic

[61] Written for the 'Reproductive Review', the journal of the British Pregnancy Advisory Service (BPAS).

elements of which they are aware. Therefore, we have research which has focused on the social and cultural structures which encourage or permit natural birth but little that explores women's agency and lived experiences within this. Furthermore, existing studies often present natural birth as a consistent and coherent ideal with little recognition of the diversity and flexibility within it. They do little to interrogate women's negotiations with this ideal, suggesting that natural birth discourses act upon women in policing and disciplining ways, neglecting the ways in which women engage with an ideal, particularly through embodied practices.

The hermeneutics of suspicion approach is exemplified in the article by Claudia Malacrida and Tiffany Boulton (2013) which I discuss further in Chapter Six. Malacrida and Boulton (2013: 1) suggest that the 'disciplining qualities of both natural and medical discourses about birth and choice' creates 'disjunctures' between women's 'expectations of choosing, planning and achieving as natural a birth as possible, and their lived experiences of births that did not typically go to plan'. Based on interview data with Canadian women and with similar questions to my own (they 'asked women about their reasons for preferring a particular type of birth, their intentions about their birth prior to labour and delivery, their expectations about birth and their actual experiences of birth and choice' (2013: 6)), they nevertheless reached rather different conclusions. Their analysis focuses on the experiences of failure, disappointment, guilt, blame and inadequacy (all terms used within the article) that the women reported when their births had not gone to plan. They suggest that preparing for a particular form of birth, epitomised in the creation of a birth plan, sets women up for failure, largely because of the illusion of choice in the unequal power dynamic of birth. Whilst not disputing the power dynamic or the experiences of the women they interviewed, I suggest that a different theoretical framework can lead to a focus on different issues. Their approach suggests that women's practices are a form of false consciousness which lead to negative consequences for women rather than interrogating whether and how these practices may have some meaningful and constructive role in women's lives. The majority of women I interviewed did not internalise blame in this way, and in the way that is assumed in media accounts of 'failed natural births', instead having much more flexibility in their interpretations, desires and practices around natural birth. I argue that the approach of Malacrida and Boulton and others, neglects women's agency

and creativity in negotiating between the ideal and their own circumstances and considerations, as well as neglecting the meanings to be found in practices.

### *An Alternative Approach to Studying Natural Birth*

I argue that the new field of PCS has opened a much needed debate about parenting with a focus on how structural social and cultural forces have created a situation in which intensive parenting is the cultural norm for middle-class Europeans and Americans and hence the 'ideal' with which most parents, including from other social classes and ethnicities, must engage in some way. Many authors who engage with this approach (Furedi 2001, Lee 2014, Faircloth 2013, Macvarish 2016, Bristow 2013) see this cultural norm as inherently negative: for parents who can never live up to the intensive ideals; for children who are overly protected and constructed as vulnerable and at risk; and for other adults who are seen by both parents and authorities as potential risks to children rather than potential helpers in raising the next generation. This has led to a situation, they argue, in which parenting is privatised, individualised and isolating. Their writing seeks to expose this cultural norm with the aim of disrupting it and bringing parenting back to a wider societal concern, shared by all adults.

Whilst I do not disagree with the analysis of PCS authors or their concern to make parenting easier for all involved, I suggest that some (although by no means all) of their writings miss the potential to analyse how the intensive parenting norm is engaged with by individual parents. Some writings from within sociology (for example, Malacrida and Boulton 2013) can even be characterised as taking a hermeneutics of suspicion approach in which women who desire a natural birth are considered as bound to failure and resultant feelings of guilt. This approach assumes that women's practices are a form of false consciousness which lead to negative consequences for women rather than interrogating whether and how these practices may have some meaningful and constructive role in women's lives.

Whilst my study of natural birth can be included as an example of intensive mothering, I feel that the approach of PCS, with its focus on how structural forces has led to the natural as ideal, tends to portray women seeking a natural birth as automatons who are caught up

in the cultural norm with little individual agency or engagement. PCS neglects the role of values and morals and their associated practices in women's lives. The PCS focus is on the demoralisation of wider society and hence on 'risk management' as the dominant form of morality in our current 'crisis of meaning and morality' (Lee et al. 2014: 14). Whilst I agree with Lee et al.'s (2014: 14) claim that all aspects of parenting now have 'pronounced moralised connotations' which 'generate powerful codes of conduct for behaviour but in a way which places the focus squarely on the individual and their way of life', I argue that we should analyse how people engage with, create and interpret these moralised connotations. This too has been the aim of Perrier (2012: 655) who writes, 'by focusing too much on processes of capital accumulation and transmission, studies of parenting risk simplifying the contradictory effects of these discourses on middle-class parents' subjectivities'. I draw on anthropological work on 'lived ethics' (Lambek 2010, 2015) which emphasises how people try to live ethical and moral lives through engagement with others. Saba Mahmood (2012) in particular, working within this anthropological approach, has emphasised not only the importance of embodied practice in ethical formation but also the lived significance of Islamic piety movements. Like natural birth, Islamic piety movements have been regarded with suspicion as inherently oppressive by western liberal feminists. Mahmood explores the meanings and uses of such movements without reducing women's participation to false consciousness or oppression. It is with similar intentions that I explore participation in natural birth groups. I attempt to develop a more nuanced understanding of women's moral investments in natural birth than that offered by PCS, including a more nuanced theoretical understanding of the significance and uses of moral meaning in social life, drawing in particular on writings on the sacred (Alexander 2003, 2006, 2010, Lynch 2012a, 2012b).

Whilst PCS literature provides useful context of the social and cultural situation surrounding parenting, I argue that by adding a micro-level analysis which draws on a wider literature, we can get closer to understanding why natural birth matters to some women. We can hear individual women's voices in all of their complexity and uncertainty in order to add nuance to the debate around intensive mothering and understand why some women work towards a natural birth. I do not feel that existing sociological literature adequately answers the question of why some women desire a natural birth and my study seeks to go some way towards remedying this.

PCS can be usefully expanded through a micro-level focus on how women actually engage with the ideals of intensive parenting - in my study how and why women prepare for a natural birth. I argue that PCS does not place enough value on the study of women's embodied practices and meaningful relationships (real and imagined). I draw on literature from the study of religion, including writings on lived religion and ritualisation, which has been used to analyse other communities, groups and networks formed around the natural. This work (such as Gould 2005, Emerich 2007, 2008, 2011, Heelas 2008) highlights the importance of the embodied and consumption-based practices that form such communities and groups, and which can be seen as an individual's search for meaning in life. I also draw on anthropological writings on lived ethics (including Mahmood 2012, Lambek 2010, 2015) in order to think about the role of relationships and the 'other' in the pursuit of a meaningful life. Such concerns around embodied practice, relationships and an individual's search for meaning, are not the focus of PCS with its macro-level focus. I hence seek to contribute to the work of PCS by adding this new dimension influenced by wider disciplines; as Lee et al. write, they seek to take a 'genuinely interdisciplinary approach…starting less with discipline-based concerns than with an interest in bringing together insights from any scholarship that can help shed light on the development and contours' of intensive parenting (Lee et al. 2014: 3). I hope that this thesis goes some way towards fulfilling this aim.

**Structure of the Thesis**

In this chapter, I have provided the social and cultural context in which my study of natural birth practices is situated. Drawing on two contrasting examples from my fieldwork, I have described the situation in which a desire for a 'natural' birth with certain characteristics, including home birth and water birth, can be portrayed in either ideological or practical terms, although in reality, most of the women I interviewed frequently moved between these two poles. I have presented this as a problem to be explored: what does it mean to engage with an ideal in a context in which moral norms are at the fore and yet practical circumstances must also play a role? What role do embodied practices and relationships play in negotiating a moral field? To what extent can preparation for a natural birth be

understood as a process in which women perform meaning and value in relation to their embodied experience and significant relationships?

I have provided information about the current situation of birth and midwifery in the contemporary UK, before turning to a history of birth with a focus on the construction of 'natural' birth, particularly in relation to religious views, from the early twentieth century to the second wave feminism of the 1960s and 1970s. I then discussed how these earlier views of natural birth intersect with current understandings of health as a mode of salvation, with its emphasis on personal choice and personal responsibility. I described existing studies of natural birth and parenting, as well as of other groups and communities formed around the natural as a moral force. I then argued that some of the contemporary, influential parenting literature from the UK, most notably PCS, has a different focus to my own study. I argued that a PCS focus on government policy can be usefully extended with more micro-level analyses of women's own voices and practices. It can also be extended by drawing on literature from other disciplines, namely religious studies and anthropology, which has a greater focus on the role of morals, practices and relationships in creating ethical paths.

In Chapter Two, I outline the theoretical framework I use for analysing natural birth approaches. I argue that sociological approaches which focus on the analysis of meaning-making outside of institutional religion are particularly relevant for understanding groups and networks built around shared practices, ideals, morals and values. The sociology of the sacred, and its conception of meaning as a sacred-profane binary, is useful for analysing natural birth manuals, the public teachings of antenatal groups and the normative statements made in interviews. However, it can be extended through practice-based approaches to the study of religion and communities of value, in order to analyse women's individual, embodied experiences which are more flexible and negotiable around the sacred or ideal. I draw in particular on literature which complicates the relationships of beliefs and practices and recognises embodied practices as constitutive of meaning. Theories of lived religion, ritualisation, ethnographies of value and ordinary ethics, are of particular use. Through the combination of these theories, I develop an approach which is sensitive to meaning-making, including flexibility and negotiation towards an ideal, through embodied practices.

In Chapter Three, I describe my research methodologies as well as providing information on both the antenatal groups observed and the women interviewed. I focus in particular on the social similarities of the women interviewed, focusing on the gendered and classed nature of natural birth participants. I also consider my own position in the research process, noting my similarities to the participants and the nature of research 'at home'. I describe my commitment to feminist research methodologies, and to narrative interviewing in particular, as an appropriate means of analysing women's lived experiences.

In Chapters Four, Five and Six, I present findings from my field-work in response to my specific research questions. In Chapter Four, I focus first on addressing the question of what the natural means in natural birth and what practices constitute the ideal natural birth. Whilst shared beliefs can be found across manuals, group teachings and individual women's statements, the interview narratives reveal a great deal of hesitation, ambiguity and flexibility around understandings of natural birth. Profane signifiers - those practices which have the potential to pollute the ideal birth - are more easily described by proponents. The meanings of natural birth are hence partly about what it is not; similarly the imagined 'other' plays a significant role in the normativity of natural birth. In line with this, I discuss a changing location of expertise away from NHS midwives towards women's chosen birth-workers (including independent midwives, doulas, Hypnobirth teachers and other antenatal teachers) from the private sector.

In Chapter Five, I consider why some women become involved in natural birth groups and practices. I suggest that a commitment to the ideal birth is only part of the picture and that women are also motivated by their own practical concerns including their previous experiences and the influence of their social networks. Their narratives are marked by the characteristic of pragmatism both pre and post birth. However, a marked difference emerges between women with one child and those with multiple children. Within my sample, women with multiple children had a stronger commitment to the ideal natural birth, marked by the construction of difference between births. This chapter considers the theme of choice as a central component of the ideal birth, represented in the much used phrase, 'the birth I want'.

Chapter Six focuses on the practices of natural birth. I build on existing literature on the work of birth, combining it with literature on working on the self in religious/spiritual communities, to consider the role of practices in negotiating the ideal birth. I consider the practices as ritualisations which comment on how birth ought to be and consider the functions which their performance fulfils. Through engaging in practices, the women interviewed suggested that they had morally 'done enough' to prepare for birth. Hence they did not internalise guilt, blame and failure in the way that a hermeneutics of suspicion approach suggests, leaving the possibility for more positive and flexible interpretations of their birth experiences. In Chapter Seven, I suggest that the practices demonstrate the women's good and responsible motherhood. The normative claims around the natural as a sacred form and the necessary 'othering' that this entails are hence only aspects of women's complex relationships with natural birth. The ideals and practices of natural birth create meaning for women not only in the moments of pregnancy and birth but in subsequent births and beyond.

## Chapter 2 - Meaning and Practice: A Theoretical Framework for Analysing Natural Birth

In the previous chapter, I suggested that there have been a number of studies which interrogate what particular forms of birth mean to women in America (Davis-Floyd 1992, Klassen 2001, Han 2013) and Canada (MacDonald 2007) and how the natural can serve as a moral force in various forms of parenting (Bobel 2002, Faircloth 2013) or lifestyle communities (Gould 2005, Emerich 2011). There have also been recent studies which focus on the social-cultural context of contemporary parenting (Faircloth et al. 2013, Lee et al. 2014) or on experiences of first time motherhood (Thomson et al. 2011) or birth place choices (Coxon 2012, Coxon et al. 2013, 2015). There have been other studies which highlight the potential contradictions and negative consequences of preparing for a particular form of birth (Malacrida and Boulton 2013). I suggested that there has not yet been a study which addresses how and why some women in the contemporary UK desire and prepare for a natural birth, whilst being aware of the strong moral norms around pregnancy, birth and parenting and the potential negative feelings which may arise if the prepared for form of birth is not attained. I suggested that existing studies could be built upon by drawing on literature from religious studies and anthropology which highlights the importance of embodied practice and relationships in meaning-making. Such literature adds nuance to debates around how parents actually engage with moral norms and expert advice. It encourages a focus not on macro-level government policy, but on individual's voices, practices and lived experiences within this broader context. It is a focus at this level which can help us understand how morals and practices can appear policing and regulatory but can actually have a meaningful and constructive role in some women's lives. This adds to wider debates within religious studies and anthropology about how and why people create networks and groups around things that matter, in seeking to live ethical lives.

In this chapter I present the theoretical framework I use for analysing natural birth as an example of groups and networks of shared norms and values which create meaning for

some women during pregnancy, birth and post-parturition.[1] My argument has three central elements. First, I explore theories which have made useful contributions to the exploration of meaning-making beyond institutional religions, namely Neo-Durkheimian writings on the sacred, exemplified by Jeffrey Alexander's (2003) 'strong program' of cultural sociology and Ann Taves' (2009) work on 'special things'. I argue, however, that these approaches have a tendency to take meaning as cognitive, as a text to be decoded, which has entailed a lack of focus on embodied practice and on lived relationships with ideals. I argue, in contrast, that practice is constitutive of meaning - it is not simply reflective of pre-existing beliefs.

Second, I explore the 'turn to practice' in the study of religion, drawing in particular on the 'lived religion' approach, which interrogates the relationship between beliefs and practice. I also argue that Catherine Bell's ritualisation theory adds a deeper analysis of how certain practices can be construed with symbolic significance, creating and maintaining a moral community. In drawing on these approaches, though, I argue that greater attention is needed within them to how embodiment is conceptualised. My use of Iris Marion Young's writings on the 'lived body' as a useful theory of gendered embodiment for thinking about pregnancy and birth, is not unique and other empirical studies of pregnancy and birth (including Longhurst 2001, Nash 2012) have utilised her writings. However, I argue that in seeking to understand women's pregnancy practices, as is my focus, theory of the 'lived body' can be combined with Marcel Mauss's writings on techniques of the body (1935/1973) in order to understand how body techniques, central to an analysis of pregnancy practices, are learnt in traditions and relationships of power. This can account for how women become socialised into a natural birth milieu through their embodied practices.

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[1] As suggested in Chapter One, there is no such thing as an organised, coherent natural birth movement in the UK at present. Instead there are different teachers, classes and practices which may or may not integrate with one another. However, I do use the terms groups, networks and communities within this thesis. When the latter term is used it should be recognised that this is not to suggest an organised movement with shared norms,values and practices but rather more a sense of 'imagined community' (Anderson 1983), in which a symbolic community can actually come to create community. In the case of natural birth, a time-limited event, this can be rather transitory, however. The importance of 'community' in terms of relationships with others, most importantly a woman's chosen expert, and a symbolic community of birthing women across time and place are discussed further in Chapters Four and Five.

If part two contains the crux of my theoretical model for analysing relationships between the body, practice and meaning, part three contains an aspect which has become of particular interest in this study, namely the relationship between a moral ideal and lived experience which is negotiated, in this instance, through practices. Here I draw on works within the study of religion which focus on the relationships between ethics and lived practices, as well as the recent 'turn to ethics' in anthropology. Writings in this field approach 'ethics' not as a distinct, bounded area of study but instead focus on 'the ethical' as intrinsic to living life, on how we live 'as if it mattered' (as the title of Michael Lambek's 2015 chapter would have it). Lambek approaches the ethical as created through relationships, discernment and judgement, and as intrinsic to trying to live a 'good' life. I argue that approaching natural birth practices as lived ethics adds to understanding the meanings of such practices and the 'messiness' of people's lived relationships with their ideals.

**Meaning-Making Beyond Religion**

A focus on communities of shared morals, values and practices, especially communities which make commentary on, or create the 'good' in some way, has been the traditional remit of the study of religion. The seminal work of Clifford Geertz in the 1970s popularised a cultural approach to the study of religion. Geertz (1973) famously defined culture as 'webs of significance' which 'man himself (sic) has spun' (1973: 5) and religion as 'a system of symbols which act to establish powerful, pervasive and long-lasting moods and motivations in men….' (1973: 90). He identified religion as one example of a 'meaning system' providing members 'with specific systems of meaning and order within which to live their lives' (Ortner 2007: 787), and the need for such systems as an innate human desire to account for evil, suffering and bafflement. Geertz (1973: 9) advocated a semiotic approach to culture and to religion in which 'structures of signification', 'established codes' and signs and symbols could be identified. Religion is, he argued, a set of symbols, representations or vehicles for meaning which can be isolated and analysed through an interpretive lens akin to a literary criticism. Geertz's approach to the study of culture and religion has been criticised, not least by Talal Asad (1993) who has argued that Geertz's definition of religion is an attempt at a universal, transhistorical definition of religion which belies the western academic construction of the category religion and its

imposition on to other cultures and time periods. Asad and others, including Mahmood (2012), have also criticised the analysis of culture as text, as something coherent and identifiable, and as divorced from power relations. How can one analyse symbols or meaning, Asad (1993: 43, 53) asks, without a focus on the social, historical and power relations in which meanings are constructed? More recent approaches to the study of religion, including the 'lived religion' approach discussed further below, have complicated the assumption that religion is primarily a system of meaning. Hence whilst David Hall (1997) has argued that lived religion is concerned with the ambiguities and contradictions or the 'play of meaning', Robert Orsi (1997, 2005) has argued that religion is not so much about meaning as about relationships with transcendent others. Orsi (2005: 144) agrees with Asad that 'meaning-making' is a 'distinctly modern, Western preoccupation' and that we should focus on 'processes' of meaning-making rather than meaning as an 'end-product'. Hence these more recent approaches argue that a more nuanced understanding of meaning is needed, one in which ambiguities, contradictions and relationships of power are recognised, and approached not primarily as text, cognition or belief but with an understanding that practices and relationships are equally as important in the creation of meaning. It is on these more recent approaches - which build upon but also critique the work of Geertz - that I draw in my analysis of groups around shared practices and moral norms. My study contributes to the project of using theories drawn from the study of religion to meaning-making practices outside of institutional religious movements.

The predominant focus of post-War sociology of religion was the secularisation thesis, defined by Bryan Wilson (1966: 6) as 'the process whereby religious thinking, practices and institutions lose social significance'. Alongside the recognition of significant change (and arguably decline) in traditional forms of religion in the West, there have been repeated attempts to conceptualise and study alternative forms of meaning-making beyond institutional religion, of which Thomas Luckmann's *The Invisible Religion* (1967) was one of the earliest. This movement towards studying new forms of religion in the West has also encouraged work on new religious movements (Barker 1984, 1990, Beckford 1975, 1985), the new age movement/alternative spiritualities (Sutcliffe and Bowman 2000, Sutcliffe 2003, Heelas and Woodhead 2005) and the emergence of a 'new spirituality' (Lynch 2007). Whilst these have become important areas of study, the numbers of people actively

involved in new religious movements or the holistic milieu are relatively small.[2] This raises questions about how we understand and research significant forms of meaning-making beyond these niche alternative spiritual forms.

These different areas of focus have given different weight to the issue of gender. Feminist scholars who engage with secularisation have argued that it is a theory developed from the perspective of white, Christian, European males (Woodhead 2001, Woodhead 2008b, Vincett, Sharma and Aune 2008). It has considered what happens when white males leave Christian churches, neglecting the fact that women remained in the churches for far longer. Woodhead (2001) argues that secularisation theory has been 'gender-blind', whilst Vincett et al write (2008: 6) that 'totalizing theories of secularisation collapse in the face of women's experiences'. Such scholars either critique secularisation theory, arguing in favour of sacralisation, a resurgence of religion in new and different forms; or accept secularisation theory but seek to add nuance through a gendered perspective; or combine these two approaches, arguing for a gendered secularisation theory which can also account for resacralisation. It is this last approach which has been applied to analysing the predominance of women in the holistic milieu, discussed later in this chapter.

Callum Brown (2001) was one of the first scholars to add a gendered dimension to secularisation arguing that during the sexual revolution of the 1960s, people's, and especially women's, identities became dissociated from religious prescriptions, weakening Christianity's significance in Britain. Sexual liberation, combined with the increasing entry of women into the work force, disrupted the gendered distinction between public and private spheres, and hence the strength of religion in the private sphere. Brown proposes that women remained more religious than men whilst both religion and women were tied to the private sphere, but that post-1963, these ties were broken and women too began to secularise. Trzebiatowska and Bruce ( 2012) make a similar argument, suggesting that there is a 'time lag' in secularisation; that men secularised first because of their movement into the public realm, but that women will follow the same pattern. Others, however, have sought to add further nuance to this picture. Woodhead (2001) has argued not only that secularisation and its related theory of 'iron cage and anomie' is 'gender-blind', but also

[2] Only 1.6 per cent of the population of Kendal were involved in the holistic milieu, and only 0.9 per cent considered this as a spiritual practice, for example (Heelas and Woodhead 2005).

that the very distinction between public and private reveals a male perspective. She suggests (2008b) that Brown and others neglect the continuity in women's lives, post-1963, whereby women still undertake the majority of unpaid domestic labour in the home, despite also being employed outside of the home, leaving them with a ‘double burden’. This leaves them with particular needs, desires and experiences which can be fulfilled by different religions in different ways.

Woodhead suggests (2001, 2008b) that far from following in men's footsteps, some women remain in religious traditions which themselves become more ‘feminized’ and ‘relational’. Whilst career-focused women are more likely to reject religion, those who embrace traditional gender roles are more likely to find validation in traditional or ‘religions of difference’. It is women who negotiate the worlds of both work and home - the majority of women in contemporary Britain - who might find support and relief in alternative spirituality, ‘spiritualities of life’ or the ‘holistic milieu’. Vincett et al. (2008: 9-10) complicate this categorisation, disrupting the public/private dichotomy which remains in Woodhead's argument, by introducing the term ‘thirdspace’ to highlight religious spaces which are ‘both/neither spaces’. This can include both traditional religions and alternative spiritualities. They suggest that women who remain in traditional religions and those who seek alternative movements challenge secularisation theory through the disruption of the binaries on which it is built. Analysis of natural birth practices, which also challenge public/private distinctions and have an overlap with the holistic milieu, can contribute to the investigation of significant forms of meaning-making in some women's lives.

Numerous recent developments within the study of religion have moved beyond the focus on secularisation and sects. These include the post-structuralist critique of the very category ‘religion’ as an academic construct, represented in the work of Asad (1993), Russell McCutcheon (1997) and others; the turn to practice represented in the work of ‘lived religion’ scholars which will be discussed later in this chapter; and, more recently, the increased focus on the beliefs and practices of the ‘religious nones’, exemplified in the work of Lois Lee (2015). These new approaches and developments share a focus on complicating the categories and boundary markers of the academic concepts ‘religion’, ‘sacred’, ‘secular’ and ‘spirituality’. Such approaches are particularly important in my study of natural childbirth in the UK, a form of significant meaning-making that is neither

straightforwardly religious or secular. Whilst there are numerous intersections of religion and childbirth (women's religious identities can impact upon their pregnancy and birth choices and practices; some women frame pregnancy and birth practices and experiences in religious/spiritual terms; alternative pregnancy and birth practices can be considered an aspect of the wider 'holistic milieu'), natural birth cannot be considered a religious movement. Hence whilst I draw on the theoretical insights offered in the study of religion, I want to move away from the analysis of communities around cultural norms as 'religion at a slant', or 'religion relocated' (Gould 2005), that is as a functional equivalent to institutional religion. In analysing contemporary forms of meaning-making, it is not necessary to rely on religious or metaphysical language, I argue. Below I discuss two different approaches to analysing meaning-making beyond institutional religion which both draw on the work of Durkheim: the sociology of the sacred and the analysis of specialness and experience. Both approaches produce insights in the study of groups around shared moral norms but, I argue, neither is sufficient unless combined with other approaches which have a greater focus on the role of practice, including bodily practices, in the creation of meaning.

### *Neo-Durkheimian Approaches to the Sacred*

Neo-Durkheimian approaches to the sacred offer one way of analysing meaning-making and communities around shared norms and values. Drawing on Durkheim's *The Elementary Forms of Religious Life* (1912/1995), these approaches seek to identify and analyse those things which are constructed as sacred and profane by any given community, and their relation to social formation and conflict. Sociologists of religion have periodically engaged with these approaches. For example, Kenneth Thompson (1990: 531) argued that 'an excessive focus on secularisation and sects' has marginalised the discipline of the sociology of religion which might be better redirected by 'a reassessment of Durkheim's sociology of the sacred and of morals'. Thompson (1990: 534) argued that this approach involved the recognition that the discipline's subject matter is not in decline but is rather 'constantly reproduced, even if transformed'. The discipline should hence seek to identify and analyse sacred forms which in contemporary society frequently mix 'elements drawn from so-called "secular" discourses with those deriving from more traditional religious discourses.... British sociologists of religion should be alive to sacralising and moralising tendencies in whatever cultural forms they are manifested' (1990: 534). One

significant recent attempt to develop a neo-Durkheimian approach to the study of the sacred is Jeffrey Alexander's 'strong program' of cultural sociology in which he argues that culture can be analysed as an independent meaning structure which permeates social life. This meaning-structure takes the form of sacred-profane dichotomies and is a constant presence in social life; however, the specific content of sacred and profane forms are historically and socially constructed and change over time. In 2010, Bryan Turner called for a greater attention to Alexander's work amongst sociologists of religion, a call which was heeded by Gordon Lynch (2012a and 2012b). Other British sociologists of religion, such as Kim Knott (2010), have drawn more on the conception of the sacred developed by Finnish anthropologist Veikko Anttonen (2000). It is to neo-Durkheimian approaches to the sacred that I first turn, as one fruitful framework for analysing meaning beyond institutional religion.

The sociology of the sacred is useful for analysing the normative realities of communities built around shared meanings and practices in contemporary western societies (including that of natural birth) particularly in its movement away from a religious/secular dichotomy and its divorcing of the term sacred from an inherent link to religion. Drawing on Durkheim's work, this approach recognises that anything can be constructed as sacred by the community in question. Hence the sacred, within this approach, is not considered as a subjective, pre-social experience and as an essential part of religion, as it has been in some ontological approaches (for example Eliade 1957). Rather, Alexander (2003) defines the sacred as part of the enduring cultural structure of social life, the internal framework of meaning and morals, and Lynch (2012a: 32) as that which 'people collectively experience as absolute, non-contingent realities that exert unquestionable moral claims over the meaning and conduct of their lives'. In this language of 'normative realities' and a focus on processes of historical and social construction, there lies the potential for the analysis of different experiences and interpretations of the non-contingent force on a continuum from transcendence to more this-worldly legitimating mechanisms including tradition and science. Hence whilst Durkheim's analysis was of religious communities, neo-Durkheimian applications have been used to analyse the underlying meanings creating normative realities in political events (Alexander 2003, 2010, Alexander et al. 2006) and in historic cases of child abuse in the Irish residential school system (Lynch 2012b). It has

been used to analyse groups and events which are emotionally, morally and politically charged but which are not necessarily religious - like natural birth.

The concept of the sacred is at the heart of Durkheim's general theory of religion as developed in *The Elementary Forms of Religious Life* - 'A religion is a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden - beliefs and practices which unite into one single moral community called a Church, all those who adhere to them' (1995: 44). This definition hinges on the distinction between the sacred and the profane. Durkheim (1995: 34) writes that this distinction, this 'division of the world into two domains', is the 'distinctive trait of religious thought'. For Durkheim, the sacred is an adjective. It is a relational value attributed to objects by a collectivity of people. It is defined not by an inherent or physical characteristic of the object but rather by its absolute heterogeneity in relation to the profane. Durkheim recognises that what is considered sacred varies across time and place but claims that the process by which things are attributed with sacredness is universal. This process involves moments of collective effervescence which generate a power, a force, which is perceived as external but which is actually created by the assembly, and this power is then thought to reside in the object which comes to have a sacred quality. The object retains the sacred quality after the assembly but for a limited time and so its sacredness is renewed periodically in further ritual acts. As Karen Fields (1995: xlvi), the translator of the 1995 edition of *Elementary Forms* writes, 'Humans acting collectively make and remake this quality of sacredness but then encounter it after the fact as if it had always been built into objects and was ready-made'. The sacred is then, for Durkheim (1995: 44), an 'eminently collective thing'. It is the collectivity of people which creates the sacred quality of the object, which is perceived as external to both the object and the collectivity. Durkheim equates religion with a 'Church', with a moral community. As the collective gathers and creates the sacred, they are also pulled into a relationship with one another - the very act of constituting something as sacred binds some people into a relationship and sets them apart from others who do not have the same relationship to the sacred.[3]

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[3] There are numerous problems with Durkheim's general theory of religion which have been well explicated by other authors (including Paden 1991 and Hamilton 1995). Criticisms focus on his evolutionary framework, his assumption that the totemism of Australian Aboriginal people was a simple form of religious life, understanding of which would lead to an understanding of more complex societies; and his sociological reductionism, his explanation of sacred things as an expression of collective power. Paden (1991: 23) suggests that we accept Durkheim's descriptive work on the sacred whilst abandoning an 'ontology of either the theological or sociological kind'.

Alexander (2003) builds upon the work of Durkheim and makes similar universal claims in his 'strong program' within cultural sociology. He argues that culture should be understood as an autonomous, independent variable, not simply as something formed by other social structures. Culture should be seen not as 'a thing but a dimension, not an object to be studied as a dependent variable but a thread that runs through, one that can be teased out of, every conceivable social form' (2003: 7). Thus social life cannot be understood without identification of the underlying cultural structure, the signs and symbols which are used in meaning-making, the internal patterns of meaning. In these claims, the influence of Geertz can be clearly identified and yet Alexander (2003: 22) states that Geertz's writings provide a 'springboard' for the strong program but are not in themselves adequate for cultural analysis. Alexander (2003: 22) follows Geertz in arguing for the primacy and autonomy of culture as a meaning system comprised of signs and symbols but argues that Geertz neglects the 'precise mechanisms through which webs of meaning influence action on the ground'. Alexander hence recognises the importance of the relationship between meaning and action or practice, and yet, as I argue below, Alexander and Anttonen both tend to approach action as derivative of meaning, belief or thought, and hence do not move a great distance away from the approach of culture as text.

Alexander (2003) argues that in many societies, including American civil society in which he is primarily interested, the underlying cultural structure can be identified as a binary discourse of sacred and profane, termed the 'master code', which has historically and socially specific representations, termed 'secondary elaborations'. Thus whilst there is the potential to focus on these secondary elaborations, their construction in historical and social processes, Alexander's work has an underlying claim that the master code is a universal phenomenon. Through empirical case studies of political events including Watergate (2003), 911 (2006), and Barack Obama's presidential victory (2010), as well as on situations of collective trauma such as the Holocaust (2003), Alexander seeks to decode the underlying meaning structure of sacred and profane.

In these case studies, Alexander goes further than Durkheim in thinking about the central role of the profane. He argues that the sacred and profane are simultaneously constructed and that it is impossible to identify one without the other - indeed the sacred only comes to the fore, is only recognisable, when there is the threat of pollution by the profane, creating

a moral and emotional reaction. Alexander (2003: 119) thus calls for the necessity of a 'cultural sociology of evil', arguing that 'evil' is not simply a residual category, and is not simply a cognitive category; rather it is experienced emotionally and rituals of punishment and purification are central to defining and revivifying the 'good'. Lynch (2012b: 31) follows this line of thinking in arguing that 'The normative reality represented by a sacred form simultaneously constructs the evil which might profane it, and the pollution of this sacred reality is experienced by its adherents as a painful wound for which some form of restitution is necessary'. Lynch (2012b: 26) juxtaposes both the sacred and profane with the mundane; 'the logics, practices and spaces of everyday life', suggesting that the sacred might only come to the fore when it is threatened in some way.

The argument that the sacred comes to the fore at times when it is threatened has implications for the empirical analysis of sacred forms. It suggests that the sacred might be identified in heightened political, moral and emotional situations. This is an argument which has also been made by Anttonen (2000). Unlike Alexander and Lynch, Anttonen suggests that the sacred comes to the fore when there are changes in the categories of temporality, territoriality or corporeality. Like Alexander though, he argues that the sacred is an anthropological constant. Anttonen suggests that the cognitive structure of the sacred - on which he focuses - is not an abstract category but is based on the 'cultural-grammar' of the universally occurring categories temporality, territoriality and corporeality. Anttonen (2000: 278) thus argues that the sacred is a category 'inseparably connected to the corporeality and the territoriality of human beings', 'which becomes actualised in specific value-loaded situations when a change in the contextually interpreted boundaries of temporal, territorial or corporeal categories takes place'. In this, he is influenced by the symbolic anthropology of Mary Douglas, who argued that the human body 'is the source of symbols and systems of symbols, which are extended outward to organise and understand the social world', in contrast to Durkheim's theory that the social group was the source of all symbols (Bell 1997: 41). Anttonen (2000: 274) argues for a cognitive theory and an ethnographic approach to the concept of the sacred, which focuses on 'the cross-cultural regularities that have guided the perception of an object as sacred in a particular specific linguistic community in a particular geographical context'. Hence whilst the representations of this cognitive structure are historically and socially constructed, and can be analysed through behaviour (the ethnographic approach), Anttonen, like Alexander,

argues that the sacred is a 'fundamental structure' in all societies, which presupposes other structures.

One benefit of the sociology of the sacred approach is its movement beyond the religious/secular and religion/spirituality debates. It has the potential to include analysis of categories that have been labelled as religious or spiritual as examples of sacred forms, whilst recognising that there are also other sacred forms which would more traditionally be labelled as 'secular' such as human rights and freedom of choice, and that many contemporary sacred forms, as Thompson (1990) argues, are a combination of 'religious' and 'secular' elements, as in my study of 'the natural' in the context of pregnancy and birth. It suggests that the secular is a redundant concept as sacred-profane dichotomies are constant meaning structures in western societies despite their specific forms changing over time and place. Or, put differently, that sacred forms are as present in what has been labelled 'traditional' life as in 'modern', although the approach contests that these terms form a sequential binary. It also argues that the majority of day-to-day living is governed by 'the mundane' and that it is only at times of potential pollution by profane forms that sacred forms come to the fore.

A cultural sociological approach is particularly relevant for studies of ideas and practices around the natural, where there is a continuum of interpretations of the authoritative force of nature - from transcendence (an explicitly religious or spiritual framing of natural pregnancy and birth) to non-transcendence including tradition, symbolic community and science as possible legitimating mechanisms. Natural birth groups transcend religious/secular and religious/spiritual dichotomies. It is possible to find women who identify as belonging to religious traditions, women who identify as spiritual, and women who describe themselves as secular, agnostic or atheist, as well as women who are indifferent to religion, in natural birth groups. Despite these different identifications, some of the women are engaged in similar practices, using similar ideas and language, and with similar motivations and desired outcomes. I hence needed to develop a framework which does not reduce experiences and meaning-making to religious, spiritual or secular identities, but which nevertheless recognises a shared meaning structure or sacred form which overarches these identifications. Within natural birth communities, the shared sacred form is the category of the natural, a point to which I shall return in later chapters. The cultural

sociology of the sacred can be utilised to analyse morally and emotionally charged communities which make normative judgements and which are not tied to particular religious, spiritual or secular identities. The sociology of religion has highlighted that in the contemporary period, however we want to label it, there is a need to analyse the meaning structures which people create and draw upon to give meanings to their life experiences, perhaps especially at times of personal change such as during pregnancy and birth.

However, this approach to the sacred is not without its limitations: it tends to retain an analysis of meaning as primarily cognitive and as akin to a text or performance to be decoded, without sufficient focus on how embodied practices themselves constitute meaning and potentially bind the practitioner to a community. It also has insufficient focus on the 'messiness' of people's lived relationships to sacred forms or their moral ideals.

General theories of the sacred such as those developed by Alexander and Anttonen over-emphasise the cognitive aspect of the sacred. Alexander's strong program, at least as explicated in *The Meanings of Social Life* (2003), approaches culture, including action, as text; the codes, narratives, metaphors, themes and values of which can be decoded, and thus it has little focus on embodiment and practice. His slightly later project of a development of cultural pragmatics in *Social Performance* (2006) is a recognition that the strong program, in its concern to take meaning seriously as an independent structure, has focused on meaning over action or has presented meaningful action as texts (Alexander et al. 2006: 2). In *Social Performance,* the strong program is combined with a 'performative turn'[4] to develop a theory of cultural pragmatics which seeks to analyse the relations between the cultural text (meaning) and actors in everyday life. Thus cultural pragmatics, it is claimed, 'interweaves meaning and action in a non-reductive way, allowing for cultural structures while recognising that it is only through the actions of concrete social actors that meaning's influence is realised' (Alexander et al. 2006: 16). This approach analyses the instantiation of culture, the ways in which social actors make the underlying cultural structures 'stick' to their actions. Alexander has developed a dramaturgical theory to analyse this, complete with a conceptual model of six interacting parts of performance: collective representation, actors, audience, the means of symbolic production, mise-en-

[4] Influenced by Judith Butler's (1988, 1990) work on the performance of gender identities.

scene and social power. Central to the theory is the claim that social actors 'implicitly orient towards others as if they were actors on a stage seeking identification with their experiences and understandings from their audiences' (Alexander et al. 2006: 2). The goal of all symbolic action, he states, is a fused performance; an achievement of authenticity through fusing all elements of the performance, creating both psychological identification (that is an emotional connection with the audience) and cultural extension (that is the projection of cultural meaning).

Cultural pragmatics, whilst recognising that meaning must be analysed in conjunction with practice, suggests that practice is a projection of pre-existing thoughts, feelings and beliefs, rather than a central component in the creation of meaning. It approaches meaning as a 'script' which comes before action. Anttonen (2000: 281) too over-emphasises the cognitive in such statements as 'people participate in sacred-making activities and processes of signification according to paradigms given by the belief systems to which they are committed, whether they be religious, national or ideological'. This suggests that people are committed to belief systems and that actions follow after in a logical sequence, an assumption which has been questioned by the lived religion approach to the study of religion (for example, Hall 1997). Below, I argue that the sociology of the sacred can be further nuanced by adding insights from theories which have a greater focus on embodiment and practice, including the study of lived religion, which adds further insights about the relationship of beliefs and practice. However, first I want to introduce an alternative approach to investigating meaning-making beyond institutional religion, that is Ann Taves' (2009) work on 'specialness'. Taves conceptualises the sacred not as a binary but as one end of a continuum of value of specialness, giving greater recognition to more fluid relationships with ideals.

### *Experience, Specialness and 'Things that Matter'*

An alternative approach to the analysis of meaning-making beyond institutional religion has been developed by Taves (2009, 2010 and 2012 with Courtney Bender). Whilst Taves also draws on the work of Durkheim, she has developed a fundamentally different approach to that of Alexander and other sociologists of the sacred, an approach which does consider meaning as more of an 'ultimate value'. As outlined above Alexander's general

theory is centred around a master code of a sacred/profane binary. The sacred consists of things which are absolutely set apart, for which people would lay down their lives, the pollution of which creates deep emotional wounds in need of serious restitution. In Taves's preference of 'specialness' as the second order tool of analysis, she argues not that some things are set apart in a binary but rather that some things are considered as of more importance than others in a hierarchy of values. She argues for a continuum approach to meaning in which things are marked as special in words and actions through their relationships to other things; 'conceptualising specialness on a continuum allows us to ask how special something is - how much we value it - relative to other things' (2010: 326).

In *Religious Experience Reconsidered* (2009: xiii), Taves seeks to 'build bridges' between the humanities and natural sciences, between the study of religion and neuroscientific studies of the mind by developing an attribution theory of religious experience or rather, of 'experiences deemed religious (and, by extension, other things considered special)'. In this, she seeks to create a general theory of religious experience and, by extension, of religion itself. The basic 'building blocks' in this theory, are those things deemed special and/or set apart. Based on a reading of Durkheim's definition of religion, she argues that 'sacred things', those things 'set apart and forbidden', can be isolated from the system of beliefs and practices - that is from the religion - that is built up around them. Hence she distinguishes between 'simple ascriptive formations' in which individual things are set apart as special and 'composite ascriptive formations' in which such things are built into systems of religions or spiritualities. Special things could be considered the component parts of religions and spiritualities, she suggests, and their identification a methodological approach to the study of religion. Furthermore, specialness could be used to 'explore processes of valuation across cultures' she argues (2010: 321), with a focus on a 'politics of deeming' in which claims about the value, meaning and significance of experiences is contested.

Taves (2009: 28) defines 'special things' as 'things that are set apart from other, more ordinary things, including things considered so special that people set them apart as singularities and protect them from other things by means of taboos or prohibitions'. The concept of singularities is drawn from the work of anthropologist Igor Kopytoff (1986) who, in his writings on processes of commodification and valuation, argued that those

things considered most special and set apart could not be commodified (that is, were considered priceless), nor could they be mentally mixed or compared to other things. Taves argues that special things exist on a continuum of specialness from the more ordinary to the set apart. Those things most often set apart as special, she argues, include ideals and anomalous things such as anomalous events (including forces of nature, meteorological happenings) and anomalous beings (including deities). Furthermore, she argues (2009: 48) that the tendency to set ideal things and anomalous things apart as special is an innate human tendency found across cultures and time periods - with a significant factor being that in 'complex societies' there are many 'competing schemes of valuation'. Her argument that some experiences and things (including biological offspring) come to the surface 'already laden with meaning' has resonances with Anttonen's cognitive approach to the sacred and to writings on the lived body which will be discussed below. The lived body approach recognises that biology can constrain the cultural and social meanings which are laid upon the body and its processes. In terms of pregnancy and birth, they can be considered simultaneously social, cultural and biological events in which changes in the body and social positioning can encourage a search for meaning, or an ascription of specialness in Taves' terminology.

Taves' use of the concept of specialness and her rejection of other terms including the sacred and spiritual, as well as her very loose definition of religion, as a 'non technical catch all' term for emic categories, raises important questions around how scholars select a choice of term for second order concepts of analysis and the wider implications and understandings of the terms selected. Taves' definition of the most special end of the continuum as 'things set apart' and her argument that special should be considered much wider than the discursive field of religion, bears parallels to sociologists use of the sacred, as outlined above. Like sociologists of the sacred, Taves is concerned with much wider processes of meaning-making than that which has traditionally been associated with the academic study of religion. She argues (2009: 12) that 'scholars can situate what people characterise as religious, spiritual, mystical, magical, superstitious, and so forth in relation to larger processes of meaning-making and valuation in which people deem some things as special and set them apart from others'. Yet whilst Taves compares her second order concept of specialness to Anttonen's concept of the sacred, she argues for the category specialness above the sacred because 'on the ground' the sacred is equated with religion

which complicates its use as a second order term. She argues that when 'first order' terms, including the sacred, spirituality and, to a lesser extent, religion are redefined and utilised as 'second order' terms, there arises a confusing blurring of emic and etic categories, which is particularly limiting when focusing on contested meanings. Kim Knott (2010: 305), on the other hand, who also draws on the work of Anttonen, argues for the sacred because, 'Unlike "special", "sacred" has deep and wide-ranging cultural resonances that....remain at the heart of popular and theological usage for signalling those things, places, values and issues that are non-negotiable, forbidden, or of deep and abiding significance'. Knott argues that the sacred has more 'weight' than the category 'specialness'. However, as Knott suggests but does not draw out here, special also has a different implication of not something non-negotiable but merely something at the top of a hierarchy of values. It is for this very reason that scholars such as Lynch utilise the sociology of the sacred; because the sacred connotes something very different to an ultimate value. Lynch (2012a: 24) writes that, 'A possible misreading of Durkheim's definition of the sacred is to think of it in terms of that which is seen as being of greatest power, value, and meaning in any given cultural system'. Not only is this a misreading of Durkheim, he writes elsewhere, 'But to define the sacred as that which is highly valued loses the particular value of this concept' (2012a: 25). The sacred is not something which can always be articulated and reflected upon, he writes, rather it is that which is experienced as a non-contingent, normative reality, as 'essential to life itself' (2012a: 25). Taves (2010: 322) is not necessarily in disagreement with this definition of the sacred but rather privileges specialness as, 'there are some things that people consider most special, which they do not refer to as sacred'. Whilst I agree with this statement, it belies the fundamental difference in the two approaches. Sociologists of the sacred are not concerned with a hierarchy of values, nor are they concerned with whether or not their second order concept overlaps with emic or 'on the ground' usage of the term, as the etic concept is well defined. Taves does not discuss special as an emic category.

The approach of a continuum of 'specialness' does have benefits over the sociology of sacred, not least that it appears to have a greater correspondence with the lived reality of members of moral communities. As I argue in Chapter Four, the sociology of the sacred, with its focus on a master code of sacred and profane, is a useful means of analysing the public discourse surrounding morally and emotionally charged communities and events -

and Alexander and Lynch have both focused primarily on such public, political and mediated examples. It is not so applicable in the analysis of individual's lived commitments to these sacred and profane forms which are often messy, inconsistent and tempered by personal and social interests and commitments. Individual members, whilst bound to moral communities through their practices, beliefs and public discourses, still might not hold the community's values as non-negotiable - hence sacred. An ordering of practices, ideas, beliefs and statements into hierarchies of value, subject to a reordering in line with changing individual and social situations, is more prevalent.

A further benefit, particularly in relation to my study of natural birth practices, is that Taves' approach to specialness has a wider recognition of the role of practices in relation to special things than Alexander's strong program. As outlined above, Taves distinguishes between special things as simple ascriptive formations and the systems of beliefs and practices which are built up around them as complex ascriptive formations, that is as religions. Central to complex formations, including religions, she argues (2009: 46), is the concept of the 'path' - 'sets of practices that individuals or groups view as effective in attaining goals associated with special things. The idea of a path implies both a goal and a means of getting to the goal'. This concept, she argues, allows for the analysis of behaviours relative to special things, and for different degrees of contestation; individuals may be in agreement about the goal but not the practices on the path or vice versa. When there is agreement about the goal and the practices this creates a closed, self-authenticating system (2009: 52). The concept of the path, and a relationship between special things and associated practices, is of central importance in an analysis of pregnancy and birth practices in which women are preparing for a particular form of birth - the goal, or the ideal in my terminology. The analysis of the sacred form or the special in relation to practice is of primary importance. However, in the building block approach, as in the sociology of the sacred, there remains the suggestion of a linear movement from creating the sacred/special to creating beliefs and practices around it. Analysis of how beliefs and practices create, or feed back into, the sacred/special is not a focus. The special is created, in Taves' theoretical framework, through discursive and cognitive practices, through the ways in which special things are talked about and reflected upon - through the ways in which they are set apart through a refusal to commodify, mix or compare. This is only part of the picture, I argue. Embodied and routine practices, in which meaning or value is built

up over time through repeated practice, is also important. Furthermore, it is through such embodied, repeated practices that some women become engaged with an ideal of natural birth and through which they construct a level of negotiation between this ideal and their own practical considerations. Taves' concept of the path gives greater recognition to practice, but her theoretical understanding of the nature and role of embodied practice in this context is not sufficiently developed.

A recognition of the central role of practice in meaning-making is continued by Bender and Taves (2012), where they focus on 'processes of valuation' across the religious-secular divide. Bender and Taves (2012: 1) utilise the question of 'What Matters?', 'What does it mean to pursue, inhabit or lead a valuable, ethical life in a secular age?' to interrogate the religious-secular binary. They draw on two movements which have emphasised the importance of practice over belief; the rejection of the concept of belief by some anthropologists and the study of lived religion. Drawing on these movements, as well as Bender's (2012) call for a focus on 'practicing' as practice embedded in relations and settings, they argue, 'We thus need to consider how practices give rise to belief (and vice versa) in a world where we can now consider the practices of belief (and, likewise, the processes of valuation) that take place across various fields and spaces' (2012: 15). Heeding this call, I now turn to those theories within the study of religion which emphasise the importance of practice, sometimes over and above that of belief.

**A Focus on Practice: Ritualisation and Lived Religion**

Just as theories drawn from the study of religion can be applied in thinking about processes of meaning-making, I argue that they can also be fruitfully applied in the wider context of thinking about the relationships between beliefs and practices. Of course, analysis of practice, and its relationship to thoughts, relationality and wider social processes, has not been confined to the study of religion and has been theorised by writers including Marx, Bourdieu and De Certeau. Pamela Klassen (2008) gives a succinct summary of the genealogy of practice in relation to the study of religion and media. She describes how Marx's notion of praxis, acts which shape and change the world, was an early theory which sought to emphasise the interrelationship of thought and action. It has been influential in later turns to practice which have used the concept of practice as a new way of looking at

an area of study, unearthing that which has previously been neglected in a process of oppression. Marx's focus, as in the lived religion approach discussed below, was on the dominated classes. This concern was continued in the work of Bourdieu (1990a: 82-3 in Klassen 2008: 140) who argued that practice could only be understood negatively, 'by what it was not' as, 'once it was recognised, it would lose its defining characteristics as a taken-for-granted, habitual common sense'. Hence 'once an actor reflected on her actions as "practice" it was no longer naturalised and or common-sense, and thus no longer a practice' (Klassen 2008: 141). This is not an understanding of practice that I find useful for my analysis of natural birth and indeed Klassen (2008: 141) notes that de Certeau criticised Bourdieu's practice theory for neglecting 'the embodied knowingness of practices'. De Certeau, in contrast, argued that practices were 'a more knowing disposition, made up of both "strategies" and "tactics"' (Klassen 2008: 141). All of these theories have been utilised in the study of religion: Bourdieu's concepts of habitus and of 'fields' have been influential in religious studies, including in Bell's ritualisation theory (1992, 1997) and Mellor and Shilling's writings on body pedagogics (2010); and Woodhead (2012a) has more recently borrowed from de Certeau in a critique of lived religion. These iterations of practice theories will be discussed below.

Scholars of religion have engaged with these theorists in numerous different 'turns to practice', whilst simultaneous moves in anthropology and religious studies have questioned the predominance of the study of beliefs in discussions of culture and religion. Simon Coleman and Galina Lindquist's special issue of the journal, *Social Analysis* (2008: 52.1), entitled *Against Belief?*, has been influential in critiquing a focus on belief over and above practices. Drawing on Rodney Needham's (1972) concern with the multiple meanings of the term belief and Malcolm Ruel's (1997) argument that the concept must be historically and social situated in the Judeo-Christian context with limited wider use, Coleman and Lindquist (2008: 2) argue that the concept of belief as a term is 'conceptually misleading and ideologically dubious'. They argue that when anthropologists apply the term to other cultures' understandings of reality, they are making a distinction between 'their' 'beliefs' and 'our' 'knowledge', in a process of 'othering' and a hierarchical valuing of different epistemological systems (2008: 7). However, they conclude that the term has 'continued vitality', both in academic and popular usage, but that its use should always be

historicised and complicated. That is, they retain the position that 'the concept of belief is generally good to think "against" rather than "with"' (2008: 2).

The relationship between beliefs and practices is not clear cut. Coleman and Lindquist (2008: 4) ask, 'How do we understand the connections between belief and experience, whether the latter is constituted by ritual or by ordinary activity?'. They argue that belief should not be considered an 'individualised and internalised phenomenon', that is a 'cognitive entity' (2008: 4), but rather as an emotional and embodied way of being. Coleman and Lindquist (2008: 14) argue that the case studies in the journal indicate that 'belief as a cognitive/emotional attitude is less relevant to understanding what people do than are embodied practices within shared ontological and cosmological assumptions'. These uses of belief and its relationship to practice are much closer to the processes I discuss in Chapters Five and Six, in which women become committed to a natural birth ideal through embodied practices. This also bears resonance with the study of lived religion which, whilst having a focus on practice in order to counterbalance the previous emphasis on belief, ultimately seeks to examine the co-construction of beliefs and practices.

Before discussing 'turns to practice' in the study of religion, it is worth noting that analysis of practice, specifically in the form of ritual, was integral to the development of general theories of religion. Indeed ritual practice has been coupled with analysis of religious beliefs and the sacred since Durkheim's work. In Durkheim's theory, the sacred is inextricably connected to ritual or rites. Contact with the sacred is guided by rites - positive rites, experiences of collective effervescence, entail an encounter with the sacred whereas negative rites, or taboos, maintain the separation of the sacred and profane. Anttonen (2000) continues this line of thinking to some extent in arguing that the sacred becomes actual in the form of observable behaviour in ritual performance. This is problematic in suggesting that the sacred is simply performed during ritual, rather than ritual practice being an essential element in the construction of the sacred, with the two feeding into one another in a continuous dialectical process. It is important to take on board here two criticisms of some approaches to ritual. First, it cannot be assumed that ritual transcends the thought/action dichotomy by simply enacting beliefs in an orderly process; as the lived religion approach emphasises, practice is inherently more 'messy' than this. It cannot be

assumed that ritual opens a window onto pre-existing beliefs, as Anttonen's approach at times seems to imply. Rather it must be recognised that beliefs/thought are in a dialectical relation with ritualised activity; with the two simultaneously constructing one another. Second, it cannot be assumed that ritual unproblematically binds people into a unified community, as Durkheim suggested. Whilst the sacred and ritualised activity are key components of boundary construction and maintenance, as activities around the sacred can draw people into a community, more recent work, such as the strong program, allows for the exploration of conflict and contestation within communities - including amongst those who share sacred forms.

***Ritualisation***

Catherine Bell (1992, 1997) has argued for a situational definition of ritual, one particular to context, noting that the term ritual, like religion and belief, is a western construct which implies an intrinsic, universal category of human behaviour. She argues that ritual is a cultural and historical construction imposed by western academics which serves to create a relationship of us and other. Part of the appeal of the category of ritual to western academics, she argues, has been its apparent role in mediating or integrating thought and action; and the resulting analysis of action as 'the execution of a conceptual program' (1997: 81). The primacy of practice is then lost, she argues, which is problematic partly because it creates a distinction between the theorist and ritual actors. Here she is influenced by the work of Asad who, as stated above, argued for 'the need to move from "reading symbols" to "analysing practices"', recognising that 'cultural values and meanings exist only insofar as they are embodied in what people do' (Bell 1997: 79). There is a tension around meaning and communication that can be identified here; Neo-Durkheimian approaches to the sacred prioritise meaning, and intentionally so, as the recognition of the underlying autonomy of meaning is the foundation of the strong program. This is explicated in Alexander's (2006) approach to symbolic performance, whether ritual or ritual-like activities, as about the communication of meaning; an authentic performance is one in which cultural meaning is 'projected' not created. Bell's practice theory of ritual, on the other hand, argues that ritual does not simply communicate meanings, it also constructs meaning through actions. Ritual is not simply communication of meanings and values; 'it is a set of activities that construct particular types of meanings

and values in specific ways' (1997: 82). Ritual does communicate a message - the very message that this act has extra significance - but it is not simply a projection of meaning. Hence I argue that post-structuralist writings on ritual, especially Bell's concept of ritualisation, are helpful in analysing the primacy of specific practices in the construction of meaning and in thinking about the wider relationships between beliefs and practices.

Bell argues that not all action can be defined as ritual as there is something distinctive about ritual, namely the act of ritualisation. She cautions that 'a universal definition of ritual can obscure how and why people produce ritualised actions; it certainly obscures one of the most decisive aspects of ritual as a strategic way of acting, the sheer degree of ritualisation that is invoked' (1997: 82). A central question then becomes, why is ritualisation seen as the correct strategy? Bell addresses this question by drawing on a scholarly tradition which sees ritual as about the subjunctive mode, the world of oughts, how things ought to be as opposed to how things are (Turner 1969, Smith 1987). Jonathan Z. Smith argues that ritual is not defined by a fixed activity or intrinsic principle but in what is selected to be done and how it is done in particular situations. He writes that 'a ritual object or action becomes sacred by having attention focused on it in a highly marked way' (1987: 104). This attention signifies sheer difference; ritual makes someone or something sacred through 'indices of difference' (1987: 105). This leads to his much quoted definition of ritual as 'above all an assertion of difference...Ritual is a means of performing the way things ought to be in conscious tension to the way things are' (1987: 109). Smith and Bell's practice approach to ritual emphasises the importance of the selection of activities and their embodied practice to a greater extent than Alexander's focus on meaning.

Central to Bell's practice theory of ritual is the concept of ritualisation. Bell (1997: 81) argues that the most that can be said of ritual as practice is that it involves ritualisation, that is 'a way of acting that distinguishes itself from other ways of acting in the very way it does what it does; moreover, it makes this distinction for specific purposes'. Later in the text Bell (1997: 166) defines ritualisation as 'the simple imperative to do something in such a way that the doing itself gives the act a special or privileged status. The style of doing creates a type of framework around the act that communicates the message "this has extra significance"'. Hence, to analyse ritual systematically, Bell argues, one must first

address how a particular community ritualises (identifying what ways of acting makes some acts distinguishable from others) and then address why ritualisation is seen to be the effective thing to do. This involves, she suggests, analysing the 'style of doing', the 'ways of acting', and in a chapter focusing on 'ritual-like' activities, she identifies six characteristics which can be found in varying combinations creating different strengths of ritualisation. These characteristics are: formalism (a restricted code of behaviour); traditionalism (drawing on a historical legacy as a tool of legitimation); invariance (routinisation with precision and control); rule-governance (established norms which impose order); sacral symbolism (activities around a symbol which merges ideas and emotions and creates the attribute of sacredness); and performance (a framing mechanism which models the world, which condenses and simplifies it and creates categories). Bell argues that these characteristics are neither 'exclusive nor definitive' but rather provide an 'initial lexicon' for analysing how activities might be ritualised.

Ritualisation is central to understanding the symbolic actions of communities around shared values, such as that of natural birth, and how routinised, seemingly quotidian activities, can both create community and make prescriptive commentary on an existing situation. Rebecca Kneale Gould's *At Home in Nature: Modern Homesteading and Spiritual Practice in America* (2005), is a valuable example of ritualisation theory applied to the study of a particular community. Gould, also following Smith, focuses on how ritualisations create and enact an opposition to an 'other'. She describes homesteading as a lifestyle of difference to the mainstream which becomes actualised through the symbolic action of ritualised activities, that is everyday choices around what food to eat and grow, how to grow it, and whether to engage in the practice of sauna. These practices, I argue, can be considered as techniques of the body, a theory which will be outlined below. The homesteading lifestyle arises, Gould argues, from a problem of meaning, a dissatisfaction with mainstream 'consumer' lifestyle and hence is a choice to live a different way. She describes ritualisations of everyday life linked to this central notion of choice and argues that whilst these may seem quotidian choices and activities, they are anything but. In the context of homesteading these choices privilege 'activities that are environmentally ethical and "close to nature"' (2005: 68). Thus, following Smith, she argues that they are comments on the way the world should be. Furthermore, she argues, these ritualisations identify nature as sacred and the American consumer lifestyle as profane - they set some

activities off as qualitatively different to others. Gould highlights the way that everyday choices performed through symbolic actions create an alternative lifestyle, distinguished as superior to other lifestyles. Ritualisations, she argues, 'are means of enacting one's ultimate commitments' (2005: 100).

It is potentially possible to identify different characteristics at work in different empirical situations, as it is part of Bell's theory that different 'ways of acting' might prioritise one or other characteristic of ritualisation. The characteristic of traditionalism is of particular relevance in the analysis of natural birth practices. Such practices are frequently legitimated with reference to tradition - the practice is labelled as natural because it is perceived as a 'traditional' way of acting. The natural as normative posits a connection between the natural, a moral evaluation of 'good', of healthy and tradition. Relevant here is Bell's (1997: 167) statement that common reasons given for participation in ritual and ritual-like activities are such claims as 'we have always done this', 'it's our tradition' or 'we do it because it makes such-and-such a positive thing happen'. Also important is Mauss's claim that there is no transmission of body techniques without tradition, as will be discussed below. The term tradition encompasses here both the literal transmission of ideas and practices as well as a more general notion of tradition as a link with the past conveying legitimacy and authenticity. As Bell (1997: 210) writes, 'part of what makes behaviour ritual like is the way in which such practices imply the legitimacy of age and tradition'. In Chapter Six, I draw on these elements of ritualisation theory as a means of analysing women's practices in preparation for natural birth as symbolic actions which make comment on how birth *ought* to be and as performing a particular subjectivity of 'good' motherhood.

### *Lived Religion and Practice*

The turn to practice in the study of religion and the questioning of the predominance of belief has complicated the once assumed relationship between religious beliefs as the underlying causal feature of religious practices. It has also questioned the analysis of religious practices as distinct, isolatable events, as in the study of ritual discussed above. The 'lived religion' approach focuses not on ritual but on the everyday, quotidian practices in which religion is lived, reproduced and contested. Not only does this approach highlight

the western, Christian construction of the academic study of religion drawing on post-structuralist critiques, but it reminds us of the very things that have been neglected in that study, namely embodiment, emotion and materiality - such as women's everyday practices of health and healing. The lived religion approach recognises that those embodied practices which have traditionally been constructed as 'female', 'feminine' and private or domestic, especially religious practice in the home and around food, health and healing, have historically been 'defined out' of the discipline of religious studies (McGuire: 2008). As Klassen (2008: 137-8) notes, it is the turn to practice which 'has brought to prominence the religious lives of women and marginalised peoples, the role of religion in seemingly "nonreligious" spheres, and the messiness and creativity of religious borrowing, appropriation and hybridity'. A focus on practice over and above beliefs has hence been employed strategically as a new way of approaching the academic study of religion. I argue that lived religion's focus on the 'messiness' of the interaction of beliefs and practices, of creativity within the confines of power structures, and on the everyday practices of those who have historically been neglected in academia, can be brought to bear on the study of communities and groups formed around shared values and practices which fall outside of the traditional remit of the study of religion. Its focus on gendered embodied practices, especially around health and healing, provides insight in my analysis of natural birth groups and practices.

The study of lived religion arose in the USA in the mid-1990s amongst historians of religion interacting with the anthropology of religion and post-structuralist critiques of the discipline of religious studies. It is motivated by a desire to analyse religion as it is lived in the 'messy' reality of everyday life entailing a focus not on religious leaders, texts, doctrine or orthopraxy but on the laity and their day-to-day practices. It prioritises the study of practices above beliefs in recognition that beliefs are often not consistent and not well articulated. Religion as it is lived, it is argued, rather has a practical coherence, although practices too can have multiple-meanings. It seeks to analyse these multiple levels of meaning of practice, recognising that meaning is often ambiguous and contradictory, which Hall (1997: x) describes as 'the play of meaning'. In this 'play of meaning', Hall (1997: xi) argues, there is always a struggle over boundaries, definition and choice; there are always tensions and struggles inherent in how 'people choose to act'. There are always power dynamics at play; thus lived religion seeks to be aware of the limits of possibility created

by power structures and the resistance that religious creativity can offer. Discipline and creativity can be regarded as simultaneous processes with the result that religious practice is neither entirely conformist nor entirely liberates the individual from her/his place in the social order (Orsi 1997: 16). Orsi further suggests that religion is not about meaning so much as about instantiated relationships - with people and with transcendent others within particular settings which are themselves historically, socially and politically situated. Religion is not a self-contained unit but an unfinished creation, constructed in relationships, on the boundaries (Roof 1998). These insights from the lived religion approach are equally applicable to the analysis of communities around normative realities, such as natural birth, as they are to communities which are more explicitly 'religious'.

In challenging the normative construction of the category religion within academia, lived religion scholars place a greater emphasis on the central role of the gendered body in the creation and experience of religious lifeworlds. Orsi's (2005) writings on the 'corporalisation of the sacred' are particularly relevant for my framework in highlighting the relationships between religious practice, embodiment and gender. Orsi uses this term to describe a process in which 'bodies of difference' (that is of 'cripples', women and children), were literally inscribed with sacred presence entailing an experience of the sacred not only for these individuals but for the whole of the Catholic community. This process was thus central to the creation of the culture of Roman Catholicism in the USA in the mid-twentieth century. Orsi (2005: 92) describes, for example, ways in which adults rendered the 'sacred corporally present' in the bodies of children, namely through 'the disciplining of children's bodies at mass, the practice of memorising prayer, and the promotion among children by adults of the cult of the guardian angel'. The experiencing body then became a 'bearer of presence' not only for the individual but for the whole community - although within this process there is room for both conformity and resistance to this ascribed role. McGuire too has focused on a relationship between gendered embodiment and suffering as the crux of a spiritual community, in this instance that of alternative healers. McGuire argues that women are more active than men in this field, both as practitioners and as recipients of alternative healing, due to a belief that the best healers are those with the characteristics of compassion, empathy and the ability to understand the experience of suffering - that is women. She goes on, 'the experience of suffering is gendered, in part because of how women's bodies are linked to the proximate

sources of physical and emotional suffering' (2008: 128). Similarly, in reflecting on why more women are involved in the holistic milieu than men,[5] Woodhead (2005: 102) argues that women are guided more by a relational and embodied subjectivity, in which they not only care for others but care for their whole bodies (see also Sointu and Woodhead 2008). Likewise, they might be more likely than men to turn to the holistic milieu for conditions specific to the female body, such as menstrual pain, the menopause, problems conceiving and during pregnancy, and in preparation for childbirth and postpartum. In a later article, Woodhead (2008a: 158) lists some of the 'female-centred rituals' on offer in Glastonbury in the UK: Intention to conceive/Conception; Blessingway in pregnancy; Birth/Baby naming/Baby blessing; Becoming a parent/grandparent; Miscarriage/Stillbirth/Abortion; Weaning/First steps/First School Day; First blood/Puberty/Coming of age; Menopause/ Becoming a crone, many of which are inherently linked to female embodiment.

McGuire and Woodhead have both engaged with the lived religion approach in writing about women's experiences of spiritual and ritual healing. In line with the lived religion approach, their focus is on groups and practices which are not so obviously 'religious' as Orsi's Catholic community, but their focus on the interrelationships of gender, embodiment, spirituality and healing, can add insights to the analysis of natural birth groups. In what she sees as a correction to the historical biases of the sociology of religion with a focus on institutional religions, doctrines and beliefs, McGuire (2008) focuses on embodied spiritual practices which she claims have been 'defined out' of the study of religions. Hence she includes vignettes on eating, work, dance, and music as examples of lived religious practice. As noted in Chapter One, she also traces the process in which 'religion' and 'health' were disentangled as two distinct social systems following the Long Reformation, whereby religious practices of health and healing were relegated to the realm of 'popular' or 'folk' religion and labelled variously as witchcraft, magic or superstition. Religious healing became, in Woodhead's terminology, a form of 'tactical' religion. Woodhead (2012a) takes issue with the approach of lived religion suggesting an alternative approach, borrowing from de Certeau, in which she contrasts a 'strategic' mode of religion (that of the powerful, including religious institutions), with a 'tactical' mode (that of the 'weak' and socially silenced). Tactical religion is not powerless, she argues, but rather operates in a different mode of power, one in which the 'spaces and conditions… are not of

[5] 80 per cent of the respondents in the Kendal Project (2005: 106-7).

their making, with tools and materials which are owned by others' (2012a: 7). Strategy and tactics are inter-dependent, forming and shaping one another; strategic religion constantly seeks to consolidate its power, including its authority over sacred spaces and times, whereas tactical religion challenges this and 'is constantly engaged in attempts to subvert such strategies of limited and controlled sacralisation and enchantment by re-enchanting places, spaces, bodies and objects which the strategic has designated mundane and unworthy' (2012a: 8). In her example of the relationship between religion and healing, Woodhead argues that religious healing in the UK was initially displaced with the founding of the NHS, that complementary and alternative medicine (CAM) flourished for a while outside of this structure of power as a form of tactical religion, but that it is now challenging, and sometimes even finding its way into, the strategic sphere as CAM becomes part of the NHS. Woodhead argues that the focus must be on the interplay of strategy and tactics and that greater attention must be placed on the structures of power than is sometimes recognised in lived religion.

The lived religion approach has been criticised for an over-emphasis on agency, despite Hall and Orsi's careful analysis of religious creativity within the confines of power structures. Ethnographic and empirical work within this approach tends to focus on description at the level of micro-analysis, sometimes with little theoretical grounding other than a desire to recognise that everyday religious practices are as authentic and as 'real' as statements about belief gathered from religious institutions, religious leaders or through large scale social surveys. It can also focus on practices to the exclusion of beliefs, reinforcing the mind-body dualism that it is so keen to disrupt, and perpetuating an argument that one form of religion (in this case embodied, practical) is more 'real' than another (cognitive, belief based). Anna Strhan's (2015: 61) work on evangelical Christians authoritatively argues that the latter form of religion '*has* been internalised in some contexts' (emphasis in the original). Woodhead (2012a: 1) too has suggested that the lived religion approach perhaps excludes too much, asking, 'if you leave out what is extra-ordinary, out-of-the-everyday, and remarkable, don't you leave out something very fundamental to religion?'. Bearing in mind the criticisms and potential limitations of lived religion, I argue that it remains an influential approach in disrupting the predominance of the study of belief and of the religious world-views of the elite and powerful, as well as the assumption of the coherence of beliefs and their translation into observable religious

practices. It is a useful approach for analysing women's embodied practices which are a search for meaning in a specific life event, such as pregnancy and birth.

**Gendered Embodiment**

In the preceding pages, I have argued that theories drawn from the study of religion can be applied when analysing social groups formed around shared values and practices which are nevertheless not necessarily religious. I have argued that theoretical approaches which seek to understand processes of meaning-making beyond institutional religious movements are a starting point for analysing wider processes of meaning-making in contemporary western societies. I then suggested that understanding of such communities might be furthered through a turn to theories which complicate the oft-assumed linear and causal relationship between beliefs and practices. Such practice based theories have a recognition of the central role of gendered embodiment in processes of meaning making, particularly pertinent in an analysis of the meanings of natural birth. Pregnancy and birth are embodied states. Furthermore they are specifically states of the female body. Pregnancy and birth entail significant and enduring changes in women's bodies. However, pregnancy and birth are not simply pre-discursive, biological events, but are rather cultural and social events with multiple socially constructed meanings. In understanding gendered embodiment in pregnancy and birth, I also draw on theories from outside of the study of religion, namely feminist perspectives which theorise the relationships between gender, sex and sexuality and the relationships between material bodies and the construction of meanings in relation to bodies. I argue that more attention could be paid to such theories within the study of communities around shared norms (such as the work of Alexander 2003 and Taves 2009) in order to understand the central role of gendered embodied practice in meaning-making.

Gender is both an integral meaning structure in natural birth communities and is a social structure which forms part of the context of this study. A number of points can be outlined here. First, my analysis of natural birth is gendered by default, as it is women who give birth and the majority of maternity professionals who help them (midwives, doulas, antenatal class teachers) are women. There are men involved in natural birth communities (the majority of women have a male partner who is involved in their pregnancy and birth

choices to varying degrees, and many of the most well-known natural birth authors are male) but my study prioritises women's own experiences, influenced as it is by feminist methodologies (to be discussed in the following chapter). Furthermore, women involved in natural birth, within the wider context of intensive motherhood outlined in Chapter One, are gendered in specific ways. Through their practices which demonstrate choice and responsibility they are performing a particular form of 'good' motherhood. Second, 'the natural' in natural birth encompasses intersecting ideas around the female body, women's corresponding social roles, claims to tradition and to a symbolic community of women throughout time and across cultures. It could be argued that these ideas make natural birth of particular salience to the women involved in the communities as opposed to men - women have a direct embodied experience of these ideas. Third, it might be the case that more women than men are involved in communities around the sacralisation of the natural in contemporary western societies. Here the social structure of gender comes to the fore. As stated above, Heelas and Woodhead (2005) have noted that more women than men are involved in the 'holistic milieu' and they relate this to their argument that secularisation and hence re-sacralisation has taken different paths and has impacted differently upon men and women. This argument has been extended by others including Houtman and Aupers (2008), Woodhead (2008a) and Sointu and Woodhead (2008).[6] Women are more likely to be involved in the holistic milieu, Heelas and Woodhead argue, for numerous reasons including that women are not only the primary carers in the home and workplace but also that they are more likely to care for 'the whole person'; they spend more time looking after the bodies of children and other dependents; and, drawing on feminist authors including Gilligan (1982) and Benhabib (1992), they argue that women's lives are situated around a relational subjectivism and a network of connections. For these reasons, they suggest, women are more drawn to the holistic milieu than men. Similar arguments have been made for the predominance of women in ritual healing groups in suburban America (McGuire 1988) and in caring for the dying in Finland (Utriainen 2010). This study contributes to the identification and analysis of communities around cultural norms, of sacred forms and

[6] Trzebiatowska and Bruce ( 2012) have sought to address the question of why women are more religious than men on a much larger scale, looking at different religions and different societies, but they make largely the same argument, 'The role of carer and primary responsibility for socialisation of the young keep women closer than men to organised religion, make more attractive belief in the afterlife, and sustain attitudes that find expression in the broader cultural worlds of contemporary spirituality' (2012: 177). However, a major difference, they argue, is simply one of time lag - secularisation affected men before women and women will eventually follow the same pattern of secularisation as men (2012: 178).

hence of meaning-making which are of importance to some women in the contemporary UK context.

Whilst a history of feminist movements, and their arguments for the relationships between sex and gender, is beyond the scope of this chapter, it is worth emphasising again the impact of 'radical feminism' on the emergence of natural birth ideas, as outlined in Chapter One. As Annandale and Clark (1996: 20) explain, second wave feminism can be seen as a continuum between liberal feminism which sees 'no intrinsic relationship between sex/ biology and gender' (a politics of sameness), and radical feminism which 'endorses a strong connection between sex and gender. It attempts to undermine patriarchal privilege by positively valuing what is distinctive about the female, rather than the male body' (a politics of difference). This valorisation of the female body is of particular importance in the natural birth milieu. The emergence of an academic study of childbirth in conjunction with second wave feminisms and the influence of such writings on wider understandings of 'natural' birth, both in the general population and amongst midwives and other birth workers, should be noted.

The reaction against second wave feminism in the late 1970s, 80s and 90s from both black feminists and those who came to be labelled as post-structural feminists, centred on a rejection of radical feminism as strengthening a dichotomous view of sex and gender, and as viewing the female body and its reproductive capacities as natural and pre-discursive, whilst assuming a unity between all women, in which women have more in common than difference which hence over-rides their similarities with men. Radical feminism was also criticised as a white middle-class woman's perspective, ignoring the roles of race and class in further oppressing some women, as discussed in Chapter One. hooks, Collins, and other black feminists, have argued that the experience of sexism does not create a universal bond amongst all women as class and race differences intersect to create further levels of oppression. These differences 'take precedence over the common experience women share' (hooks 1984: 4). Second wave, white feminists' preoccupation with gender reflected their lack of understanding of class and race, black feminists argue. Black feminists within academia used their own unique 'standpoint' to understand both 'outsider' and 'insider' perspectives, a position which Collins (1986) labelled, 'the outsider within'. Collins (1986) calls for the emphasis of the 'creative expression' which can come from a position of

marginality. She calls for a new black feminist epistemology which incorporates elements of 'both the Afrocentric and the feminist standpoints', alongside a recognition of class differences, and hence of 'multiple consciousness' (1989: 756-7). She claims that the ethics of care and of personal accountability are central to these standpoints (1989: 67-8).

Judith Butler's work complicating the relationship between sex and gender (1990) and examining the role of discourse in the construction of the material body (1993) has been influential in the field of post-structural feminism. However, whilst her writings on performance have been used in analyses of childbirth accounts (for example, Pollock 1999, Klassen 2001, MacDonald 2007), others have argued that her focus on subjectivity and agency as linguistic limits the practical use of her theories, especially for those working in the field of reproductive health, where there is acknowledgement of some biological sex differences regardless of whether and how these relate to gender identities. Whilst biological sexual differences might be better understood as a continuum rather than a dichotomy, it remains the case that to date, it is only those on the 'female' end of the continuum who menstruate, become pregnant and give birth (although by no means all women do, of course, for a variety of reasons).

***The Lived Body***

Arguing that some philosophical feminist theory has only a theoretical focus on the body as/in relation to discourse, writers such as Iris Marion Young (1984, 2005), Robyn Longhurst (2001, 2009) and Meredith Nash (2011, 2012), have called for a focus on the reality of the 'messy' body which leaks and seeps, with the pregnant and birthing body as the ultimate example. Young has called for the concept of the 'lived body' (drawing on the existential phenomenology of Maurice Merleau-Ponty [1945] and Simone de Beauvoir [1949]) as a means of describing the subjectivity of lived, material, embodied existence, whilst simultaneously deconstructing the sex-gender link.

Young (2005: 16) defines the lived body as 'a unified idea of a physical body acting and experiencing in a specific sociocultural context; it is body-in-situation'. Situation, she goes on, denotes the interplay of the facticity of the material body and its relationship to the physical and social environment, along with the freedom of the individual in relation to

this facticity, the way in which the individual is guided by the projects she has. 'The idea of the lived body recognises that a person's subjectivity is conditioned by sociocultural facts and the behaviour and expectations of others in ways that she has not chosen. At the same time, the theory of the lived body says that each person takes up and acts in relation to these unchosen facts in her own way' (2005:18).[7] R.W. Connell (2002) makes a comparable argument in her theory of social embodiment. She defines social embodiment as the multiple circuits which link bodily practices and social structures, which 'occur in historical time, and change over time' (2002: 47). Connell (2002: 47) too recognises that 'bodies have agency and bodies are socially constructed. Biological and social analysis cannot be cut apart from each other'. I argue that these approaches, which seek to analyse the lived body in everyday experience, are a way forward for studies of embodied experience which are explicitly and simultaneously both biologically and culturally significant. They recognise the importance of social structures, including gender, whilst allowing for analysis of individual agency, and, as outlined in Chapter One, my study is partly a counter-balance to existing studies of pregnancy, birth and motherhood with an over-emphasis on structure.

Bryan Turner (1992) has suggested that the lived body could be a fruitful approach for medical sociology due to its practicality - its focus on how bodies are lived in everyday situations rather than philosophical arguments about the causal relation of sex and gender. The concept of the lived body recognises the material body as fact but as only understandable through the meanings laid upon it. Nevertheless, it sees the material fact of the body constraining meanings to a greater extent than perhaps Butler would argue. It highlights that lived experience is comprised of both embodied practices and cultural meanings that are not easily separable, but are always inextricably bound up with each other, and that in some cases (such as pregnancy and birth I argue), materiality might constrain possible cultural meanings.

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[7] It would be easy to criticise this theorising as placing too great an emphasis on agency, but it must be remembered that in Young's account both the lived body and the situation are being theorised in relation to subjectivity only, with Young arguing that the concept of gender should be maintained for studies which focus on social structures. However, I think that Young's essay actually belies the separation of subjectivity and social structure which she suggests. She states that the lived body is also a theory for 'articulating how persons live out their positioning in social structures' (2005: 25). Social structures, including gender, are part of the facticity, the situation, within which the body lives.

Whilst I find writings on the 'lived body' helpful, I also draw on Marcel Mauss's (1973) concept of 'techniques of the body', with which parallels can be drawn to Foucault's ideas of the regulation and surveillance of bodies, and Butler's theory of performance and 'corporeal styles'. The lived body can be seen as constituted by techniques of the body and thus these approaches are most useful in combination, I argue.

### *Techniques of the Body*

Both post-structural feminisms and existential phenomenology seek to theorise how bodies are lived, how identities are created and maintained, through practices or performances. De Beauvoir, Young, Butler and Connell place great emphasis on what are variously termed acts (de Beauvoir 1949); habits, interactions, comportment (Young 2005); corporeal styles (Butler 1988); and body-reflexive-practice (Connell 2002). Such theories of practice and performance are essential for an analysis of communities formed around embodied practices, such as natural birth groups. These theories highlight that, despite possible claims to the contrary by practitioners, the embodied practices of particular communities are not 'natural' but are rather learnt within specific processes of socialisation. It is through such theories that a problematising of the 'natural' in natural birth communities is possible; through an analysis of how natural birth is not a biological, pre-cultural given but is rather constructed in historical and social processes with different embodied practices considered to constitute natural birth in different communities, by different teachers. Embodied practices are always learnt and transmitted in power relations. This provides a means for thinking about the ways in which natural birth communities can be liberating for the individual woman in the sense that through her practices, her agency, she is exercising choice and, in the case of the women I interviewed, making a statement of difference to the 'mainstream' (i.e. medicalised birth). Yet such communities can be simultaneously confining or condemnatory; natural birth groups can make normative judgements about what is proper and correct practice, including some women and excluding others. Whilst Foucault's concept of self-surveillance is essential to an understanding of pregnant embodiment in contemporary western societies (see Longhurst 2001, 2009, Possamai-Inesedy 2009), I argue that the bodily techniques of natural birth do not create docile or passive bodies but rather active bodies which make choices to resist the mainstream, albeit within the confines of (sometimes) regulatory natural birth communities.

Theories of ‘techniques of the body’ have focused on gendered practices to different extents. For those inspired by Foucault, including Butler, and by existential phenomenology, including Young, there is a focus on techniques which create a gendered identity (Butler 1988) or a feminine subjectivity (Young 2005). Theorists of the lived body argue that gender differences arise because of the situation of the lived body; hence the ‘female’ lived body exists in a situation in which the female gender is considered subordinate to male which itself leads to differences in body techniques (Young 1980). Butler (1988: 519) argues that gender, rather than being a stable identity, is rather created ‘through a stylised repetition of acts’ including ‘bodily gestures, movements and enactments of various kinds’ which are governed by ‘social sanction and taboo’, which she defines as the regulatory norms of heterosexuality. Gender is hence a ‘corporeal style’, an act which performs, which brings into being. The body only becomes its gender through such acts (1988: 522). However, Butler gives no specific examples of what these acts are, perhaps in keeping with her theoretical focus and her argument that the acts must not be considered as individualistic but as collective action which is rehearsed over time. My focus rather is specifically on concrete, embodied practices undertaken in pregnancy and labour, including exercise, positions, diet and consumption practices. The performance of these practices creates a specific, gendered subjectivity, that of the good and responsible mother who researches her choices and acts accordingly. I am interested in whether and how ideals can be considered as grounded in body techniques, which then commit women to a particular community and contribute to an emotional and moral charge around pregnancy and birth.

A starting point for theorising ‘techniques of the body’ is Marcel Mauss’s (1973) essay of the same name. Mauss (1973: 70) defines such techniques as the ‘ways in which from society to society, men (sic) know how to use their bodies’. Such techniques cover the whole of the individual life cycle from birth through sleeping, walking, swimming, eating, sex and more. Techniques vary according to age and sex, he argues, including different cultural practices of techniques of birth and obstetrics as an example. Whilst he provides no further theorising on gendered practices, his essay is important in its argument that techniques are not ‘natural’ - although they can have a biological foundation - rather they are socially learned especially through the education of children and the imitation of

superiors by both children and adults. Hence there is a power dynamic at play in their transmission. An analysis of techniques of the body, learnt within a social community, draws attention to the central role of tradition. Mauss (1973: 75) suggests, with regard to the transmission of techniques, that 'there is no technique and no transmission in the absence of tradition'.

Mauss introduces the concept of the 'social nature of the habitus' as important in the analysis of transmission of techniques. He argues that any analysis must incorporate a triple viewpoint incorporating the biological, the psychological and the social. Whilst the concept of the habitus arguably remains underdeveloped in Mauss's essay, it has been refined in the work of Pierre Bourdieu (1977) and Mellor and Shilling (2010). The latter's development of the term, particularly in their theory of 'body pedagogics', is particularly pertinent in suggesting a framework for the empirical analysis of body techniques deriving from and constituting 'cultural forms'. Mellor and Shilling (2010: 202) define the habitus as a 'socially structured bodily disposition that promotes a particular orientation to the world'. Following Mauss, they argue that the formation of the habitus is a process of corporeal learning, a learning of technique. They argue that a central component of the habitus is a process of body pedagogics which 'examines how and to what degree the orientations, dispositions, values and techniques validated by cultural forms, including religion, are actually embodied in the individual' (2010: 215). An analysis of body pedagogics, they argue, should focus on the interaction of three factors: the cultural means ('religious, educational and institutional means and activities') through which people encounter the key values, techniques and dispositions validated by the culture, people's experiences of these activities and the embodied changes/outcomes resulting from the cultural transmission (2010: 215). Their theory is useful when thinking about the extent to which the values and techniques taught in natural birth books and classes are embodied in the pregnant and labouring woman.

I argue that in the case of natural birth, techniques of the body, which are felt to be of the physical order and which have a concrete end-goal, can also be considered as ritualised activities with symbolic significance, making a comment on how birth ought to be. Furthermore, the different techniques within natural birth can be considered as having their own tradition (in the narrowest sense of the term in that specific techniques are associated

with a lineage of particular teachers) and as also utilising a wider generalised idea of tradition to convey legitimacy (in claiming a particular technique as a 'traditional' way to give birth, particularly in the case of those teachers who draw on anthropological and/or historical studies).

Theories of the 'lived body' and 'techniques of the body' are attempts to move away from dichotomous thinking including dichotomies of mind/body, thought/action and belief/practice, and, in the case of the former theories, sex/gender. They also emphasise how practices and bodily styles and identities are not natural or pre-discursive but are rather learnt within a social community and are maintained through the repetition of acts. They hence provide a way of thinking about how communities are created and maintained practically and materially, not just discursively. In terms of natural birth, they provide a way of thinking about how particular embodied practices embed a woman in a particular approach to birth.

Above I have set out theories - primarily from the study of religion but with the addition of a number of gendered embodiment theories - which I utilise to analyse natural birth as practice-based communities with shared morals and values. I have highlighted theories which focus on agency within the confines of structure, and on lived, embodied experiences. Continuing this focus, I turn now to a particular aspect of natural birth; the ways in which women negotiate between the ideal or sacred form of the natural and their own individual (but also social) and practical circumstances. I draw here on works on 'lived' or 'ordinary' ethics, and consider the practices of natural birth as a form of 'ethical path'.

**Negotiation and the Ethical Path**

The theories discussed above, including writings on the sacred (Alexander 2003, 2010, Alexander et al. 2006 and Lynch 2012a and 2012b), things of 'value' or 'matter' (Bender and Taves 2012) and 'specialness' and the 'religious path' (Taves 2009), all touch on the field of morals, on public moralised discourse and a generalised distinction between what is 'right' and 'wrong'. Indeed, religions and sacred forms can be seen as providing moral frameworks for their adherents. But there have also been recent moves within both

religious studies and anthropology to focus on a more situational, practical and relational field of ethics, on how things of value and judgements of right and wrong are created in processes and relationships (Bender and Taves 2012, Lambek 2010, 2015, Strhan 2015).

In the emerging field of the anthropology of ethics, the focus is not on 'ethics' as a distinct dimension of social and cultural life, but on 'lived', 'ordinary' ethics or 'the ethical' as a dimension which permeates all of life. In this, there is movement away from a traditional philosophical distinction between morals as general, abstract rules, and ethics as the ways in which morals are implemented in everyday life,[8] to use the terms interchangeably (Keane 2010: 65, Lambek 2010: 17) and to prefer the ethical as an adverb or adjective rather than a noun (Lambek 2015: 6). Lambek (2015: 16) avoids defining or locating the ethical arguing that 'the ethical is immanent' - not to human 'nature' but to the human 'condition', to our thrown togetherness, and our socially and linguistically embedded tendency to judge and discern all speech and action. He suggests that 'attending to an ethical dimension might enrich our understanding of human life as it is actually lived, experienced and reflected upon' (2015: 5-6). 'What we are addressing' (in the study of the ethical), he goes on, 'is the nature of understanding and self-understanding…coming to understand how things matter for the subjects of our particular ethnographic enquiries' (2015: 8). Saba Mahmood (2012), in her study of the women's piety movement in Cairo, Egypt, makes a strong argument for considering the ethical in all aspects of life, including politics. She argues that the embodied practices of ethical self-formation that women undertake in this particular moral reform movement actually form the subject. She presents this as a novel way of thinking about agency in feminist theory, escaping the western, secular project of considering feminist agency in terms of submission or resistance, to instead considering a wider range of 'modalities of agency', 'the kinds of capacities - embodied, rational, technical - these various modalities of agency require', and the resultant 'conceptions of the body, personhood, and politics these capacities construct' (2012: x). Her focus then is on how women's practices are not simply symbolic acts but actually form the subject. In this she challenges the assumption in some western philosophical writings on ethics and morality that ideas and values are formed first and practices follow after: for the women she studied, practices formed their morality. I have

[8] Such as in the work of Bernard Williams (1985).

argued throughout this chapter - and will demonstrate in later chapters - that practices are integral to meaning-making and can play an important role in forming values.

As suggested throughout this chapter, people's relationships with ideal or sacred forms are complex; and as such they are discussed, reflected upon and negotiated. Joel Robbins (2004), in his study of the Urapmin of Papua New Guinea's conversion to Christianity, argues that the 'ethical is a field of values' which are experienced as a 'directive force'. He goes on,

> Having defined the moral field as one in which actors are culturally constructed as being aware both of the directive force of values and of the choices left open to them in responding to that force, we have to recognise that it is fundamentally a domain that consists of actions undertaken consciously (2004: 315).

However, there is no straight forward form of engagement. His study highlights the ethical conflicts and 'moral torment' the Urapmin experience in living through the cultural change of conversion from their existing religious traditions to those of Pentecostal and Charismatic Christianity. It emphasises that ethical self-formation can be particularly pertinent at times of heightened social tension. In my study of natural birth, this tension is experienced at an individual level: women are keen to exercise their agency in their pregnancies and births in situations which sometimes work to inhibit this. This raises the question of the role of embodied practices and relationships in negotiating a moral field.

The women I interviewed were committed to an ideal of natural birth but demonstrated hesitations and ambiguities around their understandings of natural birth, justified through their presentation of it as an individual path and what was 'right' for them, as will be discussed in Chapters Four and Five. They were engaged in a constant ethical debate as to what were the best choices and practices for them and with presenting this as a coherent narrative in the interview context. They were concerned with presenting themselves as moral individuals, in this case, as 'good' and 'responsible' mothers who had taken the time to research their choices and make decisions based on what was right for them. This resonates with David Morgan's (2013: 127) work on 'the ethical turn in family studies' in which the ethical has come to the fore in empirical work on family relationships. Using a quotation in which a mother discusses with a researcher her decision to allow her 19 year old daughter's boyfriend to stay over, Morgan (2013: 127-128) suggests that the hesitations

and the 'attempt to introduce and weigh up all the relevant considerations' indicate that the mother 'is conducting some kind of ethical debate with herself and the interviewer'.[9] He suggests that this 'very everyday issue' is one that the mother has obviously considered, and struggled with, prior to the interview. 'And, while there are no references to abstract religious or moral precepts, she is very much concerned with doing the right thing and with presenting herself as a moral individual' (2013: 128). The same argument can be made of my interviewee's discussions of their pregnancy and birth choices.

As Webb Keane (2010: 69) has suggested, 'ethically marked practices' use 'different modalities'; 'forms that help endow material and verbal exchanges with their ethical character' and 'contexts that encourage or demand the explicit giving of reasons'. It is the latter that is particularly pertinent in this analysis of natural birth as, in the narration of their pregnancy and birth stories, the women I interviewed were simultaneously giving their reasons for choices made. This is a point also made by Faircloth (2013) in her analysis of women's 'accountability strategies' for extended breastfeeding practices. As Lambek (2015: 15) notes, 'We all hold ourselves accountable'. 'The interpretation of our lives…is central to the living of them' (2015: 44). In the giving of reasons to others, in persuading others and giving an account of oneself, one is engaged in an act of ethical self-formation, simultaneously persuading and forming self. 'We come to be who we are within, and by virtue of, relationships with others, their bodies, their possessions, their languages, their ways of inhabiting our imaginations and emotions' (Lambek 2010: 66). The ethical is neither a form of individualism nor a purely social construction, Keane writes. Rather it is formed through the 'sociological imagination', through relationships with others, albeit if only through the 'surface of things' (Keane 2010: 67-69).[10]

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[9] Later in the chapter he recognises that the interview context, defined as a 'conversation with a purpose', 'encourages respondents to enter into the kinds of ethical discussions, with all the hesitations and qualifications, that constitute the core of this chapter. In short, the researcher bears some responsibility for constructing this particular form of moral reasoning conducted within a familial context' (2013: 138). I completely agree with this statement. However I also argue that with regard to the pregnancy and birth narratives I collected, I had the sense that most of them were quite well rehearsed, and given that the majority of my informants were found through online social networking, it is likely that the narratives had already been shared in social groups, as well as with family and friends.

[10] Keane (2010: 68) argues that 'To one who is in the midst of action, the entire range of possible explanations for other people's actions and possible outcomes of one's own can never be fully apparent'. For this reason, people can only respond to 'the surface of things', to 'inferences' from 'perceptible experiences'. But this does not detract from the importance of relationships in ethical practices.

Ethical practices and the sharing of moral tales which account for behaviours, are then central to self-formation. In 'Technologies of the Self', Foucault (1988: 17) states that there are four major types of technologies which account for how 'humans develop knowledge about themselves': technologies of production, of sign systems, of power and of the self. His interest has been in the latter two but, he writes, 'I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of self' (1988: 17). Foucault's chapter focuses on technologies of the self in Pagan and early Christian practice and has been influential in anthropological writings on ethics. Strhan (2015: 65-66) has fruitfully combined Foucault's theories of 'technologies of the self' with Mauss's 'techniques of the body' in order to consider how conservative Evangelicals train their bodies and minds to become 'disciples'. Strhan (2015: 66) dismisses some criticisms of Foucault's understanding of morality as individualised, stating that 'Foucault is clear that the engagement with the self is a thoroughly social process'. 'Subject formation' is not just about following a prescriptive system of morals and values but is about how individuals choose to engage with these systems (Strhan 2015: 67). In the words of Tracey Jensen, it is about 'choosing to become' a specific kind of person, in this case the 'good' mother (2013: 51), albeit within the confines of a particular social and cultural situation and its associated power and governmental structures.

Like Lambek, Morgan (2013: 129) suggests that 'ethics are not a separate or rarified area of discourse but are closely bound up with everyday practices'. 'Family practices', a term coined by Morgan (2013: 10), are defined simply as relational practices 'carried out with reference to some other family member', whilst recognising that each individual is embedded in 'networks and sets of relationships' (2013: 133) and that there is no such concrete thing as 'the family', heteronormative or otherwise (2013: 3).[11] Unlike Lambek, however, Morgan (2013: 129) distinguishes morality - 'public discourses about right and wrong and how these might apply to family living' - from ethics - 'the reflections and debates that surround everyday family-based practices and dilemmas'. Neither does he draw on the philosophical debates that inform the anthropology of ethics, instead

[11] On a deeper level, 'family practices' are described as having six characteristics: Linking the perspectives of the observer and the actor; a sense of the active; a sense of the everyday; a sense of the regular; a sense of fluidity; a linking of history and biography (2013: 5-7).

referencing feminist care ethics as influential, particularly ideas of 'self-in-relationships' and 'situated questions of responsibility and agency' (2013: 128). It is concrete relationships rather than normative expectations which govern decision-making and related family practices on an everyday level. The women I interviewed balanced their normative expectations about the ideal natural birth with their own individual and family situations - a balancing act which could lead to 'the birth I want' or the birth that is 'just right for me'. Family ethics is not then about discourse but about making practical choices. Ethical decisions become part of everyday family practices, for example the decision to care for a sick relative entails practices which become routine (such as 'shopping, visiting, collecting medications etc' [Morgan 2013: 142]), or the decision to work towards a natural birth entails regular practice of certain exercises. 'When individuals are called upon to account for these everyday routinised activities they will respond with some reference to ideas of what is seen as right and proper' (Morgan 2013: 142). For this reason, Morgan (2013: 142-143) suggests, there is a 'close affinity' between a 'practice approach' (to family sociology but equally within other disciplines such as religious studies) and 'the growing interest in everyday, practical ethics'. The study of ethics and of practices are both 'concerned with links between the part and a constructed whole, between discourses and practices, and the construction and negotiation of meanings. In both cases, we are concerned with active processes, with doing family and doing ethics' (2013: 143). This also resonates with Orsi's claim that the study of lived religion is about processes of meaning-making, not meaning as an end-product, and that such processes include relationships with others. Writing of his grandmother's devotion to Saint Gemma Galgani, he suggests that this was not a relationship of meaning-making but of 'companionship on a bitter and confusing journey' (Orsi 2005: 145).

The work of birth that I discuss in this thesis is also about 'doing family' and 'doing ethics'; through the work of birth, the women balance the ideal with the practical in order to forge their own path of what is 'right' for them. Utilising anthropological writings on the ethical allows a new perspective on intensive mothering, focusing not on the subordination of women but on their everyday, routinised, embodied practices of pregnancy as just one example of the way in which everyone is involved in ethical self formation through relationships with others.

**Conclusion**

In this chapter I have argued that when analysing shared norms, values and practices within social groups, it is helpful to employ a combination of theoretical frameworks from across a number of disciplines. I have argued that natural birth groups need not be approached as a functional equivalent to religion - as some lived religion approaches might suggest - but that theories drawn from the study of religion are insightful as they are sensitive to issues of meaning-making and to the relationships between beliefs and practices. I have argued that Alexander's strong program of cultural sociology, which recognises meaning as an underlying structure represented in a sacred-profane binary code, is a means of analysing communities' public statements in mainstream and social media in which they necessarily take a polarised and seemingly intractable binary position. However, the definition of the sacred, as something absolutely set apart, does not always hold traction when analysing the meanings of participation in such communities, including women's lived, embodied and negotiated relationships with the public statements of natural birth groups. This raises questions around to what extent, or in what context, is it helpful to think in terms of sacred binaries? Are the moral commitments of natural birth a sacred absolute, failure of which leads to shame, as Malacrida and Boulton (2013) would have it? Or do women place value in the very act of preparation suggesting a more fluid and negotiable relation with the natural?

Taves' definition of specialness as a continuum of value, something highly valued in relation to other things, is an alternative way of thinking about meaning-making and participation in groups arounds 'things that matter'. Yet whilst Alexander's definition of the sacred might not be entirely applicable in the lived context, in which women have a fluid relationship to that which is most highly valued, Taves' concept of special lacks the 'weight' and 'definitional tightness' of the sacred. I hence build upon Taves' use of the term 'ideal' as a means of considering that which is most highly valued in a particular group. Whilst Taves includes ideals, such as 'Beauty' and 'Nature', as special things on the set apart end of the continuum, I use here a different definition of the term. Whilst the etymology of the term ideal is the Latin *idealis*, or idea, and it is most often defined as a thing considered to be perfect, existing as an idea or archetype, that is in the mind, the *Oxford English Dictionary* reminds us that, as a noun, it can also be defined as 'A

conception of something, or a thing conceived, in its highest perfection, or as an object to be realised or aimed at'. It encompasses, in this definition, both an idea and an action or practice. Furthermore, the phrase 'aimed at' suggests the possibility of non-achievability. Hence I use the term 'ideal' in order to convey something that is most highly valued but that is not necessarily considered attainable or even desirable in its entirety. Instead it is held as something to be worked towards with the possibility of non-attainability always present.[12]

The use of the term 'ideal', encompassing an idea of a working towards, encourages a greater attention to lived embodied relationships with the sacred/special/ most valued thing and the negotiations between upholding this and one's own desires and expectations based on practical considerations and social relationships. It allows attention to be placed on the 'working towards' which is necessary for analysing communities of practice, such as natural birth groups, in which practices are of more or equal importance to beliefs. I have argued for the use of theories which emphasise the role of practice in meaning-making and which challenge the once held assumption in the study of religion that meaning equates with beliefs and that forms of practice, including ritual, are manifestations or performances of those pre-existing beliefs. I have presented theories from the study of religion which complicate the relationship between meaning, beliefs and practices, such as Bell's theory of ritualisation and the lived religion approach. I have also traced some of the ways in which lived religion emphasises the importance of gendered embodiment in lived (religious) experience. Its focus on the 'other' within the study of religion - that is on religious lives outside of religious institutions and neatly bounded traditions with authority structures based on male leadership, texts and beliefs - includes a focus on women's everyday religious and spiritual practices around the body and health and healing. I have argued that this sensitivity to gendered embodiment in meaning-making practices necessarily draws on feminist theories of embodiment and that Young's writings on the lived body emphasise how meanings of the body can have simultaneous biological and cultural/social origins. I have argued that Young's writings can be combined with Mauss's writings on techniques of the body in order to understand how the practices of natural birth are not natural in the sense of being pre-discursive, but are rather learnt in specific ways

[12] I avoid the term failure here because of the historical negative connotations of this term in relation to natural birth. As my analysis in later chapters shows, 'failure' to attain a particular type of birth does not amount to an interpretation of the failure of the ideal.

including through classes, books and online material. It is these practices which can then embed the woman in a particular approach to birth and provide meaning during pregnancy, birth and postpartum.

I have argued that natural birth groups can be considered communities around shared moral norms, values and practices. Following Bender and Taves (2012), I argue that such groups are examples of 'things that matter' to some women in the contemporary UK. Extending this work on 'things that matter', I have engaged with the turn to ethics in both anthropology and the sociology of the family in order to consider how birth practices can be part of an 'ethical path' in which women strive to reach an ideal which simultaneously forms a particular subjectivity. I argue that analysis of such groups is an important contribution to the study of alternative forms of meaning-making beyond institutional religion. Furthermore, I argue that an analysis of such practice-based groups allows for reflection on the relationships between beliefs, practices, and meaning-making. In this chapter I have presented a combination of theories which provide a model of a way of thinking about an 'ideal', not as an abstract idea but as something valued that is instantiated in gendered body practices. This study contributes to understanding the everyday experience of trying to negotiate an ideal with more practical concerns. In the case of natural birth groups these concerns include the influence of a social network and embodied, biographical experience and knowledge, as well as, often, a lack of knowledge. In the following chapter, I outline how my theoretical interest in examining the disjunctions between symbolic meanings, practice and lived experience was operationalised in my study of natural birth.

## Chapter 3 - Methodology: Learning about Natural Birth Ideals and Practicalities

In the previous chapter, I outlined my theoretical interest in meaning-making outside of institutional religion and described natural birth in the contemporary UK as one example of groups formed around shared norms, values and practices and as 'things that matter' in the lives of some women. I further argued that analysis of these practice-based groups could extend thinking about the relationships between beliefs, practices and meaning, particularly as they have been considered within the study of religion. Hence in this thesis, I contribute to understanding non-religious forms of meaning in the contemporary UK, particularly forms of meaning which are gendered, embodied, and practiced in specific ways. More specifically, I seek to contribute to the question of how to understand the everyday experience of trying to negotiate an ideal with more practical concerns, using the example of natural birth. My focus then is on how symbolic meanings and lived experience are negotiated through practices; in this case, how women make choices and prepare for their births.

In this chapter, I describe how my theoretical interest in examining the relationships between symbolic meanings, practice and lived experience is operationalised in my study of natural birth. After outlining my research questions, I discuss the relationship between the theoretical framework discussed in Chapter Two and the methods selected for obtaining data; namely a combination of observations of different classes and events and open-ended narrative-style interviews. After a discussion of the beginnings of the research project - from secondary research to advertising the project, making contact with 'gate-keepers' and finding participants - I discuss the demographic profile of the research participants and the implications of the self-selecting, relatively similar sample. As suggested in Chapter One, participants in natural birth groups and other practices of 'intensive motherhood' are overwhelmingly middle class (Hays 1996, Bobel 2002, Macdonald 2010, Lareau 2011, Thomson et al. 2011, Perrier 2012, Faircloth 2013). These authors portray natural birth and intensive motherhood as a neoliberal concern arguing that it is the (white) middle classes, and women in particular, who feel the burden of responsibility to make the choices encouraged by current government policies in the wider healthcare context, as well as in schooling and numerous other areas. It is predominantly the middle and upper classes who have the financial and social resources to explore their various choices, including the field of natural birth consumerism. And in fact birth consumerism can be one way in which

middle class identities are made and displayed. Parallels can be drawn with writings on the holistic milieu from the field of religious studies which have made similar observations about the gender and class positions of participants. I discuss the limitations and benefits of using a  sample consisting of women of a similar social demographic profile - whilst it limits the generalisations and comparisons that might be made, it arguably allows for a deeper understanding of the community in question in relation to their class positioning and relationships to consumerism.

I then describe the two research methods utilised, observations and interviews, discussing within each section the benefits and limitations of each approach for the project, before providing more information about how I used the method. I discuss the benefits and limitations of using interviews in seeking to understand communities of practice, as well as the influence of feminist methodology on the thesis, particularly in relation to issues of ethics, sensitivity and reflexivity. The chapter concludes with a description of analysis of the data with a focus on coding techniques.

**Research Questions**

This thesis explores the ordinary experience of trying to balance an ideal with one's own practical circumstances within the extraordinary context of pregnancy and childbirth. I focus on identifying the ideal and the practical in natural birth groups and women's narratives of experiences. I explore how normative claims around natural birth, made either by women themselves in the interview context or within the natural birth literature or groups attended, fit with the women's own reported motivations for participation in natural birth groups. I focus on women's practices in preparation for natural birth and consider the role of such practices in negotiating the relationships between the ideal and the practical ends of the spectrum. I also focus on the wider social role of pregnancy practices in order to consider what significance they have, if any, beyond preparing an individual mother for a particular type of birth.

My questions focus on women's reported desires, motivations and practices in order to try and achieve a particular form of birth. They are:

- Why do some women report that they want a natural birth? Why and how do they become involved in natural approaches to pregnancy and birth?
- What does the 'natural' mean in this context? What birth practices are included and excluded from women's understandings of natural birth?
- Are there any other terms which have such symbolic significance in the context of pregnancy and birth?
- Why do some women report that they need to learn and practice natural birth and what do they do during their pregnancies to prepare for such a birth?
- How and why do women's understandings of, and commitments to, natural birth change over the course of their birth history? For example, why are first and subsequent births sometimes approached and prepared for rather differently?
- What protection mechanisms do women use if the ideal birth is not achieved and how is the ideal birth subsequently re-negotiated?
- What statement, if any, are the women making about themselves as mothers and about others who approach their pregnancies and births differently?

**A Combination of Methods**

I addressed the research questions through secondary research involving analysis of natural birth manuals and websites, and then observations of a number of natural birth classes and social events, as well as narrative-style interviews with 43 pregnant women, new mothers and 'birth-workers' including midwives, doulas and various class teachers. Whilst the majority of these interviews were one-on-one, on five occasions I interviewed two women together, and on one occasion, three women. These interviews gave particularly interesting data as the women discussed issues in conversation with one another which might not have arisen otherwise. I felt that the experience of observation would allow me to gain a deeper awareness and understanding of the issues discussed in the interviews. In this approach, I follow moves towards adopting ethnographic methods in the sociology of religion, particularly in the lived religion approach discussed in the previous chapter.

The movement away from the study of institutional religion towards lived, embodied and gendered religious and non-religious practices discussed in the previous chapter, has seen a corresponding movement away from large scale social surveys, questionnaires and

structured interviews towards ethnographic and mixed methods approaches which are more immersive and more sensitive to issues of meaning-making, ethics, and reflexivity. Indeed, the lived religion approach discussed in the previous chapter is not only a theoretical concept, it is also a methodological approach. Lived religion seeks to bring concepts, theories and methodologies from the anthropology of religion into the sociology of religion. Authors working within the lived religion framework have a preference for micro-level analysis of religious lives and practices using ethnography to counter traditional sociology's more macro-level and quantitative methods. Lived religion scholars such as McGuire (2008), argue that a focus on institutional and male-dominated religion is inherently tied to the methodological approaches of surveys and questionnaires, in which belief is assumed to be primary and coherent; hence the study of lived practices, particularly those which are embodied and within the realm of women, necessitate alternative methodological approaches. As Strhan (2015:60) writes of McGuire, 'Her dissatisfaction with quantitative sociological research methods is bound up with how these "frame" religion primarily in relation to established religious institutions and statements of belief, failing to engage with the complexities and nuances of lifeworlds that cannot be "stuffed into…[a] questionnaire's categories" (2002: 196)'. Lived religion scholars attempt to interrogate different aspects of religious life to the seemingly ordered realm of institutional religion and belief, including the 'messy' realms of often incoherent beliefs and practices.

This raises methodological challenges. As Woodhead (2012a: 4) writes, 'The study of everyday lived religion arises out of a methodological challenge. How is it possible to see that which is invisible, to scan that which has been below the scholar's horizon, and to capture the unarticulated with words?'. She offers suggestions of numerous methods which might better probe the 'invisible' and 'unarticulated' including open questions, narrative techniques, pilot interviews, the use of written or video diaries and photo-elicitation techniques, some of which I employed and discuss further below. She suggests that

> by using a variety of approaches which are designed to work with the grain of everyday life, and to allow informants to set the agenda and change the subject, research may be better able to overhear topics, themes, hints and suggestions about areas of life - including religion - which have not previously been noticed or listened to as attentively (2012a: 5-6).

Whilst I did not use all of these techniques, I attempted to not restrict the ways in which I was willing to learn about people's ideals and practices, and so used multiple forms of interview and observation. I was keen for informants to tell their own stories, often generated by a single narrative question, and to be attentive to what was said and how, as well as to what was not said, or implied, as well as to emotions and embodied states.

It is important to note that whilst this thesis is concerned with women's pregnancy and birth practices, my theoretical and methodological approach is not one of 'practice theory'.[1] My focus is not so much on a Bourdieusian understanding of practice as ontologically prior to implicit knowledge and meaning and which cannot be verbalised (Bueger 2014: 386). It is rather on specific forms of practice which are consciously chosen at 'magnified moments' (Hochschild 2003: 16)[2] and hence are often verbalised and reflected upon, including in ante and post natal groups and in online discussions, as well as in interview contexts.[3] My focus is on how these practices contribute to meaning-making in the context of pregnancy, birth and postpartum. Hence, I am not concerned with whether or not the women actually engaged in the practices to the extent which they claimed, that is with the 'truth' of what they were saying, but rather with the role of practices in the creation of meaning, including the creation of meaning through narrating the experiences in the interview context. I argue that post-hoc rationalisations are not 'worthless data', as some practice theorists might suggest (Bueger 2014: 400), but are a valid means of analysis of meaning. Hence whilst some of the preferred methods of practice theory, such

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[1] 'Practice theory' refers to a collection of theories 'which highlights the routinised and performative character of action, its dependence on tacit knowledge and implicit understanding' (Ritzer 2007). Bueger (2014: 383) defines it as 'a set of conceptualisations implying a focus on practice as the smallest unit of analysis'. 'Practice theory has its roots in anti-intellectualist and anti-dualist social philosophy' in the works of Wittgenstein and Heidegger (Ritzer 2007). In 'contemporary social theory', Bourdieu, Schatzi, Giddens and Garfinkel, are influential, and the works of Latour, Butler and Foucault also 'comprise praxeological ideas' (Ritzer 2007). Some of these authors, and some of their theories, I draw upon in this study, as outlined in Chapter Two. However, I am more influenced by writings on practice from the field of the study of religion. Klassen (2008: 137), for instance, takes a broader definition of practice as 'a concept that brings together thought and action - both how people think about the world they live in and what they do in it'.

[2] Hochschild (2003: 16) describes 'magnified moments' as 'episodes of heightened importance, either epiphanies, moments of intense glee or unusual insight, or moments in which things go intensely but meaningfully wrong'.

[3] I discuss this further below when analysing the benefits and limitations of using interviews to study practices, particularly drawing upon the arguments of Allison Pugh (2013) and Russell Hitchings (2011).

as facilitating the participant's creation of videos or diaries in the belief that this removes a layer of representation and is the only way to access non-verbalised practices, would have been interesting and would certainly have added new data, I did not consider them essential in this context in which I was concerned with the women's own narration of practices.[4] Interviews, with observations to add a depth of data, were the ideal methods.

**Secondary Research, Advertising the Project and Finding Participants**

Before starting fieldwork, alongside developing the theoretical framework outlined in the previous chapter, I engaged in analysis of existing academic literature on pregnancy and birth, as well as of different forms of published primary materials. I read a wide range of natural birth manuals, some of which were discussed in Chapter One, as well as magazines, NHS and NCT literature, media articles, and online materials, most notably Facebook pages. Initial exploratory research led me to focus on certain authors as foundational to the development of natural birth (Dick-Read, Odent) or as founding a particular approach to natural birth (Mongan, Balaskas, Gaskin, Motha). I read the main birth manuals, websites and other promotional materials associated with these teachers and their approaches. These initial readings contributed to my selection of natural birth classes to observe.

I continued the analysis of primary materials throughout the fieldwork and writing periods as a means of staying immersed in the field and up to date with key news stories and developments. I utilised a general thematic analysis in reading these materials, rather than any formal content analysis and/or coding, yet I feel that my close reading of natural birth manuals in particular gave me a good understanding of the field; the breadth of groups, practices and beliefs in natural birth; and the issues to follow up in observations and interviews. Reading primary materials made it possible to compare public statements about natural birth from key exponents with accounts from women themselves preparing for a natural birth.

[4] Some of these methods have been utilised in The Birth Project at the University of Derby. This project explored the experience of childbirth and the transition to motherhood using the creative arts and through a number of films and exhibitions - see https://www.derby.ac.uk/health-and-social-care/research/birth-project/.

My fieldwork took place over the period January 2012 until August 2013. I began by creating a website and a flyer to advertise the project.[5] An issue with which I immediately grappled was what to call the project as it had moved away from my initial PhD proposal of 'the spirituality of childbirth' to focus on 'natural childbirth' as a more relevant emic term within the group I wished to study. My theoretical interests, developed over the course of my secondary research in 2010 and 2011, increased my interest in understanding women's engagements with the highly morally, emotionally and politically charged sacred form of natural birth; a concept and practice of much wider prevalence in contemporary UK society than engagements with a spirituality of birth, the initial focus of the project. Natural birth then, despite the range of objections to both the term and the practice, remains a popular theme in the UK media, in women's own discussions and in the medical world, with an assumed cohesive meaning with which women can easily signify their agreement or disagreement. It is short hand for a complex, much contested and actually fluid and negotiable position. For this reason, an investigation of natural birth can help us to think theoretically about how we understand a particular situation where there is a discrepancy between a public moralised discourse and everyday practices which are influenced by, and contribute to, this moralised discourse and yet are more influenced by practical concerns. Natural birth is also a particular site of normative moral claims as the form of birth that is encouraged at a policy level and by the medical establishment, as noted in Chapter One. It is a 'benchmark' ideal with which many women engage even if it is not the particular form of birth they want.[6] For these reasons, I felt that the term should not be shied away from but rather engaged with directly in the very title of the project and hence my website and flyer advertised a 'Natural Birth Study'. In this promotional material, I stated that I was interested in all perspectives on natural birth. The flyer stated:

> If you are involved in any 'natural' pregnancy and birth practices (however you define this), if you just have a passing interest in natural birth or if you think natural approaches to pregnancy and birth are a waste of time or even dangerous, then I would love to hear from you.

Whilst the website stated:

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[5] A copy of the flyer is Appendix 1.

[6] Whilst the antenatal groups I observed were attended by couples, it is primarily mothers who work towards a particular form of birth through training the mind and body in particular ways, and hence it is mothers who are the focus of this thesis. I did not interview any fathers-to-be, fathers or male birth-workers.

> I would like to speak with women who currently have, or have had in the past, an involvement or interest in 'natural' birth (and I'm interested in hearing what you understand this term to mean). I am also interested to hear from women who don't think much of natural pregnancy and birth approaches, for whatever reason.

I was contacted overwhelming by women with positive views of natural birth, who wanted to discuss their plans for, experiences of, and subsequent reinterpretations and reflections on natural birth. I was only contacted by one woman who had a critical view of natural birth but we were not able to arrange an interview. I could have more actively sought to engage and include women with opposing views of natural birth - of course, for many women the ideal birth is one which is highly medicalised, with strong pain relief and/or an elective caesarean section - but this seemed to me to be casting the net too wide and losing focus on the sacred form of natural birth; how and why women hold the natural birth ideal while subsequently negotiating its meaning through their own circumstances and practices. The similarity of the research participants will be discussed below.

At the beginning of my fieldwork period, I had approached a 'gate keeper'; a midwife whom I will call Barbara.[7] When I began my fieldwork, Barbara was part of the community team of NHS midwives in the town where both she and I live, as well as the proprietor of a shop which I'll call Bambino's - a 'pregnancy and birth boutique', offering high end baby clothes and products as well as numerous treatments, classes and workshops. I had an existing connection with Barbara as she had once been a work colleague of my mother, before she became a midwife later in life, and she had also been on shift in the hospital when I was in labour with my first child, although she had finished her shift by the time my daughter was born. I am sure that it was due to this connection that Barbara took some time from her busy schedule and agreed to my request for a meeting and help with getting my research started. She kindly allowed me to leave my flyers on the shop counter, gave me the contact details for the women running the Hypnobirth classes from her shop, as well as the details of the next Hypnobirth coffee morning, and agreed that I could observe her NHS antenatal course. Whilst some of these actions proved more fruitful than others (I never made a huge number of contacts through the leaflets in the shop and her NHS antenatal course was cancelled last minute, leaving

[7] The names of research participants given in this thesis are pseudonyms. I have chosen popular British names which begin with the same initial as the women's real names - the names do not convey any other factors, such as social class or ethnicity.

me sitting alone in a deserted health centre on a cold winter's night, as the cleaner vacuumed around me), I am sure that beginning the fieldwork would have been more difficult and time consuming without her initial help. In particular, her introduction to the women running the Hypnobirthing classes was invaluable as observations at the classes and associated coffee mornings were a significant aspect of the research.

My fieldwork began then with attendance at a Hypnobirth coffee morning and then observation of a Hypnobirthing course with classes every Friday evening over a five week period. I interviewed five women associated with this particular Hypnobirth group in some way (the course organiser, two women on the course, and two women who I met at a coffee morning who had completed the course some time previously). I simultaneously placed a post about my research on a Facebook group for mums local to the area in which I live and through this I got two interviewees. Two more women made contact through seeing my flyer in Bambino's. I continued to make direct contact with experts who I had identified through my secondary research and over the summer of 2012 I interviewed two experts and attended an Active Birth class in North London. Research was thus ongoing over the first half of 2012 but was at a rather slow pace and I began to feel concerned that I would not find enough women to interview over the 20 month fieldwork period. This situation changed in October 2012 when I received 58 emails in a single week from women expressing interest in my study and a willingness to be interviewed. Two factors contributed to the surge in women making contact: a Hypnobirth teacher whom I had interviewed (not connected with Bambino's) posted a note about my research on a Hypnobirthing discussion group which was then taken up and placed on other sites and interest groups, including those focused on independent midwifery, breastfeeding and 'attachment parenting'; and the NCT (National Childbirth Trust) included information about my research in a newsletter sent to all members in the UK.[8] This created a situation in which I had clusters of participants in certain local areas, mostly in London and the surrounding home counties, who were associated with a particular independent midwife or teacher or with a particular NCT, Hypnobirth or similar interest group. I interviewed around half of the 58 contacts based on their availability for interview and the time constraints of the fieldwork - ending when I felt a degree of saturation had been reached. I

[8] For this, my research proposal had been assessed and approved by a member of the 'NCT Research and Information Team'.

turn now to a fuller discussion of the 43 participants in my study, before turning to discussion of the research methods utilised.

**A Community of 'Birth Workers'**

Of the 43 women interviewed, 26 women were non-pregnant mothers with at least one child aged under two[9] and seven women were currently pregnant - three women with their first child and four with second or third babies. The remaining ten women were 'birth workers' including three Hypnobirth teachers, three independent midwives, two yoga teachers, a doula and an NHS midwife. However, this is something of an artificial categorisation based on the women's primary identity revealed in their initial contact with me and in the focus of the interview discussion. In reality, practically all of the women flowed across these categories. Hence all women interviewed were mothers (if we include women pregnant with their first child), except for one Hypnobirth teacher who was not a mother, and one yoga teacher and one midwife who did not reveal this information and I did not feel it necessary to ask. The listing above of ten 'birth workers' is also not an accurate picture as many of the women who were primarily interviewed as mothers, were also involved in different forms of natural birth work. These included an independent midwife; a doula; a Hypnobirth teacher; a woman who was both a Hypnobirth teacher and a doula; a nutritionist who was also a pregnancy yoga teacher and a doula; and a masseuse and reiki practitioner who worked with pregnant women and new mothers. Whilst some of these women had pre-existing careers which gained a new focus after their own experiences of pregnancy and birth, such as the masseuse specialising in pregnancy massage or hypnotherapists specialising in Hypnobirthing, other women's career choices were initiated after their own pregnancies and births. This can be seen as part of the rise of

[9] As my advertising materials asked for women who had had a baby in the last two years, in the assumption that the first two years of life are still the 'baby-stage'. This is in line with the NCT's catering from pre-birth to age two.

'mumpreneurs'[10] more generally as the women seek careers both inspired by, and which can work around, their own family lives. But it can also be seen as a continued exploration of the meanings and importance of pregnancy and birth, after their own birthing biographies are complete. Birth remains a 'thing that matters' to some women after they have birthed their own children and they seek to share their knowledge and experience with others, often within the framework of a desire to help other women 'empower' and 'educate' themselves. Anthropologist Robbie Davis-Floyd (1992) writes that within her sample of one hundred American women who gave birth in a period in the 1980s, 9 per cent experienced 'cognitive distress' in which their experience of birth did not correlate with their desires or expectations. She suggests that such women either compartmentalised the experience or initiated 'further epistemic exploration of its meaning' (1992: 241) through various techniques including the construction of birth narratives and sharing them with others; further self-education about birth including reading childbirth literature; becoming involved in childbirth education and midwifery; and subsequent births themselves. My research participants were also involved in such activities as was I through my selection of PhD topic.

Davis-Floyd's seminal ethnography reminds us that many women are able to reconcile their previously held beliefs, desires and expectations with their experience of a technocratic birth. 42 per cent of her sample desired a natural birth but gave birth in hospitals with medical interventions, but nevertheless had positive experiences, agreeing that the interventions were necessary. However, the situation in the contemporary UK, is that half of all women do not experience the birth they desire and for which they had planned and prepared (Birthrights Dignity Survey 2013). My research participants included women dissatisfied with the current situation of birthing, either because of negative first birth experiences or through professional observations, as well as women pregnant with their first child who took it upon themselves to pay for additional classes, courses and resources in the belief that the NHS would not provide adequate support. They had all invested time, money, emotion and more in achieving a particular type of birth, one outside of the mainstream, medical context. Whilst this was not always described as a natural birth,

[10] Defined by Richomme-Huet, Vial and d'Andria (2013: 251) 'as the creation of a new business venture by a woman who identifies as both a mother and a business woman, is motivated primarily by achieving work-life balance, and picks an opportunity linked to the particular experience of having children'.

they prepared for an ideal birth which had common elements, although they might be stressed to different extents; including a birth that was as pain-relief free as possible, not induced and in a calm and relaxed birth environment, amongst other things (see Chapter Four for more on the ideal birth). The most common unifying factor was a desire for a home birth; 24 of the 43 participants had planned a home birth, and 15 had had a home birth (at 34.8 per cent this is a great deal higher than the 2.1 per cent of women who had home births in England and Wales in 2016).[11] Seventeen women had an involvement with Hypnobirthing, either as a teacher or course attendee; fifteen were involved in pregnancy yoga classes and six women attended NCT courses. Other practices in which the participants engaged included Pilates, Reiki, other forms of massage, Reflexology and more, as well as alternative practices post-birth such as placenta encapsulation and Lotus Birth.[12] Nine women had either employed the services of a doula or were themselves a trained doula, sometimes both. Ten women were closely connected to independent midwifery (three had employed independent midwives; three became friends or sought the advice of independent midwives and four were independent midwives); for three of these women, the choice of independent midwifery was coupled with a rejection of all aspects of NHS care for the duration of their pregnancies and births.

### *Consequences of the Self-Selecting Sampling*

The women's shared ideas around birth must be seen partly as a consequence of the self-selecting sample. As noted earlier, I was contacted by women who had a positive engagement with natural birth, both because of the title of my project and because of the initial contacts I made with Bambino's and Hypnobirthing networks. Snowball sampling and participants advertising my projects through their own social media networks, increased the likelihood of participants with similar views contacting me. Broad, shared

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[11] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/birthcharacteristicsinenglandandwales/2016

[12] Placenta encapsulation is a process through which professional companies turn the placenta into pills for the mother to ingest in the belief that this increases her iron intake and hence boosts energy. Three women in my sample had their placenta's encapsulated. Lotus Birth is the name given to a practice in which the baby's umbilical cord is not cut but left attached to the placenta until it falls off, usually about a week after birth. The placenta is dried, rubbed with herbs, wrapped in cloth and carried with the baby in the belief that this is less stressful for baby. This was practiced by two women in my sample.

ideas around the ideal or natural birth mask all kinds of differences between the women's motivations, desires and definitions which will be explored in Chapter Five, but it is important to recognise the relatively cohesive sample.

A relatively cohesive view of the ideal birth was not the only unifying factor amongst my research participants. The women also shared a social demographic profile. All of the women were white and 39 were British; the remaining four were French, American, Australian and a New Zealander. The mothers were all in the age range of mid-twenties to mid-forties, although the majority were in their thirties in line with the average age of first time mothers in the UK.[13] Some of the birth workers were older, in their fifties. All of the mothers were in stable, heterosexual relationships - although I did not ask about relationship status or age directly they often were discussed in the interview context. The women were drawn from the relatively affluent areas of London and the surrounding home counties, another consequence of the manner in which my project was advertised on local parenting social media sites. 'Local mothering cultures', such as those discussed by Holloway and Pimlott-Wilson (2014), also likely contributed to the cohesive sample.[14] The majority of mothers were either still on maternity leave or had taken extended breaks from work in order to look after their children. In addition to the birth-related careers mentioned, participants included a woman who worked in publishing, another in design, three teachers, two nurses, a chemist, a police officer and a postgraduate student, indicating high levels of education amongst the sample. I judged my participants to be middle-class based on these observations of their material and cultural resources, including their locations, their homes, their professions and 'tastes'. As discussed in Chapter One, Pierre Bourdieu's writings are foundational in conceptualising class as both a material and symbolic category based on unequal distributions of different forms of capital. 'Taste' (most associated with cultural capital) functions 'as a marker of class' (1984: 1). 'Taste classifies and it classifies the classifier' (1984: 6) as it is a judgement of appropriate aesthetic qualities, and hence legitimate knowledge, formed in relation to others who are excluded. As later feminist theorists such as Beverley Skeggs (1997, 2003) and Stephanie Lawler (2005, 2008) have argued (see Chapter One), the middle-class has successfully positioned itself as the

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[13] The average age of first time mothers in the UK reached 30 in 2014 - http://www.telegraph.co.uk/women/mother-tongue/10971560/Average-age-of-mothers-hits-30.html

[14] See Chapter Five, footnote 3 for a longer summary of their argument.

repository of all good taste, the 'real' culture against which all other classes are judged. As Lawler (2008: 249) writes 'culture and taste in the sense of the "right ways of being and doing" has been claimed as a right by the middle classes'. Childcare practices are a part of this culture and, I argue, natural birth practices can be seen as a particular taste within middle-class culture. It must also be noted that my judgement of class was based on a shared affinity with the women, partly as a consequence of our shared interests, tastes and localities. This will be discussed further below.

That this particular cohort of women had a positive engagement with natural birth and broadly shared beliefs and practices is no coincidence and other scholars including Hays (1996), Bobel (2002) and Faircloth (2013), have noted a link between natural birth and/or attachment parenting and social class.[15] Participation in any form of antenatal preparation beyond that provided by the NHS entails a significant financial cost, in addition to an investment of time and emotions, as well as the social capital to find such classes and the confidence to attend them. It is largely the middle classes who have such resources in the UK and who are encouraged, by current government policies, to explore their choices and options in various life areas including healthcare and their children's education.[16] Furthermore, these choices are gendered as it is women who are particularly targeted as being responsible for their children's health and education. Indeed, current government policy, influenced by both 'risk consciousness' and particular interpretations of neuroscience which argue that parents are responsible for their child's brain development and hence of their socioeconomic status as adults, has led to continual surveillance and monitoring of parents (Furedi 2001). This surveillance is also internalised by parents in their construction of accountability strategies and identity work to legitimate their parenting choices (Lee et al. 2014: 2-3). My research participants took on board some government policies, and certain interpretations of the latest neuroscientific research, to engage in and justify a particular form of parenting (see Chapters Five and Six). The

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[15] Thomson et al. (2011: 149) argue that age, rather than class, 'has become an organising category through which normative notions of mothering are constituted'. They argue that government policies and popular resources are geared towards a middle age group and 'it was women in the 26-35 age group who tended to position themselves in relation to these distinctions' (of natural versus medical birth and child versus adult centred parenting) (2011: 150). Social class is contained with the analytical category of age, they argue, because 'social class is encoded within the shape of the female biography' (2011: 276).

[16] Such as the policy papers *Choosing Health* (2004) and the 2012/13 *Choice Framework* discussed in Chapter One.

participants are also the demographic group of women who have been identified by Hays (1996) as concerned with 'intensive parenting'. The preparations and practices of natural birth, which take time and money, can be seen as part of the practice of 'intensive motherhood' which, I argue, can begin during pregnancy or even pre-conception. There hence exists a complex interplay of gender, class, social capital and a shared pool of beliefs and practices around socially acceptable pregnancy, birth and parenting practices.

A similar interplay has been noted by sociologists of religion analysing the wider holistic milieu and the field of CAM (Complementary and Alternative Medicine), of which natural birth could be considered an aspect. Analysis in this field has focused on gender issues, on the predominance of women involved in the holistic milieu (Heelas and Woodhead 2005, Woodhead 2008a, Sointu and Woodhead 2008, Houtman and Aupers 2008).[17] In thinking further about why women are more attracted to 'relational milieus', Woodhead (2008a: 150) writes 'The tension between living "life for oneself" and a "life for others" can be acute for women educated on equal terms and with equal expectations with men, who then find themselves "drowned" with responsibilities of care for others'. Whilst this may be a tension experienced by many women in contemporary Britain, it is largely white, middle-class and upper-class women who have the power (in the sense of the ability to consume, both in terms of time and money), to engage in the reflexive project of the self and to pursue 'me time' in the context of the holistic milieu (2008a: 156). There are obvious differences as women would not necessarily approach participation in natural birth as 'me time', but there are parallels in the predominance of the involvement of middle classes as those with the power of choice and the social capital to explore their options.

The self-selecting sample has then both benefits and limitations. I cannot comment on what women in the general UK population think about natural birth and how, or even whether, they prepare for birth during their pregnancies, nor can I comment on the beliefs, motivations and practices of women who desire a relatively medicalised form of birth including the use of strong pain killers and/or elective caesarean. Nor can I say that all women who desire and work towards a natural birth do so for the same reasons and with the same meanings as the women I interviewed. However, I can analyse the beliefs and

[17] 80 per cent of participants in the holistic milieu in the 'Kendal Project' were women for instance (Heelas and Woodhead 2005).

practices of my sample of women who have a positive engagement with natural birth in order to explore my theoretical concern of how these women balance their pursuit of an ideal with their own circumstances through their practices. Hence my focus is not only on how and why the women prepared for a particular type of birth, but what these preparations can reveal about the relationships between an ideal held and practical circumstances, and between beliefs and practices. Hence whilst a cohesive sample prevents generalisations and comparisons with other samples, it allows for an in-depth analysis of a particular group of women in order to generate theoretical ideas. I turn now to a discussion of the observation and interview methods used.

**Observation in Theory and Practice**

Observation, with varying degrees of participation, has long been a central research method in the fields of sociology and anthropology, where it forms the basis of an ethnographic approach. Some academics within the field of practice theory have advocated for a theory and method of praxiography, with a focus on practice, as opposed to ethnography, with its focus on culture (Bueger 2014). Both approaches have a focus on the micro-level of analysis, on 'looking down' in order to analyse the 'local and the non-coherent' (Bueger 2014: 389). The preferred method of praxiography is observation, as the primary means of analysing practices which can be experienced or observed in others, but it is supplemented with interview data and document analysis as 'an important mean(s) to unravel the implicit structures of meaning' (Bueger 2014: 400). Observations are preferred methods for a focus on practices and on everyday, lived experiences. They are also preferred methods for interpretative and inductive projects with a focus on meanings and theory generated from data collected, whilst recognising that 'it is theory which mediates our interpretations' (May 1998: 137). Within the observation method, the primary tool of research is the researcher herself who must engage with the field, gain access and contacts and take detailed and reflexive fields notes, recognising her role in the social world and in interactions with others. This is the case regardless of the degree of participation and some theorists (for example, Gold 1958) have found it useful to categorise different forms of participation, from the complete immersion of ethnography, to participant observation, to observation. Whilst I did participate in the antenatal classes to different extents, my status

as a non-pregnant woman immediately marked me as an observer and for this reason I describe my method as observation rather than participant observation.

Whilst this thesis is not one of practice theory, I felt it imperative to observe some of the antenatal classes in which practices for managing pregnancy and birth are taught. In line with my commitment to feminist methodology, which will be discussed below, I felt that it would not do justice to the issues discussed in the interviews, and hence to the women themselves, if I did not have an embodied and experiential knowledge of the practices.[18] Observations therefore fulfilled a number of roles in this project. My initial intention was that they would have a functional role in that my research participants would be drawn primarily from the classes observed. However, this did not transpire for a variety of reasons which are discussed below. They also had a teaching role, in that through them I learnt more, and differently, about Hypnobirthing and yoga practices, than I would have through reading the key texts alone. They also provided contextualising information, both for the manuals I had read and for the interview context, allowing me to gain a deeper awareness and understanding of the issues discussed and arguably increasing rapport with the participants. But the observations also serve as data in their own right. In-depth, reflexive field notes were made immediately after the classes and these notes were coded and analysed with the interview transcripts.

I began my fieldwork with observation of classes both because I felt that this would be a good way to make contact with women involved in natural birth practices and because I felt that it would give me a greater understanding of the women's practices, choices and desires which would be discussed in an interview context. My readings of natural birth manuals, websites, magazines and social media suggested that natural birth groups are defined by the practices they advocate in pregnancy and birth. Different natural birth teachers and groups emphasise different practices. Groups range from those offering a complete antenatal education programme, some with a focus on education and information, such as the NHS and NCT, some with a focus on a positive philosophy and practical exercises to manage pregnancy and labour, such as Hypnobirthing, Natal Hypnotherapy

[18] Of course, my embodied and experiential knowledge of the practices would not be the same as the women's, not only because two individual's experiences are never the same, but because I was not pregnant during the course of the observations. Despite this major difference, engagement in the practices was important to me.

and the Gentle Birth Method; to classes which focus more on exercise such as Active Birth classes, pregnancy yoga or Pilates. I sought to include a range of these classes in my observations in order to gain an understanding of the different classes available and to make contact with different groups of women. Classes which I attended were a complete 'Hypnobirthing: The Mongan Method' course consisting of five Friday evening classes in February-March 2012; one two hour Active Birth class in June 2012; a complete NCT course consisting of four Wednesday evening classes and one Friday morning class in November 2012; and a 90 minute pregnancy yoga class in July 2013. Other events attended were two Hypnobirth coffee mornings (organised by the Hypnobirth teachers for both past and prospective students to socialise) in February and September 2012, a Midwives' March on Parliament in March 2013 and a 'Baby and Toddler Show' in April 2013. Below I give a few more details about the classes attended.

National Childbirth Trust (NCT) and Hypnobirth classes both provide a comprehensive antenatal education package over five classes. As outlined in Chapter One, both are based on the antenatal philosophy of Grantly Dick-Read, a British obstetrician who is widely held to be the pioneer of natural birth in the UK. Whilst his first book, *Natural Childbirth* (1933) was not well accepted by the medical community, his second book, *Childbirth Without Fear* (1942) found a wide general readership and, in 1956, the Natural Childbirth Association was formed by a group of women who sought to follow his birthing philosophy. Dick-Read was the president of this Association which, in 1961, two years after his death, became the registered charity the National Childbirth Trust. The NCT is now the UK's largest parenting charity which aims to provide information and support to parents in their child's first 1000 days (from pregnancy to the child's second birthday). It provides a huge range of services from various antenatal courses, pregnancy yoga classes and doula services to postnatal courses, breastfeeding support, mother and baby yoga, baby massage, bumps and babies social groups, nearly new sales and more. It has 300 branches in the UK, run by 15,000 volunteers and claims to support over 100,000 parents each year.[19] Courses are run by those who have completed the necessary training through the NCT College which provides the UK's only 'university accredited qualification in parenting education'.[20] The NCT can be considered a 'mainstream' organisation, the

[19] https://www.nct.org.uk/about-nct/what-we-do-parents

[20] https://www.nct.org.uk/nct-college

second largest provider of antenatal education following the NHS, and is particularly valued by new parents for the social networks that participation in its courses and groups creates. However, it faces criticism on a number of fronts: some argue that it has too great a focus on natural birth and is exclusionary to women who do not desire, or achieve, such a birth;[21] whilst some argue that it does not promote natural birth enough and has moved away from Dick-Read's philosophy to more mainstream information provision and social networking, which should be the realm of the NHS. The latter arguments were made by some of my research participants, particularly those involved with Hypnobirthing.

Hypnobirthing can be seen as more of a niche interest than NCT, but the numbers of people attending Hypnobirthing classes in the UK are rising and many NHS hospitals now offer Hypnobirthing as part of their antenatal education programmes. Hypnobirthing was pioneered by the American hypnotherapist Marie Mongan, whose book *Hypnobirthing: A Celebration of Life* was published in 1989. The Hypnobirthing Institute was founded the same year and coordinates Hypnobirthing: The Mongan Method courses in over 45 countries worldwide. Hypnobirthing is described as a 'rebirth' of a philosophy of birth which existed thousands of years ago and was 'captured' by Grantly Dick-Read,[22] combined with various techniques of self-hypnosis for relaxation to create a calm and positive pregnancy and birth. The techniques taught focus on self-hypnosis for relaxation through the use of guided visualisations which are provided on both CDs/MP3s and as written scripts for the birth partner to practice reading out. Four official techniques are taught: breathing, relaxation, visualisation and deepening techniques. Positive affirmations for birth are taught as well as light touch massage for relaxation and pain relief. Worldwide, Hypnobirthing: The Mongan Method, is run as a franchise, with control of the programme remaining with Marie Mongan and the Hypnobirthing Institute in Florida. Hence whilst the course can be run by any Hypnobirth trained and registered practitioner, there is consistency in the course content and materials worldwide, with only minimum variation to take into account different countries' hospital procedures. In the UK, there is a

[21] An argument which appears from time to time in the media - see, for example, https://www.lindageddes.com/123/does-the-nct-tell-women-the-truth-about-birth and http://www.dailymail.co.uk/news/article-2256935/Kirstie-Allsopps-Twitter-attack-childbirth-charity.html#ixzz2H0fUjETy

[22] https://us.hypnobirthing.com/about/official-hypnobirthing-institute/

Hypnobirthing UK advisory board and central website[23] with numerous individual teachers listed. The tight control of the course and the 'American flavour' are common criticisms of Hypnobirthing, including amongst my research participants. They are also the reason for numerous independent Hypnobirth teachers, including some who have created their own Hypnobirthing programmes, such as KG Hypnobirthing founded by Katherine Graves; Natal Hypnotherapy founded by Maggie Howell and The Wise Hippo Programme founded by Dany Griffiths and Tamara Cianfini.[24] The Hypnobirthing course I attended was organised and run through Bambino's by an antenatal organisation called Birth Sense. The five part course cost £230 in 2012.

The NCT and Hypnobirth courses I attended had similar formats but rather different contents and atmospheres. As stated, the Hypnobirth course was run in the baby boutique, Bambino's. It was held on Friday evenings, between 7 and 10 pm, once the shop had closed but on the small space of the shop floor, where a circle of chairs was placed amongst the rails of baby clothes.[25] The intimacy of the small space was enhanced by the scent of essential oils, dimmed lighting and relaxing music playing at the start of the class, in a practical demonstration of the birthing atmosphere the couples should create. The NCT class, on the other hand, was held in the bright and colourful space of a children's nursery in a commercial gym in a neighbouring town to Bambino's. This class was also held on a weekday evening, in this case Wednesdays between 7.30 and 9.30 pm, and was busier, with seven couples attending as compared to four couples in the Hypnobirth class. It also had a busier, less relaxed feel, perhaps due to the colourful chaos of the nursery setting, the loud thumping music from the gym in another part of the building, and the movement of the class as the couples moved around for small group work. The Hypnobirth course had more of a structured lesson feel to it, following as it did the same format each week of a teaching, including reading excerpts from Mongan's book (which our teacher affectionately called 'the Bible', and more reading set as 'homework'), practical

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[23] http://www.hypnobirthing-uk.com

[24] It is interesting to note that the Hypnobirthing classes at Bambino's changed to The Wise Hippo Programme a couple of years after I had attended the classes there. I expect this was because of the criticisms of The Hypnobirthing Institute listed above.

[25] Again it is interesting to note that a couple of years after I had finished my fieldwork, Bambino's moved to much larger premises on the same high street, an indication of its financial success and popularity.

techniques and then observation of a Hypnobirth video, in which the woman was always calm, relaxed and quiet as her baby was born. We spent around a third of each class practicing a relaxation technique or visualisation whilst listening to the teacher reading a script,[26] or practising massages on one another, which increased the intimacy of the class.

The NCT class was more fluid in that it consisted largely of small group work such as discussions, passing around props (whether this be a model pelvis, a tens machine or baby dolls and nappies), or getting into different groups dependent on due date or type of birth desired, for example. One of the first exercises involved creating a list of what participants wanted to learn from the course (mostly post-natal concerns around caring for the baby, in contrast to Hypnobirthing); presumably Sally, the course leader, ensured that the following classes covered these desires. She told me that NCT teachers had freedom in what and how to teach with little consistency between courses, although the aim is for around half the content to be on antenatal issues, half on postnatal. Information was the focus of the NCT course, with embodied practical techniques discussed but only briefly demonstrated. Group learning was through discussion rather than being 'taught', with question and answer sessions in which the participants called out questions to Sally, as the preferred method. Through these techniques, Sally did not so much impart information as facilitate the social networking of the participants. In general, there was much more time for discussion on the NCT course, in line with its social focus, and I was also able to spend some time chatting with Sally when the participants were involved in group work. In contrast, I spent little time talking with Mandy, the Hypnobirth teacher, during the course.

In both cases, I had either met (Hypnobirth) or had a telephone conversation (NCT) with the class teacher beforehand in order to tell them about my research and obtain permission to observe the class. The first classes of each course began with introductions and so I was able to introduce myself and the project and hand out copies of my flyer and research documents. On both courses, I sat to the side of the class teacher and had an obvious position as observer, being the only other non-pregnant woman in the room. However, I participated to different degrees in each course. In both, I became the teacher's assistant to

[26] I cannot say that I found the relaxations or visualisations particularly effective as I often struggled to bring to mind the images the teacher described. This was in contrast to some of the participants who declared them to be 'amazing', 'so relaxing', 'I nearly fell asleep'. Of course, it could be argued that I did not have as much investment in them as I did not have an imminent birth for which to prepare.

some extent, as this was perhaps the most obvious role for me to fulfil. I became both teachers' guinea pig when they wanted to demonstrate a massage technique and I took it upon myself to join the small group work in the NCT course and volunteered to take notes for reporting back to the wider group, when necessary, so that the couples could concentrate on discussion. On both courses, I decided not to participate in group discussions when the teacher asked participants for their thoughts or experiences on a particular issue as I did not want to distract the participants or impinge upon their time, especially as neither teacher asked me to contribute. However, I did sometimes find myself wishing I could join in, particularly when the discussions were about caesarean sections and breastfeeding. Hence I imposed upon myself the role of observer more than participant, probably due to a combination of factors including respect for the teacher and class setting, and this being more in line with my introvert character.

The two exercise classes I attended also had points of similarity and of difference; both were primarily pregnancy yoga classes, but Active Birth also includes some antenatal education including Hypnobirthing teachings and teaching positions for labour. Active Birth was pioneered by Janet Balaskas[27] in the late 1970s, with the *Active Birth Manifesto* published in 1982. This was published as *Active Birth* (1983) and it has since had numerous republications including *New Active Birth: A Concise Guide to Natural Childbirth* (1989) and *Active Birth - Revised Edition: The New Approach to Giving Birth Naturally* (1992). As the 'Manifesto' suggests, Active Birth originated as an act of resistance and empowerment, and its publication coincided with a 'Birth Rights Rally' held on Hampstead Heath, organised by Balaskas to support women's free movement during labour and birth.[28] She is largely credited with pioneering both pregnancy yoga and the use of water birth in the UK, both techniques which encouraged women to resist the lithotomy position for birth and to instead adopt upright positions such as kneeling or squatting. For Balaskas, the very definition of a natural birth is an active birth in which a woman changes positions during labour and then ideally squats to give birth; squatting is the natural physiological position for birth and is in line with nature's laws, she argues. It is likely that

[27] Note that I do not give a pseudonym for Janet Balaskas or the Active Birth Centre as Balaskas is synonymous with Active Birth which is taught by her and not on a franchise model like Hypnobirth.

[28] For a history of Active Birth and explanation of its ideological roots, see http://activebirthcentre.com/janet-balaskas-story-active-birth-movement/

some of the people attending classes at the Active Birth Centre in North London are aware of this history and Balaskas's pioneering role, whilst others are simply attending their nearest pregnancy yoga class. The Active Birth Centre certainly serves as something of a birth 'hub' (similar to the birth boutique, Bambino's), offering various antenatal classes and courses including Hypnobirthing; pregnancy yoga; postnatal classes and courses including newborn care, baby massage and postnatal yoga; and therapies including acupuncture, homeopathy and massage; as well as breastfeeding support and more. Triyoga on the other hand, the North London studio where I attended a pregnancy yoga class, does not only cater for pregnant women. It was founded by Jonathan Sattin in 2000 to create a 'centre of well-being' by combining the three elements of 'yoga, pilates and treatments',[29] and now has four centres in London. Similar pregnancy yoga classes are run in yoga studios and commercial gyms across the UK.

The settings of the Active Birth class and the pregnancy yoga class were similar. Both were held at locations in North London; The Active Birth Centre has its own premises, shared with other complimentary therapists, whilst the yoga class I attended was run by a pregnancy yoga teacher and doula I shall call Aisha at a dedicated yoga studio in an affluent area of London. Both studios were similar; large, light and airy spaces with sumptuous cushions, bean bags and yoga mats in deep purples and reds. Both had adornments of statues and pictures of pregnant women, in the case of Active Birth, and of the Buddha and the Hindu God, Shiva, in the case of Triyoga. Both had relaxing music playing and incense burning as the classes started. Perhaps similarities were enhanced through my attendance at both at the height of summer, although a year apart, and whilst the Active Birth class was held on a Thursday evening, and the Triyoga class on a Monday morning, my memories of both are of hot sultry weather, a slight breeze in the trees through the open windows, and of the classes as an oasis of calm and tranquillity. This rather idealised memory is offset with a memory of awkwardness at the start of the Active Birth class as, in my concern that I was slightly late, I entered the yoga studio without first removing my shoes, a mistake I did not repeat at the Triyoga studio. Neither were all of the attendees at The Active Birth Centre welcoming, with one woman saying she did not want to speak with me if I was doing a study as she had 'had enough trouble with her GP this week', although she was placated when I explained that it was not a medical study but one

[29] https://www.triyoga.co.uk/about-us/

with a sociological or anthropological focus. Attendees at both classes were in a similar age range, roughly mid-twenties to late thirties, and most were white, although certainly not all British: I spoke with, or overheard, Swedish, Italian, German and American participants. There were thirteen attendees at the Active Birth class, who had paid £22 each for the two hour class, and nine attendees at the pregnancy yoga, who had paid £17 for the 90 minute class.

My participation in both classes was rather different. I had spoken with each class teacher beforehand and had ascertained the degree of participation that they expected of me. Hence, in the Active Birth class, I sat in one corner and observed the whole class, whilst in the pregnancy yoga class, I participated fully in the yoga exercises, positioning myself on a mat in a back corner. These different degrees of participation had different benefits and limitations; whilst my field notes are much richer for the Active Birth class, I experienced a degree of awkwardness as I did not want to make the women feel that they were being observed whilst exercising. I spent the class either watching Janet Balaskas only or, for the relaxation exercises, closing my eyes in order to participate. Perhaps it was this memory of awkwardness that led me to ask Aisha, the yoga teacher at Triyoga, if I could participate rather than observe, and she agreed that this would be her preference too. My field notes here focus on my struggles with the unfamiliar yoga exercises, rather than on Aisha's teachings. But this difference was not only due to my participation; the pregnancy yoga class was above all else an exercise class. Aisha did not teach any breathing, positions or exercises to use in labour, for instance. The Active Birth class, in contrast, consisted of much gentler exercises, with more simple yoga positions and more breaks for relaxation and meditation. It also included an information session in the middle of the class, which in the week I attended was about learning positions for birth, demonstrated by Janet, with explanations of the benefits and limitations of each position. The class also included demonstrations of massage and readings of positive affirmations. In this, it was much closer to the Hypnobirth programme than the pregnancy yoga class, and indeed Janet does also teach Hypnobirthing: The Wise Hippo Programme at The Active Birth Centre. There was also more opportunity for chatting and discussion at the Active Birth class; the women chatted to each other and to Janet over tea before the class started and Janet dispensed advice and was very tactile with the women. In contrast, there was no chatting at all before or during the pregnancy yoga class and despite Aisha saying in an earlier conversation that

the women often had lunch together afterwards and I would be welcome to join them, on this particular day everyone seemed to go their own way after the class, including Aisha, and the invitation was not repeated on the day. Perhaps this was just the result of the class being on a Monday morning, but I noted that it was fortunate I was not looking for more women to interview at this point as there had been no opportunity to make individual contacts. Whilst observations gave me an embodied, experiential understanding of the courses which I would not have gained simply from reading the course materials, in general I found it quite difficult to make contacts through the observations, and most of my interview participants responded to posts about my research on social media sites. Nevertheless, the observations were invaluable in giving me a deeper understanding and awareness of the embodied and affective practices of a number of different approaches to natural birth.

**Interviewing: Feminist Methodologies and Narrative Interviews**

In my concern with women's own experiences I am influenced by feminist research methodologies which in turn have influenced the lived religion approach. As McGuire (2008) and Woodhead (2012a) suggest, lived religion methods draw on feminist methodologies' concerns with both critiquing the 'masculine paradigm' of many social science research practices and with trying to reveal the hidden or 'invisible' aspects of social life; two concerns which are inextricably interlinked as it is argued that traditional research practices of surveys and structured interviews leave women's practices and experiences unseen.

In a commitment to the principle that women are the experts of their own lives and that a sociology for women must 'begin with an analysis of women's actual lived experience' (Bobel 2002: 180),[30] some feminist researchers (including those with a focus on pregnancy and birth such as Oakley 1981, Bobel 2002 and Miller 2005) have prioritised narrative interview methods. In this interview style, after initial conversation, the interview begins with a single, life-history type question such as 'tell me about your pregnancy

[30] Although recognising that 'experience' should be the 'staring point' and not the 'end in itself' of feminist research - individuals' accounts of their lives should be situated within broader social, cultural and political landscapes (Maynard and Purvis 1994: 6).

experiences?'[31] It is considered to be a fruitful technique when the focus of discussion is a significant life event. Indeed, the Latin term narrare translates as 'to report, to tell a story' (Jovchelovitch and Bauer 2000: 59) and this style of interviewing encourages storytelling around the life event. Arising partly as a critique of structured interviews in which the interviewer imposes the structure of conversation and language used (Jovchelovitch and Bauer 2000: 61), it is a favoured technique when the focus of interviews is on the meanings of experience. This is because it allows participants to explore issues in 'their own frames of reference', 'drawing upon ideas and meanings with which they are familiar', thereby providing 'a greater understanding of the subject's point of view' (May 1998: 112). It is a technique characterised by 'the discovery of meaning' (May 1998: 113), or perhaps by the creation of meaning in which the interviewer plays a role in raising questions and encouraging reflection.[32] Feminist researchers, such as those mentioned above, argue in addition that this style of interview is more sensitive to power dynamics, to generating conversation on a more equal level, and to allowing participants to direct the conversation and to raise the issues which they feel are important to their lives. A form of narrative interviewing hence seemed the best method to further my concern with understanding women's meaning-making practices in a significant life event through their own narrations of experiences.[33]

Feminist research methodologies have favoured open-ended, narrative style interviews in the conviction that this can help to flatten the power imbalance of the interview situation. In the 1970s, Ann Oakley drew on her experiences of interviewing pregnant women and

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[31] An opening question which I used quite often.

[32] Narrative interviewing, as with all forms of social research, is not without its problems. Andrews, Squire and Tamboukou (2013) trace some of the historical and theoretical divisions within the field of narrative research including distinctions between humanist and postmodern narrative research; event-centred and experience centred narratives; and 'big stories' versus 'small stories', and the relations between individual and society; agency and structure and internal states versus external social circumstances which each position suggests.

[33] I write a 'form of' narrative interviewing as I did create a more in-depth interview guide which I could refer to if necessary and, in asking additional questions after the initial generative question, I did not follow a purist form of narrative interviewing in the vein suggested by Jovchelovitch and Bauer (2000). For instance, they suggest that 'why questions' are best confined to the 'concluding talk' once the recording has stopped (2000: 62), whereas I freely used 'why' questions when appropriate. I feel that sticking to a rigid narrative protocol is not consistent with feminist methodologies. Andrews, Squire and Tamboukou (2013: 1) argue in contrast to Jovchelovitch and Bauer that the meaning of narrative is contested and that there are no agreed upon means of conducting or analysing narrative interviews. My interviews were in some ways closer to the 'episodic interview' developed by Uwe Flick (1998) - a combination of semi-structured and narrative interviews in which each question is designed to elicit a mini narrative of experiences.

new mothers to critique the 'masculine paradigm' of social research interviews prevalent at the time. In the chapter, 'Interviewing Women: A Contradiction in Terms', she argues that 'the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship' (1981: 41). Oakley sought to lessen the hierarchical relationship by answering all of the questions which participants asked of her and by entering into personal relationships with many of her participants, building lasting friendships, in contradiction to the normative practices of the time. Feminist methodologies have been hugely influential within the social sciences (see Reinharz 1992, Maynard and Purvis 1994) and research practices have moved on since the 1970s so that few researchers now would enter the field without awareness of the power dynamics of the interview. I found it useful to engage power dynamics in different ways for different interviews; in interviews with pregnant women and new mothers, I sought to lessen the power imbalance through generating conversation from the first narrative question,[34] whilst in 'expert' interviews with midwives, doulas and class teachers, I sought to relinquish power by downplaying my own knowledge.[35] In this I struggled with ethical issues of how much of myself I revealed to participants and in reality this varied between interviews depending on numerous factors including how interested the participants were in my perspective and the level of rapport I felt. I was never hostile to natural birth practices both in a conscious effort to establish rapport (although see Reinharz 1992: 265-267 for a complicating of this notion) and because, whilst my views on natural birth are uncertain and often changing, I am not opposed to it.[36] Like Oakley however, I always answered any question I was asked about myself or the research project. It is also interesting to note that the participants in my study were surprisingly uninterested in my

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[34] Amongst other things such as allowing the women to choose the time and place of meeting. The majority of meetings took place in either public cafes or the women's own homes but some were conducted in my home. If I was visiting someone's home, I always took something with me - usually flowers or biscuits, but on a couple of occasions items for lunch. The sharing of food and offering my home for a meeting place increased the equal power relationship - as did the fact that I shared the class and ethnicity of the majority of my participants, as well as the experience of motherhood.

[35] Whilst it could be argued that experts could easily see through this 'trick' (Jovchelovitch and Bauer 2000: 66), I did not find it problematic as those I interviewed seemed happy to give their own opinions without asking for mine and I found it relatively easy to gauge to what extent I should reveal my own knowledge in different interviews.

[36] And indeed the birth of my third child, which occurred after the research but before the writing up of this thesis, was my most 'natural' birth, with yoga techniques utilised and no pain relief apart from gas and air after baby's head was already born.

perspective and experiences and asked me few personal questions; perhaps because they took the interview as an opportunity to reflect on their own experiences as something of a cathartic exercise. In this sense, my role as 'listener' in this exercise, and hence in the co-construction of meaning, cannot be underestimated.

### *Using an Ethical and Reflexive Approach*

In 'Interviewing Women', Oakley (1981: 55) argues that the ethical dilemmas which arise from traditional interviewing are greatest when 'there is least social distance between the interviewer and interviewee', such as when they 'share the same gender socialisation and critical life-experiences'. As a mother interviewing other mothers, she argues that it would have been 'morally indefensible' not to trouble the existing paradigm of social research through answering questions and building friendships. This was not simply an issue of 'building rapport', she suggests, but rather a commitment to the principle of 'engagement' in the feminist research project. Feminist researchers of the 70s and 80s sought to interview women in order to give them a voice within both sociology and wider society and, in this, consciously chose to engage in research at 'home' rather than in the 'field', that is with those with the same gender and life experiences rather than with the exoticised 'other' of traditional anthropology. This increases rapport and lessens power imbalances to some extent. Hence whilst Nash (2011) and Faircloth (2013) have made strong arguments as to the benefit of their status as non-mothers researching pregnant women and breastfeeding mothers respectively, namely that their participants could not find them to be judgemental, I feel that my status as a mother gave me a shared ground with my participants which placed us on a more equal footing and contributed to rapport. It is perhaps worth pausing here for a moment of reflexivity as I reiterate my own interests in the field and experiences of giving birth.

This thesis had its origins in a study of religion, spirituality and birthing, and as such combined my two personal interests: alternative religions and spiritualities which have been the focus of my academic study since my undergraduate degree and subsequent

employment at Inform following my masters degree;[37] and pregnancy, birthing and breastfeeding through my experiences as a mother of three children. Its origins then, as in some feminist methodologies, is in 'staring with one's own experience' (Reinharz 1992: 259-261). However, these were origins only as the project changed over time away from religion and spirituality to a more explicit focus on the 'natural', and my own thoughts and opinions on natural birth were constantly changing as the research progressed, and of course were not the focus of the research anyhow. It might be worth noting that my own birth experiences were of an emergency caesarean, after expecting a 'natural' birth but having done nothing to prepare for this, including not attending any antenatal education classes[38] followed, two years later, by a hospital VBAC[39] for which medical staff and birth workers seem to be overly congratulatory, a point also noted by some of my participants who had experienced a VBAC. This is possibly because women who have experienced a VBAC have not fought the NHS for an elective caesarean, something which is often frowned upon in practice despite the NHS's theoretical commitment to choice for every pregnant woman. These experiences gave me some flexibility to emphasise my choices and actions in my second birth in different interview contexts. During the course of the research for this project, I experienced two miscarriages and then had my third child in the year following completion of the fieldwork. My different pregnancy and birth experiences, encompassing different experiences of pain during labour, birth and postpartum, allowed me to engage sensitively with my research participants both in terms of the questions asked and in empathising with their own experiences.

I argue that it would have been difficult to build the level of rapport and to engage so fully in the issues raised in the interviews, without the embodied knowledge of pregnancy, birth and postpartum experiences. However, it must be recognised that rapport was not only built from a shared experience of motherhood. As discussed above, my relative ease and comfort in engaging with the research participants was also based on shared class positions, locality (in that participants were drawn from my home town or from rather

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[37] Inform is an educational charity which provides information about minority religious movements. Founded by Professor Eileen Barker (Emeritus Professor of Sociology of Religion at the London School of Economics), Inform makes academic knowledge available to a wider audience. www.inform.ac I have been a Research Officer at Inform since 2001.

[38] Perhaps the result of myself and my husband's relatively young age at the time (early twenties) and feeling in other appointments rather like we were being treated as school children.

[39] Vaginal Birth After Caesarean.

similar suburbs), ethnicity, tastes and interests in issues of pregnancy and birth. I believe that a shared experience of mothering but a hostility towards natural birth would have shut down communication to a greater extent than if I had not been a mother at all. It is interesting to reflect on, but of course cannot be known, how the information gathered might have differed had I not been a mother; would I have heard less about experiences of pain, things not going to plan, and feeling a failure[40] if the participants had been maintaining a silence around birth for a woman who was not yet, but might one day be, a mother?

Bobel (2002: 177) has argued that her position as a 'natural mother' interviewing other natural mothers allowed her 'to ask insightful, incisive questions'. It also built a level of trust, she argues, stemming from attending the same groups, reading the same literature, and facing the same struggles with medical authorities around home birth and vaccination issues, 'leading to more open, honest, and revealing interviews', and preventing 'mothers from responding to questions defensively, or worse, incompletely' (2002: 177). She explains how she sometimes phrased difficult questions with her own experiences in order to gain 'richer responses' but also to erode her 'privilege as a detached, impersonal observer' by inserting herself 'in the research process' (2002: 177). However, here I differ from Bobel as I did not raise my own experiences unless I was asked directly for numerous reasons including that I did not want discussion to detract from the women's own experiences and because my personal thoughts on natural childbirth were constantly changing throughout the research process. I was not a member, and never had been, of any natural birth/mothering groups, and was much happier to maintain a fluid position on natural birth. Unlike Bobel then, who joined a natural mothering society for the twofold reason of personal support and potential research, and only raised the issue of research once she had built up relationships in the group, I only attended groups as a researcher and made this position very clear, not least because I was obviously not pregnant. In the end, as noted, the majority of my participants came from online sources and not from the groups attended.

Approaching women to participate in an interview about one of the most intimate, painful and arguably transformative events of their life is simultaneously an imposition and an

[40] Even though these did not arise in every interview and were not the key themes.

invitation to reflect on a subject which is enjoyable to discuss for some women. The relatively large number of contacts made in one week suggests that women are keen to talk about their birth choices and motivations, perhaps as it can be a cathartic experience. In some ways, my questions about pregnancy and birthing practices were not far removed from the discussions and comparisons of experiences which take place in mother and baby groups and on social media. During the interviews, most women seemed to find it easy to reflect on their experiences and to answer my questions at length. Yet it is also a sensitive topic, delving into areas of embodied experience and pain, and some interviews became emotional as women reflected upon negative experiences and difficult memories. It has always been my aim, both in the research process and in the writing of this thesis, to approach my subject sensitively. This has entailed a commitment to active listening, to seeking to understand women's own positions, and to engaging in ethical research practices.[41] These included providing all participants in the project with an 'information sheet' which explained the project and their role in it and how the data would be used; compiling some 'debriefing materials', a one page summary of different organisations offering advice and support if the interview had raised difficult issues which needed further exploration;[42] and a consent form for their participation.[43] These documents made clear that all participants would be anonymised; they would be given a pseudonym and the information they provided would be used in a redacted form with identifying details removed. The consent form asked whether the interviews could be audio-recorded and all women agreed to this. It also asked whether they would like a copy of the interview transcript, either for their own information or for checking the details, and only one woman took me up on the offer of deleting information, requesting that I delete a section of the transcript which she felt portrayed her in a bad light. In general, the women to whom I sent the transcripts seemed happy to have a record of the discussion around their experiences, with one woman writing, 'It's a really lovely record of how I felt at that time and what my memories were then - as time rushes by, it's amazing how far away I've moved from that now so I'm glad that thanks to you I have an oral snapshot of August 2013!' When the transcript was sent a good few months after the interview, as in the case above, the women

[41] The research was approved by The University of Kent Faculty of Humanities Research Ethics Advisory Group in December 2011.

[42] This sheet was never requested and none of the interviews had seemed troubling or traumatic enough for me to offer it.

[43] These documents can be found in the appendices.

seemed happy to reconnect again, with us both giving small updates in our lives since meeting. Ethical practices then were about more than having the necessary paperwork, as important as that is, but were about being a sensitive and non-judgemental listener and making people feel comfortable in the interview context and in all subsequent correspondence. Feedback from interviewees, and the fact that I am still in touch with a few women, as Oakley described in her follow up article to 'Interviewing Women', 'Interviewing Women Again' (2015), suggests that I achieved this aim.

***Can Interviews Help us Understand Practices?***

Before turning to discussion of the interview techniques I used, it is worth considering a number of recent debates about the relevance of interviews in analysing cultural practices. As mentioned above, studies with a focus on practice have often favoured observation as the primary research method. Anthropology has long questioned the worth of interviewing as a primary research method, preferring ethnographic practices of participation observation and living 'in the field'. In *New Jersey Dreaming*, an interview-based ethnography of her own peer group, anthropologist Sherry Ortner (2003: 16) describes the traditional ethnographer's view of interviews as 'the production of highly individualised, socially decontextualised talk'. However, she argues that interviews can also be used to balance ethnographic data and that anthropologists have recently turned to interviews for two reasons; 'the concern with history - that is, with longer stretches of time than would be covered in classic fieldwork - and the concern with larger areas of space (the region, the nation, the globe) than can be covered in classic fieldwork' (2003: 15). Ortner (2003: 16) thus embeds her interview data in historical and cultural narratives in a process she describes as akin to the documentary film maker who intersperses footage with talking heads. Whilst my analysis is largely focused on participant's narratives at the micro-level, in order to understand how this particular group of women negotiated between an ideal and their own circumstances through practices, I agree with Ortner (2003: 16) that the social and historical linkages between groups with shared projects, such as natural birth, can help weaken the problem of 'unrelated talking heads'. I also follow the arguments of praxiography, mentioned above, that observation data should be supplemented with interview data as a way of further interrogating the meanings of practices.

Other disciplines have also critiqued interview based methods but have not seen ethnography as the answer. Allison Pugh (2013) describes how some authors within the field of cultural sociology (particularly those who she terms 'cognitive culturalists' who draw on the fields of psychology and neurology), have argued that interviews cannot get to the heart of cultural action; only on-the-spot, snap-judgement surveys can. This is because interviews only explore the discursive or superficial level of consciousness, they argue, not the deeper, visceral level of consciousness which is more responsible for determining action. This can be accessed, they argue, through the survey in which participants are not given time to reflect on their answer and instead rely on a moral intuition. In disagreement with this position, Pugh (2013: 42) argues that this is a rather simplistic view of both culture and the benefits of surveys and that instead in-depth interviews, whilst not perfect, can shed light on the emotional landscape as a 'social dimension to individual motivation'. Cognitive culturalists ignore the role of emotion in connecting the two forms of consciousness, she argues, and interviews, not surveys, can reveal emotions.[44] Pugh suggests that critiques of interviews tend to assume that analysis is confined to a particular form of information; what people say. She argues instead that how people say things is as important and that through an interpretation which is sensitive to non-verbal forms of information, in-depth interviews can access 'different levels of information about people's motivations, beliefs, meanings, feelings and practices - in other words, the culture they use - often in the same sitting' (2013: 50).

The argument as to whether or not interviews can access the levels of consciousness which determine action has parallels to the arguments about the relationships between beliefs and practices, discussed in Chapter Two. Cognitive culturalists, according to Pugh, are uneasy about the incoherence of beliefs and practices, and argue that incoherence only exists on the superficial or discursive level, not the deeper level of practical consciousness, and hence is a result of people being asked to talk about their actions. Pugh (2013: 47) disagrees arguing that 'people are contradictory' and that the search for a 'solution' in snap-judgement surveys as the way to access 'real' culture, is not the best way to proceed.

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[44] Pugh (2013: 50-51) goes on to describe four types of cultural information revealed in in-depth interviews, all of which are factors in driving action: the honourable (the presentation of self the interviewee wishes to give); the schematic (the language and non-verbal cues that convey the framework through which the interviewee views the world); the visceral (the emotional landscapes and moral understandings); and meta-feelings ('how we feel about how we feel' or the 'cultural frames' around emotions).

The ‘after-the-fact rationalisations’ given in in-depth interviews are also ‘real’ culture (2013: 42). She further argues that the contradictory cultural accounts given in in-depth interviews are not in need of ‘solving’ theoretically, as the cognitive culturalists would suggest, but rather should be expected and analytically examined, including through a focus on unexpected discrepancies between different forms of information. As she suggests, ‘contradictions and paradoxes are powerful tools for highlighting the emotionally charged - what is emotionally difficult to claim, where anxiety lies, and what sort of cultural problems people face for which they need to reach for such contradictory explanations’ (2013: 48). Indeed the contradictions and disjunctions between subscribing to the emotionally charged discourse of natural birth whilst desiring a more open and practical approach oneself is the focus of this thesis. As I argue in the next chapter, my observations of the performance of an emotional charge in interviews allowed me to identify the ‘profane signifiers’ of natural birth which reveal important elements of the ideal birth.

Reflections on the relationships between beliefs, ideas and talk (including interviews) on the one hand and practice on the other, and the ability of interviews to access practice, has continued in other social science disciplines. Geographer Russell Hitchings (2011) has described his use of interviews to analyse social practices in his aptly named article, ‘People can talk about their practices’. Here, Hitchings (2011: 61) traces the move towards alternative methods such as photo, video and diary elicitation methods within social practice theory. Such methods are presented as removing a layer of representation and hence as beneficial when analysing routine practices which have ‘sedimented down into unthinking forms of embodied disposition’. Hitchings argues, on the other hand, that he found people were able to articulate and reflect upon their most routine and mundane practices when appropriate questions were asked and certain techniques employed, including serial interviews; allowing plenty of time; not being afraid to ask seemingly obvious questions; offering alternative scenarios to discuss and being attentive to how respondents react to questions. Pregnancy practices are not entirely mundane and routine (although they may become routinised during pregnancy) as they are selected from a range of options during the limited time frame of the pregnancy and with a specific goal in mind. They are thus subject to high levels of reflexivity and are often discussed in ante- and post-natal groups - arguably making pregnancy practices easier to talk about than more routine

practices. In this sense, my interviews could be seen as a continuation of a practice of reflexivity and discussion which is ongoing for some women, including those in my sample, during pregnancy and the post-birth period in classes, discussions with friends and family and on social media forums. My interviews capture some of the talk 'on the rough ground of everyday existence' (Hitchings 2011: 61), although of course the interview, as a more contrived social encounter adds a different dimension to talk overhead during ethnographic work.

**Interviews in Practice**

Observation of classes, combined with my reading of pregnancy and birth 'manuals', websites and social media, gave me a good understanding of some of the practices in which women engage in their pursuit of a natural birth. However, in order to gain deeper insight into women's own understandings of these practices and how they fit with their own definitions of and desires for natural birth, I felt that interviews were necessary. Interviews would give me the space to explore the complexity of women's motivations for a natural birth in a way that brief chatting before and after classes could not. I had conducted two pilot interviews in 2011, before I began my fieldwork period; one with an independent midwife and one with a mother of three children, the last two of whom had been born at home after a negative first birth experience in the hospital. Both of these women were friends of friends. As the focus of these interviews was an exploration of the issue of spirituality in relation to birth, the data is not used in this thesis. Nevertheless, the pilot interviews were invaluable in developing my abilities to raise questions, actively listen and reflect on issues of pregnancy and birth.

As outlined above, my first interviews were with women met through the observations, with a small amount of snowball sampling, before I was contacted by a large number of interested women (58) who had seen a post about my research on various social media pages. Around half of these contacts were interviewed, selected on a rather ad hoc basis including their availability and location. In total, 43 women were interviewed for this thesis, with interviews ending when a certain level of 'saturation' had been reached with no real new or unique data being uncovered in the last few interviews. Participants selected the location of interview: 22 interviews were conducted in the women's own homes; 3

interviews were held at my home; 15 were held in cafes/restaurants or the woman's place of work and 3 interviews were conducted via Skype as the women lived too far away for a day's travel. Participants were located in London and the surrounding counties of Essex, Cambridgeshire, Oxfordshire, Berkshire, Kent, Bedfordshire, Hampshire and West Sussex. As mentioned, due to the clusters of participants active in local special interest groups such as NCT, independent midwifery and Hypnobirthing, on five occasions I interviewed two women together, and on one occasion, three women. Whilst this was motivated by the practical concern of only having to travel to a particular area once, and was sometimes suggested by the women themselves, I also found these interviews particularly enjoyable and they created very fruitful data as the women entered into discussion with each other as well as with me.

Influenced by the concerns of feminist methodology, I sought to make the interviews as informal and relaxed as possible through my interview style, but the practicalities of the interview situation also contributed to the informal feel. In general, the interview setting, whether it was a public place or the woman's home, was noisy, with televisions on, children playing and sometimes crying. The women's children (both born and unborn) were present in 27 of the interviews and the physical embodied relationship between mother and child defined the practicalities of the interviews, as much as the subjects discussed, as the interviews had an ebb and flow as the children's needs were met. The embodied relationship was particularly manifested in food and feeding: infants were periodically breastfed throughout the interviews; older children were spoon fed pureed baby food, or fed themselves depending on the mother's approach to weaning;[45] whilst a two year old asked for, and was given sweets, which led to her mother saying, 'I'm a bad mother but it will keep her quiet for a while whilst we talk'. I also shared food and drink with the majority of participants, whether this took the form of buying them a drink in a cafe, sharing a lunch in a restaurant, or taking biscuits or items for lunch at their house. Hence whilst the interviews ranged in length between 30 minutes and 3 hours, with the majority lasting around 90 minutes, in reality I spent much longer with most women, helping to prepare food, walking to or from a station with them and, in one instance, holding the baby whilst the woman dealt with her supermarket delivery. My experiences

[45] Baby-led weaning, in which the child, from 6 months old, is encouraged to feed themselves with 'finger food' (never pureed) is the preferred approach of Attachment Parents and is now beginning to be encouraged by health visitors.

and reflections upon these additional interactions were recorded as detailed field notes and provided me with essential contextual information.

Whilst I was committed to a form of narrative interviewing, I did create an interview guide with anchor topics including pregnancy practices and resources; birth plans and expectations; birth experiences; and approaches to birth, perhaps in my initial concern that conversation might not be forthcoming, or might be stilted or awkward. Under each heading I had a list of potential questions. However, after only a couple of interviews, I found that it was not necessary to follow the interview guide because a fruitful conversation could be initiated with just a simple narrative-style question such as, 'tell me about your pregnancy and birth experiences'. This was often enough to generate a couple of hours of conversation but I did sometimes make notes of points of interest to return to once the woman had finished her initial narrative. I was more comfortable with this than with interrupting the flow of a story with questions. I also raised questions about the women's understandings of, and definitions of, natural birth at the end of the interview if I did not feel that this had been explored to an adequate depth within the narrative. Whilst the women knew I was interested in 'natural birth' from my research flyer or social media posts, I did not begin the interviews with questions on their understanding of this contested term. I rather waited to see how they would raise the topic and discuss it in the light of their own experiences of pregnancy and birth, in the hope that this would be less 'leading' and would allow the women to express their understanding of the topic as it fitted with their own stories. In this technique, I was influenced by both feminist methodologies and by recent work in the sociology of religion which seeks to explore the rise of the 'religious nones', those who do not identify as belonging to a religious tradition but who nevertheless have their own beliefs and practices arising from moral, ethical, and family traditions. In 'Researching Belief without Asking Religious Questions', Abby Day (2009) discusses the necessity and the difficulties of researching contemporary beliefs in the UK without recourse to religious language. She describes how she 'wanted to give informants as much control and choice as possible over how they interpreted and answered my questions so that I could capture their conceptual frameworks and vocabulary' (2009: 93). Through approaching the contested issue of natural birth definitions at the end of the interview, I could relate my questions to the women's own stories and vocabulary. My intention was that this would allow the women's own understandings of natural birth to come through the

interview data, to a greater extent than if the focus of the interview, from the outset, was definitions of natural birth, removed from any discussion of their embodied experiences.

I have argued that in a commitment to feminist methodologies, I selected a form of narrative interviewing as the ideal method for exploring women's own experiences of pregnancy and birth. Following Oakley's arguments in 'Interviewing Women' (1981), I felt that narrative interviewing would be most similar to that of a conversation which might take place 'on the ground' in an ante or post natal group, and would be the form of interviewing most likely to reduce a power imbalance. I further sought to reduce a power imbalance by being as responsive and flexible as possible in arranging interviews; allowing women to choose the interview location, to bring their children and to prioritise their children's needs, taking as many breaks as necessary during the interview, amongst other things. I have described how rapport was established in the interviews through this flexibility, through a shared experience of mothering and through shared material and cultural resources including class, locality and tastes. Whilst I revealed my own perspectives and experiences of natural birth to different extents in different interviews, depending largely on the women's interest in my position, I was never hostile towards natural birth. This was arguably a primary factor in establishing rapport; a shared experience of mothering but with divergent views on the benefits of natural birth would likely have been a major factor in prohibiting rapport as it would have entailed suggestions of judgements on their mothering choices and practices. Whilst this sometimes placed me in an ethical dilemma as to the extent to which I should downplay my knowledge in the case of expert interviews, or agree with the women's own perspectives in other interviews, I have suggested that I was largely happy to do this as I genuinely hold an ambiguous and fluid position on natural birth, having experienced three different births myself. Through this informal interview style and successful rapport, there were no interviews in which I felt it a struggle to elicit information from the women. I hence felt that the interviews provided rich data - each transcription averaged around 10,000 words producing over 400,000 words of interview transcript.

**Analysing the Data**

The theoretical and methodological approaches discussed in this chapter including ethnography, praxiography, lived religion and feminist methodologies, all share a commitment to the analysis of meanings through a focus on participants own lived experiences, practices, concepts and vocabularies. They are all inductive methods which seek to generate arguments from a close reading of empirical data. Glaser and Strauss's (1967) 'grounded theory', in which the ideal is to generate all theory from empirical data, has waned in popularity somewhat over the years in the recognition that readings of theory mediate data collection and interpretation. I have sought to pursue a reflexive approach in which some theoretical concerns guided my data collection and yet the main theories and themes of the project - that is, the relationships of the ideal and the practical and the role of practices in negotiating these relationships - emerged from analysis of the data. Hence whilst this project was not entirely one of 'grounded theory' in which the theoretical concern emerged solely from the data, I have been influenced by this approach and have sought to listen closely to what women were telling me in the interview context, in order to reconstruct theoretical meanings as closely to their own lived experience as possible. My theoretical interests in the relationships between sacred-profane, ideal-practical and beliefs-practices, emerged from my readings of theory prior to beginning fieldwork but the main themes of this project, including how these binaries are negotiated through practices in the context of natural birth, emerged from the data collected. In this I have followed the feminist principle that women are the experts of their own lives but the arguments of this thesis are based on my own interpretations of the data collected and they may or may not be recognised as valid by my research participants.

In order to gain a deep familiarity with my data, I made extensive field notes as soon as possible after each observation and interview (most often on the train home), recording a description of the event as well as my own thoughts and feelings about both the event and the participants. These added to the transcripts of the interviews and the notes of observations taken in classes. Undertaking all transcription myself, whilst time consuming, was important in order to listen to the women's voices again and add a depth of familiarity. I also re-read each transcript, making notes and picking out key terms and phrases used, in

a general thematic analysis of the data. The transcripts were then added to the qualitative data analysis software programme, Nvivo, which I utilised at a basic level to organise and manage my data, through the use of coding.

In the grounded theories of Glaser and Strauss (1967), and later iterations including Strauss and Corbin (1990), analysis of data is a reconstruction of meaning through the use of different forms of coding. Strauss and Corbin (1990: 57) have defined coding as 'the operations by which data are broken down, conceptualised, and put back together in new ways. It is the central process by which theories are built from data'. Strauss and Corbin (1990: 74) suggest different levels of coding beginning with open coding which they define as,

> ….the analytic process by which concepts are identified and developed in terms of their properties and dimensions. The basic analytic procedures by which this is accomplished are: the asking of questions about the data; and the making of comparisons for similarities and differences between each incident, event and other instances of phenomenon. Similar events and incidents are labelled and grouped to form categories.

Through a close reading of the interview transcripts and field notes I developed 68 different codes: some purely descriptive (such as home birth, doula), some 'in vivo', that is using the interviewee's own expressions and phrases, such as ('the birth I want', 'it just felt right'), and some more abstract or theoretical (such as the difference between first and second births, having to learn or practice, keeping options open and practicality). These codes were used to categorise the data, to make comparisons across transcripts, and to generate initial theories, including the selection of codes to explore further based on numerical occurrence of themes across transcripts. This then moves towards Strauss and Corbin's second level of coding, axial coding, as a means 'to refine and differentiate the categories resulting from open coding' (Flick 1998: 183). Flick (1998: 183) goes on, 'From the multitude of categories that were originated, those are selected that seem to be most promising for a further elaboration. These axial categories are enriched by their fit with as many passages as possible'. In the axial coding stage, then, 'the categories that are most relevant to the research question are selected from the developed codes' (Flick 1998: 184). Hence the codes which emerged most frequently in my data were given more weight in that I focused on their analysis and used them to construct theoretical ideas. It was my analysis of the codes which led to the main themes of the thesis emerging, including

practicality/pragmatism; tactics and techniques (practices); forms of knowledge; claims to expertise; 'the birth I want'; choice and control; and profane signifiers. My primary theoretical concern of the relationships between an ideal and practical/individual concerns and the negotiation of this relationship through practices, has hence emerged from my reading of the data.

**Conclusion**

This thesis explores the disjunction between a public, moralised discourse of natural birth and women's own more complex narratives of practical decision making and lived experiences of pregnancy and birth. I address questions which are not adequately addressed in some of the sociology of childbirth literature, not least 'Why do some women report that they want a natural birth?' and 'Why and how do they become involved in natural approaches to pregnancy and birth?'. Public discourse, including media articles and some feminist critiques, presents natural birth as non-negotiable and dogmatic and simultaneously as dangerous, unachievable, and bound to failure. This leads me to wonder, why then do some women hold natural birth as something of value to them, something that matters? Surely, women approach natural birth in a more reflexive and negotiable way than its public presentation? Surely, they have means of negotiating the potentiality of failure, or at least a reframing of this issue? At the same time, I wanted to research a community that was largely practice based in order to complicate traditional academic focuses on beliefs and values. Hence I focus on the planning, preparation and practice in which women are involved during their pregnancies, which I term the 'work of birth'. The work of birth is both the means through which the ideal natural birth is balanced with the women's own circumstances and desires and through which a particular type of motherhood is performed. I consider the work of birth as an 'ethical path' in which the women are engaged in practices that matter to them and form a sense of self through relationships with others, whether real or imagined. The story of this thesis then is a complicating of women's lived relationships with natural birth, presenting their involvement not as rigid and static but as flexible, reflexive and negotiable practices.

The three following empirical chapters explore different facets of the relationship between an ideal and the practical as the central theme of this thesis. Chapter Four describes the

ideal natural birth; I identify the key components of natural birth from both birth manuals and my interviewee's statements before discussing the simultaneous hesitation and ambiguity which my interviewee's expressed with regard to natural birth. I suggest that my participants found it easier to express what was *not* an ideal birth, five practices which I refer to as 'profane signifiers', which are central to the creation of the good and responsible mother in opposition to 'the other'.

Chapter Five discusses the practical motivating factors which temper the ideal. In Chapter Five, I further interrogate the meanings of the ideal natural birth by examining women's motivating factors for participating in private antenatal classes and working towards a natural birth. I argue that ideological commitment to a natural birth is only part of the picture and that the women I interviewed were also motivated by pragmatic concerns, by the influence of their social networks, and by financial and accidental factors. In Chapter Five, I focus on the central component of choice in the ideal natural birth, encapsulated in the much used phrase, 'the birth I want'. I argue in this chapter that the values, practices and lived experiences of the ideal birth are not as straight forward as the moniker of 'natural birth' suggests. The ideal birth is more than being about any one particular type of birth. It is equally about the woman having chosen key aspects of her birthing practice (or at least feeling satisfied with her perception of choice), rather than having decisions imposed from above by medical authority. Women's birth choices are not motivated by a simple moral dichotomy; lived experience is much more complex and numerous practical concerns play into decision making. Hence balancing the ideal and the practical takes work, and the performance of this work creates a particular form of gendered subjectivity. The issues of balancing/negotiation and the performance of a particular subjectivity are the focus of Chapter Six.

Chapter Six discusses the practices in which women engage which perform the simultaneous acts of negotiating between the ideal and the practical and creating a particular subjectivity; that of the good and responsible mother. It is Chapter Six then which answers my central research questions, 'What does it mean to engage with an ideal in a context in which moral norms are at the fore and yet practical circumstances must also play a role?' and 'What role do embodied practices and relationships play in negotiating a moral field?'.

Chapter Seven returns to the theoretical literature introduced in Chapter Two to reflect on what approaching natural birth as lived ethics allows us to understand about the women involved in such practices. I also consider how my theoretical model and empirical example of natural birth can add to current debates within religious studies about how to study meaning and 'things that matter'.

## Chapter 4 - The Ideal Natural Birth

In this chapter, I consider what the 'natural' means in the context of pregnancy and birth and how it impacts on women's birthing choices and practices. I argue that my participants' narratives of their pregnancy and birth experiences reveal an 'ideal' birth replete with normative understandings of the natural, which reflect the teachings of natural birth manuals and classes outlined in Chapters One and Three, whilst they simultaneously struggled to define the natural in more abstract terms when asked at the end of the interviews. This tension between an implied normativism and hesitancy and ambiguity around definition was consistent across the interviews.

I identify the key components of the ideal natural birth which emerged from these narratives. The natural is sometimes portrayed as a normative and non-negotiable reality which confers authority and legitimates practices. In many natural birth manuals, websites and in the teachings of some antenatal classes, strong connections are made between the natural, healthy, tradition and a moral evaluation of good, which encompasses ideas of personal responsibility. Drawing on this public literature and on the interview narratives, I identify four central components of natural birth: 1) The natural is timeless and is how women have always birthed, making a connection with other women across time and space. 2) This connection is emphasised through ideas that this is how indigenous women still birth without problems - a romanticisation of the 'native'. 3) The importance of being in tune with and trusting the 'natural design' of the body. 4) The need to follow instinct and/or experience. This ideal is often portrayed as dichotomous to a medical model of birth. The dichotomy is a foundational concept in both public discourse and in some of my participants' statements, particularly with regard to the choice of home birth. The ideal natural birth was more pronounced in some of the interviews with birth workers.

Having outlined the ideal natural birth, I argue that the women I interviewed expressed hesitation and ambiguity in defining natural birth, as well as, sometimes, an avoidance of the term altogether. Nevertheless, this ambiguity around the term does not indicate a lack of commitment to an ideal form of birth. I argue that many of my participants seemed to have a higher emotional investment in, and found it easier to articulate, how they did not want their pregnancies and births to proceed than in any absolute prescriptions. Hence

'profane signifiers' shed a great deal of light on the ideal birth. I identify five profane signifiers from my interview data: induction; the lithotomy position; eradicating pain; the TV programme *One Born Every Minute*; and internal examinations. I argue that the profane signifiers reveal a constructed 'other' who represents, to my participants, the non-ideal birth in the contemporary UK. The 'other' is one who does not birth right because she relinquishes her embodied and experiential authority to the medical profession and to the profane signifiers. I suggest that the profane signifiers and constructed other reveal a changing location of expertise, away from the NHS midwife who is constructed as part of the negative system, towards a partnership of the pregnant woman and her chosen, and paid for, expert whether this be an independent midwife, doula or antenatal class teacher.

**Women's Definitions of the Ideal Natural Birth**

As outlined in Chapter Two, I use the theoretical concept of the 'ideal' as a means of examining women's reported reasons for participation in private antenatal education and desires for a 'natural' birth. Whilst the public discourse of natural birth leaders suggests strong moral binaries and a dichotomous view of natural *versus* medical birth, my empirical data paints a more complex attachment to natural birth. I use the term 'ideal' to convey this more complicated picture of women's lived relationships to natural birth. I consider the ideal both in its most common definition as a conception of something in its highest perfection, existing as an idea or archetype, that is in the mind; but also as a noun, as an object to be realised or aimed at. It encompasses, in this definition, both an idea and an action or practice. Hence I use the term 'ideal' in order to convey something that is most highly valued but is not necessarily considered achievable or even desirable in its entirety. Instead it is held as something to be worked towards with the possibility of non-attainability always present. In this chapter, I focus mostly on the ideal as an idea, turning to a focus on practices in following chapters. It should be noted that the ideal is employed here as an analytical concept and is not a phrase that was used a great deal by my interviewees, although it was occasionally. The term is used more frequently in natural birth literature and on social media. But whether the term is explicitly used, or implied through other terms such as 'my perfect birth' or the 'birth plan', it encompasses the idea that there exists a most desirable form of birth, of most benefit to mother, baby, family and wider society, as outlined in Chapter One. My interviewees very participation in private

antenatal education (encompassing an investment of time, money, emotions, and body work, both within and outside of the classes), as well as researching and investing in private birth workers, is an indication of their commitment to an ideal form of birth. Preparing for a particular form of birth is the *raison d'être* of antenatal programmes such as Hypnobirthing and Active Birth. All of the women I interviewed, self-selected on the basis of their interest in 'natural birth' and their participation in online or physical natural birth groups, had prepared or were preparing for an ideal natural birth with common elements, although they were emphasised to different extents.

In giving narratives of their pregnancy and birth experiences, the women I interviewed drew on, and hence contributed to, the meanings of natural birth found in public discourse outlined in Chapter One. The majority of women utilised the term 'natural' when describing their choices and experiences. Katie, a mother of one and a masseuse and Reiki practitioner focusing on pregnant women, summed up the ideal natural birth when I asked her 'What does natural birth mean to you?'

> …in a place that's familiar to you, that you're happy with, surrounded by the person that you love, or people, if you feel happier surrounded by more people… and just obviously no medical intervention and… going in to that trance like state, I guess like the native woman, women, being down on the ground and just like letting my body take over like the rhythm of waves and everything and um, just letting my body do what it was built to do… maybe being in water but not all about the water, more about your surrounding and who you're with and being relaxed and positive and excited rather than frightened and unsure and negative and saying you can't do it.

This extract encompasses the central ideas of natural birth which will be further unpicked in this chapter: the ideal natural birth is about having a positive philosophy, rather than birthing in fear which increases pain; it is about having a calm and relaxed birthing environment, often in the home and with a birthing pool; and it is about having as few drugs and medical interventions as possible and instead letting natural birthing instincts and the body 'take over'. These ideas were repeated time and again in my interviews.

The ideal natural birth is also about having the birth that is 'right for you'. For instance, whilst Katie suggests that the ideal natural birth is one in which you are surrounded by the person or people you love, a couple of interviewees felt that the perfect or ideal birth would be one in which they were alone. Harriet, mother of two, told me, 'I shouldn't tell (partner) I suppose but that's what's in my mind - the perfect birth to just be completely on

your own'. Whilst Annie's mantra throughout the interview, when describing her pregnancy and birth choices and experiences was, 'we're doing it my way'. She described her natural birth as, '…a birth that I did myself, that I didn't have drugs, that he was born at home, in the pool, in the living room, you know, and my partner and I birthed him rather than somebody else birthing him'. Immediately following the description of her natural birth, Annie added the caveat, 'But I wouldn't define all natural births like that cos it's a very individual thing'. Ideas of 'the birth I want' will be explored further in the following chapter.

Maria, a Hypnobirth teacher and mother of two children born at home, gave a very similar description of her planned birth:

> I wanted a water birth, so we got the water birthing pool, and I wanted to give birth in our bedroom. I wanted everything to be very calm and peaceful. I wanted very much to be left to my own devices, I didn't want to be examined unless they needed to, I didn't want to be bothered, I just wanted them to leave me alone, so my birth plan was very clear that I wanted the midwives in the background.

These quotations indicate a tension between the ideal birth as one that is believed to be achieved solely by the woman whilst acknowledging the need to recognise the role of the supportive partner. This recognition sometimes came as an afterthought in the interviews. The idea that the woman (with or without her partner) births the baby by herself is central, indicating a lack of a reliance on medical expertise for the non-medicalised event of natural birth, as well as making the connection with other women across time and space. They also highlight the perceived peripheral role of the midwife.

Further tension exists around ideas of the natural as a motivating factor in birthing choices. The ideal natural birth described in the quotations above is focused on the benefits for the birthing mother, but these benefits are seen as indistinguishable from the benefits for the baby. The benefits of a natural birth for the health of both mother and baby were often given as the motivating factor for a desire for natural birth. Many of my interviewees made the connection between natural birth as being 'best for baby', sometimes linking this with the issue of civilisation outlined in Chapter One. For example, Elly, a mother of one, explained that

> I started to feel that actually it was really important for me to give the baby the best sort of start in life and then that's when I started thinking about what does that mean? what's the best start for that baby? and all I could, then I started reading around erm, different pain reliefs and the sort of effects on the baby, and I was kind of hooked on thinking 'I want this baby to come out as natural as possible', so vaginal delivery, no pain relief if I can do it…it was so important to me.

The quotations explaining the ideal natural birth above are women's individual definitions of natural birth. Whilst my interviewees were keen to stress that their definitions were only 'right' for them and that others would have different definitions, the similarity of the components comprising the ideal natural birth, belies this. Katie, Harriet, Annie and Maria's quotations are just a selection of the 43 definitions I collected. The definitions encompassed similar practices: home birth, water birth, no pain relief, a positive philosophy; as well as similar ideas: this is how women have always birthed, trust in your body and you can do it alone. An easy means of defining natural birth and conveying this collection of ideas was to juxtapose this form of birth with a medicalised birth. The portrayal of a dichotomy between a medicalised form of birth and a more natural form were recurring themes in the interviews. Hence, many of the women's initial definitions of natural birth focused on the use of intervention, including pain relieving drugs, in line with the NHS definitions of 'normal' birth given in Chapter One. For example, Fern, pregnant with her second child, defined natural birth as

> …just the whole kind of like using the breathing techniques, relaxation and erm, I would still consider if you had gas and air it still being natural and just trying to let your body do it rather than having the medical intervention of like the cut and the instruments and all of that.

Whilst Chelsea, pregnant with her first child, said, 'I suppose what natural birth means to us in the UK would be, you know, drug free, fewer interventions, close to how God or whoever intended it to be, I suppose'. This simple distinction of a natural birth from a more medicalised one belies a much more complex understanding of the natural on closer analysis. As suggested in the introduction to this chapter, the natural encompasses at least four interconnected ideas: 1) the natural as timeless, as essentialised and ahistorical creating an imaginary link with women across time and place. 2) indigenous women, both contemporary and throughout history, can 'naturally' birth. 3) women's bodies as being designed to 'naturally' give birth. 4) natural birth is about following instincts.

### *The Natural as Timeless*

A significant source of meaning in the observations and interviews I conducted was in ideas of the natural as timeless. For instance, Mandy, the teacher of the Hypnobirth course I observed, frequently referred to Hypnobirthing as a natural birth approach. She told the class 'Hypnobirthing is about going back in time to reclaim our natural ability to birth'. The natural here is directly equated with authenticity and authority through its timelessness and its connection with women across time and space. These ideas were repeated in my interviews with women who had completed the Hypnobirthing course. For instance, Jenny explained how 'I've gone back to as natural as possible and back to the old way of doing things'. Explaining her desire for a home birth she said, 'My view was that hospitals are somewhere you go if you're ill, not somewhere you go to do something that is absolutely natural and women have been doing for hundreds and thousands of years, there was no need in my mind to be in a medical environment for that'. When I asked Linda whether she thought Hypnobirthing was a natural approach, she said, 'yeah I think it's like an alternative therapy and it helps you have a more natural birth'. She went on, 'Childbirth is a natural process that women have been doing for hundreds of years, something you easily forget when all your friends talk about how good their epidurals were'. This sentiment was repeated by Chloe when I asked what the key point of Hypnobirthing was for her:

> It's just that basic thing that Grantly Dick-Read talks about - fear, tension, pain - and just working against all that bad publicity - the press, all the pictures on TV that really have nothing to do with what women would do, generations and generations of women before this whole kind of medicalised attitude to childbirth.

Ideas around the natural as ahistorical and as how women have always birthed, serves as an easy means of making a distinction from the mainstream, medical approach to birth, and signifies my participant's interests in what is believed to be an older, and hence better and more pure, form of birth.

***The Natural and 'the Primitive'***

Sometimes connected to the idea of natural birth as timeless is a romanticisation of primitive peoples who, in this narrative, 'easily' give birth.[1] This form of racism, which completely neglects the high mortality rates of mothers and babies in developing countries,[2] is promoted in the work of the natural birth pioneers. Mongan, for instance, provides a few anecdotes of how women birth in Africa and Balaskas credits her GP who had just returned from Botswana with reminding her to squat for her own birth.[3] It is perhaps not surprising that women who have completed these courses repeat these ideas. Hence when I asked Lucy to explain Hypnobirthing to me in just a few sentences, she replied:

> It's about having a positive experience, that's as natural as possible, but still being prepared for any situation. It's anti-intervention and I do agree with that, I think there's too much intervention….And you know I just think, if a woman in Africa who's never seen a doctor in her life can have a natural birth, then I know I can too.

Whilst Kim stated:

> It's another reason I wanted to get involved in the industry so I could help people remember this is what women are actually made to do and there's no reason why it should be so confusing and difficult, like, you know, African women squat in a field don't they (laughs).

Jane, referencing the Hypnobirthing book, repeated this idea: '… it has a section in the front of the book about the history behind it and how women in Africa just go, "breathe" and the baby comes out, well I know that's not gonna happen but it actually wasn't that far off really'.

It is interesting to note that every one of my participants who mentioned the idea of the romanticisation of the native, sometimes with some embarrassment as Kim's laughter

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[1] See also Faircloth (2015: 11-13) on the romanticisation of hunter-gather societies in the justification of extended breastfeeding practices. She writes 'The attachment mothers (or rather, the authors they cited) in London used "the primitive" as a site for playing out fantasies of the natural' (2015: 12).

[2] Rebecca Schiller (2016: 67) writes that 'Today more than half of maternal deaths occur in sub-Saharan Africa and almost one-third in South Asia. The maternal mortality ratio in developing countries in 2013 was 230 per 100,000 live births, versus 16 in developed countries'.

[3] http://activebirthcentre.com/janet-balaskas-story-active-birth-movement/

above indicates, referenced Africa above any other developing area. To them, influenced by the natural birth manuals mentioned, African women are the epitome of the primitive. That African women are not involved in any of the same practices as the women I interviewed - such as learning particular techniques for birth, attending antenatal classes, or desiring birth in water - is not acknowledged. Instead, there is a complicated understanding of 'primitive' women's competence to birth; their lack of knowledge is celebrated as instinct whilst also conveying the sense of superiority that if 'even' 'primitive' women can do it, then western women will have no problems. Problematic connections are made between African women as closest to nature and hence to the animalistic and instinctive. This can be seen as a current iteration of the stereotype of the African mother who stands strong in the face of all adversity and oppression which was challenged by black feminists in the 1970s and 1980s (see, for instance, hooks 1981: 20). It further emphasises my participant's positions of privilege and power through their accidental placement in the categories of 'white' and middle-class. Their membership in these categories of class, race and heterosexuality intersect to create a normative position in which their ideas and practices are considered legitimate. The practices of poor, black women are celebrated (although misrepresented) but sanitised for the white, middle-class context.

***Women's Bodies and Natural Design***

Ideas of the natural as timeless and as epitomised in 'primitive' births, are also combined with ideas of women's bodies as 'designed' to birth. When I asked Fiona what the most important thing she had learnt form Hypnobirthing was, she linked the idea of a connection with women across time and space with a reference to the design of women's bodies being able to birth:

> ….realising how fear can create the tension in your body which creates the pain which then obviously creates more fear and that kind of process and the realisation that your body, if you can relax, will work and is made to work and we're all built to be able to do it…

For Martha, another Hypnobirth teacher interviewed, the idea of the design of women's bodies was central to her Hypnobirthing philosophy, for when I asked her 'what are the most important things that Hypnobirth teaches?', she replied,

> Hypnobirthing is a tool to support those who believe that birth is normal, so the main kind of principles if you look at it that way are that we're all equipped to birth the babies that we conceive so, regardless of how big your baby is, your body can cope.

Nancy, one of her students who I interviewed at the same time, echoed this when she said, 'I just thought, "why can't I do this, I'm a woman, I'm designed to do it"'. Maria, another Hypnobirth teacher, spoke a great deal about trusting in her body during labour and birth:

> I surrendered to the surges, I had to surrender to everything that was happening to me, I had to let it happen without trying to fight it, without trying to question it or be worried about it, just let it happen and my body knows what it's doing and trust in my body.

Ideas around trusting the body, the body knows how to birth, and is indeed 'designed' to birth, raises interesting tensions between natural birth as something instinctual and as something that needs to be learnt and practiced. As will be unpicked in later chapters, the women I interviewed simultaneously believed that natural birth was the most instinctual form of birth, the way their bodies would birth if they 'just let it happen', and yet they had to learn this form of birth in antenatal courses and practice the techniques learnt to increase their chances of achieving their ideal birth.

### *The Natural and Instinct*

For proponents of Hypnobirthing, Active Birth and other forms of pregnancy yoga, natural birth is strongly equated with following instinct. The assumption behind Active Birth is that the labouring woman will instinctively remain upright. It was 'Founded on the belief that women know instinctively how to give birth and babies know how to be born'.[4] Similarly, Mongan (2009: 17), following Odent's ideas writes, 'Like the bodies of our sister creatures in nature, the bodies of healthy pregnant women instinctively know how to birth, just as their bodies instinctively know how to conceive and how to nurture the development of the babies they are carrying'. The importance of instinct was stressed by the Hypnobirthing teachers I interviewed, including Claire, founder of Birth Wise, who stressed that Hypnobirthing was 'about following instincts'. Bella, a mother of three, who had not practiced Hypnobirthing but who had her last two children at home with an

[4] http://activebirthcentre.com/janet-balaskas-story-active-birth-movement/

independent midwife, made a connection between natural birth, following instincts, and comparison with other mammals:

> Every mammal, every other animal on the planet, manages to reproduce without major life threatening situations. I don't see why we suddenly have to turn it into a hospitalisation drama that requires medical intervention, it should be a normal part of life and once upon a time it was, it was part of the community and people had babies.

The comparison between natural birth and the births of other animals was a recurring theme in the interviews, such as when Macy said, 'for years now people have tried to fit it into a medical model that they can manage and actually I much more easily believe the side that it's instinctive and we're all animals'. Sabine said, 'We are designed to let the body do it and we are designed to give birth all by ourselves, with no help whatsoever, just like cats do and porpoises do and elephants do'. The paradox that these women paid hundreds of pounds to learn different natural birth techniques in private antenatal classes was not raised in any interviews. Nor was the evolutionary argument that humans are unique in their childbirth difficulties because of the ratio between the size of the baby's brain and the width of women's hips.

Tensions between instinct as 'natural' and learnt practices as 'cultural' (and hence of lesser value) have been noted by scholars working in the areas of birth and parenting (Klassen 2001, Faircloth 2011, 2013, Lee et al. 2014). Klassen, in her analysis of the primary metaphors used by home birthing women to describe and understand their experiences, identifies metaphors which incorporate ideas of instinct and intuition, including birth as an 'animal act' and the body as a source of 'feminine instincts and wisdom'. With regard to the former, she writes that 'In this view, giving birth like an animal is not simply innate to women's bodies but is a socially developed "instinct" that must be uncovered, given our society's surrender to complex technological manipulation' (2001: 141). This parallels the argument within the New Age/holistic milieu that 'we malfunction because we have been indoctrinated by mainstream society and culture' (Heelas 1996: 18). My participants, in particular the birth workers, made similar statements in alignment with this, suggesting that in the past (as Dick-Read claimed) or in the perfect society (as Odent claimed) women would know how to birth instinctively but because of the fear surrounding birth in the contemporary UK, women's instincts must be relearnt through antenatal education. A number of authors (Annandale 1988, Mansfield 2008) have stressed that natural birth is

learnt. Mansfield (2008: 1085-6) stresses that analyses of natural birth which argue that it is simply a desire to return to the past, neglecting the social and practical aspects of natural birth, cannot account for its contradictions including the incorporation 'of elements of modern medicine', natural birth strategies and the need to learn techniques. As will be discussed below, my participants placed great value on birth-related education - and on the teachers who offered it to them - as a primary distinguisher between themselves and their view of birth and that of the 'mainstream other'.

Hence whilst normative statements were made by all participants, they were sometimes particularly linked to teaching others how to prepare for birth and so were more pronounced in some of the interviews with birth workers. They were strongly linked to ideas of responsibility - to research your own birth plan and, if possible, to educate others on both the importance of taking responsibility for birth in general and for making the 'right' choices, those that 'feel' right, even if they are in defiance of medical advice. Some of the birth workers I interviewed felt a particular responsibility to have an ideal, natural birth in order to 'practice what they preach' and to bring their embodied experiences and knowledge to their teachings. As Katie so succinctly stated,

> At my 20 week scan I found out I had a fully obstructing placenta so they said I'd probably have to have a caesarean which was the end of the world for me because of the job that I do with pregnant women, I'm very sort of holistic and I really wanted to experience a natural birth cos obviously that's experience and knowledge for me to take to my job as well.…for years I'd wanted this particular birth and it meant so much to me and because of the job that I did, you know, I wanted to practice what I preach.

Similarly, Maria, who had qualified as a Hypnobirth teacher a couple of years prior to becoming a mother herself, told me that she decided not to teach until she had experienced birth:

> I wanted to go through it myself before I stood up in front of people and said, 'this is how you can do it'. It felt important to have done it myself…I wanted to have the genuineness of being able to tell them my experience and that this is possible.

For this reason, Maria felt it was especially important for her to birth her two children at home, using Hypnobirth techniques, with her partner filming her labour as a resource for her students. She recognised that 'there was maybe a little added pressure that I needed to practice what I preach'.

As the above quotations suggest, the different elements of the natural as normative are inextricably interlinked and hard to pick apart. The idea that natural birth is birth as it should be because it is timeless and practiced across cultures, including still today in indigenous communities, conveys authority and authenticity from a perceived connection with other women in other times and places, a sisterhood of birthing women. These women follow their instincts and trust in their bodies which are 'designed' to birth naturally. Through birthing in this way, these women give not only their own babies but also future generations a healthy legacy and hence contribute to the salvation of society.

**Hesitation and Ambiguity in Defining Natural Birth**

The natural as normative, linking the natural with timelessness, healthy and 'good', and serving as a moral source and a source of meaning, was a recurring theme in my participants' narratives of experiences. However the idea of natural birth was simultaneously approached with scepticism, ambiguity, tension and sometimes avoidance altogether. Margaret MacDonald (2007: 93), who interviewed midwives and their clients in Ontario in the 1990s, quotes one of her participants as saying, 'I think that natural is a stupid word. What does it mean in this society? I just wanted to have my birth'. This is a sentiment that was also expressed in my interviews. For whilst the women did make normative statements around natural birth, particularly with regard to home birthing in order to resist a medical environment and because this is how women have birthed for generations, many of the women also found it hard to define natural birth. It was most often thought of initially as 'drug-free', as MacDonald also notes. But after mentioning the specific practices listed at the beginning of this chapter, my interviewees often distanced themselves from too rigid an interpretation stating that it was their plan to 'keep their options open'. They described their birth plans in detail listing the different philosophies and practices they had learnt, such as Hypnobirthing, Active Birth, water birth, yoga, massage and more whilst, sometimes, avoiding describing these as 'natural' birth practices.

I did not ask women for their definitions of natural birth until the end of the interviews, once they had already given their pregnancy and births narratives, in order to see whether and how they would raise the topic and relate it to their own desires, choices and experiences. All of the women referenced the natural in some way when giving their narratives and yet my request to them to define the concept was still one with which they

struggled, resulting in much pausing, um-ing and ah-ing and initial responses such as Annie's 'I think that's a hard question' and Linda's 'It's a real hard one…I'm trying to think....I want to answer it…' Yoga teacher Aisha recognised that 'natural birth can be quite meaningless or meaning too much'.

Whilst it is normal to struggle to define a complex term on the spot, in this context there is the added difficulty of it being a contested term, and the women were very aware of this. They knew that how they answered could further confirm their position in a polarised camp, despite that they had already identified themselves as interested in natural birth through responding to my call for participants. Despite this initial self-identification, there was a range of views of the usefulness of the term in the context of birth. Some women, such as Annie, were happy to use the term: 'I do think it is a useful term…I guess I do use it'. Whilst others were more uncertain such as Amy's reply as to whether she thought it was a useful term:

> (slight pause) nooo (a bit drawn out, uncertain), not really, because of the images of kaftans and trees and hairy women and that sort of stuff… I think it's quite a judgemental term. If somebody was in hospital, had an experience like me, and then right at the end had to have forceps that wouldn't be a natural birth and does that mean they're gonna go, 'ah I didn't have a natural birth' (disappointed tone).

There were a range of opinions amongst my participants as to whether they had experienced natural births themselves. For women who had home births, this categorisation was more clear cut and these women did tend to define their births as natural. For those who had had hospital births there was more uncertainness and ambiguity. Amy, who referenced her hospital birth in the quotation above, had experienced four early miscarriages before conceiving her son at aged 42 and so was under specialist care for the first half of her pregnancy. She was originally booked for a caesarean section until her NCT group, 'began to put doubts in my mind' and she became 'rebellious' and 'angry' and sought the advice of an independent midwife. She then decided to try for a natural birth but in the hospital. She explained that she 'wanted it to be as natural as I wanted'. Through this interesting choice of phrase she explained that she wanted a natural, vaginal delivery with no medical intervention and yet she did not want to have her baby at home or even in the birth centre because she felt that having the medical back up readily available to birth her only, much struggled for, child would contribute to her positive mental state and a calm and relaxed birthing environment. Similarly, Linda explained how she initially planned a

home birth simply because she was afraid of hospitals but that the Hypnobirthing course she attended allayed her fears and taught her that she could make her own choices in the hospital context. She hence decided to go to hospital when she was in labour and her son was born six minutes after she arrived - which became a popular story at the Hypnobirth coffee mornings. Linda, like many of my interviewees, wanted to individualise her definition of natural birth:

> I think that natural would mean the least medical intervention possible for you, so my medical intervention might be different to what someone else needs. And I don't think necessarily that natural means no drugs. It's difficult, it's a really hard one. I don't think it means no drugs. I think it means what's natural for you.

Amy and Linda's stories certainly fit with Klassen's (2001) description of 'post-biomedical' births in which women selected the medical interventions which they felt would work for them, whilst still resisting the overarching hegemonic discourse of biomedicine. In the contemporary UK context, this popular line of thinking is conveyed by the term 'the birth I want', which will be explored further in the following chapter.

Whilst Amy was quite eloquent in her thoughts on natural birth, others were less certain how the term applied to their births. For example, Alice, a mother of two children born in hospital said, when asked to define a natural birth:

> I suppose it can be perceived in lots of ways, it could just be having a baby, not having a caesarean cos that would be seen as unnatural, or it could be seen as drug free (short pause). I don't know if you'd say mine was natural in the end or not really.

Here she referred to her second birth being a planned home birth but she transferred to hospital during labour as her contractions stopped. Laura, also a mother of two children born in hospital, was one of the women more critical of natural birth in my sample. Like Amy above, she attributed her desire for a natural, drug-free first birth to the influence of the NCT class she attended. When she had to be induced and ended with an emergency caesarean she said that she 'felt a failure'. She said that she would have felt less worried in labour if someone had told her 'look, if you think you're dying, that's normal', rather than the NCT advice that 'you can breathe through it'. Unlike the majority of my participants who explicitly evaluated the natural as positive, Laura described the second stage of her birth as 'barbaric'. Despite these feelings, she described her second birth - a hospital vaginal delivery but with epidural anaesthesia - as a natural birth, in contrast to the wider

opinion of my participants who classed epidural as a non-natural birth. She recognised this ambiguity as when I asked her to define a natural birth, she said, 'um, I think it would probably mean a vaginal delivery with no pain relief but seeing as I've had a vaginal delivery with pain relief I consider that to be natural too. Probably the defining factor is vaginal birth'. She went on, 'And I haven't really considered forceps, I guess that would still be natural, no would that be natural? It would probably be more natural than other options'. She struggles here with both what would and would not be included in natural birth before suggesting that perhaps interventions could be ranked in order of naturalness. This uncertainty, ambiguity and ordering supports my argument, made in Chapter Two, that Taves's theoretical framework of 'specialness' is a closer fit to women's own understandings and lived experiences of natural birth than Alexander's framework of the 'sacred'. A strict dichotomy of a sacred natural birth and a profane medical birth is not the reality for most women who struggle with where to draw the lines of separation both in their lived experiences and the theoretical discussions of the interview context. Each woman had her own thoughts and definitions as to what practices could and could not be included in natural birth suggesting a continuum of value with the ideal natural birth held at one end.

In addition, many women, even those who described their births to me as natural, said that in everyday discourse they would choose other means of describing their births. Some selected other terms, such as yoga teacher Aisha's choice of 'connected birth' to indicate a connection to the 'support' that is needed, whilst Vivianne preferred 'undisturbed birth' to indicate that 'nobody's fiddling about with you'. Hypnobirth teacher Claire and doula Marilyn had a preference for the NHS use of 'normal' birth. However, a more common position was to take a more practical approach to description. Recognising both the ambiguity and implied judgement of the term natural, some women told me that they would rather describe their births as home births, water births or Hypnobirths. Jane described her second birth as a home birth and a water birth because, she said, she was simply aiming for a 'less painful' birth; 'natural births and less painful births seem to go together… I didn't really think, "I want a natural birth", I thought I'd like a home birth, I'd like a water birth, cos they're likely to be not as painful'. Although she then went on to talk about being in control in her own environment suggesting an alliance with the ideal of natural birth, as does the fact that home birth rather than pharmaceutical pain relief was

held as a ‘less painful’ form of birth. Chelsea, on the other hand, pregnant with her first child and so without Jane’s embodied knowledge of a previous birth, preferred not to use the term natural for her planned birth as she did not want to come across as ‘preachy’ and set in her ways when she did not yet know what pain relief she would require. When I asked, ‘If someone said to you “what kind of birth are you planning?”, would you say, “I’d like a natural birth”?’, she replied:

> err, I don’t know, it’s a bit of a funny one. I think maybe I’d put it more in a sort of practical sense than, ‘I’d like to have a natural birth’ cos I wouldn’t want to want a natural birth and you know be a bit preachy about, ‘I won’t take drugs and de-de-dah’ and then take every drug under the sun, you know (laughs).

She went on, ‘I don’t know if I can feel confident that I will have a natural birth but I feel quite confident that I will have a water birth, so I would say water birth over natural birth’. In this way, I argue, some of my participants prioritised practices over ideas. They preferred to list practices as a more specific way of describing their ideal birth than relying on the simplistic dichotomy symbolised in the catch-all phrase ‘natural birth’.

**Profane Signifiers of the Ideal Natural Birth**

Amongst my interviewees, small defiances of medical authority were frequently described with a note of pride. Routine medical procedures such as induction of labour for women aged over 40 or with a high Body Mass Index (BMI) were particular points of criticism and contributing factors to women’s choice of home birth. Kim chose a home birth for her second child who was in the breech position, rejecting routine medical procedure for caesarean section for breech babies. Hence whilst the natural did not always have the same emotional and moral charge in my interviews as in public discourse, there were clear ‘profane signifiers’ raised in some of the interviews, which seemed to pollute the women’s ideal natural birth and which sometimes seemed to create deep emotional wounds in need of restitution (Lynch 2012b). The profane signifiers represented interviewee’s moral emotions to a greater extent than any sacred absolutes. As Katie said, when she was told she might have to have a caesarean section, she ‘burst into tears’ as it felt ‘the end of the world’ for her. Profane signifiers caused grief in the interview context as some women became upset remembering negative aspects of their births. The restitution for the profane

signifiers often came in second and subsequent births as women used their embodied and experiential knowledge to gain more control and agency in their following births. Restitution was hence a motivating factor in subsequent birth choices and practices. The difference between births will be further discussed in the following chapter.

As outlined in Chapter Two, sociologists of the sacred, from Durkheim onwards, have discussed the sacred in relation to the profane; the two are necessary components of a whole. The sacred is an adjective, imbued by a collective of people, which becomes a normative reality and which must be protected from pollution by the profane. The central role of the profane is particularly emphasised in the work of neo-Durkheimian scholars including Alexander and Lynch. For Alexander (2003), the sacred-profane dichotomy is the independent meaning-structure which permeates all of social life. It is the 'master-code' of culture, the secondary elaborations of which - the specific historically and socially situated sacred and profane signifiers - can be identified. The sacred and profane are simultaneously constructed and must be identified together, but the sacred often only comes to the fore, is only recognisable, when there is the threat of pollution by the profane, creating a moral and emotional reaction. Whilst I have outlined some of the problematic features of the sociology of the sacred in Chapter Two, the identification of profane signifiers can be helpful in analysing the meanings of natural birth ideas and practices. As the sacred is a normative, non-negotiable and non-contingent reality, it can be hard for people to articulate; to identify what is sacred and what role it plays in their lives, Lynch suggests (2012a and 2012b). The moral and emotional reaction caused by the threat of pollution by the profane, is a moment when the sacred and profane are revealed. It was possible to identify five primary profane signifiers in my interview narratives: induction; the lithotomy position; eradicating pain; the TV programme *One Born Every Minute*; and internal examinations. These were issues which caused strong moral and emotional reactions in some of the women, identified through tone of voice and through such non-linguistic signifiers as body language, including tears. As noted in the previous chapter, Pugh (2013: 42) has suggested that interviews can capture the 'emotional landscape' of motivation. Tears when discussing negative birth experiences and laughter to distance oneself from a judgemental statement or from anxieties were both relatively common in my interviews. The profane signifiers are some of the foundational issues of the natural birth movement in distinction from a medical model of birth and are issues which are

discussed in the antenatal education classes such as Hypnobirthing. I argue that they shed a useful light on some of the meanings of natural birth to my participants.

***Induction***

Arguably the 'greatest evil' for many of my research participants, and for natural birth authors such as Michel Odent, is using medical intervention to speed the process of birth, including artificially inducing labour, in contrast to letting labour and birth develop at its own 'natural' pace. As independent midwife Flora told me, 'Women don't know about the problems that come with induction - that is another time constraint, another way of saying "your pregnancy has taken too long"'. Maria, a Hypnobirth teacher, told me, 'I feel a bit sad about induction. I'm sad that it's such a big thing'. She explained that she felt if a woman's body was 'forced' into labour, they could not have a 'pleasant' birthing experience as their body and hormones would not be in a natural rhythm and they would need pain relief to manage.

Odent (2011) has lamented the loss of the natural release of the 'love hormone' oxytocin, through the use of synthetic versions (most often Syntocinon) for starting or speeding labour, arguing that this is the most significant 'primal health' issue which might affect future generations. This is a teaching that is replicated in Hypnobirthing. In the chapter entitled, 'Letting Your Baby and Your Body Set the Pace', Mongan (2009: 151) describes the onset of labour as 'part of the master plan' which has a 'designated flow, but not a designated schedule'. She suggests that agreeing to artificial induction or augmentation may result in a 'surrendering' of choices and 'placing yourself and your baby on a very slippery slope' (2009: 152). This is based on a common teaching within the natural birth milieu, and midwifery more generally, that the first intervention used, often induction, increases the likelihood of the need for further interventions. Mongan (2009: 153) suggests that her readers instead try 'natural' means of induction including 'acupuncture, chiropractic and acupressure' and to try 'hugs before drugs'.

The fourth of the five Hypnobirthing classes I observed focused on the issue of induction. During the first class, Mandy had told us that a normal pregnancy is anything from 37-42

weeks and that there was no need to even think about induction before 42 weeks.[5] In the class on induction, we were told that the 40 week pregnancy is a historical and rather arbitrary marker: we were told that it comes from the 1850s, and that women's health situations have changed since then; that in other European countries a normal gestation is considered to be up to 41 weeks; and that a Hypnobirther in the UK had had a 48 week pregnancy with no problems. After providing information about the situations when induction would be medically necessary (including pre-eclampsia), Mandy suggested the natural alternatives for induction from the Hypnobirthing book, listed above. She suggested use of the acronym BRAINS for decision making in pregnancy: what are the Benefits? the Risks? the Alternatives? What does Instinct tell you? What if we do Nothing? Smile and 'be nice to avoid confrontation and get what you want'. She also stressed that there was no evidence for the success of 'stretch and sweeps', telling the class, 'you don't need this'. Hence in this class teaching, focused on choice and a questioning of authority and of assumed practice, there is the assumption that women informed through Hypnobirthing will make the 'right' birth choices. Jane, a mother of two, who had learnt Hypnobirthing in her second pregnancy, explained that her first child was due to be induced: 'They offered me a sweep, they were quite surprised when I said I didn't want it. They said, "oh most people can't wait to get the baby out." I said, "well he's obviously not ready, he'll come out when he's ready", erm, I really didn't want to be induced'.

The idea that the baby will 'come out when s/he's ready' was also taught in the Hypnobirthing class where it was explained that science has not yet discovered definitively how labour starts but research suggests that it might be triggered by the baby releasing a particular hormone. The importance of the agency of the baby in triggering the natural process of labour was a common reason given by my participants for wanting to avoid both inductions and caesareans. Sabine said that she did not want the doctor to choose her baby's birthday. Kim, mother of two and a doula, repeated this idea:

> I don't particularly like induction because baby is not ready, baby is not ready to be born, they know when they're ready to be born, all the signs happen, the hormones are released, you and your baby work in tandem, in unison, without you even having to think about it, because the hormones are released from the baby when they're ready which helps release your hormones to get you ready, and that's interrupted by induction.

[5] Induction at 38 or 39 weeks is standard medical procedure for mothers over 40 or with high BMI due to a belief in the deterioration of the placenta after this time.

Linda, a mother of one who had learnt Hypnobirthing, told me:

> You don't have to have a stretch and sweep. You can make all of these choices. Whereas half of my friends don't even know you can say no to a stretch and sweep. And to me, just the thought of having that done was unnatural, the baby's going to come when it wants to come, unless there's anything you pick up that's wrong with the baby, why do I have to have it? I'm obviously not ready, he's not ready to come out yet.

A connection between the 'unnaturalness' of induction in eradicating the agency of the baby was a common reason given for avoiding induction in my interviews. Not only were my participants keen to avoid hospital diktats in terms of timing of both pregnancy and labour, they wanted to avoid giving control over their baby's birth date to medical authority.

### *The Lithotomy Position*

Being recumbent for labour and birth, especially lying on the back to give birth with the legs elevated and feet in stirrups (the classic 'lithotomy position'), was another significant profane signifier symbolising subordination, lack of control and dignity, and being subject to the 'medical gaze' (Foucault 1973). As suggested, Janet Balaskas's Active Birth movement was founded as an act of resistance against medical birth, specifically non-upright birth. In some interviews, women told me of their disappointment when they had to birth on their backs for various reasons. These stories were often framed in relation to choice being taken away and the women 'forced' to birth on their backs. For instance, Alice, a mother of two, said:

> I was furious with the midwives at the end cos they got me on my back with legs in stirrups, said it had been going on too long and they wanted to get the baby out, and I did not want to go on my back, I really didn't, it hurt, and I wanted to be up on my knees but they wouldn't let me and that's the one bit I was very annoyed about.

Whilst Emily, a mother of one who had learnt Hypnobirthing, said: 'But then I was squirming on the bed cos I kept trying to move off the bed and she kept telling me to get back on cos she wanted to pick up these contractions. She got really stroppy, "I can't monitor you if you don't keep still"'.

Jenny, pregnant with her second child, stated the aversion to the lithotomy position most succinctly: 'With my first one I ended up on my back which is the worst position in the world, strapped to the bed, completely opposite to what you're meant to do'. The passive phrase 'ended up on my back' suggests that Jenny felt she had no agency or choice in the situation, looking back on this first birth with anger and upset. 'What you're meant to do' also implies a normative position; that there is a 'right' way to birth. Whilst Elly, a mother of one, was not so much angry as just a little incredulous and confused as to how she ended up on her back which she described as an unnatural position. She said, 'I remember saying to (partner) afterwards, "why did I give birth on my back?"' She went on:

> I remember thinking, 'urgh I really don't want to do that'. I don't know, you see it on the TV and I almost thought it just looked a bit restricting and just a bit cliche and I just didn't like it, it just didn't feel natural or comfortable, you know, I really thought I would have been on my all fours…. But I don't know how, I think you just get caught up in it. I think the room is set up almost for you to lay on your back, so you just kind of go with it. But that's the one thing I remember thinking afterwards, 'why was that?'.

The strength of feeling here, suggested in Alice being 'furious' with the midwives, highlights non-upright birth as a profane signifier. Non-upright birth counteracts the women's practising of upright positions and exercises to strengthen their bodies for active birth.

### *Eradicating Pain*

For some women involved in the natural birth milieu, particularly birth workers, eradicating pain through strong pain killers or anaesthesia rather than managing pain through non-pharmaceutical means is frowned upon and considered to be an impediment to the natural birth process. As Flora, an independent midwife told me, 'educated women do not require epidurals'. The epidural is considered to be particularly damaging to the health of the mother and new baby. Following Odent's arguments about artificial Syntocinon and epidural anaesthesia crossing the placenta and inhibiting the release of natural hormones such as oxytocin, some natural birth teachers suggest avoiding epidurals. Mongan (2009: 153) states that 'the disorientation that a baby experiences when his mother has accepted drugs can result in disconnection between mother and baby and cause a long-term feeling of abandonment on the part of the baby'. The sanctity and naturalness of the

newborn's body is to be protected from artificial and potentially harmful drugs, natural birth proponents argue. Natural birth is 'best for baby'. Following Dick-Read's teaching that it is simply fear and tension which create pain in labour, Mongan (2009: 38) suggests that 'there is no physiological reason for pain in birthing'. She states that some women educated with Hypnobirthing experience 'pressure', 'sensation' and 'tightening' but not pain and, as such, the term pain in birthing should be replaced with these alternatives. Birthing can be comfortable and even orgasmic. For this reason, she dismisses such common ideas as birthing pain is necessary and an important indicator of stage of labour; that pain is unavoidable and should be worked with and learnt from; or that birthing pain is to be revered and celebrated as in a rite de passage (2009: 37-8). Yet most of my informants did indeed talk of experiences of pain in labour and approached their antenatal programmes, including Hypnobirthing, as useful in their provision of practical techniques to manage the pain of labour, including through self-hypnosis, visualisations, massage, aromatherapy, reflexology, movement and more. The classes I attended, including both NCT and Hypnobirthing, described labour pain as unlike any other pain for two primary reasons: its intermittence and its positive end-goal. For many of my participants then, in contrast to Mongan's statement, pain was seen as inevitable, as necessary, as something to be learnt from and/or as something to be celebrated as a passage to womanhood.

Harriet, a yoga teacher, doula and mother of two, was perhaps the most eloquent in reflecting on pain in birth. In a discussion about whether she considered her births spiritual experiences, she replied 'absolutely, yeah. I mean you go in a girl and come out a woman, right, it's transformational stuff'. She then went on to suggest that only natural birth could be a spiritual experience because you need to be fully 'present'. Pain relieving drugs take this presence away; pain allows you to enter 'the trance' and in this spiritual trance, '…it becomes not pain, it's the rhythm isn't it, it's the rhythm of your body. I mean it is pain but it's intense, it's the intensity which almost takes away the pain, it's a different pain'.

Debates about pain relief in labour can be polarising with the popular assumption that natural birth equates to a 'drug-free' birth. The majority of my participants tended not to endorse this view and pain relief was equated with ideas of practicality and 'keeping options open', which will be discussed further in the following chapter. For participants with more than one child, the first birth story was often one in which pharmaceutical pain

relief was used, juxtaposed to either the wishes or the reality of the second birth in which such pain relief was not used. For instance, Bella, a mother of three, told how her first son was born in hospital with an epidural which she requested because she was worried about repeating her sister's birth experience in which her sister had to wait hours for the busy anaesthetist to administer the epidural. For her second birth, at home, Bella did not have any pain relief. She said,

> Natural birth doesn't exclude pain relief it's just that I don't see the need for it now, for me personally, but I also respect people who do feel that need because not everybody could change their mind like that and look at something from a new perspective, not everyone is open enough to do that.

A number of participants, including Bella, did recall feelings of anger at being offered pain relief during labour when their birth plans explicitly stated that they did not want pain relief. Annie said that she had written in her birthing plan and told her midwives not to offer pain relief, that she would ask for it if required, and that their offering of it, 'is the one thing that I was really mad about afterwards'. This description of feeling 'mad' suggests that to Annie, like other of my participants, the offering of pain relief in contradiction to the women's stated wishes was a profane signifier. More than pain relief in and of itself (which is fine for some women, in Bella's suggestion above), it is the perceived lack of respect accorded to the birth plan which angered some of my participants - a recurring theme in the profane signifiers.

### *One Born Every Minute*

*One Born Every Minute* (OBEM) is a BAFTA award winning Channel 4 reality television series which first aired in 2010 and attracted over 3 million viewers.[6] In 2018, in its eleventh series, the show remains hugely popular. Each episode has a similar format in which three or four couples are followed from their entry to the labour ward (of variously Bristol, Southampton, Leeds, Liverpool and Birmingham hospitals) until the births of their babies. Fly on the wall cameras document their labours, their interactions with each other and other family members as well as with the midwives (who are the regular characters of the show), and their births. Whilst different types of birth are shown, including water births and drug-free births, the majority of births, as to be expected on a labour ward, include

[6] https://www.theguardian.com/media/2010/feb/24/tv-ratings-23-february

different forms of medical intervention such as induction, ventouse, forceps, epidural anaesthesia and caesarean section. The majority of women shown use pain relief, give birth lying on their backs and are encouraged by midwives using the old fashioned instruction of 'chin on your chest and push'. For all of these reasons, the show is held in contempt by many natural birth proponents. To natural birth proponents, and to the majority of my participants, OBEM represents everything that they seek to avoid in the mainstream medical approach to birth. Natural birth proponents argue that the show is damaging to pregnant women for inducing a culture of fear around birth. Public figures have been vocal in their condemnation of the show; Virginia Howes, the independent midwife quoted at the beginning of this thesis, established a Facebook page called 'One Born Every Minute - The Truth', in order to 'highlight practices on the TV programme OBEM that are not evidence based or women centred'.[7] The page attracted over 11 thousand followers between its founding in March 2012 and May 2016 when it was last updated. Howes and other moderators posted alternative evidence, news and conference information, whilst the majority of comments were criticisms of the show. Similarly Milli Hill, founder of the Positive Birth Movement,[8] in 2015 published an article entitled, 'Love Birth? You Probably Hate One Born Every Minute'.[9] The same year, birth coach Alexia Leachman, began a petition on change.org to Channel 4 to 'portray a more balanced view of childbirth through your programming'.[10] She wrote, 'Women deserve the truth about childbirth. Not a version made for TV. It's time for us to reclaim birth as a beautiful magical event'. She goes on to say that birth can be 'pain-free, natural and beautiful'. These are just a few examples of the numerous criticisms of OBEM that can easily be found online. In contrast, these same authors are much more positive about the portrayal of birth in the BBC drama series, *Call the Midwife*. First aired in 2012 and currently, in 2018, showing series seven, with a further two commissioned, each series has attracted around 10 million viewers. This drama series focuses on the midwives and Anglican nuns of 'Nonnatus House', in the East End of London in the 1950s and early 1960s. Whilst it tackles gritty subjects, not least poverty, the figure of the community midwife who cycles to attend home births is one still

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[7] https://www.facebook.com/OneBornEveryMinuteTheTruth/

[8] http://www.positivebirthmovement.org

[9] http://www.positivebirthmovement.org/pbm-blog/love-birth-you-probably-hate-one-born-every-minute

[10] https://www.change.org/p/channel-4-channel-4-portray-a-more-balanced-view-of-childbirth-through-your-programming

held as an ideal in the natural birth milieu. Virginia Howes, mentioned above, comments on this series through her Facebook page, contrasting the programme with what she believes to be the current persecution of independent midwives by the Nursing and Midwifery Council.[11]

Some of my participants thought that OBEM was a positive and/or accurate portrayal of contemporary birth, with a couple echoing mother of two Laura's sentiment that '*One Born Every Minute* makes it look nicer than it is I think'. However, the majority were highly critical of the programme. Criticising the births of OBEM seemed to be an easy and convenient means of signifying their disdain for the mainstream, medical approach and their desires to birth differently. For instance, Alice, talking about her second birth said: 'I was quite pleased I had managed to do it without the pain relief. Cos when you watch *One Born* and things they are screaming and everything like that, at least you can say, "oh I didn't do that, I didn't need to do that" you know' (laughs).

In the Hypnobirthing class, with its focus on eradicating the fear of birth through a positive mind set, we were explicitly told not to watch the programme or to listen to the negative birth stories of relatives and friends. Instead, each class ended with a positive birthing video in which the Hypnobirthing mum gave birth at home, in water, accompanied by a supportive partner and midwife in a calm and relaxed setting. Participants who had learnt Hypnobirthing were most critical of the programme, as to be expected. For example, when I asked Jane, mother of two, whether she had watched the programme she said, 'I did, and then I started doing the Hypnobirthing classes and I stopped watching it'. I asked if she was told not to watch it and she replied:

> umm, partly. Every time I watched it I used to shout at the tele anyway going, 'why's she lying on her back?' (laughs) and um yeah I just stopped cos I thought, why put scary images in my head, so yeah, I did watch it religiously when I was trying to get pregnant, I used to watch it and then I stopped watching it.

Linda, a Hypnobirthing mother of one who liked to attend Hypnobirthing coffee mornings to share her positive experience, said:

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[11] Who in December 2017, won their case not to have to cover Independent Midwives' indemnity insurance. See Chapter One.

> I just think, looking back now, that programme's quite negative, for me its negative, for other mums that think about having a baby, they're like, 'I'm going to watch *One Born Every Minute* cos it will show me what it's going to be like in the hospital' and I just warn them off it. I'm like, 'please, please…'

Caroline, a mother of one child born at home who did not practice Hypnobirthing, nevertheless succinctly explained why she found the programme problematic:

> I do sometimes watch *One Born Every Minute* and I think, 'how those women can lay there in the hospital, listening to other women screaming, how can that be good for your state of mind and you retreating into your safe space to enable you to relax and give birth to your child?'.

A little while later, she stated: 'Part of me wants to show everyone that this is normal rather than being stuck with a load of drugs, which actually is what we think is a normal birth in our society, we think normal is *One Born Every Minute*, and that isn't normal. That is interfered with'.

For many of my participants, and presumably for those involved in making the programme, OBEM represents the normal everyday medical birth in the contemporary UK. It is this status quo which natural birth proponents seek to challenge. Meaning is found in preparing for an alternative form of birth which is believed to be better for the physical and mental health of both mother and child, and hence for family life and for society more generally.

### *Internal Examinations*

Finally, some of my research participants suggested that internal examinations to gauge the stage of labour were variously uncomfortable, painful, undignified, and unnecessary. They were seen by some as a means of medical authority exerting control over the birthing woman's body and the process of labour - as a primary means of measuring the progress of labour from 0-10 cm dilation of the cervix, measured with the fingers. Many of my participants argued that it was not an accurate measure of how fast the labour would progress and narratives of internal examinations were often given in connection with stories of midwives not listening to the birthing woman's claim that she was close to having her baby. Martha, a Hypnobirth teacher and mother of two, suggested that her

embodied experience was ignored. ‘That was the only undignified bit, that’s the only time I felt undignified when I was flat on my back getting a vaginal exam from an obstetrician who was lovely and very gentle but didn’t believe me that I was in labour’. Whilst Alice described how the midwives who attended her second labour, at home, were ‘horrible’:

> The first one came in and was like, ‘oh you’ve disturbed me on my rounds, is the other lady here yet?’. And she didn’t even ask me how I was feeling or what was happening and she said, ‘I’m just gonna go and use your toilet’ and just left me downstairs. And then the next one came in and stormed up the drive and said, ‘you will still have to go to hospital, you know, you can’t have your baby at home. Well I’ll examine you then’, and just did it really hard and it really hurt and she said, ‘you’re 10 cm’ and almost said it in a blaming way, like, ‘you shouldn’t be 10 cm this quickly’.

Some of my participants argued that a ‘good’ midwife would not need to perform an internal examination as there are other, more natural, means of gauging the process of labour including the sounds that the woman makes and observation of a purple line that develops between the buttocks (which is visible on both white and non-white women). Jenny, pregnant with her second child at the time of the interview, explained this as part of the reason why she was choosing another home birth:

> I think the problem is that the community midwives have a lot more skills which hospital midwives lose cos I found out when I was pregnant with (first child) and my midwife said they keep checking and checking and there’s no need to cos there’s a stripe that goes up the back and it shows how dilated they are. No-one knows of this, and I tell everybody, so they don’t have to keep checking you.

She went on to say, ‘So the pool’s good cos in the pool they can’t get to you, you can go into yourself and concentrate on what you’re doing without being poked and prodded every two seconds’. This sentiment was expressed by quite a few of my participants who had chosen to birth at home in water. Annie, whose second child was born at home, in water, explained that she eventually requested an internal examination because she felt the need to push whilst her midwives felt she was not yet ready. She recalled that earlier in the labour she had told the midwife, ‘I want you to just leave me alone’ and the midwife had replied that that was ‘very unusual’. But Annie ‘didn’t care’. She also said, ‘I didn't really like the midwives using the doppler because they would have to dig around and mess with me and that bothered me and interrupted my stride and all that kind of stuff and I didn’t like that’.

For these women, the aversion to internal examinations extended to being touched in labour by anyone other than their partner. Some participants stated their belief that midwives should not touch labouring women, such as when Vivianne said; 'I think of midwives, like I see hospitals, they're not a necessary part of the birthing process, they're there if things go wrong. I don't think midwives should touch women unless there's something wrong, unless the woman specifically requests something of them'.

Some also did not want the midwives to touch their babies. When I interviewed Hypnobirth teacher Martha and two of her clients, Nancy and Emily, at Martha's home just a few days before Christmas 2012, Nancy insisted that we watch her hour-long home birth video. Whilst the video itself was rather boring, of poor quality and a single shot of the back of Nancy in the pool, what was interesting was Martha and Nancy's running commentary as we watched. Nancy and her partner had created what appeared to be a very relaxed, calm and quiet birthing environment and Nancy appeared focused on her breathing and managing labour with no pain relief. The midwife in contrast was noisy, busy and bustling around the pool. She took a call on her mobile phone and then broke her doppler by dropping it in the water. Martha and Nancy laughed at this seeming ineptitude. Nancy explained to me that the midwife kept talking to her even though she had written on her birth plan to only talk to her partner. She said that she doubted she read the plan. Their greatest criticism was levelled at the midwife after the baby was born, however. Nancy had wanted to deliver the baby herself but the midwife lifted the baby out of the water so quickly that a loud whooshing noise could be heard. Once the baby was handed back, Nancy held her, waiting for her to do the 'breast crawl',[12] but the midwife insisted on rubbing her back to make her cry, saying 'we just want to hear her cry properly'. The video shows that Nancy is obviously angry with the midwife at this point. She explained to me that she did not want anyone to touch the baby and certainly not to make her cry. Again ideas of the sacrality, purity and naturalness of the newborn's body are linked. Both the birthing woman's body and that of the newborn are considered as subject to pollution if touched by unwanted hands.

[12] In which the newborn is placed on the mother's stomach and then finds her own way to the breast. This is held by many natural birth proponents as the best means to initiate breastfeeding.

**The Changing Location of Expertise**

What was particularly interesting about Martha and Nancy's commentary was their creation of a dichotomy between Nancy's ideal home birth (including the atmosphere she and her partner had created and the mental space she was in) and the interference of the bureaucratic NHS midwife who, in their opinion, did not like the situation as she was not in control and had no role to play and so was noisy and bossy in an attempt to exert her authority once the baby had been born. Harriet, a yoga teacher, doula and mother of two children, told a similar story about her second child's birth, a home birth. She explained that she was in a 'rhythm' and 'trance' like state, getting on with birthing her baby, before the midwives arrived 'stinking' of perfume and polluting her environment. She said, 'they began talking about packed lunches and I had to tell them twice to leave the room and shut up'. She felt that her birth was not 'respected'. She told me, 'In hindsight, I just wouldn't fucking ring 'em, I just wouldn't, I'd just want to free birth and do it on my own because they just got in the way of my experience'.

Whilst these might be simplified and particularly dichotomous views, not held by all of my participants, other narratives about internal examinations, the safety of the pool, and the lack of knowledge of NHS midwives, quoted above, suggest that many women no longer consider the NHS midwife to be an authoritative source of expertise on the birthing women's side. During the radical feminisms of the 1960s and 1970s, the midwife was held as the pregnant and birthing women's protector against the medical establishment. Amongst many of my participants, the NHS midwife was considered 'other', as part of the negative medical establishment, serving the bureaucracy of 'the system' and not the women's best interests.[13] This is also represented in the women's criticisms of the midwives on *One Born Every Minute* with their 'outdated' and 'non-evidence based' practices. Some of my participants explicitly blamed the NHS doctors and midwives for their births not going to plan, a point which will be returned to in later chapters. Indeed, participation in the natural birth milieu is inherently about challenging the medical

[13] The parallel development, in which NHS midwives report high levels of job-related stress, is incredibly important but was not explored in this thesis. Schiller (2016: 50) cites a 2013 Royal College of Midwives Report which states that 46 per cent of midwives surveyed reported 'high levels of work-related stress'. She goes on, 'That those who are trained and work in a system that overworks, undermines and bullies them aren't espousing an individualised, compassionate approach is hardly surprising'.

establishment's authority and hence the status quo. In Bella's words, 'I'm really pleased that I prepared myself with (son) and had the birth that I wanted. I'm sad that it meant I had to completely ignore the advice of the health professionals who were looking after me'. Locating alternative sources of expertise, an independent midwife in Bella's case, is a primary mechanism for this challenging.

Scholars writing within the field of parenting culture studies have noted the tension between embodied, experiential expertise based on instinct and intuition versus a 'scientifically based', skill set form of expertise (Lee et. al 2014: Chapter Two). Those who have traced the history and changing cultural forms of advice to parents (Hays 1996, Hardyment 2007, Lee et al. 2014, Macvarish 2016) have argued that the former has given way to the latter such that there is a widespread belief (amongst the contemporary UK government at any rate) that parenting can only be performed effectively with expert advice. Parenting culture studies seeks to challenge this belief, arguing that this situation is detrimental to parents and calling in to question the legitimacy of parenting 'experts' whose 'expertise' often has a weak basis, sometimes being little more than that they too are parents. These arguments are equally applicable to the field of pregnancy and birth where there has been a similar explosion of advice manuals (some of which have been described in detail in Chapter One). However, through looking at women's interactions with sources of expertise, we see that it is not a clear cut picture between embodied, instinctual knowledge versus 'scientifically based' knowledge, nor that women select one form of expertise over the other. Studies shaped by Foucauldian notions of governmentality sometimes assume simplistic notions of the ways in which people's behaviour and attitudes are shaped by controlling discourses tied to powerful social institutions. However, analysis of women's lived experiences reveals a more complex reality.

The birth workers I interviewed are comparable to the 'parenting experts' which Lee et al. (2014) and others have studied, often being motivated in their profession through their own experiences of motherhood and having completed courses lasting only a few days.[14] Yet it is these women that natural birthing mothers seek out either instead of, or in addition to,

[14] Doula courses range in length from one day to nine months (the latter being the NCT doula course). The huge majority of courses are four or five days. https://doula.org.uk/list-doula-uk-recognised-courses/ Hypnobirthing The Mongan Method practitioner training is a five day course. https://www.hypnobirthing-uk.com/hypnobirthing-uk-training. Independent midwifery is a different case as they are as equally qualified as NHS midwives.

medically trained experts (legitimate experts perhaps in Lee et al.'s terminology 2014: 73). They are sought for the very reason that they are believed to combine embodied, instinctual knowledge with a form of 'scientifically based' knowledge, although a scientific knowledge which is different from that of the medical establishment. They draw on their own sources of authority such as the authors Dick-Read, Marie Mongan and Michel Odent, and the interpretations of neuroscience which are popular in the field of Attachment Parenting. It is due to the import placed on this combination of learnt material and embodied knowledge that some of the birth workers I interviewed were keen to experience the natural births they advocated in their teachings.

Simultaneously, the women I interviewed were keen to distinguish themselves as experts on their own bodies. Stories of midwives not believing that women were progressing in labour, as exemplified in the quotations on internal examinations above, abound. What is often missing from these stories, however, is a recognition of the tension between the woman as her own embodied expert and the fact that she has invested time and money in learning ideas and practices which are believed to come 'naturally' or 'instinctively' during birth. The birth workers that I interviewed argued that natural and instinctive techniques of birth have been lost to women's knowledge because of the medicalisation of birth which has become the norm. Their classes, books and websites help women rediscover this ancient knowledge, in a romanticisation of the past and of other cultures as described above.

Hence my participants spoke highly of the independent experts they themselves had chosen and paid for, including independent midwives, doulas and Hypnobirth teachers. This was summed up most succinctly by Vivianne, who said, 'For me to feel comfortable birthing within the NHS environment and to tick my safety boxes, I had to have a midwife, but in order to stop me worrying about the midwife, I had to have a doula'. She stated her belief that a midwife is not necessary to the birthing process unless there are complications. The doula on the other hand, she suggested, was vital to help her keep her mental focus and not be distracted by the bureaucracy of the midwife and the system. When she was preparing for her ideal birth through visualisation, she would just 'imagine a little generic midwife to the side'. The midwife, once held as the paragon and protector of

women's reproductive rights has been marginalised in my sample and replaced with the paid for experts of neoliberalism.[15]

However, this was not true for all of my sample. Annie, a mother of a twenty year old daughter born in a highly medicalised environment in the USA, and an 11 month old boy born at home in the UK, explained how in her first meetings with NHS midwives she was 'defensive' and had 'the chip on my shoulder of "I'm the consumer and you are the provider and you will do what I say rather than the other way round"'. However, she said that she was pleasantly surprised with how supportive her NHS midwives were. Nevertheless, her thoughts and choices were still framed in the neoliberal framework of consumers and providers. Leaving aside the wider political and moral discussions of whether this framework should be applied to both the NHS and to the fields of pregnancy, birth and parenting (which are simultaneously incredibly private and yet ultimately public fields), I argue that it is important to seek to understand women's lived engagements with expertise (as is the focus of Thomson et al. 2011: Chapter Five). Many of the women I interviewed did seek out and invest in alternative sources of expertise in the belief that these experts would help them achieve their ideal natural birth. This is in line with Thomson et al.'s (2011: 124) argument that 'engaging with experts, taking advice and building a personal knowledge base can be seen as part of the work of motherhood'. Indeed, they argue, this engagement is particularly pronounced amongst the middle age group of mothers in their sample (26-35 years old), creating a 'particular version of middle class mothering' (2011: 124). Similarly, the natural birth milieu's saturation by the middle classes with the social and financial capital necessary for participation, cannot be over-estimated. Perhaps this social demographic - and most particularly women within it - is more likely to be engaged in the wider rejection of mainstream sources of authority and the pursuit of alternatives, feeling the burden of responsibility to make the choices encouraged by government policy in both health and education, amongst other fields (Thomson et al. 2011, Perrier 2012, Lee et al. 2014).

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[15] Although, that these 'neoliberal' experts do not exemplify the typically assumed characteristics of 'depoliticisation, the repudiation of vulnerability and dependency and the internalisation of competition' (Perrier and Fannin 2016: 454) but rather display ethics of care in their work, is discussed further in Chapter Six.

**Othering, Judgement and Education**

In addition to the NHS midwife as 'other', the profane signifiers reveal another 'other'; the woman who does not research, question and take responsibility for her own birth and instead goes along with medical authority and hospital protocol. In other words, the majority of women in the UK population who choose mainstream, medical births, represented by the women in *One Born Every Minute*. Identity construction in relation to an imagined opposite is a well-recognised phenomenon, including in writings on class and motherhood. For class theorists who draw on Bourdieu, social classes only come into being through relationships and distinctions from others who are not of the same class. The making of class involves the work of group boundary maintenance. This is also true of the making of cultures of mothering practices. Bobel (2002: 84), for instance, has written, 'some mothers invoked the figure I eventually termed the "bad other mother". This mother - the antithesis of the natural mother - makes few conscious choices. Rather, she "goes with the flow" of the mainstream, seldom questioning the conventional wisdom that dictates so much of parenting practice'. Perrier (2012: 658) too, in an article examining how middle-class mothers engage with discourses of 'good' parenting at a subjective level, identifies two different types of 'bad' mothers whom the mothers she interviewed sought to distance themselves from; 'whilst they sometimes othered working-class mothers they were also haunted by the spectre of the "pushy" strategic middle-class mother'. Perrier (2012: 661) examines how discussions of 'good parenting' were 'used to draw ethical boundaries between mothers'. The 'bad other mother' who appeared in my interview narratives was used by my participants in the same way; to make a distinction from how they planned and desired to birth.[16]

Bobel (2002: 84) writes that her natural mothers portray the 'bad other mother' not as 'evil' or 'malicious' but as 'simply ignorant'[17] and this is in line with my own interviews in

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[16] Dawn Llewellyn (2016: 71), in her research on Christian mothers and voluntary non-mothers, also identifies the spectre of the 'super-mum', drawing on the 'fantasy of maternal perfectibility' identified by Chodorow and Contratto (1982: 55). My participants did not seem to reflect on this figure - perhaps they felt that they embodied the 'super-mum', through working towards the ideal birth. Neither did they embrace the figure of the 'bad' or 'slummy' mummy identified by Kate Orton-Johnson (2017) in her work on 'mummy blogs'.

[17] This is perhaps in contrast to some of the writings within motherhood studies which focus more on insidious constructions of 'bad mothering', including teenage mothers and working class 'chav' mothers (Baraitser 2009, Gillies 2007, Jensen 2013, Tyler 2008).

which lack of education was the primary description of 'mainstream' mothers. This is in contrast to some of my participants' descriptions of the NHS staff, outlined above, in which they did imply a sense of 'evil' or 'maliciousness'. Whilst my participants were comfortable in attributing negative intentions to a perceived failing expert, they seemed to prefer to attribute other birthing women with a lack of education, a lack of responsibility through ignorance, and hence as being in need of their help.

In making normative statements around natural birth and about their duty to pass their knowledge on to others, or at least to make others aware of their need to take responsibility for their births, my participants often lapsed into a tone of moral superiority; a sense that they knew birth 'as it should be'. Hence my participants, who had researched their options and chosen various practices such as Hypnobirth, home birth and/or water birth, sometimes assumed a sense of superiority, as when Martha and Nancy referred to their choices as like the choice of the red or the blue pill in the film *The Matrix* (1999). Their choices were in divergence to the mainstream, they said. This resulted in statements such as Martha's (although she seems to lose the thread of what she is saying, perhaps due to a realisation that it was becoming judgemental): 'Unfortunately, the vast majority of the British public, the western public, do want to stick with what they know. For those of us who just have this little inkling that there's something they're not telling us, it's just a way of…. cos Hypnobirthing is different things to different people….'

Such statements were made in particular with regard to Hypnobirthing and to home birth. Vivianne, a Hypnobirth teacher, doula and mother of two children born at home, repeated such a sentiment but with a realisation that she was sounding judgemental:

> Cos if you have a home birth, to be honest you've probably researched things a lot more than anybody else has, so you probably know a bit more than the average woman going into labour going into hospital who just wants an epidural. Sorry, that sounds really horrible. And it's not about judgement on that person it's about a lack of education and access to knowledge, you know that sort of thing.

Whilst Vivianne was keen not to sound judgemental, the link between desiring an epidural and a lack of education was a recurring theme in the interviews. For example, Flora, an independent midwife, told me, 'I'm not saying that all women must have a natural, drug free birth, but when women are well educated and motivated, they don't ask for pain relief, they just don't require it'. The education that is referred to here is specifically a birth-

related education and is not, I think, an explicit commentary on class or general education levels. However, implicitly, it is both of these things. Bourdieu and others such as Steph Lawler (2008) have theorised how middle class culture is 'naturalized' as the epitome of 'real' culture and thus as representing 'legitimate' tastes, desires and perspectives. Part of the 'naturalization' of class, 'the "hidden training" embodied in the habitus is the ability to pass judgements on others' (Lawler 2008: 248). Furthermore, because it has to be found by oneself, and then paid for, it is not an education that is available to all. As Perrier (2012: 656) states, the growing body of work within sociology which examines class and mothering 'demonstrates that contemporary parenting discourses legitimate and normalise middle-class parenting practices, and by association pathologise working class ones'. However, she goes on to complicate this by examining the affective dimensions and lived experiences of class arguing that power is still enacted on middle class mothering despite it being the form of mothering 'legitimated in the symbolic order' (2012: 667). The commentaries on education, undertaken by my middle-class participants, were not explicitly linked to class, but were still connected to the process of othering, which is itself a central component of class-formation. They were connected to the construction of identity through opposition to an imagined other who, in this case, does not take responsibility to gain a birth-related education. Class remains implicit in these judgements as access to education is not equally distributed. It further highlights the paradox of the romanticisation of the native discussed above, as primitive women who are believed to have natural births most likely do not have any form of birth education. It corroborates the implicit view, entangled in the very history of natural birth, that it is white, middle-class women who are good and responsible mothers.

These problematic viewpoints contribute to the sense of superiority of those involved in the natural birth milieu, and the 'otherness' of those not involved, and were shared by both birth workers and their clients. Kim, a doula who had trained with Michel Odent and the mother of two children born at home, made the argument for birth-related education quite forcefully. When discussing her reasons for becoming a doula, she stated, 'I just want to be able to help other women'. When I pushed her on this, asking 'in what ways do you think they need the most help?', she said:

> I think, um, educating themselves about what their rights are so they don't have to do what the doctors say, or even what the midwife says. It's your body, your baby, you're in control

> and basically you tell them what you want, and it's their job and duty of care to do it, as simple as that, but so many women are too scared to do that, they don't believe in themselves and I want to give them the power to believe in themselves.

For many of my participants, an equation was made between birth-related education and empowerment. This educated and empowered position was considered not only in a practical sense as the most useful position for birthing women, but also with a moral judgement that this was the right position, that women should take responsibility for their own education. However, my participants - in general middle-class, liberal women who seek to help other women through their birth work - were keen not to appear judgemental and sometimes recognised and apologised for such statements. Nevertheless, they justified the superiority of their own choices through the necessary construction of an 'other' who makes different choices to their own. My interviewee's choices were hence sometimes described and justified with reference to an imagined opposite, a woman who does not know about Hypnobirthing and home birth and maintains the status quo in choosing to birth in hospital, following all of the medical team's suggestions.

**Conclusion**

In this chapter I have focused on outlining the ideal natural birth. Recognising the ideal as a theoretical construct rather than a term that was used 'on the ground', I have nevertheless described my participant's ideal birth by focusing on their descriptions of the births they wanted and planned for. I suggest that the commonalities of beliefs and practices across my participants descriptions belies somewhat their attempts to individualise natural birth and claims that natural birth is just 'what is right for you'. I have highlighted four components of natural birth which were significant sources of meaning in the interview narratives: that natural birth is ahistorical and to some extent a-cultural; a romanticisation of 'primitive' women; that women's bodies are designed to give birth naturally; and natural birth as instinctive. A distinction between a natural birth and a medical birth is central to all four components. I have highlighted the normative statements made within some of the interviews, particularly in interviews with birth workers, around the need to educate women about natural birth, with all of the implied judgements around class, gender, responsibility and moral evaluations of 'good' mothering (through form of birth) that this entails.

However I then argued that despite engaging with natural birth ideas and practices through their participation in antenatal groups, through responding to my call for participants, and in their narratives of experiences, my participants were well aware of the contested nature of the term and approached it with some apprehension, ambiguity and hesitation. Struggles with defining the term and what it meant to them at the end of the interview cannot just be put down to the on-the spot question. As noted in Chapter Three, some within the field of cultural sociology have argued that only on-the-spot, snap-judgement, survey-type questions can get to the heart of cultural meanings as they rely on a moral intuition (Pugh 2013). Whilst I am not making this argument, I do argue that the women's hesitations around defining natural birth and even, in some cases, around whether they had experienced a natural birth, suggests a more fluid, lived engagement with the normativity of natural birth than the strict separation of natural and medical practices portrayed in their ideal birth descriptions.

I argued that the ideal, like the concept of the sacred discussed in Chapter Two, is hard to articulate. The ideal, as something that is worked towards but with the possibility of non-attainability always present, exists on a continuum of value and hence is qualitatively different to the sacred which is marked by its absolute binary with the profane. Nevertheless, I have utilised the concept of profane signifiers to describe the ideas and practices which caused strong emotional reactions during the interview narratives. My participants had stronger emotional reactions when describing the birth practices they did not want, than those they did desire. Moral emotions are expressed through the profane rather than through commitments to sacred absolutes. Connected to this, approaching natural birth as an ideal rather than as 'the sacred' could help to protect women's sense of moral integrity. The theme of working on the self as an ethical project is continued in Chapters Six and Seven.

My participants found it easier to describe their ideal birth by describing its antithesis - those practices which are more firmly in the realm of the medical status quo. The five profane signifiers of induction, the lithotomy position, eradicating pain, *One Born Every Minute*, and internal examinations, are judgements on a lack of control, a lack of agency of both mother and child, a lack of bodily autonomy, and a lack of dignity. They

simultaneously reveal what is important to the women, I suggest, namely feeling that they are in control of both the situation and their bodies, feeling that they have choice, and that they are respected. Many of the women in my sample felt that they could not achieve these important factors in the mainstream, medical model of birth and so they invested in alternatives including private antenatal education, home births and employing independent experts.

I hence argued that amongst my participants (a particular middle-class social demographic of women) there was a rejection of mainstream medical expertise in favour of a combination of the women's own embodied and instinctive expertise and that of private birth workers. The NHS midwife is constructed as 'other', as is a generalised mainstream mother who births in accordance with medical authority and hence whose birth is marked by the profane signifiers. This imagined other, like the profane signifiers, served as an easy means of revealing what was important to my sample through rejection of its antithesis.

In the following chapter, I move away from ideas of the ideal birth to focus on the practical motivating factors for women's participation in private antenatal education and engagement with the natural birth milieu. I further complicate the natural-medical binary by highlighting the factors which contribute to participation aside from ascription to a natural birth ideology. I also examine my participants' changing concerns over their birthing biographies juxtaposing their first births, characterised by a lack of embodied knowledge, with second and subsequent births, characterised by an empowered and authoritative position arising from embodied experience. To conclude the chapter, I return to what the practical motivating factors and difference between births reveal about the ideal natural birth.

## Chapter 5 - Practicality and 'The Birth I Want'

In the previous chapter, I discussed women's understandings and imaginings of the ideal natural birth. I turn now to analysis of women's reported motivating factors for a desire for natural birth and participation in natural birth groups. I argue that whilst the women I interviewed worked towards an ideal birth, their narratives of experiences and choices were equally marked by practical considerations and themes of pragmatism and 'keeping options open'. The women I interviewed participated in natural birth groups, not only because of an interest in the ideal natural birth but also because of the influence of their social networks, as well as a number of practical, financial and accidental factors (such as finding a book or class and then progressive socialisation into the natural birth milieu). Even decisions around home birth, the epitome of the ideal birth, were characterised by practical considerations.

Pragmatism, or 'keeping options open', is linked to a narrative of lack of knowledge and of embodied experience. I show that narratives of first births were marked by a lack of knowledge compared to second and subsequent births which were marked by an empowered and authoritative position arising from embodied knowledge and experience. In practical terms, this meant that some of the women in my sample experienced a 'mainstream', medical first birth and then chose a more 'natural' form - often at home - for subsequent births. This adds to the Birthplace Study data which found that the majority of women sampled planned hospital births, regardless of whether it was a first or subsequent pregnancy. Birthplace researcher, Kirstie Coxon (2012, Coxon et al. 2013, 2015), has argued that women who have a positive hospital birth for a first birth do not change intended place of birth for subsequent births. However, amongst my participants, second birth narratives were often marked by a stronger commitment to the ideal because of a desire to distance from the first experience which was interpreted as negative with hindsight. A desire to experience a different form of birth was hence another motivating factor for participation in natural birth for some of my participants. For some women, a negotiation between an ideal birth and practical concerns only occurred in second or subsequent pregnancies as the ideal birth and the desire to work towards it was inspired by the women's later perception of their lack of agency in the first birth. This suggests that the

relationships between the ideal and the practical are not static but change over the course of women's birthing biographies.

In conclusion, I return to analysis of the ideal natural birth begun in the previous chapter. I argue that the focus on practicality and pragmatism reveals a central component of the ideal birth; that it is chosen and is 'the birth I want'. The ideal birth is more than being about any one particular type of birth. It is equally about the woman having chosen key aspects of her birthing practice (or at least feeling satisfied with her perception of choice), rather than having decisions imposed from above by medical authority. The ideal birth is one with the particular qualities associated with the natural, outlined in Chapter Four, but also the perception that these qualities have been chosen, both in the run up to birth and during the event. A strict medical-natural dichotomy is hence not the lived reality of my sample, as both Klassen (2001) and MacDonald (2007) have also noted in their analyses of natural birth. The ideal natural birth is a much more fluid and individualised concept than the public discourse surrounding it suggests. Nevertheless, 'the birth I want' is still a moral commentary on the inadequacy of the medical model of birth - in which you are dictated to and decisions are made for you. I argue that the concepts of the natural and of choice combine to create a moral framework of birth for the women in my sample. It is this moral framework which is negotiated through the practices which are the focus of Chapter Six.

**Women's Reasons for Participation in the Natural Birth Milieu**

In giving their pregnancy and birth narratives in the interview context, the women discussed (often with little prompting from myself) their reasons for attending private antenatal courses, engaging in certain practices and reading particular materials. An interest in natural birth was a primary motivating factor, as outlined in the previous chapter, but it was by no means the sole reason. In their pursuit of a 'nicer birth', the women I interviewed were engaging with the ideas and practices of natural birth but also with their own practical concerns and circumstances and the influences of their social networks. As Mary Nolan (2011: 12) writes, with regard to women who choose home birth against medical advice, '…there is no simple answer to the question of why they made their decision and stuck to it in the face of heavy opposition. The influences which operate on our decisions… are complex and defy any attempt to reduce them to discrete

categories'. Nevertheless, she does go on to discuss some of the women's motivations for choosing home birth, as I do below, in the conviction that this can help us to understand women's lived experiences of pregnancy and birth. 'First and foremost', she writes, 'all of these women wanted a *natural* birth' (2011: 13) (emphasis in the original). She then suggests other factors which played into the women's decisions including previous birth experiences, desires to follow instinct and to retain certain aspects of control. Coxon et al. (2015: 142) argue that 'planned place of birth is influenced by understanding birth risk and safety, culturally normative expectations, faith, past birth experiences, and peer, family, and clinician views'. They suggest that 'historical associations between birth and safety' as well as 'contemporary narratives of risk, blame and responsibility' (2013: 1) lead most women to choose hospital care. However, they write, 'the assumption that women's birth place decisions are polarised between preference for either "natural" or "medical" birth', which has gone 'largely unchallenged' in sociological literature since the 1970s, 'increasingly fails to capture the nuances of women's experiences' (2013: 3). Similarly, the women I interviewed, whilst motivated in some choices because of their interest in natural birth, also selected medical procedures that worked for them.

It is important to note that in addition to women's decisions being 'complex' and non-categorisable, they are also reported to researchers such as Nolan and myself as post-hoc rationalisations. As argued in Chapter Three, I do not see this as problematic but rather consider such rationalisations as the creation of meaning through narration. I argue that post-hoc rationalisations are neither 'worthless data', as some practice theorists might suggest (Bueger 2014: 400), nor expressions of false consciousness, but are rather a valid means of analysis of meaning. Pregnancy and birth can be included in Hochschild's (2003: 16) definition of 'magnified moments'; 'episodes of heightened importance, either epiphanies, moments of intense glee or unusual insight, or moments in which things go intensely but meaningfully wrong'. Hence pregnancy and birth decisions and practices are often verbalised and reflected upon, including in ante- and post-natal groups and in online discussions, as well as in interview contexts. These narrations and justifications can be seen as an ongoing process of trying to make sense and find meanings in experiences and are a central part of ethical self-formation. As Joel Robbins (2004: 315) argues, the moral and ethical field is one in which actors have choice 'in how to respond' to the values that have a 'directive force' over them. Furthermore, ethical projects of self-formation can

become a way of dealing with an underlying sense of difficult social tensions; in my case study, the importance of being able to exercise agency in an experience that could be both highly significant whilst also presenting considerable threats to agency. It should also be noted that whilst women might emphasise the practical side of decision-making, in an attempt to not be seen as zealous or entrenched in a natural birth camp, the women I interviewed actually discussed the practical and more ideological reasons for their birth choices and practices.

Social networks are an important influence in the women's choices and could either draw them into participation in natural birth (if a friend or female relative recommended a particular class or book, for instance), or away from it - more than a few women described to me how they would choose a home birth but their partners were opposed to it. The influence of friends and family was more marked in first birth narratives and perhaps could be seen as an alternative source of authority to the embodied knowledge which comes with subsequent births. Accidental factors were also an element, such as finding a book or website through general searches, or being in Bambino's when Barbara was spreading the word about Hypnobirthing. Finally, many women narrated stories of 'progressive socialisation' in which having tried a book or class recommended by a friend or found accidentally, they became more and more committed to the ideas and practices of the natural birth milieu. This learning of natural birth in processes of socialisation has been noted by others including Annandale (1988) with regard to midwives' constructions of natural birth in America; MacDonald (2007) in her discussion of midwifery in Canada; and Mansfield (2008) who argues that natural birth is created through three social practices.[1] I suggest that natural birth as a field of consumption is also important in this context. The women I interviewed were often engaged in practices of consumption - such as buying products or looking for exercise classes - when they discovered natural birth.

As suggested in the previous chapter and explored further below, it was sometimes an initial engagement with a course such as NCT or Hypnobirthing which lead the women I interviewed to choose further practices such as rejecting aspects of medical care, hiring independent midwives or doulas to support them during birth and choosing home birth. Hence even the choice of home birth, the epitome of the ideal natural birth, was often

[1] These are 1) activity during birth. 2) preparation before birth. 3) social support (2008: 1084). See Chapter One for a fuller discussion of Mansfield's work.

explored for a combination of ideological and practical reasons, including a desire to remain in control in the home environment; to have family members present; and a belief in a higher standard of care at home. Below, I explore three areas in turn: 1) the influence of social networks; 2) accidental factors and then progressive socialisation into natural birth; 3) and decisions around home birth. I then turn to women's narratives of 'keeping options open'.

### *The Influence of Women's Social Networks*

Women's narratives of experiences often included more than their own personal experiences - the stories of relatives and friends were given as a means of contextualising their choices and practices. This further reinforces natural birth as an example of a community of shared interests and practices which is classed and gendered. This was particularly the case for the three women I interviewed who were pregnant with their first child and is similar, in some ways, to Thomson et al.'s (2011: 123) statement that 'pregnant first-time mothers rely on people (doctors, family members and friends) rather than texts (magazines, books, websites or leaflets)'. I say 'in some ways', as the three pregnant first-time mothers I interviewed were involved in Hypnobirthing or other alternative practices at Bambino's and so reported a preference for their chosen expert's advice rather than that of their doctor. Nevertheless, learning about childbirth from friends' and relatives' experiences is not surprising as, as Nolan (2011: 1) writes, '…nulliparous women are unfamiliar with childbirth owing to its removal from the domestic domain…'. 'Scare stories' abound in the media and form the bedrock of childbirth mythology in the contemporary UK. It is in an attempt to counter this that Hypnobirthing, and other antenatal groups such as the 'Positive Birth Movement'[2] encourage the sharing of positive birth stories and discourage pregnant women from listening to negative birth stories in the media or from friends and relatives. The women I interviewed were keen to share their birth stories with me and with their own social networks in line with their belief in the necessity of changing the culture of childbirth.

[2] The PBM home page states: 'We are a global network of free to attend antenatal groups, linked up by social media. We connect pregnant women together to share stories, expertise and positivity about childbirth. We aim to challenge the epidemic of negativity and fear that surrounds modern birth, and help change birth for the better. Join us as we meet up, link up and shake up birth!'.

Much of the two hour interview with Chloe, whom I met on the Hypnobirthing course, consisted of stories about her family and friends' experiences of pregnancies and births. Chloe had already said during the Hypnobirth class that she had initially wanted a medical birth. When I asked her about this at the start of the interview she explained this as originating with her mother's and her friends' experiences. Her mother, Chloe told me, had experienced two medicalised births. But whilst the birth of Chloe's older sister had been a negative experience, having an epidural with Chloe was like 'a tea party in the afternoon', according to Chloe's mother. Chloe initially thought she would like an epidural too but as she learnt more about what an epidural was, she was 'put off'. She also wanted a birthing approach in which her husband could be very involved - especially as his mother was in favour of natural birth, having four natural births herself. Lucy, who I met on another Hypnobirthing course, said that the course had been recommended by her friend who had done the course and 'had an amazingly positive birth'. Chelsea, who had picked up one of my flyers at Bambino's, clearly situated her preference for alternative therapies in pregnancy within her family context. She explained that she had acupuncture in an attempt to assist conception and then prevent miscarriage in the first trimester of pregnancy and that she had her dad 'to thank for that' as he had been a 'guinea-pig', receiving acupuncture to 'rejuvenate' him and take '10 years off him'. She attributed her 'mind over matter' approach to her mother who took this view when she and her sister were children, not 'pandering' to 'aches and pains and things like that'.

It was not only women pregnant for the first time who reported their family and friends' experiences. Jenny, pregnant with her second child, attributed her desires for a home birth to the fact that she was born at home. She said, 'I've always been raised with "home birth, it's fantastic", so I always wanted a home birth as long as I can remember'. Mother of one Caroline, also said that her desire for a home birth stemmed from her sister having a home birth. She went on to explain that because of her sister's experience, 'I think that idea was already in my mind when I got pregnant and I am not really fond of hospitals'.

Other women reported that it was the recommendation of particular books, classes and practices by close friends which were a significant influence on their birthing choices. For instance Elly, a mother of one, said 'I've got a friend who practices in homeopathy', which 'has really made me see a different way of treating things' and 'I've definitely been

influenced by that'. Jane, a mother of two children, the second born at home, explained that her friend had had a home birth and 'raved about it', whilst her cousin recommended the Hypnobirth teacher. Fern, pregnant with her second child, explained that a mother at her son's nursery recommended a yoga teacher, whilst a friend recommended a Natal Hypnotherapy CD. Discussing her interest in natural birth further, Fern explained that this was 'a really good friend' who is 'really into all of that and she's all healthy and won't take paracetamol if she's got a headache kind of thing'. Fern said that she had talked about natural birth a lot with this friend and so she became involved in Hypnobirthing 'more on recommendation than any kind of ideal'. Family and friends' sharing of their experiences of natural birth reproduces a particular, classed and consumption-based community of interest, such as has been noted in studies of parenting practices (Lareau 2011, Holloway and Pimlott-Wilson 2014).[3]

Just as the women I interviewed had been influenced by their friends and family, so they sought to influence other friends and family members when they became pregnant. Jane, like some of the other women I interviewed, became an advocate of her particular birth practices including Hypnobirthing, home birth and water birth. She collated a folder of information from all of the courses which she attended, which she estimated was worth around six hundred pounds. She lent me this folder to browse as part of my research, contacting me a few months later to arrange collection as one of her cousins was pregnant and she wanted to pass the information on. Chloe encouraged her sister-in-law, who was pregnant at the same time as her, to also become involved in Hynobirthing, without much success. Trisha was more successful in encouraging her younger sister, Louise, to attend a Hypnobirthing course. When I interviewed them together, Trisha explained that she had experienced two caesareans after desiring natural home births each time. Unlike some of the other women I interviewed, she did not experience the 'healing' of a natural birth after her first negative birth experience (Davis-Floyd 1992: 241). Instead, she told me that

[3] Holloway and Pimlott-Wilson (2014) argue that class must be analysed in conjunction with 'local mothering cultures' - similarities of ideas and practices around child-rearing in local geographical areas, which sometimes override class differences. 'Local mothering cultures' were also likely at work in my study as participants were drawn from a number of towns in the 'home counties' which had strong independent midwives or Hypnobirthing links - see Chapter Three.

‘being there for (sister’s) birth was actually a real healing experience for me in terms of getting over my own disappointment with my own births’.[4]

The family context and the recommendation of practices by family and friends are forms of positive motivation encouraging women to explore the natural birth milieu. However, some participants had also been encouraged to engage with natural birth by desires not to repeat a friend or relative’s negative birth experience. For instance, mother of one Elly, at the beginning of the interview when we were exploring her interest in natural birth, explained that ‘My friend had a caesarean a couple of years ago and her experience was really traumatic from start to finish so I think that probably run in my head a little bit’. Whilst Bella, a mother of three, explained that she had been present at her elder sister’s two births and had ‘watched her scream her babies out’. She said that her sister requested an epidural too far along in the labour so, in order not to repeat that negative experience, Bella requested one early in her first birth. It was only a chance meeting at a mother and toddler group with someone who had practiced Hypnobirthing, Bella told me, that influenced her to change her birth choices and practices for her second and third births, which were both home births.

A different form of negative influence was in the women’s family and friends who discouraged them from participating in certain aspects of natural birth, such as home birth. Four women in my sample explained that they would have liked to have a home birth with their first births but their partners were not in agreement and so they relented, recognising the importance of their partner’s role in the decision making process. These women saw the negotiated choice of a midwifery led unit as ‘the next best thing’ to home, in line with the units own portrayal (Fannin 2003). Others explained the lengths they went to to convince their partners or their own parents. Three women explained that their choice to home birth created antagonism with their parents which was not properly resolved until after the births. They used various tactics to appease their parents, including telling them they had changed their plans, not telling them until after the birth and, in one case, inviting her mother to be present.

[4] Other stories of the importance my participants attached to teaching others about natural birth have been given in Chapter Four.

The familial context, as well as the building of a new social support network through participation in pregnancy, birth and new motherhood classes and events, can contribute to a sense of 'intentional community' around birth and new motherhood. The women I interviewed, privileged with the requisite social and financial capital, participated in private antenatal classes and their associated social events pre- and post-birth and so became part of a 'natural birth community', however transient their participation. This community is one based on shared interests and practices, including consumption-based practices. As noted in previous chapters, this bears parallels to more explicitly spiritual communities such as that of homesteading (Gould 2005) and LOHAS (Emerich 2007, 2008), as well as the 'holistic milieu' (Heelas and Woodhead 2005) and 'spiritualities of life' (Heelas 2008). LOHAS and 'spiritualities of life' in particular are intimately tied to consumption practices as their participants are concerned with changing themselves and the world through what they choose to purchase - from books, to food, to healthcare products, to classes, courses and more. Heelas (2008: 3) argues for a reappraisal of consumption-based spiritualities as not about 'the self for itself', not about 'people intent on capturing their dreams by way of commodities'. Rather, he argues, 'participation *can* serve to make a *difference* to the ways people live "out" their lives' (2008: 9) (emphasis in original). He goes on, 'holistic, face-to-face activities (in particular) can facilitate a "current" of meaningful experiences' (2008: 9).[5] With regard to birth, Barbara Katz Rothman's *A Bun in the Oven: How the Food and Birth Movements Resist Industrialization* (2016), takes a positive view of these two 'consumer-based social movements'. Rothman (2016: 9) argues that 'Birth and food, once so profoundly part of women's world of production, ultimately came to be acts of consumption, all about intelligent, thoughtful, careful shopping, and making good choices'. She does not lament this situation, however, and criticises those who dismiss these movements as 'trivial', as '"first world problems", the concerns of middle-class white women' (2016: 5). Rather, she sticks to her second-wave feminist roots to argue that 'the personal is political'; through the choices we make, 'we are making waves against the machine' (2016: 10).

Natural birth groups are an example of a community of shared values and practices, including consumption, which create meaning for some women during pregnancy, birth

[5] I continue the comparison with spiritual communities in Chapter Six in particular with regard to understandings of the self.

and post-parturition. Some of the courses, such as NCT, were purposefully chosen by women (and sometimes, perhaps, by men) in order to build a friendship network of couples' expecting babies at the same time. The NCT course I observed was taught in such a way as to facilitate this social networking. A combination of practical concerns - having a friendship group of mums with babies the same age in order to share experiences - can be seen to interplay with moral or ideological positions; some of the women I interviewed said that they had to take the initiative and responsibility for creating their own support network because they did not believe the NHS would provide appropriate levels of post-birth support. Jane, for instance, explained that part of her reason for participating in Hypnobirthing and NCT during her second pregnancy was to build the 'whole support network that I've made for myself so I didn't struggle like I did the first time round when he was born'. 'I've made for myself' highlights Jane's sense of responsibility that the support network was something she had to create herself. This self-built support network of like-minded women feeds into - and is arguably learnt from - the natural birth ideal of a symbolic community of birthing women around the world, both a-geographical and ahistorical. It is also comparable to self-help or support groups in which women's views are reinforced, and solidarity is found in the non-mainstream or subversive position *vis-a-vis* medical authority.

Jenny and Shannon, telling me about the local Attachment Parenting Facebook group of which they are a part, explained that a sense of community was important to them. They linked this to their perception of the past when there was not such a reliance on medical advice and, according to Jenny, 'you'd have the older women in the community and you'd ask them questions instead'. Shannon added, 'I think it's back to the old set-up of having a community around you, of being around your mum and your sisters and your aunties and their children, and having that knowledge and support, which we've lost, it's going back to that'. The sense of community and the social network built are important contributors to women's meaning-making around pregnancy and birth. As has been suggested throughout this thesis and will be explored further in the following chapter, the ideas and practices of natural birth are learnt in communities - whether this be a formal class or an informal discussion with friends or new acquaintances. Arguments that birth needs to be 'reframed' as 'something that happens to individual women rather than a political or moral

act' (Schiller 2016: 126) belies the fact that women often form their birth preferences, and derive meaning from, participation in various birth communities with shared moral norms.

### '*Accidental' Factors and Progressive Socialisation into the Natural Birth Milieu*

Some of the women I interviewed explained that they had not been especially interested in natural birth ideas and practices until they came across a book or class when they were searching for something else, such as an internet search for a specific pregnancy related symptom or entering Bambino's to buy a product for a friend. Some of the women explained that once they had come across a particular book or class, regardless of whether they had been intentionally searching for it, they became increasingly involved in natural birth ideas and practices, searching out more books, classes and like-minded women with whom to create support networks. The support network then provided further positive confirmation in the women's choices and practices, such as when Bella, mentioned above, attributed her decision to explore Hypnobirthing to a chance meeting at a mother and toddler group. Some of the women I interviewed attributed the particular course attended, either Hypnobirth or NCT, with their subsequent desire to have a particular form of birth whether this was home birth, water birth or a vaginal hospital birth with no pain relief. Most framed this in positive terms. Mother of one Amy, for instance, explained the process through which she moved from a positive perception of care from a medical team due to her age and previous miscarriages, to seeds of doubt about the need for caesarean sown by both her NCT cohort and women she spoke to online, to hiring an independent midwife who 'coached' her to question her consultant about the evidence and alternatives for certain procedures. Amy did then experience a type of birth with which she was content - a vaginal birth within the hospital which, whilst it did include medical procedures such as induction and episiotomy, was not an instrumental birth or caesarean. However, a couple of the women in my sample expressed regret that the course they attended encouraged them to desire and expect a form of birth which was not the birth they then experienced. Laura, for instance, attributed her desire for a natural, drug-free first birth to the influence of the NCT class she attended. When she had to be induced and ended with an emergency caesarean she said that she 'felt a failure'. Few of my participants used the term failure, however, and this will be discussed further in Chapter Six.

As Amy and Laura's stories suggest, 'experts' can play a particular role in women's decisions, choices and practices of birth. Barbara, midwife and owner of Bambino's, was instrumental in encouraging the pregnant women who entered her shop to sign up for the Hypnobirthing course. When I asked Chloe what had initially brought her to Bambino's she explained that she was actually looking for an exercise class:

> The reason we went in there was because I was looking for a Pilates class, that's what it was. It wasn't anything to do with Hypnobirthing, it was she that mentioned Hypnobirthing because she gave me a leaflet with all their classes and treatments and all the rest of it on and the details of the Pilates class as well....She said, 'Have you considered Hypnobirthing?' and I said, 'I don't really know what it is to be honest' and she kind of explained about it and the more she explained about it the more interested we both became cos it seemed to be a lot more positive and it seemed to involve (partner) a lot more.

Chloe completed the Hypnobirthing course, and planned a home birth also, she told me, on Barbara's suggestion. She resisted her obstetrician's requests to induce her until she was over two weeks overdue. She sought advice and support on how to resist induction from the Association for Improvements in Maternity Services (AIMS), an organisation which she learnt about through Hypnobirthing. Closer to three weeks overdue and after a few days of labouring at home without much progress, she eventually agreed to a caesarean section. Nevertheless, she remained positive about Hypnobirthing and her planned home birth experience, attributing these to her knowledge of her birth options, her confidence to state what she wanted, and her remaining calm during the caesarean. She was still attending Hypnobirthing coffee mornings when her son was six months old and I stopped attending.

Linda explained that she had some prior knowledge of Hypnobirthing as she used to work at the Royal College of Midwives and the book 'was always flying around'. When she later became pregnant, Barbara taught the NHS class which Linda attended and she mentioned Hypnobirthing. Linda told me,

> I just got talking to Barbara again and she mentioned the Hypnobirth and I remembered that I still had the book, so I started to read it and then I went on the course….We were just talking about it really, I wasn't inquiring particularly for it, but she said, 'oh we've got the course starting' and everything coincided at the right time….And I just think, I don't know if I'd of done it if I wasn't aware of it before cos I don't think I would have searched it out….But at the time I think it really was just by chance.

Linda became infamous at Hypnobirth coffee mornings as 'the six minute mum', as she was only at hospital six minutes before her son arrived. She attended the coffee mornings, she told me, in the hopes that her birth story would 'inspire' other mums.

Social networks are influential in drawing women into natural birth. Chloe and Linda were both recommended Hypnobirthing by Barbara, a midwife and, it could be argued, a figure of authority. Barbara and other birth workers, such as Hypnobirth teacher Mandy, played a similar role to that of the midwives employed in the American birth centre studied by Annandale in the 1980s. Annandale (1988: 95) describes the process through which the 'midwives became involved in socialising patients (who were often ambivalent about aspects of birth center care) into a model of natural childbirth'. They did this by 'selling' their practice, describing birth as natural and 'patient-controlled' and resisting obstetricians' practice of placing time limits on labour. Natural birth was then 'shaped' (1988: 105) through the use of various techniques to retain women in the birth centre, rather than them transferring to hospital, including encouraging ambulation and baths in labour.[6] Whilst the women in my sample were not necessarily ambivalent, they were often not intentionally looking for a natural birth book or course and sometimes had no prior knowledge of them. Women in my sample sometimes came across Hypnobirthing by accident, for instance when they were looking for an exercise class, or by a chance meeting with another Hypnobirther, and then learnt natural birth ideas and practices through their increasing immersion in the milieu.

### *Home Birth: An Ideal Tempered with Practicality*

For many of the women I interviewed, home birth represented the ideal 'natural' birth. Some of my informants (in line with its portrayal in natural birth literature more generally), juxtaposed home birth to 'mainstream' medical birth in the hospital context in which women's embodied authority is believed to be eroded. Many of the more ideological or normative statements about natural birth given in the previous chapter concern home birth

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[6] Annandale (1988: 106) goes on to discuss how the midwives could not always provide the model of natural childbirth they had promoted because of their use of various clinical interventions in a bid to retain women in the birth centre rather than transferring to hospital. These included encouraging women to birth on their left lateral side in order to reduce perineal tears even when women expressed a preference for upright birth.

in some way. In addition, as outlined above, some women's preferences for home birth were located in the family context - because other relatives had had positive home birth experiences. However, a simple portrayal of home birth as the epitome of natural birth and hence always chosen for ideological reasons, belies the many practical factors that play into women's decision-making around place of birth (Nolan 2011, Coxon et al. 2013). Macy, who chose a home birth for her second birth, explained that this was primarily due to 'a huge phobia of hospitals and all things medical'. Fern, pregnant with her second child in a very snowy February 2013, explained that a desire to avoid a forty minute drive to hospital in the snow contributed to her and her partner's decisions to plan a home birth. Numerous women mentioned a car journey during labour as a reason to choose home birth over hospital birth. Concerns that they might have to repeat the car journey if they were turned away from hospital as not in active or established labour[7] played on their minds. They thought this would be additional 'stress'. They termed staying at home, in prosaic terms, variously as 'nicer', 'easier' and 'less faff'. In addition to the positive moral evaluation of home birth as a natural ideal, I identified three more practical motivating factors in women's narratives of home birth. These factors were largely concerned with the control of the birth environment, including who was present for the birth and the hours afterwards. They were a desire to remain in control in the home; to have family members present; and to receive a perceived higher standard of care.

Independent midwife, Flora, explained that women retain higher levels of control of the birth environment when birthing at home as 'the midwives come to her home as guests'. The corollary of this, discussed in the previous chapter, is the few women I interviewed who felt that the midwives polluted their environment when they did not respect their wishes or the calm atmosphere they had established. Many of the women I interviewed stated that they felt more comfortable at home, both because it was a familiar and safe environment and because of practical issues such as being able to control the heating, lighting, music and scents. Both ideological and practical concerns are at play here as the women wanted to create an environment in which they felt the most comfortable (in terms of temperature for instance), but also in line with the optimum environment for the ideal birth which they had learnt through classes and literature (dark and quiet).

[7] Active labour is defined as beginning when the cervix is 4 cm in diameter.

I interviewed Vivianne (a mother of two children born at home) and Caroline (a mother of one child born at home) together and they both discussed the importance of control, perhaps one influencing the other. Vivianne said,

> I know that the labour ward is notoriously always really, really hot and I always thought, how can you relax if you're sweating and there's nothing you can do about it, and I didn't like the idea of not being in control of those sorts of things, and so being at home in my own environment was a much nicer option.

She went on to say that she chose home births because, amongst other reasons, 'I would rather be comfortable than not'. Whilst Caroline said, 'It was about the control as well for me, being at home, being able to listen to the music I wanted to listen to, go to each room as I wanted, to walk around, go to the loo and not worry about anybody else being in the loo…' These desires to retain seemingly mundane levels of control actually belie a much more complex situation. The issue of 'control' occupies a rather ambiguous position in natural birth literature and classes. Women are simultaneously encouraged to retain control of the birth environment whilst relinquishing any attempt to control the body. Mansfield (2008: 1093) aptly describes this as 'women gain control in order to lose control'. The lack of control over the process of birth and the body in labour are celebrated in natural birth literature where links between following instinct and comparisons with other mammals abound. Relinquishing control of the body is simultaneously constructed as relinquishing to a higher 'natural' or, for some, transcendent process. Yet much of the natural birth literature, including that of Hypnobirthing, suggests that in order to feel secure and comfortable enough to relinquish control and give over to the 'natural' process of birth, women have to prepare for their births by controlling the birth environment. In order to achieve the 'ideal' birth, women should seek to control some aspects of birth (the environment and who has access to it) in order to relinquish control of other aspects (including variously, the body, inhibitions, the reasoning mind, and fear and tension which could slow the birth process). The issue of control and the circumstances of birth are returned to in Chapter Six.

A second motivating factor which women raised in discussing their reasons for home birth also concerned control of the birth environment - more specifically, who was present for their births. For the fifteen women I interviewed who had experienced one or more home births, a high premium was placed on being able to choose who was present for the birth

and immediately afterwards. In the interplay of ideological and practical considerations, some of the women told me that in addition to the baby's father, they wanted their own mother or, more commonly, their chosen expert such as a doula, present in order that they could pay less attention to the midwives. For instance, Bella said,

> It was lovely to be at home because I had (partner) with me….I called mum at the same time that I called the midwives so she came over and she was there as well. I kind of just ignored the midwives, I knew I had my people with me….

More common, however, was the positive evaluation of the family context immediately after the birth. This was often juxtaposed to a first birth experience in a hospital where birth partners have to leave a few hours after the birth if it is outside of visiting hours. Mother of two, Jane, for instance, comparing her second birth at home to her first birth in hospital, said,

> And it was lovely afterwards, lying on the sofa with the towels, nobody had to go anywhere which, when my son was born, cos it was at night, he had to go home….I didn't know he would have to leave. I was all alone in this ward with a baby, all the other babies were crying, and that was one of the reasons we wanted a home birth, cos we thought, 'well we can all stay here'. And I was so glad, it was lovely afterwards really nice…

The hours following a home birth were also described by my interviewees as a means to normalise birth within the family context, establishing bonds between siblings. Bella said,

> What I loved about it, which I realised afterwards, was it was not a case of me leaving the house for a couple of days and then bringing back a new baby. (first son) got up and (new baby) was there, 'the baby's come' and yeah, he's always been really protective towards both his brother and his sister and I think it was because the birth was just part of the family…

A third practical concern that the women I interviewed mentioned when discussing their choice of home birth was a belief that they would experience higher levels of care at home. Whilst women receive care from two midwives regardless of place of birth (a midwife who stays with them through labour and birth and another who arrives just for the birth of the baby), in the hospital context, the main midwife may leave the room now and again for various other tasks, and is under numerous time pressures, as outlined in Chapter One. In the woman's own home, the main midwife has no other tasks to which to attend. When I interviewed Jenny (pregnant with her second child and planning a home birth) and Shannon (mother of three children, the last two born at home) together, they emphasised this in our discussion of home birth. Jenny said,

> But if you have a baby at home, you have a midwife just for you and when the baby's about to come, they have a midwife just for the baby, so you get that one to one attention, which is what you need. So you get better care actually having a home birth than in hospital.

This was always tempered with the realisation that there may not be midwives available to attend a home birth and so the women's plans could be thwarted at the last minute. Ten of the women I interviewed negotiated the uncertainty of being 'allowed' to home birth (whether because there was not a home birth option in their area due to midwife shortages, or because they were deemed to be 'high risk' for various reasons), by hiring independent midwives who could guarantee a home birth unless there was a medical indication to transfer to hospital during labour. At the time of my research, independent midwifery care averaged £3000, for antenatal care, the birth and some postnatal care. This was not a financially viable option for all of the women I interviewed and was a financial struggle even for some who did choose independent care. Bella told me, 'It stretched the bank almost to breaking point, but it was worth it'. Other women told me that they felt they should not have to pay for the best care which should be freely available on the NHS. This speaks to the specific UK context of the study in which moral value is placed on free NHS care, as outlined in Chapter One (footnote 4 in particular).

Hence, financial factors also play into women's decision making. Independent midwifery was generally considered the 'ideal' amongst my sample, but some of the women hired doulas as 'the next best thing'. As discussed in the previous chapter, doulas were often preferred to NHS midwives as they were outside of the 'system' and more likely to share - and to have contributed to - the women's ideas and practices of natural birth. A doula, whose services during labour cost on average between a few hundred pounds and two thousand pounds, depending on their level of experience,[8] cannot legally replace a midwife but is present for the birth, in addition to a midwife, to support the birthing woman. Macy, who hired both independent midwives and a doula for her second birth at home, suggested that women should hire a doula even if they cannot afford an independent midwife. She said, 'That's my big tip to everyone, get a doula, and they're not as expensive. They're wonderful. People think it's a lot of money but it's not really, is it? It's about priorities'. Again the ideal is tempered with practicality; an independent midwife is ideal but a doula

[8] https://doula.org.uk/how-much-do-doulas-cost/

is also ‘wonderful’ and less expensive. Macy’s statement remains normative as implicit within it is not so much a recognition of her own privileged financial position but a suggestion that those who do not hire a doula have not got their priorities right.

I have argued that women’s birth plans were motivated by an interaction of ideological and practical concerns; commitment comes from both beliefs and practices as the theories drawn from the study of religion outlined in Chapter Two suggest. The ideas and practices of natural birth in which the women I interviewed were engaged were pursued for a variety of reasons. Ideological or moral motivations that this was the ‘right’ way to birth were variously pre-existing beliefs; learnt within the family context and influenced by family and friends’ experiences; or discovered by chance and then learnt gradually through an increasing immersion in the natural birth milieu. Practical concerns, such as choosing home birth in a desire to be able to retain control of the birth environment, are both influenced by, and feed into, the accepted ideas and practices of natural birth, in which there is believed to be an optimum environment for birth, for instance. Combined with the hesitation and ambiguity around defining natural birth outlined in the previous chapter, this creates a situation in which women’s narratives of pregnancy and birth experiences are equally stories about their own and their friends’ and relatives’ circumstances and practical concerns. They stress themes of practicality and ‘keeping their options open’ in their own birth narratives, particularly, but not only, in first birth stories. This was even the case for home birth, often considered the epitome of the ideal natural birth. Hence when I asked Jane, ‘Was the home birth quite a practical decision or was it more of an ideological position that you think birth should be at home?’ she replied that it was ‘more practical’. She went on

> Just knowing that once I was in, the birth unit was busy I might end up in labour ward, if I was in labour ward they’d be more chance of interventions and I just didn’t want to go down that route cos I’d had interventions before and I thought if I stay at home, cos talking to people and doing my research, I thought staying at home, I’ve got more chance of having the birth I want, and of it being more intervention-free.

This indicates the complex interplay of ideological and practical concerns that feed into women’s decision making around birth. Jane explained that her decision was partly motivated by seeing how busy the birth unit was when she visited on a hospital tour. She realised that she might not be able to have the water birth she wanted as pools were allocated on a first come, first served basis, and that the birth unit might be so busy that she

would be sent to labour ward. Jane was working towards an ideal form of birth, 'the birth I want', and realised that a series of practical issues might prevent her from attaining this birth once she entered the hospital context. Of course a tendency to emphasise practical rather than ideological factors in the interview context might also be influenced by a wider cultural aversion to being seen as too zealous or moralistic. The complex relation between women not wanting to be seen as judgemental whilst simultaneously making normative statements has been described in the previous chapter, and a similar balancing act can be seen as underway here. The women talked in both ideological and practical terms when describing their stories. Below I explore further themes of practicality and keeping options open in the interview narratives.

**'Keeping My Options Open'**

Around half of the women I interviewed used phrases such as 'keeping my options open' and being 'open-minded'. Despite working towards the 'ideal' natural birth, outlined in the previous chapter, the women I interviewed were aware that this form of birth might not be achievable or even desirable in its entirety. It might not be 'right' for them. As I have argued, I use the term 'ideal' to encompass the concept of something that is most valued and is worked towards (both an idea and a practice) but which encompasses the potential of non-attainability. I have also outlined the women's hesitations and ambiguities around defining natural birth, suggesting a more practical approach, partly linked to a desire not to entrench themselves too firmly in a natural birth 'camp' and so to keep their 'options open'. This can be seen as a central element of the practicality of birth.

Discussions of keeping options open were particularly linked to discussions of pain relief. As suggested, a convenient short hand definition of natural birth is a birth that is 'drug-free'. However, the women I interviewed, particularly the women pregnant with their first child or narrating their first pregnancy and birth experiences, were aware of a lack of embodied experience of labour and so did not want to dismiss pain relief outright. Whilst 'natural' methods such as water, massage, aromatherapy and more, were stated as the initial preferred means of pain relief, the women were positive about the fact that they could ask for pharmaceutical means of pain relief if desired. Mother of one, Elly, told me,

> I just wanted to know what all my options were and have an open mind when it came to it, but have a preference, and that preference for me was, um, gas and air, and to avoid any unnecessary interventions….and you write your birth plan and stuff, and I specifically said on there, um, I really do not want an epidural however if the situation requires it, you know, let's not faff (laughs), if it's necessary.

Jenny, pregnant with her second child, and planning another home birth after she had to transfer to hospital for her previous birth said, 'I'm a realist so there will be gas and air with the midwife, but I don't plan to need it, but you know I'm not a fool (laughs)'. The laughter in these quotations is interesting, perhaps a means of distancing themselves from being placed too firmly in the natural birth 'camp', which is often ridiculed in popular perceptions as unrealistic. It is also likely to be a gloss for feelings of concern and anxiety about the imminent unknown experience of birth and the moral quandary that surrounds an attempt to exert agency in situations which prohibit or at least make this difficult. It could also be a nervousness over the challenging of established medical authority. The women recognise their position as subversive and marginalised.

A desire to avoid disappointment was another theme in discussions of keeping options open. Some women spoke of rejecting certain aspects of the 'ideal' natural birth, such as water birth, because it was not a practical option for them at home, or because they knew that their busy local hospital had a 'first come, first served' policy. Some of the women I interviewed portrayed keeping an 'open mind' as an important protection mechanism against feelings of disappointment. Kelly, pregnant with her second child, explained that, 'I wrote quite a flexible birth plan, noted a few things down that I would have liked to happen in an ideal world but didn't have it set in stone as I didn't want to be disappointed if it didn't work out'. Similarly, Chelsea, pregnant with her first child, said,

> Something that I've understood from other people is not to be too rigid with your expectations cos obviously things might not go according to plan and you can't be too disappointed if your natural birth turns into the most unnatural birth ever (laughs), so I'm kind of like open-minded.

Adherence to a rhetoric of 'keeping options open' can protect against feelings of failure if pain relief is required during birth, because it establishes the boundaries for pain relief to be chosen. 'Keeping options open' and having an 'open mind' can be seen as an aspect of the negotiation between the ideal natural birth which the women are working towards and their own practical, embodied and familial experiences. Both Klassen's (2001) and MacDonald's (2007) analysis of women's interactions with medical technology whilst

planning for a home birth or a 'natural' birth have focused on issues of practicality and pragmatism. Both draw on Margaret Lock and Patricia Kaufert's (1998) notion of pragmatism as a useful means of explaining women's relationships to technology. Lock and Kaufert (1998: 2) suggest that 'women's responses to the process of medicalisation… range from selective resistance to selective compliance'. However, they suggest that 'ambivalence coupled with pragmatism may be the dominant mode of response to medicalisation by women' (1998: 2). They suggest that 'women's relationships with technology are usually grounded in existing habits of pragmatism' (1998: 2). That is, 'If the *apparent* benefits outweigh the costs to themselves, and if technology serves their own ends, then most women will avail themselves of what is offered' (1998: 2) (emphasis in original). Women use technology if it suits their own purposes.

MacDonald (2007: 110) focuses on women's agency, on women's 'responses and decisions', as a range of 'strategies grounded in pragmatism'. She suggests that women 'act pragmatically' when confronted with medical technology on the one hand and a natural midwifery philosophy on the other (2007: 111). MacDonald uses the example of her informant 'Giselle's' 'negotiations with medical technology' - which is remarkably similar to some of my interview narratives - to illustrate this. She describes how Giselle chose midwifery-led care for her second birth after a friend's recommendation and a negative first birth experience in hospital. Giselle decided to have antenatal screening despite her midwife advising against this, as well as an ultrasound for dating. MacDonald (2007: 109) writes, 'While it is clear that she prefers midwifery care generally, she is not beholden to it ideologically'.

Klassen (2001), writing about home birthing women in 1990s America, argues that her participants inhabit 'post-biomedical bodies'. This she defines as 'bodies that do not entirely deny the usefulness of biomedicine but challenge its hegemony via alternative systems of knowledge, such as religion' (2001: 135). Klassen argues that the women she interviewed used medical technology to their own ends and for their own reasons, whilst still rejecting the overarching hegemony of medical birth. She too uses the notion of pragmatism writing of her participants, 'A certain pragmatism shapes their labors, as they draw selectively from medicine, midwifery and religion in working with technologies of birth as "natural women"' (2001: 136). Rather than embodying problematic contradictions,

she argues, this 'pragmatism' can be seen as 'a creative paradox' (2001: 163). The pragmatism of the women I interviewed was revealed in their use of the terms 'keeping options open' and keeping an 'open mind'. I argue that they were working towards an ideal form of natural birth but retained flexibility around what practices and procedures could be included in this, depending on the circumstances which unfolded during labour. The circumstances of labour included whether this was the woman's first or a subsequent birth.

**Changing Concerns over Birthing Biographies**

My informants tended to use phrases such as 'keeping options open' and keeping an 'open mind' when discussing their first birth decisions and practices. As Thomson et al. (2011: 244) write, many first time mothers' 'anticipatory accounts of birth planning were characterised by flexibility and uncertainty'. First-time mothers, with no embodied experience of birth, rely on alternative sources of advice from their social networks and from the birth professionals they have selected as experts. As noted above however, my sample of women self-selected as interested in 'natural' birth provides some different data to Thomson et al.'s more representative sample of women pregnant for the first time, especially around ideas of who was considered to be an expert. The difference in sample selection also accounts for differences between my data and that of Coxon and colleagues who analyse data from the Birthplace Study. In her doctoral thesis, *Birth Place Decisions* (2012), Coxon explores the place of birth planning of 41 women. She argues that understandings of risk determine planned place of birth and that the 'overall tendency' is for 'women to be increasingly conservative about their birth place options over time, but during their first pregnancies, participants views were more fluid and open to change' (2012: 2). Drawing on the work of Mary Douglas (1992), she categorises her participants based on their understandings of risk and their relationships with society, in a 'grid-group model'. She categorises the majority of her participants as holding an 'individualist perspective' (16 women), a belief that birth is usually safe and can take place in the home or midwifery unit with the option to transfer to hospital if needed. Planned place of birth here is not motivated by an ideology or interest in natural birth, she argues, but rather a consumerist view that private care is the safest and best care. The 'individualist perspective' is characterised by 'choice' as a signifier of 'expressing individuality' (2012: 75). Twelve women she identified as having a 'traditionalist perspective', that upholds

medical authority; a belief that birth is medically hazardous and should take place in the hospital. Coxon identified a minority of women as having an 'enclave perspective' (two women), that is a commitment to natural birth in which research is prioritised along with discourses of the 'morally and physically fit pregnant body'. The 'enclave perspective' is in opposition to the mainstream and 'enclave individuals prefer natural solutions such as healthy diet and exercise and are sceptical of technological solutions, including pharmacological medicines' (2012: 77). A further group (11 women) she categorised as 'isolated' or 'excluded' from choice of birth place, 10 of these were expecting their second or subsequent babies, indicating that a complication in a previous birth eradicated their choice. Coxon recognises the possible interplay of the 'individualist' and 'enclave' perspectives, which certainly came to the fore in my interviews, where women held an ideal of natural birth but were practical in their approach to it.

In later works, Coxon and colleagues have further analysed why around 90 per cent of women in the contemporary UK give birth on labour wards despite alternative places of birth (home birth and midwifery led units) being encouraged in government policy. They write that 'in first pregnancies, women were more open to the idea of birth in different settings, but those expecting second or subsequent babies usually planned hospital OU births' (2013: 7).[9] They argue that this is partly because of the historical association between hospital birth and safety, and 'the heightened perception of risk' (2013: 5) in contemporary western societies. However, they argue, this fails to take into account why some women become opposed to hospital birth. For the majority of women who favour hospital birth, medical intervention was seen in a positive light - it was only those women who favoured birth in non-hospital settings who interpreted medical intervention negatively (2013: 11-12). 'The "risks" posed by hospital to natural birth, particularly the interventive approach associated with hospital OUs, were central to women's decisions to birth elsewhere', they write (2013: 12). They explore place of birth planning further in a 2015 article, 'How Do Pregnancy and Birth Experiences Influence Planned Place of Birth in Future Pregnancies?' Here they argue that women who had a positive birth experience, regardless of place of birth, opt for the same place of birth in future pregnancies. They write, 'The assumption that women will opt for lower acuity settings for second or

[9] Although women planning non-hospital births for their first births were less likely to achieve this than women with subsequent pregnancies.

subsequent births was not supported by these data' (2015: 141) and that there is instead 'consistency' between place of first birth and subsequent births (2015: 143). Interestingly, and in contrast to some of my informants, they found that first time mothers who planned a non-hospital birth but then had a hospital birth reinterpreted their plans as 'naive or optimistic' (2015: 143). They reinterpreted their understanding of birth as much 'riskier' than they had anticipated, reinforcing the general cultural understanding that hospital birth is safest and that natural birth is not possible (2015: 146).

However, the women I interviewed, selected on the basis of their interest in natural birth, were opposed to varying degrees to 'mainstream' medical birth and were actively seeking alternative places of birth - often in subsequent births. In many of the interviews conducted, discussion led to plans for hypothetical future births, even if the women were not currently planning or expecting another child. In contrast to the majority of women discussed by Coxon et al., some of the women I interviewed progressively moved away from 'mainstream' medical birth throughout their birthing biographies. Some of the women who had experienced 'natural' births in the hospital context spoke of desires to home birth in the future whilst those who had home birthed, and been critical of the midwives who attended them (such as Nancy and Harriet discussed in the previous chapter), claimed they would have a preference for free birth in the future.[10] In the interview with Harriet, we joked that anyone could achieve the perfect birth with practice. Although discussed in a joking context, this idea encapsulates the 'work' of birth which will be discussed further in the next chapter; the idea that the ideal birth is one that can be achieved through practice.

A negative first birth experience can lead women to work towards a particular form of birth in subsequent pregnancies (Davis-Floyd 1992, Klassen 2001, MacDonald 2007, Nolan 2011). However, this is not a major focus in the works cited above. MacDonald notes this motivation in describing some of her participants, such as Giselle described above, whilst Nolan includes a negative first birth experience amongst the reasons why women choose home birth against medical advice writing, 'Some of the women were very strongly

[10] Free birth, also known as unassisted childbirth, refers to giving birth with no assistance from a healthcare professional. Whilst this is legal in the UK, it can result in referrals to social services if healthcare professionals believe there is a child protection or safeguarding issue. It is illegal for anyone other than a doctor or midwife to attend a woman in labour so any birth partners of the free birthing woman cannot fulfil a midwife's role. http://www.birthrights.org.uk/library/factsheets/Unassisted-Birth.pdf

affected by their previous birth experiences' (Nolan 2011: 13). Davis-Floyd (1992) has analysed women's negative first birth experiences as motivation for a different way of birthing. In a chapter which focuses on the 'reinterpretation of the childbirth experience' she writes that women who experienced 'cognitive distress' through their experience of childbirth in the 'technocratic model' of mainstream America either compartmentalised the experience or initiated 'further epistemic exploration of its meaning' (1992: 241). Further exploration of its meaning took the form of the construction of birth narratives and sharing them with others; further self-education about birth, including reading childbirth literature; becoming involved in childbirth education and midwifery; and subsequent births themselves. Klassen (2001: 136) repeats this idea without exploring it further when she writes, 'many of these women see childbirth as part of a lifelong process of seeking and learning. They see their approaches to childbirth evolving over the course of their procreative lives, as they read birth books, practice birthing postures, explore their bodies and learn from their own and others' birthing experiences'. Implicit here but explicit in my argument is that the women's approaches are not only evolving but are being actively 'perfected'. A negative first birth experience, interpreted negatively either at the time or in hindsight, can encourage a stronger commitment to an 'ideal' natural birth in subsequent births, and hence a change in intended place of birth. Trisha stated this succinctly when she said,

> And then when I got pregnant for the second time I started to feel very anxious about what had happened last time. It kind of bought it all back to me and I was really certain that I didn't want to have another c section cos it had been such a horrible experience but by this time I was a lot more educated, assertive, I knew my rights.

Of the 43 women I interviewed, the primary identity of 21 was as a mother of more than one child.[11] These women had embodied knowledge through experience of a previous birth on which to draw for making decisions about subsequent births. Hence whilst many of these women, such as Bella mentioned above, also attributed their initial interest in natural birth ideas and practices as happening by 'chance', their desire to distance themselves from a previous birth experience was another motivating factor in their stated reasons for involvement in natural birth. Some of the women I interviewed spoke of chance meetings with natural birth practitioners and/or the influence of family and friends' alongside a

[11] 12 were either pregnant with their first or a mother of one child and the primary identity of 10 was a 'birth worker'. See Chapter Three for more on the artificiality of these categories.

latent knowledge that their first birth experience was not 'right' and there 'must be another way'. In mother of two, Jane's words,

> The more I did and the more I found out, I thought, 'no I can have a different experience this time'….and it was kind of an on-going process, the more I learnt, the more I thought, 'well actually last time that wasn't right, it can be done in a different way'.

Different forms of knowledge, and hence power dynamics, are at play in different birthing contexts. First birth narratives are often marked by awareness of a lack of embodied knowledge of birth, a lack of experience of what labour and birth will feel like and uncertainty as to how pain will be managed and coped with. Uncertainty and flexibility mark these narratives, especially around pain relief options. A fear of the unknown is a significant factor. For instance Jane, when talking about her birth choices said, 'how can you know with your first, you've not done it before?' and Macy said, 'I think we just didn't know what our wishes could be cos we didn't know what could happen'. Alice said, 'I didn't really know how I was going to feel or what the pain was going to be like'. Only one of the women I interviewed interpreted this lack of knowledge in a positive light. Linda, the 'six minute' Hypnobirth mum who, in contrast to many of my interviewees including Jane and Macy, had a positive first birth experience, said, 'It's scary now you know what's happened whereas when you don't know anything about giving birth you're a bit like, "I don't know what's going to happen anyway"'. Her fear specifically related to not having such a positive experience for a subsequent birth.

Alongside the lack of embodied knowledge, the women I interviewed also discussed a lack of questioning and of challenging authority in their first births. Alice told me that she did not know or have the confidence to question medical authority - 'cos it was my first baby I thought I had no choice other than induction'. This led her to feel that she was 'pushed into the induction'. Bella, a mother of three children, the second and third born at home, repeated this sentiment when she said, 'I wish I knew at the beginning what I know now, but back then I didn't know induction was optional so I just did as I was told'. Some of the women also explained that they expected the NHS to provide more detailed information about what would happen during labour. Bella said,

> As a first time mother it never actually occurred to me that I would have to go and seek the information that I needed. I thought that by going to the doctor and saying, 'I am pregnant', at that point I would have been given the support that I needed. But I wasn't.

In hindsight, some berated themselves for their lack of birth related education, which they then came to value highly as outlined in the previous chapter. Some acknowledged a lack of responsibility in educating themselves for their first births. As Bella said, 'they gave me a few leaflets but a lot of the stuff in the leaflets just went right over my head, I had no idea what they were talking about'. The paradox between claiming birth should not be a medical issue and desiring the support of the NHS was not mentioned in the interviews. Others avoided reading literature because they were sacred of labour; in Davina's words she was 'just not wanting to know stuff'.

For first births, knowledge - when it is sought - is gathered from books and websites, classes, social networks and birth professionals. Second birth narratives are marked by a more empowered position deriving from bodily confidence that this has been experienced, and coped with, before. Combined with a chance meeting with someone who has experienced a particular form of birth, signing up for a particular antenatal class or reading a particular book, this empowered position led some of the women I interviewed to change their place of birth or at least become more vocal in how they wanted subsequent births to proceed.

Some of my informants related the embodied experience of a previous birth to an increase in feeling in control. Mother of two Davina said that she felt she had much more control in her second birth and when I asked her why she said,

> I think because the first time I was so afraid of what might happen, I was listening to other people, well not that the second time I didn't listen to them but I think the second time, I'd already done it and I knew that I could cope with it, and so I was more ready to say, 'no, I can cope with this, I know how bad it's gonna get and it will be fine'. But I think the first time I was just really scared about all the things that could go wrong.

Whilst both of her births were in the hospital, she refused induction for her second birth whereas her first birth had been induced due to gestational diabetes. When she became pregnant for the second time, she self-managed her diet to avoid diabetes because she 'wanted to prove everyone wrong'. She told me, 'I wanted to say to them "leave me alone, I've done this, I can do this, I'm more in control this time because I know what I'm doing"'. Davina, in relating her birth experiences when her children were four and two, linked her perceptions of her births to how in control she felt during the experience. She

told me that she was not happy with her first birth experience as ‘I don’t think I stood up for myself as much as I could have done’. She explained that she had been brought up to respect medical authority and that she maintained this position through her first pregnancy and birth. With her second birth however, ‘My thought was actually, “well I’m the mum, I’m doing this, I can say how I feel as well”’. This led to an ‘incredible’ second birth experience as ‘I was much more in control and I knew what I was doing’. In line with ideas of the need to practice birth in order to perfect it she said, ‘I improved on it the second time. I think because it wasn’t the most positive experience the first time, but I feel like I learnt from that and the second time was much better’. The sense of taking responsibility to improve upon your own births that is implied here will be discussed further in the following chapter.

Mother of two Macy told a very similar story. Her fear of hospitals and a negative first birth experience of a caesarean section, led her to choose a home birth with independent midwives for her second birth. She said,

> I just felt that you can control it as much as you can if you do as much, if you cover as many questions as possible, as well as I suppose by the second one I knew much better, like I understood my own reactions and I realised that I was the expert in myself and I needed to say to people, I needed to say, ‘no I’m like this and this is what I need’…. So I took responsibility as well as taking control.

Vivianne, mother of two children born at home, also used her embodied knowledge to take control of her birth situation. She explained that when she felt her second labour was not progressing she requested an internal examination despite being opposed to this practice on principle, and the midwife found an anterior lip on the cervix. Vivianne said ‘I felt like I listened to my body, I knew there was kind of an obstruction and I knew there was a reason it wasn’t happening, so I felt very in control of that’. She went on to explain that this embodied knowledge gave her confidence in the early days of mothering. It ‘made me feel like a more confident parent because I’d listened to my body and I acknowledged it and you know I felt much happier with that and knowing I could be a competent mother if I listened to myself’. Other women told stories of ‘knowing’ they were further along in their labours than the medical professionals claimed - often on the basis of an internal examination, which led to some of my informants’ opposition to this practice as outlined in the previous chapter.

The tension between pregnant women and medical authority over 'who knows best' was noted by anthropologist Brigitte Jordan in 1977 when she distinguished between women's 'knowledge' and the 'authoritative knowledge' of medical professionals. Nolan explains this further, 'The knowledge the women in this book held because of their lived experience as childbearing women was considered merely to be "knowledge"; the knowledge possessed by the health professionals whom they encountered was "*authoritative* knowledge"' (2011: 31) (emphasis in the original). Some of the women I interviewed, like Nolan's sample of women who chose home birth against medical advice, challenged their lack of authoritative knowledge in subsequent births.

Through including women with multiple birth experiences in my sample, I was able to gain some additional insights to Thomson et al.'s focus on first time mothers (2011), and to further the work of Coxon et al. (2013, 2015), as well as Coxon's work on the 'enclave perspective' (2012). Whilst not representative of mainstream positions, it is important to analyse why some women do change their intended place of birth between first and subsequent births, sometimes because of a developing interest in natural birth. I argue that women sometimes come to feel 'there is another way' to birth and that this search for another way, and sometimes its realisation, can lead to a sense of meaning and an empowered position in subsequent pregnancies and births.

**The Birth I Want**

Making birth decisions based on individual circumstances and familial context, pragmatism and 'keeping options open', and choosing different birth practices for subsequent births, all focus on the central issue of choice. This ties in with 'choice' being the central component of government policy on birth since the early 1990s (see Chapter One), and hence a 'top-down' cultural phenomenon which creates pressures of responsibility felt acutely along class and gender lines. Choice is inherently tied to class, as it is middle and upper class women who have the necessary capital to make certain choices. I draw here on notions of choice and agency in both motherhood studies (such as Thomson et al. 2011) and lived religion (such as Orsi 2005, Gould 2005, Emerich 2008, 2011, Robbins 2004) which suggest that women do have agency within the confines of

social structures and cultural norms. I do not draw on some feminist critiques which suggest that women do not have true reproductive autonomy because of internalised patriarchal and pronatalist values. Meyers (2002: 30) for instance, focusing on the choice of whether or not to become a mother, argues that women do not have autonomy because of a 'pronatalist ideology' which 'subverts' their 'self-knowledge' and 'self-definition'. That is, women cannot decide not to become mothers because they cannot imagine themselves as anything other - they do not have the necessary 'agentic skills' (2002: 32). The women I interviewed, all privileged in that they were pregnant or mothers through choice (leaving aside the question of whether they were blinded by 'pronatalist ideology'), demonstrated agency with regard to how they planned their births.

The rhetoric of choice has also been embraced by consumer organisations such as the NCT and private antenatal programmes such as Hypnobirthing. These courses teach pregnant couples about their childbirth choices with different teachers stressing the 'right' choices to different extents. However, numerous authors and commentators writing within the field of childbirth have highlighted the illusory nature of choice which government policy promotes (see, for example, Nolan 2011, Coxon et al. 2015, Schiller 2016).[12] The rhetoric of choice that policy papers promote belies the fact that the categorisation of women into different groups of 'risk' limits the choices that are open to them without significant struggles with medical authority or going outside of the NHS context.[13] Combined with the power dynamics at play in the medical context, the 'authoritative knowledge' of the health professionals and the 'parental type' authority exerted by some obstetricians, GPs and midwives in order to 'obtain compliance' and to prevent 'the mother from making an unsafe choice' (Nolan 2011: 44), many women cannot make the choices outlined in policy, for numerous reasons. And perhaps the majority of birthing women do not want free choice around birth. As Nolan (2011: 2) writes, 'Real choice as to place of birth, however, remains illusory for most women, and it could be that most women don't want it'. Choice is inherently connected to the issue of responsibility in pregnancy and birth as, in making individual decisions about one's own body, one is also making decisions for the child. Whilst this is true of all parenting decisions, the embodied state and potential risk factors

[12] See also the websites of various campaigning groups such as Birthrights, The Birth I Want, The Positive Birth Movement, as well as Independent Midwives UK, Association of Radical Midwives and Association for Improvements in the Maternity Services to name but a few.

[13] A choice made by only 0.5 per cent of women.

of birth increase the link between choice and responsibility in birth. And it is this link which is sometimes emphasised by healthcare professionals in order to try and obtain compliance from pregnant women. Indeed, as the literature on pre-natal genetic testing reminds us, it is the health of the unborn child which is often prioritised over that of the mother. Hence the mother is compelled to make the 'correct' choices for the sake of her child and is monitored in order to ensure that she does not shirk this responsibility.

However, that 88 per cent of births in 2017 took place in hospital obstetric units (labour wards) cannot be attributed solely to all of these births being labelled 'high risk' and including medical complications. The culture of birth in the contemporary UK encourages women to give birth in hospital, especially for first births, for which medical advice is to birth in hospital.[14] In line with the lack of embodied and experiential knowledge for first births, women choose obstetric units in line with 'keeping all options open'. It is only obstetric units which can provide epidurals, for instance, a reason given by Jane, Elly and Bella for choosing the labour ward for their first births. If women have positive experiences in obstetric units they are unlikely to change their place of birth for subsequent births (Coxon et al. 2015). If they have a negative experience, however, they might then engage in different birth practices and choices.

Despite the structural confines of culture and medical advice, that some women can have agency in the birth context is borne out by my informants and those of Nolan (2011). That these are privileged women with the social, educational and financial capital to explore and understand their various options has been highlighted throughout this thesis whilst it is somewhat neglected by Nolan. My focus on women's creativity and agency is influenced by my theoretical framework in which natural birth is approached as a community with shared norms and values, participation in which is chosen, and comparable to other communities of interest and (spiritual) practices such as LOHAS and 'spiritualities of life'. Working towards an 'ideal' form of birth is akin to Taves's concept of the 'path' (2009) and, as will be outlined in the following chapter, the practices of birth can be understood as

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[14] The Birthplace Study found that 'for first-time mothers, there was a greater risk of harm to babies for planned home births (9.3 per 1,000 births as opposed to 5.3 per 1,000 births in OUs)'. The implication of this, which is passed down in advice for women, is 'For women having their first baby, there is some evidence that planning to give birth at home carries greater risk of harm to the baby, although absolute risks are small in all settings' (Sandall 2013). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647739/

ritualisations in Gould's (2005) sense of a lifestyle choice that simultaneously makes comment on how the world 'ought' to be. Other authors have prioritised women's agency and choice in their studies of women's birthing and mothering practices (including Klassen 2001, Bobel 2002, MacDonald 2007 and Faircloth 2013). Both Klassen and MacDonald's use of the notion of pragmatism to understand 'natural' birthing women's relationships to medical technology is inherently connected to the issue of choice. Klassen's concept of 'post-biomedical bodies' encompasses the idea that women pick and choose the aspects of medical technology which work for them. MacDonald too uses the notion of pragmatism to make important claims about understandings of the 'natural' amongst midwives and their clients in Ontario. She writes that the 'troubling tension in the meaning of natural birth is often resolved by midwives and clients…by making the shift from a rigid oppositional meaning for natural birth to something more contextual, particularistic, and pragmatic' (2007: 125). She suggests that this new 'cultural' understanding of natural birth prioritises the knowledge, experience and perspective of the 'individual' birthing woman, 'promoting the primacy of informed choice as a principle and an act' (2007: 125). I argue that the same cultural interpretation of natural birth is prevalent in the contemporary UK, encapsulated in the popular phrase, 'the birth I want'.[15] Women's hesitations and ambiguities around defining natural birth (despite responding to a call for participants in a 'natural birth study'), their situating of their choices within an individual context as 'just right for me' and as part of a social network narrative, and their commitment to 'keeping options open' at various stages of their birthing biographies, indicates that women's lived engagements with natural birth are much more complex than a simple dichotomy with medical birth would suggest. The women I interviewed were not simply motivated in their birth choices and practices by a firm conviction that natural birth was the 'right' way to birth (although this was certainly an argument made by some to various degrees). They were equally motivated by the conviction, laid out in government policy and symptomatic of wider cultural understandings of individualisation and personal responsibility, that they should have a choice and control over what happened to their bodies during birth. Meaning-making during pregnancy and birth was not simply a conviction in a non-embodied ideal. It was created in women's practical, familial and embodied experiences.

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[15] 'The Birth I Want' was the name of a campaign run between 2012 and 2015 which called for one-to-one care for pregnant women (a named midwife who cared for them throughout pregnancy, birth and postpartum) and choice of place of birth https://www.facebook.com/thebirthiwant/. The term has now moved beyond this campaign and is frequently used in the media and on social media.

Sixteen of the women I interviewed couched their birth narratives in terms of particular choices and practices being what they 'wanted'. Mother of one Amy, for instance, said 'I really felt in my heart that I wanted to do things in a certain way and I knew I could do it'. When I asked her, 'what was the way that you wanted to do it?' she replied, 'well just myself, I wanted to do it myself'. Others, particularly those who had home births, told me that 'I had the birth that I wanted' (Bella, talking about her second birth. She told me this was after 'I had spent several months visualising that's the birth I wanted'). Others told me that they did not have the birth experience they wanted - 'I just had to put my hands up and say, it's not the birth that I wanted and the experience wasn't the experience I chose but, in actual fact, I was so desperate not to go to hospital, and the hospital experience was absolutely fine' (Mother of one, Katie, who planned a home birth but had to transfer to hospital during labour). Jane couched her conviction in 'the birth I want' with many caveats; 'you have as much control as you choose to have if you do the research, the classes and find out more, then you can try and have the birth that you want, if you're low risk'. Whilst Jenny was more forceful, 'It's your body, it's your baby, you know what's best for you, within reason. If you put the baby first and safety first and think about it, then why can't you have the birth you want?' She said,

> You don't have to go down the natural route to be a real woman just so you can say, 'I went pain relief free' and all the rest of it. I mean I hope to but that's just what I want to do, I don't think less of anyone else who's decided they want to have an epidural. At the end of the day it's what you want.

She went on to say that natural birth was about 'getting what you want and being happy with decisions'. This sentiment was not only expressed by the women describing their birth experiences to me. It was also a central element in some of my interviews with birth workers. As MacDonald notes, midwives in Ontario were actively reconfiguring an understanding of natural birth as being about individuality and informed choice. Consumer groups and individual birth workers have also moved towards the promotion of this perspective in the contemporary UK. As Claire, the founder of Hypnobirthing organisation Birth Wise, told me

> The joy is when your client has the birth she wanted to have, not when she had the perfect natural birth but when she is going into her birth because she got what she wanted and she was empowered to seek that out and get it. And last month we were supporting a woman

> who'd had a caesarean and really wanted a home birth and this month we're supporting a woman who had a vaginal birth last time but is convinced that a caesarean will leave her feeling healthier and less stressed after her birth and we're getting that for her.

The majority of antenatal organisations in the UK, including the NCT and the Positive Birth Movement, take the position that the ideal birth is one with which an individual woman is happy. Within organisations which promote a particular philosophy of birth, such as Hypnobirthing and pregnancy yoga, there is variation amongst teachers as to whether the ideal birth is considered a natural home birth or the one a woman wants. Yoga teacher Aisha, for instance, was critical of the notion of choice in childbirth. Childbirth should not be 'like a shopping list of choices' as 'it should have that different quality'. Childbirth should begin in the home, she said, in order to retain all possibilities and then women can transfer if they need to due to embodied experience - not a cognitive choice in which the mind is compartmentalised from the birthing body. Aisha was perhaps unique in my sample in criticising choice as cognitive, as bound up with consumption and as a reaction against the mainstream, rather than as something that comes from embodied experience. She suggested that choice was something rational whereas birth should be experienced intrinsically as a journey.

Recently established campaigning groups in the UK such as Birthrights (founded in 2013), have been instrumental in promoting birth choices as a human rights issue. Birthrights, founded by a group of lawyers, describes itself as 'the UK's only organisation dedicated to improving women's experience of pregnancy and childbirth by promoting respect for human rights'.[16] Such groups build upon the second wave feminist inspired women's health campaigns of the 1970s, such as that around *Our Bodies, Ourselves* (1971), moving the debate on from a focus on medical technology and authority as controlling and devaluing women's embodied experiences. Rather, through a human rights framework, organisations such as Birthrights (and the current Our Bodies Ourselves organisation),[17] seek to promote and protect birthing women's bodily integrity through a focus on choice

[16] http://www.birthrights.org.uk

[17] http://www.ourbodiesourselves.org

and informed consent.[18] There is overlap here with the field of 'reproductive justice' in the USA in which black feminist activists call for an intersectional analysis of 'reproductive oppression'. Reproductive justice organisations, such as Black Women's Health Imperative, highlight the discrepancies of health outcomes for black women compared to more privileged social groups. The goal of reproductive justice, following those of the black feminist Combahee River Collective (1977), are full human rights for black women. If black women had equal access to health care, and did not face multiple discriminations through the intersections of race, gender and class, such disparities as black women being twice as likely to experience stillbirths as white women, could disappear.[19]

In the UK, in which the NHS does provide equal access to healthcare, such racial distinctions are lessened, although by no means eradicated. Birthrights campaigns have focused on cases where medical technology, including caesarean section, have been used without women's consent[20] but Birthrights is equally involved in the campaign for ease of access to caesarean section through maternal request.[21] The broadening of the debate to a human rights framework can be seen as an attempt to universalise the issue away from privileged western women's concerns with the over use of technology to a recognition that women in the developing world have different concerns, priorities and access to appropriate levels of health care. Birthrights is also concerned with Indigenous Australian women's access to health care, for instance. A human rights framework allows for the inclusion of pregnancy and birth in the wider context of women's health issues including access to contraception and abortion. Women's rights to choice should be legally protected across every aspect of the reproductive sphere, and indeed in every aspect of health care. Birth groups in the UK are moving towards the promotion of this framework, and some of

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[18] The issue of consent has become particularly pertinent following the #metoo campaign which began around October 2017 to highlight women's everyday experiences of sexual harassment. It followed an outpouring of accusations against film producer Harvey Weinstein. Discussions of #metoo in maternity care and in the birthing room can be found online and in media articles, for instance, https://www.theguardian.com/lifeandstyle/2018/mar/17/punished-pushing-back-pregnancy-metoo and http://www.birthrights.org.uk/2017/10/metoo-shows-we-need-trauma-informed-maternity-care/.

[19] https://www.bwhi.org/2019/02/14/black-womens-health-imperative-and-count-the-kicks-form-partnership-to-address-racial-disparities-in-stillbirth/

[20] For instance, 'Childbirth and the Court of Protection seminar' held on 8th March 2017.

[21] See http://www.birthrights.org.uk for most recent campaigns. The campaign for ease of access to caesarean through maternal request began in May 2017.

the women I interviewed, especially the birth workers, also implicitly promoted this view. However, they were less likely to use an explicit human rights narrative and couched their arguments more in terms of what women 'want'. The ideal birth for them, which should be promoted and campaigned for, is 'the birth I want'.

**Conclusion**

In this chapter, I have sought to demonstrate how the notion of the ideal natural birth outlined in the previous chapter operates not simply as an action-guiding value, but as an aspiration that functions in varying ways that are shaped by the context of my interviewees' wider social network, their personal birth biographies and their wider sense of the importance of choice and individual agency. Whilst the women I interviewed were motivated in their birth choices by an interest in natural birth, and held to many of its key ideas and practices including an opposition to medical birth to various degrees, their birth narratives were more complex than the public dichotomy between medical and natural birth would imply. I have outlined some of the more practical motivating factors which contributed to women's birth choices and practices with a focus on the influence of women's social networks and familial context and the idea that women 'accidentally' became involved in natural birth after finding a book or class or particular birth worker by being in the 'right place at the right time'. Using the example of home birth, which is the epitome of the ideal natural birth both in popular discourse and amongst my sample, I have argued that even practical concerns come into play here - from desires to avoid the 'faff' of a car journey, perhaps in the snow or multiple times if turned away from hospital, to three reasons focused on the issue of control: to control the birth environment, who is present in that environment and a perception of a higher standard of care at home.

I have explored my informants use of the phrases 'keeping options open' and 'keeping an open mind', particularly with regard to first birth narratives and the issue of pain relief. I analysed the difference in narratives of first and second births arguing that this is a somewhat neglected area of study in the pregnancy and birth literature. Coxon et al. (2015), utilising data from the Birthplace Study which sought a representative sample of pregnant women, state that women do not change their place of birth for subsequent births if they have a positive birth experience first time. Many of the women I interviewed did

not have a positive first birth experience and, as a result, changed their birth practices in subsequent births. I analysed the different forms of knowledge at play in different birthing contexts, from the lack of embodied knowledge in first births contributing to a capitulation to the 'authoritative knowledge' of the medical profession, to a more embodied and hence authoritative, although still subversive, knowledge in subsequent births.[22] This led the women to feel more confident in challenging medical authority in subsequent births and to feel more in control of their births. This contributed to a sense of empowerment both in the birth situation and in motherhood more generally for some, supporting the claims of campaigning groups such as Birthrights that a positive birth experience leads to more confident and content parenting.

In the final section of this chapter, I suggested that women are encouraged to engage with the notion of choice in pregnancy and birth through both government and hence NHS policy, and through the private antenatal courses they attended. Many recognise that their choices are in fact severely curtailed by their categorisation as 'high risk' amongst other factors, driving them to make choices outside of the NHS. The antenatal courses they attended encouraged them to seek information on all of their choices with different teachers encouraging them to make the 'right' choices to different extents. Other campaigning groups with which some of my informants engaged promoted the notion of choice in childbirth within a human rights framework. Some of this framework had filtered down to women's everyday language but such ideas were more implicit in birth narratives which were framed in terms of individuals wants and desires.

The concept of choice is inherently connected to the natural in the ideal birth. My participants were not simply seeking a natural birth but a 'nicer birth' and 'the birth I want'. The ideal natural birth is not simply one that exists in a dichotomy to medical birth. Or, put differently, a major signifier of opposition to 'mainstream' medical birth in the contemporary UK is not a 'natural' birth but is 'the birth I want'. This is arguably a change from the 1970s birth campaigns inspired by second wave feminism in which the natural was a more obvious signifier of opposition. The change can be seen as inherently connected to the current cultural prominence of choice more generally. It is the rhetoric of choice which dominates current government policy, not only on maternity care but on

[22] See also Chapter Six for a discussion of women's tactical activities.

healthcare more generally as well as on education and numerous other areas. The middle-class women I interviewed feel some responsibility to embody the informed choice and education around it that is encouraged of them, experiencing the anxieties that this entails (Perrier 2012). Simultaneously, the middle-class women I interviewed were keen not to be seen as judgemental. Framing their birth narratives as what was 'just right for them' upholds the sentiment that every woman should have free choice. Yet, as suggested in the previous chapter, the women I interviewed did make normative statements with implied judgements of others. Much of the subtext of the birth narratives was that they had made the right decisions in working towards the natural.

The ideal birth then is one with the particular qualities associated with the natural but also the perception that these qualities have been chosen, both in the run up to birth and during the event. It is the fact that they are chosen that makes the qualities a moral force. But there is also the assumption that the right choices will be made. The ideal is equally about an encouragement to use less medical technology coupled with a woman's informed choice, and her positive evaluation of that choice. More than being about an actual type of birth, the ideal birth is one that the woman has chosen for herself, rather than one which is imposed from above by medical authority. Hence the birth I want is still a moral commentary on the inadequacy of the medical model of birth, where women are dictated to and do not have a part in decision-making. The natural and choice combine to create a moral framework of birth for the women in my sample. In the following chapter, I turn to analysis of just how this moral framework is negotiated through the women's practices during pregnancy and birth.

## Chapter 6 - The Work of Birth

In this chapter, I examine how the symbolic meanings and ideals of natural birth discussed in Chapter Four, and the lived experiences and practical considerations discussed in Chapter Five, are negotiated through practices. I focus here on the role of women's practices in preparation for natural birth. I argue that natural birth should not be understood as a reified, set-apart abstract that is either achieved or failed (as it is portrayed in the media and popular parlance and in some of the existing academic literature outlined in Chapter One) but rather as an ideal or value that is instantiated in techniques of the body. Hence whilst the ideal has the potential for generating a sense of failure, and incorporates individualised understandings of the natural, it also creates a moral framework in which certain practices make sense and create meaning. The moral framework combines ideas of the authoritative force of the natural with the primacy of choice and individual agency. Women's practices within this framework can be considered as ethical practices of self-transformation. This chapter focuses on those practices.

I focus on three questions in this chapter. First, why do some women report that they need to learn and practice natural birth and what do they do during their pregnancies to prepare for such a birth? Whilst one might expect the ideal natural birth to be about following instinct or intuition and thus not something which needs to be planned and prepared for, the women I interviewed invested a great deal in their pregnancy practices suggesting that, for them, natural birth was something to be learnt. Drawing on writings in relation to birth and 'work' (including Klassen 2001, MacDonald 2007, Thomson et al. 2011), I argue that the ideal natural birth exists as a goal to be worked towards and an attempt to attain it constitutes the 'work of birth'. This chapter begins then with a theoretical section in which I discuss existing studies which consider relationships between work, self and practice. I then argue that the work of birth is a working on the self and includes planning, preparation and practice. It encompasses at least three different but interrelated forms of work: physical practices, emotional work and mental or cognitive practices primarily in the form of 'research'. After giving an overview of the physical and emotional practices in which my participants engaged, I focus on their intellectual work and the prominence of the narrative of 'research' in my interviews. Drawing on work within the field of parenting culture studies (including Faircloth 2013, Lee et al. 2014) and continuing the themes of choice, responsibility and middle class anxieties discussed in the previous chapter, I argue

that some of the women I interviewed approached their pregnancies and birth as something of a 'research project' epitomised, for some, in the creation of a 'birth plan'. I also discuss the women's use of tactical activities, relinquishing small battles with medical authorities in order to win bigger battles, often substantiating their arguments with their research.

Having discussed the practices in which my participants engaged, I turn to the importance of 'practice' in general. Practice was a recurring theme in the interview narratives and was spoken about in two different but related ways: participants suggested that practices must be regularly engaged with, that repetition is important in preparing body and mind. In theoretical terms, it is through regular practice that the ideal birth is inscribed on the body. But they also suggested that practice provides meaning as a concept in itself - that is, whatever the chosen practices, the importance lies in that the woman has spent time selecting her practices and that she is actively working to prepare herself for birth. I argue that ritualisation theory is useful in thinking about these practices, especially Rebecca Kneale Gould's reading of Jonathan Z. Smith (1987) and Catherine Bell (1997). Ritualisations are both 'assertions of difference' in Smith's terminology (1987: 109) and strategic ways of acting that give the act a special or privileged status that communicates the message, 'this has extra significance' in Bell's writing (1997: 166). In her ethnography of homesteading in America, Gould (2005) describes homesteading as a lifestyle of difference to the mainstream which becomes actualised through the symbolic action of ritualised activities, that is everyday choices around what food to eat and grow, how to grow it, and whether to engage in the practice of sauna. These practices, defined as 'ritualisations of everyday life' (2005: 67), reveal practitioner's understandings of modern society and actively construct alternative meanings. Gould suggests that it is the repeated, embodied practices of homesteading which mark homesteading as an alternative lifestyle to 'mainstream' America. These symbolic actions do not make logical sense unless they are understood as 'ritualised behaviour' that marks the sacredness of nature and the 'dissolution of the boundary between the self and the natural world' (2005: 73). 'They are means of enacting one's ultimate commitments, commitments that transcend individualistic notions of the self' (2005: 100). Ritual actions construct and maintain the alternative lifestyle through a cultivation of the self - the ritualisations that Gould describes such as eating and work/leisure divide, are formations of the body, involving obvious physical elements as well as ideas of purification. They have elements of (self) discipline

and control creating a 'cultivated self' that is in relationship to nature. The practices of homesteading 'embody moral responsibility, to the self, to a wider community, and to the natural world' (2005: 101).

Similarly, the practices of natural birth are a working out and a working towards the ideal birth, as a statement of difference towards the mainstream, medical model of birth. The practices are a comment on how the world *ought* to be and they set the women apart as different in relation to the imagined, 'mainstream' other. This addresses a second research question; What statement, if any, are the women making about themselves as mothers and about others who approach their pregnancies and births differently? I argue that the working on the self, described as the work of birth, is also an ethical self-formation in which the women 'choose to become' (Jensen 2013: 51) a particular type of birthing woman: a responsible one who has actively researched her choices.

I then turn to a third research question; What mechanisms do women use to protect themselves from feelings of moral failure if the ideal birth is not achieved and how is the ideal birth subsequently understood? I argue that the ideal incorporates the potential for failure; the women I interviewed were aware that they might not achieve the ideal birth despite their preparation and planning. How is this understood, justified and managed? I argue that concepts of practice, control and circumstance are relevant here. It is through their practices that they demonstrate their 'good' and responsible motherhood. It is through a concept of circumstance that they absolve any potential feelings of guilt and failure by displacing blame and by a rhetoric of surrendering to a larger force. The concept of practice protects the ideal birth because if the woman feels that she has put in enough 'work', and this has been recognised and respected by others, she is more likely to interpret her birth experience positively regardless of whether all the elements of the ideal birth were achieved.

In conclusion, I consider the relationship of the ideal natural birth and the 'work of birth'. I argue that the work of birth, coupled with the concept of circumstance, protects both the ideal and the women from feelings of failure. Their work and practice demonstrates that they have done everything they can to achieve the 'nicer birth'. If it is not achieved, it is due to the circumstances on the day, they suggest, and so failure to have the natural birth

does not necessarily lead to a failure in adherence to the ideal birth. I argue that the work of birth, the repeated practices, provide meaning to the women in their pregnancies and births. This is the meaning of natural birth which is overlooked in some of the existing literature and critical media accounts which dismiss natural birth as bound to failure. Natural birth is at once about birth (as these critical accounts claim) but also about so much more, including providing a meaningful moral framework for women's own understandings of pregnancy, birth and motherhood. I will return to these implications in the final chapter.

**Work, Self and Practice**

The act of giving birth has long been associated with the concept of work, signified in the term labour itself. According to the natural birth narrative, this association has had negative consequences for pregnant and birthing women as the medicalisation of birth linked ideas of work, labour and production to concepts of factories and machines (Martin 1987). Pregnant women, and in particular their wombs, became little more than machines to grow and then expel children, with the direction and management of doctors, and with little active 'work' from the women themselves. Women disappeared from the birthing process and were alienated from their bodies. Natural childbirth writers and teachers have sought to reconfigure the concept of work in relation to birth bringing birthing women back to the centre of the process. The birthing mother may also be assisted by a 'birth worker' - a popular term, again emphasising work, for those who teach and support pregnant and birthing women. Grantly Dick-Read, the modern pioneer of natural childbirth, attributed 'civilised' women's fear of birth to the purposeful mistranslation of the word labour in the Bible to mean pain and suffering rather than rewarding hard work and toil. Women involved in natural birth have sought a more positive reconfiguration of their own hard work in relation to pregnancy and birth, epitomised in the preference of the terms 'to birth' or 'birthing', over the more passive 'to give birth'. Even for those home birthing women who embraced the metaphor of their bodies as machines, described by Pamela Klassen, a positive interpretation was given. Klassen (2001: 163) writes that 'Ironically, instead of alienating women from their bodies, the metaphor of the machine seemed to help some of them focus on their power'. The women I interviewed did not use this particular metaphor nor even the term 'work' a great deal, preferring instead the term practice, which will be

discussed further below. Exceptions were mother of two Vivianne, who said that her home births 'took a lot of work from me' and 'I worked really hard', and mother of two Macy who, when talking about her birth preparations, said, 'I did a lot of work, yeah (laughs)'. They talked about work not simply in terms of the actual labour but in terms of physical, mental and emotional preparation. I use the term 'the work of birth' to refer to the practices in which the women engage during their pregnancies in order to prepare for an ideal natural birth but which has a further social function as marking the practitioners as 'good' and 'responsible' mothers.

The concept of work in relation to birth and motherhood is well used and I draw on other authors who have utilised the concept (including Klassen 2001, MacDonald 2007, Nash 2011, Thomson et al. 2011, Faircloth 2013). These authors all have slightly different interpretations of the concept of work in relation to birth ranging from a more literal description of practices as work to a more metaphorical interpretation of the performance of certain practices as signifying a form of identity work which portrays a particular form of mothering. Klassen (2001: 136) provides a more literal interpretation, stating that 'birth requires work - cultural and physical labor'. She writes that pregnant and birthing women perform both physical and cultural/religious work: physical work in the act of birth and the technologies selected to assist in the process, cultural/religious work in their understandings of the natural and their bodies as described through metaphors (2001: 136). Authors whose focus is on aspects of mothering either instead of, or in addition to, birth are more concerned with 'identity work' (Thomson et al. 2011, Faircloth 2013), drawing primarily on Gidden's (1991) writings on the 'reflexive project of the self' and Beck and Beck-Gernshiem's (1995) writings on the self and love. Thomson et al., for instance, relate a concept of the work of motherhood to engaging with expert advice. They write that 'Engaging with experts, taking advice and building a personal knowledge base can be seen as part of the *work* of motherhood' (italics in original) (2011: 16). They go on to suggest that this kind of work 'is more a case of positioning and recognising the self within the maternal culture' (2011: 17). Expert advice, they suggest, is one resource used in the 'construction of types of mothering that have currency at the level of the local' (2011: 124). A similar argument is made by Faircloth and others in the field of parenting culture studies. Authors using this approach focus on 'signal issues', such as the feeding of babies, which place women into 'different parenting camps' (Faircloth 2015: 5), to analyse

different forms of contemporary parenting. Faircloth (2015: 4) draws on Goffman (1959) to focus on women's accountability strategies of extended breastfeeding as a form of identity work, defined as 'the narrative processes of self-making that mothers engage in as they account for their parenting practices'. In this argument, the practices of mothering are not performed simply for their end-goal but simultaneously create a particular mothering identity. The work of motherhood is thus not simply an instrumental physical activity but is also a form of self-work. The women I interviewed were demonstrating a form of intensive mothering during their pregnancies, and their practices are certainly a form of identity work as will be discussed further below. Their practices had a recognisable end-goal - the ideal natural birth - which simultaneously set them apart as practising a particular form of mothering. I argue that analysis of the work of birth can be further extended by drawing on relevant writings from the field of religious studies and the anthropology of religion. Writings on spiritual practice, lived religion and ritual will be drawn on throughout this chapter as a means of thinking about practices as a particular form of self-work.

Klassen (2001: 136), as one of the few authors to examine the intersections of home birth and religion, has suggested that home birthing women might draw, 'perhaps unconsciously, from notions of the religious life that consider authentic spirituality to require discipline and work'. There are parallels between the practices of natural birth and more explicitly spiritual practices, not least the sharing of such practices as yoga, meditation, and visualisation. The link is also explicit in some of the natural birth manuals. Hypnobirthing teachers and texts' admonitions to practice can be seen as a form of discipline through which the ideal natural (and, for some, spiritual) birth can be reached. Natural birth practice, like spiritual practice, in part takes the form of a working on the self. But it is important here to consider the nature of the self which is worked on. Forms of spirituality which became predominant in the second half of the twentieth century (but which had longer antecedents which have been traced by Schmidt 2005) have been variously termed 'new age' (Heelas 1996), 'subjective-life spiritualities' (Heelas and Woodhead 2005), 'spiritualities of life' (Heelas 2008), 'holistic spiritualities' (Sointu and Woodhead 2008), 'progressive spirituality' (Lynch 2007), 'therapeutic cultures' (Madsen 2014), and 'lifestyles of health and sustainability' (LOHAS) (Emerich 2008, 2011) to name but a few. Whilst not synonymous, each shares a particular understanding of the self in relation to others - other people, other sentient beings, nature and, ultimately, the world. This

relationship has been termed one of holism in which the self is seen as part of an interconnected whole, all parts of which are of equal importance. Hence whilst these forms of spirituality have been labelled self spirituality in which the self is central, celebrated and even sacred, they are not necessarily connected with individualism, with the creation of an autonomous, independent self. Heelas and Woodhead (2005: 6) write that 'subjective-life spiritualities' involve cultivating 'unique subjective-lives' in which 'inner sources of significance' are emphasised. However, they go on,

> 'Subjectivization' should not be confused with 'individualization'. Whilst it is true that the subjective turn sees individuals emphasizing their personal experiences as the source of meaning, significance and authority, this need not imply that they will be atomistic, discrete or selfish….subjective-life spirituality is 'holistic', involving self-in-relation rather than a self-in-isolation (2005: 11).

They claim that this is especially true for women in contemporary western societies and have used this thesis to justify why more women than men are involved in the holistic milieu (an argument which Woodhead develops in later work, including Woodhead 2008a and Sointu and Woodhead 2008).[1] The wellbeing culture and the holistic milieu are relational they claim, emphasising spirituality as love and caring for others, and as such attract women 'who seek to develop their subjective lives through associational encounters' (Heelas and Woodhead 2005: 98). The practices of natural birth could not be more relational as they are engaged in for the perceived benefit of mother and child, as a symbiotic entity.

The work on the self through spiritual practices which characterise these movements have multiple functions. There is a perfecting or healing of the self - physical, emotional and spiritual - but not simply as a means in and of itself. In perfecting the self, the individual makes spiritual connections with others, and can ultimately heal the world. This is the argument made by Emerich (2008, 2011) in her study of 'lifestyles of health and sustainability' (LOHAS) and in Heelas's (2008) defence of 'spiritualities of life' as being about more than just consumption. Emerich describes LOHAS as 'conscious capitalism', as seeking to contribute to the creation of a 'better world' through individual choices of product and service consumption. The term 'conscious' here refers not only to the notion of agency (in that the individual has some level of choice) but also to a more explicitly

[1] Houtman and Aupers (2008) make a similar argument in stating that the different impact of de-traditionalisation on men and women accounts for the dominance of women in the 'New Age'.

spiritual notion promoted by both producers and consumers of LOHAS, namely that use of these products and services has the potential to raise individual's consciousness and hence alter the world. Emerich defines conscious capitalism as a 'spirituality of sustainability' which is underpinned by the understanding of nature as an interlocking whole. The natural hence refers to 'an ideal state of human and planetary health' (2008: 7) - the planet has become unhealthy because of humanity's artificial division from nature. The only way to 'heal the world', in the LOHAS framework, is through interconnectedness and holism in which the three sites of 'the self, the social world and the natural world' (2008: 8) are reconnected. LOHAS is hence based on the idea that changing the world begins with changing the self, or rather, a healing of the self is required 'in order to heal the world' (2008: 1). Through connecting with the true, authentic, inner self, one can be healed from the wounds of modernity through ordinary means, that is through consumption practices (2008: 11).

A similar argument is made by Barbara Katz Rothman (2016), in her comparison of the food and birth movements in America as resisting industrialisation through individual choices and practices, and by Gould (2005) in her analysis of homesteading practices. The practices of homesteading are a working on the self which creates a particular understanding of the self in relation to the natural world. Through these practices, practitioners believe, they can heal themselves and hence the world. This leads Gould (2005: 101) to define homesteading as a 'spirituality of practice', that is not primarily concerned with self-discovery or self-expression but with the creation of community and of living a life committed to the 'good of nature' and thus 'in reference to what… Charles Taylor has called a "hyper-good"…the telos of '"the Good Life"' (2005: 233). '… homesteaders (along with such cultural allies as environmentalists and voluntary simplicity advocates)' - and I would add natural birthers - 'demonstrate ultimate commitments to nature, to place, to tradition, and to a community of others who share their views and practices' (2005: 233).

Parallels can be seen here with the understandings of self and society portrayed in the literature of the natural birth field, discussed in Chapter One. As suggested, some natural birth authors explicitly link natural birth with a wider, ecological lifestyle with its underlying ideas of salvation of self and society, epitomised in such phrases as 'living

lightly on the earth', and 'peace on earth begins with birth' (for example Parvati Baker, Robinson, Collings), whilst others frame natural birth as an existential question, a consideration of the legacy we want to pass on to future generations (for example Dick-Read, Odent, Gaskin, Balaskas). In both arguments, it is the responsibility of the individual woman to make the correct birth choices in order to contribute to the salvation of the planet and future generations (in the belief that natural birth and breastfeeding contribute to optimum health). I argue that for natural birth authors, and for some women who follow them, the understanding of self and its relationship to health, nature and the planet, has more in common with this spiritual legacy than with conceptions of the modern, western self as individualised and autonomous.

Within the field of geography, Perrier and Fannin (2016) have recently made a similar argument based on their analysis of interviews with 'birth and parenting entrepreneurs' in Bristol, UK. Whilst only based on seven interviews, Perrier and Fannin use their data to contest Stephens' (2012) argument that 'maternalism and entrepreneurialism are necessarily antithetical', suggesting that the self-employed birth entrepreneurs 'were building community and care economies'. Furthermore, they argue, the women 'were strongly shaped by feminist ethics of care thus challenging the representation of such services as therapeutic postfeminist technologies of self-work' (2016: 448). They argue that the 'mumpreneurs' did not display a 'neoliberal subjectivity…equated with depoliticisation, the repudiation of vulnerability and dependency and the internalisation of competition' (2016: 454) but rather displayed ethics of care in their work. They were motivated, Perrier and Fannin claim, not so much by financial interests but by desires to create communities and educate others - as I have argued of my participants in Chapter Four. The 'self-care' which they taught, including 'physical exercise', 'spiritual balance/ energy', 'creativity' and 'being connected to one's body', was not, the authors claim, the therapeutic creation of an autonomous, individual, neoliberal citizen, but rather signified relationships of ethics, 'a place of education, connection and new knowledge' (2016: 460). Self-care and self-work was hence as much about community and others as about 'self'. That the 'work of birth' is not solely about the self is in some ways obvious as my participants justified their practices as preparation for an ideal birth which is best for baby. Pregnancy and birth is always about the mother (and, in the case of my participants, her male partner) in relationship with the child, which complicates the notion of working on

the self. But this notion is further complicated by the underpinning understanding of the self which is at work in the natural birth field.

I now turn to analysis of the three forms of 'birth work' identified in my interviews: physical work, emotional/spiritual work and intellectual work. This distinction into categories is artificial as, of course, the three forms are intertwined; physical work also requires emotional and mental energy, for instance. This point will be returned to below.

***Physical Work***

As some of the primary signifiers of natural birth involve movement and bodily positions, including keeping active during labour and not assuming the lithotomy position for birth, it is not surprising that natural birth manuals and classes encourage women to physically prepare for labour and birth, strengthening the muscles needed to assume such positions as squatting. As argued in Chapter One, for Janet Balaskas, the pioneer of Active Birth, keeping active in labour and squatting for birth is the very definition of natural birth. The practice of movement and positions thus instantiates natural birth on the pregnant body. The idea that the pregnant body must be physically trained for birth has been written about by Meredith Nash (2011) in the aptly named article, '"You don't train for a marathon by sitting on the couch": Performances of pregnancy "fitness" and "good" motherhood in Melbourne, Australia'. The idea that labour and birth take a toll on the body akin to running a marathon is one that equally circulates in popular culture in the UK. Nash argues that this disciplining is one of policing and regulation in a Foucauldian sense, as it is through exercise that women demonstrate that they are 'fit' to mother - both physically and socially. She argues that this physical working on the self is a continuation of pre-pregnancy adherence to social norms around 'feminine bodily discipline' (2011: 52) and ideals of body image, including weight management, particularly linked to class. She goes on,

> Adherence to a structured exercise regimen thus becomes a means by which pregnant women in the middle-classes in particular can uphold the appearance of a tightly managed, middle-class self, one is a good mother or a yummy mummy, an image of motherhood predicated on economic privilege, whiteness and bodily discipline (2011: 54).

Whilst I do not dispute Nash's analysis, the women I interviewed were exercising for an additional reason which is not made explicit in Nash's article, namely to achieve a particular form of birth. Nash's participants continued pre-pregnancy exercise such as running, swimming and gym work. In contrast, my participants did not talk a great deal about these conventional exercise forms - only one woman, mother of two Maria, mentioned going to the gym - instead preferring those practices encouraged within the natural birth milieu, and holistic milieu more generally, including yoga, Pilates and practising birth positions at home. Additional practices in which they engaged included massage, Reiki, reflexology, aromatherapy, homeopathy and acupuncture. The practices were engaged in primarily for facilitating the ideal natural birth and avoiding such 'profane signifiers' as induction.

The different courses and classes I observed all involved physical practices. Hypnobirthing and Active Birth have a two-fold mission to provide a positive philosophy of birth as well as a range of practical techniques which can assist in a more positive pregnancy and birth. In Active Birth, practical techniques take the form of yoga exercises whilst in Hypnobirthing, the practical techniques take the form of self-hypnosis for relaxation primarily through breathing exercises and guided visualisations. In both classes there was strong encouragement to practice and the women I interviewed certainly took this on board. Hypnobirthing: The Mongan Method teaches three breathing techniques: 'Sleep Breathing', 'Slow Breathing' and 'Birth Breathing' as well as visualisation and relaxation techniques. The Hypnobirthing book, and the teachers I interviewed and observed, encouraged women to listen to the foundational 'Rainbow Relaxation' every night to begin with and then at any time during the day such as when performing routine chores. Mother of three Bella, for instance, said, 'I was really focused on, I worked, I did the practice every night. Every night I lay on the couch and learnt how to put myself into deep relaxation and I could do it like that now (clicks fingers)'. She contrasted this to one of her other births - 'when I had O I didn't practice as diligently and I didn't find it as easy to snap myself into it, so obviously it's something that you need to keep practising repetitively'. When I asked Lucy, pregnant with her first child and who I had met on the Hypnobirthing course, what aspects she was practising, she said, 'I'm doing the Rainbow Relaxation, all the time, I love it. When I'm hoovering, whenever'. She also said, 'I'm doing a lot of the breathing too, all the time'. She went on, 'The surge breathing and birth

breathing are more difficult to practice, can practice them a bit in private. But with the sleep breathing I practice a lot'.

A couple of the participants suggested that the Hypnobirthing course's encouragement to practice was a source of some anxiety. Fern, pregnant with her second child, told me that 'you have to put quite a lot of practice in yourself at home' and 'so all the stuff that you're meant to do we were just not finding time to do it so I was getting a bit panicky, "I'm not practicing enough", but we have got quite into it a bit more now'. Chloe, pregnant with her first child and also met through the Hypnobirth course, also expressed some anxiety and coupled this with the need to 'train' discussed by Nash (2011). Chloe told me,

> We've been listening to the CD every night and I've been listening to the affirmations this week, um, but we're a bit behind on our homework I have to admit…I kind of feel like we're at the stage where we're on the home straight, this is where preparation's key really. It's like, preparing for a marathon, you train for a marathon so why wouldn't you train for childbirth?

Fifteen of the women interviewed also practised yoga. This was most often discussed as a combination of 'learning techniques to use during the birth' (Jane, mother of two) and 'all round getting your body kind of supple' (Fern, pregnant with second), with 'me-time', relaxation and having a 'nice stretch' (Jane). It was often a continuation of pre-pregnancy practice and its practice was more in line with the arguments made by Nash (2011) than the Hypnobirthing practices which had a more instrumental end goal. Historian of yoga, Suzanne Newcombe (2007), has traced the growth of yoga classes in the UK from the 1960s to 1980s. She attributes the growth partly to the infrastructural support of government-subsidised adult-education evening classes in which yoga was taught as a physical exercise akin to 'keep fit' and not as a spiritual exercise. Between 70-90 per cent of participants and teachers were women - and primarily middle class - in this period, she states, suggesting that its appeal lay in its simultaneous support of women's mothering identities with 'a more independent identity promoted by second-wave feminism' (2007: 37). 'Women typically attributed better physical health and emotional well-being to their practice of yoga and this was an important reason for their participation in the classes' (2007: 37). This is supported by the women I interviewed - yoga fulfilled numerous functions including physically preparing the body for birth, improving general physical health and relaxation.

Newcombe (2007: 37) also notes that 'yoga served as an important support for women becoming more aware of feelings of alienation from traditional biomedical practitioners'. The alienation from biomedical practitioners has been noted throughout this thesis, in the emphasis of women's own chosen experts from the private sphere. It is also emphasised in their use of 'complementary and alternative medicine' (CAM) practices. These were chosen largely for instrumental end-goals. Reflexology was the most popular CAM within my sample, with six women using it during their pregnancies. Both Trisha and Alice used reflexology when they were 'overdue' in an attempt to encourage labour 'naturally' and hence avoid induction. Lucy used it to ease water retention. Others used it simply for general health and relaxation (Jane, Jenny and Kim). Jane explained it as 'just a little treat for me'. Alice had used the same reflexologist when she was struggling to conceive. Chelsea, on the other hand, chose acupuncture when she struggled to conceive and experienced a miscarriage. She continued this practice into her next pregnancy in the belief that this could help prevent another miscarriage. Katie, herself a Reiki practitioner, saw a Reiki practitioner in order to help her conceive, as well as using Bach flower remedies, and then used a cranial-osteopath in order to help move her placenta from obstructing the cervix. Many of the women I interviewed also used these treatments during labour itself - at home before entering the hospital context. The popularity of these treatments within my sample shows the overlap between natural birth and the wider holistic milieu. It also shows a discourse of taking responsibility for one's own health outside of the mainstream medical context, in a more holistic and relational context. The physical practices in which the women were engaged shows that the ideals of natural birth are literally inscribed on the body.

***Emotional Work***

Whilst the physical exercises described above obviously and intentionally induce emotional responses (both yoga and Hypnobirth exercises explicitly encourage the woman to bond and communicate with her baby), natural birth literature and classes also encourage women to engage in what I term emotional exercises such as 'fear release' and 'positive affirmation' exercises. Some of the women I interviewed also found it necessary to take on additional 'emotional work' such as 'working through' family issues, dealing with emotional issues from a previous negative birth experience and from miscarriages and

struggles to conceive. Some of the women sought the help of professional counsellors in dealing with these issues, some sought the help of birth workers - doulas in particular advertise their work as including emotional support for the mother - and others worked through the issues with their partners or alone.

Positive affirmations - literally brief positive statements which are repeated frequently and preferably out loud - are one of the key practices of Hypnobirthing. *HypnoBirthing* lists around 30 examples 'that should be listened to or read daily, especially during the last couple of months of pregnancy' (Mongan 2009: 160-1). Examples include, 'I put all fear aside as I prepare for the birth of my baby', 'I am focused on a smooth, easy birth' and 'I trust my body, and I follow its lead' (2009: 160). Mongan ends the list with the statement, 'Your birthing will unfold exactly as you see it now. You have defined it in this way, and your birthing will happen as you have defined it' (2009: 161). For Claire, owner of the antenatal organisation Birth Sense, which ran the Hypnobirth classes through Bambino's, the power of positive thinking was key to both her own births and the Hypnobirth classes which she ran. She explained that her previous career in marketing and advertising had a similar ethos (perhaps accounting for the more 'instrumental' nature of this quotation), 'it's all about using language to make people feel a certain way, manipulating people's emotions and evoking particular responses'.

Amongst the women I interviewed who practiced Hypnobirthing, some found the positive affirmations useful and others did not. Lucy, for instance, pregnant with her first child, thought the positive affirmations were 'a bit silly and very American', whilst Chloe, also pregnant with her first child, said that she understood how the positive affirmations worked through repetition as she had previously done an 'Allan Carr's easy way to give up smoking' course, which was similar. Mandy, the teacher on the course I observed, encouraged us to think of the rather American and explicitly spiritual aspects of Mongan's Hypnobirthing book namely, the 'parent's prayer' and 'daddy's promise', just as other positive affirmations, in a bid to make them more in line with the other teachings and practices. Mother of two, Kim, clearly found the positive affirmations useful in preparing for her second birth:

> I thought, 'right, I've got to get myself mentally prepared'. I thought I was but obviously not. So I listened to a few Hypnobirthing CDs, I thought, 'better late than never', spoke to

> people, put affirmations up all over the place and it worked, definitely, I was in a much better state of mind. It's funny cos I automatically thought I'd be fine cos I'd done it before and I was all prepared, you know, intellectually everything was in order cos he was breech and I was still planning the home birth and everything was in order with everything at home that I needed, but um, emotionally I wasn't ready.

Another central practice of Hypnobirthing is 'fear release' exercises. Extending Dick-Read's 'fear-tension-pain' teaching, Mongan (2009: 47) argues that any fears and negative emotions can impact the birthing process:

> It's helpful for both you and your partner to be able to identify feelings, experiences or recollections that may be painful or hurtful, thus limiting your ability to approach birthing free of harmful emotions. Take a look at those emotions that may foster a feeling of uneasiness, meet them head-on and release any conflict you may be harbouring (consciously or subconsciously) because of them.

She lists areas to examine which are not only birth-related but include 'marriage/ relationship', 'career', 'housing', 'finances' and more. On the course I observed, the homework at the end of session two was to prepare the 'fear and release scripts' which would be the focus of session three. During this session, Mandy took us on a 'deep relaxation' in which we visualised flicking through a book of our lives consisting of images of past events. At any event which had a negative emotional association, we were told to tear out the page and watch the colours of the image fade away until it became a blank white page. This was repeated until we had a pile of crumpled white pages next to us which we then placed down a chute into a fire, watching the pages turn to grey ash and the ash rising up to meet us. Presumably, the expectant couples had already planned what would be on their pages if they had completed their 'homework'.

Another fear release exercise, used both in Hypnobirthing and by other birth-workers, encourages the expectant woman to mentally run through the birth. Any aspects which are hard to visualise could indicate a particular fear, it is suggested. Mother of one, Amy, described this practice to me:

> I started to think a lot about the birth, I think everyone gets to that stage when they get worried and start asking questions, so (doula) said, 'why don't you go through the birth in your mind and just be aware if there are any bits you can't picture or you can't face, whatever, cos that will indicate you've got a fear there, maybe a block that you need to have a look at'. And there were certain points that I didn't want to face and I knew that I had to face up to them because I think there are two approaches, you can either go in and say, 'I'm just going to go with it and see what happens' or go in totally prepared for every eventuality and I was the latter. So I was going through this in my mind, visualisations and relaxations and just noting down things that were wrong.

Ideas around the 'power of positive thinking' are central to the 'self-improvement' branch of the holistic milieu and abound in the therapeutic cultures which have developed since the 1960s onwards. However, such ideas have longer antecedents and can be traced back to the New Thought movement of the early nineteenth century. Phineas Quimby (1802-1866) is frequently cited as one of the first proponents of the idea that health and illness are predominantly matters of the mind. As an early practitioner of mesmerism, which became known as hypnotism, there is a direct link between Quimby and Hypnobirthing.

The practices of positive affirmation and visualisations have become somewhat mainstream following the 'subjective turn' (Heelas and Woodhead 2005). Some of the women I interviewed engaged in more explicitly spiritual practices, such as Amy's practice of 'Shamanic journeying'. The practice of Shamanic journeying involves entering another reality, a higher consciousness, through a trance state. Amy, whose fear release practice was described above, contacted the Australia-based School of Shamanic Midwifery for further advice on facing her birth fears. She received a number of practical suggestions to help with her journeying including asking to 'meet the spirit or soul which was going to be my child in order to discuss the issue with them' and to 'gather a birth bag of objects and images representing the emotions that I would need for the birth'. Both of these practices helped Amy with relaxation in the run up to and during her birth and she spoke of the pregnancy and birth as a 'journey' for both herself and her son multiple times. She linked this to a spiritual experience in which she had a vision of power during the birth. The 'vision' was suggested to her by the School and was aided by the birth bag, through which she was getting 'help', 'reassurance and assistance'.

Other women I interviewed sought counselling for issues related to previous births, miscarriages, struggles to conceive and post-natal depression. Some spoke of a fear of birth and/or a fear of hospitals or needles. They spoke about receiving counselling as something necessary for them in order to have a positive pregnancy and birth experience this time around. Fern, for instance, who was pregnant with her second child at the time of the interview, had experienced post-natal depression after her first birth and saw a specialist counsellor. She went back to this counsellor after she experienced a subsequent miscarriage and further struggles to conceive, and it was through this counsellor that she

found out about Hypnobirthing and Bambino's. Jane too, who had just had her second child at the time of the interview, also saw the Bambino's counsellor to help with various issues when she was pregnant:

> I wanted to clear up issues from previous pregnancy and birth before I had her, I wanted to talk through the breastfeeding, and I'd had an early miscarriage just before getting pregnant with her, so we talked through that and we talked through, I was a bit scared about how I was going to cope with two, so yeah I had two sessions with her to talk things through.

Catherine, who was pregnant with her third child at the time of the interview, explained to me that she felt particularly 'emotionally vulnerable' during pregnancy and used it as a time to do 'head work' and to think about family issues. She explained:

> I kind of feel like in each pregnancy I end up with work to do, head work to do... I always learn a heck of a lot about myself… we (herself and partner) both end up thinking about things and learning about things and going off and reading things. One of the things that came out with this pregnancy…I hadn't realised there would come a point where I started looking at people in my life, in my family and my extended world and working out who was going to be there for me and who was not and some of the people I really wanted to be there for me, either couldn't or wouldn't be.

She justified this 'head work' as, 'trying to learn more about the stuff that was upsetting me'. Annie engaged in a similar practice after the birth of her daughter in the USA.

> I started doing some research and I started doing some looking. Actually I started doing a lot of research for a long time. I researched for a lot of years and thought about it and talked to people and I talked to a counsellor and I saw, you know I went and saw a midwife to talk through my experience and did a lot of processing with that.

In line with the other pregnancy and birth practices with which the women I interviewed were engaged, these women sought counselling in the private sphere and on their own initiatives as part of their preparations for their next pregnancies and births. This was part of their 'work' to be emotionally and mentally prepared to be the best possible mothers. Presented simultaneously as part of their 'lifelong learning' about birth (Klassen 2001: 136) and more instrumentally as preparation for this particular birth, these practices of the emotions seem to work partly just through the time investment in preparation. They work because they are work. Through investing time in preparing themselves emotionally for birth, the women seemed to find positive meanings in the work of preparation.

***Intellectual Work***

A number of women discussed the importance of the 'mental' aspect of birth, and the importance of preparing yourself mentally, including through the emotional work discussed above. Many of my participants, however, described a different or additional kind of mental preparation - the need to research and educate themselves about birth choices and processes. This was especially emphasised for those choosing home birth, perhaps because home birth requires an additional form of accountability in contemporary UK culture. This mental preparation largely took the intellectual form of reading, following the ideas of self-improvement through education also discussed in Chapter Four. Reading materials included the natural birth manuals discussed throughout this thesis (in particular the work of Dick-Read as providing the philosophical basis of both NCT and Hypnobirthing), more 'mainstream' pregnancy and birth books such as *What To Expect When You're Expecting* (Murkoff and Mazel 2008), and websites, social media sites and apps. The interview narratives abound with talk of 'Googling' as a first port of call for information. These practices contribute to natural birth as a classed project, as they require sufficient levels of education and access to materials, both online or physical, to engage in the necessary 'research'. Anthropologist Sallie Han (2013: 39), in her ethnography of 'ordinary pregnancy', notes 'The fact that women in my study not only read so much, but that they also generally responded so positively to their reading is revealing of their status as educated, middle-class American women, most of them married and most of them white'. The same can be said of my (mostly) British participants.

Many of my participants directly invoked a narrative of 'research' describing and approaching their births as something of a 'research project'. American mother of two, Annie, actually described herself as a 'research-based parent' and used the term research 29 times in the interview. Mother of two, Jane, told me, 'I know that doing research is a good thing'. Whilst Jenny, pregnant with her second child, told me, 'There's a saying I think on Facebook which is, "a concerned mother does more research than the FBI"'. She went on (in conversation also with mother of three, Shannon, who I interviewed at the same time), 'and it's true cos we're all research mad aren't we? We ask questions and we refer each other to articles and stuff'. The sharing of materials is something which happens a great deal on social media and many of my participants engaged in this practice, partly in

their mission to 'educate' others. The sharing of materials also reinforces socialisation into the natural birth milieu and contributes to the creation of 'local mothering cultures'.

Macy, for instance, when I asked what advice she had for pregnant women, said 'I would just say, do all the work that I did, all that research'. Macy here explicitly uses the terms both work and research. Mother of three, Bella, also explained that she did a lot of research after her first birth:

> I researched birth, I researched everything I could about birth experiences and I read other people's birth stories cos I had such an experience with (first child) that I walked away feeling like I'd been hit with a mallet…So I had that combination of learning all the Hypnobirthing stuff and at the same time at work, I was reading everything on the home birth website and everything on every website I could possibly find, still going to the NHS appointments but making a bit of a nuisance of myself this time round.

This resonates with Klassen's (2001: 136) statement that 'women see childbirth as part of a lifelong process of seeking and learning'. Annie also spent time researching childbirth after her negative first birth experience, as mentioned above, despite that she was not pregnant nor intending to be at that point in time. She said that a few years after her daughter was born, she wondered why she was still feeling so much guilt and failure around the birth and she 'started doing some research'. 'I started doing a lot of research for a long time, I researched for a lot of years'. Mother of two and doula, Vivianne, also explained that she started her research before she was pregnant. 'It took me about two years to get pregnant with my first child and in that time I was very interested in parenting and birth and did lots of research and stuff'. Again this expresses middle-class and middle-aged women's anxieties about the need to prepare for 'responsible' motherhood and supports Thomson et al.'s (2011: 13) findings that women in a middle age group defined their pregnancy and birth experiences as 'effective biographical planning'. Dow (2013) too has described the ways in which the women she interviewed spoke of the need to build a 'stable environment' before they became parents. 'All agreed that the first steps in becoming a parent should be to plan and get everything ready' (2013: 36). Furthermore, the stable environment, Dow suggests, is 'an ethical concept that condenses gendered and classed ideals of good parenting' (2013: 36).

The women I interviewed spoke a great deal about home birth websites and support groups. Vivianne voiced the idea that 'if you have a home birth, to be honest you've

probably researched things a lot more than anybody else has'. This idea was explained more fully by a doula, Marilyn, who described a common view amongst my participants that engaging in a great deal of research in preparation for a home birth leads to a more positive birth experience, regardless of whether the home birth is actually achieved:

> I think that's why women who plan a home birth, even for that proportion of women who end up having their babies in hospital, the fact that they've planned their home birth has meant that they're more informed, more empowered, more in control and when they change environment from home to hospital, that being in control of the situation carries on, they're more able to make sure that they get the information that they need. Because planning a home birth empowers you.

The idea of birth as a research project has been written about by other scholars, including Thomson et al. (2011) and Malacrida and Boulton (2013). Thomson et al. (2011: 243) write that within their sample, categorised into three age groups, it was the older mothers (aged 36 and over) who 'tended to undertake serious research when planning the birth, were often sympathetic towards natural birth literature and were most likely to plan for home births'. This is true of my sample too, despite them not all falling into this age group. Malacrida and Boulton focus on the disjunctions between women's birth plans and their subsequent lived experiences, critiquing both medical and natural perspectives on birth which give a false sense of women's ability to choose. They argue that in both perspectives, '…women are charged with - and themselves take up - the responsibility of making informed and conscientious birthing choices through engaging in "reflexive modernity", characterised by collecting information about, understanding and evaluating risks…' (2013: 5). They take particular issue with the practice of writing 'birth plans' as offering a false sense of choice. I will return to this discussion below.

Han (2013) has written a more sympathetic account of the role of research in pregnancy in describing pregnancy as a 'literacy event'. In her focus on 'ordinary pregnancy' in the USA, she writes that pregnancy is marked by literacy and consumption (2013: 7). She argues for another perspective to the feminist critique of pregnancy and birth literature as controlling and disciplining, suggesting that linguistic anthropology offers such a perspective. Han argues that 'literacy' includes much more than reading and writing conventional texts and she includes such practices as 'reading' pregnancy tests, fertility charts and ultrasounds; attending birth classes; and talking to the baby *in utero.* She argues that literacy is considered 'more expansively as a process of interpretation' and that the

'importance and meaning' of pregnancy is 'shaped and influenced by literacy practices' (2013: 24). Han hence focuses on the meanings of the ordinary and everyday experience of pregnancy. She writes that, 'the approach I take here both builds upon and departs from previous readings of women and advice literature, which has emphasised the policing of women…In contrast, I argue…that literacy is how pregnant women themselves come to make sense and meaning of their lived experience' (2013: 31). Han goes on to give insightful descriptive analysis of pregnant women's literacy practices and her focus on meaning-making aligns with my own. However, Han does not analyse different forms of advice manuals and the forms of knowledge suggested therein.

***Scientisation***

My participants utilised numerous different resources for their research from books to leaflets to websites, social media, apps and physical support groups. They had a preference for materials in line with 'natural' birth approaches, particularly Hypnobirthing and home birth resources. They had a preference for sources outside of the 'mainstream' medical approach, seeking to supplement the scant information received from GPs and midwives with information they sourced themselves, through their support networks and through their self-selected experts. However, when discussing their research with me, many were keen to stress their preference for 'medical', 'scientific' or 'evidence-based' materials. Mother of two, Annie, for instance said, 'I think I would have to say that our house is a bit sceptical and if there's not research backing it up we tend to think it's a little silly'. She used this argument to justify her practice of aromatherapy whilst discounting reflexology as having no supporting research as to its benefit. Jenny stressed that the articles she and her friends shared were 'all medical based, it's not all airy-fairy' (with the recognition that some of it was 'airy-fairy' and that she was fine with that; 'I mean I'm a very practical, logical person and I research stuff but I am open to kind of use the term, alternative, it's just alternative cos people don't look into it, they do the standard'). It should also be noted that I did not have the sense that the women were trying to impress me, as 'the academic', with their scientific knowledge. As discussed in Chapter Three, it was clear that I shared their middle-class habitus and I was treated as an equal. I did not have the sense that the interview was a great deal different to the conversations that happen in circles of friendship based on mothering or in mother and baby groups of various kinds.

Arguments about the primacy of scientific or evidence-based practice were particularly made with regard to Hypnobirthing. Two of the Hypnobirth teachers I interviewed emphasised that there was no critical information about Hypnobirthing to be found online. Claire said:

> I read about Hypnobirthing and thought that sounds interesting. But I'm a natural sceptic so I looked for stuff, as natural sceptics do, I've seen all the good stuff, all the propaganda, as a marketing person I understand how this works, so I went looking for the negative. I couldn't find anything which was interesting cos normally you'll find 'this is a bunch of crap'.

Whilst Martha made a very similar argument:

> I didn't want to commit to something too hippy, alternative, I wanted to go with something that was more anthropological, so that's always been my interest is science, which is why I'm always quite cocky when it comes to 'oh my husband's sceptical'. 'Whatever'. Cos I know that everything I teach is guided by the best science that I have available.

Authors within the field of parenting culture studies have discussed the primacy of scientific claims within both government policies and parent's own accountability strategies as the 'scientisation' of parenting. Lowe, Lee and Macvarish (2015) have focused on the utilisation of neuroscience theories in early years intervention and in 'expert' advice to parents. They argue that recent 'brain claims' that emphasise the 'extreme vulnerability' of babies and children's brains to parental influence 'concretize' 'ideas of parental determinism' (2015: 198). Drawing on the work of Furedi (2001) they argue that childhood in contemporary western cultures is safer than ever and yet parents are deemed to be both solely responsible and yet inadequate in caring for their children. This argument, which informs current government policies in the UK, utilises particular interpretations of neuroscience which argue that parents are responsible for the very core of the child's being, their brain development, and hence of their socioeconomic status as adults. It simultaneously denies the personhood of the child, they suggest. This 'hiding behind babies' brains' is also 'an abdication by adult society of its responsibility for deciding how children should be socialised' (Macvarish 2016: 15). Macvarish (2016) has termed this 'neuroparenting'. She describes neuroparenting as

> a way of thinking which claims that 'we now know' (and by implication, once and for all) how children ought to be raised. The basis for this final achievement of certainty regarding child-rearing is said to be discoveries made through neuroscience about the development of the human brain, in particular, during infancy (2016: 1).

The ‘oughts’ of ‘good parenting’, in the neuroparenting argument, are ‘the norms of highly attentive maternal care and the presumption that the early years last forever’ (2016: 15). However, the requirements of neuroparenting, such as making eye contact with and talking, singing and reading to babies, Macvarish (2016: 9) suggests, are ‘pretty banal repetitions of all contemporary parenting advice in its most generalised form’.

Neuroparenting rests on the presupposition that infancy is a ‘critical period’, a ‘window of opportunity’, in the argument that ‘the first years last for ever’ (Macvarish 2016: 6). The ‘critical period’ is deemed to be variously until the child’s first, second, third or fifth birthday (2016: 2), but most often three years, represented in ‘the first three years movement’ (Macvarish 2016: 6). This argument of a ‘critical period’ finds parallels in the natural birth manuals discussed in Chapter One, particularly the writings of Michel Odent who focuses on the impact of birth on ‘primal health’. Odent (1986) argues that the period between conception and a child’s first birthday has a critical impact on life long health. The NCT has also taken such ideas on board in their ‘first 1000 days’ focus with online material stating that ‘Leading child health experts worldwide agree that care given during the First 1,000 Days has more influence on a child’s future than any other time in their life’.[2]

The policy focus on neuroscience has led to the continual surveillance and monitoring of parents which is also internalised in the construction of accountability strategies and identity work to legitimate parenting choices (Lee et al. 2014: 2-3). This is Faircloth’s (2013) focus with regard to full-term breastfeeding and attachment parenting more generally. She argues that ‘attachment mothers use the term “science” to refer to evidence derived from physiological and psychological studies concerning developmental and health benefits of full-term breastfeeding and attachment parenting’ (2013: 144). My participants also did this with regard to natural birth, Hypnobirth and the attachment practices in which they engaged (including full-term breastfeeding and co-sleeping). She goes on to note that ‘it is ironic that the women here use science as one of their accountability strategies, since many attachment parenting advocates are openly sceptical about scientific knowledge’ (2013: 145). Like my interviewees, and Klassen’s (2001) home birthing

[2] https://www.nct.org.uk/about-nct/first-1000-days

women who inhabit ‘post-biomedical bodies’, Faircloth’s selectively used ‘scientific evidence to support certain (moral) discourses about parenting’ (2013: 145). As Macvarish (2016: 41) writes, ‘Neuroparenting relies on the authority of nature as providing an eternal, universal, cultureless blueprint for child-rearing but also on the authority of science, as nature’s modern interpreter’.

Faircloth argues that science has become the new dogma. Its use to justify parenting practices ‘has the effect of shutting down debate’ (2013: 153) because, she suggests, many people find it difficult to argue with a government paper which says that a particular practice has been shown by ‘science’ to be best or healthiest for a baby. Furthermore, Macvarish (2016: 21) writes, ‘To claim that “we now know” how babies should be cared for because “the science says” is therefore fundamentally unscientific’ (because the scientific method is that ‘truth’ will be ‘continually tested, developed and probably eventually overturned’). ‘Science’ is viewed as the best currency through which to defend alternative ideas, despite their operation in different fields of logic. Such ideas implicitly circulate in my interviewee’s arguments about natural birth and the need to educate others. For, they assume, once someone has been told that a natural birth is best for baby, how can they desire anything else? As Faircloth (2013: 153) suggests, there becomes no distinction between description and prescription. The issue of prescription - what ought to be - will be returned to below in discussion of pregnancy practices as ritualisations. First, I turn to the birth plan as the epitome of the ‘research project’.

***Birth Plans***

The practice of writing a ‘birth plan’ in which the woman’s (or couple’s) hopes and desires for birth are conveyed to her medical carers has its roots in the grassroots, consumer movements of the 1960s and 70s most associated with natural birth, including the National Childbirth Trust, the Association for Improvements in Maternity Services and the Association of Radical Midwives. In the contemporary UK, birth plans are now commonplace, with the NHS encouraging the completion of such a document, providing space for ‘birth notes’ in the ‘maternity record’ which women carry with them to all appointments. An online search for ‘birth plans’ yields more than three million results, many of which take the form of downloadable templates from various commercial

websites such as Bounty, Cow and Gate, and Baby Centre to name but a few. The relevant NHS webpage provides the option to create an online plan which takes the form of tick boxes around various issues such as place of birth, birth companion, use of birthing equipment and complications.[3] The NCT website provides a range of birth plan templates for different birth choices including home birth, hospital birth, planned caesarean and VBAC. Participants on the Hypnobirthing Mongan Method course receive copies of the 'birth preference sheets' which are also found in the Hypnobirthing book (2009: 220-226). These also take the form of tick boxes, in this case around the different stages of labour. The statement, 'We request: The patience and understanding of caregivers to support our wish to refrain from having any practice or procedures that, in the absence of medical urgency, could unnecessarily stand in the way of our having the most natural birth possible', is repeated three times in these six pages.

In the contemporary UK, the NHS creates the expectation that women will complete a birth plan and the onus of responsibility is on pregnant women to 'research' their birth preferences. The webpage mentioned above states, 'Before you start to fill in the plan below, get informed about the topics you'll need to consider'. The majority of women I interviewed did complete a birth plan and a couple of participants also sent me copies for my information. Most of the participants described their plans as 'simple' and 'flexible'. They were indicative of the 'keeping options open' idea discussed in Chapter Five. Amy said that her birth plan 'got shorter and shorter as the time approached'. This is in line with Thomson et al.'s (2011: 63) statement that,

> As a testament to the medicalisation of pregnancy in the West, the birth plan exists as a document of negotiation, encouraging women to think about what kind of medical encounter they would like during labour. In the birth plan matters of pain relief, type of birth and birthing partner offer women preparatory moments of 'choice' within a medical framework.

Amongst the women I interviewed, birth plans focused on the 'profane signifiers' discussed in Chapter Four whereby induction was placed as an absolute last resort along with, for some, various means of pharmaceutical pain relief, such as morphine based injections and epidurals. Many women stated that they had requested, through their birth plans, that such drugs were not to be offered - the woman would ask if she required it. Fern felt that this backfired in her first birth however when she found that she did want an

[3] http://www.nhs.uk/conditions/pregnancy-and-baby/pages/birth-plan.aspx

epidural and the midwife was loathe to transfer her from the birth centre to labour ward where one could be administered. More positive preferences focused on such issues as the birth environment, active labour and upright birth positions, physiological third stage of labour for some, and practices after the birth including delayed cord clamping, immediate skin to skin contact and the establishment of breastfeeding.

In line with the idea of the birth plan as part of the 'cognitive' or 'intellectual' work in which some women engage, some of my participants spoke about collecting research papers to add into their birth plans. Mother of two Macy, for instance, looked at natural caesareans for her second delivery. She described finding a research paper by Professor Nicholas Fisk, pioneer of natural caesareans - 'I pulled out his paper and put it into my birth plan'. Mother of two Trisha joked about how her collection of research papers might have detracted from her birth plan:

> No-one paid any attention to my birth plan (laughs). I'm not even sure they read the right thing because I had my birth plan but you know I said to you I'd done loads of research on uterine ruptures and stuff, I had loads of stuff that I'd printed off and whatever, and I think that might have been hanging around and they read that instead (laughs). Like, what is this? (laughing) and didn't really pay any attention to it.

In general, the women I interviewed expected that their birth plans would be read and respected. Linda for instance said, 'my birth plan, how I'd written it, if you tell a midwife that is how you want it, as long as you're not putting yourself or your baby in clinical danger, then they are happy to go with your wishes.' Whilst Elly said, 'I did feel listened to, I felt like people read it, it didn't feel like it was there and had been shoved in the folder and wasn't looked at, they kind of had everything out, you could see she had all my notes.' My participants unanimously found the writing of a birth plan useful as an exercise in crystallising their own preferences - as the manifestation of the 'research project'. Linda explained that she and her husband found writing the plan together 'enjoyable' and that through it she was expressing that she felt 'liberated to make a choice' - 'this is how I want to choose to have my birth'.

However, not all of the women felt that their birth plans were respected. Indeed those consumer groups who were instrumental in developing the 'birth plan' as a practice, have long recognised its contradictory nature. The presentation of a birth plan to an unknown midwife on arrival at hospital can mark one as a 'troublemaker', one not inclined to listen

to authority and so can actually contribute to less support and encouragement from medical carers and a greater chance of intervention.[4] A controversy which played out on social media in November 2017 saw doctors move from discussing a research paper about the effectiveness of birth plans to joking about and mocking birthing women, with one writing 'the bigger the plan, the bigger the caesarean cut' and another writing 'laminated birth plans are helpful only in the case of massive haemorrhage'.[5] This caused an uproar on many natural and positive birth pages with calls for letters to be written to the General Medical Council. Milli Hill, founder of The Positive Birth Movement and author of *The Positive Birth Book* (2017), which advocates a visual birth plan, wrote that it is precisely because of comments such as these that birth plans are needed, to ensure that women have a voice in the very unequal power relationship of the hospital birthing room. She wrote, 'making a birth plan is not about the plan itself as much as the process which is helpful to ALL women in ALL circumstances - the process of getting informed, learning about your options and rights in every eventuality, and being clear about what you want' (emphasis in original).[6]

Those women who had been slightly more forthright in their plans, or who had drawn more on Hypnobirthing, reported less positive receptions of their plans (although this might be a question of perception - they had invested more in their plans and were more sensitive to their reception perhaps). Lucy for instance, who was pregnant with her first child, said

> One midwife did laugh at my birth plan which I felt a bit put out by. Because I'd put on it, no pushing. And she said, 'are you a first time mum?' and I said 'yeah', and she said, 'how do you think the baby will come out?' And I just went 'hmm', but I meant no directed pushing, no-one shouting at me, 'push, push', cos I would hate that.

The avoidance of this 'valsalva' form of pushing - and indeed of the term 'pushing' in general - is something that is encouraged in Hypnobirthing and was repeated in many of the interview narratives. Similarly, mother of one Emily, talking about her midwife said,

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[4] This according to Beverley Beech (head of AIMS) writing in the AIMs Journal 2011, vol 23, no 2. Online at http://aims.org.uk/Journal/Vol23No2/challengingmedicalisation.htm

[5] The Positive Birth Movement Facebook post, 14th November 2017 - https://www.facebook.com/positivebirthmovement/posts/1450318828409642

[6] The Positive Birth Movement Facebook post, 14th November 2017 - https://www.facebook.com/positivebirthmovement/posts/1450318828409642

> I didn't really like her anyway because she said, 'oh I've read your birth plan and ok, fine'. And my birth plan wasn't really controversial, you know I'd written it quite simply and you know I'd just said, 'I'm going to be using Hypnobirth techniques, respect that, but we respect that you need to do your job as well'. But she didn't really, you could tell that she didn't buy into it, thought I was a bit naive.

Mother of two, Maddie, analysed the 'mismatch' between consumer groups' suggestions and the realities of the NHS; 'the NCT were very vocal about having a birth plan written out, but in the hospital it's very dismissive so again its like a miscommunication between one sector and another'. Maddie was one of few women who suggested that the private antenatal course she had chosen might have given her false expectations about birth. The majority of women I interviewed defended their antenatal choices and placed any blame for a mismatch of their desires and experiences either directly on the NHS and its staff or more vaguely on the circumstances of the day. This will be returned to below.

The interview narratives did not convey a great sense of feelings of guilt and disappointment caused by the creation of false hope through the birth plan as some have argued. Malacrida and Boulton (2013: 1), for instance, argue not only that there is a 'disjuncture' between women's 'expectations of choosing, planning and achieving as natural a birth as possible' and their 'lived experiences of births that did not typically go to plan', but also that the creation of a birth plan directly contributes to this disjuncture. They suggest that one mother's sense of failure after a natural birth was not realised was partly attributable to 'having a Birth Plan that promised her a false sense of control and certainty, yet failed to provide any real guarantees in the actual event' (2013: 13). With regard to another mother they write, 'her experience further highlights how a Birth Plan can provide women with a heightened sense of individual responsibility in relation to childbirth, leaving women with a feeling of failed in their birth expectations and in their actual births' (2013: 13-14). Whilst I do not dispute Malacrida and Boulton's findings, I suggest that through a different theoretical frame and perhaps a different sample and different questions, we can arrive at different findings in relation to birth plans and desires for natural birth. I suggest that the majority of women interviewed, albeit selected on their basis of an interest in natural birth, placed a positive value on the creation of the birth plan, as a useful practice in and of itself, regardless of birth outcome. The practice of creating a birth plan is a manifestation of the pregnant woman's research and her intellectual work. They are seen as a useful exercise in research and decision making and, as such, are an

embodiment of the negotiation between the ideal and the practical - a written out thinking about the balance. Through the plan, the woman negotiates her path towards the ideal natural birth.

Han's (2013) argument about the need for an alternative perspective to the feminist critique of birth is again relevant here. As Han argues in her analysis of birth as a literacy event, (American, middle class, white) women find meaning in the reading, collection and analysis of written materials. She suggests that much feminist critique of birth focuses on the 'policing' of women through advice literature, on 'how others impose their expectations and experiences on women' (2013: 31). The policing focus might explain women's participation in the reading of advice literature and the creation of a birth plan as a burden of responsibility, fulfilled due to societal expectations and pressures. It cannot, I argue, adequately explain women's critical engagement with such materials and practices and the meanings they seem to find in the collation of such materials and their discussions with others. Han (2013: 31) claims, in an argument I find more convincing and which my narratives seem to support, that 'literacy is how pregnant women themselves come to make sense and meaning of their lived experience'. Interestingly, although she includes a wide range of literacy practices in her chapter, she does not include the creation of a birth plan. My participants suggested that the collection and creation of written materials was a positive experience and a source of meaning-making. In a quotation which highlights the striving for a 'nicer' experience epitomised in the title of this thesis, mother of two Davina, told me

> They gave us a booklet that we had to take to the hospital, you know that package of notes that you carry around like your Bible everywhere, um, and the first time I even took it out of that horrible plastic wallet and I put it in a pink plastic wallet cos I thought it was nicer to carry around and I had all sorts of old gumph in there that I used to pick up and think, 'oh this is a really good idea, I'll put that in there'.

Davina valued her pregnancy notes as something much more than an instrumental medical record. The Biblical metaphor (which some women also applied to the Hypnobirthing materials) is an indicator of the significance of the document. She felt that her medical record necessitated special care and an appropriate aesthetic. The quotation suggests that she found meaning in this practice.

***Other Tactical Activities***

Malacrida and Boulton (2013: 9) include the creation of a birth plan, alongside hiring a doula, and choosing a birth centre as 'strategies' women utilise to 'maximise the potential for a natural birth'. However, their focus on the 'controlling' and 'oppressive' discourse of natural birth neglects the meanings which the women I interviewed found in such strategies, expressed in the positive descriptions of their activities and their adherence to the natural birth ideal in later births. The women described numerous tactical activities in which they engaged, often in collaboration with a 'birth worker' or sometimes an NHS midwife, in a practice of negotiation. I use the term 'tactical' over 'strategies' here to emphasise their coming from a place of powerlessness, of 'other', into the authority of the medical environment (De Certeau 1984: xix). This also has resonances with Woodhead's (2012a) use of the term 'tactical religion' to emphasise the different modes of power at play in different spaces and times. Tactical religion, she suggests, challenges and subverts in order to re-enchant the 'mundane and unworthy' (2012a: 8). In a similar vein, my participants described ways in which their tactical activities were central practices in their path towards the ideal birth, challenging and subverting medical authority. The women relinquished what they considered as small battles with medical authorities in order to win bigger and more important battles. As in the creation of the birth plan, it was the women's intellectual work in the form of research which substantiated the tactical activity, not least decisions as to which battles could be relinquished and which fought.

Some of the tactical activity discussed in the interview narratives concerned the profane signifier of induction. As explained, all of the women sought to avoid induction and used various tactical means to avoid this. Amy said that the consultant wanted to induce her but she and her husband wanted to 'use yoga' to 'try and get this moving on our own'. She told me, 'the consultant really wasn't happy, you could see it in her face'. The consultant asked if she could give Amy a 'sweep' and Amy agreed so that the consultant would leave them alone. Amy felt that if she submitted to a smaller medical intervention, which she still did not want, she would gain more time and so maximise the chances of having the birth she wanted. Jenny and Shannon, who I interviewed together, as well as Vivianne, interviewed separately, all justified their agreements to sweeps as 'the lesser of two evils'. Some of the women agreed to different interventions in order to avoid instrumental births. Maddie for

instance told me ‘the threat of ventouse or forceps made me agree to the stirrups’. In these cases, there is a negotiation of practice based on a hierarchical valuing of different forms of birth - sweeps were ranked not as ‘bad’ as induction, using stirrups - and hence a non-assisted vaginal delivery - not as ‘bad’ as an instrumental delivery.

Some of the women’s justifications for choosing a home birth invoked a narrative of tactical activity; they chose home birth because they thought they would receive better care. Other women reported that they laboured at home as long as they felt able in order to avoid medical interventions. Laura for instance said, ‘The reason I stayed at home longer as well was cos I didn’t want to be put on a monitor at the hospital and like then not be able to move around’. Other women reported that they had changed hospitals as they had learnt about higher standards of care elsewhere to where they were registered. Trisha told me how she changed hospitals for her second birth and then managed to get a place in the birth centre with the help of a sympathetic midwife (which would not normally be an option for a ‘high risk’ mother, like Trisha, who had had a previous caesarean).

> So what I did was I changed hospitals and I booked into (name) hospital cos I’d heard much better things about that and I fought to get into the birth centre and at first they weren’t very happy about it and I brought it up with one of my midwives at an appointment and she very loudly and very clearly said, ‘no that’s against hospital policy’. She got up and shut the door and said, ‘if that’s what you want to do, I’ll get you in to see this consultant, he’s likely to be the most sympathetic’. So there was this big public show, ‘no you can’t do that’, and then very quietly saying, ‘look, we’ll try and work this out but you’ve got to convince this guy’.

Whilst this tactical activity was successful for Trisha, she still felt ‘very angry’ that she ‘had to jump through all these hoops’. Her story also illustrates the power dynamics at play in such tactical activity. The midwife ostensibly has less power than the consultant - only he can approve the entry to the birth centre - but the midwife knows how to manipulate the ‘system’ in order to help Trisha achieve her desires. Trisha, with no power in the consulting room, needs the support of the midwife as she would not be able to negotiate the system alone. Trisha however, reported a sense of empowerment derived from her research: ‘So I went anyway and did all this research and I went in to see this consultant armed with three pages of A4 notes’. The consultant ‘reluctantly signed it off’ and Trisha became ‘a bit of a celebrity in the hospital’. Trisha’s research, birth plan and tactical activity were negotiated practices which were steps on the path towards her ideal birth and as such contributed to meaning-making during the experience of pregnancy.

**Practice as Ritualisation**

Whilst I have broken down the concept of practice into components for analysis, it should be noted that this division is not an entirely accurate representation of how the women I interviewed spoke about practice. They did describe different elements of their pregnancy and birth practices, including describing physical, emotional and mental 'work', but they also recognised that their work was a holistic exercise engaging the body, mind and emotions simultaneously. No aspect should be neglected in preparing for the ideal, natural birth, it was suggested. The women I interviewed hence conveyed two different meanings of practice. They suggested that the practices must be engaged in regularly throughout pregnancy - that it is the repetition of the practices which is important in preparing body and mind for the ideal natural birth. In theoretical terms, these practices are techniques of the body, the practice of which inscribes the ideal birth on the body. The quotations used above, particularly those that discuss women's anxieties over whether they are practising enough, and doing their 'homework', convey this idea. So too does Jane's statement with regard to Hypnobirthing, 'I knew that the way it worked was through practice, that was the core way it worked. Through reading the book and talking to them I thought, "No, I need to practice, this is the secret to it, I need to practice it" and that is how it worked'. The women suggested that it was only through practice that they had a chance of achieving the ideal natural birth.

The second way in which practice was described suggests that practice provides meaning as a concept in itself - that is, whatever the chosen practices, the importance lies in that the woman has spent time selecting her practices and that she is actively working to prepare herself for birth. These two inter-related meanings of practice were emphasised in the interview with mother of two, Vivianne and mother of one, Caroline, who both had home births. I asked them, 'what about the idea that a good birth is purely down to luck?' Caroline said, 'no I don't agree with that' and Vivianne said, laughing, 'no I worked really hard to get the birth that I got'. Caroline agreed, 'yeah I did too'. She went on:

> You work hard, you prepare in your pregnancy and you prepare physically and mentally to have the birth that you want and that for me meant, I did plenty of exercise, I got out and walked our dogs every day, right up until the day, I walked them on the day I gave birth, that was my physical preparation. And mentally, I made sure that I read lots of stuff and

> surrounded myself with people who were positive and had similar views on things and I spent a lot of time visualising my labour and thinking about how I wanted it to go…..

They went on to discuss the circumstances in which someone might work 'really hard' and still not get the birth they want, which will be returned to below, but here they suggested that they practiced and 'worked hard' in order to give themselves the 'best chance' for a successful home birth. In such statements, the women I interviewed made a distinction between themselves - women who work hard and take responsibility to prepare - and the 'mainstream', 'uneducated' 'other' described in Chapter Four. The practices are hence more than an instrumental working towards the end goal of a particular birth. They are simultaneously symbolic actions which fulfil a moral value for the women who engage in them. They distinguish these women who practice as different from the mainstream and make comment on how pregnancy and birth ought to be. The practices which my participants described are at once quotidian (including taking exercise, walking the dogs and reading information books) and yet fulfil a particular function in the context of pregnancy and birth. In this, they can be analysed as ritualisations.

The repeated practices during pregnancy which my participants described, and the importance of the concept of practice in general, are ritualisations comparable to those of homesteading and LOHAS, if fulfilled for only a temporary time. During the months of pregnancy, the practices described are instrumental in the creation of meaning through marking the women as committed to a particular form of birth. My participants might have come across natural birth texts or classes almost accidentally, as suggested in Chapter Five, but they came to invest in natural birth through their repeated practices. They became committed to the idea that they had to practice in order to achieve a particular form of birth. And through these practices they marked themselves as different to the mainstream other woman who does not practice and hence does not take responsibility for the outcome of her birth.

### *Health, Responsibility and Identity*

The work of birth also fulfils a social function. Through sharing stories of their practice with others, including in the interview context, on social media and in various groups, the

women were performing a particular type of 'responsible' motherhood. They were making a statement about themselves as mothers and about others who approach their pregnancies and births differently. As suggested throughout this thesis, drawing on existing literature (such as Perrier 2012), the middle-class women I interviewed experience a particular burden of responsibility to make the best possible health choices for themselves and their children. Adhering to a form of the 'natural' adds another layer of complication to this already demanding situation as ideas of the natural, health and responsibility all intertwine, as discussed in Chapter One. In the holistic worldview, such as that promoted in LOHAS, homesteading and some natural birth manuals, it is only through optimum personal health that the world itself can be saved.

That my participants were already engaged with ideas of a healthy lifestyle is evidenced in such comments as Aisha saying, '…we're living longer and stuff and I think we've just got to kind of work with that, prolong it as much as we can and the only way to do that really is to stay healthy. I think it's really basic as well, staying healthy and looking after yourself'. As a yoga teacher, it is not surprising that a healthy lifestyle is of paramount importance to her both personally and as her livelihood. Harriet, another yoga teacher and naturopath, told me

> I think really as human beings we're moving, we're either, there's two things going on, we're either moving more and more towards naturopathy, which is what I'm into or we're getting further and further away from it into this kind of fear stricken NHS kind of lifestyle where people just constantly go to the doctors, constantly take whatever the doctor gives them, constantly don't take any responsibility for their own health.

She went on

> I think that once you get on that ladder of, 'my doctor says this, this, this and this' and you don't take the responsibility of your own healing, then I think it's very hard to get off that. I think that if you come from where I stand and you take your own responsibility from the beginning, like with my children, they don't go to the doctors, we just deal with it all at home….

Harriet is perhaps a little unusual in representing the more extreme end of my sample, engaging in such practices as non-vaccination and a vegan/raw-foods diet for her family, in addition to the home birth and attachment parenting practices which were more common across the sample. Harriet clearly placed her understanding of responsibility outside of the NHS context: she was being a responsible citizen, taking care of her own and her family's

health, by engaging with the NHS as little as possible. These practices, and her disengagement from the NHS, were clearly a source of identity, as well as central to her profession. However, Jenny expressed a similar sentiment when she told me

> but I think it's more a case of just knowing that, like other health issues, yeah I believe in medicine completely, but I believe you can do other stuff alongside it and you can still be in control of your own body and do things to help yourself, rather than going, 'I'm ill, doctor make me better'. It's also like, 'oh I can also do this' and be in control.

For the women I interviewed, who had various reservations about NHS care for different reasons, being a responsible mother meant using services and practices outside of the NHS context. And this stance was inherently tied to their mothering identity; they took pride in their non-mainstream approach which meant that they researched their options and then made different choices to what they perceived as the norm. Jenny, in the quotation above, turned to Shannon, who I interviewed at the same time, and said, 'I think we're all that kind of mentality aren't we? We do other options'. They had a common identity from their membership of a Facebook group on attachment/gentle parenting. Vivianne and Caroline (who were also part of this group but who I interviewed together on a different occasion) linked their birthing and parenting practices to a sense of identity and a sense of 'defiance' of the mainstream:

> Vivianne - I quite like to be different. I like to go against the grain, I don't like to just do what everyone else does. I don't like to take the easy route on anything. If there's a way of doing something a bit more complicated but getting a better result out of it, I'll do that one, thanks very much.
> Caroline - that's like me. I'm always questioning. I wouldn't take anything at face value.
> Vivianne - so for me I think it was like, 'okay, I'll show you lot'. It was a bit of a sort of defiance thing really.

Vivianne and Caroline were reflexive about this identity work when, in a discussion about 'controlled-crying', Caroline said, '…you do end up losing friends who don't see things the same way as you. I mean it depends on the person but I think parenting defines who you are as a person'. Vivianne added,

> hmm, that's what I've found. I think as women when we become mothers, we do get a redefined sense of self, who you see yourself as being, and it's a very big adjustment and I think a lot of women at that time are very vulnerable, very emotional, and I think that's where the judgement thing comes, it's not necessarily that anyone is judging you but it's how you view everything people say, because it's so important to you, you know, everyone wants to do the best job that they possibly can, so if someone's saying the opposite to what you feel is necessary for your family to function, I think that can be really hard.

Some of the women, including those mentioned above, built a mothering identity in opposition to an imagined other, as has been discussed throughout this thesis, particularly with regard to processes of 'othering' (Chapter Four). Their sense of pride and defiance in taking responsibility for their own health, and that of their children, through making alternative choices - frequently outside of the NHS context - is tangible. They perform this identity, not only through parenting in public as all parents do (Baraitser 2009), but by sharing their birth stories, pregnancy practices and opinions in online and face-to-face groups. In such groups, this identity is verified and confirmed by others practising the same path. It is built in relationship with others, whether real or imagined. However, the women were reflexive about their mothering identities, recognising that mothering was 'so important' to them, and speaking eloquently about the problems of judgement in this field.[7] Whilst parenting and mothering in particular - including how one gives birth - is a judgemental and moral field, the religious studies literature drawn on in this thesis encourages a more positive focus on meaning-making. The women were not simply making moral statements about the need to take responsibility and their superiority in doing this (although that they were doing this cannot be denied), they were also seeking to make ethical decisions, through relationships, in the moment of pregnancy, birth and motherhood. The work of birth, the balancing of the public, moralised and generalised discourse surrounding the ideal natural birth with women's own individual and practical situations, can also be seen as walking an ethical path.

**Circumstance and Control**

My participants were aware that they might not achieve the ideal birth despite their preparation and practice. As Vivianne and Caroline suggested, they engaged in such practices in order to give themselves the best possible chance of achieving the ideal birth whilst recognising that the circumstances on the day might prevent an achievement of some or all elements. The possibility of elements of failure is inherent in the ideal natural birth. However, the women did not consider the ideal natural birth as a discrete category from the non-ideal, medical birth - rather different birth practices were ranked in a

[7] As discussed in Chapter Four, the majority made highly normative statements whilst stressing that they were not judgemental.

hierarchy of values with the profane signifiers at one end. Through their practice and preparation they hence hoped that they would be able to achieve at least some of the elements of birth they desired whilst avoiding the profane. They suggested that their practice and preparation would stand them in good stead for a positive birth experience, as indicated in the idea which arose in numerous interviews, that women who had planned a home birth were more likely to have a positive birth experience, regardless of whether the birth took place in home or hospital, because they had done the necessary research and so were empowered in their own decision making.

The preparation and practice of pregnancy is also about a desire for control. As noted above, Malacrida and Boulton (2013: 13) argue that the creation of a birth plan offers a false sense of control which does not offer 'any real guarantees in the actual event' and hence contributes to a sense of failure. Only one of the women I interviewed (Laura) agreed with such an analysis; the remainder of the women suggested much more complex understandings of both the notion of control and their work in relation to it. As outlined in Chapter Five, the notion of control occupies an ambiguous position within the natural birth milieu as control of some aspects of birth are deemed positively, whilst a desire to control others aspects is deemed negatively. Natural birth ideals of 'giving in' to instincts and the body require a relinquishing of control and yet, it is taught, this giving in is only possible in a controlled environment. The birthing woman, her partner and chosen birth professionals must create the ideal, optimum birth environment of dark, quiet, relaxing soft sounds and scents, and as few people and intrusions as possible. This is believed to require high levels of control, especially when birthing in the hospital context. The birth partner and professionals are required to police this environment, maintaining it for the birthing woman who is focused on relinquishing control to the birthing process. Natural birth literature and teachings hence imply that different actors are vying for control in birth. They state that control should always lie with the birthing woman who should be supported to give up control to the higher, natural and, for some, transcendent process of birth. Medical authority, it is suggested, seeks to assert its own control, especially through the profane signifiers of induction, timing labour, the lithotomy position and encouraging various interventions such as continuous monitoring, all of which eradicate the woman's own bodily control. The question of just who or what control is relinquished to in the event of birth hence becomes an important factor in women's evaluation of their birth

experience. The women I interviewed suggested that if control is relinquished to medical authority, such as agreeing to induction, continuous monitoring and lithotomy when it is not medically indicated, this is the profane, non-ideal, medical birth. This is the birthing practices of the mainstream, uneducated and unprepared mother, who agrees that 'doctor knows best' with no value placed on her own intuition, instinct and bodily power. Relinquishing to these medical practices is a form of moral failure indicating a lack of responsibility for mother and baby's own health and best possible start in life.

The women I interviewed used numerous strategies - in addition to engaging in all of the preparation and practice outlined in this chapter - in order to avoid these potential feelings of guilt and failure, and to protect natural birth as an ideal concept. First, some of the women I interviewed who did not achieve the natural birth they had planned, absolved potential feelings of failure by displacing the blame on to others - most often NHS doctors and midwives. This has been discussed as 'the changing location of expertise' in Chapter Four, in which the NHS is portrayed as 'other' to the women's chosen experts from the private sector. Some of the women I interviewed displayed anger at the NHS's apparent ineptitude, rather than internalising feelings of failure. This is exemplified in Jenny's analysis of her first birth which was a planned home birth using Hypnobirthing techniques but ended as a hospital birth because, in her own words, 'they had no midwife available so they made me go into hospital and it all went very pear-shaped and I ended up with everything apart from a caesarean'. She described the 'pear-shaped' process in which she became dehydrated and 'got stuck in labour for four days'. Her daughter was 18 months old at the time of the interview, and I asked Jenny, 'when you talk about your first birth now do you find it easier to talk about it positively?'. I was struck by the anger with which she replied,

> erm, no (laughs). No, I think the problem is something went wrong, which obviously can happen, but it's cos the NHS mucked it up cos they didn't listen to me. I still have a lot of anger. I could have gone and discussed it but I didn't see the point of discussing it with someone cos there's nothing to undo it. It's more that, I haven't gone to positive births group cos you know I help them by not going. And I believe that birth can be positive, that's part of the problem, it was not positive cos of other people intervening which is what really annoys me, and I should have refused and stayed at home but I didn't know I could.

Whilst Jenny does portray some sense of self blame in the last sentence of the quotation ('I should have refused'), that the general displacement of blame helped protect both Jenny from a feeling of internalised failure and the concept of the ideal natural birth itself, was

evidenced in Jenny (a few weeks away from having her second baby at the time of interview) planning the same birth that she had planned the first time - a home birth using Hypnobirth techniques. It also refutes Coxon et al.'s (2015: 143) claim that first-time mothers who plan home births but transfer to hospital generally re-evaluate their plans as 'naive and optimistic'.

The second way in which the women I interviewed avoided feelings of guilt and blame and hence maintained the ideal birth, was through a concept of the circumstances of birth which unfolded on the day. The women recognised that in the event of birth, some aspects that they had planned for and sought to control - such as an avoidance of all pain relief - might have to be relinquished in a tactical move to maintain other aspects of the ideal birth. The circumstances of birth might require that some ideals are relinquished. When control is relinquished because of the circumstances on the day (for example the baby being in a particular position, baby's heart rate changing or the mother's own body presenting a condition such as a cervical lip), this is not interpreted so negatively, but as more of a resigned position, as beyond anyone's fault. Circumstance here might be comparable to the concept of fate; a predetermined course of events dictated by a higher power (however interpreted) and beyond any human control. This is distinguished from chance which is seen as more of an unprepared position. Whilst the women interviewed did not explicitly use the concept of circumstance, I use it here to suggest that through this general idea of surrendering to a larger force - which is termed positively in natural birth circles - they were able to absolve potential feelings of guilt and failure. The complex relationship between practice and preparation 'to give yourself the best possible chance', relinquishing control to a higher force and a sense of circumstance or fate in how things are 'meant to be', is exemplified in the following quotation from Vivianne:

> I listened to relaxation scripts and CDs every day, at least once a day, from the time I was about 14 weeks pregnant. And my husband had to read scripts to me and do light touch massage. You know, I thought, 'I'm not leaving this to chance' because if it all goes horribly wrong, I can say, 'I've done everything within my power, and that is the birth experience I was supposed to have.' But if I go into birth thinking, I sort of half-heartedly did it, it will be my own fault. Maybe it's a lot about self blame, I would have blamed myself, whereas I thought, 'if I give it everything I've got, then c'est la vie then'. However it happens, its supposed to happen and I can't then berate myself afterwards for not putting in enough effort.

For Vivianne and the other women I interviewed, there was a sense of moral responsibility to prepare and practice for birth which simultaneously protected them from feelings of failure and protected natural birth as an ideal which was also strived towards in subsequent birth, regardless of whether it was attained in its entirety in previous births.

**Conclusion**

In this chapter I presented the 'work of birth' as a working on the self incorporating three areas of practice: physical, emotional and intellectual. Drawing on writings within religious studies which focus on working on the self as spiritual practice, I argued that the self cultivated in natural birth bears more resemblance to this spiritual legacy than some contemporary western individualised notions of self. It is cultivated as a self in relation - to the baby, partner, experts, community and to nature as a whole. The self is in a holistic relationship to each of these others and hence (healing) work on the self has a beneficial impact on nature and on the legacy of future generations. In this way, work on the self is also an ethical self-formation, as an ethical self is relational.

I analysed the three different elements of practice, including the primacy of a narrative of research epitomised in the creation of birth plans and the choice of tactical activities, before suggesting that practice itself is a central concept in natural birth. I argued that the practices of the self can usefully be considered as ritualisations. They are repeated, embodied and symbolic actions, the practice of which marks them as of special significance and as making a comment on how pregnancy and birth ought to be. Through these practices, the women suggested, they both increase their chances of achieving the ideal natural birth whilst simultaneously marking themselves as good and responsible mothers who make time to prepare and invest in their births. The work of birth, these repeated practices of ritualisation, provide meaning to the women in their pregnancies and births. The meaning of ordinary pregnancy practices (Han 2013) is dismissed in some feminist accounts of natural birth which focus on it as controlling, policing and ultimately unachievable (for example, Malacrida and Boulton 2013).

Finally, I argued that the work of birth, coupled with the concept of circumstance, simultaneously protects both the women from internalising feelings of failure and the

concept of natural birth as an ideal. Through their work and practice, the women have demonstrated that they have done everything they can to have the 'nicer birth'. If it is not achieved, blame can either be displaced onto the 'other' of the NHS or neutralised through a general concept of circumstance or fate. In this way, failure to have a natural birth does not necessarily entail a failure of the ideal. As described in Chapter Five, the women I interviewed also worked towards the ideal birth in subsequent births, often despite - or perhaps because - of a non-ideal first birth experience. I argued that through the performance of their practices - including talking about them with friends, online, and in the PhD interview, the women are doing two different but related things. First, the women are protecting both themselves from feelings of failure and ultimately the concept of natural birth itself. Second, practice contributes to their formation as, and performance of, responsible mothers. I have argued that my participants are engaged in making an ideal real through practice whilst at the same time using practice as a means of maintaining a sense of moral integrity.

In the final chapter, after giving a brief summary of the central arguments of this thesis, I discuss some of the limitations of the study and areas which could be developed in future research, either by myself or others. Finally, I return to the theoretical framework I have used in this thesis, and reflect further on what this adds to the existing literature on parenting in the contemporary UK.

## Chapter 7 - Intensive Motherhood and Lived Ethics

Throughout this thesis I have drawn on literature on 'intensive motherhood' (Hays 1996), which suggests that the predominant form of culturally sanctioned mothering are the practices of the middle classes, in which mothers takes responsibility for the labour-intensive act of child-raising and prioritise children's needs above their own. The work in which the women I interviewed engaged during their pregnancies can be seen as part of the practice of intensive motherhood. Not only does intensive mothering begin pre-conception, as evidenced in my participants' work during and even prior to pregnancy, but it places a particular burden of responsibility on mothers. Current neoliberal government and health policies in the UK have contributed to a situation in which citizens are encouraged, indeed compelled, to take responsibility for their own health and wellbeing, including looking to the private sector to fulfil this function. The middle classes, and especially women, are targeted in this agenda creating particular anxieties (Perrier 2012) and, for some, personal health (and children's health), has become internalised as an area in which responsibility must be demonstrated. The class bias of this cannot be underestimated; the public narrative of current government health policy and resources to 'choose health' for themselves and their children, are largely geared towards middle-class women, such as those I interviewed, and they come to embody this sense of responsibility to make their own, but correct, choices. Indeed, the category of middle-class itself is associated with 'real culture' and 'legitimate knowledge' instantiated in bodies rather than something acquired through work or an accident of birth. Current health and parenting policy geared towards lower-income families takes a different form leading to a different lived experience which was beyond the remit of this thesis. The women I interviewed also demonstrated another form of middle class anxiety in their desire to avoid me labelling them as judgemental. However, as argued, the performance of good and responsible motherhood of necessity entails juxtaposition with a generalised other. Because of the historical entanglements of natural birth with class and race, the good and responsible mother is more likely to be perceived as white and middle class.

Whilst not wanting to detract from intensive motherhood literature, I have argued that it is useful to bring this work into conversation with other approaches from the fields of religious studies and anthropology which have more of a practice focus. I have analysed

women's pregnancy practices through a religious studies framework. This framework - a broadening of the cultural sociology of the sacred with practice-based approaches to the study of religion, moral communities and ethics - has allowed me to explore the field of natural birth in an innovative way. By utilising a religious studies lens which is sensitive to meaning making, I have shed new light on why some women want a natural birth and why they think it necessary to plan and practice for a natural birth, even whilst they realise that it might not be entirely achievable. Whilst the study of 'meaning-making' has been criticised as a western preoccupation within religious studies (Asad 1993), I have expanded my focus to include insights from lived religion, most notably the works of Orsi (1997, 2005) and Hall (1997) who emphasise that meaning-making should be considered a process, not an end product, as a search for meaning often remains unresolved (Orsi 2005: 144). I have also drawn on anthropological work on lived ethics which considers how people try to live ethical lives through self-formations in relationships with others (Lambek 2010, 2015, Mahmood 2012). The theories used encourage analysis of meaning-making through a focus on practice to a greater extent than is found in some other disciplines. Hence I have focused on women's agency, creativity and choice to a greater extent than studies which focus on policy implementation or self-policing and regulation of women, not as a replacement but as a balance to these studies. Whilst I have not neglected the social and cultural norms and restrictions governing birth in the contemporary UK, my analysis has foregrounded women's own stories of their lived experiences and their own accounts of their practices, choices and decision-making processes.

There exist few studies of birth which utilise a religious studies framework. Pamela Klassen's *Blessed Events: Religion and Home Birth in America* (2001) remains the seminal text and has been influential in this thesis which inevitably has a different focus; this thesis is UK based and has a wider focus than women who choose home birth for religious reasons. Whilst my own study was initially more directly focused on women with a self-professed religious or spiritual identity, an interest in moves within religious studies to identify and analyse moral communities formed around the sacred or shared values and lifestyle practices, led me to take a broader focus of women who identified in some way with desiring a natural birth. This allowed me to analyse the natural as a potential sacred form or, as I came to define it, an ideal. Academic work on the 'spirituality of birth' seemed to gain purchase for a while in 2009, when I began this study, such as the

Australian Religion Studies Review *Special Issue: Religion, Spirituality and Birthing* (2009, volume 22.2), but did not have a lasting impact, partly due to the lack of definitional clarity around the concept of spirituality in this context. Midwifery writings on the spirituality of birth, as well as practitioner texts, have continued to proliferate however, indicating that there remains a popular interest in this topic. There have also been anthropological studies which have utilised theories most often applied to the study of religious communities - namely ritual studies - to analyse aspects of pregnancy and birth. Robbie Davis-Floyd's *Birth as an American Rite of Passage* (1992) was perhaps the first study to analyse pregnancy and birth as a medical, secular ritual, in which medical authorities attempt to mould women into subjects conforming to biomedical knowledge and expertise. More recently, Florence Pasche Guignard (2015) has analysed American 'gender-reveal' parties as a 'new ritualisation' during pregnancy and Sallie Han's (2013) ethnography, focusing on the 'ordinary practices' of American pregnancy, includes analysis of baby showers as a form of 'communitas'. Existing UK-based studies have not tended to focus on issues of religion, spirituality or the sacred with regard to pregnancy and birth, neither tackling these as direct issues or using theoretical frames from their study. Neither have they been especially focused on women's practices. Thomson et al.'s *Making Modern Mothers* (2011) for example, includes analysis of women's information-gathering in preparation for birth, but nothing on the physical practices of exercise, diet, or attending antenatal classes. The newly emergent field of parenting culture studies is a major influence in UK works. This largely libertarian approach, with a focus on critiquing government policy, has produced a number of works which have been influential in my study, not least Charlotte Faircloth's *Militant Lactivism?: Attachment Parenting and Intensive Motherhood in the UK and France* (2013), and to a lesser extent, Jan Macvarish's *Neuroparenting: The Expert Invasion of Family Life* (2016). But, as suggested, a religious studies approach can add a new dimension to UK-based studies.

Recent moves within both sociology and religious studies have sought to investigate meaning-making beyond institutional religion. A focus on communities of sacred forms (Alexander 2003, 2010, Alexander et al. 2006, Lynch 2012a and 2012b) or shared morals, values and their associated practices (Bender and Taves 2012) have been two instrumental

approaches.[1] I have combined these approaches in my framework, arguing that the sociology of the sacred is useful for analysing public, moralised discourse but not the complexities of lived experience in which relationships with ideals are more negotiable, flexible, reflexive and practice-based. To understand lived relationships with ideals or sacred forms, it is necessary to move beyond an analysis of discourse and resulting practices, to analysis of the ways in which practices are constitutive of meaning and can embed the ideal in the body. I have drawn on theories of lived religion, ritualisation, techniques of the body and the lived body in order to foreground the embodied and practical aspect of relationships with ideals. I have also conceptualised natural birth as an ideal rather than a sacred form as, as the empirical data emphasises, the women I interviewed did not approach the natural as a non-negotiable category in a dichotomy with medical birth, but rather as something 'special', at one end of a hierarchy of value, which could be worked towards but with the potential for failure inherent. The women I interviewed did not reject all aspects of medical birth, keeping their options open and dependent on the circumstances that unfolded on the day of birth. In this way the question of whether natural birth succeeds or fails is mistaken in the eyes of practitioners as their understanding is much more complex than an idea of a single, coherent way of birthing that is either achieved or not.

I argued that an ideological commitment to the natural as a sacred form was just one of the reasons why women became involved in natural birth groups and practices. In Chapter Four, I asked 'What does the natural mean to the women I interviewed interested in natural birth in the contemporary UK? What birth practices are included and excluded from women's understandings of natural birth?'. The sociology of the sacred was invaluable here in its focus on analysis of the sacred through its relationship with the profane - that which has the potential to pollute. It soon became apparent through the narratives I was collecting that women found it both easier to articulate and had a stronger emotional reaction to the aspects of birth which they considered less natural, those on the more medical end of the spectrum. The women I interviewed - particularly the 'birth workers' - did sometimes portray natural birth as a non-negotiable reality and in a dichotomous

[1] Recent writings on 'non-religion and secularity' such as the work of Lois Lee (2015) is another instrumental approach which was not engaged with in this study but is certainly a possible future area of analysis - bringing together my work on natural birth as a thing that matters with Lee and colleague's focus on the existential, meaning-making dimension in the lives of nonreligious people.

relation with medical birth. However, the women I interviewed still demonstrated a great deal of hesitation and ambiguity when describing their understandings of natural birth. Many of them described what natural birth was not and these shared characteristics I identified as the five profane signifiers of natural birth. Midwives, NHS trusts and writers of midwifery policy might benefit from reading this section of the thesis which emphasises the real negative, and often long-lasting, emotional impact these quite standardised medical procedures have on women, as well as their impact on future birth choices.

Analysis of profane signifiers can shed light on understanding something of value. In the case of natural birth, the profane signifiers reveal the central importance of the birthing woman retaining a sense of control and dignity of her body, her baby, the birthing environment, including who is present, and the general 'situation' or 'circumstances' in the event of birth. The profane signifiers also reveal the central importance of the role of the 'imagined other' in the construction of the ideal natural birth. The imagined other is one who willingly gives in to the profane signifiers, relinquishing her autonomy to medical authorities, and does not take responsibility for her body and her birth. The women I interviewed were anti-authoritarian, rejecting the authority of biomedical practitioners in favour of the birth workers they found themselves from the private sector. This 'changing location of expertise' away from the NHS midwife to the private sector is a new research finding as historically midwives in general have been portrayed as on the side of women against the (male) medical profession. The situation is no longer so straight forward I suggest.

The anthropology of ethics add another dimension to this discussion. David Morgan (2013) suggests that concepts of 'fairness' and 'sacrifice' and the telling of moral tales, which involve accounting for actions and the construction of reputations, all play a role in ethical practices. Indeed, the concept of 'sacrifice' in particular is bound up with intensive mothering practices and arguments which state that natural birth is 'best for baby'. As a post on the Natural Pregnancy and Childbirth Facebook page stated on 28th December 2017, 'To all the mamas who are waiting patiently for labour to begin on its own:

remember that is your first act of selflessness as a mother'.[2] As suggested in Chapter Four, the ideal natural birth is one that avoids the profane signifier of induction, and this avoidance was a central narrative in many of my interviews. It was also the source of much moral judgement, to the extent that I have described it as the most important profane signifier. The practice of induction was one that caused some women grief and a need for reparation, sometimes through subsequent births. The avoidance of induction was not only seen as a sacrifice as best for baby, however, it was also seen as best for mother. In the natural birth field, it is the concept of the mother-baby as a unified concept which is paramount; what is best for one is usually seen as automatically best for both. A critical account would emphasise that this worldview reinforces the trope of the self-sacrificing mother and, in general, writings on lived ethics do not take account of gender as comprehensively as writings on intensive motherhood in which it is prioritised. Nevertheless, in the accounting of stories in which they avoid induction, the women are presenting a particular moral stance, a particular maternal subjectivity, in which they retain control and responsibility of their bodies, their baby and the situation in general.

In Chapter Five, I continued to investigate the question of how and why women become involved in natural birth groups and practices. I argued that commitment to the sacred form of natural birth is only part of the picture and the women I interviewed were also motivated by pragmatic concerns, by the influence of their social networks, and by financial and accidental factors. This was also the case for home birth, which is often portrayed as the epitome of the ideal natural birth, thus complicating the dominant media portrayal of home birthing women as 'hippies' who endanger themselves and their babies.

Social relationships are integral to women's motivations and choices around natural birth - their social networks can influence them either into or away from certain birth choices and practices; they intentionally build support networks in their choice of private antenatal courses which again influence their birth choices and practices; they forge important relationships with their chosen birth workers who they come to rely on as experts over and above the biomedical practitioners of the NHS; and of course pregnancy entails a

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[2] https://www.facebook.com/NaturalPregnancyAndChildbirth/photos/a.580532478678806.1073741825.188895944509130/1613940352004675/?type=3&theater The quote is attributed to Lauralyn Curtis, founder of 'The Curtis Method of Childbirth Education', which runs classes in Utah, America, and which combines Hypnobirthing and Active Birth methods.

relationship with the baby and, in the case of my informants, the father of the child. Community is as important as the more narrow family in natural birth. As suggested, many of the birth workers in my study (and those discussed by Perrier and Fannin [2016]) are motivated by ethics of care, community and education. Birth workers partly draw their expertise from their own experiences. Those I interviewed were frequently drawn to this career choice after their own pregnancies and births in both their desire to help others (specifically to 'empower' and 'educate' others) and to continue working and thinking about pregnancy and birth as it became something of matter and value to them; too precious to relinquish even after their own birthing biographies were complete. A sense of community and of sharing knowledge after the birth were important to many of the women I interviewed - not only for the practical support network, but because it demonstrates to others a particular form of birth and hence a particular form of mother.

In Chapter Five, I also explored the question, 'Are there other terms, such as 'choice', which have symbolic significance in the context of pregnancy and birth?'. Themes of practicality, pragmatism and 'keeping options open' reveal another central component of the ideal birth; that it is chosen and is 'the birth I want'. The concepts of the natural and of choice combine to create a moral framework of birth for the women I interviewed.

Closely connected to the themes of pragmatism and keeping options open is the women's portrayal of difference between first and subsequent births. In addressing the question, 'How and why do women's understandings of, and commitments to, natural birth change over the course of their birth biographies?' I add new findings to the sociology of childbirth literature. I further illuminate a small section of the Birthplace data, a major study examining the safety of four different places of birth[3] in 2008-2010. Researchers found that 90 per cent of women give birth in hospital obstetric units (labour wards), despite alternatives being offered and sometimes encouraged, and that those with a positive birth experience do not change their place of birth for subsequent births. Those who had planned alternative settings for first births but transferred to hospital then chose hospital for subsequent births in the belief that their first birth planning had been 'naive or optimistic' (Coxon et al. 2015: 143). Many of the women I interviewed however did have a

[3] hospital obstetric units, 'along-side' midwifery units, 'free-standing' midwifery units and home births

negative first birth in the hospital which resulted, not in an acceptance of the safety of hospital, but in a stronger involvement in natural birth in subsequent births. Hence a negative first birth was another motivating factor in their working towards natural birth as an ideal in subsequent births. A need for reparation from the pollution of the profane signifiers experienced (albeit interpreted as such with hindsight) led to a greater commitment to the ideal natural birth. This indicates that relationships with ideal forms are not static but can change over an individual's lifetime.

In Chapter Six, I addressed the research question, 'Why do some women report that they need to learn and practice natural birth and what do they do during their pregnancies to prepare for such a birth?'. I introduced the concept of the 'work of birth', expanding existing literature on this theme (including Klassen 2001, MacDonald 2007, Thomson et al. 2011) by combining it with literature from the study of religious, spiritual and moral communities (including Bell 1997, Gould 2005, Emerich 2008). I argued that the planning, preparation and practice in which the women I interviewed felt it necessary to engage during pregnancy constitutes the 'work of birth' which can be considered akin to working on the self in religious/spiritual communities. The concept of self in relation to others and to nature prevalent in the natural birth field bears more similarities to a western spiritual legacy than contemporary ideas of individualism, I argued. The work of birth consists of embodied practices which inscribe the ideal birth on the body, highlighting the central importance of practices and body techniques in forming commitment to an ideal and creating meaning. The simultaneous symbolic role of the practices, conceptualised as ritualisations, in highlighting difference to the mainstream and an alternative vision of how birth *ought* to be, was emphasised.

I have described the work of birth as a working on the self - it is also an 'ethical self-cultivation' (Keane 2010: 80). The work of birth, the pregnancy and birth practices I described, can be considered as ethical or moral projects of the self, forming a particular self in relation to others. The work is the creation of a particular subjectivity through an embodied practice and through relationships with others - the natural birth teacher, other practitioners in the class, one's family, the imagined other who practices differently and more. This subjectivity is performed through the narration of it. In the sharing of birth narratives then, not just in the interview situation which I initiated, but with family and

friends and online and in various social groups, the story-telling becomes a moral performance. Through their repetitive, embodied practices and through the narration of them, the women I interviewed were making a moral commentary on the type of mother they are - a responsible one, who has actively researched her choices. It is both the practices, which mostly take place in the private realm of the home, and the talking about these practices in the public realm, which demonstrates this. Talking about the work of birth is also a constant, practiced ethical negotiation of the balance between the ideal and the practical. This addressed the question of the social role of the practices - 'What statement, if any, are the women making about themselves as mothers and about others who approach their pregnancies and births differently?'

I also addressed the question 'What protection mechanisms do women use if the ideal birth is not achieved and how is the ideal birth subsequently re-negotiated?' I argued that the work of birth is also central here as it is through engaging in embodied practices that the women interviewed came to feel that they had morally 'done enough' to prepare for birth. Hence if the ideal birth was not achieved in its entirety on the day, which was a real possibility, this was put down to 'circumstance' and a rhetoric of surrendering to a larger force. In this way, the majority of women I interviewed did not seem to internalise blame. Instead, they displaced failure onto the medical establishment and, as a result, the ideal birth was actually reinforced. This finding counters the predominant question in public discourse of whether natural birth 'succeeds' or 'fails'. Such discourse reinforces binary thinking when questions of success and failure (like medical and natural) are more complex in reality and subject to individual interpretations. Through listening to individual women's voices as to their reasons, meanings, and practices of natural birth, we can come to a closer understanding of this complexity. We can understand their interpretation of their successes and failures rather than taking an oppressive, hermeneutics of suspicion approach which suggests that they have failed - or will feel that they have failed - if they did not achieve a natural birth. This finding is also a counter-point to the common claim that natural birth sets women up for failure leading to self-blame and guilt. Some women are able to avoid this through their creative and flexible interpretations of and commitments to natural birth. Hence natural birth is a meaningful moral framework for some women and this, I feel, is neglected in some of the existing literature on the sociology of birth.

**Limitations and Future Possibilities**

Inevitably, this thesis has its limitations and there are a number of areas for possible future study. Despite my research flyer and website stating that I was interested to hear all opinions on natural birth, whether positive or negative, I was only contacted by those with a positive perspective. This was largely a result of the places in which I distributed my materials, both physically and online. Once a number of Hypnobirth and NCT teachers posted my materials on social media pages, a snowball effect took place through which I was inundated with contacts from women sympathetic to these approaches to birth. As these approaches involve financial investment in terms of classes and materials as well as the social capital to meet frequently in coffee shops and to host events in homes, it was also inevitable that my cohort would be relatively similar in terms of social class, age, ethnicity, heteronormativity and social 'tastes' and styles. That I was also part of this social world cannot be ignored. In Chapter Three, I reflected on my own position with regard to natural birth and my similarities with participants. I explained that I felt my position as a mother sympathetic to natural birth allowed me relatively easy access into this social world and a good rapport with my participants. It is interesting to reflect on how I could have done things differently - if I had been more vocal with statements with which I disagreed or if I had not downplayed my knowledge with 'experts' to the extent that I did - but of course the potential impact of this remains unknowable. In terms of research methods, it would have possibly been beneficial if more of my interviews had come directly from the classes observed and if more women had agreed to multiple interviews, in order to understand women's changing practices and values across a pregnancy. However I soon discovered that, in general, women with young children were more keen to participate than pregnant women, perhaps because they were on maternity leave (which can be a tedious and lonely experience) and enjoyed the opportunity to reflect on past practices. In this way, I got a lot more 'data' from these interviews as we could discuss not only pregnancy practices but birth stories too. That these stories were then told post-hoc, as rationalisations and in hindsight, must be emphasised, especially as the practical side of the stories might have been emphasised. As suggested throughout this thesis, I do not see this as problematic and instead see these stories, which I sensed had been shared before, as a form of moral reasoning and ethical self-formation which created a particular subjectivity; the good and responsible mother.

I made the decision to retain focus on the cohesive sample, not actively seeking participants opposed to natural birth or of a different social class, age or ethnicity. This was in the conviction that whilst a cohesive sample limits the arguments that can be made in terms of generalisations and comparisons, it arguably allows for a deeper understanding of the community in question. The existing literature utilised also focuses on the intensive mothering practices of the middle-classes and their particular anxieties from a perceived sense of obligation to embody responsibility and choice. My study adds data to this field. However, it would be valuable to extend my study to include women opposed to natural birth and of different social classes, ages and ethnicities. The theoretical framework that I have developed could be useful in studying any community of shared values and embodied practices and, as such, could equally be employed to study women's commitment to medicalised birth. A study of women choosing elective caesarean is equally necessary as they too are demonised in the media as being 'too posh to push'. This eradicates the emotional issues which are usually at the fore in such a choice, and the experience of birth trauma as a contributing factor.[4] Hence the experience of a negative first birth led the women I interviewed to become involved in natural birth groups and practices, but it equally leads some (more, according to Coxon et al. 2015) to desire more medicalised births. In 2011 NICE guidelines recognised the importance of offering elective caesarean as a valid option for women[5] but anecdotal evidence suggests that women still experience a real struggle in obtaining this. The human rights charity, Birthrights, states that 'the right to choose a caesarean section remains one of the most common enquiries' they receive.[6] The Report of the Morecambe Bay Investigation (Kirkup 2015) also highlights the resistance of some maternity units to offering this as a valid choice. Women choosing caesareans and women choosing home births hence share more than might be expected; a conviction that this is the right path for them and the strength to fight for this whilst they are vilified by both the media and, sometimes, medical authorities. Both approaches refute the commonly made popular argument that 'all that matters is a healthy baby' - an argument which completely devalues women's experiences, bodies and 'work'.

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[4] http://www.birthtraumaassociation.org.uk

[5] https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance#planned-cs

[6] http://www.birthrights.org.uk/2017/05/do-i-have-a-right-to-choose-a-caesarean-section/

It is also important to analyse the birthing strategies of women of different social classes, ages and ethnicities. Do they operate with an entirely different logic as Lareau (2011) suggests with regard to American parenting practices and Macvarish (2016) with regard to the UK?[7] Are low-income and young women excluded from natural birth because of their lack of financial and social capital or does it simply hold no interest for them? Is birth in general not reflected upon to the same extent as it is considered a brief life experience that is soon over? Thomson et al.'s study (2011) which analyses the pregnancy and birth experiences of different age groups does suggest this. A middle age-group saw their pregnancies as 'effective life planning' whilst older mothers saw it as their 'last chance' of motherhood; it was they who were most interested in natural or home birth. For young mothers, pregnancy was considered the end of their own childhoods. Is the popular assumption that young mothers need the least medical intervention due to their generally 'fit' bodies and lack of medical issues correct? Does this impact the way they prepare for birth? Similarly, how do different cultural norms impact on UK women's birthing practices? Why did no ethnic minority women respond to my research posts? Why are such popular practices as Hypnobirth, yoga for pregnancy and NCT dominated by white women? Are ethnic minority women excluded by this predominance or simply a lack of interest as their own cultural backgrounds provide different resources? As I have suggested in this thesis, natural birth does share a historical legacy with western spiritual practices and with white feminism, and does include a romanticisation of 'primitive' peoples, a form of racism, so it may hold no interest to other ethnic groups. Obviously, this is a huge field and sensitive studies of different ethnic groups is needed, rather than too broad a cross-comparison. A 2017 BBC article highlighted UK Chinese women's lack of engagement with the NHS after childbirth for instance, and the NHS's resulting lack of knowledge of this community's pregnancy, birthing and post-parturition practices.[8] These questions have not only theoretical and empirical value but also real policy implications.

Finally, an analysis of fathers' perceptions of birth practices and preparation would be useful. I decided to focus only on women's accounts of pregnancy and birth as the prime

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[7] Recognising Holloway and Pimlott-Wilson's (2014) argument that class must be analysed in conjunction with local mothering cultures and that, in their study at least, lower-class parents embraced middle-class parenting ideals as aspirational.

[8] 'Why Chinese mothers won't go out after giving birth, BBC News, 13th November 2017 - http://www.bbc.co.uk/news/health-41930497

agents in this embodied experience. Whilst partners did attend the Hypnobirthing and NCT courses I observed and did assist in such practices as visualisation and massage, other physical exercises are solely women's embodied practices. The women I interviewed almost unanimously claimed that the research in which they felt it necessary to engage to make their birth choices was something they did alone, relying on the advice of female friends and experts, then relaying the information to their male partners. The importance of social networking with female friends, especially with children of the same age, was lauded often over and above that of gaining a male partner's perspective. Is this common beyond my heteronormative sample or is it unique to an interest in natural birth in which the importance of birth as women's work is emphasised? Are men excluded from this realm as an integral aspect of natural birth is the celebration of the female body and feminine instinct and intuition, as well as the importance of female birth workers such as doulas? How do father's feel about this? Do any fathers hold to an ideal of birth which influences their partner's pregnancy and birth practices? Are men ever the driving force in natural birth groups?[9]

This thesis has a number of policy implications including in the directions it could be taken in future research. It's rich data on women's complex relationships with the lived experience of natural birth is directly relevant to policy makers and health professionals who are keen to increase women's satisfaction in their birth experiences. Maternal health policy is increasingly geared towards the centrality of the pregnant woman in choosing her own care and my empirical data both supports this as an overall policy whilst highlighting the potential negative consequences of it including judgement and othering, anxiety to embody 'correct' choices, and its correlation with the necessary financial and social capital to research choices. It is something of a contradiction that this is occurring at the same time that independent midwives have lost their search for indemnity insurance resulting in an uncertain future[10] and that The Royal College of Midwives has identified a shortfall of 3,500 midwives[11] in conditions in which existing midwives are an ageing workforce who

[9] The male authorship of some of the foundational texts of natural birth, including those of Grantly Dick-Read and Michel Odent should be remembered. Are there any new such instrumental male voices that I did not discover in the course of this research?

[10] In December 2017, see http://www.imuk.org.uk/news/message-to-our-supporters/

[11] https://www.rcm.org.uk/news-views-and-analysis/news/'eliminate-the-midwifery-shortage'

experience high levels of stress and workplace bullying.[12] It is paramount that we also seek to understand the perspective of women who do not want to be primarily responsible for their own birth choices - whether natural or medical - but who do want to be guided by medical authority. This is a challenge to the class-based assumption of health policy that everyone wants to be in complete control of their health care. However, as argued, this thesis has theoretical contributions as well as empirical, and I end this thesis with some final remarks on what my theoretical framework adds to the existing literature on contemporary parenting practices, as well as to wider debates about how to study meanings.

**Refining the Study of Meaningful Practices in Contemporary Society**

In this thesis I have sought to develop a more nuanced understanding of women's moral investments in natural birth than that offered by some of the existing literature, particularly within the field of parenting culture studies, including a more nuanced theoretical understanding of the significance and uses of moral meaning in social life. Studies affiliated with PCS have eloquently and informatively analysed the historical development and resulting current social, cultural and political situation of the moral field of parenting in western societies. Such studies outline the anxieties of intensive mothering as a symptom of conditions of late modernity in which untold pressures are placed on mothers in particular to take full responsibility for every aspect of their child's development. PCS, with its aim of exposing this situation in order to challenge it, necessarily sees intensive mothering as ultimately oppressive and mothers who embrace it as blinded by false consciousness. This is an important area of work and the roots of current parenting practices do need to be exposed. However, within the confines of current cultural and social structures, there are opportunities for positive identity construction and meanings drawn from practices and I present these in this thesis as a balance to critical analyses focusing on structures. My interest lies in how those practising a particular form of parenting – in my study, women engaging in natural birth practices – actually describe their commitments, motivations, choices and practices. I call for greater attention to women's own voices as to how and why they engage with a particular moral field.

[12] https://www.rcm.org.uk/news-views-and-analysis/news/stress-affects-almost-50-of-englands-midwives

I have used different theoretical writings to reconsider and reframe the issue of mothering and responsibility away from an analysis focusing on policing and regulation to one focusing on meaning-making, creativity and agency. This arose from a conviction that women would not recognise themselves or their stories in some popular and academic accounts which employ a 'hermeneutics of suspicion' approach which sees women pursuing a natural birth as blinded by false consciousness. An ethic of responsibility towards research participants means that they should at least be able to recognise their voices within our accounts even whilst we expand, analyse and interpret them according to our own theoretical frameworks and subjectivities. I hope that the women I interviewed would agree with much of my analysis even whilst I know there are some more controversial points with which some might disagree, especially around the issues of judgement and othering.

I argued that utilising religious studies and anthropological writings allows a new perspective on intensive mothering, focusing not on the subordination of women but on their everyday, routinised, embodied practices of pregnancy as just one example of the way in which everyone is involved in ethical self-formation through relationships with others. In this way, the normative claims around the natural as a sacred form and the necessary 'othering' that this entails - the focuses of some studies - are only aspects of women's complex relationships with natural birth. The ideals and practices of natural birth create meaning for women not only in the moments of pregnancy and birth but in subsequent births and sometimes in career changes to birth work. For these women, natural birth is something that 'matters' and is perfected throughout their birthing biographies and in sharing their stories with others. I have shown that natural birth groups are 'things of value' or 'things that matter' in the lives of some women as they prepare for a life-transformative event. Furthermore, I have shown that adherence to an ideal is not always rigid and non-negotiable but can be reflexive, fluid and flexible. Natural birth as an ideal can exert a strong moral force whilst simultaneously being approached practically. In the words of Jane, the embodied practices of natural birth are about the more prosaic pursuit of 'a nicer birth'.

The women I interviewed were seeking to make a balance between a public, moralised and generalised discourse about the ideal natural birth and their own practical and ethical decision making which was individually and socially situated. Through their lived, ethical practices, the women's performance of choice became a public moral statement. Partly this was a form of intentional identity construction, in which they presented themselves as good and responsible mothers in juxtaposition to the generalised other who is not these things. But the hesitations, ambiguities and reflexivity in which they tried to embed their choices and decisions as 'just right for them', also suggests that they were trying to navigate their own way through a highly moralised domain which is always in the public eye, and where current government health policy forces the issue of choice. Hence it must be remembered that structural forces encourage this way of thinking; as the demographic to which resources and public policies are largely geared, women feel responsibility to make choices, and to make the right ones at that.

The women I interviewed should not just be seen as engaged in an individual or narcissistic pursuit of 'the birth I want' (or rather, this is only part of the picture), or of making moral statements about the need to take responsibility and because they do this they are morally superior to others (again, they are doing this, but this is not all of the picture either). They are also seeking an ethical life, through relationships, in the embodied event of pregnancy and birth and beyond in the form of mothering and sometimes a career change to 'birth work'. In making a balance between the public, moralised and generalised discourse and their own individual and practical situations, they can also be considered as seeking to make ethical decisions, through relationships, in the moment of pregnancy and birth. I have argued that it is through embodied practices that women interested in natural birth construct meanings. It is the planning and practice of birth itself - and the interpretation of this practice in relation to the specific form which birth takes in the end (whether the women have felt respected and in control and that their planning and practice was not wasted) - which provides meaning. The practices can hence be seen as lived ethics which women seek to share with others not simply to be moralising but because they provide them with significant meaning, during pregnancy, birth and after. As such, natural birth workers and proponents, including many of the women I interviewed, hope to change the field of birth for the better for everyone.

I have argued that a micro-level focus on women's actual engagements with the morals, values and norms of natural birth – most notably through focusing on women's practices – can change our focus away from these morals as necessarily policing and inhibiting to how they can contribute to meaning-making. However, whilst I have emphasised a micro-level focus in this thesis, I have not neglected the wider social, historical and cultural context. I have emphasised throughout that the women I studied are living under particular conditions of uncertainty and anxiety created by the general conditions of modernity which emphasise individualism, and specific government policies around health which encourage women in particular to take full responsibility for the health of themselves and their children – not to mention their children's education, moral formation, their very 'brain development', as Macvarish (2016) argues. This creates all sorts of pressures and anxieties which are gendered and classed. In the specific case of pregnancy and birth, a rhetoric of free choice and agency, which influences white, middle-class women in particular in the legacy of second wave feminism, is simultaneously curtailed by the medical authorities preoccupation with risk. Many of the women I interviewed believed they had free choice in their pregnancy and birth practices to then discover that their choices were only within those deemed to be acceptable by medical authorities – which, for instance, class high bmi women or those expecting twins, a breech baby, or with a previous c section as 'high risk' and hence excluded from many practices, such as birthing in a midwifery-led unit. This discrepancy, I suggest, creates a particular form of 'moral torment' (Robbins 2004). Robbins (2004) has analysed the Urapmin's moral torments from trying to live with cultural change, in which they live with two cultural systems (traditional culture and Pentecostal, Charismatic Christianity) which are not synthesised but exist as two systems, often in contradiction. Whilst the situation of my participants is not comparable – they are not living under two complete cultural systems at odds with one another – a small note of comparison could be made with the discrepancy between the choice in pregnancy and birth which is encouraged at the policy level and the reality of the medical system. A similar discrepancy has been noted by authors theorising why there are more women than men involved in the holistic milieu (Woodhead 2008a, Sointu and Woodhead 2008, Houtman and Aupers 2008); women now expect to live a 'life of their own', but in reality spend a much greater proportion of their time than men caring for others, still experience a gender pay gap and still experience low-levels of everyday sexual harassment, as the recent #metoo campaign has revealed. For these authors, participation in the holistic milieu is

seen as offering women some respite from this discrepancy and a re-confirming of a worldview in which ethics of care and relationality are prioritised. We should be alert to situations in which people experience discrepancies, anxieties and torments, and seek to analyse how they manage such situations. We should focus on how moral meanings are created through practices.

The work of birth, perhaps including agreeing to be interviewed, involved thinking through and reflexivity on these torments in order to work out the balance of free choice versus restraint. The women I interviewed worked hard to make the choices that they felt were 'right' for them. This often involved a resistance of medical authority, a preference for independent experts, and subtle moral judgements on others who did not make the same choices. Moralising is an inherently negative term, with its connotations of superiority. The women I interviewed did sometimes moralise and did sometimes convey a sense of superiority but, I argue, rather than dismissing this or accepting it as negative, we should more closely analyse the functions that moralising performs. In this instance, moral meanings were used to negotiate, and perhaps resolve, some of the specific problems and anxieties for women in the middle classes in late modernity.

In my focus on practice, I add to some writings on lived ethics which remain at a theoretical level (such as Lambek 2010, 2015). I have emphasised that ideals in contemporary society should be studied as both beliefs and practices. I argue that it is women's embodied practices during pregnancy and birth that put them on the path of working towards an ideal, natural birth. The ideal birth can only be understood through these embodied practices, as the ideal birth is more than a thought or an idea about how birth should be. It is also a practice with which one lives at a bodily level. It is worked towards and is not considered as a sacred absolute which is achieved or failed. Other ideals circulating in contemporary societies could also be approached in this way.

Whilst Chapter Four focuses on the beliefs of natural birth portrayed in natural birth literature and my interview narratives, in general I have focused on practices in this thesis. This is for a number of reasons: 1) as a counter-balance to the traditional academic primacy of the concept of beliefs; 2) to challenge the assumption that practices are always, and only, a performance of pre-existing beliefs, that is, that the logical sequence is always

beliefs come first and practices follow after and; 3) because the women I interviewed themselves emphasised the importance of practice – not only the specific practices in which they engaged to form the body, emotions and mind, but the very concept of practice itself as a means through which they negotiated the ideal and the practical. The women emphasised that they must practice in order to prepare for the ideal; and in some ways what they practiced did not matter. Practice worked because it was a tangible expression of their choices and embodied responsibility. It showed – to themselves and to others – that they were 'good' mothers. The role of embodied practices in the creation of moral meanings and the living of an ethical life must be taken seriously. Practices are formative of beliefs and identities. In terms of social groupings around ideals, people might become involved without strong adherence to the ideal and it is repetitive, embodied practices which then embed them in the movement, as Mahmood (2012) argues with regard to the Islamic piety movement, and I have argued throughout, specifically using the term of 'progressive socialisation'. In this, I have emphasised the role of community, and I have suggested that women's social networks are integral to both their practices of natural birth and the strength of an imagined community around natural birth. This takes particular expression in the weight my participants gave to their chosen 'birth workers'. Exploration of communities of experts on the margins of authority is likely to be an increasing area of academic focus in the current neoliberal age.

Within my own discipline of religious studies, I seek to contribute to recent moves towards understanding what matters in the lives of some people outside of a framework of institutional religion or spirituality - the latter of which, in the 1990s and early 2000s, became a catch-all term for religious beliefs and practices outside of an institution. I have drawn on work which seeks to move the debate around 'what matters' on from religious and metaphysical language. As others have argued (Alexander 2003, 2006, Lee 2015) we need to recognise that there are significant moral forces at play in people's lives which are not necessarily connected to religion. This is not a particularly new argument. In 1990, Kenneth Thompson argued that the subject matter of religious studies was not in decline, as was a popular argument at that time with the focus on secularisation and the apparent retreat of religion from the public sphere, but the subject matter was rather constantly reproduced, even if transformed. He recognised a mixing of secular and religious discourses and called for their analysis. In contemporary society, nearly 30 years after

Thompson wrote, there might not even be a mixing of secular and religious discourses but rather new ideals which need not be labelled as either religious or secular. As recent writings on the sacred and specialness remind us, we do not need to label the ideals with which people live their lives as either religious or secular. The 'third term' of spirituality has also proved to be less than useful as having no definitional clarity and, in my study at least, as alienating participants. I have used the term ideal but others will find more useful terms. I have also demonstrated the relevance of gender and class to processes of meaning-making and the creation of communities around ideals.

I stress that such communities, groups and networks should not be approached as the functional equivalents of religion but that theories from religious studies can usefully be applied in their study. The theories I have used, including lived religion, ritualisation and the anthropology of ethics, are particularly pertinent for studying ideals as embodied practices and moral meanings as lived ethics. We can move away from an understanding of beliefs, morals and values as always connected to the metaphysical. Meaningful embodied practices and relationships are as important for scholars of religion to study as more traditional organised religious movements or spirituality networks, especially in the contemporary context with the rise of the religious 'nones'. There are ways outside of religion to live ethical lives and people engage in beliefs and practices, and form communities around things that matter to them.

I hope that the theoretical approaches which I have utilised bring a little more nuance to some of the existing literature on intensive motherhood and parenting through the change in theoretical focus. The approaches recognise the restrictions of social structures, and the anxieties and moral torments they engender, but focus on how people search for meaning within this; how they seek to make the best out of their situations and live ethical lives. Ethical practices emerge in our thrown togetherness (Lambek 2010), in our relationships with others. Hence we must look at all aspects of relationships. Whilst popular focus might be on natural birthers constructions of themselves as morally superior and others as inferior – which some undoubtedly do imply, as outlined in Chapter Four – we must also look at the communities of care and education formed around birth workers. There are undoubtedly similar communities being formed around other ideals or things that matter to people in contemporary western societies, such as around approaches to death, healing, and

education, to name but a few. In such societies, in which there is a rise of religious 'nones', disproportionately amongst young people (Lee 2015), it will be increasingly important for academics in the field of religion to analyse other moral forces by which people live their lives. In the increasing uncertainty of such societies, in which many people have little faith in religion or the political process, matters of life and death might come particularly to the fore as things of certainty. Death studies has been an established academic field for a while.[13] Perhaps it is time to turn our attention to the embodied, practice-based and relational meanings women construct in bringing life into the world.

[13] There has been a journal with that name since 1977. https://www.tandfonline.com/loi/udst20

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## Appendix 1: Natural Birth Study Flyer

# Are you 20 weeks+ pregnant?

Are you interested in natural / normal approaches to pregnancy and birth?

Would you like to take part in a PhD study exploring the meanings of women's participation in natural birth practices?

*Would you like me to buy you a cup of tea in a location of your choice?*

If yes, then read on.....

# NaturalBirthStudy

My name is Sarah Harvey and I am a PhD student at the University of Kent (in the School of European Culture and Languages). I live in Loughton, Essex and have two primary school-aged children.

I am looking for women who are over 20 weeks pregnant to interview for my study on natural approaches to pregnancy and birth. The study is about exploring the meanings of women's involvement in natural birth communities and practices. Some of the things I want to understand are:

- what are your desires and experiences around pregnancy and birth?
- how have you made choices around pregnancy and birth practices?
- why have you chosen particular pregnancy practices including different types of exercise, relaxation techniques, complimentary therapies, diet, different products and books?
- what do the terms natural and normal birth mean to you?

---

If you are involved in any 'natural' pregnancy and birth practices (however you define this), if you just have a passing interest in natural birth or if you think natural approaches to pregnancy and birth are a waste of time or even dangerous, then I would love to hear from you.

There is more information on my website:

**www.naturalbirthstudy.org**

Please contact me on:
sarah@naturalbirthstudy.org or 07974 303 441

This PhD is funded by a grant from the Arts and Humanities Research Council (AHRC) and has ethical approval from the Humanities Research Ethics Advisory Group at the University of Kent.

University of Kent

## Appendix 2: Interview Questions Guide

I am planning for the interviews to be only loosely structured, focused around just a few open questions, in order to generate narratives. The pre-birth interviews will be more structured than the post-birth interviews which will fall closer to the ideal of the narrative interview by focusing around the question of, 'tell me about your birth experience'. I have organised this guide around a limited number of open questions, listing possible prompts beneath. Not all of the prompts will be raised at each interview, as I will need to gauge during the course of the conversation which will be appropriate. The prompts will need to be raised sensitively and the specific wording will likely vary from case to case.

**Introductory Questions**

Open Question: Tell me a little bit about yourself

Possible Prompts: education, occupation, hobbies

Open Question: Tell me about your family situation

Possible Prompts: partner, children, close family, extended family - location of these.

**Pregnancy Questions**

How far along in the pregnancy are you?

Open Question: Can you tell me about your pregnancy so far?

Possible Prompts: general feelings about health, well-being, emotions, hopes, fears, perception of body/body changes.

Are you seeing an NHS midwife? Have you had routine examinations - e.g. blood tests, screening tests, ultrasound? Any non-routine or private ultrasounds - such as 4D scan? would you consider such a scan - why or why not? (if it seems appropriate - did you ask the sex of the baby - why or why not?)

Are you employing an independent midwife? If yes, why did you decide to do this? If not, is this something you would consider? Why or why not?

If you have given this consideration yet, are you planning a home or a hospital birth? why? (more questions on birth choices below).

Are you attending any type of private pregnancy class?

**Practices during pregnancy/preparations for birth**

Open Question: Can you tell me what you've been doing to prepare for the birth?

Possible Prompts (phrased sensitively using such opening phrases as, 'the sort of things some people have thought about are...'; 'I've seen in the literature that some people....' and then, 'have you thought about this yet....':

*Classes* - have you attended any during pregnancy? If so which ones - NHS antenatal, private antenatal, exercise classes - yoga, swimming, relaxation classes - meditation, hypnotherapy? How did you feel about these classes? Why? What did you get out of these classes? Did you feel different after the class and if so, in what ways? Were they social events? Have you made friends from these classes? How did you find out about these classes?

*Books* - have you looked at any pregnancy and/or birth books? If so, which ones? Which did you enjoy/ not enjoy? Why? How did you find out about these books? Did anyone recommend/ lend them to you?

*Internet* - have you looked online for any information about pregnancy and birth? Which sites? Which have been helpful/unhelpful? Why? Have you used any forums? Have these been helpful/unhelpful? How do you feel about these websites?

*Treatments* - have you had any treatments during pregnancy - such as massage, reflexology, aromatherapy, hypnotherapy? If so, why did you choose that one? How did you feel about it? at the time - and now? In what ways, if any, did it make you feel different? would you do it again?

*Products* - have you used any particular products during your pregnancy? such as vitamin supplements, herbal teas, massage oils, yoga/pilates balls, other? Why did you choose these? Were they recommended in a class, book? Have you found them helpful/unhelpful? Why? Any products which have been particularly important to you?

Additional questions:
Are there any books/classes/products that you wouldn't use? If so, why?

How do these choices relate to other choices you make in your life? - i.e.. have you tried these forms of exercises/treatments/products etc before you were pregnant? If so, why did you choose them then?

Do you feel particularly 'in tune' with your body whilst pregnant? why or why not?

**The Birth Plan**

Open Question: Have you written a birth plan? If so, might I see it? Could you talk me through it?

Possible Secondary Questions:

Why do you think it's important to have a birth plan? What made you write one? Did anyone (e.g midwife, birth teacher, friend, book, website) recommend this?

Does it state who the birth partner will be (e.g. partner, mother, sister, friend etc)? What do you see as the birth partner's role?

Did you write it with you partner? (If applicable and if this seems appropriate). Does your partner agree with all of the points? Have you negotiated on any points?

Have you shown/discussed the plan with anyone else (midwife, mother, friends, peers in pregnancy classes etc.)?

Can you tell me which are the most important points on your plan? Why? Are there any points which you're not so concerned about? Why?

If you haven't written a birth plan yet, do you think you will? Why or why not?

**Expectations for Birth**

(n.b. this covers similar areas to the birth plan, if one has been written, so will need to gauge whether these are still relevant to ask. But I am hoping that this open question will generate more of a narrative than talking through the birth plan which could be quite specific).

Open Question: Can you tell me, in as much detail as possible, how you would like the birth to be?

Possible prompts:

Where will it take place? How/Why did you choose this location?

Who would you like to be present? Why?

What pain relief would you like to use?

What kind of atmosphere would you like - e.g. any particular music playing?

Any particular objects/products that you will use? have present at the birth? why?

Do you plan to welcome the baby in any particular way? (e.g. place on stomach straight away, straight to breast)?

Have you thought about the third stage of labour (delivery of placenta)?

Who will cut the umbilical cord?

Have you thought about how you will feel if the birth does not go according to this plan?

**Approaches to Birth**

Open Question: What does 'natural birth' mean to you?

Possible Secondary Questions:

Is natural birth particularly significant to you? why or why not?

In what ways is it important for you to have a natural birth?

What do you think are the key practices of natural birth?

Do you think there is something of a community around this approach? why or why not? Do you feel a part of this community? why or why not?

What do you think is not part of this approach?

Open Question: What does 'medical birth' mean to you?

Possible Secondary Questions:

What practices/procedures do you think of as part of medical birth? what do you think about these?

Additional Questions:

Some people think it is not possible to have a purely natural birth. What do you think about this?

Do you think natural birth is always opposed to medical birth? why or why not?

**Post-Birth Questions**

Open Question: Please tell me, in as much detail as you can, about your birth experience?

Possible Prompts:

How closely did it match your expectations?

Did you follow your birth plan? If no, what was different? Did you find it easy to give up these points of the plan in the situation? How did you feel about this then? And now?

Did you feel in control during the birth? If not, who do you feel was in control?

How do you feel about the birth experience? Did you find it empowering - or not? Has this feeling lasted over time?

Do you think it has changed you? (not only literally in becoming a mother but do you feel different? more - or less - confident?)

What do you think about the preparations you did during pregnancy? Do you think any books/websites/classes/exercises/products etc. were particularly helpful or unhelpful? Why? Were there any that you would now particularly recommend or not recommend?

If you were to have another child, is there anything you would do differently - in the sense of any books/websites/classes etc etc that you would or would not use? Any different expectations for the next birth? (obviously this would have to be phrased sensitively and might not be appropriate in every case).

What did you like best about the birth? And least?

## Appendix 3: Participant Information Sheet

Thank you for agreeing to meet me/ for letting me participate in the class which you attend and for helping with my research on natural birth communities in the UK. This sheet explains what my research is about and what your part in it will be but please do feel free to ask me any questions, about this sheet or about the project, at any time.

My name is Sarah Harvey and I am a PhD student in the School of European Culture and Languages at the University of Kent. My PhD research is being funded by a grant from the Arts and Humanities Research Council (AHRC). My PhD research is about how and why some women become committed to natural birth practices and communities in the UK. It aims to identify the key beliefs and practices in contemporary natural birth approaches and to investigate the many meanings behind the term 'natural' in natural birth. It also aims to investigate women's own experiences and interpretations around the event of pregnancy and childbirth, and how their choices and practices in this context relate to other issues in their lives, including any religious or spiritual identities. I am especially interested in the practices of natural birth including exercise, practising positions for birth, alternative and complimentary therapies, diet, and choice of products.

I am collecting data for this project in different ways. Your participation in my project might be allowing me to attend a class, workshop or treatment which you attend, or it might be agreeing to an interview - or both. If you agree to my attendance at a class, I will either sit and observe or participate in the class, whichever the class leader feels most appropriate. I will take notes either during the class or afterwards. These notes will be my observations and descriptions. Information recorded about you and other individuals will be anonymised so that there are no identifying factors - you will remain anonymous unless you expressly give me permission to use your name and/or other identifying features.

If you agree to be interviewed for this project, the interview will be informal and will be one-to-one. It will take place at a location of your choice and will most likely last between one and two hours. The interview will be recorded, if you agree to this. You have the right to refuse to answer any of the questions or to stop the interview at any point. You also have the right to ask me to stop recording the interview at any time.

Attached to this information sheet is a consent form. You will be asked to sign this form before the interview. With regard to the observation of classes, it might not always be possible to collect the consent forms of all attendees before the class starts, so you can return the form to me as soon as you are able. If anyone voices objection to my presence in a class I will not stay in the class. If after the observation or after the interview, you change your mind about participating in my research project, you have the right to withdraw and to ask me to delete any information that you gave me that you would not want me to use. You do not have to give a reason for withdrawing from the project. You can also ask me to provide you with a written brief summary of my observation of the class and/or your interview transcript. You can then let me know if there is anything you disagree with or wish you hadn't said and we can then have a conversation about what to do with this information, including you asking me to delete that piece of information.

The information that you have given will be stored on my personal computer in the form of a written document (for participant observation) or an audio file and typed transcript (in the case of interviews). Only I will have access to this information. The transcript of the information will be anonymised - your name will be replaced with a pseudonym, unless you explicitly state that you want me to use your name. It is the anonymised notes and interview transcripts which will be used to write up the results of my thesis.

The information gathered in this research project will form the basis of my PhD thesis. The PhD thesis is a public document because it is held at the university library. The information might also be used to write articles for academic journals and some of it might be used in presentations at academic conferences. The information might eventually be used to write a book.

If you would like to contact me the best way to do this is by email. My address is sarah@naturalbirthstudy.org

Thank you for your time and your interest in my project.

## Appendix 4: Participant Consent Form

I have read the Information Sheet and have had details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time, including in the middle of the interview, and to decline to answer any particular questions. I understand that I have the right to ask for the recording equipment to be turned off at any time during the interview.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. The information will only be used for this research and for publications that might arise from this research project.

I agree to be part of the participant observation study and allow Sarah Harvey to observe some of the classes I attend.
Yes / No

I agree to being interviewed.
Yes / No

I agree to the interview being recorded.
Yes / No

I would like a pseudonym to be used in the research project.
Yes / No

I would like to be sent a brief written summary of the observation and/or my interview transcript.
Yes / No

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signed……**

**Name…….**

**Date……**

## Appendix 5: Debriefing Materials

Thank you for your participation in my study. If this interview has raised issues which you feel you would like to discuss further or with which you need further support, there are a number of organisations which should be able to help you.

Your **GP, health visitor or midwife** should be able to offer advice and support.

**NHS Direct** 0845 4647
http://www.nhsdirect.nhs.uk/

Other organisations which might be able to help:

**The National Childbirth Trust** Charity no. 801395 http://www.nct.org.uk/
"The UK's largest charity for parents".
NCT Helpline Numbers:

Pregnancy & birth - 0300 330 0772

Breastfeeding - 0300 330 0771

Postnatal - 0300 330 0773

Enquiries - 0300 330 0770

Shared experience - 0300 330 0774

**The Birth Trauma Association**
http://www.birthtraumaassociation.org.uk/
"helping people traumatised by childbirth"
Charity no. 1120531
They do not at present have a telephone support service - support is initially via email:
enquiries@birthtraumaassociation.org.uk

List of different support groups at

http://www.bbc.co.uk/health/support/pregnancy.shtml - BBC information pages

# Appendix 6: Participant Profiles

| pseudonym | primary identity | number of children | type of birth | home birth | hypnobirth | nct | yoga | doula | independent midwife | other alternative practices |
|---|---|---|---|---|---|---|---|---|---|---|
| Trisha | mother of 2 | 2 (7 and 2) | 2 cesareans | planned for 1st | | | | yes - for both | | reflexology for overdue, acupuncture |
| Louise | mother of 1 | 1 (18 months) | hospital | | yes | | | | | |
| Chloe | pregnant with 1st | n/a | n/a | planned | yes | | | | | |
| Claire | hypnobirth teacher | 2 (5 and 18 months) | | | yes | | | | | |
| Marilyn | doula | n/a | n/a | n/a | | | | yes | | |
| Linda | mother of 1 | 1 (12 months) | hospital | | yes | | | | | |
| Lucy | pregnant with 1st | n/a | n/a | no | yes | | yes | | | reflexology for water retention |
| Katie | mother of 1 (and masseuse / reiki practitioner) | 1 (19 months) | hospital | planned for 1st | | | | | | cranial-osteopath, homeopathy, massage, reiki, flower remedies |
| Francine | yoga teacher | n/a | n/a | | | | yes | | | |
| Stephanie | independent midwife | n/a | n/a | | | | | | yes | |
| Chelsea | pregnant with 1st | n/a | n/a | | | | yes | | | acupuncture |
| Kelly | pregnant with 2nd | 1 (2 years) | hospital - induced | | | | | | | |
| Elly | mother of 1 | 1 (15 months) | hospital | no | | | | | | |
| Jane | mother of 2 | 2 (4 and 10 weeks) | hospital then home | yes | yes | yes | yes | | | reflexology |
| Jemima | hypnobirth teacher | none | n/a | | yes | | | | | |
| Laura | mother of 2 | 2 (2 and 4 months) | hospital | no | no | yes | | | | acupuncture |
| Maddie | mother of 2 | 2 (2 and 6 weeks) | | | | yes | yes | | | acupressure, homeopathy, osteopathy |
| Maria | mother of 2 and hypnobirth teacher | 2 (19 months and 8 weeks) | home | yes | yes | | yes | | | |
| Jenny | pregnant with 2nd | 1 (18 months) | hospital | yes - planned both times | yes | | | | | reflexology, aromatherapy |
| Shannon | mother of 3 (and a nurse) | 3 (6, 4 and 1) | home with 3rd | yes with 3rd | | | | | | |
| Annie | mother of 2 | 2 (20 and 11 months) | home with 2nd | yes with 2nd | | yes | yes | | | aromatherapy |
| Zara | mother of 1 | 1 (6 months) | cesarean | planned | yes | | | | | |
| Harriet | mother of 2 and yoga teacher | 2 (5 and 18 months) | home with 2nd | yes with 2nd | | | yes | yes (is trained doula) | | is a naturopath, Vegan, anti-immunisations |
| Martha | mother of 2 and hypnobirth teacher | 2 (check ages) | home with 2nd | yes with 2nd | yes | | | | | |
| Nancy | mother of 1 | 1 (4 months) | home | yes | yes | | | | | |
| Emily | mother of 1 | 1 (12 months) | hospital | | yes | | | | | |
| Catherine | pregnant with 3rd | 2 (4 and 2) | home | yes | | | | | yes | |
| Fern | pregnant with 2nd | 1 (4 years) | hospital | planned for 2nd | yes | | yes | | | |
| Flora | independent midwife | n/a | n/a | | | | | | yes | |
| Bella | mother of 3 | 3 (5, 3 and 1) | hospital with 1st, home birth for 2nd and 3rd | yes - for 2nd and 3rd | | | | | yes | |
| Aisha | yoga teacher and doula | 3 | home for 2 and 3 - check | yes | | | yes | yes | | |
| Vivianne | mother of 2 and hypnobirth teacher and doula and reiki | 2 | home birth | yes | yes - also trained teacher | | yes | yes - also trained doula | | Lotus Birth, reiki during labour |
| Caroline | mother of 1 | 1 (2 years) | home birth | yes | | | yes | | | |
| Victoria | independent midwife | n/a | n/a | | | | | | yes | |
| Michelle | independent midwife and mother of 2 | 2 (2 and 4 months) | home births | yes with both | | | | | yes | |
| Kim | mother of 2 and a doula | 2 (4 and 2 years) | home births | yes | | | yes | yes - is also just trained as a doula | | reflexology |
| Sabine | mother of 2 and a doula and a hypnobirth teacher | 2 (4 and 6 months) | hospital | planned home birth with 2nd but didn't get | yes - also trained teacher | | yes | yes - also trained doula | yes (friends with but didn't use) | |
| Rebecca | NHS midwife | n/a | n/a | | | | | | | |
| Amy | mother of 1 | 1 (2 years) | hospital | no | | yes | yes | | yes (friends with but didn't use) | trained hypnotherapist - not hypnobirth |
| Alice | mother of 2 | 2 (2 and 6 months) | hospital - induced with first | planned with 2nd - didn't get | | yes | | yes (family friend, not paid though) | yes (friends with but didn't use) | reflexology for overdue |
| Ruth | mother of 2 | 2 (2 and 10 weeks) | hospital | planned with 2nd - didn't get | | | | | | |
| Davina | mother of 2 | 2 (4.5 and 2 years) | hospital (first induced because of gestational diabetes) | no | | | | | | |
| Macy | mother of 2 | 2 (5 and 2 years) | cesarean then home | yes with 2nd | yes - both times | | | yes - second time | yes - both times | |
| | | | | | | | | | | |
| Barbara | midwife - owner of Bambino's | | | | | | | | | |
| Mandy | hypnobirth teacher | | | | | | | | | |
| Sally | NCT teacher | | | | | | | | | |