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# “Called Her Women Together” Home Birth in Maine

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**“Called Her Women Together”**

**Home Birth in Maine**



**Margaret Kruthoff  
American Studies  
Colby College  
May 2012**

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## Acknowledgements

Nine months ago, I set out to write a thesis on childbirth: hippies having their babies in the woods, hospital politics, and women's rights. The final product is very different than what I had intended. Instead of finding crazy hippies in the woods, I found a community of kind and skilled midwives and loving, openhearted mothers. I am deeply indebted to these inspiring women for their stories and wisdom, which fill the pages of this thesis. Interviewing these mothers, midwives, and home birth advocates was a tremendously empowering experience for me, a young woman.

Professor of American Studies, Margaret McFadden, advised me on the writing of this thesis. My midwife of sorts, Margaret never once doubted my ability to do this work. Her devotion to this thesis and to my academic success is unfathomably deep. I have known Margaret for all four years of my Colby career as a professor, a mentor, and a friend. Having her as my senior thesis advisor was a true gift. Our weekly meetings were the best combination of American Studies courses, feminist consciousness-raising, and conversation between friends. She continually encouraged me to challenge my assumptions, think critically, and grow as an individual. I am most certainly a changed woman for having spent good time with Margaret McFadden.

Finally, I would like to thank Professor of History Elizabeth Leonard for reading and critiquing drafts of my thesis; my friends for listening to me describe childbirth in great detail over meals; my doctor parents for playing the devil's advocate and challenging my romantic notions of home birth, while also being incredibly supportive; and Polly Shyka, my dear friend who inspired me to write this thesis after our conversation about her home births on that peaceful, fall morning at Village Farm.

## Introduction

I began this exploratory study on home birth in Maine because of a feeling, a deep, inside-the-chest sense of knowing that something is right and in line with the universe. I first felt this way while talking with Polly Shyka, an organic farmer in Freedom, Maine, about her experiences having home births with all three of her sons. As the morning light slowly spread across the green pastures, we reclined in rocking chairs on the farmhouse porch, and she told me how she had given birth right upstairs in the bedroom with her husband and the midwives supporting her. A baby, her son Joseph, was born eight years ago, and then years later, Benny, and when Benny was two years old came little Abel. Did she feel safe? I asked. At the time, I thought it a bit risky of her to have her babies at home, far away from the hospital, the surgeons, drugs, and technology that could save lives. What if something were to go wrong? My parents are both in the medical field, and in those early days of my American Studies thesis project on childbirth, I was firmly of the belief that medicine and doctors could be trusted to handle and heal all ailments. Polly just smiled, her gaze steady and gentle, and told me that yes, she felt safe and supported. Everything was all right: they were home.

I initially chose to study childbirth because it was a neat package containing many of my interests: women's biology, women's reproductive rights, a cultural history of medicine, and the role of nature in our lives. I had also heard about this home birth movement popular among the sustainable farming crowd in Maine, a community of which I am a part. Talking with Polly that September day piqued my interest in home

birth, and so I began to read books with titles like *Spiritual Midwifery*, *Birthing From Within*, and *Childbirth Without Violence*. While I learned about contemporary midwifery practices and women being empowered through their birth experience, I was also examining the history of childbirth as a cultural phenomenon: the entrance of male physicians into the birthing room in the 1800s with their limited knowledge of obstetrics and unrestrained use of forceps to “aid” deliveries; the cultural oppression of women in the 1940s, ‘50s, and ‘60s as reflected in hospital birth practices which alienated women from their bodies and babies; and the 1960s and ‘70s embodied movement for change in women’s health, which ran concurrent with radical ideas around politics, sex, and alternative lifestyles and provided the context for a resurgence in midwifery and home birth. Such foundational knowledge of childbirth as an evolving practice influenced by structures of power and authority in our nation would prove essential to understanding the significance of the home birth movement and the courage and activism of the midwives and mothers whom I would meet.

“These are extreme times and if we are going to make change we have to be radical and courageous in our choices” (E. Daniels, personal communication, January 11, 2012). Sitting across the table from me at an organic, farm-to-table sort of café where we held our interview, Ellie Daniels, a certified professional midwife, used these passionate words to describe her work as a midwife in the small coastal town of Belfast, Maine. One of her home birth clients would later describe Ellie to me as a “powerhouse and a community leader” (N. Littrell, personal communication, January 19, 2012), and from our conversation in the café, I’d add feminist, educator, and expert on toxins in our environment and in consumer products to the list of her characteristics. Ellie was the

second midwife I spoke to out of eleven total interviews with three midwives, four mothers, two home birth activists who were also mothers, one family practice physician, and one apprenticing midwife. Ellie Daniels was the first midwife to convince me that home birth within the midwifery model of care could change the world.

Before embarking on my journey into Maine's midwifery and home birth community, my ideas about home birth glowed around the edges in a hippie, natural-is-good sort of way. I was pro home birth, but for romantic reasons and because of feminist critiques of doctors' control over women's bodies. I expected more of the same when I actually sought out the mothers, midwives, and activists to talk about their experiences having or attending home births. What I found was so much more real and exceptional than I could have ever imagined. I met midwives who were not afraid to make emotional connections, mothers who were confident in their parenting, strong in their bodies, and kind in their hearts, and home birth activists who envisioned a new kind of feminism that included birth and motherhood as sites for women's empowerment and choice, not oppression.

These women inhabit a world in which birth is a natural, normal event made meaningful for the woman and her baby through emotional, physical, and physiological support from midwives and the community. The midwifery model of care is a holistic approach to healthcare. Prenatal exams are one and a half to two hours in duration, and the emphasis is on making connections and building trust among the mother, her partner, and the midwives. One mother recalled her prenatal appointments with Ellie Daniels fondly: "We would laugh and laugh and they would ask us about our sex life and my emotional state and [there was] a lot of emphasis on nutrition and supplements, and red

raspberry leaf tea and nettle [tea]” (N. Littrell, personal communication, January 19, 2012). In taking the time to understand the whole person, the certified professional midwives I spoke to could provide care specific to their individual clients on nutrition, wellness, and emotional matters. For the midwives, it was this time spent during pregnancy not only educating and counseling their clients, but also building a relationship that prepared expectant women to have their optimal birth experience.

Home birth is a radical notion in America because it is not in line with our core values, which promote science, technology, and capitalism (Davis-Floyd, 1992, p. 47). Less than 1% of all births take place out of the hospital (MacDorman et al., 2012). Yet, studies conducted in America and Europe have shown that home birth is just as safe as, if not *safer* than hospital birth for low risk pregnant women (MacDorman et al., 2012, and Johnson and Daviss, 2005). According to Arielle Greenberg—poet, home birth activist and educator, and mother—“80-90% of women are low-risk and would be best attended by non-medicalized care”(A. Greenberg, personal communication, January 16, 2012). Despite these facts, “hospital birth is the dominant ideology [in American culture and it has] infiltrated so deeply into our popular culture: T.V., greeting cards with baby bottles and [the words] ‘put in your order for your epidural now!’” (A. Greenberg, personal communication, January 16, 2012). All of the mothers I spoke to encountered disapproval, or at worst, criticism from family members and the general public over their choice to have a home birth. Ruth Jacobs, a first time home birth mother, told me she encountered a lot of resistance: “My father warned me at the very beginning, ‘Make sure you do your research,’ and then he just shut his mouth...I’m sure he didn’t agree with my



decision and he was really nervous about it, but he knew that it was my decision” (R. Jacobs, personal communication, January 12, 2012).

Fielding skepticism from concerned parents was a common issue among the home birth mothers I interviewed. However, their belief in midwifery care and the benefits of home birth for themselves and their babies was not swayed by popular opinion. Once immersed in the midwifery model of care, which holds that “the human body is a living organism with its own innate wisdom...The mother’s body knows how to grow a baby and how to give birth; she can trust the ‘knowing,’ for it belongs to her” (Davis-Floyd, 1992, pp. 156-7), the mothers considered it unsafe to give birth in the hospital because of dangerously high intervention and cesarean section rates, infections, and compromised care. When people would tell Jacobs, “Wow! You’re brave” to have a home birth, she would say to them, “Well, I kinda think it’s brave to have a baby in the hospital.”

Certainly, the birth statistics for hospitals in the United States are discouraging if not frightening. In 2007, the cesarean rate was the highest ever reported in the U.S., at 32% (Menacker and Hamilton, 2010). The U.S. has a poor maternal mortality ratio (maternal deaths per 100,000 live births), coming in far behind other developed countries like France, Sweden, Canada, Australia, and the U.K. (MMEIG, 2008). “The U.S. ranks behind thirty-three other nations in neonatal mortality rates, and forty other nations in maternal mortality rates” (Gaskin, 2011, n.p.). The World Health Organization (WHO) recommends cesarean section rates not exceed 10-15% (WHO, 2002). However, the U.S. spends more money per capita on maternity care than any other country in the world (Gaskin, 2011, p. 126). Home birth activist Arielle Greenberg does not mince words in her interpretation of these statistics:

It is a disaster. Over one in three women are c-sectioned when they go into a hospital. The World Health Organization likened a c-section to having a limb removed unnecessarily. It's major abdominal surgery. They cut through many layers of tissue and muscle, take your intestines out and lay them beside your body, take the baby out of a slit cut [in the uterus], and sew your stomach back up together. [Hospitals are] doing this every day across the country for women who don't need it. If that's not a crisis, I don't know what is.

When necessary, a cesarean section can be a life-saving operation for mother and baby.

However, medical interventions such as electronic fetal monitoring, inducing labor before the completion of 41 weeks gestation with synthetic hormones, and the use of epidurals for pain relief early in labor increase the likelihood of cesarean delivery (Childbirth Connection, 2010). Other factors such as women's limited knowledge of their choices surrounding prenatal care and delivery, the casual attitudes about cesarean section, and doctors' fear of malpractice claims and lawsuits also contribute to the high rates of cesarean section in this country. For this reason, women are beginning to question hospital birth practices. They are instead turning to the midwifery model of care, which does not view childbirth as a medical condition but rather a physical, emotional, and spiritual experience that can be tremendously empowering for women.

## Part I

### Chapter 1

#### **A Short Cultural History of Childbirth in America**

For a practice that has been going on for as long as humans have been on this planet, childbirth has a long and complicated past. In America, the history of childbirth is fraught with cultural ideas about women and power, science and medicine, and most recently, money and malpractice lawsuits. In this first chapter, I will trace the history of childbirth in America from the woman-centered and midwife-attended event of the 1700s to the medically managed, pathologized procedure of the early 1900s. The biology of childbirth has remained largely the same for the past three centuries. Diseases, malnutrition, and organ displacement due to period fashions like corsets (Wertz and Wertz, 1977, pp. 110-111) disrupted normal biological processes for certain laboring women over the course of history. However, the politics and cultural significance of childbirth has changed the practice of giving birth in America many times over and not always to the benefit of women. In fact, to chart the history of childbirth is to plot the position and power of women through various stages of our nation's development.

Childbirth was a woman-centered and women-controlled practice in Colonial America. Local midwives, who may have been skilled healers or simply a female relative who had witnessed several births, attended women in labor. Maine was home to one such famous midwife and healer, Martha Ballard. We know a great deal about Martha and her

work because she wrote a diary from 1785 to 1812. Although childbirth was still quite dangerous in that time, Martha successfully delivered close to a thousand babies in and around Hallowell, Maine with few incidents of fetal or maternal death (Wertz and Wertz, 1977, p. 9). She would sometimes attend births or house calls in the middle of the night, canoeing the Kennebec River to reach her client's homes.

Midwives, the title meaning "with woman," were influential community figures in pre-industrial America (Wertz and Wertz, 1977, p. 6). In their comprehensive history of childbirth in America, *Lying-In*, Wertz and Wertz (1977) write, "Many of the existing fragments of information about colonial midwives consist of church and court records...they do imply that the colonists accorded midwives considerable authority about women's physical condition, trusted them to speak knowledgably and reliably, and treated midwives as if they were servants of the moral and civil order of the state" (p. 8).

Midwives were not the only women who attended births in the 1700s. Many scholars cite birth as an important female ritual in this time and thus term the experience, "social childbirth" (Wertz and Wertz, 1977, p. 2, and Leavitt, 1986, p. 37). Kin and friends supported the laboring woman while she gave birth and during the three or four week lying-in period after the birth. These women "provided emotional support [and] took over the household chores during the lying-in period" (Wertz and Wertz, 1977, p. 4). Martha Ballard writes in her diary on July 23, 1785: "Daughter Town unwell all day. Called her women together about two o'clock, afternoon; was safely delivered of a daughter at 7 o'clock, but somewhat weak. I sat up with her all night" (Woloch, 2002, p. 63). Scholar Carroll Smith-Rosenberg argues that such giving and receiving of support

among women during the uniquely female experience of childbirth “formed the basis of women’s domestic culture” (Leavitt, 1986, p. 37).

Industrialization, urbanization, and advances in modern medicine during the nineteenth century changed childbirth practices in America. Aspiring doctors capitalized on childbirth as a moneymaking and skill-refining enterprise. In the first half of the 1800s, midwives and doctors competed to attend women in labor. “Doctors carved out as their territory pathological or abnormal births. They then went on to define all births as either inherently or at least potentially pathological and abnormal, so that there was no room for the midwife,” writes Barbara Katz Rothman in her chapter “Laboring Then: The Political History of Maternity Care in the United States” in the book *Laboring On: Birth in Transition in the United States* (2007) by Simonds, Rothman, and Norman (p. 9). The doctors, with their new-fangled forceps and anesthetics to ease the pain of labor and make birth more efficient, out-competed the old-fashioned midwives. However confident they seemed, emerging obstetricians in the early 1800s had typically never seen an actual birth, and were “armed only with theoretical knowledge about how parturition was supposed to proceed” (Leavitt, 1986, p. 42). Throughout the 1800s, obstetricians caused their laboring patients much distress including infection and childbed fever, perineal lacerations, uterine lacerations, fetal injury from forceps, and more, in exchange for their expertise (Simonds et al., 2007, p. 12). Yet upper class white women desired the presence of male doctors at their births as they “believed male physicians offered additional security against the potential dangers of childbirth” (Leavitt, 1986, p. 39).

In the Victorian Era, changing ideas about women’s role in society and her virtue influenced childbirth practices dramatically. Birth was a complicated process in the

Victorian Era—what with all the clothing. Corsets, extreme prudery in all sexual matters, and women’s poor health made for difficult births for middle and upper class white women. Lower class women did not fare well, either. High rates of infection and disease as well as medical experimentation and interventional practices at charity hospitals increased the likelihood of these women dying in childbirth.

Social mores of the Victorian Era further complicated the medical profession’s view of women’s health. Wertz and Wertz (1977) explain, “Nineteenth-century medicine added a moral dimension, holding that the healthy functioning of a woman’s organs was a measure of her personal and social worth” (p. 105). In other words, the “fitness” of a woman’s sexual organs determined her character and wellbeing (Wertz and Wertz, 1977, p. 100). However, extreme modesty during Victorian times forbade women to acknowledge their own sexuality. Modesty also prevented doctors from physically examining women, and so they had to rely on other factors, like a woman’s disposition and social class, to provide a diagnosis. Medicine in this time was faulty, to say the least. Furthermore, the mysterious sickness doctors called hysteria or neurasthenia, which plagued middle and upper class Victorian women, befuddled doctors and further confirmed women’s weakness and subordinate position. Victorian women’s poor health and near-constant patient status justified moving birth to the hospital in the early 1900s.

By the 1930s, it was commonplace for middle and upper class women to give birth in the hospital, and by 1950 most all women were going to the hospital to give birth. Surgical intervention and pain management characterized hospital birth in the early 1900s. In the first half of the century, hospitals offered pain relief in the form of ether, chloroform, or “twilight sleep.” Twilight sleep was a state induced by the administration

of scopolamine (an amnesiac) and morphine (an opiate). “A woman under twilight sleep can feel and respond to pain; the claim is only that she will not remember what happened. Women in twilight sleep therefore had to be restrained lest their uncontrolled thrashing cause severe injuries, as the drugs left them in pain and disoriented” writes Rothman in *Laboring On* (Simonds et al., 2007, p. 17). Anesthetics offered the illusion of safety and sometimes allowed women to relax, which was important during delivery; however, these drugs further alienated women from their bodies and allowed doctors to dehumanize their female patients.

Another influence on hospital childbirth practices was the practice and publications of Dr. Joseph B. DeLee. DeLee was a prominent obstetrician in the 1920s whose article “The Prophylactic Forceps Operation,” printed in the *American Journal of Obstetrics and Gynecology*, set the standard for obstetrical intervention for decades to come. DeLee believed that birth was inherently dangerous for women and required careful monitoring and medical management. He recommended routine use of forceps and episiotomy, manual extraction of the placenta, and ergot to induce uterine contractions after birth (Leavitt, 1986, pp. 179-180). These recommendations were based on his theory of labor and birth as something akin to “a baby’s head being crushed in a door” (Simonds et al., 2007, p. 16). DeLee also looked out for fathers: “DeLee claimed that the episiotomy would ‘restore virginal conditions,’ making the mother ‘better than new’” (Simonds et al., 2007, p. 17).

Obstetricians’ eagerness to operate in the twentieth century—“Approximately 25 percent of hospital deliveries were operative” in the 1920s and 30s (Leavitt, 1986, p. 182)—made hospital childbirth unsafe for women. Despite medical advancements in

obstetrics, women were not better off laboring in hospitals under the authority of doctors. Leavitt (1986) writes, “rather than making childbirth safer, physicians in the 1920s and 30s...were responsible for maintaining unnecessarily high rates of maternal mortality” (p. 182). Hospitals continued to treat women for the “condition” of childbirth in an operative and interventional manner into the 1940s and 50s. Fortunately by this time “maternal mortality had fallen in the wake of increasing hospital regulation of obstetrics practices, antibiotics to treat infection, transfusions to replace blood lost by massive hemorrhaging, and prenatal care to identify many potential high-risk cases” (Leavitt, 194). The “natural” childbirth methods of Dr. Grantley Dick-Read in his publication *Childbirth Without Fear* in 1944 and the breathing techniques popularized by Dr. Lamaze in 1959, hinted that the medicalization of childbirth had gone too far.

However, the misogynistic climate of the 1950s prohibited women from challenging medical authority. Issues like Betty Friedan’s “the problem that has no name,” the repressive environment of the Cold War, and strict gender roles that kept women in the home to buy material goods and raise children limited women’s opportunities in the 1950s. Also, women at this time were having more children than they were in the 1930s, thanks to post-war affluence; this spike was called the “baby boom” (DuBois and Dumenil, 2009, pp. 589-597). The public’s dissatisfaction with American politics, the oppressive climate for women, and limited opportunities for African Americans in the 1950s led to mass movements for civil rights, women’s rights, and alternative politics and lifestyles in the 1960s and ‘70s.

Thanks to the counter-culture movement and Women’s Liberation in the late 1960s and early 1970s, reproductive health for women and childbirth practices improved



dramatically. In the next chapter I will talk about the influence of two texts at this time—*Our Bodies, Ourselves* and *Spiritual Midwifery*. I will discuss how these books empowered women to take control of their own bodies and health. For some women this meant advocating for safe contraception and abortion rights, for others, it meant returning to a natural way of giving birth and reviving the practice of midwifery. The 1970s was the beginning of the home birth movement. For many of the midwives I interviewed, their participation in this movement determined the course of their future. The next chapter will explain how the “changin’ times” of the 1960s and ‘70s set the foundation for the home birth movement in Maine.

## Chapter 2

### Books and Bodies: Reimagining Women's Health and Childbirth in the 1960s and '70s

The most striking aspect of the books *Our Bodies, Ourselves* by the Boston Women's Health Book Collective (1973) and *Spiritual Midwifery* by Ina May Gaskin (1975) are the illustrations and photographs of women and their bodies. Women with pregnant bellies, young women engaging in conversation, older women exercising, women enjoying their birth experience, and lesbian couples interacting are some examples of the images in these texts. These photographs of women in many different states illustrate the central message of both texts, which is that a woman is a multi-faceted, ever-changing, and whole being. Before the women's health movement and the counterculture movement of the 1960s and '70s (the two cultural contexts from which the texts *Our Bodies, Ourselves* and *Spiritual Midwifery* emerged, respectively) women were confined to a narrow, limited role. *Our Bodies, Ourselves* and *Spiritual Midwifery* were seminal works that changed the way women thought about their bodies, particularly childbirth. Through their ideas and language, and as icons of counterculture movements, these texts revolutionized women's health, concepts of women's bodies, and childbirth

practices. Most significantly for my interests, the publication of *Spiritual Midwifery* marked the start of the home birth movement.

Both *Spiritual Midwifery* and *Our Bodies, Ourselves* are part manifesto, part manual, written by women for women, and quite radical in their comprehensive information and illustrations detailing female bodies, sexuality, and female body processes such as childbirth. It is well known that these texts were emblematic of their respective counterculture movements in the 1970s. For example, Sheryl Ruzek, author of *The Women's Health Movement: Feminist Alternatives to Medical Control* (1978) cites the publication of the first edition of *Our Bodies, Ourselves* in 1973 as the spark that ignited a “full-blown feminist health movement” (p. 33). In *The 60s Communes: Hippies and Beyond* (1999), Timothy Miller lauds Ina May Gaskin’s pioneering work as a midwife at the Farm (a commune established in 1971) and as author of *Spiritual Midwifery*; Miller (1999) calls the Farm “a pillar of the American home birth movement” (p. 188). Yet despite their close publication dates (1973 and 1975) and their similar ideas about revitalizing the closeness and community among women, and the importance of emotion in connection to the physical body, scholars rarely compare or associate these texts with one another. Anthropologist Emily Martin, in her book *Women in the Body: A Cultural Analysis of Reproduction* (1987), presents home birth as the most radical form of resistance to the medical institution, noting that it solves the problem of women’s lack of control over their bodies and experiences during childbirth in the hospital because, “When they give birth at home, they own the whole shop and can be in charge of the entire enterprise” (p. 143). Ruzek (1978) briefly recognizes the collaboration between the hippie/communal movement and the Women’s Health Movement saying, “Feminists,

“hippies,” home-birth and prepared childbirth proponents, and breast-feeding advocates all recognized their common interests and sought to work toward common goals, despite their many differences in life-style and political orientation” (p. 59).

It will be my work in this chapter to discuss how *Our Bodies, Ourselves* and *Spiritual Midwifery* shaped women’s views about their bodies and women’s health matters, including childbirth. I will first examine how *Our Bodies, Ourselves* educated women about their unique biology and offered new perspectives on women’s health. Then, I will present how an alternative way of living communally from the land gave rise to the home birth movement and Ina May Gaskin’s work *Spiritual Midwifery*. With this groundwork of the books and their cultural contexts in place, I will go on to discuss the places where the texts intersect, either in agreement or disagreement. Finally, I will emphasize the revolutionary work of these two texts in creating new imagery and ideology about women’s bodies and childbirth. Born out of revolutionary counterculture movements in the 1970s, *Spiritual Midwifery* and *Our Bodies, Ourselves* marked new beginnings for women and childbirth in America.

\* \* \*

In the late 1960s and early 1970s, women across the nation were getting together in small groups to discuss their dissatisfaction with the medical system’s treatment of women. These women were frustrated at best and traumatized at worst by experiences with doctors who were “condescending, paternalistic, judgmental and non-informative” (BWHBC, 1973, p. 1). They felt kept in the dark about matters important to their own

health. Historians DuBois and Dumenil (2009) summarize attitudes about women's health in 1950s like this: "The authority of physicians, roughly 90 percent of whom were male, routinely went unchallenged, and women's complaints were often treated as psychological rather than physical" (p. 691). One group of women aimed to ameliorate this situation by exercising greater control over their bodies and their health. The newly formed Boston Women's Health Book Collective spent the summer of '69 pouring over textbooks and medical journals, and critically evaluating medical institutions and their own experiences with doctors and health matters. The women planned to write papers that they would present to one another on subjects such as "anatomy and physiology, sexuality, venereal disease, birth control, abortion, pregnancy and childbirth, medical institutions, and the healthcare system in the context of a capitalist society" (Ruzek, 1978, p. 32), however, the series of papers soon became the book *Our Bodies, Ourselves*. It was a new kind of textbook—one that valued women's experiences as much as "facts." *Our Bodies, Ourselves* "contain[ed] real material about our bodies and ourselves that isn't available elsewhere, and we have tried to present it in a new way—an honest, humane, and powerful way of thinking about ourselves and our lives" (BWHBC, 1973, p. 2). *Our Bodies, Ourselves* provided women reliable health education and support through stories so that they could become their own health experts and advocates.

In the 1950s, women's ignorance about their own bodies due to the repressive and anxiety-driven Cold-War culture and the inherent sexism within medical institutions resulted in negative health consequences for women. In *The Women's Health Movement: Feminist Alternatives to Medical Control* (1978), Sheryl Ruzek writes of the 1950s: "Because physicians expect emotional causes, they sometimes fail to diagnose organic

conditions, inaccurately misclassify whole syndromes and disorders, and improperly prescribe mood-altering drugs” (p. 78). Understood as “persons to be sheltered and protected from unpleasant facts and relieved of responsibility for decision making”(Ruzek, 1978, p. 33), women had little access to medical information and minimal rights to decision making in their own health matters. This proved disastrous as many standard medical practices and procedures were found to be ineffective or hazardous in the late 1960s and early 1970s (Ruzek, 1978, p. 34). Examples of iatrogenic (an illness or complication that is the direct result of medical treatment) health issues for women at this time include the alarming side effects of oral contraceptives, and the prescription of the synthetic estrogen drug, diethylstilbestrol (DES) to approximately 3 million women between 1945 and 1970 to prevent miscarriage. Despite six scientific reports that DES was ineffective in preventing spontaneous abortions, many doctors recommended the drug. Tragically, DES caused a rare form of vaginal cancer to develop in daughters who had been exposed to the drug *in utero* (Ruzek, 1978, p. 39). The women’s health movement of the late 1960s and early 1970s addressed these concerns and others including abortion rights, birth control rights, childbirth practices, and perceptions of female sexuality.

As a crucial text of the women’s health movement, *Our Bodies, Ourselves* begins with this guiding statement in the preface: “Our bodies are the physical bases from which we move out into the world; ignorance, uncertainty—even, at worst, shame—about our physical selves create in us an alienation from ourselves that keeps us from being the whole people we could be” (BWHBC, 1973, p. 3). The book addresses such ignorance,

uncertainty, and shame for “our” female bodies in a manner that goes far beyond what any women’s biology textbook might achieve.

In detailed illustrations, women’s stories, and useful, comprehensive, medical information, *Our Bodies, Ourselves* broadens the definition of a “normal woman” in a number of ways. Firstly, the book expels cultural stereotypes about women’s embodiment and sexuality, and presents instead a wide range of normal possibilities and ways to be; the book unabashedly takes on taboo subjects like sexual fantasies, masturbation, lesbian lovemaking, and abortion. Second, the book includes in most all of its chapters real women’s stories and opinions, which add to the discussion and create a we’re-all-in-this-together feeling of community about the book. In doing this, *Our Bodies, Ourselves* shows that women’s feelings are of equal value to facts. By including these stories, the book emphasizes the importance of sharing experiences, talking about body issues, and coming together as women to effect change on individual and societal levels. Third, the book recognizes the harm in mystifying women’s body processes. For example, in the chapter entitled “Childbearing,” the authors write:

Words like “mystery,” “ultimate,” “beautiful experience”...“that exclusive sorority called Motherhood” [to describe pregnancy]... Mystifying words and attitudes keep us ignorant, immobile, and passive at a time when we most need to know specific details about what to expect and what to do. Why such mystification? Women, who menstruate bloodily, carry children in their wombs as animals do, give birth with obvious effort and some discomfort, are close to nature. But our male-dominated culture is threatened by this physicality and creates pretty myths about us, which we come to believe. (BWHBC, 1973, p. 158)

*Our Bodies, Ourselves* equips women to become their own health experts by translating medical language, describing body parts and processes, and coaching women on how to interact with the medical system. Furthermore, *Our Bodies, Ourselves*

embraces and seeks to understand the culture in which it exists. As a text functioning within the women's health movement and reacting to 1950s misogynist society, the book frequently unpacks societal views of women to expose how they diminish women's power. *Our Bodies, Ourselves* reconnects women with their biological nature, yet does not singularly define women by it. Barbara Rothman, author of *In Labor: Women and Power in the Birthplace* (1991), sums up this stance *Our Bodies, Ourselves* takes when she speaks of "a feminism that embraces rather than denies women's biological realities" (p. 49).

\* \* \*

For some involved in the hippie counterculture movement of the 1960s and '70s, rejecting social norms or "the rampant individualism of American culture and the greed, injustice, and violence of society" meant getting back to nature and living communally (McLaughlin and Davidson, 1990, p. 92). Ina May Gaskin, author of *Spiritual Midwifery* (1975), was one such hippie. Ina May and her husband, Stephen Gaskin, caravanned from California to Tennessee with 270 other like-minded folks. They established The Farm commune in Summertown, Tennessee in 1971, which while "dedicated to ego-denying communal equality" was largely based around Stephen Gaskin's spiritual leadership (Miller, 1999, p. 118). Like many other newly formed communes at that time—and there were many, Corinne McLaughlin and Gordon Davidson write in *Builders of the Dawn* (1990), their study of communes then ('60s) and now ('90s), that America experienced the "largest wave of communalism in the 1960s...there were over two thousand



communes ‘of significant size’ in thirty-four states” (p. 92)—The Farm espoused free sexuality, marijuana and natural psychedelics, agricultural self-sufficiency, Eastern spirituality, and land-sharing. Tim Miller sums up the philosophy of the ‘60s communes in his book *The 60s Communes: Hippies and Beyond* (1999) as “seeking to rebuild society from the ground up, the spirit of ecstasy, expressiveness, naturalness, interconnectedness, and getting back to essentials” (pp. 150-51).

In this spirit of getting back to nature, it is not surprising that communes were the birthplace of the home birth movement. Ina May witnessed her first birth in a school bus camper in a parking lot at Northwestern University. She says in *Spiritual Midwifery*, “Everything went perfectly...the baby...came out easily and started breathing by himself. There were no complications with the mother. I was in a state of complete amazement for several days. I felt a definite calling to be a midwife...I began to study whatever I could find about delivering babies” (Gaskin, 1975, p. 19). With this auspicious start to her midwifery career, Ina May Gaskin studied the science and art of natural childbirth, and she and her team of midwives opened up The Farm Midwifery Center, an extremely successful, nonhospital, birthing center still in operation today. What began as a sensible practice of giving birth within the cultural context of the communal/hippie movement — that is, naturally, at home, and surrounded by supportive midwives and loved ones—was really the start of the home birth movement in the United States. Ina May Gaskin’s work and book, *Spiritual Midwifery*, was crucial in moving home birth from the communes to the mainstream.

The ‘60s communal movement was all about collectivity—of people, of work, of belief. The hippies were going to find a new way to live, and they were going to do it

together. Miller (1999) quotes John Sinclair, a musician, poet, and civil rights activist of the '60s, as saying “We have to see that it’s all connected, that we are not going to be free *individually* until *all* people are free *collectively*. Dig it” (p. 151). Living collectively meant living naturally too. Many '60s communes practiced vegetarianism, grew their own food organically on shared land, and generally lived environmentally friendly lifestyles by subsisting on the bare necessities and investigating alternative energy sources like passive solar (Miller, 1999, p. 158). Rural communes were more than a viable alternative to the industrial, politically corrupt, polluted, and alienated cities (Miller, 1999, p. 152), they were places where one could “be healed by the beauty of nature” and experience the transformative power and wisdom of Mother Earth. Timothy Miller (1999) writes of the ethos of the commune:

A persistent theme within the larger 1960s-era cultural critique was the rejection of modern society’s dalliance with the artificial, the plastic, and the processed. The new consciousness called for a return to the natural, the unashamed, the organic, the raw and unprocessed—and for as much local self-reliance as possible, rather than dependence on massive industrial production of food, energy, medical services, and the like. The affirmation of the natural began with the human body (p. 197).

Miller goes on to discuss nudity, sexuality, food, and health in the communes, however I see his words as directly applicable to Ina May Gaskin’s work as described in *Spiritual Midwifery*.

*Spiritual Midwifery* (1973) is not the average childbirth guide. Filled with pictures of naked birthing women (some happy, others in great discomfort), flowery motifs, and words like “psychedelic,” “telepathic,” and “flowing energy,” the book is part midwifery-manual, part women’s birth manifesto. It is split up into three main chapters: “Amazing Birth Tales,” “To the Parents,” and “Instructions to Midwives”; important information on

equipment and record keeping is detailed in the “Appendices” section. The natural way of birth depicted in *Spiritual Midwifery* goes beyond rejecting anesthetics. Ina May has a true understanding of women’s natural capabilities to give birth, and she views birth as a spiritual, meaningful experience in a woman’s life. For example, in an address to midwives she writes, “The spiritual midwife brings about states of consciousness in ladies that allow physical energy transformations of great power, great beauty and great utility” (Gaskin, 1975, p. 284). By maintaining a respect for the natural birth process, *Spiritual Midwifery*, like *Our Bodies, Ourselves*, changed women’s ways of thinking about their bodies, particularly childbirth. Two tenets of Ina May Gaskin’s midwifery work—a faith in natural processes and the importance of the mind/body connection—derive directly from The Farm commune, a holistic community that elevated nature and spirituality.

In her more recent midwifery guide, *Ina May’s Guide To Childbirth* (2003), Ina May states emphatically that “birth is a normal physiological process” (p. 131). This guiding principle of her work is exemplified in *Spiritual Midwifery* by the positive birth stories that take up nearly half of the volume and by how Ina May chooses to speak about birth: her terminology and imagery. In contrast to mainstream birth stories, which are characterized by painful, dramatic labors and a doctor who saves the day, the birth stories in *Spiritual Midwifery* speak of an intense, women-centered, spiritual, and empowering experience. The women begin these birth stories with the first faint contractions and continue to the final stages of labor and the birthing, all the while detailing their emotional states and the support they received from midwives and partners gathered around. The stories depict a range of birth experiences, from orgasmic birth to

miscarriages. In one story, a husband describes his laboring wife like this: “She was letting out these amazing lion roars while she pushed, and kind of giggling and relaxing on me in between” (Gaskin, 1975, p. 216). Another woman writes, “When I started pushing, it was with my whole thing...Douglas held up a mirror for me to see my pussy and I was amazed. It looked very psychedelic, like the big pink petals of a flower opening up. It was really beautiful. It surprised me and I felt like I had a new respect for my body” (Gaskin, 1975, p. 217). These women emphasize how giving birth made them feel strong, whole, and in tune with their bodies. Also, the language and imagery these women use is quite different from the dehumanizing, medical language of hospital births: women are compared to lionesses, and vaginas are called pussies. Such natural, understandable language makes birth seem more like a normal human process and less like a disease or a condition. The birth stories are woman-centered; there are no male-doctor heroes to save the day or “deliver” the baby. As Rothman (1991) says, these “women are the subjects, the doers, the givers of birth” (p. 34).

Ina May continues to employ this non-conventional, women-friendly language in the second half of *Spiritual Midwifery* in which she offers instructions to parents and midwives. She claims, “Pregnant and birthing mothers are elemental forces, in the same sense that gravity, thunderstorms, earthquakes, and hurricanes are elemental forces” (Gaskin, 1975, p. 282). To fit this perspective, she invents a new way of speaking about birth, which honors women and naturalizes the experience. The sensations of childbirth are considered in terms of energy, not pain. For example, a mother describes her labor like this: “[Laughter] got the energy up higher and of course the rushes came on stronger. It was far out to keep on integrating each new level of it” (Gaskin, 1975, p. 153).

Contractions are called rushes, and the woman plays an active role in her experience as either “a passive vessel through which the force flows or an active participant ‘riding’ the energy” (Martin, 1987, p. 158).

Language like this dissolves the culture of fear surrounding birth, which comes from the perceived pain of childbirth. Ina May explains, “women at The Farm know that labor can be painful, but many of them know as well that labor and birth can be ecstatic—even orgasmic. Above all, whether or not they experience labor as painful, to a woman, they found labor and birth a tremendously empowering passage” (Gaskin, 2003, p. xiii). The interpretation of pain is one crucial difference between home birth and hospital birth. In a hospital, the sensation of pain is indicative of something being wrong in the body, and in the case of childbirth, pain legitimizes medical intervention. However, Ina May holds that the pain of childbirth “is clean...Labor pain is a special type of pain: It almost always happens without causing any damage to the body” (Gaskin, 2003, p. 165). Rothman (1991) goes further saying:

Pain means different things at different points. What would be taken by itself as a painful sensation, when felt at orgasm, may be incorporated into the orgasm and never felt as pain at all. And birth does have much in common with orgasm: the hormone oxytocin is released; there are uterine contractions, nipple erection, and, under the best circumstances for birth, an orgasmic feeling. (p. 82)

From contractions to rushes, pain to intense energy, *Spiritual Midwifery* teaches that a woman’s experience of childbirth is very much dependent upon her mindset.

The mind/body connection is a guiding principle of natural childbirth and in keeping with the spirit of wholeness at the Farm commune. One woman whose birth story was featured in *Spiritual Midwifery* understands that the connection of body and

mind is essential to a fulfilling and empowering birth experience. “If you decide that you want to keep yourself together and get high off the energy of your kid being born and have that agreement with your man and the midwives, it can easily be the most holy day of your life” (Gaskin 1975, p. 126). In *Spiritual Midwifery*, Ina May gives as much attention to mother and child bonding, energy, and telepathy during labor as she does hematocrit values and breech presentations. Furthermore, her method of care maintains this holistic approach: “Since body and mind are One, sometimes you can fix the mind by working on the body, and you can fix the body by working on the mind” (Gaskin, 1975, p. 350). For example, if a woman’s labor has stalled, Ina May considers both the mental and physical factors that might be halting her progress. In *Ina May’s Guide To Childbirth* (2003), she discusses how emotions and feelings can inhibit or enhance the physiological process of childbirth. She writes, “I learned that true words spoken can sometimes relax pelvic muscles by *discharging emotions* that effectively block further progress in labor” (p. 135). In this more recent work, Ina May also discusses her concept of “Sphincter Law.” Sphincters are circular muscle groups surrounding and serving to guard or close openings in the body such as the anus or the vagina. When it is necessary for the body to eliminate waste or birth a baby, the sphincter muscles will relax and open, allowing the passage of whatever must move through (Gaskin, 2003, p. 170). There are several properties of sphincters, which Ina May has recognized and incorporated into her theory of Sphincter Law as it applies to childbirth. These properties are commonly known, yet not commonly applied to hospital childbirth practices. Here are a few. Sphincters do not obey orders: sphincter muscles will not open on command, and so “Pushing will take place without the mother requiring someone to shout at her when and how to do it”

(Gaskin, 2003, p. 172). Sphincters function best in an atmosphere of familiarity and privacy. Laughter, deep breathing, making sounds, or speaking words—particularly kind words—all help open the sphincters. “The state of relaxation of the mouth and jaw is directly correlated to the ability of the cervix, the vagina, and the anus to open to full capacity” (Gaskin, 2003, p. 170). Most all aspects of natural childbirth as detailed in *Spiritual Midwifery* honor the mind/body connection by honoring the woman and her sphincter muscles.

This new way of birthing naturally, pioneered by The Farm midwives, offers women a new way of experiencing childbirth. *Spiritual Midwifery*'s birthing philosophy is very much in keeping with the '60s communal movement's respect for nature, spirituality, and wholeness in body and community. Natural birth in *Spiritual Midwifery* is a woman-centered practice, which melds medical expertise with traditional wisdom and spirituality so that women “can experience the true wisdom and power that labor and birth have to offer” (Gaskin, 2003, p. xiii).

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The issues over which *Spiritual Midwifery* and *Our Bodies, Ourselves* clash or converge are, not surprisingly, the most controversial ones. Can a feminist also proudly call herself a mother? What is the most effective course of resistance in response to harmful medical practices and procedures? How can women assert their wholeness in the context of a medical system that fragments their bodies and dismisses their minds? The intersections of these texts and their respective movements attest to the scale and

significance of the general movement for women's empowerment during the 1960s and '70s.

In the remainder of this chapter, I will discuss two places where the women's health movement and the natural childbirth movement meet in text and ideology. The feminists and home birth advocates disagreed over the issue of motherhood. Feminists saw motherhood as a limitation to higher aspirations and professional goals while home birth advocates considered motherhood an empowering experience and an important aspect of womanhood. The two movements agreed on the issue of sexuality in birth—both texts critiqued the dehumanizing way the medical system treated women's bodies, especially during childbirth. Whether or not the women's health movement and the home birth movement agreed, it was around these issues—motherhood and female sexuality during birth—that much of the consciousness-raising and change-making work occurred, which was ultimately the aim of both movements.

Many of the key objectives of the women's health movement such as fighting for safe, reliable contraception and abortion rights, demonstrated the movement's "central thrust...to free women from self-definition based on reproductive functions" (Ruzek, 1978, p. 197). Therefore, the alliance between feminists and home birth proponents was "tenuous" (Ruzek, 1978, p. 196) because of differing views on motherhood. Feminists aligned with the women's health movement recognized the need for "supportive settings for childbirth, where women could be in control of their bodies at all times in order to promote an emotionally satisfying birth process," (Ruzek, 1978, p. 197) however they considered motherhood a limiting vocation. Ruzek (1978) writes, "with the growth of feminism, many women showed indifference or even hostility toward motherhood as a



career” (p. 194). The energy of the women’s health movement was spent broadening the acceptable roles for women in society beyond motherhood. Ina May recognized this dissonance between the two movements. In *Birth Matters: A Midwife’s Manifesta* (2011), Ina May writes about the convergence of second-wave feminism, birth, and motherhood. “Some influential feminist voices that were otherwise quite insightful almost exclusively saw motherhood as a trap to women’s advancement, one that should be avoided by whatever means possible” (p. 17). Ina May believed this difference of opinion over the value of motherhood originated because feminists were “seeking the kind of empowerment that was measured solely in masculine terms,” for example; success in the professional world, rather than empowerment in other areas of womanhood like childbirth and motherhood (Gaskin, 2011, p. 19). The general gist of the home birth movement was that a woman was powerful and successful because of her ability to give birth and nurture life, while feminists of the women’s health movement acknowledged and supported women’s ability to give birth and raise children but wished for women to derive power from other areas in life, like their careers.

The women’s health movement and the natural birth movement were in absolute agreement that the medical system’s denial of the sexual aspect of childbirth alienated women from their bodies and made them less-than-whole people. Central to *Spiritual Midwifery* and *Our Bodies, Ourselves* is abhorrence for the medical system’s fragmentation of women’s bodies, especially during childbirth. It is strongly emphasized in both books that *whole* women—those having ownership over mind, body, and sexuality—are empowered women. Both texts aim to change women’s understanding of childbirth from a pathological procedure to a natural part of their total sexual experience.

Ruzek (1978) points out that the organization of the medical system inherently fragments women into a series of reproductive organs. She explains how women literally “enter” the health system through their reproductive organs, “We would think it very humorous to have men entering the health system through their penises, reproductive systems, and urologist; why do we not find it equally ludicrous that women’s health care is principally organized around her uterus and her reproductive potential?” (p. 11). In spite of the various medical specialties devoted to caring for women’s sexual organs, once women enter the hospital, they are stripped of their sexuality by hospital practices and bedside treatment, especially during pregnancy and childbirth. For example, in the 1960s and ‘70s, the standard position for a woman to deliver her baby in most hospitals was the lithotomy position, in which the woman’s legs are held up and apart in stirrups while she lies flat on her back (Martin, 1987, p. 161). She is also draped except for her genital area, which “depersonalizes the woman into a nonsexual being” (Romalis, 1981, p. 84). These practices put the laboring woman in a passive position where she cannot be in control of her experience. Moreover, the only person for whom the lithotomy position is convenient is the doctor, as the laboring woman must work against gravity to deliver her baby, and her pelvic diameter is actually smaller lying down than if she were squatting or kneeling (Gaskin, 2003, p. 229). The BWHBC adds in *Our Bodies, Ourselves* (1973) that “the modern practice of having a laboring mother lie flat on her back throughout the entire birth process is unreasonable and unnecessarily dangerous to the baby. It is much less efficient to have to push our babies uphill to be born” (p. 188). Doctors’ language and bedside treatment also fragments women. Emily Martin interviewed many women about their experiences with the medical system in her book

*The Woman in the Body* (1987). One woman said, “ ‘Somehow being referred to as a “section” after a cesarean does not help you feel like a whole person’ ”; another woman agreed, “ ‘[The doctors] talked over me and to each other, but not to me. I felt like an object and not a human’ ” (p. 83). By addressing the body—the organs—but not the self or the sexuality of a woman, the medical system is dehumanizing and disempowering woman. Shelly Romalis, in her article, “Natural Childbirth and the Reluctant Physician” in the book *Childbirth: Alternatives of Medical Control* (1981), points to the “larger cultural control of women” as to why such harmful practices are acceptable in hospitals (p. 84). She explains, “Where female functions have a central role, as in childbirth, the denial of sexuality and depersonalization become especially marked...Control over the event of birth by the doctor is, in fact, control over a woman’s sexual experience” (p. 84). Decidedly, both movements agree that removing the sexual aspect of childbirth and treating woman like an assemblage of parts, as the medical system does, denies women power and control over their childbirth experience. Therefore, both texts are committed to reintegrating sexuality into the birth experience and making women whole again through body education and stories.

*Our Bodies, Ourselves*, as a text, is very much aware of the cultural context in which it is working. The BWHBC acknowledges the fragmentation of women’s bodies by the medical system, addresses internalized sexist values that women and men hold, and supports women through education and stories that broaden what is considered natural and normal for women in terms of sexual expression, relationships, feelings, and life choices. Ultimately, the goal of the book is as Martin (1987) says, “to reintegrate the whole person from the jigsaw of parts created by modern scientific medicine” (p. 159).

*Spiritual Midwifery* works similarly, presenting birth stories and practices which acknowledge that, “Birth is fundamentally a creative act, as is the act of sexual union. The quality and intensity of the energy present and the ultimate surrender during both events are closely related” (Martin, 1987, pp. 157-8). *Spiritual Midwifery* does more than *acknowledge* that birth is a sexual experience; the philosophy of natural birth relishes and makes use of the sexuality of birth to provide the woman with a deeply fulfilling, empowering experience. “As the contractions got stronger, it felt like I was making love to the rushes and I could wiggle my body and push into them and it was really fine,” writes one woman who gave birth at the Farm (Gaskin, 1975, p. 53).

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By presenting new ways of giving birth healthfully and wholly and also educating women about their bodies in an empowering and self-respecting way, *Spiritual Midwifery* and *Our Bodies, Ourselves* created new imagery for women’s bodies and childbirth. These books were just as radical and alternative as the movements propelling them, and they allowed readers to imagine radical and alternative ways of being and treating women. Through language of various styles, including stories, medical terminology, and cultural analysis, these books changed the discourse on women’s bodies and childbirth. Born out of movements for women’s empowerment, these texts empowered many, many women and precipitated actual change in women’s lives, healthcare practices, midwifery, abortion and contraceptive rights, and other matters in women’s health. *Spiritual Midwifery* and *Our Bodies, Ourselves* are a testament to the power of words to reshape

ideology. Old stories of strict gender roles, passivity, and lack of reproductive control were traded for new stories and new beginnings replete with whole, self-aware, and self-assured women. *Our Bodies, Ourselves* and *Spiritual Midwifery* truly did change the way women thought about their bodies and childbirth.

## Part II

It was the most profound experience of my entire life.

-Nicolle Littrell, mother and filmmaker  
*At Home in Maine*, about her home birth

Women are strong, strong, terribly strong. We don't know how strong we are until we're pushing out our babies. We are too often treated like babies having babies when we should be in training, like acolytes, novices to high priestesshood, like serious applicants for the space program.

-Louise Erdrich *The Blue Jay's Dance*

We are all born, and it is my firm belief after speaking to members of the home birth community in Maine—mothers, midwives, and advocates—that how we are born matters. Experiencing birth as authentically and naturally as home birth allows has profoundly positive implications for the mother and the baby—at birth and for their relationship as the baby develops. In this American Studies thesis I will demonstrate how home birth can truly change the world—our culture, our communities, and our environment. It begins with the midwifery model of care—a holistic, continuous way of caring for and empowering women throughout their birth experience. The emphasis on nutrition, community support, and emotional needs throughout pregnancy within the midwifery model of care draws attention to the importance of organic foods, connected communities, and a non-toxic environment. A woman who feels empowered in her body and trusts in the natural process of birth—“this thing [your body] absolutely knows how to do” (A. Greenberg, personal communication, January 16, 2012)—is likely to parent in the same way, trusting her intuition instead of relying on “experts” eager to sell her parenting advice. Consequently, as a result of a gentle home birth and loving, connected

parenting, these children have the potential to become exceptional human beings, to give back to their communities from a place of love and confidence.

Nicolle Littrell is a home birth advocate and educator through her film project, *At Home in Maine*, a documentary series on home birth in Maine. A scholar in feminist theory, she works to display visually how women are empowered through birth and motherhood. Discussing home birth and feminism on a bitterly cold January afternoon, Littrell, like Ellie Daniels, inspired my belief that it all comes back to birth:

Birth need not be a site of oppression for women; in fact, it can be incredibly empowering and sacred. The experience for that woman, if she has a powerful and empowering birth, can assist her in becoming an empowered parent and raising happy, empowered children that can help change the world. I mean, we're all born. *We are all born...* Birth matters, and if you look at this world, there is so much research that has come out over the past 5-10 years about birth trauma, for the baby and the mother, in terms of...substance abuse and other kinds of dependencies. You look at all of the problems—ADHD, violence... You can't necessarily bring it all back to birth, but you can bring it all back to birth. (N. Littrell, personal communication, January 19, 2012)

I will begin with home birth as experienced by the mothers and midwives whom I interviewed and then extend outward to discuss the ramifications of this grassroots movement on our communities, our culture, and our environment. In Belfast, Maine, this change is already apparent in the strength and connectedness of the community, and I will argue that such prosperity has much to do with the two thriving midwifery practices right downtown. The transcripts of my eleven interviews will serve as my primary documents, and I will bolster much of what the mothers, midwives, and home birth advocates so passionately proclaim with scientific research and scholarly texts. The history of the radical changes in understanding women's health and of the communal living and back-to-the-land movement of the 1970s described in chapters one and two provides an understanding of the roots for much of today's home birth movement. Many

of the midwives I interviewed were, in fact, participants in the 1970s back-to-the-land movement; the story of the home birth movement is their personal story as well. I aim to tell a story. A story that begins with birth and ends with life: flourishing communities; content, confident children; empowered women; a respect for the natural world and the nourishment it provides; and an appreciation for real and authentic experience and connection among humans. We are all born.

### **a note about this study**

This study examines home birth in a specific context. All of the women I interviewed for this study lived and worked in central and mid-coast Maine. All of these women were middle to upper-middle class, living simply in rural and small town environments. Many were involved in sustainable farming in Maine, either as farmers or consumers. All were white.

I understand that for these women, the choice to have a home birth under the care of exceptionally skilled midwives is a privilege that many women in America and around the world do not have access to. In fact, the majority of women in this world direly need medical care during pregnancy and birth. These women were also privileged in the respect that “home” offered a loving and gentle environment.

Finally, I do not condemn women who chose to give birth in the hospital, nor do I fault women who require medical care during pregnancy and childbirth. I value modern medicine; doctors and medical technology save lives. I merely seek to present an alternative way to give birth. I believe it is most important that women are informed of their choices regarding birth, so that they can make the best decision for themselves and their families.



## Chapter 3

### **An Intimate Sort of Healthcare: Contemporary Midwifery in Maine**

[Midwifery care] is holistic care in the broadest sense and in ways I think people who have only had Western medical care cannot even begin to fathom. No one has any idea what's possible in healthcare...[the midwives] took care of our whole selves.  
(A. Greenberg, personal communication, January 16, 2012)

Arielle Greenberg's experience of the midwifery model of care differs from that of other home birth mothers I spoke with because her baby was stillborn. I met her two other children, both born healthy and at home (one with the support of an underground, illegal midwife in Illinois) during our interview at the Belfast Cooperative Store. Arielle, a self-titled "birth activist," is the author of several books of poetry, including *Home/Birth: A poemic*. She also teaches childbirth and breastfeeding education for Morningstar Midwifery, an independent midwifery practice located in downtown Belfast, Maine. Arielle's case exemplified the holistic nature of midwifery care. Although Arielle's midwives, Ellie Daniels and Donna Broderick of Morningstar Midwifery, knew

the baby would be stillborn, the care they gave her did not waver. On the contrary, Arielle lauded Daniels and Broderick for attending to her and her husband's emotional needs: "you're still going to have a birth [with a stillborn], a full on labor, and to have that kind of care during that experience was mind-blowing...[they tended] to our spirits, to our hearts and souls." The midwifery model of care regards the pregnant woman as a whole, complex person with individual and specialized needs during such a transformative time in her life. For Arielle and her husband, the emotional support from their midwives allowed the pair to come through intact "what could have been an excruciating experience that could really shatter people" (A. Greenberg, personal communication, January 16, 2012).

To understand what midwifery care looks like and feels like, I interviewed three certified professional midwives and five home birth mothers. A certified professional midwife, according to the North American Registry of Midwives (NARM), the national accreditation society for CPMs, is "a knowledgeable, skilled, and professional independent midwifery practitioner who has met the standards for certification set by NARM and is qualified to provide the Midwives Model of Care" (NARM, 2012) Today, student midwives typically attend midwifery school and then apprentice with an established midwife before taking the CPM exams. Even after becoming certified, it is common for midwives to work in pairs.

CPMs work in partnership with their clients to provide continuous care throughout pregnancy, delivery, and the postpartum period. The midwifery model of care is based on trust between midwife and mother, informed choice, and a faith in the natural process of birth. I also interviewed a family practice physician who delivers babies, and

one of her patients, for the sake of comparison and to gain a wider perspective on childbirth in America. Through these conversations with midwives and mothers, I learned about a model of care genuinely different from Western medical care in its values, approaches, and rituals. The midwifery model of care empowers women during their pregnancy, thereby changing the way women approach birth. Employing these women's stories and supporting literature, I will discuss what I see as the three tenets of midwifery care: an unequivocal belief in natural birth and women's bodies; the importance of the spiritual and emotional aspects of birth; and a firm emphasis on community support and involvement for mothers and pregnant women.

The midwifery model of care is woman-centered. "We just know that whatever a woman's body is telling her to do is probably the right thing...cause she's giving birth, and her cells understand that" (E. Daniels, personal communication, January 11, 2012). Ellie Daniels' perspective on women's health and biology is radical, for since the rise of Western medicine, women's bodies have been considered inferior to men's bodies and problematic (Ehrenreich and English, 1978). In her 1993 anthropological study of childbirth in the U.S., *Birth as an American Rite of Passage*, Robbie Davis-Floyd discusses the prevalence of the technocratic model of birth, a model that mechanizes the female body and aligns the birth process with dominant values in American society like science, patriarchy, and technology. She argues that, while the male body with its linear form and straightforward function is particularly suited to the technocratic model, the female body with "uniquely female anatomical features such as the uterus, ovaries, and breasts, and uniquely female biological processes such as menstruation, pregnancy, birth, and menopause" is not and is, therefore, "subject to malfunction" (p. 52). Instead of

marveling in the complexity of female biology, Davis-Floyd (1993) notes that in recent history, “our medical system has done a thorough job of convincing women of the defectiveness and dangers inherent in their specifically female functions” (p. 53). The women I interviewed agreed that this view of women’s bodies as “abnormal, inherently defective, and dangerously under the influence of nature” fueled the medical system’s underlying fear around birth and drove the obsessive need to manage birth (Davis-Floyd, 1993, p. 51). Arielle Greenberg traces this cultural fear around birth to the Victorian era, a time when the fields of obstetrics and gynecology were gaining a stronghold: “Women giving birth [naturally] are enormously powerful. If you witness a woman having a baby naturally, you are in the face of unbelievable power and it can be scary for men who are not prepared for that. It’s very animal [which is] a fear that came about so deeply in Victorian times: it was very scary for human beings to see that animal side...[they also] feared women’s power.” Such fear of women’s bodies and women’s power manifests in medical management of birth; some semblance of order can be found if birth fits into the technocratic model, but at what cost to women, their babies, and our society?

The midwifery model of care is drastically different from the medical model for its steadfast belief in women’s bodies—in her very cells, as Ellie Daniels says—and in birth “as a process larger than ourselves...something we can seek to learn from and to know, but cannot control” (MANA, 2010). Heather Stamler, an independent CPM working out of her rambling yellow farmhouse, reflects these values in the midwifery care she provides and in the relationships she builds with her clients. “I watch, I watch a lot...my major role is comforting and protecting that sacredness [around birth]...the body, when it is listened to, will resolve a lot of problems. There isn’t one magical thing,

it might just be holding her feet and paying attention” (H. Stamler, personal communication, January 9, 2012). Sarah Ackerly, a Naturopathic doctor and CPM practicing in Topsham, Maine, echoes Stamler’s statements: “I think a lot of healing occurs when people are able to be heard and listened to” (S. Ackerly, personal communication, January 17, 2012). It is this time spent getting to know each other that allows midwives and their clients to form relationships based on trust and mutual responsibility. A woman’s body inherently knows how to grow a baby and give birth, so the midwife’s role is to nurture and empower the woman to do so, while also caring for her physically and emotionally. Dr. Ackerly explains the relationship between client and midwife best:

It is a collaborative arrangement. . . one big difference with this kind of care is that there is a lot of informed choice. It’s not, “Here’s the form, sign it,” it’s “This is the test that’s offered, here are the reasons on both sides.” Ultimately, it’s the patient’s choice. It’s not my pregnancy. So, there’s a lot more trust built. [There is] lots of time to get to know each other, so women don’t feel like it’s going to be strangers walking through their door when it’s time for them to have their baby. They know we’re interested in them; we know their names, we know their husbands, their children, we’re a part of their whole life. I think the kind of care and interest we take sets up a dynamic that’s about collaborative care and it’s more about having an equal footing and not this hierarchical relationship. [The clients] have all of the information, and ultimately, birth is so much bigger than all of us and we can’t control it. We do all we can to make sure people are healthy, and ultimately, it’s way bigger than me.

The empowering effect of this relationship was felt by all of the home birth mothers I spoke with. Ultimately, as Dr. Ackerly says, it comes down to trust—trust in a woman’s ability to give birth. Expectant mothers practice this trust through the deep human connection they form with their midwives and by taking responsibility for their bodies and their babies, with nutrition and health practices. In learning to listen to and trust her body in pregnancy while being supported by midwives and loved ones, a woman can approach her birth with faith and serenity in her body and the process. Nicolle Littrell

adds, “It’s a radical way of thinking because we so often defer our trust and responsibility to other people and to authority. It’s a very different way of being—to trust yourself. I see birth, a safe, natural, empowered birth, as providing an opportunity for a woman to really trust herself, really get in tune with herself, listen to her own authority, and be supported by others” (N. Littrell, personal communication, January 19, 2012). Trusting in the body and in real experience *is* radical for our society, yet with the support of midwifery care, the home birth mothers I spoke with were able to do just this, and the effect on their sense of self and confidence was astounding and palpable from the way they spoke and cared for their children.

Within the midwifery model of care, the belief in the natural process of birth is so absolute that a common adage among the home birth midwifery community is “Midwives have skilled hands and they know how to sit on them” (MOM, 2010). Much of the concern the home birth community has with modern obstetrics revolves around the high rate of unnecessary medical interventions during labor and birth. Women are induced with the synthetic hormone Pitocin if their labor is not progressing rapidly enough for the hospital’s schedule, a timetable based on concerns of risk and liability. Due to the intensity and frequency of the Pitocin contractions, an epidural is usually administered. All of these foreign drugs imposed upon a woman’s natural hormone activity cause confusion in the body and manifest as fetal distress on the Electronic Fetal Monitor reading. A cesarean section is then ordered for the safety of the baby. Thirty minutes later, the baby has been born in the operating room, and the mother has to recover from the physical and emotional trauma of a major abdominal surgery, which could potentially have been avoided if labor had been allowed to progress naturally and in an environment

where the woman felt safe and supported. Of course, the hospital is a very important place to receive excellent, rapid care in the event of a medical emergency during birth, however, unnecessary interventions due to the medical management of birth are too frequent, in the opinion of the midwives I spoke with.

The waiting and watching quality of midwives is radical even for mothers who choose home birth. One woman I interviewed joked about her midwife sitting on the couch and knitting while she was laboring. Nicolle Littrell remembered asking her midwives what exactly their role would be while she labored: “[they said], ‘We’re just gonna sit there basically and do what we need to do as needed.’ It was just so radical. You think about the doctor being there and waiting and messing and fussing with you and nurses coming in and out; that’s the picture you get. The best quality in a midwife is to just wait, wait, and observe.” Arielle Greenberg put the job of a midwife into sharper focus with this statement: “[The best care during childbirth] is being able to stay in a room and wait patiently and do nothing until a woman is ready, and give nothing but emotional support. Obstetrics is a surgical practice. Why would you want a surgeon attending you for something you hope is going to be a non-surgical procedure?”

Both Littrell and Greenberg made references to negative aspects of the medical model of care during childbirth, namely the propensity of doctors to intervene when the best action to take is no action at all. This is not to say that midwives care by simply not doing. On the contrary, midwives support and educate their clients a great deal, spending “about 15-18 hours in prenatal appointments with women” (E. Daniels, personal communication, January 11, 2012). This high level of contact allows midwives to detect problems early on in the pregnancy and transfer care to an obstetrician, if necessary.

Midwives also order lab work to test for blood type, RH factor, urinary infections, or thyroid abnormalities. Nutrition is the cornerstone of prenatal care for midwives.

Midwifery care pays due attention to the emotional and spiritual aspects of childbirth as well, a topic I will delve into next.

The waiting room of Morningstar Midwifery practice is a visual example of the holistic care midwives offer—a continuous model of care that extends to the emotional and spiritual as well as the biological aspects of childbirth. Decorated in a colorful, kid-friendly, yet sophisticated style, the room’s purpose is suited more to “living” than “waiting.” A tall bookshelf filled to the corners with books on topics like breastfeeding, the politics of birth, and hypno-birthing covers one wall, while a plump couch and corkboard-turned-collage occupy the other. On top of the bookshelf are belly-casts artfully decoupaged. Ellie Daniels, CPM and owner of Morningstar Midwifery with her partner Donna Broderick, CPM, explained to me how the belly-casts, plaster moulds of a woman’s fully pregnant belly, were made during a blessingway ceremony. A blessingway is a ceremony celebrating and honoring childbirth as a life passage for a woman. Blessingways are one way in which midwifery communities attend to the spiritual and emotional aspects of childbirth. “Rather than a commercial event of a baby shower with a lot of crap that is polyester and plastic, a Blessingway is a ritual that honors the mothers and grandmothers who came before [the pregnant woman]” (E. Daniels, personal communication, January 11, 2012). Yana Cortlund, Barb Lucke, and Donna Miller Watelet, the authors of *Mother Rising: The Blessingway Journey into Motherhood* (2006), write, “Rituals have historically been used to bring meaning to the passages between different stages in life. They make it possible for us to approach any



life change or transition with clarity, respect, and awareness by raising our level of attention and participation” (p. 7).

A blessingway marks this transition and celebrates women’s culture by bringing together women “to raise a mother-to-be’s energy and strength that she can carry with her throughout labor and birth and on into the life-changing role of motherhood” (Cortlund et al., 2006, p. 12). Many of the home birth mothers I spoke with recalled their blessingways with a smile and a sigh; clearly this ritual had been a significant and meaningful part of their transition to motherhood. The women closest to the mother-to-be gather to create a safe, nurturing, and empowering environment in which the women can connect and send positive energy to the mother-to-be and reflect on the greater spiritual nature of birth. One blessingway ritual, explained to me by Ellie Daniels, has all of the women in a circle with beads and a single strand of thread. One by one, each woman strings a bead for each of the women in her family’s maternal line. When the necklace reaches the mother-to-be, it is long and beautiful. She can wear the necklace—tying together the strength of women who gave birth before her—while she gives birth. I think the quote by Jean Shinoda Bolen, author of the book, *The Millionth Circle*, in *Mother Rising*, points to the significance of this particular ritual: “A safe circle holds the dream of what [a woman] could be in confidence and nourishes the possibility” (Cortlund et al., 2006, p. 46).

Blessingways, two hour-long prenatal appointments, and plenty of emotional support and positive reinforcement from their midwives helped the home birth mothers I spoke with come through the major life transformation that is pregnancy and childbirth in a self-trusting and confident way. What better way to ready oneself for the act of giving

birth? “I felt like a goddess. I *loved* the way my body looked during pregnancy... I loved the sensations, the heaviness of my belly” gushed Nicolle Littrell who went on to have a home birth she described as “sacred.” Prenatal care that focuses on potential problems, as does the medical model of care with its barrage of routine tests at every 20-minute appointment, only plants seeds of self-doubt and anxiety about giving birth. Emotions—for their connection to hormones—play a large part in the biological process of birth, and besides, who wouldn’t want the sort of care that makes one feel like a goddess?

I felt the genuine sense of community that midwifery care provides and fosters most sincerely in Belfast, Maine. Home to two thriving midwifery practices, Morningstar Midwifery and Fist Light Community Midwives; several hip restaurants that source all or most of their ingredients from surrounding sustainable farms (and there are a lot of organic, diversified farms in Waldo County); Maine’s largest and oldest cooperative market; and a whole host of on-going community events like art shows and contra dances, Belfast, Maine, is a thriving community in structure and atmosphere. I once remarked to a friend of mine who runs a cookery school a couple of miles down the coast from Belfast in Lincolnville that I never knew Belfast had a surprisingly large population of neat, sustainably minded young people as I had seen on the streets and in the cafés of the small town. Why didn’t they all get out and down to a real city like Portland? (As that is typically the objective if one is a neat, sustainably minded young person in Maine.) After spending several afternoons in Belfast interviewing area midwives, mothers, and home birth advocates, at the Co-op, at restaurants like Chase’s Daily and The Lost Kitchen—both of which source exclusively local and produce outstanding dishes, and at

Midwifery practices—I realized that the neat young people don't need to venture down to Portland for entertainment or “culture” because they have everything they need in Belfast. My cookery school friend added, rather poignantly, “*And they have each other.*” I believe the predominance of home birth in Belfast is a large part of what makes the town a sustaining and nourishing place.

Arielle Greenberg travelled to Belfast, Maine, from Illinois exclusively to have her baby with Morningstar Midwifery. She and her family later moved to the Maine town permanently. She tells me in our interview, “In this community, the number of home birth moms is astounding, the ratio is really off from the rest of the country, which is one of the reasons we moved here” (A. Greenberg, personal communication, January 16, 2012). Community is paramount to holistic midwifery care. Midwifery practices not only provide a supportive, positive community for home birth mothers, but also foster community by encouraging their client families to rely on each other—ask for help from their friends and neighbors, accept and provide meals and childcare during labor and postpartum, and celebrate new life and new life-stages together. And there is no place better to witness this sort of genuine community than Belfast, Maine.

Ina May Gaskin, America's leading midwife and reviver of safe, empowered home birth in the 1970s, argues emphatically that positive birth stories are essential to a mother-to-be's emotional welfare and confidence. Gaskin devotes a substantial portion of each of her books on natural childbirth to “Amazing Birth Tales” or “Birth Stories.” In *Ina May's Guide to Childbirth* (2003), she writes, “Have you never heard anyone speak positively about labor and birth before? If so, you are not alone. One of the best-kept secrets in North American culture is that birth can be ecstatic and strengthening. Ecstatic

birth gives inner power and wisdom to the woman who experiences it, as you will learn from many of the birth stories told here” (p. xiii). Midwives in Maine also acknowledge the importance of positive affirmation and encouragement for expectant mothers.

“[Belfast] midwives are really good about connecting their clients to one another,” said Greenberg. Ellie Daniels described to me the importance of creating community among home birth families:

Four times a year we hold “Babies and Bellies” potlucks. We try to make sure people meet each other: people who have already had babies and people who are still pregnant. Because you don’t believe [you can give birth] until you’ve talked to someone else who’s like yeah, it was so intense and I didn’t believe it [either] until I was like pushing my baby out. People need to hear that story a hundred times—but for the most part we don’t hear birth stories in our culture unless they’re like, “oh the doctor had to cut me open” or “the doctor saved my life.”

A community of home birth families with positive, powerful stories to tell about their births abolishes the fear around birth that popular culture perpetuates. “Like how sad is it that women have to tell horror stories about their births in order to be recognized for having given birth. In our home birth community, women talk about their births like they are the most empowered stories, even if [their births] were hard” (E. Daniels, personal communication, January 11, 2012). For Nicolle Littrell, “being a part of a community that was making these same choices...felt nice” (N. Littrell, personal communication, January 19, 2012).

Arielle has experience in childbirth education and breastfeeding support, and she “feels very strongly that none of us were meant to be raising children in isolation the way we mostly are in this culture so far” (A. Greenberg, personal communication, January 16, 2012). It is a relatively recent phenomenon that most children are raised in small family units. Children in pre-industrial America would have grown up seeing newborn babies

and caring for their younger siblings, essentially apprenticing for parenthood. Nowadays this is not the case. I held a two-week-old baby for the first time in a long time while interviewing a home birth mother for this project. Baby John Sawyer's body was so small and soft, and yet the weight of this tiny person was overwhelming—I felt immediately like I was holding the most precious thing in the world; I had to be so loving and careful. Imagine what our society would be like if more people held a baby in their arms regularly?

In addition to providing a wonderful, supportive community for mothers-to-be, midwifery care nourishes and grows community. Midwives know that expecting and new mothers fare better when helping hands and positive emotional support surround them. Arielle noted that it is difficult at first for pregnant women and new mothers to rely on others: “[There’s] this American idea that we’re supposed to be independent and not ask for help. The hardest part [for the women] of my childbirth education classes is to practice asking for help” (A. Greenberg, personal communication, January 16, 2012). Yet ultimately, women recognize that community support is invaluable during pregnancy, childbirth, and the postpartum period. Arielle joked that her baby shower was nice and generous and all, “but what you really need is a meal train!” A meal train is when folks in the community deliver meals on a regular and organized basis for about two weeks after the baby is born.

If Belfast is any indication of what a community can become and provide for its members, especially the mothers, then midwifery care is changing the world one small corner at a time. Through the midwifery model of care, its values including an unequivocal belief in natural birth and women’s bodies; the importance of the spiritual

and emotional aspects of birth; and a firm emphasis on community support and involvement for mothers and pregnant women, a whole new culture is being created around birth. This culture is genuinely different from Davis-Floyd's technocratic model of birth, which dominates our nation and, I argue, does a disservice to women. The culture of midwifery empowers women in their bodies and in their lives, provides and fosters a healthful community, and inspires women to reach their full potential. Empowered women are strong, have ideas, and can make change. In Belfast, I witnessed women leading in community organizations, businesses, and restaurants to change the way we parent, interact, and eat. In the words of Margaret Mead (1901-1978), "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

## Chapter 4

### Home Birth

Me: Could you describe your birth experience for me?

Michelle Miller: It was a trip.

Me: In a good way?

Michelle Miller: Yes!

For, even though it wants at times to lie down and quit, the body is an honest hardworking marvel that gives everything to this one task.

- Louise Erdrich *The Blue Jay's Dance*

Nicolle Littrell awoke in the dark hours of a cold Maine December night with the song, *The Lion Sleeps Tonight*, playing over and over in her head. She was in labor with her son Leo. “It was a full moon night, zero degrees outside. The woodstove was cranking in our small drafty old farmhouse. The Christmas tree was up and the birthing tub was right next to it” (N. Littrell, personal communication, January 19, 2012). During labor, she told me “she felt like a lioness. The noises I was making were not of this world and yet they were.” Supported by midwives Donna Broderick and Heather Stamler and

her partner, Orson, Littrell labored through the night and into the next day. When her contractions increased in intensity (“like period cramps times ten”), Littrell summoned strength from within:

There was this tree [outside] that had a huge hole in it. I called it the cervix tree and watched it while contracting... What I did was I had a mantra. I just kept saying, “you can do this, you can do this, open up, open up.”

And then, in the birthing tub by the Christmas tree, Leo was born into the waiting hands of Orson, Donna, and Nicolle. Littrell said this about the moments after giving birth: “It’s super shocking because it’s like, ‘shit, a human being just came out of me!’ It’s an abstraction when it’s just this round belly and you’re feeling the baby kick. You know there’s a baby in there, but you don’t know it’s a human being. It’s not realized until you see this human being with eyes and body parts... It was the most profound experience of my entire life.”

Giving birth in any setting is a transformational experience for a woman. However, a home birth within the midwifery model of care, in which birth is allowed to occur spontaneously and proceed naturally, can be a profoundly empowering experience for a woman. In this chapter, I will discuss birth as experienced by the woman doing the work. And it is work; it is painful; it is intense. Yet experiencing birth naturally, in an environment that is favorable to the release of oxytocin, the hormone that causes uterine contractions “and is associated with feelings of love, trust, gratitude, and curiosity” (Gaskin, 2011, p. 33), can have tremendous implications for a woman’s confidence, her trust in her body, her ability to parent, and her relationship with her baby.

After Nicolle Littrell gave birth on that cold December day, the experience transformed her life. Not just in the way of her person, but in the way of her career. A



talented filmmaker, Littrell went back to school to get a master's degree from the University of Maine in Women's Studies and New Media/Communication. Her Master's Project was (and still is) *At Home in Maine*, a film series on home birth in Maine. Her intent is to use "film as visual proof that home birth happens" and share birth stories as an educational/advocacy tool and a community-building platform (N. Littrell, personal communication, January 19, 2012). In her films, Littrell captures details of the house and snippets of family life to dispel the notion that home birth "is a bunch of hippies in the woods." She is also greatly concerned about women's access to home birth and midwifery care. Although the number of women having home births in America is on the rise (U.S. home births increased by 29% from 2004 to 2009, according to a recent CDC study) the population is predominantly white (MacDorman et al., 2012).

Littrell is "trying to call attention to feminists" about birth (N. Littrell, personal communication, January 19, 2012). She acknowledges that, especially in the second half of the twentieth century, birth and motherhood were seen as sites of oppression and disempowerment for women—because they were. However, nowadays within the home birth movement as begun by Ina May Gaskin in the 1970s and continuing to grow in places like Belfast, Maine, birth and motherhood can be transformative, empowering experiences. Littrell asked this of me in our interview:

Wouldn't you want your sister, daughter, granddaughter, or friend to have the best possible experience she can have if she's going to have a child? Wouldn't you want her to feel good about it, [for it] to be as safe, even empowering for her? ...The mother is the authority; it's her body. She should have as incredible of an experience that she can have.

Based on my research and interviews with Maine midwives, mothers, and home birth advocates, as well as a family practice physician, I believe that the "best possible

experience” for a low-risk pregnant woman receiving attentive and continuous care from certified professional midwives who she trusts and shares an honest relationship is home birth. Using stories I’ve collected from my interviews I will discuss the ways in which home birth can be deeply transformative and empowering for women. I will also speak to the benefits of natural hormone activity, un-anesthetized body experience, intimacy, and mother-baby bonding, which are all vital components of home birth.

Giving birth is an intense experience—intense, overwhelming, painful, and yet doable. As midwife Heather Stamler put it, “[Giving birth] has a lot to do with life, with the person that we are” (H. Stamler, personal communication, January 9, 2012). Each of the women I interviewed had a different birth experience that was right for her; however, there were consistent themes across the stories. The women dealt with feelings of extreme physical sensation during labor in different ways: rocking on a yoga ball, moaning and making other noises, being in water, walking, and being intimate with their partner. Most all of the women expressed that giving birth was the most connected they’d ever felt to their body and one of the most real experiences they’d ever had. All of the mothers described the bliss and amazement felt directly after birth, and the confidence, empowerment, and trust in themselves that remained days, weeks, months, and years after the experience.

Many of the qualities and experiences described above are unique to home birth, and come about because birth is allowed to proceed spontaneously and naturally in a safe, familiar environment. Hospitals, by their very structure and function, do not acknowledge birth as the intimate, sexual act that it is. Arielle Greenberg believes: “Women shouldn’t have to be in the presence of strangers while giving birth, it’s an incredibly intimate act.

People say it's the most like sex compared to anything you could do...you're naked, pooping, puking...why would you want to be in the presence of strangers [in a hospital]?" (A. Greenberg, personal communication, January 16, 2012). Greenberg makes two important points in this statement about sexuality and intimacy during birth, the first of which is confirmed by the well-known French obstetrician Michel Odent, who has written extensively on the correlation between birth practices/environments and health/behavior later on in life. In *The Farmer and the Obstetrician* (2002), a text linking the industrialization of birth and farming, Odent points out that the same two hormones, oxytocin and beta-endorphins, are involved in "different episodes of sexual life such as intercourse, childbirth, and lactation" (p. 73). Therefore, childbirth is physiologically very much like sex; childbirth is integrated into a woman's whole sexual experience.

Greenberg also refers to the importance of intimacy during childbirth—that laboring women feel unobserved and unafraid to be vulnerable. This is to facilitate the release of oxytocin and beta-endorphins, and why the "home" part of home birth is so important. Oxytocin, or the "love hormone" which causes uterine contractions, has an inverse relationship to the hormone adrenaline. If a woman is feeling scared or threatened, her "fight or flight" hormone kicks in. When adrenaline levels rise, oxytocin levels fall, and labor can stall or stop completely. Therefore, the optimal environment for a woman to give birth in is one where she does not feel threatened or self-conscious. Similarly, beta-endorphin levels "rise when we are warm enough and, most importantly, when we are feeling secure" (Gaskin, 2011, p. 34). Beta-endorphins are the "reward" hormone; they are natural opiates the body produces and they have powerful pain-numbing effects—an essential hormone for the physical effort of childbirth. High levels

of oxytocin and beta-endorphins are necessary for vaginal tissues to swell and open wide enough for a baby to pass through. Gaskin (2011) plainly states, “Obviously, such hormone levels are not possible when women are in great pain, feeling threatened, or being subjected to constant interruption—just as men don’t get erections when they’re terrified or being threatened with sharp objects” (p. 35).

Perhaps the reason why so many women giving birth in hospitals need to be induced by synthetic oxytocin is that they feel insecure and unsafe in the hospital—a place with unfamiliar faces, constant monitoring and tests, and where the overall purpose is to treat the unwell and the diseased. Greenberg strongly believes that hospitals do not provide the right environment for birth: “Birth is not a medical condition; it’s not a disease. Hospitals are places for disease. Just entering the hospital puts you in this mindset that there’s something wrong with you that you need help with...and that’s not true for most women. Most women have low risk pregnancies” (A. Greenberg, personal communication, January 16, 2012). Administered continuously through an intravenous drip, Synthetic oxytocin causes uterine contractions but does not “induce feelings of love, trust, gratitude, and curiosity in the way that the mother’s own oxytocin does” (Gaskin, 2011, p. 33). This is because synthetic oxytocin does not cross the blood-brain barrier (Odent, 2002, p. 76). Contractions caused by synthetic oxytocin are longer and stronger because the drug streams continuously into the woman’s body, whereas the pulsating quality of natural oxytocin allows for pain-free rest periods. Michelle Miller, a spunky, cheerful home birth mother, described this phenomenon of natural labor to me:

What was really cool about it was, once the contraction was over, you had clarity...basically I could sit down and have a conversation with you and then a contraction would come, and I would have to go inward and focus. But you were really clear in the middle, which is like a gift. They say with the Pitocin in the hospitals that it

will come on so strong that you don't get the rest and it's too much and your body doesn't have enough time to make the hormones that help you deal with pain. So really, when it's natural, [your body] gives you enough time to get your shit together before the next one [contraction]" (M. Miller, personal communication, January 18, 2012).

A safe, familiar environment—like a one's own home—is most favorable for the release of essential hormones oxytocin and beta-endorphins to the birthing process.

For optimum labor, a woman must go into a sort of “primal state” by abandoning her intelligent brain. Ina May Gaskin (2011) tells women to “Let your monkey do it” (p. 37). It is the deep, primitive brain structures that release the necessary hormones for birth, not the neocortex, the sophisticated part of the brain associated with language and intellect. Like the adrenaline-oxytocin antagonism, neocortex stimulation inhibits hormone activity and thus hinders labor. In his most recent book, *Childbirth in the Age of Plastics* (2011), Michel Odent says, “When our neocortex is at rest, we have more similarities with other mammals,” and so, “a woman in labor needs to be protected against any sort of neocortical stimulation” including, language, light, observation, and the perception of danger (p. 47-9).

In light of Odent and Gaskin's theories on the “primal state” during labor, hospital practices seem entirely inappropriate. Harsh lights, uncomfortable beds, medical monitoring equipment, a steady flow of observers coming and going, the ever-present possibility that “something could go wrong,” people talking, asking questions, and giving orders are common characteristics of some hospital birth environments. Some hospitals have taken steps to make their birthing rooms homey; however, many of the elements listed above still exist. Odent described beginning and continuing labor like falling and staying asleep or having sex. Imagine trying to fall asleep—much less tap into a very primal part of the brain that leaves one extremely vulnerable—in an unfamiliar bed,

surrounded by bright lights, with people observing and asking questions. Similarly, in *Ina May's Guide to Childbirth* (2003), Gaskin describes one midwife's teaching exercise on the importance of privacy and familiarity during labor and birth. At a couples' childbirth-education class, the midwife offered a fifty-dollar bill to the first father would come forward in front of everyone and pee in a stainless-steel bowl. According to the story, the midwife has not yet relinquished her fifty bucks. And remember the joke about the midwife sitting on the couch knitting while her client labored? This midwife was not being negligent; rather, she was allowing the laboring woman to feel safe yet unobserved. Odent (2011) also notes that adrenaline levels of others present at the birth can affect or "be contagious" to the parturient woman. Therefore, "one of the main preoccupations of an authentic midwife should be to maintain her own level of adrenaline as low as possible...A repetitive task, such as knitting, is a way to lower the levels of adrenaline" (p. 50).

Home birth allows for the natural release of hormones necessary for a safe, normal birth. Women who give birth in the familiarity of their home, accompanied by skilled midwives and loved ones in front of whom they can be vulnerable and allow themselves to go into that "primal state," have a much greater chance of having a safe, less-painful, and empowering birth experience.

I believe that so much of the need to control birth in our society via medical care (or at least provide the illusion that there is a way of controlling birth) is due to our society's fear of pain and un-anaesthetized, unfiltered body experience. Every midwife I spoke with accepted that birth was something bigger than she or anyone could control. Sarah Ackerly put it this way: "That unknown, that mystery of birth is sometimes, for a

midwife, challenging. You don't always know, but that's again part of trying to trust in what is bigger than you. That's where I think as a midwife that faith comes in—calling on whatever I need to help direct me so that I can be present to what needs to happen” (S. Ackerly, personal communication, January 17, 2012). In this way, midwives embody two minds; they trust in the natural process of birth and the innate wisdom of women's bodies, but they also rely on modern medical and nutritional practices to ensure women's wellness and safety during birth. Midwives in Maine are licensed to purchase, carry, and administer certain medications used for the control of hemorrhage, shock, resuscitation, and newborn prophylaxis (MANA, 2010).

For the mothers I spoke with experiencing birth as a genuine embodied experience was incredible and transformational. In my interviews, there was some mention of pain and intense sensation; however, there was little question as to the purpose and nature of that pain, and so our conversation veered towards being deeply in tune with and trusting one's own body, and experiencing birth as something bigger than the self. Michelle Miller emphasized staying light and experiencing labor in a way that works for the individual: “[Your birth experience] has to be who you are, and so for some people that is going to be loud and raucous, and for some people that's going to be totally internal. I think I was somewhere in between—I did both of those things. I did some yelling; I'm not too proud to admit that it hurt. That's something I'll admit: it's painful. I think that's part of it: really feeling this life changing thing that's happening to you and not just letting someone else do it to you” (M. Miller, personal communication, January 18, 2012). In letting go and experiencing birth as authentically as possible, there is a level of control and clarity gained. The work of prenatal midwifery care to assuage women's

fears around birth by demystifying the process and placing responsibility and control with the woman herself, to provide emotional and spiritual support through counseling and larger community support, and to inspire that trust in one's body and the not-fully-knowable natural process of birth, prepared the mothers I spoke with to jump into birth believing they would come out on the other side. Ellie Daniels explained birth in this way:

[In our culture, there is] this false illusion that we can control every situation. For mothers who give birth for the first time, everyone says 'Oh you'll be fine,' but she's [thinking] *Oh I'm just supposed to walk up to the face of this cliff and I can't even see the bottom, I don't know what it is, and I'm just supposed to jump off?* That's how it is. There's this kind of chaos about birth because it pushes us to an extreme of physical sensation where you're like, 'this can't possibly be right, my body is going to split in half or the baby is going to come out my butt!' **You don't get experiences like this in your life: it's intense.** [During labor and birth] you're grunting and there's these smells and these sounds and these fluids coming out of you and you're like 'Holy shit, I couldn't really stop this [process].' You are totally flying apart and then you give birth and the whole thing comes back together and you're like 'Holy shit, that was the most amazing thing that ever happened to me, and I'm here on the other side, and I've got this baby that came out of my body that I grew, and now I'm going to nurse it and continue to grow it and grow it.' For our culture that likes to plan things and schedule things and have the code and formula for everything, it's a big deal to ask people to enter that chaos and unknown and come out the other side, so it's really like you're saying to people: **believe in it, trust it.** (E. Daniels, personal communication, January 11, 2012)

Ruth Jacobs, a first time home birth mother, spoke in the same vein as Daniels about her connectedness to, yet inability to control her body during labor: "My body was in control [during labor]. I wasn't doing this; I, mentally, was just along for the ride; I had to go along with whatever my body did. So, it's empowering, but it's also like...I sort of had to let go and let nature take its course within my own body... There are so many ways we are disconnected from our natural beings, and this was just the most raw nature, and I thought it was really cool!" (R. Jacobs, personal communication, January 10, 2012).

Experiencing birth naturally and authentically is more than just "a trip" as Michelle put it. When normal hormone activity is present and women actively birth their



babies themselves with the support of midwives and loved ones, the ramifications are immense and life altering.

The hormones oxytocin and beta-endorphins required to start and progress labor, flood a woman's system in the moments after she has given birth. Ina May Gaskin (2011) writes:

...the highest levels of oxytocin of all occur in mothers and their babies during the first hour just following birth. This is the time of bonding, when mother and baby are programmed by nature to adore each other and share moments that neither will ever forget...Interestingly, when such important moments are allowed to unfold without interruption, the risk of postpartum problems in mothers and babies is reduced. Babies breathe better and their heart rhythms are more regular when they have skin-to-skin contact with their mothers' chest. Mothers are less likely to hemorrhage in these circumstances as well. (p. 34)

Ellie Daniels described the moments after giving birth as “blissful” and “ten times the most fantastic orgasm” for the woman (E. Daniels, personal communication, January 11, 2012). The baby feels this love too and with it comes the understanding that he/she is loved and safe. I will discuss the experience of home birth for the baby in the next chapter. For the mother, it is an incredible high. Ruth Jacobs said, “The high lasted for three days. I felt like I was on something. It was pretty wild. I don't know if everybody gets that, but I definitely did...it was like a mellow contentment...[I was] untouchable...like there was no way I was going to get sad about anything” (R. Jacobs, personal communication, January 10, 2012). While a woman's hormone levels will eventually fall, the feelings of empowerment, confidence, and self-trust remain long after birth. Michelle Miller said she felt differently about herself after giving birth: “I am powerful, competent. I knew I could do it, but now that I have, it's a whole other thing” (M. Miller, personal communication, January 18, 2012).

Just looking into Michelle Miller's eyes and listening to her speak about her birth experience was inspiring. She seemed so calm and self-assured in everything she said and did. She was not the typical nervous-wreck that our culture makes new moms out to be. Michelle and all of the other home birth mothers I spoke with remarked on their smooth transition to motherhood after giving birth. Michelle put it this way: "Yeah, you're empowered, like they say. If you have this birth, and you know you can birth this baby, then you know you can parent this baby." This sort of empowerment cannot be gleaned from advice books, despite what the "experts" say. It is a power that comes from within, and is the direct result of experiencing birth naturally and authentically. It is a sense of empowerment that transfers to all aspects of a woman's life as she enters motherhood. Imagine what our world would be like if more women knew they could experience their births and even be empowered by the process? Michelle imagined it like this:

I think that more women should have unmedicated births and feel it. Maybe we would have a less over-populated world if people had to feel it. If you can just conk out and anesthetize your whole body and have the baby surgically removed from you, yeah you'll have a pretty intense recovery period, but you'll never have had to push that baby out of your body like it is naturally supposed to happen and maybe people would be more intentional about...creating life...and how they parent.

I asked Nicolle Littrell, the mother whose story opened this chapter, how she hoped her films would impact society's view of women. An interesting and poignant conversation followed. At first, Nicolle echoed Miller, saying how she hoped her home birth films would change people's views about life in general, impel people to think about the sacredness of life. I, then, told her that every time I watch any one of her *At Home in Maine* films, I always cry a little bit and I'm not sure why. Littrell probed me, asking why I thought the images of a person being born at home made me cry. I mumbled something about how it made me feel calm and hopeful and assured that there's

something bigger out there. “It’s pretty pure, isn’t it?” Littrell responded, nodding to acknowledge that she understood my inability to put the feeling in words. Then she went on to say this: “I would like to think that if more people could see this [home birth], it would help people to value women more. That more support would be available for women in all areas of their life” (N. Littrell, personal communication, January 19, 2012).  
Imagine a world like that.

## Chapter 5

### Being Born at Home

This is not an insignificant experience in a person's life—being born.

-Ruth Jacobs, home birth mother

A local physician says [to Ellie Daniels], "I love seeing your babies. I can pick them out across the waiting room because they're the ones in a sling or some kind of a wrap on the mom's body and because they're so connected to their parents and visa versa. And they're so healthy."

-Ellie Daniels, CPM on a local physician's observations of home-birthed patients

Midway through my interview with Ellie Daniels, one of her clients, a chipper and cosmopolitan mother of two daughters born at home, one just a couple of weeks ago, stopped by our cafe table to say hello and share her and her husband's recent theory as to the cause of their new baby's "head sensitivity." The mother reminded midwives' Ellie Daniels and Donna Broderick (Broderick is Ellie's partner at Morningstar Midwifery; she joined Daniels and me for lunch and part of the interview), that her newborn would cry whenever she dressed her, especially when clothing or a hat touched her head: "like putting her hat on [just a minute ago] sent her into a full scream" (E. Daniels, personal communication, January 11, 2012). Discussing this over lunch a few tables away, the client and her husband had developed a theory.

So, [my husband] Riley thinks [her “head sensitivity”] is because...she got stuck momentarily on the way out. Imagine that’s true, [so then] what happens to the baby that’s born with a c-section or forceps or vacuum extraction—what kind of issues does that baby have?! Cause on the Richter scale of 1 to 100, her birth was about a 2 as far as births go: dark, warm water, quiet, fast. (E. Daniels, personal communication, January 11, 2012)

“What kind of issues does that baby have?” mused Broderick, smiling at her enlightened client. Then, she added in response to her client’s concerns about her newborn’s head sensitivity, “Just keeping hanging her upside down.” Bewildered, I looked to Daniels for an explanation of this strange practice. Daniels told me casually, “It just helps [the baby] un-kink from their birth—using the weight of the head to stretch out the baby’s spine. It is a cranial-sacrum technique that we teach parents at 2 weeks.” Ah yes, baby-yoga.

Home birth certified professional midwives, like Ellie Daniels and Donna Broderick, recognize that birth is as much a transformative experience for the baby as it is for the mother. The midwifery model of care views mother and baby as one unit: what is good for the mom is good for the baby too. Statement D in Section II: Mother and Baby as Whole, of The Midwives Alliance of North America’s Statement of Values and Ethics reads, “We value the process of labor and birth as a rite of passage with mother and baby as equal participants” (MANA, 2010). By valuing the mother and baby as integral and interdependent, the experience of the baby during and after birth is considered just as important as the mother’s experience, as discussed in Chapter 4. Several elements of home birth, such as a gentle birth environment, immediate skin-to-skin contact for mother and baby following birth, and non-interruption of mother and baby excepting medical emergencies during the bonding period directly after birth, reflect midwives’ value of the baby’s experience.

Outside of the midwifery community, I don't believe such emphasis on the baby's experience during birth exists. In hospital settings, the focus is superficially on the baby's health and responsiveness. For example, the baby's heart tones are continually monitored throughout labor and a c-section is usually performed "to save the baby." Actual hospital practices, however, are not in the best interest of the baby. Vacuum extraction, cesarean section, immediate cutting of the umbilical cord, and separating mother and baby in the moments directly after birth when skin-to-skin contact is best are common hospital practices that have detrimental effects on the baby's emotional development, immune system, ability to breastfeed, and general wellbeing and growth. If synthetic hormones are used to induce or progress labor, then the extremely beneficial effects of natural oxytocin, prolactin, and opiates present in very high levels in the mother directly after birth are lost on mother and baby. By disrupting the natural process of birth, most times unnecessarily, hospital birth practices alter the way a baby begins life. Recent studies show that primal health, the conditions during that crucial period following birth, have lasting effects on a person's health and personality (Odent, 2011, p. 16). Hospital birth is a fairly recent phenomenon; birth moved from the home to the hospital in the period between 1910 and 1930. With current technological advances and drugs, babies are being born in hospitals today in ways never before been experienced by previous generations. Michel Odent (2011), founder of the Primal Health Research Databank, explains, "For the first time in the history of our species, most women do not rely any more on the release of their natural hormones to have babies: either they use pharmacological substitutes, particularly drips of synthetic oxytocin, or they give birth by cesarean. In other words the human oxytocin system has become useless in the critical period

surrounding birth” (pp. 24-25). Again, the hormone oxytocin is the “love” hormone, present during all “episodes of human sexual and reproductive life” (Odent, 2011, p. 25) and instrumental in a person’s ability to trust and socialize with other human beings. Odent (2011) is concerned about the effects of interventional hospital birth practices on humans’ “capacity to love.” His databank is a pioneering endeavor in the emerging field of primal health research, and it compiles numerous sources linking the environmental factors of the “primal period” (fetal life, perinatal period and year following birth) to health and personality later in life, particularly the onset of diseases which involve aggressiveness or impaired capacity to love or socialize such as “juvenile criminality, autism, suicides, and other conditions one can interpret as self-destructive behaviors, such as drug addiction and anorexia nervosa” (p. 16).

Birth is not merely a process by which a baby is born; it is the start of one person’s life and a remarkable life-transition for another. By valuing both the mother and the baby’s experience of birth as a whole, home birth ensures that a baby’s entry into the world will be gentle and allow for proper systems’ development. Current research as to the long-term effects of medicalized birth only further supports home birth. In this chapter, I will discuss in depth the physiological, psychological, and developmental changes babies experience at the time of birth and directly afterwards. Using this scientific framework, I will argue that home birth practices, such as allowing for natural, spontaneous labor and skin-to-skin contact between mother and baby in the hour following birth support a baby’s optimal health, emotional well being, and development in the moments and years following birth. If more babies were born at home, I think our

world would be populated with more loving, connected, and emotionally stable people.

Dr. Sarah Ackerly sees this connection in her work as a midwife and naturopathic doctor:

If we can welcome babies into a gentle environment where they know they are loved and wanted, then we are not disrespecting who they are at the time of their birth. [With a home birth,] they can come into this world and learn to trust and be more peaceful. So I really do think that the way we birth affects who people grow up to be and how they go through life. (S. Ackerly, personal communication, January 17, 2012)

There are many levels on which the experience of birth is important for the baby. Physiologically, being born is the catalyst for major biological systems to start or adapt to an environment different from the womb; the immune system and the circulatory/pulmonary system are two examples. On another level, spontaneous, natural birth involves complex hormone activity, and high levels of oxytocin, prolactin, adrenaline, and natural opiates rushing through the mother's system are transmitted to the baby via skin-to-skin contact in the crucial hour or so following birth. The "hormone bath" during this period is critically important for mother and baby bonding as well as the baby's ability to socialize, love, and trust other humans in the years to come. On a developmental level, a gentle birth followed by skin-to-skin contact improves breastfeeding and reduces the risk of postpartum breathing or heart problems for the baby (Gaskin, 2011, p. 34).

To illustrate the physiological changes a baby experiences in the moments after birth Ellie Daniels has her students at Birthwise Midwifery School, a three-year direct-entry midwifery education program located in Bridgton, Maine, perform a play. One student will play the part of the lungs, expanding wide when the baby takes its first breath, while other students act out the diverted blood flow as the newborn transitions "from receiving oxygen second hand via the mother's blood and circulating it in a three-



chambered system in their heart” to pulmonary respiration and circulation in a four-chambered heart (E. Daniels, personal communication, January 11, 2012). It really is an incredible physiological performance and a huge transition for the baby. Daniels explains it like this:

So the baby comes out, takes a big breath and that one-way valve closes [foramen ovale which allows highly oxygenated blood from the inferior vena cava to pass from the right atrium to the left atrium], the shunt to the lungs opens, the lungs profuse, the umbilical artery closes, and the baby is oxygenating with air. It’s a huge transition to a four-chambered heart.

While the physiological transition in a newborn from a three-chambered heart dependent upon placental blood flow to independent lung respiration certainly wins the award for best production, the kick-start of the baby’s immune system, however subtle, is no less noteworthy and deserving of attention. Immune system activation occurs when the baby transitions from the sterile environment of the uterus, “a sealed water bag where they are no organisms, through the vagina which is a fairly dirty, organism-rich place—it’s full of bacteria and yeasts—and then coming wet, covered with vaginal fluids out onto the mother, skin-to-skin with her, and that is the moment in which the immune system of the infant is activated and starts to work” (E. Daniels, personal communication, January 11, 2012). Studies in immunology and bacteriology in the 1970s documented “the easy and effective transfer of maternal antibodies (IgG) across the human placenta” (Odent, 2011, p. 42). Michel Odent (2011) argues these studies imply that “the microbes familiar for the mother are also familiar, and therefore friendly, for the germ-free newborn baby. From immunological and bacteriological perspectives, ideally a newborn baby needs urgently to be in contact with the only person with whom he (she) is sharing the same IgG” (p. 42). Home birth practices abide by these scientific understandings, by

providing a familiar, friendly germ environment for the baby and advocating for skin-to-skin contact immediately following birth. However, Daniels cautions, “When you take birth out of the home and put it in the hospital, you are exposing that baby unnecessarily to tons of foreign organisms that its mother knows nothing about and has no antibodies to [combat]” (E. Daniels, personal communication, January 11, 2012). Furthermore, the overuse of antibiotics in the hospital birth environment affects this most primary immune start up.

In addition to the immune system and the pulmonary/circulatory system start-ups, a newborn experiences significant changes in the functioning of the liver, urinary, integumentary, gastrointestinal, and temperature regulation systems. Such massive transformations in the body have a profound effect on the baby’s central nervous system. This is why birth environment and gentle birth practices matter very much to a baby’s physiological development. Birth is the time of initial patterning of response to stress.

Remember that “bliss” hormone? Or the orgasmic, ecstatic feelings the home birth mothers in Chapter 4 experienced moments after giving birth as they held their slippery new baby in their arms? Or that incredible high that went on, for some mothers, for weeks? The baby experiences all of this because “hormones cross the skin” (E. Daniels, personal communication, January 11, 2012). Lying on the mother’s warm breast, a familiar heartbeat nearby, the baby experiences the complex cocktail of hormones coursing through the mother’s system. The mother’s oxytocin levels peak after giving birth for the biological necessity of delivering the placenta. This surge of the “love hormone” triggers the release of prolactin, the “motherhood hormone” which also serves to let down breast milk. “The association of oxytocin plus prolactin means love for

babies” (Odent, 2003, p. 72). Midwife Heather Stamler describes it like this: “and then you have this baby which you have never loved anything as much [in your whole life]. It’s just this incredible oneness feeling, you know, you’ll do anything for this baby” (H. Stamler, personal communication, January 9, 2012). Also mixed into the cocktail are natural opiates and adrenaline. These hormones facilitate mother-baby bonding as the natural-opiates provide for a morphine-like state in which the mother can give her complete attention to her newborn and the adrenaline triggers “aggressiveness [which is] an aspect of maternal love” (Odent, 2003, p. 73). In all of the home birth videos I have watched, the mother’s immediate impulse after giving birth is to reach for her baby to bring it to her breast. None of these mothers resemble the drowsy, exhausted women often pictured in hospital birth scenes in films or television shows. Home birth mothers are alert, often sitting upright in a bed or on their knees on the floor after giving birth. Their faces display feelings of euphoria, empowerment, and unbridled love, in addition to exhaustion, as they gaze into their baby’s eyes and around them at their midwives and loved ones. I cry every time I watch this scene play out, and I have never met any of these women.

Birth is a major event in a baby’s life. To go from the mother’s womb, a place of nourishment, comfort, and security, through the squeeze of the birth canal, and out into this strange, complicated world is a massive transition for a baby. Some babies, like the one in the café, get stuck in the birth canal on their way out, or some babies have the umbilical cord wrapped around their neck when they are born. With or without these added complications, being born is a stressful and difficult experience for a baby. Home birth recognizes this stress and provides resolution by creating a gentle birth environment

and allowing for skin-to-skin contact for mother and baby directly after birth. The baby experiences the mother's surging hormones oxytocin, prolactin, natural opiates, and adrenaline and feels safe, protected, and loved.

Nicolle Littrell was interviewed about her home birth advocacy and film work for the *Camden Post*, a local, alternative news source. In this interview, she beautifully described how home birth attends to the baby's experience of being born:

Being born is work for the baby, too! It's work to go down that vaginal canal. It's work! And [the vaginal canal] is compressing the brain, squeezing the brain, stimulating the brain. Vaginal birth has a purpose. So, to be born with that stress—it's positive stress, but it is stress—into this loving environment where you're brought to your mother's breast, and there's love and support and quiet and low lights and peace and you recognize all the voices... To have that experience after the stressful experience [of being born] means that you are *safe*. There's [psychological] programming that happens in that moment that [you feel] you are safe. [It means] you can experience challenge and stress, but *you are okay*. Just think about how that world could be different if more people felt safe. I think that potential really lies in home birth, in normal birth, in safe, empowered birth.  
(Camden Post, 2012)

Babies that experience their mother's "hormone bath" through skin-to-skin contact in the hour after they are born are better able to respond to stress and socialize with others later in life. Michel Odent writes in *Childbirth in the Age of Plastics*, "We know today about the role of oxytocin in our capacity to establish eye-to-eye contacts, to interpret facial expression, and to be in a situation of trust. In other words we understand the paramount importance of the oxytocin system in the process of socialization" (Odent, 2011, p. 25). How a person is born has lasting psychological effects: the initial lessons learned from the birth experience matter as to how that person will go out into the world and interact with others.

"People comment on how mellow and content he is, and I just keep thinking it was because he was born at home. He is content because of the way we chose to do

things. That's how I feel and I'm sure people would disagree with me and say it's just his nature," says Ruth Jacobs about her son (R. Jacobs, personal communication, January 10, 2012). Over and over I saw and heard stories about home birth kids acting differently from other children. They were more connected to their parents; they had better coping skills, better conversational skills; they were generally happy and curious; they were good at socializing with other kids and even adults. As babies, they cried less, slept better, and were more easily able to breastfeed. For Sara Perry, a home birth mom to two teenagers, a toddler, and another soon to be born, "the biggest piece of [home birth] is the relationship with your baby from the moment they're born is much more comfortable. I feel like a home birth is a much less invasive way to be born as well as to [give] birth. [The newborn] is surrounded by family, they're in their house, there aren't any bright lights or strangers, and so I think for me it really has to do with the full experience from labor and birth to the beginning of motherhood—that it's all connected, that it's such a smooth transition" (S. Perry, personal communication, January 24, 2012).

Birth matters for the baby. Michelle Miller said her son was born into water at home, and he "came out so much more alert. Under water his head was out and he was already looking around" (M. Miller, personal communication, January 18, 2012). A gentle birth followed by unmediated skin-to-skin contact between mother and baby benefits the baby's physiological and psychological development. This includes emotional well being, sleep patterns, and breastfeeding. Studies in the 1970s showed "that when there is a free undisturbed unguided interaction between mother and newborn baby during the hour following birth, there is a high probability that the baby will find the breast during the hour following birth: human babies usually express the 'rooting reflex'

(searching for the nipple) during the hour following birth, at a time when the mother is still in a special hormone balance and has therefore the capacity to behave in an instinctive ‘mammalian’ way. The result of the complementary behavior between mother and newborn baby is an early initiation of breastfeeding” (Odent, 2011, p. 42). The differences I noticed in home birth kids’ demeanor, behavior, or sociability were formed at birth and developed through gentle parenting. These children have the potential to be exceptional people. I know, because I’m a friend to some, and one thing is for sure, they make great eye contact and have wide, true smiles.

## Chapter 6

### Beginning with Birth

I have seen how having a strong, empowered birth experience can activate [a woman] in other ways. It can be the start of [her] political career. It can activate [her] to care more about her community, to get involved in meaningful ways in her community. [It can activate her] to really start paying attention to other areas of [her] life, like the food [she's] eating, like [her] child's education, like the products [she's] buying—where they're coming from—and also to our political officers...I think that birth can really lay the groundwork and provide the value-set for getting more activated in other areas of your life. (Anderson & Littrell, 2011)

Beginning with birth, the Maine home birth community is organized around love, valuing process and people, direct experience, and nature. These values that make up the midwifery model of care and inform the lives of the people who choose home birth precipitate actions in their lives after the birth of their children. These actions, for their divergence from mainstream America, dictate a new way of life and a new culture. By valuing women and birth, the Maine home birth community creates a society that follows suit. The new stories that home birth folks tell themselves about themselves are revolutionary for our time because they are based on everything that our current society is not: love, sharing, trust, and honoring women and nature. What the home birth community of Maine has done, evidenced most clearly by the coastal town of Belfast, Maine, is to create a society that by its very existence disproves dominant capitalist,

consumerist, and misogynist ideologies in American society. It all begins by valuing women and birth.

Home birth is not just an alternative setting in which to give birth, it is a radical departure from societal norms and an opportunity for women's empowerment. When empowered, women can change the world beginning with their families and communities. Ellie Daniel's view is this:

I am a hard-core woman-centered person. I believe women are the center of our family structures, the center of our communities. Women are the peacemakers in the world; women are the ones who hold enough for everybody; women are the nurturers, the agriculturalists...it's evident all the way down through our history. Why have we become so oppressed at different points through our history? Because women hold the secrets of reproduction...sperm is cheap, but pregnancy and birth is a huge commitment. So my work [as a midwife] is all in the belief that what you offer to women during their pregnancy and at the time of their birth as mothers extends out for the rest of their life, through their whole community. (E. Daniels, personal communication, January 11, 2012)

A strong, empowered home birth gives women confidence in all other areas of life. I've had it described to me as a "If I can do *that*, then I can do *anything!*" sort of feeling. Such confidence, authority, and self-trust are incredibly necessary for the task of motherhood—and fatherhood as home birth also empowers men. When men see their partners giving birth in a really incredible, powerful way, they too are affected. Men become feminists, reflect upon their own births, and become more involved fathers. For women, having a home birth prepares them for the challenges of motherhood. Home birth advocate and mother Arielle Greenberg says this about her transition to motherhood after having a home birth:

The fact that I had a home birth with my first [child] really ushered me into motherhood in a totally different, more self-confident, empowered way. More than would have ever been possible with a birth in any other setting. [In mainstream culture] we have an epidemic of postpartum depression, an epidemic of expert parenting books...I can really see that we live in a culture where people don't trust themselves to parent, and it's been my experience that the kind of disempowering that goes on in standard hospital birth sets women up to feel completely unconfident to mother. (A. Greenberg, personal communication, January 16, 2012)



Over and over I heard similar exultations of home birth as an empowering and transformational experience that directly informed a woman's parenting style. Sara Perry put it this way:

I really feel like childbirth is a woman's warrior process, a process of growth. When you go through labor you learn your own personal limits and you face yourself and your fears. I feel like that really gives you the trust in yourself to then parent from a self trusting place and be more sure of yourself when you are making decisions and choices—more able to think from your own perspective and parent from your heart, not from what the culture or the group says. (S. Perry, personal communication, January 24, 2012)

Nicolle Littrell agreed with both Greenberg and Perry on the subject of self-trust, saying this:

It's a radical way of thinking because we so often defer our trust and responsibility to other people and to authority [figures]. Trusting yourself is a very different way of being. I see birth, a safe, natural, empowered birth as providing an opportunity for a woman to really trust herself, really get in tune with herself, listen to her own authority, and accept support from others. (N. Littrell, personal communication, January 19, 2012)

An empowering home birth experience gives a woman self-efficacy in all other areas of her life. Having home births inspired both Nicolle Littrell and Arielle Greenberg to become activists for women and home birth. Through Nicolle's films and Arielle's poetry, other women are made aware of home birth. For both of these feminists, awareness and informed choice is the goal. They see the right to a safe, empowered birth experience, be it in the hospital or at home, as a part of woman's reproductive rights. They, and I, hope that more people, younger women especially, will take up this issue as a feminist issue. Birth affects all of us, and it really does matter how we are born, as I have discussed in this thesis. To value birth and the women who give birth is the first step towards changing our world for the better.

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