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NEAR BIRTH: GENDERED POLITICS, EMBODIED ECOLOGIES, AND ETHICAL FUTURES IN CALIFORNIAN CHILDBEARING

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ANDREA LILLY FORD

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This work is dedicated to my parents,

whose support has been constant, unconditional, and without bounds.

I am immensely grateful.

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Abstract

This dissertation is concerned with utopian/dystopian projects of future-making, which I examine via the embodied experiences and theoretical implications of caregiving relationships surrounding birth. I'm particularly attentive to those who see such relationships as having transformative social potential, and I argue that the childbearing body is iconic of society in the visions of birth workers, caregivers, medical institutions, parents, and activists. By advocating for particular practices during pregnancy, birth, and infant rearing, these actors work to shape social values and institutional structures. Childbearing is not merely a site for social control, consumer choice, or aspirations to justice, as many popular, professional, academic, and activist works argue. What happens "near birth" is really grappling with assumptions about personhood, the social contract, and foundational American cultural categories.

Near Birth builds out from three years of ethnographic fieldwork based in the California Bay Area. The Bay Area is not a paradigmatic site, but a vibrant one that generates opinions, imaginaries, and potentials. With its boom-and-bust industries, high immigrant concentration, massive wealth disparities, and reputation as a haven for free-thinking, it is a bellwether and a place in which tensions over American futures are highlighted. During fieldwork I trained and served as a doula, attended childbirth classes and activist gatherings, participated in professional conferences and salons, and volunteered serving vulnerable childbearing populations. I also followed national and local media, wrote for a medical blog, and interviewed new parents and birth practitioners. In my theoretical framing, I avoid re-inscribing the dichotomies that characterize much scholarly and popular work on the subject. While recent anthropologists of childbirth have produced important topical studies, they have

overlooked the illuminating connections and tensions that become visible when the terrain of American childbearing is viewed broadly.

There are enormous disjunctures between aspirations, fears, and realities near birth. Utopian and dystopian fantasies of what birth might be are at work in these disjunctures, building upon and referencing each other. The questions raised near birth are nothing less than what is the future of society, and what kind of human is being built for it? Reactionary nostalgia, dystopian panic, and utopian vision motivate the birth worlds of California's Bay Area. Gendered politics, embodied ecologies, and ethical futures are imagined and contested, near birth.

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Introduction:

California and its Dystopian Utopias

When I showed up at Roxanne's victorian farmhouse on Walnut Street in Santa Cruz's westside suburbs, she made me tea with local honey -- to support our immunity in the cold season -- and sat me down in her warm living room. Pictures of her five children lined bookshelves and an old curio cabinet, and the green upholstery of the sofa was adorned with beautiful tapestry pillows that caught the colors in the intricate rug underneath our sock-clothed feet. She was probably in her sixties, and her red hair was streaked with white above her fine-boned face. She told me how she and her longtime partner in her midwifery practice, Kate, had founded what she called Santa Cruz's "birth culture" in many ways, gesturing at a flagstone path to a door in a building across the lawn that was their office for many years. In thirty years of practice, she had been present at over 2000 births. Among other things, I asked her if she thought that the way babies are born can influence the future. "Oh, goodness yes!" she replied, face bursting into a smile. Roxanne was among the first people who offered to meet with me when I started fieldwork, and I came to know that she was one of the busiest and most established of the midwives, one of the "originals." She and Kate were instrumental

in making Santa Cruz a "mecca for Nurse-Midwifery" for the past 40 years[1]. But there was no pompousness or self-importance in her manner. Roxanne invited me to assist at her enormously popular class, Mindfulness Based Childbirth Education, and that got things rolling for me, the new anthropologist in town. Not long afterwards, I learned that she had just been diagnosed with terminal cancer.

When I attended a memorial service in honor of her life two years later, one of the speakers uttered a phrase that captured that first meeting: the warm mischief in her blue eyes made you feel you were a close friend, even if you had just met. Her memorial service was steeped with a Santa Cruzan variation of "birth world" culture: old hippies, new idealists, the largely-unreflective privileged, and a kind of reverence for nature, spirituality, community, and the feminine. Hundreds of people overflowed the Community Room at the Buddhist-influenced Mount Madonna Center, which had been an important community hub of the home birth movement in the '70s, to remember Roxanne's life. Having arrived a little late, I added my flip flops to the massive pile of shoes in the entry hall and snuck around to the side of the auditorium, where I knelt down on the carpet surrounded by people standing or lounging or seated on the floor, babies breastfeeding and toddlers making (and smashing) towers of wooden blocks. The long service featured speakers who were not just Roxanne's friends and family, but the doctors, midwives, nurses, mothers, and fathers whom her work had touched. A reception with cookies and chai made by favorite local businesses followed. Chatting with a few friends, I remembered Roxanne and talked about how the service had reinforced the importance of connecting deeply with people, and being a force of love in the world. One friend was a doula with whom I had been thinking of starting a full-spectrum

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[1] Grusauskas, *Santa Cruz Good Times*, September 24, 2014.

practice; another was a midwifery student who was moving to Oregon after just having finished her long and difficult apprenticeship.[2] We nibbled gingersnaps and sipped milky spicy tea while leaning over the redwood deck railing, looking out over the forested Santa Cruz mountains down to the gleaming Monterey Bay.

Birth Worlds

I spent two and a half years involved in the "birth worlds" of California's Bay Area, as a doula and anthropologist. A doula is an assistant who provides emotional, physical, and informational support for a woman's reproductive life, most commonly those parts of it pertaining to birth; by contrast, a midwife is a medical professional who can make diagnoses and recommendations, and who is responsible for outcomes.[3] The two were often confused by those outside of the birth community, likely because both professions -- or callings, as many are wont to call them -- are part of a vibrant set of lifestyle practices, conceptions of health and the body, and ideas about women, family, and community that supplement, contradict, and interweave with conventional medical protocols. I call this interwoven fabric a "birth world," composed of parents, practitioners, infants, activists, media, technologies, and ecologies that interact "near birth." Rather than demarcating divisions and distinctions among

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[2] A full-spectrum doula supports a woman through "all reproductive outcomes or decisions", including pregnancy termination through abortion, stillbirth, or miscarriage, as well as birth and infant care. Full-spectrum practice often overlaps with support of queer and trans family making, and poverty/racial justice awareness. That woman was the only full-spectrum practitioner I knew of among the many doulas in Santa Cruz. Abortion is a divisive issue in the "birth worlds" I encountered.

[3] See Morton's 2014 sociological study of the doula profession/phenomenon, *Birth Ambassadors*.

approaches to childbearing, thereby reifying particular camps as somehow cohesive, I take the fabric as a whole and trace particular threads throughout it.

Birth worlds engage with contradictions and dichotomies in American values, and marshal utopian and dystopian visions of the future. They nurture specific kinds of knowledge and relationships with liveliness.[4] The question of how new life should come into the world invokes a multiplicity of ideological stakes, which are negotiated alongside social and material constraints by childbearing people and practitioners alike. Edward Said wrote that the human condition is the unstoppable predilection for alternatives (1983:247); in examining the dynamic relationship between "alternative" and conventional childbearing practices in the US, I'm arguing that seeking alternatives is an understandable effort to grapple effectively with social and personal conditions, potentials, and dissatisfactions. We can see social problems being worked out in the decisions surrounding birth. In the birth worlds of the Bay Area, the childbearing body is a synecdoche for society; it is part of the social whole *and* representative of it. Pregnant, birthing, and nursing bodies are also microcosms of society; they are sites where social and material relations that operate on much larger scales are worked out and made manifest. The emotionally charged ways people know, interact with, and inhabit the childbearing body enact different visions of what social and material relations could be like. In many cases, they polemically assert visions of what social relations *should* be like. Contests over bodies are always, in some ways, contests over the social order, but this microcosmic relationship is intensified in the bodies that are bringing new members of that social order into being.

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[4] See Lock and Farquhar's theorization of "the lived body" in the introduction to their anthology *Beyond the Body Proper*.

Birth worlds are the scope of ideas and practices about childbearing in a given community. This is an emic term, though not ubiquitously used. Birth worlds are promoted and circulated by people: those who bear children and their intimates, and practitioners including doctors, nurses, midwives, doulas, childbirth educators, and lactation consultants. They are also influenced by human productions like media, including newspapers, magazines, blogs, movies, and pamphlets, and professional organizations such as the Midwives Alliance of North America (MANA), the American College of Obstetricians and Gynecologists (ACOG), Doulas of North America (DONA), the Association for Pre- and Perinatal Psychology and Health (APPPAH), and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN). Human productions belonging to birth worlds also include stores and studios selling childbearing wares, offering classes ranging from childbirth preparation to perinatal yoga and massage to post-pregnancy weight loss, and hosting meetings like "meet the doulas" nights and support groups for new dads; Luma in Santa Cruz and Natural Beginnings in San Francisco are examples. It includes academic work featuring scientific research and statistics, and embraces consumer products and their marketing, anything from baby slings, formula, and maternity clothes to breast pumps, strollers, and co-sleeping platforms. Birth worlds are composed of tools and technologies like epidural needles and the elastic bands of fetal monitors, hospital sheets and plastic suction cups on breast pumps, contraction-monitoring mobile apps and monitors to listen to the baby sleep in the next room. Birth worlds are influenced by human productions that are several times removed from their origins, such as industrial toxins in the environment, and also by non-humans such as microbes.

In conceptualizing and researching "birth worlds," I do not intend to evenly encompass anyone and everyone who gives or attends births, but rather to particularly emphasize those

who are actively opinionated about birth. Those who are, in a sense, more "near" to birth through the attention they pay it. My fieldwork looked not just where babies were happening, but where people were *concerned* with how babies happen. Birth worlds have childbearing as an object they intend to influence, not passively consume. This means I juggled, on the one hand, people considering childbearing as an idea over and above actual instances of childbearing -- not to discount their practical involvement or concern about real and specific people -- and on the other hand, the sensory, messy details of the actual near-birth situations in which I took part. The former particularly fueled my thinking about social imaginaries, while the latter was essential to my thinking about materiality, embodiment, and ethnographic specificity; in this dissertation, I try to merge and navigate between those aspects.

California and the Bay

The California Bay Area is the American site *par excellence* for emerging social imaginaries. With its reputation as a haven for free-thinking, it draws people who like to consider themselves iconoclastic and visionary, whether they are libertarian techies, new-age spiritualists, or nostalgic homesteaders. It has a rich history of civil rights activism that is being revived in response to massive gentrification, a growing wealth divide, and Trump-era regressive politics. Its high immigrant concentration and legacy as a haven for the LGBTQ community fuels California's role as a lightning rod for national debates over reproduction, as the first minority-majority state and a forerunner in the mainstreaming of "queer" domestic arrangements. In the '60s and '70s, the Bay was not only the site of much utopian fantasy and distinctive lifestyle practices called "alternative" or "natural," but specifically incubated ways

of bearing children that would also carry these adjectives for decades. Fifty years later, the legacy of "natural" birth has become dogmatic and stale in many ways, yet the Bay is still a crucible for emergent thought about childbearing and society.

I began my fieldwork in Berkeley, a notoriously liberal East Bay hotspot dominated by the University of California, where I had attended college ten years earlier. I lived at the end of a narrow, winding road up in the hills with a queer Jewish nurse-midwife and her two teenage children, in a house made lively by our combined collection of dogs, cats, and plants. I spent two years in the field, from September 2013 to September 2015; during the latter part I lived in Santa Cruz, which is technically on the Monterey Bay to the south, not the San Francisco Bay after which the "Bay Area" is named. Santa Cruz was a fascinating bubble of progressive, privileged white thought, which impressed me as narcissistic and self-righteous at times, genuinely idealistic at others. There, I lived with my partner on a sunny hill in the mountains to the northwest of town, a little spot of warmth surrounded by ravines and towering, shady redwood forests. Ferns grew as weeds in my garden. I maintained strong connections in the Bay Area proper that often drew me up north; San Francisco and the East Bay were where much birth activism took place, and I remained involved in it as much as I could. In addition to being dynamic and interesting birth worlds in and of themselves, Santa Cruz and the Bay Area (which for my purposes primarily consisted of SF, the East Bay, and the Peninsula) were complimentary as sites. The Bay is diverse, urban, and cosmopolitan, dominated by the figure of the high-powered tech worker. Individual municipal areas have no clear boundaries, melded by a tissue of suburbs and commuter arteries in a massive sprawl; it

is "connected" to a fault, in a virtual/digital sense as well as a physical one.[5] Santa Cruz is a small college town sheltered by a crescent of mountains and abundant parkland, oriented towards the beach and notorious for surf culture, a place people go to disconnect from a fast-paced life they find obnoxious.

Let me guide you on a brief geographical tour. Let's begin in my Santa Cruz mountain home not far from the UCSC campus. We'll drive, as there is very little public transit in Santa Cruz; the situation is marginally better in the Bay proper with the sparse BART and CalTrain lines. A twenty minute drive west toward the coast brings us to Highway 1's meandering route through world-renowned scenery, and we travel north along the edge of rocky cliffs that drop off into surf or sand, passing swaths of bright orange native poppies decorating hillsides, and the fleshy magenta-flowered vines of invasive sea figs clinging to the dunes. Protected agricultural and park land makes up almost all of the 90 minute drive to Pacifica. Continuing further north, San Francisco's municipal sprawl is upon you by the time you reach the suburbs of Daly City, which inspired folk singer Malvina Reynolds to write the dystopian (and perhaps sanctimonious) "Little Boxes" in 1962 about the rows upon rows of pastel houses blanketing the hillsides like vineyards. Further north, driving through the city and across the Golden Gate bridge, we arrive in exclusive Marin, with the literal vineyards of Napa and Sonoma to the northeast, and Mendocino's fishing villages of aging hippies to the northwest. No transit lines extend to the North Bay, reinforcing its exclusivity.

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[5] Kristin Miller's 2014 article "Mapping our Disconnect" describes how transit in the Bay Area is increasingly being privatized by the tech industry, raising questions of "the commons" and public good. Transit infrastructure can disconnect people and places as much as it connects them, reinforcing geographical lines of class and race separation, which is certainly the case in the contemporary Bay Area. I characterize the Bay as "connected" to emphasize an imperative to movement, not to suggest an evenness of accessibility.

But the coastal route is for joyrides; generally, commuters use Highway 17, which joins Santa Cruz with San Jose at the southern tip of the Bay. The treacherous mountain pass is a connection that also enforces Santa Cruz's isolation, notorious for its steep curves and reckless drivers. This climb brings us through Los Gatos, southernmost of the wealthy hillside communities that line the Silicon Valley. Descending down 17, we arrive in the heart of San Jose, a sprawling suburbia on the flatland. This flatland extends north up the peninsula, bordered by verdant foothills and Highway 280 on the west, and the industrial bayshore and Highway 101 on the east. In between lies Silicon Valley proper: Mountain View and Palo Alto, where the tech giants including Google, Apple, Intel, and Facebook reside, awash in a sea of suburbs. The Santa Cruz mountain foothills north of Los Gatos are dotted with the most expensive real estate and "snobbiest towns" in the nation: Atherton, Saratoga, Los Altos Hills, Portola Valley. Across the Valley on the bayshore, the ghetto of East Palo Alto, a few miles from Stanford University, was the nation's "murder capital" for many years.

San Francisco sits atop the peninsula like a crown of dense lights and mobile fog. The broadly "SOMA" area (south of Market street, which is a main thoroughfare cutting from northeast to southwest, along which the BART line runs) is tech-hipster central, where the vibrant Latino Mission District, proudly gay Castro District, and industrial piers of Potrero Hill are all rapidly gentrifying as startups move in and warehouses are converted to loft apartments. Slightly to the southwest, the small area called Noe Hill is distinguished by stereotypes about yuppie moms who push Audi strollers and shop neurotically at Whole Foods. The northwestern part of the city is home to somewhat more established businesses and residents, while the southern bayshore is gentrification's frontier. Let's cross the recently re-built Bay Bridge with its elegantly lit rows of cables into Oakland, once a notoriously

scrappy port city but now also gentrifying and hip as people priced out of San Francisco move across the bay. It merges smoothly into liberal-elite Berkeley just to the north, with the once-industrial now-commuter cities of Richmond and Vallejo above that, and similarly Hayward and Fremont to the south. Cities in the East Bay are among the most diverse in the nation.[6] Much like the peninsula, the East Bay has flatland on the bay side, in this case the West, and hills on the East, where the wealthy communities gather: the Berkeley and Oakland Hills, and beyond that Walnut Creek, Castro Valley, Livermore.

If we travel south from my house in the mountains instead of heading towards the Bay, we'll arrive in the little town of Santa Cruz with its beaches on Monterey Bay, famous for surfers and the fairgrounds of the Boardwalk. Swaths of San Jose pleasure-seekers flock there in summer months, greatly resented and yet economically essential. Nestled in its topographical basin, Santa Cruz is cut off from the urban culture of the Bay Area, yet it's also isolated from the towns to the south, this time by class- and race-inflected cultural differences, not geography. Watsonville and Salinas are overwhelmingly Latino/a and intimately connected with the agricultural land that extends south along the coast to San Luis Obispo and east into the Central Valley, where most of the nation's produce is grown. Immigrant workers are instrumental in producing California's many labor-intensive specialty crops that are not grown commercially elsewhere: asparagus and artichokes, almonds and garlic, strawberries and raspberries. This divide between "north county" and "south county" was troubling to some Santa Cruzan birth workers I encountered -- the Perinatal Mental Health

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[6] The Penn State research series on recent trends in American society by the US2010 Project found that California cities (namely Oakland, Vallejo and Suisin City, all in the northeast Bay) dominate the list of most diverse places.

Coalition, for example, made a point of holding their meetings in the south -- but mostly members of this community gravitated up to the Bay for social and professional contact.

As opposed to Santa Cruz's bubble, the Bay Area's professional and social networks are spread out, and this applies likewise to birth networks. "The Bay" itself is a highly salient unit among people who make it home. Midwife friends in the East Bay worked in the North Bay or the city, parents often worked in San Francisco but lived in Silicon Valley (or vice versa) and so mined multiple cities' shops, classes, and resources, and friends frequently traveled up and down the peninsula for social and professional gatherings. Doulas and midwives living in Santa Cruz had many clients in San Jose and Silicon Valley because these specialists were too numerous to be sustained by Santa Cruz's small population, which speaks to Santa Cruz as a kind of mecca of progressive/alternative practitioners, and to the frequently acknowledged idea that there was more money "over the hill." My personal and professional contacts drew me throughout this region, and I spent a lot of time driving, as did many of the people I interviewed or worked with. In claiming such a geographically expansive site, I'm not pretending to have evenly absorbed its cultures; the birth worlds I studied are not demarcated primarily by geography but by social channels maintained through infrastructure and demographic gravity, and they are heavily inflected with racism and classism. Such channels connect certain places while bypassing others, and I moved along them as a white, educated, straight female with tons of cultural capital if not much money. These channels are also evident in the media that composed much of my ethnographic material; blogs, magazines, books, movies, advertisements, and events circulate similarly, in an uneven spatial diffusion.

Northern California is where I grew up. Though as an adult I had lived in the American Midwest, West Africa, and Southern Europe, I was drawn to study "home." I spent a peaceful

childhood in the oak-studded foothills of the Sierras, traditional lands of the Nisenan and Miwok people, a few miles from Coloma, the very seat of the Gold Rush's human and ecological devastation. My people came to California's central valley via Oklahoma for agricultural work during the Dust Bowl era, bringing Cherokee blood with them from Georgia via the Trail of Tears, a heritage worn with mingled pride and resentment; others of my recent ancestors were newly immigrated to Los Angeles from Sweden, or were Californian-Americans with old Anglo-Irish ties. My affection for the land and people I know as home is thoroughly interwoven with my complicity in settler-colonialism and the many ways I've benefited from white privilege. In choosing this project, I wanted to understand the discontents and aspirations of the people for whom I feel a mixture of belonging and distance, among whom uneasy depression and individualistic optimism mingle freely, where a sense of connection to the violence, inequality, and exploitation that run rampant in the world are so often missing.

By moving two hours west from the rural Republican foothills to attend college at notoriously liberal UC Berkeley, I became intimately familiar with the ways that progressive and conservative politics are geographically coded. It fascinated me that certain nostalgic and countercultural lifestyle practices, like home birth, home schooling, and homesteading, were advocated in both rural and urban places by people who would have considered themselves ideologically distinct, to say the least. Progressive and reactionary visions are blurred in such realms; living "off the grid" is popular in California both with libertarian and socialist sympathizers, and home schooling is practiced by both those who seek a conservative religious education and those who desire a radically open-minded and anti-authoritarian education. This seemed to be the case in birth practices as well. I came to recognize California

as a place of extremes that caricature and highlight American culture, and to some extent late-liberal society generally.[7] California is in no way *representative* of the country at large; it is not a paradigmatic site, but a vibrant one that generates opinions, imaginaries, and potentials significant far beyond its boundaries.

California has a unique role in the national imagination, epitomizing "the frontier" and manifest destiny (Cattelino 2010), science fiction and the magical fantasy of Hollywood and Disneyland (Miller 2013)[8], and an "American dream" of personal prosperity epitomized by the overnight millionaires of the tech world. Entertainment and technology, the primary drivers of California's economic growth, are industries established on the imagination of various futures. The state functions as a national bellwether, setting trends that index both utopian and dystopian visions of the future. There is a trope that the northern part of the state (particularly the Bay Area) epitomizes idealistic utopia while the southern part (particularly Los Angeles) epitomizes decadent dystopia (Callenbach 1975, Miller 2013, Davis 1999). In books and movies, the Bay Area is richly associated with fantasies of ecological sustainability

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[7] In an apt irony, California is home to geographical extremes as well: the highest and lowest points in the continental United States are located within 100 miles of one another in Southern California: Mount Whitney measures 14,505 feet and Badwater Basin in Death Valley is 282 feet below sea level.

[8] In her 2013 article "Postcards from the Future," Kristin Miller writes that in the science fiction movie trope, sometime in the future "California has succumbed to natural disaster/ economic and governmental collapse/a pandemic, which leaves Southern California a corporate-fascist-military state with gross financial and racial inequality and urban squalor-- while Northern California rips up its pavement, learns permaculture, gets spiritual, and models better living through technology and communitarian diversity." Mike Davis writes about Los Angeles as dystopia in *Ecology of Fear*.

and peaceful communal life,[9] while these cultural productions associate Los Angeles with apocalyptic chaos and self-indulgent excess; California offers "final frontiers" for both idealists and cynics.

Utopias to one group are dystopias to another. Consider the Silicon Valley tech industry: in more utopian frames of mind, technological innovation and entrepreneurship has been called an equalizing force where anyone with a good idea can succeed and the internet allows access to information, masks identity politics, and facilitates political organizing, while the dystopian assessment shows that venture capital is predicated on outrageous wealth inequality, while the sorts of self-absorbed software that make money promote a digitally distracted and depoliticized populace. (The tech industry also illustrates California as a bellwether: the dot-com bubble burst in 2001, forecasting the instability and collapse of high finance that recurred nationally in 2008, yet did not deter the massive investment money that flows into tech speculation, or again into Wall Street on the national level.)

The "Utopian Dreaming" of Santa Cruz in the '70s likewise has ambiguous valences. Santa Cruz almost prides itself on being in a bubble, pure and different, largely oblivious to its own privilege, with undertones of white supremacy and classist exclusivity. This is influenced by UC Santa Cruz's anti-establishment history (for example, the school didn't issue grades regularly until 2001, focusing instead on a Narrative Evaluation System). The town and university have a rich history of utopian sensibility that drew heavily from feminist and environmental movements, which have both been critiqued for having a largely white and

[9] See Miriam Greenberg's 2013 "What is Sustainable?" Northern California has epitomized the "sustainability" movement at least since Callenbach's *Ecotopia* in the 1970s, but while sustainability has come to seem commonsensically post-political, Greenberg points out that the situation implicitly "sustained" is hardly given or universal.

middle-class perspective that overlooks the concerns of marginalized groups (Greenberg 2013, Sanchez and Pita 2015, hooks 1981, Collins 2000, and many others). In Fall 2015, a conference was held on campus entitled "Utopian Dreaming: 50 years of imagined futures in California and at UC Santa Cruz,"[10] which celebrated the legacy of Ernst Callenbach's 1970 book *Ecotopia.* Such utopias as were dreamed up in Santa Cruz were simultaneously received as dangerous and dismissed as ridiculous by the conservatively oriented white middle-class.[11] Northern California was the epicenter of "utopian" communes and alternative lifestyle movements in the '60s and '70s (Boal et al 2012), and the Bay Area nurtured many activist-scholars from this generation, including black justice powerhouse Angela Davis in Oakland, celebrated critical feminist theorist Donna Haraway at UCSC, ecofeminists Carolyn Merchant, Starhawk, and Susan Griffin in Berkeley, and lesbian poet-scholar Adrienne Rich who lived her later years in Santa Cruz.

California is a vanguard for American conflicts over raced and queer bodies (Maharidge 1999, Weston 1991). It offers a privileged window onto the national consciousness about reproductive controversy, and is an ideal place to ask questions about whose sensibilities get marked as "good" or "normal" in American culture at large. Proposition 8, which bans gay marriage, was passed in 2008, but challenged in the courts and declared unenforceable in

[10] Videos are available online. http://rachelcarson.ucsc.edu/news-events/news/Utopian%20Dreaming.html

[11] See, for example, Sherman's 2009 work on poverty and morality in rural Northern California (the far north coast around Humboldt); it's important to note that her interlocutors' community and sensibility is steeped in whiteness, as well. In Santa Cruz and much of the Bay, liberal politics are presumed and Republicans are jokingly said to be "closeted;" in the 2016 election primaries, Bernie stickers on Prius bumpers and yard signs abounded, and the rivalry between the Bernie and Hillary tables at the farmers' markets masked the total absence of Republican candidates. Libertarian politics are increasingly strong in the area, however.

2013. Prior to the well-publicized Stonewall Riots in New York, the 1967 Black Cat protests in Los Angeles initiated the Gay Rights movement.[12] Reactionary anti-immigration Proposition 187, passed in 1994, was closely followed by the Rodney King riots and civil rights legislation in 1996;[13] by 1998, white people were a minority in the state, largely due to disparities in fertility rates, making California the first "majority minority" state (Maharidge 1999). By 2014, Latinos alone outnumbered whites.[14] California leaders pushed for Japanese internment during World War II, and in the early 20th century there were laws that prohibited Asians from owning property, building on a history of sinophobia since the Gold Rush (Aoki 1998). Now, in the wake of the Trump presidency, the state of California is aggressively defending immigrants from deportation.[15] In February 2017, the *New York Times* ran a piece titled "Immigrant Shock: Can California Predict the Nation's Future?" In the wake of Trump's anti-immigration white-supremacist election success, the article claims that California lashed out at diversity before embracing it. "The demographic change California underwent between

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[12] Romero, Dennis. "Before the Stonewall Riots, the Gay Rights Movement Was Born in Silver Lake". *LA Weekly.* February 6, 2017.

[13] Proposition 187 denied state services to undocumented immigrants, including public education and health care, and was part of the re-election campaign of Republican governor Pete Wilson. The appeal to conservative whites is now thought to have hurt Republicans in the state in the long run. It was followed by voter rejection of affirmative action and bilingual education; in 2016, bilingual education initiatives passed (Prop 58).

[14] However, they may not be a "full" majority (over 50%) for several decades. See Reese and Magagnini, "Census: Hispanics overtake whites to become California's largest ethnic group." *Sacramento Bee.* June 30, 2015, and Lopez and Krogstad, "Will California ever become a majority-Latino state? Maybe not". *Pew Research Center Publications.* June 4, 2015.

[15] Sanctuary cities abound in California, and there is a proposition to make it a sanctuary state. See Medina, "California Weighs Protections for Immigrants Threatened by Trump Policies", *New York Times*, December 4, 2016, and Cooper, "California lawmakers eye immigration measure to fight Trump." *AP News.* February 1, 2016.

1980 and 2000... mirrors the change (and projected change) in the United States since 2000 and up to 2050, when whites are expected to be less than half of the nation's population."[16] The article implies that by looking to California as bellwether, we can see current American politics as regressive, fearful whining that comes before a widespread acceptance of non-white power. Yet California's massive gentrification problem, especially in the Bay Area, belies the inclusive rhetoric, as black and brown working-class families are tacitly pushed to the margins.

National concerns with the politics of birthrates, encompassing access to abortion, birth control, and sex education, distribution of welfare funding, and the needs of an aging white "baby boomer" population, are brought to the fore in California.[17] Consider the hubbub made in 2015 over Chinese "birth tourism" and "maternity hotels," through which as many as 60,000 Chinese babies are born in the US each year to secure them access to citizenship, and, later, an American education, primarily in the Los Angeles area. While not technically illegal, this phenomenon raises ethical questions about resources, the social contract, global relations, and California's history of Sinophobia. The Bay Area epitomizes both current national immigration stereotypes: "high-skilled" Asian tech workers feeding Silicon Valley's expanding industries, and "low-skilled" Latino/a agricultural laborers, drawn to the North Bay's vineyards, the Central Valley's orchards, and the labor-intensive specialty crops around Monterey. Immigrant and LGBTQ communities nurture ideas about family, parenting, and medicine that deviate in some ways from white middle-class American narratives (Weston

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[16] Badger, Emily. "Immigrant Shock: Can California Predict the Nation's Future?" *New York Times*. February 1, 2017.

[17] See Nori 2016, and *Rolling Stone's* August 2015 "Welcome to Maternity Hotel California"

1991, Fadiman 1997, Ong 2003, Hayes-Bautista 2004), producing a Californian stew of non-hegemonic childbearing thought.

Along with race, ethnicity, and sexuality, American class relations are showcased in California, and the Bay Area in particular. The tech world is the vanguard of a new, largely white American elite that both spurns stale class aesthetics (consider the startup uniform of hoodies and t-shirts/jeans, or the hipster embrace of both urban grunge and rural chic, eschewing middle-class suburban aspirations) and fuels the growing national wealth divide. As a young adult, I watched Silicon Valley expand and infiltrate the Bay, much as the hardware and software it produces have infiltrated daily life. The ensuing gentrification is displacing long-time residents of San Francisco and Oakland, pushing working class families and artists further and further from the cultural centers (Solnit 2001). The tragic and deadly 2016 fire in an Oakland warehouse that was serving as an unregulated and affordable creative space and home for artists epitomizes the resulting precarity.[18] Urban slums and hilltop mansions sit side by side all over the bay. Homeless populations are at national highs in Oakland, Berkeley, and San Francisco, while these are among the most expensive places in the country to live and also boast the highest number of billionaires. Yet inequality is widely recognized as a problem, for example by strong voter support for raising the minimum wage.

With Silicon Valley's expansion, the libertarian-inflected politics of young male millionaires have started replacing the socialist-leaning politics of the hippies of the prior

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[18] See *East Bay Times*, December 2016, "The last hours of Oakland's Ghost Ship warehouse"

generation.[19] Approaches to childbearing pioneered on radical ideological fringes are increasingly trendy among "young urban professionals" who have money and consume heartily, if discriminately, and lack strong activist commitments; this is in contrast with the hippies of the 1960s and '70s, who usually did not lead affluent lives even though they largely came from an educated, middle-class background. The Bay's current youthful vibrancy is entwined with unbounded capitalist development and entrepreneurship, and a wildly out-of-control consumer culture based on luxury items, particularly food. Neoliberal ideologies of individual responsibility underly gross exaggerations of self-sufficiency, including a not-insignificant movement of the Silicon Valley elites preparing to save (only) themselves from impending apocalypse.[20] Much yuppie/hipster Bay Area birth culture, then, combines "innovation" of both ideological and entrepreneurial sorts; it combines countercultural sensibilities with exaggerations of late-industrial neoliberal consumption. Consumption has become a primary mode for ethical, aesthetic, and political expression in a frequently self-righteous "lifestyle" politics that privatizes and domesticates social commentary. Childbearing options that were once confined to social fringes are becoming widespread as part of a hip, elite parenting culture, yet these developments are happening against a late-liberal backdrop

[19] Fred Turner (2010) has interesting reflections on the connections between the hippies and the tech world, and how computers went from symbolizing the despised Cold War military-industrial complex to being tools of a collaborative digital utopia. See *From Counterculture to Cyberculture: Stewart Brand, the Whole Earth Network, and the Rise of Digital Utopianism.*

[20] See *The New Yorker*, January 2017, "Doomsday Prep for the Super-Rich".

of rising inequality and the gap between those who have access to options and those who do not (Harvey 2005, Povinelli 2011, Maharidge 2011).[21]

While privileged parents obsess over the significance and intricacies of childbearing options, contemporary American childbearing as a whole has been described as in crisis due to poor maternal-fetal outcomes, huge disparities by race and class, and a privatized healthcare system. Amnesty International's 2010 report titled "Deadly Delivery: The Maternal Health Care Crisis in the USA" ranks the United States 40th in the world for maternal and infant outcomes, despite spending the most money per capita of any country.[22] American management of childbearing has reflected and reproduced broader social trends since the formation of the country, including the professionalization of medical expertise, the separation of family life from civic life, the devaluation of knowledge marked by race or gender, and the rise of institutional-technological approaches to bodily processes (Wertz and Wertz 1989, Ehrenreich 2010). While this reflection is no less relevant in recent decades, the direction of change is becoming more unclear, with strongly divergent trends and a proliferation of hybrid options. Much popular, professional, and academic discourse still relies on polarizing

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[21] Notably, both "hippie" and "yuppie" culture are steeped in whiteness. There are plenty of people *without* much money who are part of trendy Bay Area birth worlds, but in the style of the original hippies, they generally have abundant racial and class privilege to counteract their eschewing of immediately remunerative pursuits. Students living in coops in the woods, pot growers, entrepreneurs developing the next big thing in a garage, people cobbling together a living trying to find themselves and do meaningful work without being a "corporate slave," while facing no structural disadvantages or obstacles to conventional economic success. Doulas often fall into this category.

[22] Importantly, California's maternal mortality statistics diverge from the national trend. They have lowered significantly over the past decade, while the nation's have grown, largely due to the California Maternal Quality Care Collaborative (CMQCC), which has compiled statistics and developed protocols specifically for maternal emergencies. See Belluz' June 2017 *Vox* article.

frameworks that reify stale dichotomies, such as "natural" versus "technological," "midwifery" versus "medical" approaches, and "stay at home" versus "career-oriented" mothers. In day-to-day practice and speech, however, parents and practitioners shuffle, recombine, and re-imagine such categories. They both embrace and reject associations between practices, beliefs, and their social significance; they balance ideals with practical possibilities (as not everyone can afford to make the same choices); and they weave together the various kinds of knowledge used to support their decisions. This bricolage process is deeply affected by class, race, and ideological orientation, yet does not follow such lines in any neat way.

Childbearing, and particularly the birth event, draws forth discourses that cross and blend ideological and identity-based distinctions. Calls to experience one's body deeply, or to make use of the latest technology or make the safest choice, or to reconnect with the land and each other in community, or to have concern for the well being of the future generations, are resonant across political and religious lines, and within native, black, white, Latino, and Asian communities. Yet ideological and historical differences are far from irrelevant in people's negotiations of childbearing, apart from differences in material wealth. I am fascinated by the sorts of alignments beliefs about childbearing make visible, alignments that do not correspond neatly to other categorizations but which are always influenced by them. It is not uncommon to find people who practice childbearing similarly, but with different reasons or motivations; conversely, it is also not uncommon to find individuals who share a background or identity yet have very divergent ideas about childbearing. Within my own white, middle-class Californian

family, in which all of us are healthcare professionals of some sort, we have very different ideas about medical care during labor, as well as about gendered caretaking roles.[23]

It is important to note the general background of American privilege against which all these negotiations, innovations, and disparities take place. The United States is a wealthy industrialized country, where most people giving birth are not concerned with dying in any immediate sense -- though they may fear physical and emotional damage from prejudicial treatment, or bankruptcy from hospital bills. The technology and advanced industry that forms the backdrop for all decision making include things like ambulances and phone service, sterilization and an uninterrupted power supply, blood banks and a literate population with ready access to health information via Google. These stave off death's association with birth in ways that cannot be taken for granted in other parts of the world.

In my fieldwork, Santa Cruz epitomized the privileged, progressive, white culture where "alternative" childbearing care practices (and pressures) flourish, and the East Bay was a rich source of interracial activism for justice in reproduction, gender, sexuality, and living conditions broadly understood to include poverty, political representation, and ecological contamination and destruction. This is not to say that the Bay Area didn't have its own privileged narcissism as well (particularly considering the newly exaggerated tech influence!), nor is it to gloss over the poor or the genuinely socially conscious in and around Santa Cruz, but to show what each site contributed to this project through a bit of caricature. Together, these sites provided a window into "cutting edge" imaginaries about what bodies are, how they

[23] Generation/age is clearly relevant to these sorts of discontinuities, in ways I don't systematically observe or theorize here.

can be known, and how knowing or valuing bodies in certain ways can lead to utopian or dystopian social futures.

Methods

This study is based on ethnographic information gathered from participant observation, interviews, and media analysis. I conducted participant observation as a birth doula, which included my training, attendance at social/professional events, and interfacing with childbearing women who were my clients, including attending their births. I trained in Chicago with Doulas of North America (DONA), the country's largest certifying organization, and got my feet wet with a volunteer organization there, where my clients were often poor and non-white. Upon moving to California, I found clients through word of mouth and by participating in birth classes and local networking events. Sometimes I was paid, and sometimes I worked for free. There was a pressure against doing doula work on a volunteer basis, and consequently there were no volunteer organizations, which would undermine the ability of professional doulas to make a living and arguably perpetuate a perceived under-appreciation of doula care-work.[24] Overall in my doula practice, I served close to the same number of white and non-white people, and had more non-paying than paying clients. All my clients birthed at hospitals (though I interviewed several people who had home births), and

[24] This adds to a long history of the devaluation of female care-work, particularly galling when doctors, nurses, and often midwives who are not present for the majority of the labor earn quite a bit more than a living wage. In Santa Cruz, the question of poor women's access to doulas was generally answered with a sliding fee scale. Siena House had volunteer doulas (and was thus popular among new doulas seeking experience, evoking troubling histories of "practicing" on vulnerable bodies), and the Birth Justice Project had a grant that allowed its minority and/or formerly incarcerated doulas to be paid while their clients received services for free. The question of doula pay is an ongoing negotiation.

most but not all were interested in non-medicated birth. I also volunteered as an assistant at four different childbirth education courses that lasted 6-8 weeks each, and at Siena House, a Catholic home for childbearing women in vulnerable circumstances in Santa Cruz. I regularly attended meetings of the Doula Salon in Santa Cruz and the Bay Area Doula Project in the Bay, twice attended the national conference of the Midwives Association of North America (MANA), and attended multiple film screenings, concerts, benefits, and other events hosted by birth-oriented groups. I also attended a doula retreat, a continuing education course for labor and delivery nurses, meetings of the Santa Cruz Perinatal Mental Health Coalition, the first BirthKeepers' Summit of birth activists in Berkeley, a hospital-sponsored "Mothers' Fair," and demonstrations in front of the capital in Sacramento to comment on pending legislation. I participated in a knowledge-sharing "find your cervix" group, attended classes about home methods of reproductive care, and was recruited to help a retiring generation of midwives find a home for their archives. Innumerable other small instances of participant observation filled the two years of fieldwork.

I conducted extended interviews with a number of new parents and a few doulas. The parents I talked to had usually either hired doulas or paid to attend extended childbirth education classes, and thus were disproportionately privileged. I met some interviewees through social connections - renting a room in the same house, or a friend's friend from working the farmer's market. Santa Cruz was a small world - a housemate turned out to have a famous midwife mother, a neighbor was a now-retired doula, my women's health provider invited me to assist with the Certified Nurse Midwife benefit/celebration coming up, and friends all over were getting pregnant and having babies. People wanted to talk to me; I had a

few unsolicited offers of research participation from interviewees, which speaks to something about the birth story as confessional mode.

My ethnographic material leans toward a well-educated, middle-class, white perspective, which is partially due to the ease of connecting with this population (because of my personal demographics and because of their visibility in public childbearing culture, which speaks to disposable income and leisure time), and partially due to a strong and unanticipated local bias against marginalized women being "helped" by women from privileged communities. A good portion of my fieldwork was conducted as a doula, and there was a strong ideal of women receiving childbearing support from people who looked and spoke like them, refining the common political/marketing adage that "every woman deserves a doula." Well-meaning white people were encouraged to use their money and time to promote doulas and midwives of color, a stance I completely respect. I formed professional relationships with providers working in less privileged communities, and did some volunteer work with low-income, homeless, and otherwise vulnerable childbearing women. I worked with lesbian couples, but no trans parents, a subgroup which is gathering increased attention among birth activists.[25] In future iterations of this project, expanding the range of ethnographic material will be a priority. As it stands, with the limited time and resources available for a dissertation, it speaks to privilege and the hegemonic power attached to it.

Media analysis, both national and local, was a nearly constant process of attention to blogs, magazines, movies, books, pamphlets, advertisements. I would notice ads on billboards

[25] Among providers who are aware of and sensitive to trans concerns, there is an emergent/contested convention of wording to advertise one's openness to these communities. Many provider websites are oriented around care for "women", so inclusive language can require a lot of compromise.

or bus stops, regularly read the New York Times column Motherlode (which changed its name recently to Well Family), devoured topical studies and memoirs describing contemporary American childbearing, picked up parenting-focused weeklies at the supermarket, and followed links through cyber mazes of blogs, forums, stores, and websites for organizations or individuals. Relevant blogs/websites were too numerous to count, but a sampling includes AnHonestMom, BirthAnarchy, BirthingTheFuture, BirthTraumaTruths, EnjoyBirth, GivingBirthNaturally, HurtByHomebirth, MamasMidwife, MommaTraumaBlog, NoWombPods, NursingBirth, RadicalDoula, RebirthNurse, SkepticalOB, Unnecesarian, WonderfullyMadeBelliesAndBabies, and WiseWomanChildbirth. I kept tabs on magazines including *Midwifery Today*, one of the flagship publications of white revival midwifery, *Squat*, a hipper, younger version of birth/reproduction activism, *International Doula* published by DONA, and *Hip Mama*, Ariel Gore's push-back on intensive, middle-class, heteronormative mothering, and came across various zines expressing even less hegemonic perspectives.

Throughout participant observation and media analysis, I was committed to being *with* others in birth worlds in a way that lead to a particular kind of reading and writing. People, discourses, and research with which I engaged were often part of birth worlds while also doing the work of examining them. I include myself in this -- as a doula, I had responsibilities to both my clients and my peers that situated my anthropological work. In addition to being a research anthropologist and member of the birth worker community, I was a producer of publicly consumed content about reproduction through a job writing for Stanford Medicine's blog, and also an American woman who intends to bear children myself. People who wrote about childbearing provided empirical information for me on several levels, and were collaborators in thinking about it. Such people included midwives, doulas, doctors, activists,

and parents, and occasionally medical researchers (formal "evidence based research" was far more a fascinating object to stand outside of and think about than it was kin to my own thought process). I negotiated between the need to ever-more remove myself, thinking about how they thought as itself an object, reflexively thinking about how I thought or acted, refusing the temptation to partisan fervor; and the need to be practically engaged, immersed in the sensory worlds of birth and a stakeholder in their ethical-political terrain. All my informants were theorists, whether in formal or informal ways. So I adopt their theory, reference it, add to it, and piggy-back on it, while simultaneously attempting to step outside of it and show the role it plays in contemporary practice, using the work of other theorists to do so. I thought of it like a set of refracting mirrors, or a "Chinese finger puzzle", a woven tube with a finger placed in each end; trying to pull a finger out results only in the fibers tightening around it. Because efforts to disentangle only result in being trapped, I found it best to relax and gently allow fluidity between "them" and "me". As an American anthropologist writing for a largely American audience about America, I strive and struggle to make Americanness strange. As a woman without personal experiences of childbearing, I have a sort of clean perspective that is both a challenge and a boon for a doula as well as for a researcher.

"Near Birth" is a term I developed to reference four things: 1) the temporal period encompassing pregnancy and infant care, which I call childbearing; 2) the relational, haptic, tactile, intuitive approach to bodies that marks much contemporary thinking about childbearing; 3) the array of objects and actors connected with childbearing; and 4) the potentials that cling to birth as a re/creation of the future.

Impressive as the moment of parturition may be, my research shows that the cultural work of birth happens *near* it. Childbearing discourse and practice is replete with references to who should be near whom, when, why, and how, as well as to the personal and social effects of different kinds of nearness. Investigating embodied nearness as a research object allowed me to step outside the assumption that there are different, coherent approaches to childbearing. I was able to bypass the ideological divisions and stale dichotomies that characterize much popular and scholarly work on the subject, and which I have not found to be particularly salient categories in my informants' everyday life (their persistence in the media is, therefore, itself of interest). These include the various iterations of "natural" childbearing and the champions of medical advancements, the "mommy wars" between career and stay-at-home mothers (and the specter of the welfare mother), and antagonism between midwives and doctors.

Investigating childbearing as opposed to birth, pregnancy, or infant care likewise allowed me to see outside of standard frames and divisions, to follow threads that linked these periods/activities, disregarding the overdetermined boundaries between fetus and baby, pregnancy and infant care, and mother and infant bodies. Childbearing is a liminal period when the embodied boundaries of the self are inherently blurred, as one body becomes two and a new person's embodied reality and social existence are formulated. I argue that this liminality extends across pregnancy, birth, and infant care, and that thinking broadly about childbearing has much to teach us about our present moment.[26] Yet the anthropology of

[26] Notably, I am excluding conception from childbearing, and with it new reproductive technologies such as in-vitro fertilization, egg and sperm donation, and surrogate motherhood. Conception's new iterations, while increasingly fraught and important, have received disproportionate attention in recent anthropological literature. For example, Thompson 2005, Twine 2011, Franklin 2013, Speier 2016.

childbirth has fragmented; in recent decades, the discipline has produced important topical studies of reproductive phenomena, but very few broad examinations of childbearing itself.[27]

I set out to research *tactility*, *intuition*, and *care*, three cornerstones of contemporary childbearing ideologies that all deal in nearness. *Tactility* investigates physical connections between bodies, objects, and other bodies, *intuition* is concerned with knowledge derived from subjective embodied experience of the proximate world, and *care* denotes relational intimacy through which embodied needs are met. Ideas about tactility, intuition, and care are dispersed throughout birth worlds, surfacing in the ways that people discuss a bad mother, an ideal birth, a disagreeable practitioner, or a desirable child. They are present in how people practice interactions, give advice, describe their experience, and conceive of ways to change social conditions that influence childbearing outcomes. In turn, ideas about nearness in childbearing inform American logics of family and life course, and are a window onto American medical reasoning.

Tactility: Ideas circulating in birth worlds posit that tactile connection has powerful positive effects. It has become common (though hardly ubiquitous) for parents and medical practitioners to think that immediate skin-to-skin contact between mother and newborn is crucial for bonding, and for both parties' optimal psychological processing of the birth event. Some assert that the touch of a doula holding the mother's hand or massaging her lower back

[27] A few of many possible examples: fetal surgery (Casper 1998), amniocentesis (Rapp 1999), home birth (Klassen 2001), IVF (Thompson 2005), and milk banking (Boyer 2010). The most recent comprehensive look at American childbirth from an anthropological perspective is arguably Davis-Floyd's work from 1992, *Birth as an American Rite of Passage,* which does certainly reify an opposition between midwife/woman centric care and doctor/hospital centric care. Jordan's 1978 *Birth in Four Cultures* is seminal in the field. Notably, sociologists Simonds, Katz Rothman, and Norman's 2007 *Laboring On*, a sequel to Katz Rothman's 1991 *In Labor,* is more comprehensive in scope.

affects not only her psychological relaxation but also her physical experience of pain. Other associations focus on negative instances of tactility: hands intrusively measuring a cervix can stop the progress of labor, and the electric fetal monitor's proximity to the fetus can shift the room's attention away from the laboring woman and onto a screen. Still others highlight ambivalence: the numbness following an epidural's insertion brings immobility, dislocated itchiness, and profound relief from pain; a nurse's clinical touch taking vital signs can be either unpleasant or reassuring.

Intuition: Intuitive knowledge is lauded in some circles and ascribed positive moral qualities, such as the proper connection between a good mother and her child, whether fetus or infant, or between a woman and her own body. Sometimes a laboring woman is encouraged to position herself however "feels right" instead of lying supine, or thought to be able to read subtle signals about her infant's need to eat or eliminate. Intuition is evoked in the increasingly common injunction that a woman should give birth wherever she is comfortable, be it hospital, home, or elsewhere. In other situations, intuition is cast as untrustworthy, whether in deference to the "expert" voice of certain professionals or because of historical and cultural associations of incompetence with certain kinds of women and bodily experiences. Such doubt often falls along lines of class and race.

Care: Ideas about how intimacy should be cultivated between caretakers and infants resonate with concerns over how to produce a child who can be kind and well in a 21st century world – parenting can be a utopian endeavor, tinkering with the balance between discipline and provision, and cobbling together a bricolage of care practices in an effort to craft subjectivity (Mol 2008). Proper care and its implications are at stake in rhetoric about approaching a woman as a "whole person" and allowing her to "maintain autonomy" over her

own body, and in hyperbolic, moralizing media statements about the dangers of home birth or caesarians. References to care can be exhortations to cultivate intimacy and social connection, or can idealize medical protocols and the beneficial use of various technologies. They can also specify power relations and evoke accountability, as in the idea of "patient voice" or one's responsibility for self-care. Care is a shared fuzziness, a boundary object recruited for various uses, elaborated in different ways (Mol 2008). In American culture, it is treated as both priceless and worthless.

Outline

What I uncovered about these three research objects, or manifestations of "nearness", cohered for me into seven thematically distinct chapters. They thematize the tensions that are found in practice near birth, and their implications for understanding American culture at large. They grapple with different fantasies that circulate near birth, building upon and referencing each other; fantasies about potential kinds of social and material relationships, or about what a body is or could be. The childbearing body, in which one body becomes two through a process that is always both ordinary and extraordinary, was what first attracted me to investigating "birth worlds." This body was both a phenomenological intrigue and productive practical reality I wanted to grapple with. As I thought about differences in how people "know" the body, it reinforced the anthropological insight that bodies as such don't exist prior to being known.[28] The tinkering I observed around how to *know* bodies was

[28] This insight could arguably be traced back to Mauss' seminal 1934 "Techniques of the Body." See Lock and Farquhar's 2007 anthology for further examples and a helpful introduction.

simultaneously tinkering with how to *experience* bodies, how to live bodies. I likewise found that ideas about how bodies should be lived were inseparable from beliefs about how (and whose!) bodies should be valued. Differing valuations of bodies inevitably led to the imagination of various social pasts and futures by differently invested actors.

Chapter 1 introduces and explores the physiology of childbearing. I develop two physiological archetypes that childbearing people and practitioners negotiate when considering how bodies can (and should) be known, experienced, and cared for: contextual and regular. I use the word "physiology" to refer to a mutually-constituted epistemology and ontology of the body, and claim that approaches to bodily ontology and epistemology are a reflection of the historical and contemporary social terrain surrounding them. As such, physiologies reflect the ways different kinds of bodies are valued. I insist that these contextual and regular physiological archetypes are never enacted as such, but function as gravitational poles that are referenced and deployed in decision-making, shaming, advocacy, and aspiration. These archetypes extend outward from individual bodies and are referenced to make claims on how humans can/should understand and inhabit the social and material world, as well. I discuss the role of intuition, which I conceive of as a learned, embodied attunement to one's surroundings, as a way of knowing/being that underlies contextual physiology. Finally, I discuss the hybrid figure of "evidence based medicine" that is ubiquitous in birth worlds, and how it does and does not align with scientific and medical traditions of credible knowledge.

Next, I turn to questions of personal and political power that cling near birth. Who and what are trustworthy; who and what need to be controlled? In Chapter 2, I discuss how "trust" and "control" are used to navigate fear and pain in birthing situations by cultivating feelings of empowerment in various ways. I do this by examining the decisions and

impressions of three childbearing couples in Santa Cruz. I describe a difference between "inward-oriented" control/trust directed toward a given childbearing body, and "outward-oriented" control/trust directed toward a given social situation. I show how regular and contextual physiological archetypes are marshaled alongside control and trust to negotiate with providers and perceptions of expertise, and to craft ideas about a good birth. I explore these childbearing people's impressions of pain and intuiting their bodies, and consider the desire to experience birthing bodies as full of spiritual power, be it through a reclamation of feminine power, transformative self-knowledge, or liberation from reliance on patriarchal, industrial medicine.

In Chapter 3, I trace the gendered politics of responsibility and vulnerability through questions about care relationships. Who is responsible for the quintessentially vulnerable infant? Who is responsible for those who become vulnerable by bearing children? The answers to these questions are necessarily intersectional, and I consider classed and raced implications while maintaining a focus on women as a category of persons both oppressed and empowered by the social terrain of reproduction. I think about affective investments in care relationships by considering the metaphor of "wars" used to explain mothers' interactions with each other and women's interactions with the state: the "mommy wars" and the "war on women" that divide and distract childbearing people and thereby limit their imagination about how socio-political contexts for reproductive capacities could be otherwise. The co-embodiment of childbearing profoundly upsets the foundational Western idea of the autonomous individual; likewise the embodied care-work near birth requires that one take responsibility for someone other than oneself, contrary to neoliberal trends toward "responsabilization." Yet the destabilizing implications of co-embodiment have both

progressive and regressive potential, as broader social responsibility for reproduction potentially compromises the autonomy of the childbearing person over her own body and capacities. This chapter explores American social tension between "post-gender" aspirations and nostalgia for "traditional" families. Dismissing anti-woman attacks as retrograde and media mommy-hype as shallow misses the point -- both are trenchant and current sites where anxiety about gender, family-making, and the individual's role in her community are actively played out.

The next two chapters explore the boundaries of the human via the socially and materially liminal figure of the childbearing body. Childbearing people disturb the division between "nature" and "culture" and provoke exaggerated thought about the past and future of the human species. They disturb the idea of an individually bounded subject and provoke re-thinking the person in terms of fluidity with what surrounds and inhabits its body. In Chapter 4, I discuss the intensified pasts and futures that cling to childbearing via fantasies of a primal/primitive/primate past and a technologically transcendent "cyborg" future, both of which have utopian and dystopian casts. These temporalities help explain the enduring fascination with the "natural" in birth worlds, and the ambivalent relationship to technology. Such ideas are bolstered by a popular anthropology of primitive/primate parenting, and belied by the effacement of visceral corporeality in the spiritualizing aesthetic of "natural" birth.

In Chapter 5, I think about microbes, chemicals, and affects as transgressive object-actors that blend a person's external and internal material-affective environment, blurring the boundaries of the "object" and not just the subject. These are manifest in new concerns about the long-term health effects of infant contact with the vaginal "microbiome," the presence of toxic chemicals in post-industrial landscapes, and the intergenerational embodiment of affects

from historical traumas and stress-filled lives. This section theorizes bodies as themselves ecologies, using models of fluidity to think through a more intimate manifestation of "the anthropocene." Both material and immaterial "flows" manifest themselves in the diagnosable ailments and (un-diagnosable) nervous systems of mothers and infants, and do so in ways unevenly distributed across race and class lines. These problems presage a broad concern with human inextricability from an increasingly toxic world, a world that transcends boundaries of geographical locality and makes defending "safe zones" impossible even for the most wealthy consumers. The actor-invocation of species-level concerns speaks to how childbearing populations are imagined to be in a unique position to respond to threat, risk, and damage. This question extends to the immaterial - how do anxieties and other circulating affects manifest in the nervous systems and diagnosable ailments of mothers, of infants? In particular, I explore concerns about ecological toxicity and its effects on gestation and breastfeeding, concerns which are conspicuously absent from the majority of childbearing circles, and advocate a broader concern with human inextricability from an increasingly toxic world that affects *all* reproductive bodies (albeit unevenly). Childbearing populations are in a unique position to respond to threat, risk, and damage.

Finally, Chapter 6 explores how the potential for social change is imagined among birth activists, broadly conceived. The future that some of them advocate could be described as one in which differently distributed futures and relations enable rethinking major social infrastructures and organizing principles. Spring 2015 witnessed the first annual "BirthKeepers' Summit", a four-day conference convened in Berkeley and organized around the premise that "saving birth" and "saving the world" are intimately linked. Indeed, birth was conceived as the common root all social justice endeavors could rally around: injustices of

race, class, gender, and environment were seen as not only inextricable from childbearing, but from each other. I use this event and its potentials and failures as a hub to trace other lines of reproductive justice thought and activism through Bay Area birth worlds, considering the implications of attempting to unify diverse oppressions under one banner. Such universalizing goals are at odds with the identity politics to which many activist groups subscribe; likewise, upholding reproductive autonomy is at odds with often-prescriptive ideas about "good" births. Potential to live otherwise that is genuinely exposed near birth is often and easily co-opted by liberal discourses of rights and "diversity/inclusion", and by neoliberal discourses of private consumption, both of which advance present relationships between power and profit. The tensions that have run throughout this dissertation between individual autonomy and empowering relations, and between collective support and liberation from institutions, are nowhere more strongly manifest than among the activists who conceive, birth, and wield the discourses and practices of Californian childbearing futures.

Language

But first, a note on words, since as Haraway writes in her introduction to *Simians, Cyborgs, and Women*, "Grammar is politics by other means". In this work, I use the word *childbearing* to include pregnancy, birth, and infant care, since I find that the overdetermined distinction between these phases obscures the larger social role played by reproduction. I call someone who bears children a *childbearing person* (or *pregnant person, nursing person,* or *birthing person,* as the case may be), and only use the terms *mother* and *woman* in specific contexts. This is to acknowledge that:

1) *Mother* is connotatively loaded in ways I want to be careful about, and is imprecise because sometimes different people birth and raise the child (as in the case of adoption), and sometimes a variety of people contribute to bearing the child by providing eggs, wombs, sperm, breastmilk, money, and legal lineage, as in the case of IVF, surrogacy, lesbian conception, or milk donation. A large part of my method, writing about the US for a largely American readership, relies on "making the familiar strange." To do this, I want to unify what is culturally separated and separate what is culturally unified. Saying nursing person, birthing person, pregnant person, or caregiver allows me to separate out childbearing functions, breaking up the idea that one figure, "the mother," does all of these things. Of course, I refer to mothers and motherhood as realities in the social imagination.

2) *Woman* evokes a host of loaded feminist and anti-feminist rhetoric, and is a category marked as subsidiary to the generic human/male one (Scott 1986). I think using *person* might unmark and unsequester childbearing as a woman's issue in interesting or productive ways. It posits female experience as the "default" from which male readers must reconcile their difference, and I appreciate the politics of that. However, I continue to use female pronouns for simplicity, and do so consistently whenever I refer to someone of an unspecified gender. There is a good argument for *not* unmarking the category, basically stating that not saying "woman" hides or evades the fact of women's categorical repression, and limits political rallying power (as Katha Pollitt convincingly argues in an essay pertaining to abortion politics)[29]. I'm not insensitive to this, but chose to use person in the spirit of experimentation

[29] Katha Pollitt. March 13, 2015. *The Nation.* "Who Has Abortions?" and a series of response letters.

and wider comparative promise. And of course, when discussing feminist and women's identity politics, I use the term woman.

3) Not all women bear children, and women are not the only people who bear children: some trans men and other genderqueer folks do too. Being pregnant or nursing is an intensely feminized activity that can be awkward for people who don't identify with outward markers of femininity -- see AK Summers' graphic novel *Pregnant Butch*, for example. Lesbian and gay couples who choose to raise children have long negotiated the responsibilities of childbearing in less gendered ways.

I had a similar thought process about terms for children, but decided to not specify a usage. Available terms roughly line up on this developmental spectrum: zygote, embryo, fetus, neonate, baby, infant, toddler, child. In common usage *baby* (sometimes *child*) is used both before and after birth, so technical-sounding words like *fetus* and *neonate* have a potentially-productive estranging effect. On the other hand, I argue that birth is fetishized and overdetermined as a distinction, so using different language for pre- and post-birth reinforces what I'm trying to undermine. I conceive of the child borne as a "person in process", but am not sure if using a spectrum of terms supports that fluidity or contradicts it by marking distinct stages. Stages are problematic in childbirth contexts because they give regressive politics something to grip onto -- "when does life begin" etc. The politics of this conception of fluid human development I'm proposing do imply that a zygote is a person, which I am not

opposed to intellectually, morally, or politically[30] (see Williams' unapologetic *Salon* article in which she argues that abortion is indeed a death, and that that doesn't undermine the moral landscape in which safe, accessible abortions are necessary and good; in fact, such an acknowledgement enriches it).[31]

America

The current terrain of American pregnancy and infant care is rich with epistemological instability, ontological questioning, raced and classed entanglements, political stakes, and moralizing rhetoric that illuminate cultural tensions and desires. The Bay Area can be seen as a showcase of emergent approaches to childbearing's cultural management in the US as a whole, its fraught aspects intensified and its emergent iterations catalyzed.

The embodied practice of childbearing speaks to fantasies of what is required to prepare a person for 21st century American life. And there is much that is specifically American about these imaginative investments in bodies – the valorization of "the natural", the romanticization of experience, the belief in the nobility and utility of pain, and the faith in the inevitability of technological progress. Embodied experiences and the apparatuses of their cultural management are mutually constructed and perpetuated (Kleinman and Kleinman 1986,

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[30] My political position on abortion is compatible with the idea that it ends human life, but human life in an extremely immature form that, while meaningful and valuable, falls entirely under the purview of the person embodying it. The moral weight of "persons" is not universal in this context. Abortion is a loss of life (a sacrifice of potential, a discounting of the value of a person) and as such it should be mourned, honored, and recognized. But we likewise need to mourn, honor, and recognize the sacrifice of potential and discounting of the value of a person that happens when a woman is forced to carry a pregnancy she doesn't want. Neither is a glib or easy thing. To allow the "interest" of severely immature life to supersede that of the human life producing it trivializes childbearing, motherhood, and personhood.

[31] Mary Elizabeth Williams. *Salon*. January 2013. "So What if Abortion Ends Life?"

Martin 1987, Lock 1995, Lock and Farquhar 2007). Thus, the crafting of childbearing experiences both reinforces and poses challenges to authoritative paradigms of knowledge and value that regulate the experience of embodiment (Davis-Floyd and Sargent 1997, Wendland 2008). I think of this implicit and explicit process as "tinkering" with the process of embodiment, paralleling the way Annemarie Mol thinks about care as tinkering and craftwork (2008). Embodiment, like care, is something done, a shared work and collective achievement cobbled together from materially heterogeneous practices and entities that are always local and specific. Mol de-centralizes the human, conceptualizes actors as carriers of practice, emphasizes uncertainties and the importance of the non-verbal, and views technologies as something constantly adjusted, much like people's habits, hopes, and expectations. While "care" as a concept is employed in birth worlds and surrounded by a substantial theoretical and programmatic discourse, "embodiment" is not usually a topic of explicit popular concern, leaving me rich territory to think with.

Birthing and parenting choices are laden with moral overtones in increasingly complicated ways, which involve essentializing narratives about how bodies are to be known and managed, judgments about what birthing choices signify about a person, and visions of transformative potential, whether utopian or dystopian. Values, desires, fears, and commitments are always in relationship with a self-crafting of identity. When people adopt or advocate practices, there is a specter of qualities they reject: "I'm doing this, but I'm not like *that* person who also does it," or "I'm doing this *because* I'm not like that person who does otherwise." The bricolage of childbearing involves a lot of dissociating and recombining practices and their signification, to craft hybrid identities. Active self-fashioning and the idea that one *can* create oneself anew, at will, involve a kind of narcissism, optimism, and

uprootedness that is quintessentially American. American "individualism" as a value underpins birth worlds; this even extends, ironically, to the way individual empowerment and autonomy allows people to engage in counter-cultural discourses/practices emphasizing communal responsibility and individual vulnerability. An American heritage of meliorism (the belief that the world can be made better by human effort), combined with the neoliberal American cult of happiness, do much to suppress acknowledgement and contestation of structural barriers and inequalities (Ehrenreich 2009, Gore 2010, Berlant 2011).

The idea of individual autonomy ties in substantially with discourses of freedom, and there is significant overlap between American discourses of freedom and utopia – the one implies the other (Jameson 2005). In the best case, cultural tinkering with what it means to be embodied has the potential to offer glimpses of a society with more evenly distributed possibilities for happiness, comfort, and choice, with a more situated, enabling, and communal manifestation of "freedom." Rather than a neoliberal "freedom to choose" that holds the individual accountable for failures, I want to evoke here something more like an ontological "freedom to be," which of necessity includes access to the basic materials for living a decent life in one's society, such as a healthful body and the ability to feed, clothe, educate, and spend time with one's children, and implies a non-hierarchical relationship between genders, races, sexualities, and nationalities. At their best, the critiques that come out of childbearing posit freedom as an enabling presence, not an absence of constraint. Yet utopian promises fail and there are disjunctures between expectations and reality; tinkering can yield unproductive breakdowns, and some people's situated, embodied experience gets recruited while that of others gets bypassed. There are always tensions between moral ideals and concrete possibilities for practice – ie, not everyone can afford to make the same choices. By describing

the tensions and antagonisms of childbearing in the context of California's hyperbolic diversity, reactionary panics, and progressive idealism, I will articulate where such potential for freedom/utopia fails, and where it succeeds.

Contradictions inherent in hegemonic American values that are based on impossible dichotomies -- like the dichotomies between public and private, love and money, or individual and society -- are responsible for radically divergent childbearing desires among otherwise similar people. The broad salience of such foundational American ideas is what enables trendy, fringe, or innovative discourses/practices within birth worlds to be more than just yuppie fantasies. Solutions to perceived problems with contemporary American life are sought via "better" births, on issues as diverse as pharmaceutically-numbed emotions, post-industrial toxicity, race and class disparities, the inescapability of stress and fear, and the sterile mass-production of goods, services, and lives. It is my contention that childbearing exceeds the categorical dichotomies that are fundamental to American culture, which is why it is (and has been) so contested. My claims here are in line with Latour's (1993) argument that although the rigid binaries of modernity have (and have had) concrete effects *as an ideal*, they have never been implemented in practice, always instead giving way to hybrids and bricolage. I build on studies of how childbearing transgresses boundaries between private and public, otherwise called domestic and market/civic, or love and money (Cussins 1998; Taylor 2004; Clarke 2004; Thorley 2008; Swanson 2011), nature and culture (Macdonald 2006), and body and mind (Young 2005) to argue that such categories and myths are reified, transgressed, and reified again in a creative, fraught, and ongoing process. For example, the "private" sphere of domestic decisions, family-making, and infant life is highly politicized at the same time as such politicization retrenches the neoliberal consumer-citizen and her public/civic impotence

(Berlant 2007). The passion with which "alternative" childbearing practices and philosophies are promoted suggests that people may practice them as a kind of antidote to social norms of alienation, norms that promote the gradually detrimental lifestyles Berlant calls "slow death" (2011). Such practices and philosophies are focused on profound and self-reliant forms of "well being," yet such self-reliance and self-realization paradoxically retrench the ideal of the autonomous individual. Childbirth transgresses the boundary between illness and health via pain. It's culturally strange to think of the body in pain as something good and non-problematic.[32] Medical management of birth may be predicated on the idea of birth as pathological, as many have argued (Arms 1975, Martin 1987, Jordan 1993, Rooks 1997, Gaskin 2002, Davis-Floyd 2003, MacDonald 2006, Cheyney 2011, and others), yet the fact that the majority of births are uncomplicated and successful and happen to people who consider themselves healthy and broadly happy to be in this situation, begs for an anthropological treatment of the process as a non-pathological link between body and society.

Within Americanist anthropology, recent work has explored how America and other late liberal polities are enduring extreme inequality along with a destabilization of cultural values and foundational myths (Harvey 2005, Povinelli 2011 and 2016, Berlant 2011). The theoretical approach of this project draws from the work of Berlant and Stewart on the affective ordinary, which examines the frustrations, pleasures, unease and aspirations that

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[32] Even though non-technological pain-management techniques like Hypnobirthing and Lamaze are predicated on the experience of pain, their attitude toward it is one of minimization rather than valorization. One notable exception to the cultural pathologization of pain is in the valorization of intense exercise among certain circles (consider "no pain no gain," "feel the burn," the idea of being "tough," etc.), which has resonance for certain people eschewing anesthesia in labor. Birth pain is an interesting phenomenon where health and happiness could be presumed, instead of illness, suffering, and the necessity of techno-bureaucratic management.

circulate throughout the contemporary American moment. The potential for cultural disruption inherent in childbearing, even and especially a troubling of the idea of a unitary, autonomous individual (Dumont 1992), makes it a site where foundational beliefs become visible, and social anxieties are highlighted. Dissatisfactions, aspirations, pleasures, and unease that are nebulous in broader society (Stewart 2007, Berlant 2008, Dumm 2008) become concentrated in childbearing. The anthropology of childbirth has been marginalized from mainstream currents in anthropological theory (except for the subfield analyzing reproductive technologies), and unfortunately so, since it can be a lens that offers a privileged perspective on fundamental questions in 21st century society, such as what health and wellness are, where authority and responsibility lie, and how social disparities are perpetuated and could be changed. Fetishizing fetal-infant life as the site where social problems are perpetuated, and looking to models of "natural" or "primal" childbearing to solve social problems, both stem from a fantasy of human origins. This fantasy speaks to anxiety about an uncertain future, and is undermined by the way new human life is always already part of existing generational chains via (extra)ordinary co-embodiment with one another and the material/affective environment that is conditioned by politics and history. Reactionary nostalgia, dystopian panic, and utopian vision motivate the birth worlds of California's Bay Area. Gendered politics, embodied ecologies, and ethical futures are imagined and contested, near birth.

Chapter 1

Ways of Knowing and Being Near Birth: Physiologies, Intuition, and Evidence

> Is there something inherently queer about pregnancy itself, insofar as it profoundly alters one's "normal" state, and occasions a radical intimacy with -- and radical alienation from -- one's body? How can an experience so profoundly strange and wild and transformative also symbolize or enact the ultimate conformity?
>
> Maggie Nelson, *Argonauts*

"I'm sorry to disturb you, but I'm legally required to let you know that I recommend a caesarian," says the obstetrician. She is addressing Molly, who is squatting on a low chair with a hole cut in its seat, called a birth stool. Molly is flushed, naked, and has a trembling, panting glow that is somewhere between triumph and exhaustion. She's a marathon runner, as my elderly doula mentor, Anna, proudly explained in our earlier meeting with Molly. She is used to persevering through intense physical situations. Suzanne, the midwife, is kneeling at the base of the stool, fuzzy blond ponytail brushing the linoleum as she practically lays her head on the hospital room floor, watching Molly's vulva and encouraging her with praise and reports on progress. Molly has been "pushing" for over two hours.[1]

This quantity - 120 minutes - is what precipitated the obstetrician's entrance. I don't know her name, as she didn't spend time in the room with us, but she was tall and elegant, the only black person I saw at the hospital that day, and had an imposing, all-business air. Although I did not record her exact words, the phrase above captures her meaning: she would apparently have been making herself vulnerable to lawsuit if she did not advise a c-section at this point. It is clear she's making a gesture on principle and does not really expect Molly to change course. Her effort at persuasion seems perfunctory, and I find her admission quaint in its frankness -- we are at the most "natural birth friendly" hospital in the city, after all. Molly did not want medical intervention in the birth, and has thus far managed without a drop of medication in the twelve hours since we arrived at the hospital. She consults with Suzanne and Anna, and decides she would prefer to keep pushing. We two doulas and Molly's partner Eric swab her with cold wet cloths, offer her water and juice, and speak words of encouragement, though she largely finds these ministrations annoying and prefers to be undisturbed.

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[1] The names have all been changed in this and subsequent anecdotes.

Suzanne, the midwife, watches the baby's descent with her cheek on the floor. She uses her hands to massage Molly's perineum, the tissue between the vulva and the rectum, oiling it and softening it for the "ring of fire" when the child's skull emerges. The awkward angle seems cumbersome, but Suzanne is engrossed.

Close to hour four, Suzanne sets in motion a rapid chain of events. Did she shout out something? Call on her pager? Flip a switch on a call box in the room? I didn't register. But within tens of seconds the obstetrician has returned with a flood of people. Molly is lifted bodily onto the hospital bed, laid on her back, and somehow I am stationed by one of her legs, told to raise it to her ear. Someone else is on the other one. "Shoulder dystocia," I hear someone say. The obstetrician is manually attempting to loose the baby while Molly is stretched open like this, and when it doesn't work, she cuts Molly's perineum with a flash of steel scissors and pulls. In a flush of bloody fluid and greenish excreta, the baby is out.

I'm struck by Molly's lucidity under the circumstances. She is intent on knowing about her baby's well being. Aside from the presence in the amniotic fluid of meconium, the fetal feces that is said to indicate distress, the baby is just fine. She's wiped down by the nurses or the pediatrician (I'm not sure who is who anymore), her Apgar score is taken, and she is shown to Molly, who holds her for a few moments and breathlessly coddles her.[2] The obstetrician gives Molly a shot of pitocin to stimulate the uterine contractions that deliver the placenta and close the uterus' bleeding blood vessels. Soon the obstetrician explains that although the baby is fine, Molly needs to be taken to surgery where her perineal damage will

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[2] The Apgar score is a method to quickly quantify the health of newborns, developed in the 1950s by obstetrician Virginia Apgar. To obtain the score, a practitioner will evaluate the baby on five criteria, each on a scale of 0-2, then add up the values into a total ranging from 0-10. The five criteria are remembered via a "backronym" for APGAR: appearance (skin color), pulse rate, grimace (reaction to stimuli), activity (limb flexion), respiration effort.

be repaired. She has a fourth degree tear, the highest level, in which the tissue dividing the vagina from the rectum is completely rent. To give the greatest chance of functional recovery and avoid the serious inconvenience of leakage between the two channels, Molly will be put under general anesthesia for the repair. When she asks, she's told that the drugs will likely be in her bloodstream when she breastfeeds her baby for the first time.

Molly is wheeled to surgery on her hospital bed, and a crew of janitors and nurses clean the room's slippery spattered floor. They dispose of the delivery table's tools and packaging, which had been set up when Molly was nearing the pushing phase. A new, bigger bed is wheeled in, and under the attentions of a nurse, the new baby is settled on her dad's bare chest to sleep.

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An hour or so after the birth, which was the second I had ever witnessed, Anna and I went to fetch food for ourselves and Eric. We were all hungry after the nearly 24 hours of birth support. The two of us debriefed on the bench of a Chipotle. Shoulder dystocia means the shoulder got stuck in the birth canal, essentially. *Why didn't they try the Gaskin maneuver!?* Anna wondered aloud. For years afterward when I retold the story to doulas and midwives, many would indignantly pose this question. I had not yet heard of the Gaskin maneuver, which consists of relieving shoulder dystocia by getting the birthing person onto her hands and knees, thereby slightly altering the shape of the pelvis and allowing the impacted baby to pass through. It is named after Ina May Gaskin, the American midwife with cult-like status

introduced in the previous chapter, who learned it in Belize from a woman who learned it in Guatemala, where the technique apparently originated.[3]

For whatever reasons, the obstetrician did not attempt the Gaskin maneuver, and neither did the midwife.[4] But what struck me most strongly from my conversation with Anna was the ambiguity over the C-section: would it have been better to have gone with it? Fault, blame, and regret were in the air, even though Anna explicitly rejected them, saying we could never know which way would have been better. Was the baby really in distress? Its Apgar was fine, yet there was meconium. Was it really such an urgent situation that it needed to be resolved as though seconds counted? The baby had been compressed with its shoulder for *four hours*, after all. Maybe the obstetrician's rapid reaction was what saved the baby from harm. Maybe it was hasty and damaging, precipitated by unnecessary panic within a fear-based approach. Did the slower, less-intervention approach facilitated by the midwife fail in this instance? It was certainly overwhelmed by the imperative of an "emergency." If protocol had been heeded,

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[3] The politics of naming it after Gaskin have been critiqued by some midwives, who are by and large a politically self-aware group. The critique is reminiscent of Heldke's food colonialism argument calling out authors of "ethnic food" cookbooks for not attributing the material to the people from whom it was gathered, or compensating them. Gaskin doesn't profit from the maneuver, but it does further her reputation.

[4] The movement she did orchestrate is called the McRoberts maneuver. Shoulder dystocia is rare, unpredictable, and has no accepted protocol for prevention or treatment. The WHO describes it thus: "Shoulder dystocia occurs when the fetal shoulder gets stuck behind the maternal pelvic bone following the delivery of the head. It is regarded as one of the high-risk situations in obstetrics and its unpredictability continues to be a major concern for obstetricians worldwide. It's estimated that the incidence of shoulder dystocia varies between 0.6% and 1.4%... in the majority of cases the condition occurs unexpectedly, leading to episodes that can be very traumatic not only for the mother but also for the health-care professionals involved." http://apps.who.int/rhl/pregnancy_childbirth/childbirth/2nd_stage/cd005543_melob/en/

would the abdominal trauma of the caesarian have been lesser or greater than the perineal trauma Molly sustained? Are these even the relevant questions to ask?

Situations like Molly's, where there are many "what ifs" clinging to the actions of those present, are very common in the birth stories I came across, whether by attending births, talking to people I knew, or reading online forums and blogs. (Books, however, were by and large much less ambiguous in their presentation of scenarios. They tended to be polemical -- not that blogs or forums were unbiased!) The "right" course of action for any person present was rarely an accepted thing, whether that be the birthing person, the doctor, the midwife, even the doula and partner (for some reason, the nurses' actions seemed less fraught). Someone could usually have done something different, which might have made for better "outcomes", variously defined. While to some extent different actual events precipitate different actions and foreclose other possible events, it seems to me that nonetheless different potential courses of action often come down to contention about how to understand the physiology of birth.

Regular and Contextual Physiology

To what extent can physiology be understood as grounded in the physical body? Is this physicality better thought of as a metabolism of molecules or a machine governed by laws of physics? Could a "better outcome" have been achieved if the hospital protocol took more account of the emotional and psychological factors at play?[5] Are outcomes defined as

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[5] I say "hospital protocol" or "common protocol" instead of medical or obstetric protocol, because often the real medical recommendations are more up-to-date with evidence-based research than what actually gets practiced in hospitals; this latter is largely based on customs of the unit and the practitioners.

mortality and morbidity, or do things like patient satisfaction and maternal-infant bond count as well? Was the protocol itself at fault, as something arbitrary, litigious, and operating on a patriarchal doctor-oriented model of the female body? (Arms 1975, Martin 2001, Davis-Floyd 2003, Wendland 2008). Was the midwife too trusting of wishy-washy body-worship and not inclined to recognize and take emergency action when needed? (Tuteur 2016).

I want to describe the physiology of birth.[6] But how to do so? Every term I could use is contested within my field site, even down to the anatomy in the case of fallopian tubes (they were named after a male anatomist, Gabriele Falloppio, and some people are calling them ovarian tubes instead). Physiology is both a system of knowledge and something embodied and experienced. It is neither purely constructed and contingent, nor a "natural" given that merely needs discovery (Kuriyama 1999, Kukla 2005).[7] In the Bay Area's birth worlds, there are different threads of physiological thought that weave together and pull against each other, such that description cannot be neutral. But let's begin somewhere:

During birth, the uterus has to open, the child has to pass through the birth canal, and the placenta has to follow it out. This process can last from a few hours to a few weeks. During labor, the cervix, a thick rubbery donut of muscle that is the gateway to the uterus, keeping the child in during gestation and letting it out during birth, opens in diameter (dilates), becomes paper-thin (effaces), and tilts upward toward the birthing person's belly to reduce

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[6] I say birth instead of childbearing because birth is the fulcrum of the conflicts over physiology. Contention spreads from there out to conception, abortion, pregnancy, nursing...

[7] The term "physiologic birth" is currently in use to describe birth as natural/normal process and not pathological/damaging process. It is often used contentiously against obstetric philosophies. In centering my analysis here on physiology, I am not taking this emic term at face value. My rather expansive conception of physiology encompasses "physiologic birth" and "pathological birth".

the angle between the uterus and the vagina. Sometimes this is called "ripening." This happens in conjunction with uterine contractions, or tightening of the muscle at the "top" of the uterus (the fundus), which stretches open the "bottom" of the uterus (where the cervix is). The child's head descends toward the cervix, into the pelvis, easing its way into the tight passage; the relation between skull and pelvis is measured as a transition from a negative to a positive station.

Usually the back of the skull (the occiput) leads the way, which happens when the child is facing the birthing person's back. Children-in-utero can also face the person's belly (occiput posterior, or "sunny side up"), be in any degree of rotation between these two positions, or extend their neck and exit face-first. A hand or shoulder might descend next to the head (a nuchal hand and shoulder dystocia, respectively). Alternatively, the part that descends could be the child's bottom or feet (a frank/complete breech and footling breech, respectively). If there are two or more children, one will descend into the pelvis first, and the others will follow. At some point, the birthing person will push the child through the birth canal, and the child's skull or other presenting part will rotate through the pelvis. It will emerge, stretching the perineal tissue.

Because the infant is connected to the placenta via the umbilical cord when it emerges, all its basic functions are still provided for, but at some point, it will commence to breathe, expel waste (meconium), and gather nutrients (generally by drinking colostrum, the first and especially rich breastmilk). The uterus will contract again, detaching the placenta from the uterine wall and expelling it through the birth canal. The blood vessels that previously supplied the placenta via the uterine wall will stop bleeding.

How this all *works*, exactly, are the contested aspects. There are not clear "sides" to this confusion, though I will advance two poles around which I see currents of physiological thought gravitating: regular and contextual physiology.[8] *Regular physiology* is predicated on the idea that bodily processes are predictable, uniform across persons, and objectively knowable as interactions between material substances. *Contextual physiology*, on the other hand, assumes that bodily processes are constantly in flux and responsive to the environment, that they differ from person to person, that they are only subjectively knowable, and that the substances involved are heavily influenced by energies of various sorts. These are archetypes, not reified approaches or philosophies. They are ideal poles around which currents flow, overlap, and clash; the currents are "real" but the poles are not. I saw neither of these archetypes enacted *as such* in my field sites: actual practices were always mixtures that fell somewhere within a matrix of possibilities. In this chapter, I use these poles to explore discordances in how the physiology of birth is understood. In Chapter 3, I explore the current social terrain of childbearing, and in subsequent chapters I develop my assertion that physiological discord is connected to contrasting visions of social organization.

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One fundamental contention between these approaches is whether the process of giving birth can be split up into discrete and measurable units, or not. For example, labor, pushing, and delivery of the placenta are conventionally called three separate and sequential

[8] I'm using the term "physiology" to describe a co-constituted epistemology and ontology of the body. I am not sure "physiology" is the best term for this, but am committed to thinking about the two facets together.

phases; this is language used by all medical texts and most practitioners. But can this process be understood in terms of reified divisions, chronological order, and standard rates of progress, i.e. as something regular? Or is this process always subjective, idiosyncratic, and based in a particular environment, i.e. contextual? Cervical dilation is an excellent illustration of "regular" and "contextual" as differing physiological archetypes.

Cervical dilation is the key marker for distinguishing "subdivisions" of the labor phase -- early labor, active labor, and transition. Early is 0-4cm, active is 4-7cm, and transition is 7-10cm.[9] The cervix becomes "complete" when it is 10cm dilated and "100% effaced," meaning paper-thin. Only then can pushing safely begin, or the cervix will be damaged, says most medical protocol. In a regular model, dilation is posited as a mechanical process that is dysfunctional if taking place outside of a consistent and standard rate of progress.[10] The obstetric partogram, which describes this rate, was first developed in 1954 by a male doctor named Friedman, who conducted a study of 100 laboring women and found that average dilation was approximately 1cm per hour. The rate was not linear but accelerated in the second half of labor.[11] A normal labor should last around twelve hours, he concluded. If abnormal slowness is observed in dilation, measures should be taken to augment progress.

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[9] There are other distinguishing features of the sub-phases, such as apparent discomfort and inability to focus on external stimuli, which both increase with dilation, but such qualitative distinctions are not present with analgesia, particularly epidural analgesia.

[10] Generally, only slower than standard progress poses mechanical concerns; this is likely because faster than standard progress seems efficient, a key value in a body-as-machine (Martin 2001)

[11] I was surprised to find that the partogram does not posit a linear rate of dilation, since a linear rate seemed to be a popular argument against obstetric protocol - a straw man, apparently! Or perhaps my own biases in perceiving my field site, or a confusion between the words "linear" and "regular."

Most commonly, this augmentation means an intra-venous drip of pitocin, which is a synthetic version of oxytocin, the hormone that stimulates uterine contractions.[12] This often leads to more intense and painful contractions than those from oxytocin alone, not least because oxytocin is also a pain reliever. The intensity prompts women to request pain relief. Often this is in the form of a spinal epidural, in which a thin tube is inserted into the spinal column to deliver anesthetic, numbing the birthing person from the waist down. The pain relief is extremely effective in most cases. The birthing person may be able to shift her legs, but cannot stand or walk, and so must lie on a hospital bed. This sedentariness often stalls labor, so pitocin is increased. The sedentariness and the intense pitocin-induced contractions increase discomfort not only for the birthing person, but for the child as well, who can become "distressed," meaning a lack of oxygen is demonstrated by changes in heart rate. This hypoxia makes it urgently necessary that labor progress, which may involve more pitocin, manual assistance like grasping the child's skull with forceps or a vacuum, or performing an emergency caesarian. This is called the "cascade of interventions" by its detractors. They claim the cascade keeps tumbling once the child is born, when she will have a fair amount of drugs in her blood stream and may be dull or agitated, which may cause trouble initiating breast feeding. Neither the child nor the mother will have had the "natural hormone cocktail" primarily consisting of oxytocin, which stimulates love and bonding, the narrative goes. Of course, such interventions could and do happen for other reasons or at other moments in labor, but much of the time they stem from a focus on cervical dilation as something regular, that should happen in a particular way, and that should be managed via purely technological

[12] Oxytocin is naturally secreted during the birth process, and stimulates contractions as well as providing pain relief and stimulating bonding (a.k.a. "the love hormone"), functions which pitocin does not have.

inputs. (Recall, readers who might be bristling at this unidimensional account, that this is an ideal model, and that actual hospital practices are more nuanced and flexible!)

Alternatively, the cervix can be seen as a sphincter. This is proposed by Gaskin in *Ina May's Guide to Childbirth,* a frequently referenced classic among those sympathetic to "natural birth," which presents a viewpoint very similar to what I call relational physiology. The cervical sphincter functions like other voluntary sphincters, such as the throat, urethra, and anus; that is, "they do not obey orders, they function best in an atmosphere of familiarity and privacy, and they may suddenly close when their owner is startled or frightened." Dilation is not in fact regular, but involves bouts of rest, gathering, and rapidly melting open that cannot be predicted. The opening of other sphincters facilitates cervical opening: the laboring person could open her throat by breathing deeply, singing, moaning, grunting (or, in Enright's forthrightly bovine metaphor, "lowing" (2004)). Rhythmic, deep noises work better than erratic, high pitched noises. Often defecating and vomiting are signs of labor progressing. Shifting and moving help the sphincter open, and the ability to move freely creates a sense of security for the birthing person. It is easier to open the cervix at home and while no one is watching, just like it is easier for most people to urinate or defecate at home and while no one is watching. I've frequently heard the birthing person likened to a mama cat seeking a dark corner of the closet, or a mare or cow stepping away from the herd to birth[13]: they want to feel sheltered and private, the narrative goes. When new people enter the birthing space, or hands enter the vagina to check dilation, the cervix might react protectively by retreating,

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[13] Fraser's beautiful study of midwifery in the American south describes a traditional belief among black communities that the birthing and recovery space needed to be dark. Newborn eyes risked damage, among other things. She describes how such ideas of bodily needs changed when hospital births became accessible in these communities; that bodies themselves were understood to have changed. I'll discuss this more elsewhere.

contracting. The release sensation of parturition is comparable to other sphincter releases: of excreta, full bladder, sneezing, orgasm. Gaskin contrasts this "Sphincter Law" with the obstetric "Law of Three Ps", which are the Passenger (baby) Passage (pelvis and vagina) and Powers (strength of uterine contractions). She claims the latter approach blames the woman for "dysfunctional" labors that don't produce a baby in the allotted time, by saying she grew too big a baby, has too small a pelvis, or doesn't have strong enough contractions. By contrast, "Sphincter Law" attributes longer than average time-to-birth as a problem of "lack of privacy, fear, and stimulation of the wrong parts of the laboring woman's brain". Troubleshooting a stalled labor involves thinking about the birthing person's fears and whether any of the relationships in the room are strained.[14] The implications of this physiological model are that creating an amenable environment is paramount, which can involve concerns ranging from crucial --having sympathetic and respectful providers -- to superficial -- soundtracks and familiar pillows.

Both of these positions are archetypes of approaches that extend beyond cervical dilation itself, into other aspects of birth as well as into pregnancy, infant care, nursing, and conception. As I argue throughout this dissertation, they extend into conceptions of personhood and modes of social organization. As archetypes, these regular and contextual approaches were always present in my field site (if only spectrally), and never purely enacted. The vast majority of people I encountered incorporated aspects of each into their approach to childbearing, whether as a midwife, doctor, nurse, doula, or birthing person. Many people also

[14] Stories of women anxious about how the baby will affect their relationship with their partner, once they discuss it labor moves forward again; stories of how women angry with their doctors require more interventions, how a mother can be asked to leave the room and her daughter will finally relax and have the baby...

distanced themselves from one or both archetypes, by mocking them or making comments about not being "that kind" of person (often followed by a "but..."). My intention here as an anthropologist is not to argue for one model over the other. I intend rather to describe the contention that arises and plays out in the decisions and concerns of people near birth in the Bay Area.

I often saw this negotiation taking place via the manual vaginal exam used to assess dilation. It is one of the few obstetric practices that has no technological supplement or replacement; practitioners simply must learn to assess the diameter and effacement of the cervix by touch (and without the aid of vision!). In high-intervention settings, vaginal exams are simply done more frequently, as they are relied upon as the only way to assess labor's efficacy (other quantities are monitored, of course, such as the fetal heartbeat and strength of contractions, but dilation is the baseline).[15] In many Bay Area hospitals, fewer vaginal exams are being done as practitioners and birthing people place more value on minimizing interventions.[16] This is not necessarily because exams "cause the sphincter to retract," but because they can be demoralizing to a laboring person who is very tired and very uncomfortable and who expected to be "farther along by now." This happened in almost every birth I attended. This disappointment can in turn stall labor. My doula clients often had opinions on the matter, either requesting/demanding fewer vaginal exams on the "birth plans"

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[15] An epidural facilitates more straightforward and mechanical decisions on the practitioner's part - for example, a slow dilation would indicate a need to increase pitocin - because there are not complicating personal factors such as the patient feeling uncomfortable or wanting to move around.

[16] Of course, there are always exceptions; Peggy Vincent, RN/CNM and influential birth activist said in a talk that she likes vaginal exams, finding them encouraging, as opposed to the "no-exam trend," and calling for some "middle ground."

they brought to the hospital, usually to avoid such demoralization, or deciding that they wanted more checks to "know what was going on," as part of a regimen of informed decision making. However, hospital practitioners have a lot of power in determining whether exams happen or not, and with what consequence. In a hospital known for being very liberal with protocol, a birthing person's dilation was actually regressing after a long and exhausting labor. Instead of hooking her up to medication or even telling her, the midwife chose to encourage the acupuncture being performed by the patient's guest (turning a blind eye to hospital regulations prohibiting this), which re-started labor.

A similar difference to that between "regular" and "contextual" has been described before by other theorists using different terms. Something like regular/contextual physiology has been called the medical/midwifery models of birth by Rothman (1982) and technocratic/ wholistic models of birth by Davis-Floyd (1992). Davis-Floyd describes a "natural" model of birth as an attempt to reconcile the two extremes. My thinking about regular physiology owes a debt to Martin's writing about Western medicine's view of women's bodies as machines or factories (1987). I use regular/contextual for three reasons. First, I want to use terms that are as lightly loaded with connotations as possible, to avoid polemicizing the situation, and to focus attention on the negotiations that happen "in between" the archetypes or poles, which is where all practices take place. Second, I want to use terms that are as capacious as possible, so that analogies can easily be drawn between physiology and modes of living and organzing society. Third, and perhaps somewhat paradoxically with the second of my motives, I want to be able to separate a specifically *physiological* orientation from its (non)institutional context for purposes of clarity and specificity. I intend to insist on the links between physiological knowledge and institutional and industrial contexts, but I don't want this alignment to

overdetermine the deployment of physiologies, since actions can be, and often are, contradictory. Birth practitioners working in hospitals, for example, constantly negotiate physiological ideas in person-level negotiations, and have structural constraints on their practice that many of them resent, including litigation, insurance, staffing, and scheduling. How the body is understood is intimately connected to large-scale profit and capitalist structures, but not in ways that parents and practitioners inevitably grapple with in their everyday awareness and interactions.

So, then, how would I describe contextual and regular physiology? Contextual physiology is rooted in particular bodies instead of in ideal standard bodies. In this model -- which again, is a model and not a reality -- variation is not only not alarming, it is to be expected. In contextual physiology, the body is known via intuition, which I conceive of as embodied subjective knowledge drawn from a sensory relation to the world and both personal and collective memory.[17] Intuition is a learned skill, not an inherent ability, as I will discuss below. By contrast, regular physiology operates via the disembodied "objective" knowledge of bureaucracy, institutionalized science, and mechanics.[18] Intuition as physiological knowledge is not about predictive power oriented towards outcomes, but about the present situation, about feelings and needs in the moment. In other words, it is not instrumental. In addition to this temporal difference between physiologies, there's what might be called a spatial difference

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[17] See Csordas 1993, who thinks with intuition as "embodied knowledge" (147) and argues that healers and their patents share "a highly organized set of bodily dispositions" (Bourdieu's *habitus*) from which they draw sensory intuition.

[18] Note that while mechanics is heavily based on physics and mathematics and machines often represent an ideal of regularity, people who work with machines in reality do so in highly embodied and idiosyncratic ways. People with great affinity for and experience with machines could be said to have "machine intuition." This is another example of how ideals are different from practice.

-- regular thinking promotes a "bird's eye view" of the situation, a view from outside and above: comprehensive, progressive, encompassing, rigid, uniform, orderly. By contrast, contextual thinking promotes an "on the street" view: flexible, surprising, malleable, idiosyncratic, fleeting, interactive, person- and perspective-oriented. This difference is analogous to that between looking at a topographical map of a city and actually walking through that city. This particular analogy is drawn from de Certeau's description of the difference between "strategies" and "tactics" (2002) -- the former are organized, top-down approaches to social management by those in power, derived from a totalizing view from above, while the latter are tactics of resistance that are diffuse and sporadic among those with less power.[19] (As such, his distinction has clear class resonance, which certainly echoes in the physiological distinction I'm making, expressed in the tendency of the elite professionalized knowledge of doctors to be regular and regularizing, and the perceived unruliness of the contextual body). Contextual thinking is predicated on relationships -- both those between people in a given situation, and those one has with one's own non-unitary self. Contextual thinking is inherently less able to be capitalized upon, as it resists scalability.[20] Indeed, it has a lot of resonance with the magical or enchanted pre-capitalist thinking that was eradicated in the witch hunts.

Regular physiology, by contrast, is precisely predicated on scalability. It is by essence reproducible under any circumstance and applicable anywhere, independent of social-

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[19] See also James C Scott, 1990.

[20] This doesn't mean that it is necessarily immune from profit-making schemes - one might argue that contemporary luxury goods and services are "personalized" in an attempt to contextualize them, particularly technological goods. Nonetheless, such personalization is still a long way from capturing fleeting and irreproducible encounters and truly idiosyncratic ways of being.

emotional inputs or contextual expectations. Regular childbearing is divisible into discrete and measurable units, whereas from a contextual perspective childbearing is processual and unpredictable. Beneath this distinction are diverging idealizations of the bodily impetus for labor: the body as a machine that requires managerial inputs, and even needs to be externally set in motion (ie, induction of labor)(Martin 1987), versus the body as a site of organic "instinctual" processes by which it sets itself in motion, with an "innate wisdom" that manifests when external people abstain from interfering.[21] The question (often posed by opinionated actors in my field) of whether or not childbearing falls under medical purview at all marshals these physiological archetypes: in a regular frame, the unpredictibility of birth makes it seen as an inherently risky undertaking that puts the body in an abnormal state and warrants treatment as a pathology (and of course the response to such an irregular event within this epistemology is to attempt to regularize it, leading to the irony that within such a view, virtually every birth is an exception and no birth is actually "regular"). By contrast, contextual physiology has no trouble incorporating unpredictibility into "normal" bodily functioning. An extreme idea of intuition in birth likens it to breathing or defecating, something "bodies know how to do," despite the glaring differences in these functions' frequency of occurrence. There is a medical maxim that a birth can only be declared "normal" in retrospect, which can be compared to injunctions among the midwifery community to "believe in" and "trust" birth.

The ideal of regular physiology historically came into being with the medical profession, and is heavily influenced by a capitalist-mechanical philosophy of the body and a rationalized, disenchanted world. Something like contextual physiology probably informed

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[21] Hormones are an interesting "border" case, which I'll discuss more below. They are influenced by contextual emotions and in turn influence physiology in predictable ways; they have a place in both "physiologies."

many birthing situations that existed outside of this norm, including pre-capitalist Europe, the American frontier, and many poor non-white American communities. The evolution and distribution of the physiological archetypes was undoubtedly uneven, like all of childbearing's trends and developments. However, to reiterate and clarify, I'm *not* claiming that regular physiology is coextensive with hospitals, medicine, or "science," or that an appreciation for contextual physiology entails rejection of those things. Many indigenous reproductive justice advocates want access to technologies predicated on a regular body, but within a context of indigenous birth workers and traditional spiritual support. During a talk she gave in Oakland, Peggy Vincent, a well-known RN/CNM who spent most of her career working in hospitals, said "abnormalities aren't abnormal, everyone has them." At a childbearing class at a large hospital, the instructor said that uteruses are just like one's lungs or heart; they work without being told what to do. Another hospital midwife I knew as both a new mother and provider in Santa Cruz joked with me about "The Ps." We had a laugh over the fact that Ina May doesn't like them and only uses her "sphincter law," and about how the Ps have been around long enough to make their way into the "Mindfulness Based Childbirth Education" class we were both involved with, and long enough to multiply, apparently, as she could recall at least ten of them; the new ones incorporated ideas that lean towards a more contextual epistemology.[22]

A further clarification: I am using the term "physiology" to refer both to an epistemology and an ontology. Physiology is neither purely a system of knowledge nor something embodied and experienced; it is not simply how bodily processes get thought and talked about, nor how they "actually" happen. These aspects are co-produced and mutually

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[22] They were: Powers, Partner, Provider, Passenger, Pelvis, Placenta, Position (of baby), Pain coping, Psyche (of mom), and Patience.

entwined. "Knowing" is a kind of expectation, such expectations shape what happens, and what happens in turn shapes expectations. Separating out ontology from epistemology reifies a binary related to cartesian dualism, or nature/culture.

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Another excellent example of near birth negotiations of indeterminacy and regularity happens in the fluster about the phases of labor. While I never encountered anyone who contested the division of the process of giving birth into three discrete phases -- labor, pushing, and placenta delivery -- the borders between them were contested as to their measurability and variability. The "labor" phase starts far before most women come to the hospital; many find out at a routine check-up that they are two cm dilated or that they've lost their "mucus plug", a thick secretion that blocks the "hole" in the donut of the cervix. The majority of labors do not start with the rupture of the amniotic sac, contrary to popular media presentations (and ruptures are by and large a trickle, not a gush or flood). The general rule I've heard repeated by hospital providers, as well as in my doula training and materials, was "4-1-1" or "5-1-1", that is, call us when your contractions are four minutes apart, lasting for at least one minute, and this pattern has been going on for at least one hour. This supposedly indicates the arrival at "active labor." The convention moved from four minutes to five and I've now been hearing rumors from providers that "six is the new four!"[23]

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[23] A Santa Cruz midwife friend reported that one of the midwives at UCSF was pushing this maxim. My friend's reaction was "Good! Four is too early" - it's a convention among people inclined toward contextual physiology that the longer the birthing person labors at home, supposedly a place she's comfortable, the better.

In addition to this indeterminacy, such a universalizing marker is unreliable. Stories of "surprises" are ubiquitous in birth media, as are tales of induction/augmentation if either early or active labor take "too long" arriving. In January 2016 a birth story went viral on Twitter where a dad describes his son's "accidental home birth" because they waited to go to the hospital until 4-1-1, but by then the baby was crowning! Another version of this type of story is that a person arrives in the hospital and is sent to triage because she looks relatively calm, even though she insists she's having the baby, and when she's finally checked she is either fully dilated or already pushing[24]. Or she may reach the "411" metric and arrive at the hospital to be sorely disappointed that she is "only" at 3cm; indeed, it's not uncommon that such a labor might stop altogether and she might catch an extra night's sleep, unless the staff decides to medically augment labor (by this point in pregnancy many childbearing people are far and away ready to get the baby out and would prefer not to pause, so it can take some convincing to get them to go home!). Roxanne, the Santa Cruz midwife, insisted one could determine dilation by looking at the birthing person's face, to see what kind of emotional-physical state she was in -- this epistemological practice is just as embodied and learned as manual exams, though it is acquired through continuous presence at numerous births, whereas manual exams can be taught "objectively" in a school setting. Thus, judging a face is no more "natural" or

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[24] In the account of one of my interviewees: I remember going into this room at [the hospital], and it looked like some weird storage room, and I remember [being confused and thinking] "Are they so overbooked I'm going to give birth in a storage room?" And it turns out it was their triage room. And they're still sort of looking at you like "Are you sure you should be here, you're a first timer, how long have you been in labor for?" And I remember like saying, "Someone give me a trash can!" and I puked, and they're like "Ok, maybe we'll take you seriously now. And they checked me, and they're like "Holy --, you're 9cm dilated! Prep a room!!" All this commotion is happening. "Get a room ready! She's going into labor!" She said "she's almost ready to push" and I remember being like, "So I can't have anything for pain then?" Nope!

"intuitive" than exams, though they are, respectively, more "contextual" and "regular." Manual exams are inherently subjective to some degree because they take place between two particular bodies.

Likewise contested is the date by which labor should have started, or, said otherwise, how long a pregnancy can safely persist. Generally, 38-42 weeks of pregnancy is the range in which labor should start. Before that is "premature" and after is "overdue" or "postdates." The "due date" is at 40 weeks (though how the start of pregnancy is calculated is also contested). Like the "six is the new four" quip, I've heard that "41 weeks is the new 42 weeks," and that babies start being called "overdue" at 40 -- this trend is met with hostility from the contextually inclined, as it leads to more inductions. I've heard "postdates" or the related "macrosomia" (meaning one's baby has grown too large) called myths, with attempts to debunk or show the shortcomings of the science indicating that these lead to problems.

The second phase, pushing, ends when the baby exits the childbearing person's body, but at this point it is still connected by the umbilical cord. Common protocol is to cut the umbilical cord as soon as possible, and in many cases to take the baby to another location -- formerly the nursery, but increasingly a station in the same room -- to check it over and clean it up. However, it is increasingly being argued that the cord should be left intact as long as it is pulsing, i.e., as long as blood, oxygen, and nutrients are still being transferred. To cut it earlier is said to compromise the baby's health, especially if it has experienced some trauma in the

birth.[25] Barring extreme emergencies, it is increasingly accepted that there is no reason to remove the baby from the birthing person, either, and that many benefits come from "skin-to-skin contact" in the immediate postpartum.[26] These developments make the "baby exit" criterion for termination of the pushing phase more fuzzy.

The third phase, delivering the placenta, is likewise indeterminate. This phase supposedly ends when the uterus stops bleeding, but low-grade bleeding and fluid discharge happens for weeks and sometimes months postpartum (a situation about which many newly postpartum people are indignant at not having been adequately warned!). At what point does bleeding become a postpartum hemorrhage that requires emergency action? How soon after the baby's exit should the placenta be delivered? What, if anything, should be done to stimulate the uterine contractions that deliver it? (Often a pitocin shot is given as a prophylactic against

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[25] Some people opt to cut the cord and collect this "cord blood," which is full of stem cells, to be either donated for scientific research or stored in a bank for the baby's future use, should it develop a particular disease for which stem-cell therapies are useful (or might become so). Another possibility is a "lotus birth" in which the placenta and umbilical cord are left attached to the baby until they "naturally" wither away. I've never heard of either of these actually being done. These extremes share the view of umbilical blood as something precious, instead of generic bio-waste.

[26] One doctor's entertaining expression of skepticism regarding "vaginal swabbing", which I'll discuss in Chapter 6, included the phrase "Everyone and her mother now wants skin-to-skin and delayed cord clamping," a testament to trendiness. Her article is another illustration of how medical practice and regular physiology cannot be collapsed. She wrote, "As an OB-GYN physician, I've seen my fair share of strange and quirky birth plans. I've talked women out of encapsulating and eating infected placentas. I have kindly asked male partners to please not get naked and push alongside their laboring counterparts. All of this I've done for reasons of hygiene or hospital policy--if it's freaky but doesn't hurt anyone, well, you do you. I love a good birth plan.... If one thing is clear from years of delivering babies, it's that no two births are the same. That's why it's ironic that "individualized" birth plans are, in fact, anything but that: Everyone and her mother now wants skin-to-skin and delayed cord clamping. And yet every birth is different, because birth is a natural, humbling event--regardless of the mode of delivery or whether you swab your baby with your vaginal juice." Conti, *Slate*, February 2016.

hemorrhage, even in home births). In horror stories, a piece of the placenta is retained and causes massive problems in the days after the birth. Uterine recovery is an inexact matter.

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Let's return to Molly's case. How were these physiological archetypes present in her birth, and differently so for each of the people in the room? I'll explore this along two lines. First, what constitutes a physiological emergency? Second, do interventions cause problems or alleviate them?

In a regular approach, any deviation from a standard can conceivably constitute an emergency, while in a contextual approach, practically nothing does. A contextual physiology avoids death and injury by cultivating an environment and attunement that enables processes to work smoothly.[27] Was Molly's shoulder dystocia really an emergency, as it is generally accepted to be in obstetrics, or could it have been dealt with most effectively by calmly moving the woman into a Gaskin maneuver and taking a few minutes to help her dislodge the

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[27] There are two uncomfortable extremes to which this logic can be extended. The one is that such attunement is always successful at forestalling death and injury. Anthropologist Robbie Davis-Floyd asserts this in her "wholistic" model of American birth: "under this wholistic model, the needs of mother and baby are complimentary: there will be no conflict, for example, between the emotional need of the mother for a self-empowering home birth, and the safety of the child, as the baby and the mother choose each other and form one energy field, so that what is good for one is good for the other" (1992:157). The other extreme is that a contextual approach encompasses death and injury in its purview as normal and unpredictable aspects of living, "risks" which are accepted. Perhaps hypocritically, last-resort transfer to emergency medical care is a way to stave off this unpleasant reality.

child?[28] An occiput posterior baby, not to mention a breech baby, is cause for a c-section in many hospitals, while the midwife who writes the anti-intervention blog *Midwife Thinking* asserts that even a baby who emerges with the umbilical cord wrapped around its neck is not a cause for emergency intervention.[29] By contrast, the obstetrician's blog *Skeptical OB* rails against unnecessary risks taken in the name of picturesque ideologies that then cause infant deaths.[30]

Or the episiotomy that contributed to Molly's terrible tearing: was it justified by the emergency? These used to be done as a matter of course, but are falling to the wayside along with prophylactic edemas and pubic shaving as practices that all have absolutely no rationale

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[28] Gaskin's website provides a host of resources for "naturally" dealing with "dangerous" situations thought to require medical intervention, including shoulder dystocias, breech births, twins, etc.

[29] In the case of a nuchal cord, as this is called, the baby is still getting most of its oxygen from the placenta; hypoxia is a concern because of compression of the umbilical cord and pressure on the carotid artery, not from an inability to draw breath. The writer claims that common protocol is to cut the cord as quickly as possible, then extract the baby immediately and resuscitate it, but if one is able to exercise a bit of patience and keep the head close to the vulva while the body is born, then unwind the cord, the placenta will be able to re-oxygenate the baby far more effectively.

[30] This particular obstetrician is furious about home births, which take place out from the supervision of an obstetrician and are, as such, really the only places where pretty ideologies about the natural body could carry the day. In a hospital, the physician is always at the top of the power relations of people present (which is not necessarily inappropriate), and simultaneously constrained by concerns about litigation. Their judgment trumps that of midwives and nurses, and even if birthing people (advised by partners and doulas) have legal rights to act against medical recommendations, it's a fallacy that they would do so in a situation declared an emergency. (It's even arguable whether they have this right, as the interest of the fetus is starting to trump that of the pregnant person, and the doctor is often understood to be the voice of the fetal interests).

apart from physician convenience and a perceived need to not be inactive.[31] The idea of an episiotomy is that it makes more room for the child to "crown," and it is easier to sew up a clean cut than a ragged tear. However, jagged edges actually mend more easily from the injured body's perspective, and flesh tears more readily when a cut is already made (many times I've heard the "ripping fabric" metaphor). In Molly's case, there was actually an acute problem of room at the point of parturition, though this had to do with bones more than tissue.[32] Did the episiotomy save the baby, and/or did it produce unnecessary suffering for the mother?

The second approach to teasing out the physiological archetypes in Molly's birth is considering whether interventions cause problems or alleviate them. Opponents of a regular approach accuse interventions of causing the problems they then claim to fix. This is clear in the "cascade of interventions" described above. "Directed pushing" is another example: Molly was directed to push once she had reached complete dilation. Suzanne was coaching her to hold her breath and bear down with all her might for ten seconds, three times per contraction. This was a standard formula I saw repeated at nearly every birth, often with apparent success. Birthing people would need to be told which muscles to use (the same ones as pooping), how hard to push (until you're purple in the face), and when to push (at the same time as the

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[31] Davis-Floyd argues that such practices, as well as making the birthing person wear a hospital gown and be transported in a wheelchair, serve to ritually infantilize and disempower her relative to the authoritative physician (1992). Patterson (1999) writes about how the historical development of male midwifery/obstetrics required that physicians not be "inactive spectators."

[32] Likely, the obstetrician performed the episiotomy to give her hands room to manually rotate and dislodge the child after the McRoberts maneuver failed. My point here is not to evaluate the obstetrical decisions made in this particular case, but to present ways such decisions are confronted with uncertainty when taken up in birth worlds more broadly.

contractions indicated on the external fetal monitor's screen readout). This is in contrast to a contexual approach that posits that the birthing person will push when she feels the urge (thanks to an attunement to her body), and the urge will be non-negotiable. Trying to prevent pushing until the cervix is fully dilated is unnecessary, because she will intuitively shift positions to relieve pressure on the "cervical lip" and slip the baby's skull past it; furthermore, preventing pushing is counter-productive because it undermines the person's confidence in her body, which is paramount for intuition to work. Likewise for trying to "correct" her pushing rhythm. If the person doesn't feel a strong urge, the best course is to wait until she does.

Pushing is hard, athletic work compared to labor, which must simply be endured in some way.[33] At the most popular childbirth class in Santa Cruz, centered around mindfulness and taught by the midwife Roxanne at a yoga center, new parents were instructed that women either push spontaneously or need to be shown how, and that it's just a toss of the coin which kind of woman you are. Unstoppable instinct doesn't kick in for everyone; the rest of us have to slog through with concerted intention.[34] Another truism from this class was that some people are more suited to activity vs passivity; they were asked at the beginning how much

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[33] I heard this active/passive truism frequently. Labor is best negotiated by calmness and a "release" of control" to the intensity. Unanesthetized birthing people in active labor enter the "zone," get that zoned-out "look." Hospital staff say that if she's really in active labor, she won't be able to talk on the phone, even between contractions; by contrast most pushing people I've seen are alert and looking around for external guidance. Of course, people do take "actions" to enter the "zone", like breathing or hypnosis techniques, and I heard at least one story of an instinctual unstoppable pushing urge that had to be surrendered to.

[34] All four birth classes I attended were favorable to the idea of "natural" or intervention-free birth,, yet they viewed interventions as tools to be used strategically, not as defaults but neither as failures. Hypnobirthing was the least friendly toward interventions; the class at the main city hospital was the most positive about them.

they liked to "fix" or "control" things. Molly anticipated preferring the activity of pushing to the passivity of labor when we spoke in a prenatal visit, and she thought of herself as athletic and strong.

From a regular point of view, effective pushing is not a given, and thus if pushing deviates from a standard, the person needs to be coached, augmented by pitocin, or assisted by vacuum or forceps (or, of course, a caesarian). The concern when pushing is that the child will become "distressed," which means lacking oxygen, usually indicated by a slow or erratic heartbeat. Some think that directed pushing can *cause* distress.[35] Because common hospital protocol links distress with pushing for "too long" or "failing to progress," directed pushing is supposed to make pushing more efficient. But if the birthing person is deoxygenated because she's holding her breath, might this not cause the baby to become so, too? If she was encouraged to push before her body was ready, did she miss the rest period her child needed? Molly's baby didn't exhibit enough distress to alarm Suzanne, who was deciding how much variation in heartbeat was acceptable.[36] Was she overconfident that Molly's body was doing what was best for the

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[35] Fetal distress could also be indicated by the passage of meconium, or fetal stool, which is both a symptom of distress and presents the relatively small risk that a fetus hypoxic to the point of gasping might aspirate it. Changes in the fetal heartbeat are easy to determine because it is continuously monitored in most obstetric settings (the benefit of this is debated on the grounds that it's an excessive amount of only one type of information and is not an evidence based practice. See Sandelowski 2000 for an excellent discussion of the role of the ubiquitous "external fetal monitor" in nursing practice). In 2005, ACOG (the American College of Obstetricians and Gynecologists) denounced the use of the term "fetal distress" as "imprecise and nonspecific," as well as the term "birth asphyxia" pertaining to newborns, stating "The communication between clinicians caring for the woman and those caring for her neonate is best served by replacing the term fetal distress with "nonreassuring fetal status," followed by a further description of findings." (PMID: 16319282) In my fieldwork, I found the term "fetal distress" to be common.

[36] It is very common for monitor readouts to be visible at the nurse's station outside the patient's room, where every staff member can see them. Presumably if there were any alarming variations Suzanne wouldn't have had full discretion over the situation.

baby, ignoring small decelerations and leaking meconium until they became emergency issues? Should protracted pushing have been read as signaling a problem, the shoulder dystocia, well before hour four, as the obstetrician attempted to do? Should either of them have intuitively known to switch position to all-fours during pushing, and would that have resolved the dystocia?

Knowledge and being are entwined in these speculations. What caused what? Who should have known? Did intuitive attunement to the body "fail" or did conditions prohibit it from ever being achieved? Such entangled questions are unanswerable in the space between two divergent systems of knowing/being, and it is partially because of this divergence, this implicit contention over physiology, that the indeterminate sense of guilt, blame, anxiety, and uncertainty followed the shoulder dystocia. Divergent physiologies make for convoluted near-birth practices and explanations![37] In fact, birthing is a particularly good site to see how inseparable knowledge and being are, how ideologies and culture are inextricable from the things to which we relate, and vice versa.

Molly's case is comparatively straightforward, as shoulder dystocias are rare and poorly understood, thus emergency measures are tolerated; how much more ambiguity and contention follows outcomes that are unexpected, unwanted, or unpleasant during a "normal" birth? Maybe the birthing person's fear stopped her oxytocin from working; maybe the doula

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[37] Note that the people I studied largely had very similar epistemologies and ontologies due to similar cultural backgrounds; this would have been much more complex to untangle, and more dramatically obvious, in a group from varied backgrounds. Expanding the study to include perspectives of immigrants etc would be interesting, but beyond the present scope. Also note that in an area or among a population where regular physiology was more dominant and accepted, there wouldn't be such conflicts.

wasn't confident or reassuring enough to relax her out of fear.[38] Maybe labor induction started the "cascade of interventions," or maybe it saved the child's life because if it had stayed in the womb for too long it would have died. Maybe the pressure to make progress created anxiety that halted progress. Maybe the intensive technology of the NICU (neonatal intensive care unit) saved the life of the child born too early, or maybe the fact that it was separated from its mother made its recovery far more difficult, as is being shown by the success of "kangaroo care" for preemies. Or maybe, even, the premature birth was precipitated by internalized stress, which is a prominent hypothesis explaining racial disparities in pre-term births, and which introduces a whole host of sociological factors into near birth physiology. It's not only decisions about procedures or techniques that are in question, but the fluid, indeterminate watercolor of affects and hypothesized possibilities.

Because of the co-constitution of epistemology and embodiment in physiology, I argue that knowing the body in a certian way does indeed *make* the body a certain way (such, then, that it can be known in that way). Consider Fraser's beautiful oral history of midwifery in the American south in the 1960s, which describes a traditional belief among black communities that the birthing and recovery space needed to be dark. Newborn eyes risked damage, among other things. She describes how such ideas of bodily needs changed when hospital births became accessible in these communities; bodies themselves were understood to have changed.

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[38] I remember one particular birth I attended where the staff determined that the birthing person needed an epidural in the middle of pushing - this is very weird, as usually epidurals aren't given past 7-8cm of dilation - because she needed to "relax" so the baby could descend. But then the baby became distressed and she was told pushing was harming her baby, so she had to hold her breath and not push, which is very hard, until the baby was vacuumed out. I felt unequipped to participate in this unforeseen medical discussion, but wondered afterwards if I really should have done something different, advocated for her or "her body" better, calmed her better so she could "relax" without the epidural...

People told her that the kinds of bodies that had responded to "home remedies" and midwives *no longer existed*. Not only bodies but temperaments and the very nature of the community had changed, such that in their view scientific medicine now provided the only effective and appropriate means of treating and diagnosing illness and birthing children. The shift in knowledge and bodies even affected the environment's ability to grow the necessary herbs and plants for traditional remedies. Consider Apple's assertion that formula and bottles were taken up by "modern" white housewives in the early 20th century as tokens of a newly scientific world where women's breastmilk wouldn't be adequate food. These housewives began to conceive of their bodies as incapable of breastfeeding. A 1909 women's magazine states that although in more sheltered times women capably nursed as a matter of course, "times have changed, and in *this nervous high strung age* it often happens that a mother is not able to nurse her little ones, or even when she is it is not deemed advisable, for her or the children's health, for her to do so" (1987:140, my italics).

Understanding bodies, doing bodies, and living bodies is made up of both knowledge and being. The rise in the late 20th century of contextual physiology to contest dominant/ hegemonic paradigms of regularity is a turn to the experiential, away from ideal and normative protocols evacuated of the particular. This turn to experience takes two forms: *intuition* as situated immediate experience, and *evidence* as empirical generalizable experience. Experience in either form is opposed to decontextualized abstract regularity, which is epitomized by bureaucracy. Experience reclaims things that have tended to be set aside in the rationalization and regularization of medicine: emotions, sensations, perspectives, even "facts." (Again, I am not claiming that these things were not present or acknowledged in the *practice* of

medicine; they were only absent in its rational professional ideal, at least pertaining to childbearing).

Intuition

Contextual physiology, as both an ontology and an epistemology, is dependent on intuition as an embodied function. Intuition figured largely in the worlds of my informants, both implicitly and explicitly. Here I lay out my own understanding of intuition, which I will use to think through emic usage throughout the dissertation.[39] Intuition, like physiology, involves both a way of being and a way of knowing, which are coproduced and dependent on one another. As knowledge, it gathers through the senses, through attunement to relations with oneself, other beings, and the material world, as well as through embodied memory of this attunement.[40] This is different from empiricism, which is also based on sensory perception, but this is conceptualized as "observation" and is essentially passive, whereas intuition is active. A tension between passive and active concepts of "experience" has been a

[39] To clarify, these are my thoughts and claims about what intuition may actually be, an epistemological theory in itself, not my theory of what people in my field site think intuition is doing. Such gymnastics are part of my effort to position myself within blurred actor/theorist worlds! The emic usage/theorization of "intuition" is varied and imprecise; it is sometimes cast as "spiritual", which I discuss in Chapter 2, and sometimes as pseudo-biological "instinct," which I discuss in Chapter 4. Davis-Floyd discusses intuition in birth in a more naturalized way (1997).

[40] See Stewart 2011 on "Atmospheric Attunements" for a imaginative take on being attentive to the surrounding world and its affects.

theme of Euro-American epistemology.[41] Empiricism also tends to make/support generalizable claims; intuition is only pertinent to the particular present. Intuitive bodily knowledge can't be anticipated, even if it is anticipatory, and while it may draw on memory or be remembered, such is in service of the present.[42] It is particular to the person intuiting. Without this attuned way of being, intuition cannot be said to take place, which is why I consider it both an ontological and epistemological concept. A birthing person may sense what she needs or wants, a practitioner may know her patient via her own sensorium, and likewise a new parent may sense her newborn's wants or needs; thus embodied knowledge of this intuitive sort need not be confined to the individual. Intuition can be trans-personal, though always particular.

As mode of knowledge, intuition is non-reproducible, though highly share-able and teach-able. It is no more inherent or "natural" than rational, "mind-based" knowing; both are learned. Intuition can be refined but not collected and stored; it is the epitome of situated knowledge. I say intuition is situated and not subjective because it is not predicated on a subject-object distinction; the world the intuitive knower knows is not apart from her. She is immersed in it and constituted by it. By contrast, the "objective" knowledge underpinning both regular physiology and empirical evidence is un-situated, cumulative, factual, static,

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[41] See Jay's 2005 *Songs of Experience,* in which he claims that scientific empiricism is underlaid by a "cult of experience." The (re)valorization of intuition is not so much a new turn to the experiential then, as it is a romancing of a certain idea of experience, as not alienated/ alienating, and as popularly accessible. Perhaps relevant to the romance attached to intuition in birth worlds is the Frankfurt school lamentation of the destruction of experience in the standardized, modern world, rooted in Heidegger's view of modernity as "The Age of the World Picture" - a connection I will not explore here.

[42] This claim echoes that of Oakshott about historical experience, any significance or coherence of which, he says, is a creation of the present. *ibid,* "History and Experience". It also echoes Seremetakis' "The Memory of the Senses," in which memory of rich sensory experience creates an affective sense of longing or loss in the present.

predictive, and transferable. It is predicated on individuals who are entities unto themselves; individuals are prioritized at the expense of relationships. This is resonant with the history of science, but the figurehead for regular epistemology, one might argue, is not the scientist but the capitalist bureaucrat.[43] Hannah Arendt (1970) called bureaucracy "the rule of Nobody" -- apt, in this case, as the extreme of regular physiology was something that no one actually adhered to or upheld, but which exerted its inexorable influence through channels of regulations, litigation, insurance, and convention. Many of the most influential scientists see knowledge as creative and dynamic, as well as embodied, and perhaps acknowledge its situatedness; of course, "science" is also a bureaucratic industry that forms the context in which most scientists work.[44] Thus the alignment of science with regular epistemologies is not *necessary*, but it is nevertheless common.

As mode of being, intuition is an attention and an interaction. Its sensibility is not about assessing the world unidirectionally: hearing, seeing, touching. Nor is it about measurable qualities: loudness, brightness, temperature. This is another difference between

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[43] Engineers, who are taking a place of cultural epistemological prominence in the Bay and America in general since the Silicon Valley tech boom and ubiquity of personalized internet-connected devices, are in some ways analogous to the "scientist" figure I'm posing here. The founders of Apple and Google, etc, were iconoclasts, not official figureheads -- though their influence is enabled by an army of grunt-work engineers. These innovators (at least originally) were not capitalists, either, nor funded in ways that made them beholden to someone else's agenda.

[44] See Laura Nader's work on the professional-industrial constraints on scientists (for example, "Three Cornered Constellation - Magic, Science, and Religion Revisited"), and the biography of iconoclastic and ostracized but ultimately influential geneticist, Barbara McClintock, *A Feeling for the Organism* (Keller 1983).

intuitive sense and empiricist sense.[45] Intuition involves *interaction* or relationship via the senses: hearing and making noise, looking and being observed, tasting, smelling, and touching and being tasted, smelled, and touched. Intuition is not tactile, but haptic; it is what happens between things. "Intuiting oneself" is not a contradiction, because one's self is never not immersed in and constituted by material and affective relations. The difference between perception and intuition is in some ways analogous to that between emotion and affect. Perception inheres in a particular body with a particular perspective, while intuition takes place in more fluid intersubjective spaces. Emotion is something one person feels (or "has"), while affect is something sensed between people, including on a broad public scale and via collective memory. Emotion is mediated by linguistic and cultural categories, as a quality that inheres in a subject with a particular self-awareness and formation; by contrast, affect is pre-subjective and unmediated. While a relatively standard, clear language can be used to describe perceptions, intuitions are much more complicated to convey discursively, particularly the question of "how" one intuits.

Affects are a significant part of intuitive sensibility. Mazzarella writes that affect implies a way of apprehending social life that does not start with the bounded, intentional subject, while at the same time foregrounding embodiment and sensuous life. Describing Massumi's thought, he "asks us to imagine social life in two simultaneous registers: on the one hand, a register of affective, embodied intensity, and on the other, a register of symbolic mediation and discursive elaboration" (2009:293); the relation between these registers is not one of conformity or correspondence, but of resonance, interference, amplification, and

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[45] Unidirectional experience is the empiricist ideal, thought I'm not claiming that is actually ever possible. Subject/object forms of knowledge impose object-hood through various kinds of erasure.

dampening. Intuition's role in near birth situations might likewise be said to resonate or interfere with more mediated ways of knowing, and such mediated ways of knowing to amplify or dampen one's intuitive sense. Relations between these several registers comprise "experience," which is often mobilized as something people "have" and consider their own, yet it is also shaped by factors external to the individual, and is in many senses collective (Jay 2005). My concept of intuition encompasses both sides of this tension by not naturalizing the individual as a unit, though it begins from the presumption of an individual (but not autonomous) consciousness.

Doula work often requires intuition, while also being responsible for creating the conditions in which the birthing person's intuition can flourish. A doula's role, along with that of a less-hospital-influenced midwife, is often said to be "holding space" for the birthing person. Doing so allows the birthing person's intuition -- and likewise, contextual physiology -- to work by keeping out distraction. But the person holding space also needs to *intuitively* know when to step in and coach, when to step back and allow the hospital staff to do their thing, and when to intervene on behalf of her client (how much conflict will protect her interests, versus how much will be detrimental by creating bad relationships with staff and a stressed atmosphere). This negotiation is always done in-the-moment, an attuned interaction not just with the other human actors, but with the circulating affects and material surroundings. Of course, it is often done clumsily or inexpertly or there is maybe no "best" strategy to be sensed, so intuition doesn't always "work." In many ways such intuition is deeply practical, utilitarian almost; in others, it takes on a cast of spiritual significance; either iteration paves the way for something powerful to happen.

In the protected space "guarded" by the doula, the birthing person is supposedly able to become attuned to her relations with her surroundings, feelings, materiality, and baby. A few people at a Doula Salon meeting joked that "do-las" should instead be called "be-las" -- all attendees were in agreement that "what [mothers] need is less distraction." Doulas should just "witness" and be "inversely obtrusive," as too much interference is negatively stimulating and can "stall progress." Is the birthing person's attunement with her world so delicate, then? Those at the Salon insisted she requires a stable environment to be attuned, which presumably the doula's attunement is in service of creating. Both improve with skill, training, and practice.

The way the intuitive body is deployed in Bay Area birth worlds poses the danger of reifying certain expectations of childbearing people. The idea that mothers are supposed to know their bodies and their babies' bodies without any instruction or practice, or else their aptitude for motherhood is in question, can quickly become oppressive. This reification is not a problem with contextual physiology or intuition per se; the problem is when the ability to practice intuitive knowledge is attributed to mothers *as a category.* Intuitive knowledge is accessible (or inaccessible) to any person regardless of her maternal status. Anyone can intuit, though it might require varying degrees of attention, concerted effort, talent, or inclination. People who become mothers may or may not have been inclined to practice this way of knowing/being prior to having children. If there are ways in which being a mother via contextual-intuitive knowledge are superior or beneficial, then being a *human* via contextual-

intuitive knowledge has those same potential benefits. Intuitive knowing/being happens in relationships other than the mother-baby one.[46]

Intuitive, sensory mothering becomes problematic when essentialized as part of the embodiment of motherhood, both because this creates hegemonic categorical expectations described above, and because it creates conflicts with regular thinking such as those Molly experienced. The burden of resolving these conflicts falls problematically to individuals, whether childbearing people or the practitioners caring for them. This is not to say that people shouldn't have creative epistemological/ontological power within their own lives, much less to suggest that institutions should take on this work instead and impose their conclusions, but rather to point out the trend towards *responsibilization* in childbirth, where individual "choices" are blamed and moralized almost entirely outside of the context in which they are made, a trend mirrored in other aspects of neoliberal/late-liberal life (Rose 2007). The individual as choice-making, rights-bearing actor forecloses other ways of discussing social issues, like the care of childbearing and infant bodies as being appropriately shared. It forecloses discussion of mutual obligation, reciprocity, state-sponsored violence, harmful economic structures, toxic environments, accountability for the past, social ethics, nurturance of the social goods of creativity and compassion, etc, which I'll discuss more in the following chapter.

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[46] Arguments for intuitive abilities stemming from the co-embodiment of pregnancy, and therefore being largely feminine, perhaps have basis - assessing this claim is beyond the scope of this dissertation, but in any case, such claims do social work by naturalizing gender categories.

Evidence Based Medicine

A different contemporary turn to the experiential in birth worlds is the trend to talk about "evidence based medicine." I see this empirical trend as reviving the practical empiricism of the midwives who have operated without formal training or protocol. It evokes rationalist empirical science apart from (or prior to) constraints of institutional power and convention.[47] This is a turn towards contextual physiology and away from regular physiology both in its epistemological underpinnings, which are based on experience and not abstraction, and in its on-the-ground usage by activists attempting to change hospital protocol to be more aligned with what I call contextual physiology (which they might call the midwifery model of care, woman-centered care, or, as an end in itself, evidence based practice). Much existing hospital protocol is not based on any sort of empirical evidence pertaining to patient outcomes, having evolved to suit doctors' convenience and to support a power structure in which they wield authority[48] (Ehrenreich 1975, Oakley 1984, Wertz and Wertz 1989, Katz-Rothman 1991, Davis-Floyd 1992, Cassidy 2006, and others).

Evidence in this context is not the same as randomized controlled trials or double blind experiments, which are currently the gold standard of research in many fields of medicine,

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[47] Any midwives without professional (ie abstract) training necessarily did much of their work by observing what practices generate which outcomes, i.e. they are empiricists. Those who were literate often kept records. Midwife Martha Ballard's 18th century diary is unique as a historical record for weaving births and deaths together with everyday life (a midwife's perspective, indeed); when the regional doctor visited, he used *her* "minutes" to account for the births and deaths of the past year (Ulrich 1991:40).

[48] Examples of common practices that are not evidence based and are contested by non-interventionists are episiotomies, continuous fetal monitoring, routine use of pitocin, induction for postdates, interventions for "big babies," directed pushing, lithotomy position, and removing newborns to the nursery. See Marc Berg's article on the centrality and power of "protocols" in medicine (1998).

including obstetrics. Claire Wendland, an obstetrician-anthropologist, harshly critiques the use of such research methods to bolster a hegemonic and narrow idea of good practice that gives little consideration to outcomes while disguising itself as "objective". Such research functions basically to cement obstetrical authority through a rhetoric of risk, safety, and tragedy, a religious respect for technology, and a promotion of bodily mistrust, while propping up obstetrical rituals that "ward off the terror that lurks near each birth" (2008).[49] Though Wendland calls this "evidence based obstetrics," what I came to know in my field as the ubiquitous "evidence based practice" is almost the opposite. Wendland claims that as a result of narrow, purportedly-objective obstetrical knowledge (what I would call regular knowledge),

> technological inventions without proven benefit, such as external fetal monitoring, may be enthusiastically adopted, whereas nontechnological interventions, such as the presence of a trained support person during a woman's labor, remain little used despite excellent evidence showing improved outcomes for mother and infant (2008).

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[49] Burt (2004) claims that, implicitly, doctors have to *learn* that they are doing good, learn to negotiate the ambiguity inherent in their role and banish a sense of wrongdoing for behaving with patients in ways that would usually be suspect (not just cutting them open, but looking, touching, and asking questions). They have to suppress a sense of violence/terror inherent in the encounter, and are simply more practiced at it than their patients. He cites a "natural" strong inclination to submit to institutional authority: doctors are socialized to believe they're doing good, which can lead to a "slippery slope" of rationalization, absolving their actions in the name of protocol or science. Perhaps obstetricians who chained manic drugged women to their beds with handcuffs lined with rabbit fur, or performed gynecological experimental surgery on unanesthetized slaves, were as much *conditioned by* the voice of authority as speaking with it?

The "evidence" referenced by people I encountered in Bay Area birth worlds was precisely the latter, marshaled against the former. Most of the time, "evidence" in the trend I'm referring to is statistical tabulation focused on anecdotal patient outcomes, not experimental results.[50]

At the first MANA conference I attended in 2012, medical anthropologist and homebirth midwife Melissa Cheyney gave an impassioned talk about the MANA Stats Project. She urged the audience to keep records of their births (which most did anyway) and to *submit them* to the MANA committee to be tabulated and aggregated.[51] The data would, it was assumed, show that home birth and midwifery care are safe and beneficial when rates of various mortalities and morbidities were compared with those of hospital or obstetrical care. It was a massive project of legitimation[52]. Since then, I've noticed the ubiquitous phrase "evidence based" used to challenge hospital protocols, justify controversial decisions, consolidate surety, and persuade. It sometimes seems an almost requisite language in which to discuss decisions

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[50] Neither obstetricians nor midwifes can simply make decisions based on evidence, of whatever sort they are aligned with. Decision-making is also influenced by concerns about litigation and liability, which are in turn and to some extent dependent on protocols and evidence; midwives also have basic concerns about legal practice at all (Craven 2010). "Best practices" are embedded in larger operations of power: a pharmaco-insurance-research industrial complex, which reproduces itself in circular fashion by: 1) being the main treatment people can access and thus 2) having the best ''evidence-based'' track record because it has been around and researched, and, therefore 3) securing the most funding for continued research and distribution (Willey 2016). Medical care is provided by large corporations beholden to shareholders, therefore hospitals spend their money on lavish furnishings and advertisements, not on staffing so that nurses have fewer patients or doulas have recognized paid positions.

[51] The collected stats start in 2004 and number over 40,000 cases. This was considered a crucial initiative to "prove" that home birth is safe. http://mana.org/research/mana-stats

[52] It is my perception that most people who seek a home birth do so *not* because they're concerned with safety and risk, but because they have certain qualitative aspirations. Safety and risk are not irrelevant, but neither are they the crucial consideration. However, many who birth in the hospital simply say it's "the safest place," by way of explanation. Perhaps statistics disproving this rationale would indeed recruit more home births.

and preferences. To the extent that "maternal satisfaction" and "postpartum wellbeing" are becoming counted as outcomes, instead of only the standard mortality/morbidity rates, the potential to challenge "regular" protocols using empirical evidence grows. Yet for all this confrontational power, demanding evidence-based practices is a relatively palatable way to reconcile contextual and relational physiology. Empirical outcomes are at least theoretically important to proponents of both contextual and regular physiologies, and no one is "against" evidence. Evidentiary claims speak more strongly to medicine than arguments based on intuition, tradition, or faith. Yet this marshaling of evidence undermines the medical profession and institution as they are currently predominantly organized. Proponents of activism-via-evidence are, in effect, using one of medicine's totems against itself, challenging it on what they perceive to be its own terms. In some ways, this empirical evidence is an epistemological hybrid.

However, philosopher Isabelle Stengers (2003) argues that not all "evidence" is equal in medicine. In "modern" medicine, controlled experiments are considered legitimate scientific proof, whereas empirical results are what charlatans produce, she claims. "Seeing is believing" is not good science, nor is the invocation of "what works," because cause is not proven. Modern medicine had to prove causes in order to differentiate itself from the infinite generations of healers who came before. It had to discredit them as charlatans, so successful curing alone could not be enough to constitute medicine. The body is an ambiguous and frustrating witness to science -- one can be cured for the "wrong reasons": the imagination, randomness, the self-limiting character of many disorders, what became known as placebo effects. This, compounded with the necessary artificiality of experimental situations, the impossibility of reaching experimental equilibrium, and the messiness of variables in

embodied doctor-patient interactions, made it impossible to prove causality! Medical experimentation could only *disprove* causes. Stengers claims that modern medicine hopes experimentation can be redeemed, that it can eventually identify causes rather than merely eliminate them. But on the contrary, she says medicine should eschew experimentation; doctors are hamstrung by the imperative to rationality. They should dispense with the anguish over separating causes (facts) from experimental situations (artefacts) and "invent new types of facts". Medicine cannot be defined as that which is proved to not be a charlatan's beliefs. Hers is not a call to embrace charlatans, but to invent a medicine focused on positively identifying cures rather than merely eliminating "fake" ones.

This position is what is amorphously taking shape in the "evidence based" activism of contextually-inclined people near birth. Midwives were, of course, among the original "charlatans" from whom doctors needed to distinguish themselves, and who effected cures doctors needed to discredit. The experiment-based obstetrics Wendland decries is precisely not focused on developing cures (i.e. on effecting positive outcomes), for reasons Stengers' genealogy illuminates. In Stengers' call to reform, obstetrics should give up on defining itself as that which is proved to not be midwifery (via experimentation's authority about causes, instead of midwifery's mere dealing in effects). Stengers' call is a compassionate one: there is a place for experimentation, but there is also a place for healing, where curing should be more important than proving. By modern medicine's logic, the "MANA Stats" project to gain legitimacy by compiling anecdotal statistics on outcomes is precisely the work of modern charlatans, who do not belong in the experiment-oriented medical profession because they make claims about "what happened" without attempting to prove why. Stengers suggests "at her peril" that there should be a radical disjunction between experimenting/proving and

curing/healing; obstetricians could join midwives in seeking empirically good outcomes no matter their rationale. This is, in fact, what has been happening in Bay Area birth worlds. Empirical evidence is an epistemological hybrid around which variously positioned actors can, and do, rally.

Stengers warns that doctors will cry out for some way to identify charlatans, for some kind of proof so medicine is not just arbitrary, especially if medicine loses the fiction that the suffering body "should" be able to tell the difference between real medicine and fake -- between labor induced by an intravenous drip of pitocin, and that brought on by spicy food, nipple stimulation, and walking up stairs, for example. Stengers could have had MANA Stats in mind when she writes that a modern charlatan is "someone who thinks that by getting results he is getting proof, conducting a 'real life experiment', who is thus rationalist" (30). She distinguishes this charlatan from "curers" who "are not haunted by the idea of being able to disqualify others, but rather who have cultivated an 'influencing practice'" (30), and asks if modern medicine does not indeed have something to learn from them. Contemporary indigenous midwives and the older generation of "hippie" midwives from California in the '70s are perhaps just such curers. Roxanne explained to me that, "pre-stats," she and her cohort just had a *feeling* that home birth was ok, they didn't feel the need to prove it, nor to consolidate a best practice, as the "nature of midwifery appeals to independent minds, and there will be diverse opinions... we practice from our own innate wisdom, not protocols." While anyone can use suggestion, imagination, or placebo effects, Stengers says that influence is something only experts can do. The growing influence of contextual physiology in the Bay's birth worlds, both for childbearing people and providers, is testament to revival-midwifery's

accumulated influence on individuals' births and the social understanding of birth.[53] Or perhaps, as revival-midwife Peggy Vincent claimed at an Oakland talk, between highlighting her detailed record keeping, rejecting the label "scientist", and calling for evidence based practice, "Midwifery is an art; obstetrics is a science. We lost sight of the art [in 20th century birth practices], and that's the problem."

[53] I don't want to erase the persistence and vibrancy of non-white traditions of midwifery, but in this particular instance I think the rise of contextual physiology in hegemonic Bay Area birthing situations is due largely to white revival midwifery of the natural birth movement, as this group had more power/privilege to shift norms.

Chapter 2

Feminine Power:

Negotiations of Pain, Fear, Control, and Trust

Your body knows the way, heiey,
Your body knows the way, heiey,
And your mother, and her mother,
and her mother before you,
Bringing new life to be born.
Bringing new life to be born.
(Repeat in round)

Wombsong lyrics, Santa Cruz 2014

It's not just the making of babies, but the making of mothers that midwives see as the miracle of birth.

Barbara Katz Rothman

What does the negotiation of physiology look like in practice? I find it helpful to consider it an interplay between trust and control. These are not poles of any sort, nor a binary -- they are discernible threads woven in a complicated pattern that expresses a struggle around power. Trust and control, and the various sorts of empowerment and disempowerment they mobilize, animate the contested territory near birth. This chapter explores intuition and several degrees of contextual embodiment among three childbearing couples I interviewed in Santa Cruz. It considers how they navigated pain and power, both experientially and in terms of the discourses that surround birth in California. These three couples were all relatively privileged: white, educated, and at least outwardly heteronormative, though not wealthy due to fairly unconventional occupational choices. Contextual and intuitive framings and practices near birth activated romantic and nostalgic ideologies about power and pain, and also real potential for radically different ontologies and social relationships.

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Dani had just returned from work in Santa Cruz when I met her to chat about the birth of her baby, Serena. She showed me around her two-acre farm with its yurt and leafy outdoor bathroom while we waited for Jonah, her husband, to join us. He had picked up two-month old Serena from his parents' house on his way home from teaching at UCSC. We talked in their orchard at dusk, under the fruiting avocado trees and next to blackberry brambles that had just passed their season. Leaves crunched underfoot as we shifted from hammock to chair and back again. The baby gurgled and cooed. When the sun had set completely, we made our

way into the yurt, its angle-less interior warmed by a yellow light that was bewitchingly cozy. I was not aware of this idyllic agricultural lane where they made their home, merely a few hundred yards from Hwy 17 and its notorious narrow curves, reckless drivers, and traffic jams of pleasure seekers from Silicon Valley's cramped suburbs.

Dani and Jonah introduced their birth by saying they "went the traditional medical western route, although in Santa Cruz that's pretty different." Indeed: Dani was unmedicated throughout the entire labor and birth, was attended by a nurse midwife, and had a vaginal birth despite her baby being breech, due to a successful external cephalic version, a very rare manual practice.[1] She breastfeeds exclusively, and we met through a mindfulness-based childbirth class. Yet compared to their friends, this was conventional:

Jonah: We [and our friends] have these insanely parallel lives: mirrored partner roles, professional interests, got pregnant and had babies the same weeks, but they chose to go like total hippie style. They never had a sonogram, basically didn't enter a western medical facility *at all -*

Dani: And we were having sonograms like every 3 weeks, non-stress tests, low fluids...

Jonah: First she was breech, but [home birth] midwives can figure that out. They would've known, it wasn't like they were clueless, but there's a lot that will not be known if you don't take blood samples and, you know, do sonograms. There's a whole lot of risk involved there and [our friends] just were like, psssh.

Dani: We wanted to know. I wanted to know EVERYTHING. I got all the blood tests, I wanted to know if my kid was gonna have Down's Syndrome, and yes, I would have aborted... I wanted to know, so I could make those informed decisions.

Jonah: Risk management was basically in my mind.

Here, decisions about bodily management are being compared based on differing assessments of how and whom to trust, and what kind and amount of bodily control is agreeable: managing risk, making informed decisions, *having knowledge*. Their friends, Kim and

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[1] An external cephalic version means a practitioner manually rotated the baby in the womb by pressing from the outside. During the birth, Dani did have one medication, Cervidil, a vaginally-inserted cervical softener that is a "gentle alternative" to pitocin for inducing labor.

Paul, who were in the same childbirth class and whom I had interviewed earlier, trusted that by paying "inward" attention, they could access all the knowledge they needed about their pregnancy, bodies, and child.[2] They were frustrated when friends and family called the validity of this kind of knowledge into question. As was evident in the thinking of these two families, trust and control are two prominent themes in knowing and managing the maternal-fetal-infant body, and childbearing people and practitioners often invoke them to navigate the terrain of childbearing decision making. In particular, the ubiquitous discourses of risk in and around medical settings can be read as statements about what one can/should trust, and what one can/should control. Regular and contextual conceptions of physiology were entwined with these negotiations. Tactical maneuvers used to navigate this territory also problematized relations between knower/known, object/subject, and spirit/matter.

Phrases like "trust your body" were ubiquitous in the birth worlds I moved through; the idea was evoked variously with reverence, doubt, and scorn. Consider the shirts being sold by the Midwives Association of North America at the 2012 conference: they had "Believe" printed on them in large letters, beneath which were printed "Women, Babies, Birth, Midwives." I had not started field work at the time, and I was intrigued and perplexed: what on earth does it mean to "believe in babies" or "believe in birth"? Clearly, it means more than accepting that these things exist. The phrase invokes a religious kind of faith, as opposed to scientific proof whereby truth is demonstrated via evidence. It is clear to me now that this shirt was intended to assert that these people/processes have an inherent knowledge or an

[2] They did have home birth midwifery care, and the midwife's competence and expertise in assessing the course of the pregnancy. The true extreme in this direction are people who have unassisted home births, which is an extremely uncommon thing to do, but its proponents are disproportionately vocal.

inherent power in which one might trust. Such trust might take a variety of forms, from skepticism about the benefit of medical "interference" in birth, to a politics of de-regulating abortion access and midwifery practice, to a social welfare system that offers material supports for mothers without moralizing stigma.[3] Here, I'll focus on the idea that medical interference undermines women, babies, birth, and midwifes by disrupting their intuition; the idea captured on this shirt could be read as a belief in intuition as a mode of relating to the world. As discussed in the previous chapter, I conceive of such a mode as an embodied attunement to one's surroundings and relationships that must be developed and learned, despite the tendency to romanticize it as "natural". Intuition, like the contextual physiology that is derived from it, is necessarily particular and internally derived, so it can't be standardized, institutionalized, or replicated. Thus it is not legitimate in the frames of externalized reproducible knowledge that characterize much of medical practice (what I have called regular physiology). This delegitimation, and the forms of violence that have accompanied it, which some birth world voices trace back to the witch hunts, is at least partially responsible for the combative tones of much current discourse championing "trusting" bodies, women, and midwives.

Dani and Jonah's friend, Kim, describes how she was challenged on her decisions to trust her intuition and eschew the medical testing Dani sought out. She and Paul met with me in their rented bungalow a few blocks from the beach, welcoming me on the wide front porch with a summer concoction of blended juices and herbs. Kim was late in her pregnancy, but didn't look too uncomfortable in her sundress and sandals as we sat down at the backyard table, their wiry-furred dog making his bed at our feet. They were planning a home birth.

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[3] These latter two implications are discussed in the following chapter.

Much of our discussion revolved around their pride, pleasure, and determination in looking "inward" for all aspects of the pregnancy and birth, and how they've negotiated the backlash that has caused among their friends and family.

Kim: I feel like I have been operating on intuition the whole pregnancy because I've really been, like we have done very few tests. And you know, that's been something I've really had to check in with... trusting that everything's ok, and that I would know if it's not ok, you know? And that hasn't always been easy. ...

I was like, "I really feel I know the position of this baby, being head down. I'm very clear on that." And people were being like, "You should confirm the position with an ultrasound, be 100%," and I'm like, "Well, I've had five midwives palpate my stomach, acupuncturists... and I just *know*. I can close my eyes and visualize the baby, and I have the confidence to just trust that." And it's like, "What if it's breech, or what if it's this and that."

With the gestational diabetes, [my midwife friend says] "I see women every day who are completely healthy, eat this and that, everything's normal in their pregnancy, and they come out with gestational diabetes. It's just something you *wouldn't* intuit, you wouldn't know." There's things like that... and it gets in my head, and there's definitely been a lot of things I've been challenged on.

Kim said she's never thought of herself as a "radical," but has simply decided "as things have arisen" that she doesn't find procedures necessary because she feels "good and confident." That feeling has in turn "boosted [her] intuition" and confidence. Nonetheless, she said she would feel validated in trusting those instincts after having a "good birth and a healthy baby," because "it haunts you" to think about having possibly been able to prevent something if only the test had been done. But, she said, "I haven't really let that seep in." Kim said that adverse reactions among her acquaintances against home birth had definitely been a big challenge.

Kim: For my [family, home birth is] very uncommon, like I was saying, in the midwest, so their initial reactions, my parents were very like, "It seems like an unnecessary risk. It seems selfish, like you're making it all about the mother when it should be about the baby." All these things which did make me feel very defensive. And my mother had two c-sections, her own birth she was born premature, so all her experiences have been birth as a medical emergency, not birth as a natural non-medical experience. So she had all her fears and anxieties.

That was hard for me because I felt like, you know, at first I was wanting to educate my family, sending them materials, then that started to really feel draining to me, and put me on

the defense a lot, and so I was really more just like "I'm very confident in this decision, I don't want to discuss it anymore, I want support, and if not then keep your mouth shut."

I went home to a baby shower, and was really anxious because I knew that everybody [was] so curious, and even when it's genuine curiosity, not criticism, I still felt like I had to be defensive. They're like, "Well, why would you want to do that? I just don't get it, if there's pain, if there's medication that covers up pain, why would you want to experience pain?" So I found it really exhausting. It was causing me stress to have to do that.

I tried [to tell people] "Please, there's so much information out there, if you're interested do some research, maybe we'll talk afterwards." But I couldn't keep it up, like [she parodies herself] "Did you know 99% of births are totally normal?" You know, I had to be this expert... Of course you go through waves of having fears or anxieties of your own, and I felt I couldn't express those fears or anxieties. I felt like I just had to project pure confidence, and be like everything's great, fine, perfect, smooth.

But it's been a process for me, something I had to work on and heal... But I do think that at least now they're in a place where they're supportive and do understand it more. It's not like a little old lady showing up with a towel. [laughing] ...this is a doctor [sic] who has studied this, has more experience with birth than any obstetrician, because [obstetricians] don't learn that anymore, a natural birth. [Midwives] show up with equipment. We live two blocks from the hospital. Most things you can detect pretty early on if there's issues.

Here, risk and safety are evoked by Kim's parents and friends in a coercive way, though not necessarily intentionally so. The discourse of risk is loaded with cultural concerns, marshaling things like death, pain, and moral judgments of self-centeredness.

Whereas information was empowering for Dani, Kim found it burdensome. About genetic testing, she stated "I don't even want that information, because I don't know what I would really do with it." When I asked Kim how she had explained her intuition to people, she said that she didn't use that language with everyone and had to justify herself with numbers and "hands on" information instead.

Kim: I don't live in a world that's completely, where I'm interacting with only, like, spiritual people who live in that reality. I feel like most people in my life are very practical minded, very scientific minded, so... I feel like I've had to, you know, back up some of those decisions... "We've done these kinds of measurements," there's a lot of like hands-on things.

Paul: We've heard the heartbeat.

Kim: Yeah, "We've listened to the heart tones, we get all the same information that you would get with an ultrasound without doing the ultrasound." Just kinda like have to put it more in that language. But some people really understand the intuition piece, and other people just think it's really bogus if you're like, "I just *feel* like it's a boy." They're like, "That means

nothing." So, I'd say it's a full spectrum and I'd say in this town, you certainly do have a lot of people that speak that language of intuition. So I just kind of gauge it.

Many women I talked to found solace in trusting medical protocols, including Dani in her desire to "know" based on tests.[4] Sometimes this trust manifested itself in a sort of agnostic reticence to do research or develop opinions about their care or desires, though often it was the result of such deliberate investigation. Such trust in medical protocol is predicated on the idea that a large-scale institution with a standardized and regularized practice is the best source of knowledge (or at least, a reliable one). In effect, the knowing is ceded to generic professionals, who are trustworthy because they claim to (and/or are believed to) be able to effect control over outcomes. Institutional medical knowledge is predicated on being able to control the body through techniques of monitoring, prediction, diagnosis, and intervention. This type of control is about dominating the body, bringing it into order. Consider the medical adage that a normal or low-risk birth only exists in retrospect; the bodies and processes involved are unpredictable and consequently untrustworthy, and because childbearing itself is a deviation from a "normal," unmarked state, it is sometimes considered inherently pathological in medical discourses. Disorder could erupt at any moment, and need corrective external management to mitigate damage.

Concern with control was also manifest in discourses asserting that childbearing people should be able to make all decisions about their care, their bodies, and their children's bodies. These discourses were often elaborated in frames of rights, choice, and/or consumer politics. Likewise, trust could refer not only to one's body's inherent capacities, but to a person's trust in her own decisions or research, a particular professional or a kind of professional, or a

[4] Trusting particular medical professionals themselves was a separate matter. Both discourses existed in the birth worlds I studied; sometimes they overlapped, at other times they didn't.

technology to which she may or may not have access and over which she may or may not have autonomy. We could make a distinction between *outward-oriented* control or trust, entailing making choices about one's body in the social world, such as what kind of care it receives or provides, versus *inward-oriented* control or trust, entailing relating to one's own body's behaviors in a certain way, including cultivation or discipline. They are entwined with one another. The practices of "trusting one's body" are complicated if one doesn't have access to certain kinds of education and relationships; for instance, women who have negative relationships with their bodies because they've experienced abuse, or who don't have family, partner, or doula/midwife support during their childbearing process, or who don't have easy access to a computer or library as sources of information and alternative perspectives. "Controlling one's body" is likewise complicated by social circumstances; I was told by a few activists that black women are less likely to receive epidurals quickly when they've requested them compared to white women (who often get epidurals despite requesting to *not* have them), manifesting racist ideas of black bodies as less sensitive and "hardier" to pain.

Outward oriented control is having the power to make "medical" or "consumer" decisions, and also having good options from which to choose. Discourses of rights and choice assert that women themselves -- not politicians or institutions -- should be in control of their fertility, motherhood, and bodies, and that women should be *trusted* to make such decisions.[5] More profound critiques, such as those within Reproductive Justice movements, assert that women should have access to the means that *enable* them to be trustworthy, such as the material resources for raising a family, education, mental health, communities safe from crime and

[5] It was, in fact, usually women and not families that I heard invoked in this way. The sociocultural terrain of partners and families will be discussed below.

police brutality, and healthcare provision of whatever format they are comfortable with. Outward oriented trust is the ability to assume that hospital staff have the best intentions toward you, that your interests are protected by the law, or that your family or partner will helpfully share the burden of care work and decision making. Both outward control and trust are a privileged relation to the world, more accessible for those who are white, wealthy, male, cis-gendered, and straight. If someone is thwarted in her attempts to control a situation, she also likely has little reason to be "trusting" within that forced dependency; likewise, someone who is distrusting and suspicious of institutional authority may have a long inter-generational history of not being empowered to assert control in those relationships. This is certainly exaggerated along lines of class and race.

Inward oriented control can be mediated via technology, of which there are innumerable examples: amniocentesis tests, ultrasound wands, external fetal monitors, speculums, pitocin drips, intravenous fluid, anesthesia needles, even thermometers and stethoscopes. Technologies create power over bodily processes, by being able to know and influence them at will. Inward control could also be a toughness or determination, akin to willpower, often called upon in order to *reject* technology. Inward oriented trust is likewise a relationship to power. The idea of relying on one's inherent embodied capacities offers some women a taste of "liberation" from historically white and masculine institutional strongholds and hegemonic convention. This activates Californian themes of self reliance and iconoclasm, but also black power themes of refusing oppression (Saleh-Hanna 2016). Inward oriented trust also ties in with ideas of spirituality and self-knowledge that can resonate variously with indigenous traditions and new-age/progressive religious philosophies.

Trust and control of both orientations are inseparable. Just as a person can decide to trust someone who will seek to control her body from without, a person can seek to control a situation in order to trust her "inner" body. Chelsea, a doula client of mine, was comfortable deciding to have an epidural, and with deciding when she had had enough of the physical sensations of labor and wanted it put in. For a few reasons, including a progressive/permissive Bay Area hospital, the presence of a doula, class/race privilege, and self-education, she was able to do just that. The epidural itself, predicated upon medical knowledge and a philosophy of intervention, was also epistemologically based in an idea of control. Both aspects enabled Chelsea's feeling of control over the situation. Conversely, technologies that control the body can be foisted upon unwilling birthing people, removing any decision making powers they have claimed. Forced sterilizations after hospital births of many black, Latina, and indigenous women is an extreme and distressing example, and the history of this and other abuse contributes to an ongoing lack of trust in medical institutions among these communities (Davis 1983, Roberts 1997, Washington 2006).

Trusting in the efficacy of technological management was a primary draw to hospitals among those I spoke with, even for those hoping to birth without interventions, most of whom could have afforded a home birth if they had wished. The ubiquitous idea that the hospital is the "safest" place to give birth is predicated on access to *emergency* equipment and procedures, but given that most births are not emergencies, routine care was subject to negotiation between the woman's preferences and the hospital's insistence. The interplay between control and trust is evident in negotiations over using fetal monitors, epidurals, prenatal tests, and other routine aspects of medical management. Ilona, another new mother I interviewed, had a fourth-degree perineal tear after her baby's birth, which she certainly wouldn't have chosen

had she had perfect control of her bodily processes, but she was overall quite pleased with the birth experience because she felt in control of the social dynamics and decisions being made throughout, including to have an episiotomy that undoubtedly contributed to the tearing but also allowed her baby's "unusually large" head to emerge after a period of apparently fruitless pushing.

Threads of control and trust, and tensions between those threads, were ubiquitous in the discourses I encountered about birthing bodies. Teasing out this tension provides a tool to make sense of birth worlds' conflicts and contradictions.

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A little after Dani's due date, one of her non-stress tests came back with alarming results. For their midwife, Alix, there were too many concerning factors suggesting the need for intervention: being past due, having low amniotic fluid, the fact that the baby had been breech, and the fact that Dani had had a large cyst on her placenta throughout the pregnancy the likes of which no one had seen before (but which evidently carried no ill effects). The test result tipped the scale and Alix told Dani that she needed to be induced immediately.

But Dani, who had been having these tests done every week for months, felt sure that the test was run improperly. In Jonah's paraphrase of her reaction: "Your person just [screwed] up, the kid was asleep, they put the things on me wrong, they just, it didn't go well, you've gotta redo it." Furthermore, the smaller, more intimate, and low-intervention hospital where Dani and Jonah had been receiving care was full at that time, and they hated the idea that they would have to be induced at the higher-intervention, more mainstream hospital down the

road. So the test was re-run at Dani's insistence, and it came back with "totally reassuring results." Jonah explained that Dani "had the confidence to basically push back on what allopathic medicine is most known for, which is being like, 'the numbers told us this! and we have to avoid lawsuits immediately'... Most people don't advocate for themselves or have the confidence that something else is possible or probable."

Dani and Jonah negotiated medical care in the birth of their daughter; they were committed to not having "unnecessary" interventions, but actively negotiated with their provider over what counted as necessary. They were not resistant to technology, and indeed thought of themselves as "going the western medical route," but they wanted to be active and intentional in how they used technology, and have a say in how decisions were made about Dani's body. They agreed to be induced because of the list of "risk factors," but only when they could get into the smaller hospital a day or so later, and using a "gentler" method.[6] They were gratified to find power in having some control over the situation, noting that such power comes from being informed, having confidence, and recognizing that providers are not the voice of infallible authority but are also negotiating values and structural constraints.

In his retelling, Jonah recognized Alix, the midwife, as doing a balancing act: "Western medicine's very litigiously minded and risk averse, and manipulation-oriented or technically oriented... They were like, these are complications and that's more risk," even though

[6] As mentioned above, they used Cervidil, a vaginally inserted and locally acting cervical softener, instead of Pitocin, a synthetic oxytocin applied intravenously that stimulates uterine contractions and has been criticized for leading to a "cascade of interventions" if used early and/or excessively. Cervidil use was relatively common in Santa Cruz, but less used in other parts of the state. Laminaria, or sticks of seaweed that gently expand when inserted into the cervical os (or hole), are another gentle method that is even less common. Cytotec (misoprostol), a systemic medication, is another relatively recent way to induce labor that is more gentle than pitocin, though it is controversial and not FDA approved for this use; it's also used to start abortions.

midwives at this hospital are committed to minimizing interventions. Jonah thought Alix was "obviously a wonderful person," but "they're dealing with tradeoffs." In his impression, medical providers have to compromise on what they think might be the best course of action because they are vulnerable to lawsuits, an idea that has been confirmed without exception by the doctors I've spoken to.

> **Jonah**: [Litigation] governs probably half of their decisions, and they have to say things in certain ways, recognize certain things. That doesn't mean that we have to go with their recommendation, at all. They can't tell you that they're just telling you this information to cover their legal ass, but that *is* what they're doing. So it's hard to be in a situation where that's what they're telling you and *you're supposed to have confidence in them because they're the experts*... I mean people in medicine don't want to deal with legal issues, systems, costs. If you can put a filter on those interactions and just expect that they're going to recommend the conservative route because that's what they need to do, and you need to re-weigh the recommendation. (My italics).

Here, expertise is a boundary object, a situation I saw frequently in my field site. In the archetype of contextual physiology discussed in Chapter 2, the only expert on the childbearing person's body is that childbearing person herself. All institutional expertise is thereby called into question *as* expertise. By contrast, in the archetype of regular physiology, the expert must be apart from the body in question in order to have any pretense of "objectivity," as well as be the voice of broader institutional structures. In the reality of my field site, the ideas that expertise derives solely from a body's experience, or that only a doctor can be expert, were always present but never purely enacted. People negotiate their intuitions and desires with and against institutional knowledge and structural constraints. Undermining institutional expertise is done in multiple ways: recognizing that "experts" also face institutional constraints on what they can desire or do, valorizing self-knowledge, critiquing industrial systems, or building faith in the contextual-intuitive body's power.

Sarah and Roger, the third couple I'll consider, put no stock in external expertise whatsoever. They were also based in Santa Cruz, and lived in a small studio in the mountains with their son Gabriel, who was eight months old when I interviewed them. Their humble house was in disarray and they were full of laughter as we talked and made pancakes, the rosy, chubby Gabriel amusing himself under their ever-attentive eyes. During the two and a half hours that we chatted, and as I got to know them better in the following months, it was clear that their attention and priorities, particularly Sarah's, revolved around Gabriel. Of the three couples, the structure of their life in terms of work and home was the least conventional and stable, and their deviance from medical management the most complete. Sarah had been raised in a family that embraced Waldorf philosophy and eschewed institutionalized medicine entirely, and Roger worked teaching survival skills and nature-connection to groups of kids, college students, and adults. It was beyond obvious to them to birth at home, and Sarah was effusive about how wonderful it had been.

After showing me a photo album of Gabriel's first six months, and after I had washed some dishes and the cast iron pan in preparation for pancakes, Sarah talked about her midwife. "She's really carrying the old lineage of looking at birth, and I don't know that anyone else in the area is really doing what she's doing anymore." When I asked what that meant, she said "She looks at birth as a rite of passage for the mother and father... she wasn't coming as a doctor, she was coming as a witness to the process of transformation we were going through." This involved lots and lots of listening, they said, and bringing exercises to develop Sarah and Roger's imagination and awareness about what the transformation would have in store for them, and how they felt about it.

Sarah: She was completely, um, aware. Of what a big transformation [birth is] on all levels of the human being, the body, the whole emotional life, your identity as a person, and that felt amazing, it didn't feel like having a doctor coming to "check on" you. She would do the little things of feeling where everything was at, weighing, you know the basics of checking on the process, and that was it. Otherwise we would just sit and share and talk. We entered into a relationship with each other from the get go. If she would say things that would bother me, I'd say, "You know, it doesn't feel so good when you talk about all the negative things in the world, because I feel so open right now..." We entered this relationship from the beginning that would then be the basis for the birth experience. It was incredible, totally incredible. It felt like someone was taking our hands and slowly guiding us toward this transformative experience.

Only a few weeks before the due date, the midwife brought *information* in the form of Ina May Gaskin's book, recommending it for its birth stories, a "beautiful, simple birth preparation presentation," and some videos that her daughter had taken at births she'd been a midwife for. "She really focused on the fact that each birth is a unique experience for the parents, and not to get a lot of ideas about what it is, or 'what you're going to do during it,'" said Sarah. It turned out that Gabriel was born "sunny side up," meaning rotated backwards, and the midwife didn't even notice until watching the video footage later. Clearly, it was not an issue for anyone present, which, when Sarah told me about it, was precisely her point. The midwife did practically no preparation for what to expect as a physiological or medical process, no counseling on choices, no discussions of possible outcomes, yet Sarah and Roger both emphasized how *prepared* they felt. I was surprised at their assertion that their neighbors, who birthed at the small well-loved progressive hospital with a doula, seemed shockingly unprepared by contrast.

Roger: ...and our neighbors were saying all the information they were getting was all the scary things that could go wrong.

Sarah: And all the *opinions* that are just, the current medical opinion on what you're supposed to do for this and that, which, is irrelevant.

Sarah's indifference to medical opinion was bolstered by talking with people about infant care, notably her friend who had been a lactation consultant for decades at the large hospital in town, who told her the current opinion but that "'you know, we actually don't know a lot about milk, and about the relationship between mother and baby'" which Sarah said "felt so honest and true." She also talked with a few mothers she respected, each of whom had four or five children, and who emphasized that each child had completely different needs around sleep, nursing, birthing, etc. Her midwife responded to her questions about breastfeeding with:

Sarah: "I hear that you're asking the question, and that's what's important. You're in a relationship with your baby, to find out how to have this nursing relationship. Try asking your baby." She never said you're doing that wrong, this is what you should do. Just "I celebrate and honor you for being in the question. Search toward that."

Me: That sounds more empowering, not an ideal that you're missing or failing.

Sarah: Yeah! Because what I found out from talking to all those people is that there is no one right way.

Her midwife's non-answer helped Sarah feel that instead of going to a doctor, she was "going to an elder, who's celebrating the process I'm in, and helping guide me toward *health* through that process." To find out what Gabriel needed, Sarah in effect conducted her own empirical experiments. She talked a lot about how important "tracking" is, to see what factors get what results. Through a systematic guess and check, she and Roger learned how to "intuit" their baby's needs, which was evident during our breakfast.[7] They were both very attentive to him, though they largely didn't "play with" or "talk to" him; at one point Sarah looked over at

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[7] They also talked at length about how Gabriel learned about his world through empirical observation, experimentation, and attentiveness, by "tracking" patterns and results. They elaborated on how this is a natural behavior of all children, if they are not stifled by over-mediating caretakers.

him and said "You're pooping. That's good." I was intrigued and asked her how she knew, and she imitated the telltale grimace for me. They rejected the idea that an infant behavior is ever "just what happens." She said, "If you ask your question and you get a really cookie cutter answer, you get a skinny crying baby."

They explicitly stated that they had a lot more *trust* than most people; they embraced it as a general attitude.

Roger: We realized who [the midwife] was used to dealing with: people who just don't understand how to tune into babies or tune into the learning process, and grow.

Sarah: And to trust life. We just live our lives out of a lot of trust, rather than out of a lot of fear and control. And so we were approaching birth completely from that perspective. Wow, this is crazy and big and I fully trust this process.

Trust and control, both inward- and outward-oriented, are differing ways of feeling *powerful* when confronted with an unknown and/or intense bodily experience set in a charged social situation. The dance between embracing and rejecting biomedical and intuitive knowledge, technical expertise, institutional structures, etc., is a negotiation of feelings and experiences of empowerment. Spiritually-inflected discourses of self-trust emphasize that power can be accessed via undiluted and unmediated experience of intensity, such as labor and birth with no pain relief, or from recognizing the enormity of the female body's creative and nurturing capacities. Very significantly, stories of "bad births" overwhelmingly feature talk of feeling disempowered, whether one's body "failed" to come through or one felt manipulated, ignored, disrespected, or outright abused by authority figures (Pollock 1999, Oparah and Bonaparte 2016). The power of technology, which is distributed in institutional channels conferring authority and legal rights and responsibilities, is sometimes unclear or contested. If a c-section is indicated by protocol but refused by the birthing person, for

example, does that person have authority to make a decision that presumably endangers her life or that of her baby? Does an obstetrician have the authority to defy a person's directives for her own care?

Over and above a generalized appreciation for empowerment, certain circumstances can precipitate a more compelling need to feel powerful -- for example, in response to fear. In its most extreme, this is a fear of death, whether the death of the birthing person or her baby, and might be felt by the birthing person, her partner or family, or the doctor or provider who feels responsible for the outcome.[8] The ubiquitous discourse of "risk" refers to this fear of death. Medical systems and the doctors within them, particularly because they are so entwined with legal vulnerability, are necessarily oriented toward death as the ultimate enemy to be avoided at all costs (Burt 2004). There is not a strong concept of a "good death" in American medicine at large, and certainly not in childbearing, which is supposed to be about bringing forth life. Fear on the part of the childbearing person can also be fear of pain, abuse, damage, or simply of the inevitable changes to her life that will result. Discourses of empowerment often speak to these fears. However, the most hegemonic discourses, such as that of risk, use a very flat metric of success, which is an alive mother and baby. Popular deployments of trust and

[8] Indeed, feeling (and legally being) responsible for the outcome is intimately related to the medical epistemology of control; of course one would use any technologies at one's disposal, technologies over which one has control, to ensure that the bar of an adequate outcome is met; such technologies were developed with attention to outcomes, after all, not to process. Doctors are legally accountable for not performing a c-section when it might have avoided mortality or morbidity, but are not accountable for performing a c-section when it was superfluous or detrimental, nor for not performing one sooner when it would have avoided prolonged maternal suffering through a stalled labor. See also Kaufert (2007) on how hospital-based doctors in cities charged with overseeing Inuit births were (fearfully) oriented around preventing mortality.

control are ways to complicate and nuance this metric, to insist that other aspects, particularly qualitative ones, matter as well.

Among Bay Area birth worlds, the idea that the "most important thing" is "a healthy baby" (including "at least your baby is healthy") was omnipresent in a variety of circumstances and expressed by parents and providers, including as a foil in discourse criticizing medical protocol or advocating for more nuanced, qualitative evaluations of births and maternal-infant well-being. The phrase points to a medical focus on "outcomes" instead of process, subsumes the mother's experience in the child's, and negatively defines health as absence of death or disease. "Healthy baby" quips were used to justify trust in medical institutions or to alleviate disappointment in a birth process. Assertions of the importance of qualities and process also speak to conditions in which a live mother and baby can largely be taken for granted. The point is not to pitch a "lovely process" against a "good outcome", as Kim's parents do, for example, when they insist it is selfish of her to want a home birth because it focuses on the "mom's experience" instead of the baby's well being (setting aside for the moment the assumption that a baby's well being is best insured at a hospital).[9] Rather, I want to examine the cultural scene in which it makes sense that a lovely process and a good outcome are presumed to be mutually exclusive. Were trust and control reshuffled, technological insurance against death and the immanent, contextual power of a well-attuned birthing body might work beautifully together toward the same ends.

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[9] **Kim**: For my [family, home birth is] very uncommon, like I was saying, in the midwest, so their initial reactions, my parents were very like, 'It seems like an unnecessary risk. It seems selfish, like you're making it all about the mother when it should be about the baby.' All these things which did make me feel very defensive. And my mother had two c-sections, her own birth she was born premature, so all her experiences have been birth as a medical emergency, not birth as a natural non-medical experience. So she had all her fears and anxieties.

As means of experiencing bodily empowerment, control and trust reference the regular and contextual physiological archetypes discussed in Chapter 1. Implicit beliefs about physiology influence what it seems reasonable to want to trust or control (and how to do so), and considerations of trust and control influence what conceptions of physiology make sense and feel comfortable.

The idea of a regular, predictable, standardized physiological process enables practices that seek to "control" the body through medical interventions. On the other hand, a contextual, emotional, and interpersonal physiological process that is managed via the play of certain kinds of affect lends itself to the idea that relinquishing such control -- i.e., cultivating feelings of confident submission, or "trust" -- will allow the body to perform and function. In some ways, expressing physiology in terms of trust and control exaggerates the opposition between the archetypes. Regular physiology requires controlling the body, which can't/shouldn't be trusted because it is unpredictable, while contextual physiology requires trusting the body, which can't/shouldn't be controlled because that quashes intuition and inherent functioning.

In the Mindfulness Based Childbirth Education class where I met Dani and Jonah, one of the first questions Roxanne, the instructor, asked the class was "who likes to be in control and "fix" things? what are you like when you're not in control, when things don't go your way?" She talked about how many people, particularly those socialized as men, want to "fix" problems, but that the birth process requires letting go of that desire and simply bearing mindful witness to a strange and intense situation. Likewise, the person doing the actual birthing must submit her "thinking" brain to her "animal" brain. Roxanne asserted that different personalities are differently suited to the inherent nature of labor, or rather, have

more or less work to do to accept that labor cannot be controlled. "The only way out is through," was a common refrain about labor that I encountered throughout fieldwork, invoking surrender, acceptance, and, perhaps paradoxically, the power and will to continue on. In later classes, Roxanne also had us engage with what might be called control measures: she discussed the sorts of available medical interventions and their uses and benefits, and we practiced various methods of coping with discomfort by having the pregnant person dip her hand in ice water and do something, perhaps breathe intentionally, receive massage, receive affirming words, or practice a kind of dissociated awareness or non-attachment. The class was, in some ways, a preparation for developing tactics of trust and control.

Preparing a "birth plan" has been a trend among progressive birthing people the last ten years or so. In a birth plan, expectant mothers (sometimes with the input of partners, doulas, or family members) come up with a list of instructions about procedures they do or do not want done, and under what circumstances. It's an attempt to exert control over the hospital environment and feel agency in the birth, though it can backfire when it's conflated with control of the body and the body doesn't "obey". The idea that emotions have a strong impact on physiology, or that intuition about childbearing embodiment should be "natural" and doesn't need to be learned, can lead to blaming oneself if the physiological process appears to malfunction (tying in with the cultures of mother-blame and gender essentialism). One didn't "trust enough", or wasn't able to subdue fear, many are led to believe. To circumvent this problem of the unruly body, I observed a trend for doulas to say "birth wishes" or "birth intentions" instead of birth plan, to mark this inability to control and avoid setting birthing people up for failure. The phrasing was a concession to unpredictability.

Yet it was also a concession to pushback from the hospital environment itself, where experts often refuse to be controlled by a patient. Birth plan rhetoric and action could at times be militant and defensive in anticipation of a struggle for control over decision making power in the birthing room, and this was not a misplaced concern. "Fight for your rights" coaching from birth education media (which might variously include childbirth educators, doulas, books, webpages, blogs...) was thought by some birth world actors to have encouraged a problematic antagonism between hospital staff and "that kind" of patient. Good relationships with staff have been reprioritized in response. Contextual physiology ideas about how the body responds to emotional tensions in the birthing space have contributed to this, though not without some concomitant relinquishing of patient control. In turn, the hospitals I experienced were trying to be more accommodating of "that kind" of patient, who was in any case becoming more common. The birth plan thus appeared to function more as an indication of style than as an actual set of procedural preferences. There was a standard set of "non-medical" requests that would generally go together: no epidural, no drugs, not to be offered drugs, not to be asked about her pain level, minimize cervical checks, hep lock instead of prophylactic IV, mobile monitors, baby stays with mom after birth, not offered any bottles, formula, or sugar water, not bathed immediately (if at all) leaving the waxy vernix, wait to do shots and vitamin K cream (if at all), etc.

One hospital midwife I spoke with explained that when she teaches childbirth education at the hospital, she shows the gathered expectant parents the epidural needle and all manner of medical implements, and gives full disclosure of side effects, such as that an epidural can lead to life-long lower back pain. She said, "Ignorance is bliss -- the moms won't even see the needle go in, do they really need to know what it looks like? But knowledge is

power. I walk that line in teaching." She explained how her training at UCSF emphasized ethics, and mused about the possibility of truly fully informed consent, or fully unbiased presentation of facts; she was not uncomfortable admitting that neither ever happen in a medical setting, "but you have to think about it." At least in this case, medical providers also are called upon to balance trust and control in the power relationships around birth. She felt she was empowering childbearing people with medical knowledge -- the sight of the tools, the feel of the plastic, the potentials that cling to them for relief and damage. In an approach like that of Sarah and Roger, however, such information would not have been empowering, but fear inducing. In their epistemology/ontology, only cultivating a rich sense of trust "in life" and "in birth" would have enabled their bodies to birth safely and peacefully (though hardly painlessly!).

Pain and Fear

The "sensations" of labor -- the pain itself -- was rarely the focus of people I talked to about their births. Childbirth education and a lot of doula prenatal work was focused on preparing for pain coping, and people who had experienced labor never reported that it was anywhere near comfortable, but no one was hung up on raw pain. Pain was mediated with myths and stories, about its purpose and effects, about eluding it or controlling it. Pain is not unreal, but neither is it straightforward, or -- I came to realize -- necessarily significant. A widely referenced adage was that pain is not the same as suffering; suffering comes from resisting pain, suffering is a choice. Suffering, in this adage, is a second-order experience, a mediated experience; pain itself still requires mediation and in mediating it, one has some amount of control, and therefore power. Yet pain is widely interpreted as suffering in most

American childbearing contexts. Kim's friends, when she went home to the midwest for a baby shower, were genuinely baffled about her decision to eschew pain medication: "...even when it's genuine curiosity, not criticism, I still felt like I had to be defensive. They're like, 'Well, why would you want to do that? I just don't get it, if there's pain, if there's medication that covers up pain, why would you want to experience pain?' So I found it really exhausting." The question becomes, in what kind of society is pain so obviously and immediately interpreted as suffering? Because reinterpretations of pain as not-suffering push against that kind of society.

Many in the natural birth movement of the 70s used the word "rushes" or "surges" instead of "contractions", and talked about "intensity" or "sensations" instead of "pain. Dani did not consider labor painful but likened it to Hell, a decidedly unpleasant otherworldly experience:

Dani: I wouldn't call labor pain. I would call it, like, a deep physical sensation that is NOT comfortable.

Me: Intense?

Dani: Uncomfortable.

Jonah: Uncomfortable.

Dani: But it's so differeent from cutting your finger or breaking your arm, that's why I don't call it pain. ... I mean I definitely didn't have an ecstatic birth, it was *hella uncomfortable.*

Jonah: Orgasms -

Dani: And there were NO orgasms involved. But I wouldn't call it, definitely not pleasurable, but I wouldn't call it pain just because pain is something different, it just has a different category in my brain.

Me: How was your brain working when you were in labor?

Dani: I was like an animal. I kinda describe it as like, you know how dogs want to just crawl into the backyard and die under a bush by themselves? That's what it felt like my labor experience was! [Laugh] I didn't want any light, I didn't want any major stimulation, closed curtains, turned off all lights. Even when it was the middle of the day I didn't want to know what time it is, I just went into it like a timeless space of being intensely present to what was. At some point I was like, holy shit, this has been going on for a really long time.

Me: Did you ask about hours?

Dani: No, I did not want to know what time it was... so that's what I mean animalistic, just intensely present to what was going on right there. My labor came on so quickly and my

contractions were so close together that I could only get a couple of words in between each contraction...

Me: What do you think of that phrase, "labor land"?

Dani: Labor Land sounds like Candy Land, sounds like something really light. I've been describing it as I went to Hell. It's birth hell, it's totally birth hell. Going to the moon and back. It's like intergalactic travel. But it really is like going to the underworld and bringing a baby back. You have to go down, you have to meet the devil, you have to like -

Jonah: Wow, intense -

Dani: Shake his hand and do a little dance, and yeah, then you have to climb back up from Hades. ...Oh yeah and bleed like hell. No yeah, it was very Grecian, like otherworldly.

Jonah: At the beginning, the kid, she would stress out when we were talking about the story -

Dani: She was really sensitive to it.

Jonah: She'd start to tense up.

There is a widely circulating idea that a birthing person will feel more comfortable and empowered if she can move around freely. "Changing positions" is a key part of the "doula's tool kit" for alleviating labor discomfort, or "pain management".[10] One doula collective described one of its members as the "ninja doula" for positioning; if they suspected a positioning issue at a long labor, they would call her in to work her magic. Further, there is the idea that for the most part, the person will move her body to where it needs to be *physiologically* -- hunched forward for occiput-posterior babies that induce back pain, leaning back to relieve a pinched cervix if the baby descends before full dilation, on her hands and knees or squatting to deliver using gravity. Dani didn't have a strong sense of *which* position to move into, but appreciated moving and had compulsions or desires she illustrated with comparisons to goats and dogs (above).

Dani: I was just trying to get into the most comfy position, which is hilarious because there IS no comfy position! We had done a lot of yoga, went into yoga stretching mode,

[10] I've worked with childbearing people who were very concerned to know how many items were in my "tool kit" - the more positions I could think of in our prenatal sessions, with rationale for which circumstances they would be useful in, the better, as well as other comfort measures like heat and coolness, scents, visualization, breathing patterns, affirmations, TENS electrical stimulation units, etc...

couple of yoga balls, a mat on the floor. ...There's no position, just so you know, but it helped to move around.

Me: You said pressure helped -

Dani: Yeah, Alix said she saw a laboring goat one time and it just wanted to ram its head up against a wall. That was me. I just wanted someone to push my head really hard.

The intensity of the sensations -- or pain -- invites a tactile language of intensity, in which pressure is welcome. One woman for whom I was a doula appreciated being held and rubbed during labor, but found it very obnoxious when her mom or partner would do it. Because they clearly wanted to be involved, and because I would get tired, I showed them how to touch really firmly and solidly, the absolute opposite of the tickly gentle caresses they had been administering. It worked well. Embodied attunement often needs an active nudge in the right direction, such as Dani's midwife coaching her on pushing:

Dani: Once I was to the point of needing to push, I didn't know how to push, which was really fascinating. It was really scary and hard to learn, in the moment of really needing to do something desperately and not knowing how to do it. And so, they coached me on how to make that happen.

Me: What worked?

Dani: Alix physically demonstrated what I needed to do. Like she physically demonstrated holding her breath and turning beet red and squatting and looking like she was incredibly uncomfortable [laughter]. And that's what worked. And then she also stuck her hands up inside my vagina and showed me the muscles I needed to activate.

Me: She was like, push my hands out?

Dani: Yeah. That was really trippy.

Sarah didn't need or want instruction in managing her labor, which she said was very painful, particularly during pushing. She also explained that due to her family's Waldorf-based beliefs about illness and injury, she had voluntarily never used pain medication for anything, including intense menstrual cramps and dental procedures, and she said she had a best friend who underwent 12 leg surgeries with no form of anesthesia. Even though she didn't do any pain management preparation for the birth, she recognized that she had in effect been preparing pain coping techniques her entire life. "I just knew pain is something we can

have a relationship with," she said. Her midwife told her that "pain during birth stands for Purposeful, Anticipated, Intermittent, and Necessary... something you're expecting, that is completely natural, and not saying something is wrong, but that your body is opening." I had earlier asked her if she would call labor painful, and she said "oh goodness, yeah, definitely! I knew that the pain was asking me to open more and more rather than contract, which is the natural gesture toward pain, to contract, withdraw, and I knew that in birth you need to do the other gesture." A Gaskin book she had read prepared her with this philosophy, and when the pain grew to more than she herself could handle, she grabbed onto her husband and "looked in his eyes to ground myself."

Sarah: It got to a place where I, within my own abilities, I couldn't continue to stay open to the pain. It was beyond what I could alone move, and you have to somehow move that energy, rather than have that reaction, and get stuck. So then I remembered she said look into the eyes of someone who trusts and knows that you can do it. So for an hour, Roger also just said I was squeezing his hand with more strength than he knew I had! It kept the energy moving and not causing me to contract... The pushing was really, very painful.

For Sarah, pain was anything but pathological. She was an extreme example, as even illness itself was not pathological to her, but an indication of an emotional root cause she sought to remedy whenever she displayed symptoms. Yet as an extreme iteration of an ideology of natural birth that includes an implicit valorization of pain, her case is indicative. Filmmaker and UCSC professor Irene Lusztig, who directed the *Motherhood Archives,* a film about the lessons childbearing women were given over the past centrury regarding what they should want and feel, said in an interview that today birth is suspended between two ideas: it is both natural and pathological. The medical explanation of pain as a pathological symptom of a disease is inadequate; yet revalorizations of labor pain evoke a problematic Christian heritage wherein labor pain is God's punishment of Eve. Grantly Dick-Read, the British

obstetrician who coined the term natural childbirth and wrote the first books about it, made an explicitly Christian appeal to the experience of being inside pain as a form of spirituality. That history has been erased, along with an argument formerly used to support women's access to twilight sleep in the early 20th century, namely that humans experiencing intense, abject pain and suffering have a right to have it relieved. This could be considered an earlier iteration of "human rights in childbirth" discourses, though today such claims often insist that women have the right to not have their bodies interfered with. It is a right to self-determination and autonomy, including to decide to feel pain. In an interview, Lusztig says "It's kind of ironic that the space feminists occupy now is a redeployment of this incredibly Christian and misogynist argument about women's bodies... That it's empowering and self-actualizing for a woman to be fully present in that experience of pain, that that's a really desirable state -- to me that's really problematic."[11] I don't find the idea of non-pathological pain inherently problematic, as Lusztig does, though it's important to not erase the misogynistic history of this idea. As in so many childbearing binaries, there is an elusive possibility of negotiating between the "natural" and the "pathological" (or the contextual and the regular) without slipping into reification of more foundational binaries, such as essentialized genders, or a nature that either needs to be valorized or transcended in relation to culture. The terrain of childbearing is wrought with tensions between binaries of which either side is problematic. The potential lies in hybridizing them, or seeing outside of the two options given.

Both poles of medical control of the unpredictable body and spiritual trust in the natural body are, in some ways, reactions to fear about birth as a liminal state imbued with

[11] Gonzales 2013.

both vulnerability and power. Both are ways of assuaging fear by either denying vulnerability or denying power. Claiming that natural pain is empowering effaces danger and provides a tool by which female/subordinate suffering can be naturalized. Implying that pregnant bodies are disasters waiting to happen reinforces dependency on institutions and the hierarchical social relations they naturalize. What would it look like to embrace liminality, vulnerability, and power altogether? Is there a way to embrace embodied, intuitive power without turning it animal or female or otherworldly, to have it be merely and completely human, and thus social?

Chapter 3

The Gendered Politics of Responsibility and Vulnerability: Mommy Wars and the War on Women

The connections between and among women are the most feared, the most problematic, and the most potentially transforming force on the planet.

Adrienne Rich, "Disloyal to Civilization: Feminism, Racism, Gynophobia," *Chrysalis*, 1979

In January 2015, an ad came out and went viral through social media. The setting is a city park, where a young auburn-haired woman sits on a bench, baby cozied up to her chest in a padded carrier. Birds chirp. Then pounding music starts as three stroller-pushing women round the bend, heads haughtily raised. Two other baby-wearing mothers appear and sit next to Auburn Hair, emphatically dropping bulky pastel diaper bags. The ridiculous posturing accelerates! Another trio of mothers descends the park stairs, spraying milk from baby bottles. Yet another trio talks on cell phones while sporting black skirt-suits and black bassinets. Next, the camera cuts to a contingent of five baby-holding dudes grilling at their picnic table, and then a queer family sitting on their picnic blanket. A final trio of mothers appear, doing the warrior pose on their yoga mats, with babies in slings around their torsos. "Oh look, the breast police have arrived," says one of the bottle-spraying moms, aiming her comment at four women wearing capes to cover what are ostensibly nursing babies. A full-scale war of words breaks out. "Drug free pool birth, dolphin-assisted" says one gloating woman, gesturing inside her blue stroller. A mocked baby-wearing dad calls out sexism, and in another spat the environmental impact of disposable diapers is levied against the epithet "crunchy granola mom." In retribution for being called "part-time moms," the skirt-suited ladies accuse stay-at-home moms of getting mani-pedis all day.

They all move in for the kill, storming the park's play structure, when suddenly someone lets her stroller roll down a hill. The bumping soundtrack goes silent as, in slow motion, everyone leaves the battle to chase the endangered baby. The stroller slows and the baby's mom picks her up, breathlessly reassuring and thanking the crowd. In a communal catharsis, the unharmed baby evokes hugs, tears, and soft piano music, with the words "No matter what our beliefs, we are parents first" fading onto the screen. "Welcome to the Sisterhood of

Motherhood."[1] This ad was called "The Mother 'Hood Official Video," and was paid for by Similac, one of the two large American formula companies. The final image is the word "Similac" against a black screen. As of October 2015, it received over eight million views on YouTube.

This commercial caricatures one aspect of the current gendered politics that forms the backdrop against which near-birth practices are negotiated. "Choices" about how to practice motherhood are highly charged with moralizing rhetoric, while completely erasing the experience of mothers for whom poverty, racism, and non-heteronormative family making dramatically constrain the "options" from which they have to choose. The tensions in this commercial represent the "Mommy Wars," a term that has been popularized to describe cultural tussles over the right way to parent (well, to mother, as the most intense cultural pressures about childbearing fall upon female shoulders)[2]. In the term's most narrow sense, Mommy Wars oppose "stay at home" and "working" mothers, "pitting them against" one another, as popular media critical of the so-called "war" often phrases it (though such purportedly critical media often ends up merely reinforcing the terms and the tensions).

I interpret the phenomenon more broadly to include a number of stereotyped "battles", including disagreements over how to feed, transport, diaper, and birth one's baby, and also how involved fathers or other partners should be. Essentially, it is a proliferation of

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[1] It can be watched via YouTube, https://www.youtube.com/watch?v=Me9yrREXOj4

[2] See Nancy Chodorow's seminal *The Reproduction of Mothering*, which explores why women "mother" and men don't, using a psychoanalytical heteronormative-nuclear framework to claim that female psychic experience is heavily shaped by the mother-daughter relationship in ways that dispose women to prioritize connection and nurturing more than men do, and to source their sense of self-worth from it. I would add that this prioritization and pressure in "female subjectivity" is culturally reinforced, and thus mutually produced by external cultural hegemony and interior psychic formation.

discourses protesting and reinforcing a hegemonic imperative toward "intensive mothering" (Hays 1996), or what Douglas and Michaels call the "new momism" (2004). The Similac commercial parades some of the stereotyped characters in this "war", from the executive "part-time moms" to the cloth diapering "crunchy granola moms" to the defensive-sensitive dads. Staged in popular media, the Mommy Wars are catchy jabs at various parenting practices that impugn mothers' morality and trap them in a variety of catch-22s: damned if you do work, or breastfeed, or have an epidural, and damned if you don't[3].

These "wars" are highly classed. For example, the figure of the "stay-at-home mom" carries moral valences opposite from those of the "welfare mother," suggesting that giving up a career in order to mother is noble, while declining to do unskilled and poorly paid work for the same reason is lazy or disingenuous. In referring to women's negotiations between career aspirations and child-rearing as calculated expenditures of time, labor, and love, the term's premise is that women do have a choice about working, an assumption that excludes a huge swath of mothers who are poor and/or single, and who face different kinds of stigmas and

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[3] The phrase "the Mommy Wars" originated in the mid-2000s, notably referenced by two popular nonfiction books, Miriam Peskowitz's *The Truth Behind the Mommy Wars: Who Decides What Makes a Good Mother?* (2005) and Leslie Morgan Steiner's *Mommy Wars: Stay-at-home and Career Moms Face off about their Choices, their Lives, their Families* (2007). The term was popularized by several pieces in the New York Times' parenting blog, "Motherlode," started in 2008 (in 2016, the title was changed to "Well Family" to include men and other caregivers, though in her 2008 inaugural post Lisa Belkin made a statement about gender inclusivity, mother-pun notwithstanding). For example, the sociological survey "Signs of a truce in the mommy wars" (2015), "Mommy Wars: The Prequel" (2012) featuring Ina May Gaskin and the home birth question, and "'Mommy Wars' redux: a false conflict" (2012) and "The eternal, internal mommy wars" (2012). The NYT seems to be the preeminent media outlet for these discussions. Bay Area publications did not emphasize the "mommy wars" in the same way - SF Gate ran a few articles 2007-09 discussing the topic but without the term (in its column "the Mommy Files"), and the Santa Cruz Sentinel and East Bay News (a 2016 merger of the Oakland Tribune and a few other papers) did not have coverage. There was an SF Gate piece in 2014 about 'mommy wars' over social media pictures of breasts and naked children, and a 2007 piece on how mommy wars exclude poor mothers.

expectations. A sister term, the "Opt-Out Revolution," describes well-educated professional women "opting" to stop their careers and focus on reproductive labor instead. Stereotyped characters, such as those in the commercial, do not necessarily belong to different social classes, and present parenting practices as choices or identities instead of complex negotiations of situational constraints and desires that are culturally coded and socially enforced. The mommy wars discourse effaces the social conditions in which many Americans make childbearing decisions, which as often as not may be based on material survival, not ideology. These stereotypes tend to collapse mothers into one dimension, calling into question whether they love their baby enough or not, while erasing other dimensions such as poverty, racism, lack of institutional support for parenting, women's aptitudes and desires that don't pertain to mothering, and a culture that devalues reproductive work as well as women's "productive" workplace labor. As polarizations, these stereotypes also obscure how the majority of people make hybrids and compromises between value extremes, and that they must learn and negotiate the actual person that is their particular baby!

The Similac commercial touched a nerve, at least among those parents who frequent the internet as public space. The myriad comments and blog posts that sprang up in its wake evidenced emotional rawness, defensiveness, belligerence, and vulnerability. Cries of agreement with the commercial's message about the harmful divisiveness of judgments met with defensive statements about how hurtful it is when someone "questions my choices as a parent." There were quite a few emphatic refutations of the ad's sentimental manipulation: "They're selling formula," after all, and have good reason to make pro-breastfeeding judgments seem petty. Along this line, the refusal of many internet voices to consider "all choices equal" were particularly interesting, as they defended a stance that perpetuates

conflict. Some of these voices contended that the mommy wars are "good for society" because they encourage dialog and sharing of perspectives. There were also a number of voices that leaned toward a more socially critical position, pointing out the difference between making "fully-informed choices" from among a number of accessible options, and choosing the least-bad option from a space of constraint or ignorance. In my experience, however, the practices that stem from such discourses lead more often to patronizing advocacy initiatives and "education" programs for certain groups of people, than they do to critiques of racism, capitalism, or other factors that perpetuate social inequality.

"The War on Women" is another term that became widely used around the same time as the phrase "the Mommy Wars[4]," and it epitomizes the other part of the gendered politics that form the backdrop for Bay Area birth worlds. It describes largely Republican policies attempting to restrict women's rights, particularly their reproductive rights. It has primarily been used in reference to restrictions on access to contraception and abortion, but also to sexual violence and workplace discrimination. Californian Democratic senator Barbara Boxer and representative Nancy Pelosi were active in popularizing the term after the 2010 congressional midterm election, in which Republicans won a majority of the house. The premise of the term's critique is that a regressive view of women's social role is being institutionalized through legislation and forms of government regulation. The war on women includes many ways of policing childbearing people, from "monster mother" media scandals

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[4] It originated around a decade earlier, in the mid-90s, with several books including former Republican political consultant Tanya Melich's *The Republican War Against Women: An Insider's Report from Behind the Lines* (1996), and feminist Andrea Dworkin's *Life and Death: Unapologetic Writings on the Continuing War Against Women* (1997), followed by Bush-specific critiques such as Laura Flanders' *The W Effect: Bush's War On Women* (2004) and economist Barbara Finlay's *George W. Bush and the War on Women: Turning Back the Clock on Progress* (2006).

like Purvi Patel's criminalized miscarriage in 2013, to the 2016 FDA ruling that all sexually active women of childbearing age who are not taking birth control should not drink alcohol, regardless of their intent to get pregnant.

This "war on women" is part of a legacy of eugenic thought in the United States; concerns with women's sexual and reproductive freedom are deeply entwined with ideas about shaping and managing the population. This legacy includes the forced sterilizations of indigenous, black, and other non-white people (Davis 1983, Roberts 1997), as well as Margaret Sanger's birth control campaign in the early 1900s, which yielded Planned Parenthood. The idea of "race suicide," which refers to white, wealthy women self-limiting the number of their children (a term President Roosevelt used in 1905 when speaking to a national women's conference)(Briggs 2000), is not unrelated to recent conservative valorizations of women's role as mothers and home makers. This varied heritage also includes the pathologization of the black family, largely by Senator Moynihan's efforts in the 1960s, tracing its "degeneration" to a matriarchal structure; others have argued that this structure is deeply implicated in the troubled kinship relations during slavery. More current manifestations of eugenics include how the fertility of some American women is heavily invested in via expensive assisted reproductive technologies (ART), while that of other women -- generally poor, non-white, disabled, and/or without a heteronormative family structure -- is heavily discouraged and stigmatized with terms such as "welfare mother" (Collins 2005). It continues internationally under the rubric of "population," which extolls the dangers of population growth among the poor, non-white, and colonized for a planet with limited resources, while neglecting the vastly disparate resource use of the populations of wealthy, largely-white, colonial nations (Murphy 2017).

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These two "wars" characterize the gendered politics undergirding contemporary American childbearing. I argue that they both stem from and enact the ways that co-embodiment of the childbearing person and the child is disruptive to both fundamental cultural assumptions and entrenched power dynamics in US society. Co-embodiment is politically fraught in multiple and contradictory ways. Its stakes are manifest in the relationships near birth, which are both real and imagined, which are invested with affective fantasies, and which have important material and psychological effects. These include relationships with the state as both provider and policer, with care providers who are variously positioned in relation to institutions, within families, and among childbearing people themselves. The fraught political stakes mean these relationships often take on disturbing casts, such as "war", marshaling experiences of judgment, isolation, coercion, and control. Providers might continue in this vein and evoke institutional heartlessness, or on the contrary be attributed with empathetic communality, filling in "gaps" where childbearing people's needs are not considered met.

Ideas about affectively-charged relationships, including "wars," are negotiated, hybridized, ignored, and transformed through the quotidian practices of Bay Area birth worlds. We can see these negotiations through ideas about care, which is an essential aspect of near-birth relationships: what are caregiving relationships supposed to be like, and how should they be valued and contextualized in broader society? Power relations structure care, and care practices both contest and reaffirm power relations. The "mommy wars" are contests

over *how* women should care, over the proper way to negotiate demands, expectations, and "choices" women face related to reproductive labor, while "the war on women" is a contest over *who* should care, over who should be doing what kind of reproductive labor and absorbing its consequences, and who is responsible for making (and is enabled to make) decisions about childbearing. Care is not only done but deployed; it is talked about and managed in ways that have political motivations and effects.

Care is occupying oneself with the needs of another. It is deeply entwined with vulnerability and responsibility. I follow Annemarie Mol (2008) in saying that it is never unidirectional but always reciprocal, a process of bricolage and craftwork collaboratively produced by both the givers and recipients of care. I also follow Mol in stating that it is not exclusively human but intimately involves tools and technologies. And I will add that it is always profoundly interconnected with power, structures, institutions, and inequalities, because the questions of who does care work, how it's valued, and what resources are available for it, are hotly contested. Discourses of care – whether promising to meet needs, or blaming for having needs – are often a rhetorical pawn in this contest. A newborn baby is perhaps the quintessential object of care, in its utter vulnerability, its neediness begging the question "who is responsible for this?"

Care is contested when childbearing needs cannot be met by the responsible party, by default the mother, which may be because she is doing the work of two (or more!) humans, because the "needs" are inflated with affect-ridden hype, and/or because the social context in which she is trying to meet needs is hostile to her. The specter of infant needs not being met is tossed around culturally like a hot-potato, moving between mothers, fathers, state programs, personal networks, charities... somehow always landing back in the lap of the mother. State

subsidies for food, housing, or other basic parenting needs are politically contested at best, so the vast majority of parents are expected to work while their children are young, yet neither is the state offering to pay for childcare. Privatization of services like education increases this pressure. Mothers are responsible for nourishing their babies as best as possible, which is widely accepted to mean breast milk, but it is not the responsibility of their employer to provide lactation facilities or of the state to regulate that it do so. Mothers must intuit care, which manifests as expectations of being "naturally" or instinctively caring, or the law faults them in ways it never would men. Anna Tsing (1990) describes how the "monster mother's" first failure is one of nurturance, how juries and newscasters wonder, appalled, "how could a mother do that?" (In the case of abortion, the state is being called on to protect vulnerable fetal life *from* mothers.) The latest iteration of mother-friendly birth discourse invokes the romantic "village" that it takes to raise a child.[5] But who is this village? A desperate fall-back on friends and family who are themselves not remunerated or supported for doing care work? "Village" discourse recognizes the problem of placing complete responsibility for infant care on mothers' shoulders, yet it falls short of critiquing inhospitable social conditions for child rearing or village-making, and thus in effect tosses responsibility for banding together right back to mothers.

This tossing back and forth of responsibility gets at the level of fundamental cultural assumptions – who is responsible for whose needs? In dominant American ideology, this always comes back to the autonomous individual. But when the vulnerable infant is involved,

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[5] In fact, two San Francisco moms looking for niche parenting communities, and "inspired by the success of dating sites," started a website called The Village in 2014. (See Bologna's August 2014 Huffington Post article). Likewise, in Santa Cruz a childbearing resource center that closed just after I started fieldwork in 2014, was called The Santa Cruz Village Birth and Family Enrichment Center, popularly known as "Village."

the ideology breaks apart and becomes exposed, in a parallel with how the embodiment of pregnancy upsets the myth of autonomous individualized bodies. The question of care, at base, is the question of the social contract: What is one owed? What does one owe? This is an uneven contract, of course – women, minorities and the poor are not granted the same ethical assumptions as the supposedly generic white, Christian, middle-class man. In other words, some needs are more worthy than others, and individuals have differing levels of social resources to draw from.

The awkward social accommodation of childbearing's co-embodiment entails that incomplete (child) persons and overflowing (childbearing) persons be fitted into the mold of autonomous individual persons. But what if, instead of searching for a moment when child personhood is achieved, a line between life and non-life, rights and non-rights, mother and infant bodies, the child were seen as a person *in process?* This process might well extend before conception and into childhood, pushing the edges of what I have called the near-birth "childbearing" period. The moment at which personhood is conferred is by no means natural or given; the anthropological record contains many examples of personhood rituals that take place some time after the birth, waiting until a relevant and meaningful point in babyhood to welcome the new person to the community (for example, Weiss 2007). One might say parturition is fetishized in Western/US culture as the moment of new personhood (consider the hospital practice of issuing birth certificates very shortly after birth, naming the child and recognizing it bureaucratically as a citizen), though conservative abortion politics and new technologies like fetal ultrasound "photographs" have pushed this moment further and further back into the womb (Rapp 1999).

It is not uncommon in Bay Area birth worlds to refer to a "motherbaby" or use some related phrasing positing the childbearing person and child as a single unit, a single organism. There is widespread acknowledgement of the "fourth trimester" of pregnancy that, along with the standard three, constitutes the "childbearing year"; this is to assert and recognize the continued experience of embodied intimacy on the part of both the infant and the childbearing person (presumed to have gestated, birthed, and be nursing the child). Trendy birth plans include push-back against many rituals of separate infant personhood, including delaying the cutting of the umbilical cord, deferring shots and vitamin K, and refusing baby baths and swaddling, not to mention "rooming in" instead of taking the baby to a separate nursery, which has become quite standard in the Bay Area. Breastfeeding is increasingly emphasized as a crucial way the nursing person's body continues to protect, nurture, and build the infant person's body, including via the real-time transfer of antibodies and immunities in the substance of the milk, as well as via the provision of emotional comfort in the act of nursing.[6] "Attachment parenting" practices like bed sharing and extended breastfeeding push the moment of independent personhood further after birth. In many ways co-embodiment extends (or can extend) well into toddlerhood.

It seems to me that such childbearing practices and discourses are in fact arguing for a processual conception of personhood. Such a conception is potentially a powerful way out of the abortion stalemate over "life" and "choice" that pits mother and fetus against one another, refocusing on the relationship between the two and thereby making space for the complex

[6] It is becoming more common for those who have trouble producing (enough) breastmilk to feed formula (or donor milk) via a thin tube attached to the nipple, to preserve whatever aspects of the "experience" of nursing are lost in bottle feeding (one of which is sometimes said to be the baby's skill at coaxing milk from a nipple, perhaps "lost" once an artificial nipple is introduced, since the two require different oral muscles/techniques).

emotions, constraints, and situational imperatives that go into the decision to terminate or keep a pregnancy (Pollitt 2014, Parker 2017). However, suggesting that mother and infant bodies are one and the same also has troubling political implications. It potentially naturalizes female biological capacities as imperatives to mother, or to do so in an all-consuming way. On the other hand, asserting perinatal intimacy as necessary to maternal and infant well-being could be used to claim social support for policies like extended paid parental leave that would enable breastfeeding, rest, and bonding, of which many postpartum people would like more.

Essentially, the co-embodiment of childbearing destabilizes the presumption of an autonomous individual, which is foundational to Western liberal social and political organization. Women, who are generally interpolated as child bearers, are caught in a double bind. To oversimplify for the sake of argument, on the one hand, if they assert their autonomy as political subjects and value as individual contributors to economic and social life (that is to say, if they claim to be no different than men in this respect), they compromise the support and value they are able to claim as necessary for reproductive work, and also perpetuate a supposed "public" life on which "private" circumstance has no bearing. On the other hand, if they claim that domestic circumstance, childbearing, care work, and reproductive biology require recognition and accommodation in civic and working life, they risk compromising their professional advancement, voice, and compensation, and their ability to be seen as valuable, serious, and productive apart from their reproductive capacities.[7] This promotes a politics in which women are naturalized as caregivers and reproductive beings and

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[7] Of course, people of all genders are caught in a similar bind insofar as the ideal of an autonomous individual citizen-worker-consumer, who is free to engage in or break off commitments, who is not compelled by obligations to care (for), who is not defined by her relationships but by her "work", is an inherently limiting ideal, yet an appealing one that holds the liberal promise of equality, democracy, and "the pursuit of happiness."

consequently seen as less fit for other kinds of contributions and roles. This double bind leads to the situation wherein *both* reproductive domestic labor and women's "productive" remunerative labor are undervalued. The infamous "wage gap" is acknowledged to be largely a function of motherhood, whether actual or potential, and a "second shift" of unpaid reproductive labor awaits many women at home after their formal work (Hochschild and Machung 1989). This is hardly the first time this problem has been raised, as will be discussed below, but it is inflected in particular contemporary ways.

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This particular Western "double bind" wherein women have a conflicted relationship to the polis can be traced back at least to the 18th century.[8] Philosopher Rebecca Kukla (2005) cites the 18th century as a crucial turning point in Western thought about mothers' bodies.[9] She shows that before this point, back to Hippocrates, medical tracts were emphatic about the ability of the mother to impair her offspring in the womb. A pregnant woman's thoughts, desires, and experiences were understood to be able to mark or harm the fetus, causing the delivery of a "monster," precipitating a miscarriage or stillbirth, or irregularizing the child with a birthmark or prominent physical or temperamental features, which were all considered highly probable. A live and "normal" child was the height of what could be hoped for. Women's bodies were seen as highly porous, leaky, unpredictable, and susceptible to

[8] Arguably, it dates back further, to the advent of capitalism. See footnote on "the Woman Question" below.

[9] Notably, her analysis only considers written perspectives, not folk wisdom.

influence, needing firm direction and protection. In Hippocratic medicine, Kukla claims, the womb was considered mobile and able to float throughout the body, causing hysteria, which was the seat of all women's ailments. These beliefs yielded what Kukla calls the archetype of the Unruly Mother, who was potent, dangerous, unpredictable, and in need of regulation to prevent harm. By contrast, after the 18th century, another archetype emerged and coexisted with the Unruly Mother. This archetype -- the Fetish Mother -- was an ideal of motherly perfection, in which a mother could shape her child through an all-encompassing and flawless exercise of maternal care, with no upward limit on how positive her influence could be. Both archetypes persist to this day, Kukla claims, and it should not be hard to recognize the Fetish Mother in the "new momism" and "intensive mothering" contemporary popular writers describe (Hayes 1996, Douglas and Michaels 2004).

The changes in Euro-American political thought in the 18th century were intimately linked with the rise of this ideal motherhood. In this period, the political and cultural division between public and private (or civic and domestic) spaces was intensified, and with it a set of gender relations that naturalized women's "place" in the latter. This separation of public from private followed the division of productive from reproductive work that accompanied wage labor and the transition to a market economy (Federici 2014, Ehrenreich and English 1975, Pateman 1988). Political theorist Carol Pateman argues that the new civic institutions and democratic governance that were part of Enlightenment-era political shifts originated a new kind of public sphere, which is described in most Enlightenment histories, but also that these new politics entailed the creation of a "shadow" private sphere where domestic concerns would take place; the one was the condition for the other, she claims (1988). She also argues that under the aegis of liberty, equality, and individual rights, a social organization based on

monarchic patriarchy changed to one of democratic fraternity, where men were made equals in a social contract and women were implicitly written out of political subjecthood, as they became the domestic counterparts to the newly empowered citizens, forced by circumstance into what Pateman calls a "sexual contract" instead of a social one.

In this period, contractual relationships between parties who were supposedly self-interested and equally endowed with rights and protections became the primary basis for politics, law, and trade, but because women (as well as people who were not white, free, or property owning) were not fully members of this political fraternity and were in fact conscripted to a necessary supporting role in the socio-political order, they were never self-owning individuals "free" to make contracts.[10] Pateman argues that subordination is implicit in the idea of contracts themselves, because they treat people in different social positions and different bodies as if they were equally free with equal options and concerns; such is clearly not the case in the heterosexual marriage contract, the employment contract, or the indentured servitude contract. The decontextualized, disembodied, contract making, self-owning individual is "the fulcrum on which the modern patriarchy turns," she writes (14). It is not possible to simply treat women "the same as men" within this framework, as the framework itself is predicated on the exclusion of domestic life from political life, and for historical, cultural, and biological reasons women have different stakes in domestic life than men do.

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[10] Pateman argues that Enlightenment politics instituted the subordination of women to men *as a group,* instead of to one's particular husband, father, lord, or king. She claims that entering the 19th century, embodied sexual difference was not only inherently linked with economic difference via reproductive labor, but political difference as well, via the categorical right of men to access women's bodies and domestic spaces/labor, and women's categorical exclusion from political life.

Sociologist Barbara Ehrenreich sheds light on women's alignment with the domestic, private sphere by examining "the woman question," a public discourse about women's place after these Enlightenment-era economic and political transformations that created a host of divisions and differences in social life, and particularly after industrialization caused more social upheaval (2005).[11] Bourgeois women increasingly and unsurprisingly began to find their political and economic exclusion hypocritical, frustrating, and depressing.[12] (Non-whites, slaves, and those who did not own land were also excluded, thus for women in those situations the conditions of oppression were heavier and less able to be "questioned").[13] Ehrenreich claims that there were two socially current approaches to answering this woman question, which she calls Rationalist and Romantic. Within the Rational approach, if "progress" meant mechanizing and industrializing the functions of life, why not include domestic and reproductive tasks in that movement, and include women in the workforce just

[11] "The Woman Question" was a topic of social discourse in two epochs, France/England entering the 16th century, and US/UK/Russia in the later part of the 19th century. The first epoch coincided, unsurprisingly, with the transition to capitalism. "Querelle des femmes" was first used in France to describe a debate about the goodness of women in general and whether it was good for a man to marry; subsequently there was debate about whether or not women should be allowed in universities or could be capable rulers. More commonly, and more aligned with Ehrenreich's usage, "the Woman Question" describes social unrest in the latter half of the nineteenth century over issues of women's suffrage, reproductive rights, bodily autonomy, property rights, legal and medical rights, and marriage.

[12] This question was not simply an academic curiosity - energetic women of privilege were having depressed, nervous breakdowns, unable to either care for their household or enter public life. Where they belonged, and what was the point of their life, were not questions former generations of women had had to consider in the same way. Jane Addams, Margaret Sanger, Charlotte Perkins Gilman, and Ellen Swallow are famous examples of those who recovered from years or decades of dysphoria and were motivated to change society. See Gilman's well-known short story "The Yellow Wall-Paper."

[13] The Enlightenment and the French and American revolutions were anti-nobility and steeped in sentiments of class uprising, but far from establishing an egalitarian order, they heralded a kind of oligarchy in which the interests of the wealthy were protected.

as men?[14] The competing Romantic approach won out in bourgeois thought. According to its logic, the domestic realm was equated with *home* and romanticized -- along with women -- as the site of the emotional-biological appetites for food, sex, rest, beauty, and associate with powerfully evocative connotations of intimacy, feelings, comfort, nourishment, and softness, fundamentally opposed to the ugly, brusque, calculating working world of factories, and later offices. In the Romantic view, Ehrenreich claims, women were both subordinated and held on a pedestal. Children also became associated with the realm of home, and not coincidentally this is when childhood started being romanticized as a time of innocence and purity apart from the harsh realities of the world. Prior, children were household members who participated in the work and life of the family to the extent that they were able (Zelizer 1994)[15]. Ehrenreich argues that bourgeois women found this Romantic account compelling because it was linked with rationalist Science, which was held to have liberated society from the patriarchy of church and king. It heralded progress, and bourgeois women had a "romance" with it that obscured its more regressive usage. They accepted its authoritative

[14] Such a possibility has been expressed in recent fiction from *Brave New World* to *The Giver*, notably both considered dystopian. In Huxley's *Brave New World*, babies are made in factories in glass incubation bottles, "decanted," and raised/educated in institutions until adulthood. "Mother" is a disgusting word/concept and women and men are encouraged to practice sexual promiscuity. In Lowry's *The Giver*, only certain females are chosen to gestate young as a career/calling, and the babies are nursed in institutions and placed with a family unit around toddler-age.

[15] Of course, the romanticization of childhood happened first in wealthy families and gradually expanded to include poor children, through child-labor laws and universal education. Child participation in work (both wage and domestic labor) is still class coded.

voice for "150 years" (the title of Ehrenreich's polemic is *150 Years of the Experts' Advice to Women*).[16]

The romance of motherhood was also an important part of the political project of the Enlightenment era. Enlightenment philosopher Jean-Jacques Rousseau's *Emile*, which was a polemical tract about child rearing, was highly influential during the period in which it was published (1762). A new political order required a new kind of person -- a citizen -- and that required a new kind of education. The (male) child's education depended largely on his mother (the final section of the book discusses "Sophie," a female child, as a sort of afterthought). *Emile* instituted and naturalized women as caretakers, upholding their reproductive work as a kind of sacred patriotic duty. Kukla cites it as very influential in the development of the Fetish Mother archetype. *Emile* was particularly emphatic about the importance of breastfeeding, not for the nutritional reasons that are much touted today (nutritional science did not exist), but for emotional and "natural" ones that hailed bodily maternal nurturance as crucial to the new citizen's formation. Science historian Londa Schiebinger (1993) shows how the politics of breastfeeding of this era were so important that they influenced the adoption of the term "mammal" in the new taxonomic science, marking mammary glands as the most important shared feature of the group that included humans, and establishing breastfeeding as crucial to humans' place in the "natural" order of things.

[16] Ehrenreich's chronicling is of the hegemonic class's values, norms, and concerns; for poor women, not to mention slave and indigenous women, the terrain of options and questions was completely different. Yet neither were hegemonic values and norms unrelated to the aspirations and dissatisfactions of marginalized people.

Chapter 4

Exaggerated Temporalities:
Nature, Nostalgia, and the Bounds of the Human

> From week to week I felt my body shift into different cycles, like some slow-motion, flesh-based washing machine... I did not feel like an animal, I felt like a clock, one made of blood and bone, that you could neither hurry nor delay... There was no technology for it: I was the technology."
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> Anne Enright, *Making Babies*

Birthing From Within

"There are three types of knowing in labor," explains Kristen, the childbirth educator hired to give private lessons to my doula client, Jasmine. "Primordial, modern, and self." It's a cold and grey summer Saturday in the Mission district of San Francisco, and we are seated in the bedroom of Jasmine's tastefully decorated loft apartment, Parisian prints on the wall and the sound of her roommate's kitchen tinkering muffled in the next room. The two of us are facing the large pad of paper leaning on Kristen's easel, where she is writing down the three kinds of knowledge. "Primordial" she scratches with her marker. "This is like a gut feeling. It's something you know without thinking about it." I had been listening for references to "intuition," one of my key terms, and my mental flags went up at Kristen's words.

When I later looked up the three terms on the Birthing from Within website, which was the childbirth education franchise that had trained Kristen, I found primordial knowledge described as "the innate maternal instinct. Women have this knowing in their bones! And they are in this knowing when they are *not* in their thinking mind!"[1] I was surprised by the extent to which the language of the website naturalized a Cartesian trope, locating such knowledge in the body and actively opposing it to "thinking" and the mind. The fact that it was called "primordial" likewise called upon dualist tropes of mind-body hierarchy: primary, primitive, first, lower. It called up *primates,* but not to denigrate them. In a way, it flipped a dominant hierarchy on its head, if only for this particular situation. The website explained that social conditioning has taught modern humans not to trust or act on such gut knowing until we have "thought it through" via research, second guessing, or checking with others. Therefore, "One of women's modern tasks of pregnancy is to first *learn to feel* their gut instinct and to

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[1] This was an article on the Birthing From Within Blog, England and Bobro 2014.

distinguish this feeling from fleeting fear (or the contagious fear of others)" (my italics). I wanted to know more about this skill that is innate yet must be learned. A rather classical paradox was already apparent. The class was oriented around *learning* how to access this kind of knowing, how to recognize it and trust it. Doesn't such intentionality make it acquired rather than innate? The idea that "primordial" knowing is innate is part of its romanticization and naturalization. Romantic naturalization is also present in the biological gender essentialism that accompanies such discourse. The website's final point about primordial knowing was that birthing people must "awaken the fierce protective mother within and boldly act on their gut instinct," naturalizing such instinct as part of feminine biology.

Back in the loft, the scent of green tea wafts in from the kitchen, mixing with the marker's sharp chemical aroma. Jasmine stands up to shut the bedroom's french doors against the ruckus of a delivery truck in the alley below, men hollering as they service the Thai restaurant downstairs. She sways from foot to foot as she walks back to her chair, her curtain of straight black hair mimicking the motion, and when she sits she distractedly strokes her grey chenille tunic where it's stretched over the round protrusion of her belly.

Kristen continues to explain that "modern knowing" has to do with understanding the logistics of the situation: physiology, hospital protocol, information about risks, tools, and options. She waves her freckled hand in the air as if to dismiss this as kind of boring but necessary. Finally, "self knowing" is "knowing who you are and where you come from. It's

knowing what you feel comfortable with, and why," explains Kristen.[2] This third kind is the most important, she says, and the focus of our sessions. This is in line with what I know of Birthing from Within's philosophy, which incorporates couple-based artwork and spiritual metaphors like labyrinths to guide parents on their "childbearing journey." Jasmine's course is held over two Saturdays in her home. Jasmine couldn't fit a standard childbirth preparation class into her full-time work schedule at a philanthropic investment consultancy; such courses often meet on weekday evenings for six to eight weeks, and many of them were already full, so she opted for a private "crash course" and invited me, her doula, to attend.[3]

A little bit later, Kristen revisits the broad topic of knowing. "There's a hormone cocktail in birth that switches moms from left to right brain thinking." Kristen's blunt-cut blond hair swings over her shoulder as she leans forward to explain. "It's about activating that deep brain stem area, the amygdala, not the prefrontal cortex." In basic neuroscience, with which she

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[2] The website, which was speaking to educators, elaborated:

"The second kind of knowing is **modern knowing**: being savvy about what's happening in the hospital. Like it or not, and whether parents are planning to birth at home or in a hospital, one of the modern tasks of birth preparation for **all parents** is to learn about the hospital birth culture in their community. Modern knowing includes holistic preparation for all kinds of possibilities, including inductions, cesarean birth and navigating through postpartum. This kind of knowing may actually help parents decide where they want to labor. Even if they are planning to labor and birth at home, knowing about the hospital they would transfer to if needed will help them to be resourceful in a crisis.

"The third kind of knowing, **knowing thyself**, is the most important. It should be mother's first priority during her preparation for birth as a rite of passage--and the priority of your classes and sessions. Before she can know where she is going, she need to know from where she came and where she stands now. The reason is this: We inevitably "choose" books, classes and birth companions that are in alignment with our assumptions about birth. We rarely "choose" based on what is happening Now, and what we are learning NOW. Usually we just do what feels right or familiar. What feels right is usually what fits with what we learned to trust as a child."

[3] Her husband declined to be involved with the birth process, which was something she struggled to accept and account for.

presumes we are conversant, the brain stem is thought to be responsible for systemic and motor function, the amygdala for emotional response and memory, and the prefrontal cortex for decision making and cognitive behavior. Analytic thought is supposed to come from the left brain hemisphere, and creative thought from the right; it's become a truism that people are "right brained" or "left brained" depending on which kind of thought they have more affinity for. According to the Birthing from Within epistemology, the "hormone cocktail" acts the same for all birthing people, moving them from controlled, organized, logical thinking, to a "Labor Land" where "instinctual, emotional, intuitive, creative, and meditative" thought reigns. This instinctual-emotional state is at once a goal and a compulsion, as hormones are thought of as an involuntary biological response, yet one can learn to be more or less open to their effects. "Natural" and "biological" hormone function is presumed to be both desirable and obligatory, yet also somehow apart from the self that can accept or fight against such bodily imperatives. There is an interesting blend of intention and inevitability in this philosophy: one can set out to practice accessing and trusting "gut instinct" and also mentally (i.e., using the prefrontal cortex) prepare oneself for the biological compulsion to shut off the prefrontal cortex. Such preparation is the goal of Kristen's course.

At a longer-format Birthing from Within class in Santa Cruz at which I assisted, the instructor emphasized the importance of a meditative mental state, of being "present," a state that enables "non-reactive behavior." A reaction is a defense. In a properly cultivated birthing space, one is safe and there is no need to defend, but "your body doesn't know that," she said. "One can't think clearly when the brain is flooded with adrenaline." Certain hormones like oxytocin are helpful (even essential) to a "primordial state" for birthing, but fear and stress hormones like adrenaline and cortisol are not. So, the thinking brain has to override the body

in order to enable the body to act, in a deliberate crafting and cultivation of "instinct" through a parsing of embodied faculties. The instructor's guidance encouraged birthing people to similarly craft the social situation, by "calmly working out problems" from their meditative state, without either creating or avoiding conflict, and speaking "from a place" where they didn't desire to appease anyone. Such a place was presumably available to them because of all the self-knowing they had cultivated. Deliberate self-knowing enables "trusting" one's judgment, and deliberate management of hormones via managing one's own affect enables "trusting" the body to do what it needs. Evidently, some kind of self apart from the three knowledges exists to arbitrate between them. Such are the acrobatics of teaching people to be animals.

There is a lot of slippage in this epistemological theory -- primordial knowing is similar to, but not quite the same as, "right brain" knowing, which is likewise similar to but not exactly brainstem and amygdala function. The same is true for the overlap between modern knowing, left brain knowing, and the prefrontal cortex. Self knowing is presumably a mixture of emotional and analytic thought. This explicit discussion of the knowledges needed to birth "well" mixes neuroscience with primate-nostalgia, blends woman as hyper-self-aware with woman as instinctive animal. Contemporary Bay Area birth worlds are a site of active play with the nature/culture binary, wherein the idea of the "natural" is fetishized in myriad ways. One way to conceptualize this is via an intensified temporality, where "nature" overlaps with an idealized past and "culture" is problematized as coextensive with "futuristic" widespread technology use and the late-liberal, post-industrial ills that accompany it. Broader cultural anxieties about the future, and particularly about whether it is developing in the right direction, are exercised in birth worlds with often-nostalgic rhetoric about natural states,

practices, abilities, and qualities. At times, the essentialized natural is exemplified by the primate, a figure wielded as unequivocally pre-cultural and therefore authoritative. Less frequently, the figure of the cyborg is likewise wielded as indexing a dystopian future where technology compromises what it means to be truly human.

Donna Haraway's *Simians, Cyborgs, and Women* (1990) introduced the primate and the cyborg as figures occupying border zones and troubling the persistent dichotomy between nature and culture in Western modernity. The cyborg, a term that now rings quaintly of science fiction from before the personal computer, evokes escape from rigid dualisms through its combination of organic and technological components. The simian, as a primate "like us" and yet located on the other side of the human-animal divide and thus wholly different from us, likewise troubles categories and presents epistemological problems. Haraway's collection of essays argues that women are likewise such a liminal figure, having been culturally associated with nature and bodies yet persistently claiming membership in economically and politically charged cultural and intellectual collectives. In Californian childbearing, intensified futures mix with intensified pasts via hyper-technologized processes and the imagination of a primal reified nature, tussling over the territory of women's bodies and energies. Haraway calls simians, cyborgs, and women "monsters," which demonstrate, which signify: "The power-differentiated and highly contested modes of being of these monsters may be signs of possible worlds -- and they are surely signs of worlds for which we are responsible" (2). She writes that border monsters are "those who refuse to adopt the mask of either 'self' or 'other' offered by dominant narratives of identity and politics" (2). The ways in which ideologies of nature and culture are both reimagined and reified in childbearing practice and discourse speak to this kind of potent instability, and with it they offer opportunities for different futures.

Paleo Parenting

Haraway explains that in animals, but most especially primates, we polish a mirror "to look for ourselves" (1990:21). "Primal pregnancy" or "primal parenting," terms I coined, refer to how supposed biological urges and instincts are used to justify so-called "natural" practices, thereby naturalizing gendered views of social production and reproduction. This justification of certain childbearing practices by looking to primates is epitomized by a panel at the 2014 annual meeting of the American Anthropology Association called "Paleo Parenting." It used the anthropology of primates and "primitive" societies -- who were problematically fused in the epistemological premise of the panel -- to advocate for "modern" adoption of intensive parenting practices. Such practices included extended breastfeeding that delays weaning until well past the toddler years, skin-to-skin bonding immediately after birth and, subsequently, baby wearing, placentophagy (eating the placenta), and continuous cooperative childcare wherein the baby or young child is never left alone, but is also not the responsibility of one person. I'm not commenting on any of these practices in and of themselves; what's interesting is that they are justified via beliefs about "earlier" evolutionary states[4], whether cultural or physical.

[4] Haraway asserts that feminists have struggled "over the modes of producing knowledge about, and the meanings of, the behavior and the social lives of monkeys and apes" (1). Indeed, such primal parenting ideas are both upheld and decried by feminists, though most of the childbearing people I spoke to didn't take a strong ideological stance; they weighed such ideas against other constraints and imperatives in their lives and lifestyles.

At the Paleo Parenting session, panelists discussed some fabulous neologisms, including "skinship" and "breastsleeping."[5] One argued that behavior in the first hour after birth "was probably critical to survival in the past," as wide-awake babies would root for the nipple and start breastfeeding, releasing oxytocin in the birthing person that helps prevent uterine bleeding. Another claimed that the mom's body is the baby's habitat, its "MEEA" (Micro Evolutionary Environment of Adaptedness), the only environment to which its brain is adapted. In turn, she claimed, babies' cuteness is evolutionarily designed to appeal to humans' brains. A panelist speaking on weaning claimed to have researched what was previously "just a matter of opinion" by "equating humans to primate measures;" the bio-cultural evidence suggests that 2.5-7 years is the appropriate age to wean. Panelists laughed about absurd attempts made to try to measure bonding, and claimed "babies have no wants, only needs," implying that denying them is an essential deprivation.[6] Following this was the research-based assertion that the "sustained tactile interaction" of sleeping next to one's baby and feeding it throughout the night gives babies much more neurological stimulation, leading to better emotional security and problem solving abilities as toddlers, and that as teens and adults, bed-sharers are "more happy, optimistic, confident, and close to their family." In an example of intuitive attunement, such a baby and mother affect each other's "sleep

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[5] "Breastleeping" as a term and concept -- namely that infants and their mothers are biologically intended to sleep in close proximity such that breastfeeding and sleeping seamlessly become part of the same activity, said to reduce the risk of Sudden Infant Death Syndrome (SIDS) among a host of other benefits -- was introduced by Dr James McKenna, anthropology professor and director of the Mother-Baby Behavioral Sleep Laboratory at Notre Dame. See ""There is no such thing as infant sleep, there is no such thing as breastfeeding, there is only *breastsleeping*," McKenna and Gettler 2015.

[6] I encountered this latter truism about babies having no wants, only needs, on multiple occasions during fieldwork. It is a core tenet of Attachment Parenting.

architecture," and infants thus influenced are far less susceptible to SIDS (Sudden Infant Death Syndrome).

Discussing tribes in Central Africa, a panelist argued that the model of continuous care and contact between moms and babies was not really common. She claimed that other primates and non-modern people have multiple attachment figures or develop "attachment networks;" among one group, this involves about twenty caregivers, ten of whom are more intense, while another group has a similar distribution of care but after one year the babies become more attached to juvenile females than mothers. The *primacy* of mom as a caregiver should not be confused with *exclusivity,* she asserted. The mother-infant dyad is part of a network that is not supplementary, but essential. A different speaker discussing the practices of "forager societies mostly in Africa" advocated "allomothering" of children in indulgent, low-punishment, mixed groups doing play-oriented work. She asked, "Now that we've established the benefits of paleo parenting, can parents go paleo in the 21st century?" Yes, she answered, there are ways to do it and alleviate pressure on working moms (dads were not mentioned); "paleo" can be modified to be synchronized with "our" lifestyle, though the specifics of doing so were not discussed.

Literally looking to monkeys radically ignores the context in which Americans live today, despite claims about possible modifications. It locates a kind of inexorable truth in primal/primitive/primate states, implying that industrial, modern, and post-modern cultural influence is a corruption of past purity. "Erasing" such cultural influence by examining groups presumed to be outside history, and therefore without such problematic influences, romanticizes "tribal" people as closer to an idealized truth. Most often this truth is couched in the language of supposedly a-cultural biology, asserting that health and well-being stem from

proper biological conditions. As such, this discourse is a bid for authority, a search for a rudder in the sea of divergent "options."

However, not infrequently the deployment of such biological truism is merged with affective and emotional aspiration or discontent, suggesting that much more is at stake. Consider the book *The Continuum Concept,* a popular volume cited on several occasions during fieldwork by proponents of attachment parenting, in which the author (Leidloff) is impressed by the pro-social, well-adapted qualities of the children in the "stone age" Amazonian tribe with which she spends time. Its subtitle is "in search of happiness lost." Searching for the natural in the bodies of childbearing people and their infants is not merely an expression of anxiety about modern health and optimal wellness; it is a commentary on the malaise of modern life. Cultural anthropologist Nadia Seremetakis argues that the American usage of nostalgia involves trivializing romantic sentimentality, "freez[ing] the past in such a manner as to preclude it from any capacity for social transformation in the present, preventing the present from establishing a dynamic perceptual relationship to its history." By contrast, she says, the Greek sense of nostalgia (or *nostalghia*) is "the desire or longing with burning pain to journey [home]. It also evokes the sensory dimension of memory in exile and estrangement," mixing bodily and emotional pain (1996). Bay Area birth worlds' nostalgia for the "natural" past is based not on sensory memory of actual experiences, but on an imagined past presence that speaks to present experiences of lack. Decoupled from experience and memory, this nostalgia is unlike the Greek *nostalghia* Seremetakis describes, but yet it is not quite her American version either. In ways it may be highly sensory, full of longing for a more sensuous relation with the material world and embodied reality, exalting the perhaps-remembered delights of physical closeness with one's infant or parent, and the intensity of labor pain in an

anesthetized world.[7] The practices surrounding nostalgia for the natural in birth worlds suggest that such a longing does transform the present, and is not merely "frozen" sentimentality or mere projection. Yet such longings are rarely expressed in terms of sensuous desire, instead rapidly becoming appropriated into politically and epistemically charged discourses about the "right" way to do things. Seremetakis' Greek *nostalghia* is a sense-memory of home, a longing for a return journey; likely the nostalgia felt by those for whom primal discourses are compelling is not actually a desire to return to prior conditions, but it does seem to voice a desire for a difference located not in an ever-improving future, but in a painfully absent past.[8] Such nostalgia is romanticizing, but it is also potent and transformative.[9]

Many of the doulas and midwives I spoke with extolled the beauty and power of "primal," "instinctive," "animal" states during labor, characterizing them by internal awareness, spiritual intensity, and disregard for social and cultural conventions. Alzbeta, an experienced doula with a preternaturally calm presence, offered this explanation when I asked her about the "labor land" from the Birthing from Within curriculum:

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[7] There is a comparison that might be drawn between the physical-feat appeal of non-medicated labor, and the appeal of extreme sports, both popular among white middle-class crowds -- perhaps both resonate with a search for a non-mediated experience of physical intensity and uncertainty, a reaction against an eminently predictable and comfortable lifestyle. But seeking intensity is playing with fire, and accompanying stories of empowering reward are narratives of trauma and PTSD near birth, though these latter often stem at least partially from the problematic social seizure/management of intense situations. There is an indeterminate matrix of how intensity resonates. This desire for immediacy is also not unrelated to the largely-white appreciation for "spending time in nature" or seeking out "wilderness," which Maria Mies and Vandana Shiva write about as related to colonial-imperialist guilt, loss, and longing (1993).

[8] Fantasies of the past or of origins are foils for the fantasy of techno-medical triumph over pain, death, and uncertainty that characterizes modern Western "regular" medicine.

[9] See also Matt 2011 on the particularly American relationship with "homesickness" and its version of nostalgia.

> It's that place where you really need to get out of your head and go within. Just work with it. Go with the flow, and don't go against it. And I dunno if that's the right terminology, calling it labor land, but definitely I've seen it. An animal instinct. You'll ask a lot of women, they'll say, "Oh my gosh," or the partner will say, "She's gone to that place, and it was really surprising but she went there." You have to go there in order to have this baby.
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> It sounds scary when people talk about it like that. I don't like talking about it because I think it's misunderstood: "Oh my gosh, I need to go to a certain place" or something, no, not everyone needs to go there, but maybe if you're really letting go, maybe do it. It really depends how you process it.
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> Recently with a mother I walked in [the room], and it didn't look like she was in labor. Even the doctor was like, that's not labor, I'm going to send her home, and checked and she was 9cm. She did hypnobirthing... she really internalized everything, right there, went with it. Others it's very different, every birth is individually different, incredible. Maybe that's what she needs to do. I really think it will help you if you go to a different place, call it labor land or whatever else. Ignore everyone around you, think "I don't care."

She talked about the brain, referring to the brain stem rather than the prefrontal cortex, explaining "We are taught in our culture to stay in our frontal brain." She called it a sacred beautiful thing, trusting in a body that knows, a body apart from one's self: "don't try to analyze, just let go and let your body do it."

Extolling the idea that women get into a totally different "place" of primal or animal knowing in order to birth does, for some, activate nostalgia as I described above, yet it is also suffused with biological gender essentialism and class and race privilege. The ability to consider it romantic and sacred to be compared to an animal bespeaks a certain privilege. It requires a confidence that you are generally *not* seen as an animal, that you can *choose* to be "primitive," rather than being dubbed so by others. This confidence is likely more accessible to those who can claim Caucasian heritage, which was at the top of the racial "evolutionary ladder" underlying colonial thought and practice. Animality is coded by gender as well as race (Briggs 2000), and the devaluation of women by association with nature, bodies, and

irrationality has long been a form of masculinist oppression, so it is strange to see it revived as a vocabulary of feminine empowerment. Explicitly dismissing compulsions and habits of acting "appropriate" and caring what people think is ironic, when mere decades ago feminist insistence on pain medication was at least partially because it was "civilizing." Is the shift merely reactionary, and if so, against what exactly?

Ideas about primal purity can be taken to extremes with troubling social implications, yet these extremes also function to reinforce more moderate adoption of "natural" rhetoric. Consider the anti-vaccine movement, which is similar in many ways to contemporary advocacy for "natural birth." In addition to an idealization of "unaltered" bodies, this movement shares a suspicion of technology and medical institutions, conspiracy-theory rhetoric, and an unacknowledged reliance on the social presence of technologies that enable such eccentricity by keeping death at bay. Most childbearing people I spoke with during fieldwork vaccinated their children, but they were often aware of and actively responding to anti-vax rhetoric. Another extreme iteration of an idealized natural body is unassisted birth, or "free birth," which happens without a trained support person present. This is not exactly legal, so birthing people who want a free birth wait longer than advisable to go to the hospital or call the midwife, "planning" to do other than "officially" planned. Free birth was a troubling trend to one of the grandmother doulas from the natural birth movement, evoking, she said, the deaths of mothers in the 19th century due to postpartum hemorrhage or the inability to jumpstart a heartbeat. To what ends do some people pursue such a reactionary push against the intensive pro-technology regulation and management of the 20th century? Again, among my informants, free birth was a limit figure, an acknowledged extreme against which most negotiated their own practical stance. Like anti-vax, it allowed people to subscribe to an

idealization of the natural, a degree of nostalgia, and a critique of institutionalized medicine while still being able to claim that they were not "extreme." By pointing to characterizations of what they were not, they reinforced the social acceptability of their particular nature-culture hybrid.

If primate-nostalgia is the extreme of intensified pasts near birth, what is the corresponding extreme of intensified futures? French obstetrician Michel Odent, who is also a prolific author and much-lauded figure in many Bay Area birth circles, lays out such a portrait in his 2014 book *Childbirth and the Evolution of Homo Sapiens*.[10] In it, he considers how the rising rate of caesarians is causing the human species to evolve such that it might not be able to birth new generations without intensive medical involvement. He posits a thought experiment, asking what would be wrong with a global practice of ubiquitous caesarians, considering how safe and easy they now are? Perhaps a caesarian-dependent species is appropriate to the times. Odent argues, however, that the period near birth is crucial in the formation of lifelong (and intergenerational) human wellness. He calls it the "primal period" and details the probable long-term effects stemming from various experiences a human might have (or not have) during this vulnerable time, from hormone cascades to microbial colonization. Evoking the ways in which humans are processes, rather than entities, he posits that the nature of an environmental factor is often less important than the time of exposure to this factor. (Much newer science about chemical exposure similarly argues that harm depends more on context and timing than quantity, rejecting the framework of looking for "safe thresholds" and disproving the truism that "the dose makes the poison.") Using the language of epigenetics to consider evolution, and citing "epidemics" of non-communicable diseases, from obesity to

[10] First published in 2013 as *Childbirth and the Future of Homo Sapiens*

autism, Odent extrapolates the possible damage caused by near-birth practices not just to maternal-infant outcomes, and not even to lifelong health metrics, but to the fate of the species.

Odent attempts to cut across the grain of conventional chains of cause and effect, positing, for example, that the pertinent difference is not between vaginal and caesarian births, but between births where synthetic oxytocin is present and those where it isn't, or births where the "physiological hormone cascade" has been initiated and those where induction bypassed this process, or births where the trauma hormones of adrenaline and cortisol are present and those where they aren't. Odent writes that due to inductions, pitocin, and caesarians, "at a planetary level, the number of women who give birth to babies and placentas thanks to the activity of their own oxytocin system is becoming insignificant" (18), while reduced breastfeeding also lessens the usage -- and perhaps functionality -- of the oxytocin system. He argues, "There are no other examples of physiological systems that have suddenly been made useless under the effects of changes in lifestyle... oxytocin is involved in all aspects of our reproductive/sexual life, in socialization, and in all facets of the capacity to love, which might include respect for 'Mother Earth'" (18). His book is a call for more research into correlations that have not been adequately investigated, and to this end he started the Primal Health Research Center in London, which collects studies and data from diverse fields that, he writes, could together be used to map the many complicated effects of primal period practices from an angle which is not currently driving research.

In Odent's formulation, the "natural" is hardly romantic or nostalgic; identifying the important and efficacious aspects of body processes from which the muddling effects of culture have been removed (a premise he takes seriously, advocating that births take place in a

dark room, undisturbed, with the presence of a silent knitting midwife as the only "cultural" intervention) is no less than a task on which the qualitative survival of the species as human depends.[11]

Fantasy Breast Pump

The breast pump meeting was being held at one of the "incubators" that helps lucky San Francisco tech startups get started up by providing them a workspace, funding, and mentorship. Three Stanford graduates who had set out to design a better breast pump were chosen by the incubator, and were now hosting a user experience meeting to brainstorm design goals for their nascent product. I had interviewed them a few weeks before, and they invited me to sit in to offer my perspective as a doula. The refreshments included varieties of "Mrs. Patel's lactation treats and teas," made with fenugreek seed to stimulate milk production; the other attendees were nursing mothers.

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[11] An example of a similar, though more logically convoluted, chain of thought comes from the "Indie Birth" podcast series: "*This sort of [natural, midwife-led] birth process really is what's going to keep us going as humans.* That's a pretty big jump, but there's tons of research there behind that, whether it's undisturbed birth allowing bonding to proceed more organically, and then the bonding being what holds us together as glue. These are the relationships that we need to grow up into healthy responsible caring people, and so it matters that these relationships are able to happen. Worst case scenario, 50 years from now, *if every baby is just being born by caesarian section because no one knows normal birth anymore, then we're going to have a big problem with preservation of our species*. So that really is the huge picture for many of us that are choosing outside of this system. It's not just to be different, it's not to be radical, although it is in may ways, it's not to be anti-governmental or, you know it's not always super politically charged for many women. It's simply that they understand that this is the safest way for them to bring a baby into this world. (Midwife Myth 1, about 19:00, emphasis mine; http://www.indiebirth.com/the-midwife-myth-how-to-hire-an-expert-who-isnt-an-agent-of-the-state/). It illustrates the kinds of investments that are being attached to the process of birth. It's "not super political" but the species depends upon it. It's radical but people are choosing it because its' "safe". Relationships are what enable good people, and they begin at birth or even before. The apocalypse is 50 years out.

If middle-class women in the early 20th century thought their bodies were not capable of producing the right *quality* of milk to nourish a newborn human in such a newly modern world, as Apple claims, they were supplanted by early 21st century middle-class women plagued by anxieties about not producing *enough* milk. Beginning in the 20th century, childbearing trends tended toward consumption and expert advice on modern motherhood, intertwined with technological advances marketed as conveniences; this is epitomized in infant feeding. The development of milk-evaporation machines in the 1920s enabled infant formula to be a real possibility, and "scientific" bottle-feeding was championed by early feminists as liberating, while it was vigorously promoted by the medical profession and burgeoning formula industry as more healthful and hygienic (Apple 1987, Baumslag and Mitchels 1995, Swanson 2009 and 2012).[12] Apple describes how some women in this time thought of the resonance between their bodies and their surroundings as having changed over a generation, such that their milk would no longer nourish a baby to thrive in its modern environment[13]. Breastfeeding advocacy in the later 20th century re-established breast milk as the "best" food for infants, evidenced by the Surgeon General's 2011 Call to Action to Support Breastfeeding. Formula feeding persists, often along class and race lines, due at least partially to the logistical difficulty of breastfeeding while working (which is intensified in jobs in which one has little autonomy). Breast milk versus formula is a politically and emotionally charged issue. Particularly among privileged communities, the imperative to feed one's baby breast milk is

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[12] Note that formula was likely very helpful to women and infants who had difficulty breastfeeding, whether the difficulty was iatrogenic or not. Prior, wet nurses would have been used, as animal milk is a very poor substitute.

[13] This echoes Fraser's argument that Southern black women understood childbearing bodies to have different needs after birth in their communities moved to hospitals. (1987)

highly moralized, which, when combined with the logistical difficulties of breastfeeding while working, yields a swath of anxieties about one's ability to produce adequate quantities of breastmilk.

Such anxieties and frustrations were projected onto the fantasy breast pump we were envisioning. The mothers in the group said it should ideally work under clothes, with people around, and while the lactating person did something else (with workplaces that don't provide time to pump, multi-tasking is essential). It should be easy to clean with few parts and crevices, simple to use with no instructions, have mix and match components to suit various outfits and contexts, and work without fail. It would be lovely to not feel like a cow while using it, one stated. Perhaps it could sense when it wasn't set up correctly and alert the user, and have a light to see in the dark for nighttime pumping. Feeling "like skin on skin" would be nice as well. Most of all, it *must* be a stress reducer, not a stress enhancer.

Most interesting was the mobile app that would accompany the pump to track data and provide moral support. It would offer a high five after pumping and let the user know how much milk had been pumped, unless it was less than usual, in which case such information might be "crushing." The app seemed to me an interesting kind of technological "intuition," as the nursing people at the meeting wanted it to not only assuage feelings of failure and guilt, but to help them "connect with the baby's needs" through tracking, praise, and education. "Like a baby health fitbit," one said. It could help them relax about breastfeeding, provide positive reinforcement and reminders, and sync with their phone's backup so the data would be available constantly and not vulnerable to loss. The tenor of our meeting was relaxed and seemed incongruously lacking in high-strung nerves, considering the anxieties being spoken about. When we started talking about whether the app might present information about the

quality of milk, it was suggested that perhaps this bordered on "TMI." But the possibility for empiricism was tempting: one could run an experiment on oneself to see what difference consuming fenugreek products makes!, someone joked. One thing we *didn't* talk about, however, was keeping the pump affordable; when I asked, the price range given by the developers was well out of the reach of the majority of American mothers.

Such a wonderful machine would seamlessly blend into the physical and emotional contours of the childbearing person, enhancing her capabilities and fortifying her wellness. Its fantastic cyborg possibilities reminded me of a hilarious evening of early labor with a doula client, Sylvia. Her water had broken and she was in the hospital trying to get labor started, since infection is said to be a risk of waiting a long time with a ruptured amniotic sac. The staff encouraged starting with "gentle" induction methods before moving to pitocin, and suggested trying nipple stimulation, which releases natural oxytocin that stimulates contractions. Sylvia and her partner didn't think the hospital was a particularly appealing place to do this manually, so the nurse suggested using breast pumps. Sylvia wasn't lactating yet, but they could be used dry without a problem. The nurse helped her hook both of them up, and it was such an awkward funny thing, Sylvia sitting there chatting to us with her dual canisters suctioned on, comparing herself amusedly to the fembots on Austin Powers. If only laughter released oxytocin! The endorphins that it does stimulate surely did no harm, though, and with giggling to break up the tedium and anticipation, her labor started fairly quickly.

The technological marvel of the breast pump illustrates the hybridity of the nature-culture negotiations near birth. It is highly "cultural" as a technological object, yet enables the "natural" practice of breastfeeding. It is a crucial tool for whatever adaptation of "Paleo Parenting" to modern life, in which women work apart from their babies, might be possible.

The childbearing body is surrounded by technologies that empower and disempower, depending on who you talk to: contraction monitoring apps and synthetic hormones, the thin tubing of epidural drips sneaking out of the spine, cotton *rebozo* shawls to manage and relieve the cumbersome pregnant body, fetoscopes replacing ultrasounds for the low-tech inclined, and the specter of the ambulance which enables home births to be "safe." Whether declined or sought, the panoply of technologies proffered by the medical establishment constitutes birthing bodies, and a birthing person's idea of the "kind" of person she is.[14] Most of my informants appropriated technology in mixed ways -- being adamant about not having an epidural or caesarian could be perfectly contiguous with having several rounds of egg extraction and in-vitro fertilization, for example. Often technology is not a "choice," either, but something foisted upon a childbearing body, or found to be unavailable to her when she is in need of it. According to infant microbiome researcher Dr. Dominguez-Bello, C-sections are misdistributed globally -- those who need them can't get them, and those who don't need them are pushed into having them.[15] One can suffer from technology's abundance as well as its lack.

Tools that extend bodily capabilities also complicate body boundaries and beg the question of who controls these remarkable enhancements. The tools that enable sight, passage, and light into the body were "seized" in speculum house parties in the '70s (which were still being held in hotel rooms at some conferences during my field work, advertised by flyers asking "Can you find your cervix?"). The simply constructed menstrual extractors of that era are replaced today by the contraction-inducing drug Cytotec (misoprostol), distributed in semi-

[14] See Grosz 2005 on feminism and prosthetics.

[15] Film, *Microbirth*.

legal channels to facilitate abortions outside the control of medical institutions.[16] Helpfully, the drug also has the benign indication of aiding stomach ulcers. In an internet-facilitated wave of phone-based apps to time contractions, monitor fertility, set up meal trains, post newborn photos on Facebook, and blog birth stories, it is not only bodies but sociality that takes on the cyborg quality of being composed of both organism and technology.

Machines interact with bodies in ways that are thoroughly tactile, from the itchy pressure of the ubiquitous fetal monitor belt, to the chill gel slide of the ultrasound wand extending and enhancing the doctor's vision. Machines offer information about a given situation that shapes a mother or provider's grasp of the experience, including such a role as "intuition" might play in it, as she attunes her senses to account for that information.[17] Machines' presence or absence interacts with human notions to shape the affects circulating in the room. Protocols for proper care involve techniques, medicines, machines, and expertise, all of which change dramatically as technologies evolve. Far from simply offering better diagnosis or treatment, technologies profoundly alter professional responsibilities and relationships between providers, and between providers and clients, not to mention shaping the embodied

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[16] For further information see the resources produced by UC Berkeley Law's Self Induced Abortion (SIA) legal team, https://www.law.berkeley.edu/research/center-on-reproductive-rights-and-justice/projects-and-initiatives/sia-legal-team/

[17] Wendland argues that safety and consumer ideology interpenetrate with the veneration of technology, the institution, and patriarchy in such a way that they become located in the hospital and embodied in the doctor, whose tools and technological expertise become the safe fetal space to be purchased by expectant mothers. "Her eyes extended by ultrasound, her hands by scalpel and laparoscope, her brain linked to databases of the latest clinical research, the cyborg obstetrician seems to guarantee the perfectly predictable product–baby." How can a conscientious pregnant consumer justify buying anything less? Wendland continues to argue that the recent growth in consumer desire for cesarean section demonstrates that many women share a faith in technology, science, and the institution, and perhaps even a distrust of their own bodies (and of the processes of labor and birth) as sites of risk.

experience of all involved (Strathern 1992, Rothman 1993, Rapp 1999, Thompson 2005). In this sense, technology has agency – the fact of something's presence motivates and enforces its use – though this is also true for "low tech" technologies like bathtubs or birthing stools.[18] Sandelowski (2000) argues that Americans feel ambivalence between hope and fear regarding medical technology; in the figure of the nurse negotiating the use of the fetal monitor, she claims we see the essential questions of medicine: is it about care or cure, suffering or science, technology or people?

Cyborg technologies are predicated on their nearness to the body: so near as to be incorporated into somatic awareness, into intuition. Heidegger discusses nearness in his essay "The Thing," claiming that a globalized, technologically mediated world becomes distanceless as near and far become irrelevant. Only by attending to what is physically proximate -- objects, "things," which are particular and not generalizable -- can nearness be known. It is through proximity, and not shared substance, that things that are near each other interact -- via the space between, the space of touch and effect, the void that is filled and against which each party to the nearness is constituted. Technologies *near* childbearing humans are in constant constructive interaction with them. Technology facilitates the regular physiology discussed in Chapter 1 only insofar as it is "distanceless" and abstract; it facilitates contextual physiology insofar as it is immanent and particular, part of the sensory attunement of a given human's intuition.

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[18] Technologies' agency depends on the environment – it is likely that an obstetrician who knows the technique for an external version (manually turning a breech baby by pushing on the mother's belly) will recommend a c-section instead, as per accepted medical protocol; meanwhile it is also likely that a home birth team will use a Mexican *rebozo* shawl to apply pressure for pain relief before they will give pain medication, though both might be on hand.

Similarly, in "The Question Concerning Technology" Heidegger makes a fundamental distinction between technologies that connect us to existence and the world we inhabit, and others that separate us from it. The former are the crafts, the latter are standardized machines; the former work *with* natural forces, the latter challenge them; the former are submissive to rhythms, the latter expedite the "revelation" or "bringing forth" by forcing yielding, exposure, and unlocking. His distinction aligns with the one I made between contextual and regular physiology, refusing the idea that "technology" is inherently and always one or the other. The regular/standardized iteration is more popularly aligned with the term "technology" and its "unnatural" modern associations, though the actual practice of "natural" childbearing is enabled by an entire industry of standardized consumer goods. This is similar to the way homesteading practices that valorize craft production, popular along demographic lines that often overlap with those interested in natural birth, are facilitated and promoted by niche goods stores selling equipment and books that standardize and expedite the craftsmanship. My intent is not to critique the presence of standardized and standardizing technologies, but to point out that "natural" practices are often highly cultural in material ways, and that technologies of both sorts can be put to divergent ends. Craft production of household goods can facilitate a truly "off the grid" and anti-consumer lifestyle, or be itself commodified towards a hyper-consumer luxury mode: craft breweries, craft bakeries, craft babies.

Viscerality

Technology is also present in birth via documentary and aesthetic representation, carried out by cameras, editing software, and social media sites. While browsing my Facebook feed, I encountered a friend's post about a doula who offers birth videography, surrounded by

exclamations to the effect of "How beautiful!" and "Isn't birth amazing?" The videographer filters most of her footage in a gentle grayscale and overlays it with a soundtrack of inspirational acoustic music -- a hand bathing a forehead with a cool cloth to smooth flute notes, a hugely pregnant woman swaying on all fours in the birth tub against soft piano chords, the newborn's pinched face alongside vocals about love. In these personalized videos, the birthing body's viscerality is muted -- no bloody water, flushed and sweat-streaked face, or blotchy purple infant; no vomit or wrenching groans, no smell of feces as the birthing person pushes, mixed with the peppermint oil the midwife matter-of-factly shakes onto the Chux pad to cover the scent and spare her embarrassment. The occasional vocalizations are only rhythmic moaning and gentle encouragements. The montaged format gives no sense of duration, effacing tedium and exhaustion.

In these videos, it appears that the "miracle of birth" and the "power of women" must be sanitized of their corporeality before they can be idealized. The messiness, pain, and danger near birth are not infrequently glossed over in birth world documentation to make way for an aesthetic proper to an empowering physical accomplishment, a peaceful and intimate moment, or a joyous outpouring of love. Even in circles where embodied processes are so romanticized as "natural," the physical body's visceral aspects can be embarrassing. The naturalized idea of the "bond" between mother and baby doesn't allow for complex emotions, including ambivalence, fear, and depression. It is not that this is a fraud or farce -- there certainly are peaceful and gentle births or rushes of love, and the power of the experience is not diminished by skipping over the feces -- but the editing illustrates what is valued about the experience, and visceral corporeality is not it.

Bearing new life is profoundly corporeal. As much as motherhood, parenthood, and reproduction are social, relational, structural, political, significant, and mediated, the material of the birthing body stretches open and pulls and pushes as a new body exits it. Tissues tear. Tissues are compressed and cut and exhausted. Birthing bodies awash in affective intensities tense and sway, moan and grunt, scream, curse, sing, pant, and keep silent. When drugged, they may chat, laugh, sleep. This opening of the flesh can have any number of experiential effects: it can be empowering, cathartic, violent, triumphant, traumatic, gentle, groggy, numbed, frightening, peaceful, orgasmic. Though I don't intend to reify an unmediated "body proper" or the "truth" of sensory experience, I'm tempted to suggest that if there is a "natural" near birth, perhaps visceral corporeality is its closest approximation. Effacing this viscerality is another contradiction and hybrid in the nature-culture negotiations near birth: renouncing the material body as gross while uplifting bodily experience as spiritual and empowering, bowing to norms of propriety, dignity, and hygiene while rejecting "civilizing" technologies. The childbearing body's vulnerability, suffering, and embarrassing tendencies can make people uncomfortable or reactive. It is easier, and not necessarily any less true, to represent the childbearing body as serene and powerful. The frequency of this sort of aesthetic in birth worlds speaks to an uneasiness and defensiveness about unmediated bodily experience, even while romantic discourses about the primal and natural abound.

When I looked through the numerous videos on the videographer doula's website, I didn't recognize in any of them the swooning, tight feeling that floods my chest whenever I'm present at the moment of parturition. For me, this is a feeling equally precipitant to teary smiles and nausea, not categorizable as an emotion. I saw hands being held in the videos, but didn't feel the clammy grip of the birthing person's palm clamping down on mine, my fingers'

tingly complaints about blood flow. There is no sense of time in the videos; I remember, looking through them, a moment when I brushed damp dark hair from a birthing woman's forehead and was struck by how long ago it seemed I had plaited that hair into a French braid, from which those strands had by now come loose; the tender calm intimacy of that act of braiding seemed worlds away from the panting pungent exhaustion that now engulfed us.

Lost in my sensory memories of births, I recalled the rhythmic drone of 1 - 2 - 3 - 4... all the way to ten, when her beet-red face gasps for air. My voice telling her she's doing wonderfully, that this is just what it's supposed to be, that it will be over soon. The doctor's order to press her knee, which I'm holding, out and up towards her shoulder in a seemingly impossible angle, opening the pelvis, and the chaos as new physicians and interns crowd the room to watch the delivery, as if they could understand the hours by being here these few minutes. I remembered bending to the side to peek at the perineum, seeing the black hair matted and waxy and telling her the head is visible, her baby is coming! When I speak, she locks eyes with me, and I feel like I'm naked, like I had better not let go. Sometimes my voice catches. The doctor pours oil onto her gloved fingers and massages the opening, stretching it, preparing it, pressing against tissues that stretch to accommodate the head's circumference. Once the "ring of fire" is past, the rest of the baby is flushed out very quickly. It's a rush of fluid, perhaps greenish from stool, reddish from blood, an unharmonious rainbow against the baby's bluish-purple skin. Parturition has a particular smell -- is it the amniotic fluid? Mingled with sweat, blood, feces, the plastic film on Chux pads and the latex of gloves. Sort of cloying, somehow stale and clean at the same time. The rush of the fluid mirrors a rush of feeling on my part, unbidden, not what I would call sentimental. It's highly somatic -- the nausea -- but when I lean down to tell her her baby is here, she's perfect, she did it, I'm usually tearing up

from relief and an oddly impersonal joy. I stay with her, continuity of touch between our hands; I am careful not to move an inch as the rest of the room crowds around the baby. Somewhere between a few seconds and 10 minutes, the baby is brought to her chest, perhaps swaddled and cleaned with a little striped hat, perhaps in her waxy slimy nude beauty, the throbbing, lumpy, rubbery, pale violet umbilical cord still linking her to the womb.

Chapter 5

Fluidly Surrounded and Inhabited: Microbes, Toxicity, and Stress

"We should swab our grandmothers' vaginas, before it's too late!"

Clara, *Microbirth* film screening, Santa Cruz, September 2014

"Human beings are affected by their environment as soon as they have an environment, and that means as soon as they are implanted in the womb." Gabor Maté, a doctor and author, says these words in the trailer to a 2015 documentary film, *In Utero.* This emphasis on origins may seem extreme, but some emergent birth world discourses consider how human beings are affected by their environment in even more far-reaching ways, ways that challenge the very idea of an origin, an environment, or a person. In the preceding chapter, I took up the technological and the primal (and with them the temporal play of imagined futures and pasts) as figures against which near birth re-negotations of the nature/culture divide are mapped. In some ways, these are negotiations about the semiotic boundaries and constitution of the human. In this chapter, I will consider three different figures that are taken to trouble the *material* boundaries and constitution of the human: microbes, toxicity, and stress. These occupy a new horizon of border transgressions, manifest in childbearing but with more wide-ranging implications. These three figures blur the separation between a human and her environment, both conceptually and materially. They stand in for symbiotic life, synthetic chemicals, and affective connections, respectively. They not only trouble the idea that human bodies or human subjects are discrete units moving through an "environment" external to them; they also trouble the temporality of the human-environment relationship as something experienced in a discrete historical moment. Humans are themselves environments, and environments move and flow through human psychosomatic material being. Effects from this interaction are not immediate or straightforward; they may be latent, persistent, partial, symptomatic, ambiguous. They may be carried throughout generations.

Microbes

I'm walking down a Santa Cruz sidewalk on a warm September Friday, towards the Ugly Mug coffeeshop. Its window is lined with clay mugs sprouting grotesque faces in the tradition of gargoyles, with a hippie-craft twist. I walk into the coffeeshop and meet Juno, the doula whose childbirth class I've been helping at. Her blond hair is spilling out from her messy bun, her soft face smiling warmly, a bit tired at the corners of her eyes. Her speech strikes me as slightly slow; calm, maybe. I owe her money - she paid my dues at the Meet the Doulas night a few weeks before, where doulas and potential clients "speed date" -- so I buy her her chai latte. Other familiar doula faces circulate. Emily, elfin and dark, a young SF transplant I met when we sat next to each other on a log around a mountain bonfire at the doula retreat in June. I thought she seemed too cool upon first impression, with her flowing black clothes and tattoos, but I soon warmed up to her goofy earnestness. Barbara, her face fabulously creased with age and sun, is wearing jeans and polar fleece, the epitome of unpretentious. We both volunteer at a home for new moms in rough circumstances, where she is a wonder: Methadone baby? Struggle with Child Protective Services? She "just loves on them," she says about the mothers, with a dismissive wave of her hand, though it is clear from her stories that she wins their trust through a fierce loyalty, refusing to leave their side even in 48 hour hospital debacles. There is the doe-eyed, intimidatingly smart Alzbeta, with her lovely Eastern European accent. And Meg, who used to be my boss at a foreign language teaching gig; she dropped me an email at the end of the program saying she "actually loves babies" and is going home to the UK to train as a midwife, and could we chat birth sometime?

We are gathering for a film screening of *Microbirth*. The title is a play on microbiome - or microscopic lifeworlds. The film's poster is Earth seen from space: a faintly luminous horizon

beneath dark sky and stars. There is a magnifying glass over the "O" in the title, within which floats a shadowy fetus. The play on scale is not coincidental - here are minuscule ecologies with enormous consequences.

In May 2013, a year and a half before the evening of the film screening, celebrated American food journalist Michael Pollan published the cover story of NY Times Magazine: "Some of my Best Friends are Germs." This was back when the American Gut Project was relying heavily on stool samples from its scientists' own families, before "microbiome" was, if not quite a household term, at least one that doesn't raise many eyebrows in an educated crowd. Pollan writes that there are 10 microbes per every human cell (making us "10 percent human") and that "To the extent that we are bearers of genetic information, more than 99 percent of it is microbial." American guts are microbially impoverished, due to an industrial diet of processed foods, high antibiotic use in medicine and agriculture, living in increasingly sterile environments, and low rates of vaginal birth and breastfeeding. Communities of microbes live in the gut, on the skin, in the eyes and mouth, up the nose... yet the fetus is microbe-free. It is sterile in its amniotic sac. Where does our microbial universe come from?

Pollan describes how, during birth, the fetus is "colonized" by the vaginal microbiome through which it passes, which means that it is covered with the bacteria of the highly non-sterile person who birthed it. This is followed by contact with her skin and her breastmilk, each of which has its own microbiotic ecology. Babies born by Caesarian miss out on this colonial event, and have different microbial gut communities than vaginally born babies (theirs more closely resemble the skin colonies). This difference might affect their immune development and account for higher rates of allergy, asthma and autoimmune problems in C-section babies. A newly born child's microbial colonies are further encouraged via breast milk.

The "mystery of milk" was one of scientists' earliest clues to the microbiome: breastmilk should be food perfectly engineered by evolution, so why does it contain sugars which are indigestible by infants? Scientists puzzled about the presence of these sugars, called oligosaccharides, for decades, and formula companies didn't include them in their products. Now it is known that oligosaccharides are actually "prebiotic" - that is, food for bacteria. Instead of nourishing the baby itself, they are eaten by *Bifidobacterium infantis;* healthy levels of these bacteria keep harmful microbes at bay and ensure that the lining of the intestines is healthy, which is critical to preventing infection and inflammation. So childbearing practices nurture not only the infant but its microbes. Not all microbes are fit to be nurtured, of course, and "nature" has provided for that as well. Breastmilk transfers the mother's immune system to the baby in real time, priming her for the actual pathogens she is encountering; it contains antibodies that kill harmful bacteria and viruses on contact, yielding "old wives tale" remedies like using breastmilk to relieve infant eye infections.

Back at The Ugly Mug, *Microbirth* picks up where Pollan's article left off. It emphasizes the importance of vaginal births, breastfeeding, and immediate skin-to-skin contact between infant and birthing person, then introduces "vaginal inoculation." When c-sections are inevitable, says Dr. Maria Gloria Dominguez-Bello, the newborn could be swabbed with vaginal fluid to attempt to simulate vaginal colonization. This "vaginal swabbing," another term by which it is known, is under formal clinical trial in Puerto Rico, led by Dominguez-Bello.[1] The film is full of apocalyptic rhetoric backed up by science. The

[1] It's worth noting that Dominguez-Bello does not vilify c-sections themselves, but their overuse. According to her, c-sections are misdistributed globally - those who need them can't get them, and those who don't need them are pushed into having them (this problem, one might say, is true for technology in general).

"initial colonization" in the first few moments of non-sterile life is the "one chance" babies' guts have to learn which microbes are good, and which are bad. Bodies are described as ecosystems, which, like other ecosystems on the planet, are shrinking in biodiversity. Our lifestyle has corrupted not our bodies, but our ecosystems; people are not sick, "the system" is. The film gestures towards an "antibiotic winter" when antibiotic-resistant bacteria will be unstoppable, expresses concern that an interconnected world will soon make pandemics inevitable, and warns that non-communicable diseases (NDCs) will bankrupt our healthcare system.

But most striking are the implications of the idea that compromised microbial ecosystems are not just related to the diseases of a generation, but that the consequences are *heritable*. Microbial genes outnumber human genes in a human adult by a factor of at least one hundred to one; it appears increasingly likely that this "second genome," as it is sometimes called, exerts an influence on our health as great and possibly even greater than the genes we inherit from our parents. But while inherited genes are more or less fixed, it may be possible to reshape, even cultivate, the second genome, a process which spans generations. Detrimental epigenetic consequences of microbial colonization don't stop in one person's gut, and can't be headed off by swabbing a new baby with vaginal fluid. You can't go back in time. You are what your grandma ate. There is a "maternal microbial heritage," which is compromised by c-sections, artificial hormones, and formula, among other things. The film continues by discussing how gut bacteria affect the nervous system and brain. The stress of labor primes the baby's immune system epigenetically via hormones that have long-term effects on metabolism. Hormones and stresses in vaginal birth have a lifelong effect:

"Emotions [in birth] set the template for future life."[2] The film ends with a call for big research into the question "how do we know we're not altering the course of humanity?"

After the credits run, and the lights are turned on, the atmosphere in the Ugly Mug is heavy. The 30-40 person audience is mostly birth workers -- doulas and some midwives and nurses -- and all stay for the discussion. Most of us practice in hospitals, as by far the majority of births happen in hospitals. We discuss the prevalence of antibiotics in birth and childhood. If a mom runs a fever during labor, the baby gets antibiotics via an intravenous drip in the mom, and/or after birth. Antibiotics are prescribed for many infant and childhood illnesses. Thirty percent of women are positive for group B streptococcus (GBS), and their babies receive antibiotics during birth (we should use chlorhexadine instead, the speaker asserts).[3] Regarding reducing caesarian rates, Juno says "Everybody's jumping on the band wagon now, and that's fabulous." Tara, a midwife whom I know only by name, says that the film mounts further evidence from within the scientific community against casual Caesarians, widening the gap between evidence-based medicine and common hospital protocol. "Obviously we're not using evidence-based practices," she asserts, referring partly to the lack of knowledge about long-term effects of many medical procedures, partly to the force of arbitrary conventions which stubbornly endure in medical protocol. Someone I don't know complains that "We interfere instead of defaulting to nature," presumably referring to

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[2] Pitocin, the ubiquitous synthetic oxytocin used during labor to stimulate contractions, only works via the bloodstream, while biologically produced oxytocin goes into blood *and* neural matter; presumably, oxytocin is not produced when pitocin is driving the birth process, and the neural effects are lost.

[3] Chlorhexadine is an inexpensive antiseptic that has been shown to be as effective as antibiotics at preventing transfer of GBS from mother to infant when used as a vaginal wash during delivery.

American medical culture at large. There is no medical protocol yet for vaginal swabbing, "so let's make one," a third person suggests. "We'll *force* evidence based medicine." The totem of evidence-based medicine is fetishized among reformers in birth communities, as discussed in Chapter 1: science, insofar as this refers to conclusions based on empirical results, is not the enemy of "natural birth" and "women," but sometimes seems to be hailed as their foremost weapon against patriarchal medicine and paternalistic convention! They are in effect claiming that what is needed is not a different epistemology, but better science on its own terms.[4] The audience largely agrees that this film is for birth care providers, not mothers. What we have just witnessed is depressing, heavy, and huge. They suggest that moms could watch a shorter version, maybe, perhaps to sway those on the fence about home birth, but above all it should not be shown to women who've had c-sections - they have enough guilt![5] The overwhelming feeling is that this film screening was preaching to the choir. To conclude our discussion, tall and sagacious Clara in her colorful peasant skirt laughingly-seriously suggests "We should swab our grandmothers' vaginas, before it's too late!"

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[4] This is similar to Adriana Petryna's claim in her book on Chernobyl, *Life Exposed,* in which she says that scientists dismissed empirical material from Chernobyl decades after the incident because it was inconvenient and disadvantageous to corporate-industrial interests and international politics; Petryna doesn't fault "science" itself for failing to account for the biological life that endured after the disaster, but rather the context that caused it to be carried out improperly.

[5] Surely, I think, it's true that washing another layer of anxieties and responsibilities over childbearing people is not helpful, but these statements strike me as promoting their own form of paternalism. Is shielding vulnerable mothers from what might harm them a form of care? A professional or a sisterly consideration? It goes unsaid that c-sections produce guilt among parents in this community, which is itself interesting and marks Santa Cruz as a particular kind of place.

Ideas about vaginal colonization are not without pushback. *Slate* ran a story in February 2016 titled "Forget what you've read: swabbing your baby with vaginal juices is pointless and weird." The obstetrician who wrote the article has a sense of humor and considers birth "natural and humbling," but she is not convinced by the evidence that vaginal swabbing is helpful, and sees a few reasons it could be harmful. Trends such as vaginal swabbing -- like the older trends for delayed cord clamping and immediate skin-to-skin contact -- influence "consumer choice," whether it's items on a birth plan or the decision to supplement one's diet with fiber and probiotics to support microbe colonies. But consumer choices are inadequate in scope: microbial transfer raises questions of how humans are interconnected temporally between generations, both via transfers of actual microbes during vaginal births and breastfeeding, and via inherited epigenetic markers influenced by the presence of microbes and their genomes. It also raises questions of how humans are interconnected spatially with surrounding ecologies. People who live with a dog have more diverse gut microbiota. People who live in dairies and interact with cow manure have far lower incidence of autoimmune syndromes like asthma and allergies. Sparing infants contact with diverse microbial ecologies is not in their interest. As Pollan wrote in his article, "The nuclear family may not be conducive to the health of the microbiome."

Trends and conventions in social and technological practice stem largely from consumer-oriented advertising and short-term corporate profit, instead of consideration of longer-term effects. The technologies that purportedly enabled and promoted microbial degeneration, including hospital birth, industrial food, and antiseptic products, were all hailed as wonderful during the period in which they became common. Heidegger discusses this short-sightedness

about new technologies, stating that technology's power and danger comes from the "enframing" that humans do (1954). Enframing is seeking to manipulate a set of possibilities, but without necessarily understanding the consequences of doing so (or rather, without being able to see all the contingent possibilities). Technology acts on the "occult" level, a level where it cannot be directly experienced -- its effects are unknown, and they outlive its creators. This makes technology insidious. A given technology itself is the tip of the iceberg, as it were - its implications are far greater than meet the eye. Eva-Maria Simms (who I will discuss at length below) argues that to redeem technology, we must recognize that it operates beyond human control or even perception, and interact with it accordingly (2009). She references Goethe's poem, "The Sorcerer's Apprentice", which in my mind is inextricable from Disney's animated *Fantasia* sequence: Mickey, the young apprentice, cleverly puts a spell on a broom to make it carry water, relieving him of his chores. However, he soon realizes he doesn't know the spell to make the broom *stop* carrying water. Desperate as the house floods around him, he breaks the broom in half, but finds that there are now two brooms carrying water. He chops it into splinters with an axe, and the shards rise up into an army of enchanted brooms that drown the house. Modern technologies introduced a host of unintended social practices and biological/ecological consequences that were not foreseen by their creators or promoters, from television, to plastics and pesticides, to epidurals and c-sections.

Ivan Illich (1973) describes technological "watersheds" in a multitude of industries, in which new technologies have amazing positive impacts up to a point, after which they do more harm than good. After the watershed moment, he claims, it is not people who are using the technologies, but technologies that are using the people. He makes examples of transportation and medicine. In the former, the railroad made moving goods and people

enormously more efficient, but the personal automobile introduced household regimes of deadening commuting and bills, as well as national oil-dependency. Likewise in medicine: penicillin and insights about hygiene yielded dramatically better outcomes for sick and poor people, but once a medical industry was consolidated, iatrogenic diseases were increasingly produced, i.e. those arising from medicine itself (see also Illich 1976). A relevant example near birth is the ubiquitous external fetal monitor, which is strapped onto the bellies of the vast majority of birthing people. It has been shown to be inconsequential in reducing morbidity or mortality, and in fact makes it more difficult for the laboring person to move around (which *has* been shown to improve outcomes, in empirical "evidence based" studies). Sandelowski also details how the monitor produces "data" and a routine of tasks for managing the equipment and its data, around which nurses' work revolves, instead of these nurses orienting themselves toward the embodied patient (2000).

If contemporary American society has passed the watersheds for many modern technologies and is wallowing in a sea of unintended consequences to which we are just waking up, where does that leave us? How do we stop the brooms? On the other hand, what is the risk that anxieties about unforeseen consequences will cause a backlash that "regresses" too far (for example, disease outbreaks as a result of the "vaccine choice" movement)? The body is being seen increasingly as teeming with non-human life, on which its survival and health depends. Theorists have turned their attention to such inter-species relationships on divergent scales, to a "microbiopolitics" that calls for a different valuation of non-human life (Paxson 2010, Scaramelli 2013, Yusoff 2013). More particularly in biomedicine, with its institutional memory of the vast improvements wrought by germ theory and its present haunting by antibiotic-resistant "superbugs", such revalorizations of microbes imply a

transformation of medical care itself, not as preventing or treating disease but as promoting health in advance of human pathology.

Toxicity

I'm seated on a wooden bench in the beautiful Asilomar retreat and conference center just outside of Monterey, CA, attending the 2012 annual meeting of the Midwives Alliance of North America (MANA). A fair number of the women seated around me are knitting or doing other handwork in the light of big leaded glass windows, old floorboards creaking with the collective gentle shifting of our weight. The cathedral-meets-cabin main hall with its vaulted ceiling is open to the sea breeze and views of scrubby cypress nestled among sand dunes. In my pressed skirt, black jacket, and flats, I "don't look nearly midwifey enough," as my friend joked when she dropped me off. Soft cotton dresses, chunky sweaters, and boots with tights predominate, as do scarves and colorful earth tones. I am distractedly admiring the long grey braids of the woman seated in front of me, when Sandra Steingraber captures my attention. This is the first time I've heard her speak, and she is brilliant.[6] She's an ecologist talking to us about biomagnification, aquatic ecosystems, and the accumulation of toxic industrial runoff in fish flesh. Biomagnification means that with every link in the food chain, toxins become more concentrated because they remain in the flesh of the consumer. Because there are so many more food chain links in aquatic ecosystems than terrestrial ones, fish are particularly prone to carrying high concentrations of toxins, especially carnivorous fish.

[6] Dr. Steingraber is a scientist, author, and political activist. One of the most daring things she's ever done, she says in an interview, was passing a cup of her breastmilk around the UN when speaking there about embodied toxins. See Buntin 2007.

Mercury is an industrial byproduct of manufacturing some plastics; it is released into waterways, where it bonds with carbon and becomes methyl mercury, a neurotoxin, then starts making its way up the food chain. It is notoriously associated with the epidemic of neurological disease surrounding Japan's Minamata Bay in the 1950s. During fetal development, cells that are being differentiated and knit into organs or into the nervous system are extremely vulnerable - one mistake in the unraveling of a zygote into a fetus can have disastrous birth defect consequences. The womb is not a safe impermeable bubble, as the commonsense contemporary idea has it. The placenta, in fact, actively pumps methyl mercury across the so-called placental barrier, acting more like a magnifying glass for the misidentified molecule. There is a well-known advisory against eating tuna, a large carnivorous fish, during pregnancy because of its mercury content. However, Steingraber insists that not only should tuna be avoided, but there is NO fish that is safe for a pregnant person to eat - all of them embody methyl mercury and other toxins in levels that threaten fetal development. Every fish *on the planet.*

You see, water flows -- it flows through irrigation canals and urban river dump sites, into water tables hundreds of miles from the source of contamination, into the ocean where it evaporates and travels the sky in clouds, and rains down on a different continent. Toxins transcend national borders and their regulatory jurisdictions. Polluted water in warm countries evaporates, condenses over cold countries, and rains down on them. The environmentally conscious people of Finland have some of the most polluted fish in the world. Children living in pristine arctic snow take in seven times more PCBs through their breast milk than infants in California. And toxicity is not just about what one eats: municipal water is often contaminated with agricultural runoff. Most of the exposure to toxins in water doesn't

come from drinking, but from inhaling water vapors, so even if one buys purified bottled water to drink while pregnant, the difference is made up while taking a shower, Steingraber claims. There is no escaping our planet, not even for the wealthy, clean, and thoroughly eco-conscious.

I've used mercury as an illustration here, but there are a number of other highly toxic chemicals that cause damage during gestation and breastfeeding[7]. Lead became notorious around the time of its ban in the 1970s, but is still present in many residential environments via paint, and on major roadsides via leaded gasoline exhaust dust. PCBs, or polychlorinated biphenyls, are carcinogenic neurotoxins that were widely used in industry prior to the 80s. BPA, a component of plastics, is still touted by the plastics industry as safe. Pesticides such as atrazine have been shown to cause devastating sex mutations in amphibians (Hayes 2004). Another reactionary documentary film, *The Human Experiment* (2013), seeks to expose the problem of untested chemicals in consumer products, notably Johnson and Johnson's use of carcinogenic chemicals in baby shampoo sold in the US but not in Europe.[8] A panelist on toxicity at the BirthKeepers' conference, which I will discuss in Chapter 6, claimed that there is an average of 200 chemicals known to be toxic in the umbilical cord blood of a given American baby. The speaker explained that agricultural runoff and fertilizer use in California's Central Valley is causing a concerned-citizens campaign to warn about not drinking the water or eating food that was cooked in it because "babies are dying from it;"

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[7] It's not just female reproductive capacities that are affected: "Many scientists think that the drastic reduction in male sperm count and the rise in infertility in the Western world is due to these hormone disrupting synthetic chemicals which were developed after World War II" (Carlsen et al, 1992).

[8] They have since reformulated the American product, as Thomas reports in a January 2014 New York Times article.

handmade signs proliferate in the neighborhood. "We are the ones who have to write a new future," she concludes, though her call to action focused on elite consumer politics like buying organic food.

All of these toxins are transferred via the placenta. Physicians used to think it acted as a barrier; while it does prevent *bacteria* from entering, the placenta facilitates the transfer of chemicals, including harmful ones. Methyl mercury and pesticides become even more concentrated in umbilical cord blood than in the mother's blood. The barrier myth was shattered in the 1960s with the thalidomide scandal, in which mothers given that drug for morning sickness gave birth to babies with severe deformations, like no arms or legs. The DES scandal followed swiftly in the 1970s, in which teens and young adults suffering from unusual cancers and deformities of the reproductive system were discovered to all have been born to women who took DES during pregnancy in the 1930s, when it was commonly prescribed to prevent miscarriage. DES taught us that birth defects are not always immediately visible. The placenta adapted to harm prevention over millennia, and it doesn't recognize many modern chemicals as invaders and destroyers, of which trace amounts can have major consequences on fetal development. Many others toxins are shared through breast milk. They are more concentrated in the milk than in the nursing person's body; in her talk, Steingraber uses this fact to claim that it is not the adult human at the top of the food chain, but the human infant. Breastfeeding people actually lose toxins from their fat stores in decreasing proportion to the number of children they've nursed; the first child to suckle serves as kind of detox, and after nursing many children, a person gets rid of her own toxins by passing them on.

Chemical transfer via placenta and breastmilk connects generations on a material level every bit as much as microbial transfer does. Both also connect individual humans with their environment in profound and uncontrollable ways. Steingraber insists on taking this broader view of the phenomenon, and refuses to capitulate to the ideology of salvation through consumer choice. But there is a woman in the audience at this midwifery conference who nonetheless raises her hand and asks what fish are safe to eat during pregnancy. What can she tell her clients? Does Steingraber have a list of the most dangerous ones? Steingraber is patient, and explains that that's not the point. We need to take care of the Earth - everyone's babies are at stake, everyone's babies matter. The woman repeats herself, asking what, then, she should tell her clients?

"Tell them to become abolitionists", answers Steingraber after a small pause. Earlier in her talk she had advocated an explicit parallel between ending global dependence on fossil fuels and abolishing slavery in the United States. Slavery was a deeply economically entrenched system upon which rested ways of life cherished by the powerful, a system which adversely affected everyone in society, even if they were not absorbing its worst effects. The same, she says, is true of the petroleum economy. Steingraber is trying to fight "well informed futility syndrome," or feeling complacent about impotence, which she claims is "our" biggest problem. "Abolitionists fought and marched and died," she says. "Political action is part of good parenting; it reassures your children that the world will be OK. Mom's on the job."

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We are what we eat; we are interconnected with other species in this seemingly-straightforward way. But we are also part of food chains and commodity chains that span the globe in political-economic webs that far exceed consumer choice. We are what our food eats, absorbs, and breathes; we are what we wear, what we sleep on, what we breathe, and what the buildings we live and work in are made of. Recent anthropology has explored this imbrication, showing how "contamination" is not a problem of purity but of infrastructure-ecologies in which human and non-human bodies are enmeshed (Murphy 2015, Shapiro 2015). In my fieldsite, what I might call the "politics of Whole Foods" as an organic refuge for those wealthy and enlightened enough to shop there, a way of purchasing peace of mind, was widespread as an ideology even among those who could not afford to put it into practice; such a politics is a social problem. Consumer choice is a distraction, like the "mommy wars" over parenting choices discussed in Chapter 3; both offer the idea that some kind of control or redemption amidst social ills can be achieved through individual consumer practice. The ideology of consumer choice ensures that "solutions" to problems do not transcend the individual level (or, at best, that of the household). Systemic problems are not given attention as such, and cures are prioritized over causes.

Frameworks of consumer choice are appealing in the United States because they rest on the moral and political primacy of the idea of autonomous, contract-making individuals who are responsible for themselves. The purchase relation is, in effect, a contract; however, it is not one entered into on equal terms, as consumers never have complete information about a

product's effects and production, to the extent that they have information at all.[9] As scholars and activists have pointed out, access to relevant information is unevenly distributed along lines of race and class. For example, the Environmental Working Group evaluates cosmetic and household products for environmental and personal safety and shares the information on its website; however, many cosmetic products used by black women are not represented there, and many do not have printed ingredient lists, either (Flint 2017). Moreover, even if such information were available, one person can't monitor everything that she comes into contact with; the anxiety and energy demands would be immense, especially because vulnerability to toxic chemicals is gendered, and women already do an outsize share of selecting, procuring, and using household, personal, and grocery products. Thus, such activists and scholars argue that change needs to happen "upstream" via regulation on manufacturing, and that consumer-citizens need to exert pressure to make that happen (Steingraber 1997, Jain 2013). Rather than a market privileging of choice, an ethic of (mutual or state) responsibility is relevant here -- toxic products should not be among the choices consumers may make, not least because chemicals from purchased products and their manufacturing processes affect the human and non-human collective.

Although fetal and infant development were considered terribly important by many groups in Bay Area birth worlds, risks and strategies for health in the process very rarely included consideration of toxins. I found concerns about toxicity to be conspicuous only by virtue of their absence. Health risks and strategies were primarily articulated by the medical

[9] Access to this information is the focus of San Francisco based consumer advocacy group MOMS, which stands for Making Our Milk Safe. It is part of the Center for Environmental Health, founded in 1996. It is focused on consumer empowerment, not social change. www.safemilk.org

industry; Western medicine is a science of the individual, and, with the exception of fields in public health, not accustomed to commenting on systemic problems, particularly not those that criticize capitalist-corporate enterprises and investments. Pregnant people were concerned with their diets, but the focus of such concern was more on getting enough protein and gaining the right amount of weight than avoiding toxins. The FDA issued a recommendation in 2016 that fertile women not using birth control refrain from drinking alcohol even if they don't intend to get pregnant, recruiting fetal alcohol syndrome to police female sexuality (Victor 2016); but it doesn't advertise methods of checking for teratogenic chemicals in municipal water supplies to people who are actually pregnant, or trying to be so.

The early 2016 outbreak of the mosquito-borne Zika virus that causes birth defects received much media attention, including recommendations that people living in infected areas not get pregnant for at least two years. In my perception, the hype was tellingly disproportionate to the attention given to everyday threats like plastic food containers, flame retardants in sofas, hormone-disrupters in fabric softener, pesticides in tampons, and antibiotics in meat, not to mention looking farther up the production chain at cotton clothing that leaves massive pesticide waste in Indian soil or electronic goods that contaminate Chinese waterways with manufacturing byproducts like mercury. The birth defects that stem from these chemicals, which do not respect national or even continental boundaries, are not much reported or even much understood, though the research that is being done suggests important correlations. Malformations resulting from Zika, by contrast, were easy to identify and easy to avoid, as the risk was localized.

My point is not to assert greater dangers in one thing or the other, but to show that attention (and research) is directed towards problems that are containable, "preventable," and

spectacular, rather than those that are mundane, cumulative, and inextricable from the logistics of quotidian living. As merely a further illustration of this, some scientists suspect that the Zika virus itself originated from changes in climate patterns due to global warming, but cuts to greenhouse emissions are not discussed when media and medical outlets inform people about protecting themselves from Zika. Toxic chemical interference might be responsible for many of the spontaneous miscarriages said to "naturally" occur in up to a third of first-trimester pregnancies, and might cause male and female infertility, medical responses to which center on assistive reproductive technologies to "overcome" the problems, not determining cause/risk for the conditions in the first place. The temporal focus of American cultural-medical attention is on treatment or perhaps prevention, but not on cause. Anthropologist Lochlann Jain (2013) and, again, Sandra Steingraber (1997) both discuss how there is abundant evidence that cancer, that modern nemesis, is *caused* by environmental toxicity that the massive industry of research into "cures" completely ignores.

Media attention on toxicity is bent toward sensationalizing. The 2015 water contamination crisis in Flint, Michigan, brought lead poisoning onto the radar of many younger Americans. While the situation is scandalous at best, murderous more accurately, there are other longstanding sources of lead and contaminated places that outweigh the damage done in Flint. Ordinary, everyday, durable toxicity is much harder to sensationalize. It's easier to think that lead poisoning is a localized issue that can safely be ignored by the non-proximate consumer. Chipping paint in old buildings all across the country, or urban garden soil laden with car exhaust from before lead was removed from gasoline, is not as scandalous as state and municipal government cover-up schemes (though certainly the injustices in Flint, which largely affect poor people of color and which paint the actions of the powerful unfavorably,

are also not reported as much as they could be -- there is much that could be said in this vein about corporate interests, the profit motive, corporate-owned media conglomerates, and political lobbying). The situation in Flint illustrates how toxic exposure is intensified along class and race lines. No one can escape toxicity, but some can certainly afford to limit their exposure. Buying organic food and glass bottles does help; more dramatically, so does not living by an oil refinery or pesticide-sprayed field, not to mention working in one. To quote a midwife at the 2012 MANA gathering, "Midwives may be experts in low risk 'normal' birth, but the world is becoming a high-risk world," especially in low-income communities of color. "The population who can enjoy low risk, normal pregnancy is shrinking," she said.

Nicholas Shapiro writes about how the embodied human sensorium attunes to its airborne chemical surrounds, incorporating domestic chemicals and tracking somatic changes attributable to them (2015). Such attunement makes it impossible to rely on Enlightenment-era ideas about how the transcendence of immaterial reason might "quell spectacular material threats... thereby affirming human distinction and existing social orders." Instead, such "indistinct and distributed harms are sublimated into an embodied apprehension of human vulnerability to and entanglements with ordinary toxicity, provoking reflection, disquiet, and contestation" (369). Such disquieted reflection is on the edges of birth worlds, an emergent field for anxiety, contestation, and perhaps radical imaginaries. The creation of a new life -- the knitting together of its cells, the unfurling of its genes' instructions, the seeding of its microbial populations -- is a process and period ripe for thinking new ontologies.

Stress

I'm in the hallway of an Arts-and-Crafts style office building in North Berkeley, where I've just gotten my hair cut. There is a yoga studio next door, and in the corridor full of windows is a shelf with a potted plant and variety of post cards and advertisements. I pick up a card with a spherical belly on it, human hands forming a heart shape around the navel. APPPAH: The Association of Pre- and Peri-Natal Psychology and Health, is holding a retreat for those who would like to become Pre- and Perinatal Educators. I slip the postcard into my bag, along with one on baby sign language classes, peek into the yoga lobby where there is a big poster advertising prenatal yoga for pregnant women, and step outside into the warm eucalyptus-scented air. As I walk down Shattuck Avenue through the "gourmet ghetto," as this neighborhood of Californian ethnic-fancy eateries is known by students, I think back to the first time I heard of APPPAH. It was also at the 2012 MANA midwifery conference where I met Steingraber, though I encountered APPPAH in the exhibition hall instead of during a session, at a table manned by one of the very few men present. Back then, when I chatted with that man, I'm sure my mouth was slightly agape, as I did not quite believe that people would really attempt to relive traumas suffered during their own births via group hypnosis. Remembering my initial reaction is instructive to me, since APPPAH's premise came to seem pretty normal over my two years of fieldwork.

Perinatal psychology, a field of study and practice that originated in California in the 1980s, is concerned with fetal psychological experience in the womb and during birth. The claim is that the fetus can sense the feelings of the pregnant person whose body she shares, and can sense the tension and hyperactivity of the modern world. The implication is that we humans carry the psychological effects of our gestation, birth, and infancy with us throughout

our lives, whether we know it or not. My initial impressions notwithstanding, APPPAH is less concerned with retroactive healing of adults, and more with shaping the emotional fabric of future humans through coaching the parents of infants. The 2015 documentary film *In Utero* features APPPAH's co-founder, Thomas Verny, MD.[10] In the film, another MD, Gabor Maté, states, "People are conceiving, carrying and birthing children under increasingly stressful conditions. Stress that affected one generation will be played out in the next generation."[11] The trailer juxtaposes fast-forwarded clips of crowds on subways and at intersections, rush-hour traffic, riots, and assembly lines, with voices saying "When we see dysfunction in people, we're actually seeing the imprint of that early experience... An adult trauma is really a fetal trauma."

Thus far, I have used microbes to discuss bodies as ecologies of interdependent life forms whose interaction suffers from industrial effects. I have used mercury to discuss how chemicals flow in and out of bodies with little deference to class membership, ideological identification, geographical location, or even the passage of time. My final liminal figure, stress, is more immaterial than these two, but no less pervasive. It is present in the traumas APPPAH seeks to prevent and heal, and the hyperactivity and aggression of modern social life against which *In Utero* seeks to caution its viewers.

In Bay Area birth worlds, the period before speech is increasingly seen as formative of personhood, and concern with fetal and infant experience is not confined to marginal activist organizations. This is a far cry from the mid-20th century idea that infants couldn't feel pain,

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[10] https://birthpsychology.com/press-room/apppah-co-founder-thomas-verny-md-featured-new-documentary-utero

[11] http://www.inuterofilm.com

used to justify hospital practices like unanesthetized circumcision. Adult personality traits, as well as health problems, are being traced back to the events of the near birth period and their affective resonances. For example, people who oppose infant male circumcision -- who often call themselves "intactivists" -- not only find the procedure cruel and unnecessary, but some make a connection between early nonconsensual trauma to the reproductive organs and adult sexual violence, as if behavioral dispositions were coded in pre-linguistic embodied experience. The logic behind the very popular trend of postpartum "skin-to-skin" contact emphasizes that the moments after birth are infants' first impression of the world, and claims they will be less shocked -- which contributes to "birth trauma" -- if they sense a familiar warmth, smell, and voice. Furthermore, some of my interlocuters, such as those who support APPPAH, claim that the benefits of mitigating shock exceed the short-term; a gentle birth makes a gentle human. The sense that this near birth period is heavy with significance extends to the mother as well. One of my doula clients who lives in San Francisco and is a wealthy, professional woman with European sensibilities -- in other words, *not* a hippie -- asked me about placenta encapsulation. Ingesting one's own placenta (usually dried, powdered, and put in pill casings) is an increasingly popular practice rumored to stave off postpartum depression, about which she was concerned. Although she wasn't particularly inclined toward placentophagy, this woman expressed a vague but intense concern that if she didn't do so, she and her baby might miss out on something crucial that they could never get back again.

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Let's revisit Sarah and Roger, Santa Cruz parents introduced in Chapter 3, who were strongly opinionated about the well-being of their chubby and thriving eight-month old son, Gabriel. They were deeply skeptical of institutionalized medicine and did not participate in it in any way. As such, they represented a more extreme ideological position than most of my informants, in which some of these alarmist ideas about affective significance near birth were more visible. About halfway through our interview, we moved to the backyard after a pancake breakfast shared in their small studio in the mountains, where Gabriel amused himself with a stone mortar and pestle and listened for birds. His favorite toy was a wooden hand drill, which looked like a somewhat elaborated dowel that I learned can be used to start fires. They told me they considered beginnings and origins to be crucially important.

Sarah: I wanted Gabriel to be born in a nurturing loving space, and in a hospital it's really hard to create that there. For me, I put a lot of significance in his beginning in the world... I think it affects you for the rest of your life.

... Not that you can't do something about things later, that you can't transform and heal traumas later on, but as a parent, I want to do my best to give Gabriel really positive healthy experiences to build his life on rather than traumatic ones that he later has to overcome and heal.

They also considered infancy to be a time of exceptional openness, receptivity, and wisdom in realms with which adults have lost touch.

Sarah: [Gabriel] has some good friends, that are our friends, and when they come over and they're in a good space, he's just excited to see them. And when they come over and if they're in a dark, challenging space, he'll see them and burst into tears. His ability to see, to just *see*, to read us, in our spiritual emotional selves -- and that's not just him, that's any little person. I try to give him that space to be, celebrating that right now he's developing parts of his being that, as we become more mental and more engaged in the adult world, we lose. Now's the chance to cultivate those things, so that maybe a little thread can be re-woken as an adult by choice, because the seed is there.

That's straight from Waldorf, and from indigenous cultures. We're just reading this incredible book [describing an indigenous perspective], and they just view children as wise connected beings who are much more connected to the spirit world and the ancestors, and much more connected to the elders than they are to the world of the parents. They give space to children so they can connect, and carry it through to adulthood when we forget, we shut down our level of awareness, not perceiving someone's emotional state... As a parent that is my most sacred duty, to allow him the space to grow and cultivate all the parts of his being while he has such full access to them.

They explained how they don't have a TV and don't use screens of any sort in front of Gabriel, that neither Sarah nor Gabriel left their home for the first six weeks after birth, and that they waited for two months to put him in a car for first time. They protected him from loud things, mechanical things, shocks and disturbances, and chaotic spaces like the grocery store.

Sarah: He felt so, so *open*. The newborn is in a state of what as adults we would call enlightenment. Buddha, just total connected, tuned in, heart of everything, they're not separate, they're not -- they're absorbing in part of everything that they're around, so I was extremely protective of that space he was in.

... You go into a lot of homes with children and there's recorded music blaring constantly, never space for the silence. We let him say when he's ready to do something else, give him all the time to do whatever he's doing rather than interrupting with "How about this, let's do this." He's in a place of completely in the present moment, in a way that most adults *long* to be. When he does something, he does it with his whole being. He's wholly in it, and, I just feel totally like, that's the duty of a parent, to give him a nurturing, safe space to cultivate that.

This conception of parenting is incredibly demanding, as discussed in Chaper 3. Sarah was devoting her time and energies to it, while Roger's main work was "doing nature connection" with kids and sometimes adults, which involved leading survival skills courses at UC Santa Cruz, summer camps, and different groups during the school year. He explained that his mentoring model includes "awareness of all the different aspects of nature," and works to connect kids with "really embodied methods, using their own curiosity as inspiration," to

"connect with deeper indigenous parts of our being that have been covered over by modern industrial lifestyle." Sarah chimed in that "that's another theme question" of their lives, in addition to understanding children and babies. She elaborated, "How do we bring what is really healthy about past times when people were connected with each other and themselves and the earth, how do we bring it forward in a way that is truly in our current time? Help us move into the future with real health, for the earth, as individuals, in our connections with each other."

Protecting Gabriel's receptivity was a very embodied endeavor. They always carry him; it was only a few weeks before our interview that Sarah borrowed a friend's stroller for walks because, at eight months, he was just getting too heavy. Carrying babies, they said, requires them to use their muscles and be aware of themselves, as opposed to the passivity afforded by carriers. "I would be horrified to put him in one of those bouncy doohickies," Roger stated, possibly referring to any number of currently trendy infant bouncers, rockers, and swings. Roger talked about the love that he knows Gabriel can feel when he's in his parents' presence. He explained "limbic resonance" as "what mammals have that makes them mammals": a synchronized emotional-somatic attunement to other mammals in their presence, and a need among young mammals for emotional-somatic connection. It's what enables empathy. He told me about a centuries-old experiment in which infants deprived of any adult contact beyond basic care all died, and referred me to the book *A General Theory of Love* to learn more.[12]

Roger said he could remember being a three-year-old kid in a stroller at Disneyland, feeling dazed, overwhelmed, and not safe. This prompted Sarah to recount how at a "welcome Gabriel to the community event" they had hosted when he was three months old, Gabriel, who

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[12] Lewis et al, 2000

was in a wrap on Sarah's stomach, would somatically tap into Sarah's ability to navigate what would have otherwise been an overwhelming amount of attention.

Sarah: Each person came to greet him, and some of the energy coming toward him was intense.

Roger: Even though it's "hi!" [mimics friendly but hyper greetings]

Sarah: So him being on me, I could sense, in my fields of, it's almost like my membrane, that allows me to take things in or gently hold them at bay, he was able to utilize my membrane. I was building the space for both of us, of what comes in and out. A baby doesn't have a filter, and up to quite old --

Roger: Seven, energy healers say... until seven, they can't analyze the incoming stimuli like an adult would.

Sarah: They can't separate themselves from the stimuli. He literally is sharing in the protective space that allows me to choose, "Oh that person has that weird intense energy, or this grocery store is sure really loud, a lot going on here, lot of people's energy, I'm gonna do my bubble." So for me that's almost the biggest thing, direct experience of sensing [him relying on me to feel safe]. He would indicate so clearly, would turn and cuddle into me. If someone else came up with gentleness and invited him to meet them, then he would totally reach out and make sounds. His response to people was so different based on what I could sense in myself was good, safe, respectful.

Roger expressed that newborns need to feel safe; people that have had traumatic births themselves, he said, have greater need for safety as adults than other people. If they didn't get nursed enough as infants, they'll have a sense that they will never get what they need, or alternatively project a callous John Wayne-esque lack of needs. "You can track back these patterns in adulthood, back to certain ages when they're small." He said that Gabriel's birth was healing for he, Roger, himself, who had been born not breathing during a c-section; he said he remembered his mom fighting with the doctor during this time, and knows that he became jaundiced soon afterward (I didn't ask more about what kind of memory one might have of one's own birth, but it rings of APPPAH's idea of tapping into preconscious traumas via hypnosis). Roger said, "With [Gabriel] it was so natural." As discussed in Chapter 3,

Roger and Sarah learned to intuit Gabriel's needs by guessing, checking, and tracking their results, which was a very demanding process; however, meeting what they perceived to be their young child's needs was the unquestioned priority in their life, because of the lifelong implications of such care.

Sarah: By the parent taking the easy way out and making the choice to not be fully available for the baby, for the rest of the child's life, every person it's around is going to pay the price... It has been incredibly hard for me this year, super intense! But the result of that, for the rest of his life and everyone he's gonna interact with for the rest of his life, is so huge. He goes into the world as a secure, healthy person who reaches out to interact out of joy of connecting, rather than need of attention. That is worth whatever challenge and struggle I have been through. You have to raise children you will enjoy being with. You'll be involved intimately for the rest of your life, you can't raise a perfect person or be a perfect parent, but you can give it your all, and see the results of it.

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For Roger and Sarah, it was of crucial importance that Gabriel go through babyhood without "stress" -- which they variously identified as exposure to chaotic and overstimulating environments, a break in his access to emotional-tactile love, and an inability to get his needs met as soon as possible after they arose. Roger and Sarah, like the directors of the film *In Utero*, projected near-birth stress into the future and were concerned with its long-range implications.

In popular discourse, "stress" is a capacious term. It can both result from and manifest as anxiety, pressure, insecurity, and negativity. I consider these experiences of stress as affects, pre-subjective and pre-mediated feelings that are embodied, sensed, communicated, shared, and influenced by -- but not directly dependent on -- person-level events. Affects can be

accumulated in the body through small experiences. They can manifest in the body as tense shoulders, stomach ulcers, headaches, nausea, cortisol production, or a sense of unease. Some actors in birth worlds are claiming that these cumulative affects can be transmitted across generations via the co-embodiment of pregnancy, that they are not contained in the time or space of one individual subject, though the details of how this happens are indeterminate in such discourses. Somehow, such discourses posit, stress affects (re)make our nervous system, that site of fluid passage between molecular materiality and subjective sensation. William Mazzarella (1999) explains that affect is both embodied and impersonal, thus not the same as emotion, which is subjective; interpreting Brian Massumi, he states that "from the standpoint of affect, society is inscribed on our nervous system and in our flesh before it appears in our consciousness. The affective body is by no means a tabula rasa; it preserves the traces of past actions and encounters and brings them into the present as potentials" (292).[13]

[13] A fascinating area for application of this idea is the fetus – people engaged in prenatal psychology, for example, claim that experience in the womb and during birth fundamentally shapes the psychology and nervous system of the people fetuses become. The ways in which the fetus can be said to experience must be affective in nature, if they are not understood as complete subjects yet, and considering that they lack a "surface" for engaging the world as something external to themselves.

The embodied subject is contingent upon, and continually being shaped by, socio-environmental affective intensities across timescales. How do various pasts (including pasts that are communally remembered but not individually experienced) influence childbearing as an embodied, sensory experience for diverse women? Can the idea that senses have histories be explored in reverse – that is, that by creating and sustaining particular kinds of embodied, emotional encounters in the present, the affective register of society-to-come can be shaped? If affect brings past traces of past actions into the present as potentials, as Massumi claims, then affect can carry present encounters – over which we have some control – into the future as potentials. I understand this to be a claim and direct project of various actors near birth, including, but by no means limited to, Sarah, Roger, and the filmmakers.

Parents I spoke with did mention "stress" as such, though it didn't dominate our conversations; more interesting was how the words in childbirth classes were meant to assuage "anxiety", or how emotional "insecurity" was presumed in childbearing discourses, whether they validated or placated it. The affects of stress are recursive and multi-layered. Ideas of stress circulating in birth worlds might include the stressful experience of living in a ubiquitously toxic, aggressive, and fast-paced world; stress about this world in which one's baby will grow; stress about the effects of one's parenting on one's baby, including the effects of one's own stress; stress from the demands of parenting, particularly from doing so in such a way that takes care to avoid subjecting one's baby to stress! Causes of stress are contradictory and unavoidable: stress about losing one's individuality to constant care-taking demands coexists with stress about damaging one's baby by being selfish and claiming personal needs. Ironically, insofar as films like *In Utero* and organizations like APPPAH succeed in spreading concern for perinatal psychology, they also spread anxiety about the effects of stress, which

arguably does little to mitigate the stress itself! This messiness is due in part to the fact that medical, popular, and critical uses of "stress" are blurred, as are ascriptions/descriptions of stress from the perspectives of parents, infants/fetuses, and society. The nature of "stress" itself is at issue in such complex instantiations.

In many of its possible formulations, the causes of stress are unevenly distributed by class, race, gender, and many other demographic markers. It is complicated to compare stress, though, as such an indefinite object does not lend itself to being either quantified or qualified. Vastly different circumstances can generate stress affects, from police brutality to standardized testing. In birth discourses that presumed emotional insecurity, material insecurity was largely overlooked, marking some birth spaces as distinctly privileged. Presumably for parents experiencing material insecurity, such elision would compound the stress of actual precarity with the stress of misrecognition. In a New York Times article from early 2016, a homeless mom who had just left a destructive relationship followed by a long custody battle describes the toll taken on her infant: "I'd failed her even in my womb, dragging her through my stress and heartache. When she was born, she had two scabs on her hands called sucking blisters from trying to self-soothe."[14]

While the perinatal psychology crowd is largely white and well off, concern with affects surrounding birth is not limited to the privileged. For example, the best explanation for the marked disparities in maternal health outcomes between racial groups, notorious from the 2010 Amnesty International report declaring a "Maternal Health Crisis" in the United States, is that they are caused by cumulative embodied racism. The Amnesty report delivers statistics that black and American Indian women are *eight times* more likely to die in birth than white

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[14] Land, February 2016, NYT.

women, while Hispanics are four times as likely; significantly, the high rates of African-American maternal mortality, pre-term birth, and low birth-weight persist after socioeconomic status is controlled for. Disparities, then, are not entirely, or even centrally, a question of prenatal care, education, nutrition, or financial means. Embodied racism, both accumulated slowly over one's own life and passed down through generations, manifests in non-subjective bodily occurrences near birth, and is compounded by the fact that racism is experienced in the hospitals where women give birth and receive perinatal care. The trailer for *In Utero* shows an old photo of a woman picking cotton, while a young black woman says "My grandmother had undiagnosed depression, which then contributed to my mother's stress level as well." It cuts to a scene of her playing with (presumably) her two young sons climbing trees, as she ponders "how that got transmitted to me, and how I was going to transmit that to the next generation... " Stress, here, is used as a sort of racially-coded catch-all for structural, systemic, emotional, and physical malaise and hardship.

Fluid Ecologies

These themes of symbiotic life, toxicity, and near-birth affective connections and tensions were not overt or overwhelming in most of my fieldwork, but they were articulated around the edges where possibilities were played with and futures were hinted at. Judging from the spread and increased traction of much of the activist discourse near birth that has come from the Bay Area and its birth worlds over the past few decades, I anticipate that these themes will become more and more widely salient to the experience and decision calculus of childbearing people, and those who care for them. On a theoretical level, I argue that these

concerns urge us to explore less socio-psychological frameworks for speaking about human experience: ecologies and fluidity.

The term *ecology,* as opposed to environment, marks the myriad actors at work in even the most basic organismic functions: metabolizing, sensing, reproducing. Such actors are human and non-human, material and immaterial, lively and inert. Ecologies are interactions, not the form/field relationship of a human "in" an environment. Furthermore, ecologies are processual -- they take place over time and are contingent, evolving, responsive. They are interconnected with each other, somewhat like networks, but networks presume nodes, and ecological thought as I intend it is better described in terms of fluids. Ecologies encourage us to think not only of spatial fluidity, but temporal fluidity, as boundaries between "now" and "then" are undone, and process becomes more relevant than stasis. In creating the next generation, there has long been a utopian promise of purity, of the future as a fresh start, a chance at redemption -- yet developments in science and theory are increasingly demonstrating how much the past is brought forward into the future. Toxicity and injustice are perpetuated through cells and nerves; "polluted" affects and troubled dispositions are embodied. This is a far more intimate way of thinking about the crises of the anthropocene than mass pollution and global climate change, though of course those also acknowledge the effects of past centuries on the conditions of life for generations to come. When scaled up, as well, intimate ecologies yield a different picture of global crises. Research into the microbiome and "restoration ecology" of the human gut not only reveals each person to be host to (and composed of) a teeming ecology, it raises the question of whether the health of our *species* is a primarily human concern. Is human health perhaps the collective property of the organisms

that are symbiotic with us? Relational thinking always works both ways; it acknowledges that not only can we not thrive (survive?) without them, they cannot thrive or survive without us.

The physiology of childbearing instantiates this relational thinking. Placental blood, vaginal secretions, and breastmilk transfer microbes, chemicals, and possible stress-inducing hormones from mother to baby. These sites of co-embodiment between generations are also sites of co-embodiment with the surrounding world. The connections are not just temporal but spatial. The "motherbaby" is an ecology nested in a wider context. In her piece "Eating one's mother," psychologist Eva-Maria Simms writes "The sojourn in the womb is not merely a matter of the relationships of a series of female bodies with their fetuses. The fetal ecosystem is nested in the ecosystem of the mother's body, which is nested in the larger ecosystem of the Earth" (2009:271). Simms rejects Steingraber's image of the infant at the top of the food chain, because she rejects the idea of a hierarchy altogether. The child "eats" its mother, and the mother gathers her material being from the food, water, air (and, I would add, chemicals, microbial life, and affective intensities) surrounding her. Simms writes, "The fetus' health and the well-being of future generations are intimately entwined with the health of our planet. *The infant is the missing ecological link between human beings and the natural world*: the damage to our environment is not just 'out there,' but it goes as deep as our placentas" (271, my italics).

Simms thinks about phenomenology following Merleau-Ponty and Irigaray, but instead of metaphors of vision or touch, which she says they respectively privilege, she uses the metaphor of the placenta to think about fleshly existence, describing an ontology of fluid permeability and interconnectedness. The placenta is the only mammalian organ that is made up of cells from two separate organisms -- it is neither one nor the other, both one and the other. Placentas are also born, and they die, potentially many times within the lifespan of one

woman. An entire organ in a childbearing person's body exists only to make other life possible. And this is not without a cost: delivery of the placenta is statistically more dangerous than delivery of the baby, as hemorrhage is by far the leading cause of maternal death (Say et al 2014).[15] Simms develops a "placental ethics" in which humans might see themselves as a conduit that holds substances for a time but always eventually passes them back into circulation, via elimination, death, and birth. A decision like taking medication or ingesting pesticides has effects beyond one's own body. Placental ethics, enabled by a "lacto/placental imagination," calls on us to recognize ourselves not as individuals but as integrated in a field of being. We cannot pretend that our embodied reality does not have ecological effects, and neither can we pretend that ecological troubles are external to us. Simms writes, "While it is easy to depersonalize the extinction of other species as the erasure of 'objects'... the toxic placenta affords us no such luxury: the extinction of our species is happening in our bodies" (2009:277). Her claims are alarming and perhaps alarmist, yet her linkage between ontology and practical ethics is compelling.

Human ontology might be reimagined via childbearing, wherein human bodies are open to the world in ways more intimate than perception. We are not *in* the world via vision, nor even via touch, but via a material and temporal fluidity at which microbes, mercury, and stress hint. The female body's power to bring life and death out of itself, to regrow and shed itself cyclically, to be materially intertwined with human and non-human being, is a very different metaphor for life than the self-contained individual immersed in a world of form or

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[15] Notably, California has far outpaced the nation in reducing maternal mortality (it has declined significantly in the state over the past decade, while the national average has risen), and has done so largely by developing specific protocols for dealing with postpartum hemorrhage. See Belluz's 2017 *Vox* article.

sensation, engaging across a distance with other self-contained entities. Visual transcendence (of the tactile) is about rising "above" the world, becoming impersonal and disconnected, as Heidegger describes in "The Age of the World Picture;" placental transcendence is about depth, sinking into the intensely intimate space of the womb, where there are no separations that need to be bridged by touch because the material of existence is more easily understood to be fluidly shared and undivided by surfaces dividing the internal from the external, the self from the world.[16]

Michelle Murphy developed the term "alterlife" to think about human and non-human persistence in the toxic aftermath (2015). The term presumes continuity of life instead of extinction, albeit in indeterminate, altered ways. Survival on a damaged planet necessitates altering how life is conducted; life will persist, but it cannot persist unchanged. Indeed, it is always-already changed -- the concept of alterlife moves away from presuming a prior purity which is then lost or lose-able. It works against the nostalgia described in Chapter 4. Neoliberal value systems present false distinctions and notions of choice, such as between contaminated and uncontaminated spaces, bodies, or products. By denying false binaries and illusions of choice, the question becomes: which violences do we attend to, and which do we ignore? Alterlife disturbs the conceptual chasm between kinds of life, and even between life and non-life, evoking a world aswim with matter, bodies, and energies that bump and melt into one another. An attention to *qualities* thus becomes essential. In Elizabeth Povinelli's words, the difference between life and non-life is a difference that makes no difference (2016). Her term "geontology" signals the obsolescence of the distinction between geology and

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[16] Other scholars have thought with water, fluidity, and gestation as productive metaphors for ontology and ethics. See Neimanis 2012, and Chandler and Neimanis 2013.

ontology, the inert and the lively, wherein the figure of the virus could be seen as a limit. She thinks with geontology in protest against the recent predominance of biopolitical (and necropolitical) approaches to thinking life, but -- as Povinelli notes -- geontology does not succeed these approaches, because something very like it preceded them in the indigenous movements and ecological activism of the '60s and '70s, which was not coincidentally a period of birth activism, as well.

I want to think about altered sociality and alternate conceptions of material relations along the lines of fluidity. My health is tied to your comfort and her convenience, our electricity is the same process and substance as our fish and our plastic goods. A childbearing-inspired fluid ontology such as this would require a different way of being in the world than that offered by liberal rationality. The ability to turn one body into two via pregnancy destabilizes the idea of a bounded body and a subject's proprietary relationship with it. Feminist ethicists, anthropologists, and care theorists have argued for the imperatives of community, responsibility, mutual obligation, and empathy to take precedence over the "freedoms" of contract-making, rights-bearing individuals. Both social and epistemological/ ontological organization are differently visible during childbearing because the concepts, figures, and categories Americans use to negotiate life are both weakened and entrenched during this liminal phase. Fetuses are not in a protected bubble, isolated from the world; apart from their chromosomes, everything from which they are materially formed comes from the air, food, and water that stream through the people bearing them, including what passed through them in the past, even generations ago. The future is not a blank slate, the womb is not a world apart. In a present moment, where the certainty that air, food, and water will sustain human life as we know it is no longer a given, new ontologies made visible via

childbearing are inextricable from new social relations compelling collective responsibilities and protections. Such newness can expect resistance, as almost anything is more palatable than the idea that an entire society's way of life is the problem, except perhaps the idea that scale does not render one person futile. If we are irreducibly related, then one person's actions have incalculable rippling effects through the time and space of our fluid ecologies.

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In conclusion, let's revisit Dani and Jonah, new parents with their two-month old infant daughter whom we met in Chapter 2. They live in Santa Cruz on a small organic farm, and are involved with the University's Center for Agroecology and Sustainable Food Systems. Dani didn't have medication during the birth of their daughter, yet they saw themselves as "going the conventional Western medical route," primarily because they were in a hospital, even though a midwife was their care provider. I asked them if they thought it mattered if Dani had drugs during the birth or not. Jonah quickly quipped that he wasn't particularly concerned about that; microbes were far more important.

Jonah: I think it matters that [the baby] got a really, really large dose of Dani's vaginal juices on the way out, that's what I think is the most important.

Me: The microbe -

Dani: Inoculation -

Jonah: Yeah, and I was really surprised that no one has talked about how to reinoculate if you come out c-section... you need to do something to inoculate, breastfeeding of course, but you need the vaginal fauna.

Me: There's a study that's being done about vaginal swabbing -

Jonah: Yeah, I would've stuck that kid up in Dani's crotch, for sure, for sure [laughter], absolutely. It's so obvious that wherever our microbial activity is taking place on our body, that culture is our immune system, is our intelligence.

While the crickets chirped in the background, Dani breastfed the baby and a friend made dinner for them. Jonah continued to elaborate with a good-natured intensity on how the physical and emotional, the environmental and interpersonal, are interwoven as part of his child's developing consciousness. He described how, around his kid, there was "an unbroken consciousness of being present, and some kind of robust microbial reality." I asked him to elaborate, and his account touched on all three of the figures I've been exploring.

Jonah: So like - she's never had a break in connection with what she needs around her. And what they need is super affectionate, nurturing, supportive energy. On a material level, but also on a psychological, emotional, vibrational level. [Kids need to know] that somebody's always very attentive to their needs and delivers shit before it gets too crazy. ...So there's an unbroken sense of trust and confidence and connection, right? The question of "Am I gonna get enough?" ...hasn't entered the creature.

This morning I was like, "The kid is unapologetic about asking for anything it wants." Like, that's amazing, there's no, there's *nothing* between just joy when feeling joy, and then feeling some hunger or whatever, and expression for wanting it. I feel like that's the psychological emotional piece.

Now, being able to process the nurturance as it comes in at the material level, that's basically the milk. That gastro-intestinal process, that digestion, [is] between whatever's going on digestively with the flora, and then the constant cues of safety and security, allowing the biological, the metabolic, the physiological attention to be on growth, instead of being distracted from growth. You follow me?

So there's these interlocking supports that buffer from stress and line things up and make them productive. So she's able to take advantage of all the nutrition that's being provided, because... there's no stress, there's no psychological/emotional distraction. And because of touch, constant skin to skin, because of constant eye contact, because of constant audio-verbal contact.

In Jonah's account, conventional "categories" blur - material milk and physical touch create a mental/emotional state, and a stress-free infant psyche enables the physiological processing of the material world. Food nourishes the emotions, hugs comfort the gut. Furthermore, it's the microbes, the "symbiont" in Jonah's words, that enable these feedback loops between mental and physical effects, between parent and infant embodied subjects. Microbes support "the material digestion of the nurturance." Jonah next grapples with the

category-blending implications of his philosophy, saying that one could try to separate out the physiological from the emotional or the microbial from the interpersonal, "...and basically sterilize everything and just have a lot of contact, or flip it around and have all of the probiotics without as much psychological-emotional contact stuff." He insists that they are separate but (and?) intertwined, articulating his belief in interconnection while using the category-making words available to him.

Jonah was among the few of my interviewees who discussed the ecological concerns I've been elaborating in this chapter, but I suspect that such concerns will become more and more vocalized among childbearing Californians. Health is increasingly talked about in terms of well-being, an idea which typically encompasses both "mental" and "physical" qualities and their interaction. The origins of well-being are being traced earlier and earlier, to childhood and infancy, sometimes back to fetal existence and epigenetic inheritance, and very occasionally back through a fleshy, affective chain of mothers' bodies, through links of milk and blood that carry past experience into the future.

Of course, whether such increasingly ecological philosophies will inspire action beyond consumer choice is a significant question. Jonah went on to speak about chemicals and their place in the interlocking processes he has been describing. Predictably, he noted the damaging effects of chemical consumer products and how various people in his life made different choices, but did not discuss the role or reach of industrial chemicals, nor any actions designed to push against the problem of systemic toxicity. From his relatively privileged perspective, one can more or less choose to not engage with toxic chemicals if one desires; such is more obviously not the case for communities who have suffered environmental abuse and degradation, like farmworkers exposed to heavy pesticides, residents of poor

neighborhoods with refineries or factories built nearby, or indigenous people living on reservations subject to nuclear testing and oil pipelines.

Jonah: The biosphere of this place [gestures around their home], we don't use biocides, there's no dioxins, bleaches and anti-whatever products. It's really interesting because we have family members, people that basically are using all kinds of hormone disrupting artificial scents, like fabric softeners and colognes and all this shit. It's just -- nasty, and it's so distracting.

Me: Does it disturb her?

Jonah: I think, again, it's kind of middle path [a term he's been using to describe not being ideologically extreme]. She's gonna survive. It's not that big a deal. I don't really stress about it, but it's totally confusing. For us, it's confusing because our kid does not smell like our kid.

Me: Oh, when she comes home?

Jonah: It's like a Jersey parkway factory... I do think it has effects. It could be beneficial in that it's a little stimulating. In terms of adaption, it could actually prompt some good things. But I can't imagine how kids grow up in [an environment saturated with artificial chemicals], and I think it's gotten more and more severe just in the last, like, 30 years, with the invention of all the more and more complex chemical compounds. We're awash in so many of them.

Jonah discusses smells, hormones, distractions - an environment saturated with interlopers. This recalls the ideas both of "the natural" and of "alterlife" discussed above. What kind of intra- and inter-human ecologies are predominating (and where and how), and what are their implications? What kind of human actions can/should be taken to promote or cultivate certain ecologies, and dissuade or stave-off others? What is a "good" ecology for nurturing the life of the future? These are emergent questions near birth.

Chapter 6

The BirthKeepers:
Activism and Utopian Imaginaries

"We need to get our eyes off the perineum!"

Much-reiterated mantra at the 2012 meeting of the Midwives Alliance of North America

You've thrown the worst fear that can ever be hurled,
Fear to bring children into the world.
For threatening my baby, unborn and unnamed,
You ain't worth the blood that runs through your veins.

Bob Dylan, "Masters of War"

It is frustrating to park in the heart of San Francisco, especially when you're very late. Eventually, I snagged a spot in a Whole Foods garage and speed-walked the few blocks to the Moscone Center, where colored prayer flags waved above the sidewalk and a blond woman in a turquoise sparkle cape addressed a small crowd from a podium.[1] I was heading towards the final event of the BirthKeepers' Summit, a three-day conference held in Berkeley. The crowd who showed up for the "action" in front of the annual convention of the American College of Obstetricians and Gynecologists (ACOG) numbered about thirty, small in contrast to the 350 or so who populated Berkeley City College the prior three days. It was there that conference participants made the "prayer flags" by hand-drawing messages about birth on squares of fabric, and a vendor told me that "turquoise is the color of the birth revolution."

For a small group, the thirty people certainly did have a lot of energy! Following the woman in the cape, a black mom with her baby in a sling stood to speak at the podium. She announced herself as part of the group "Just a Mom," the name a tongue-in-cheek answer to the implied question "who are you that you have an opinion about birth?", which welcomes anyone who recognizes a mom as "the primary decision maker regarding her body," as one of the group's other members explained to me. Other speakers included a Latina midwife who emphasized her gratitude for surgeons (i.e. obstetricians) in appropriate contexts, which in her opinion did not include the majority of births, and a white man with greying hair and a prepared, thoroughly researched speech about the importance of considering the impact of living conditions and social and economic inequality on health. A brusque and businesslike

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[1] A man handed me a leaflet denouncing infant male circumcision, and I noticed a group across the road from the group toward which I was heading, the "intactivists" whose white pants had a red circle sewn across the groin. When I later spoke to a woman at "my" demonstration about them, she said she had worked with them before, but didn't care for their shock tactics.

woman advocated evidence-based (i.e. empirically outcome-focused) medical care that would alter many of ACOG's policies and tacitly-upheld practices, which, she explained to me later, are done for liability reasons: obstetricians are "asking women to... bear the weight of their liability issues. So we're having to do c-sections because they're scared of losing their practice. So we've got to come together, because that's not ok for anybody, it's not ok for them, it's not ok for the women."[2]

The BirthKeepers' Summit took place during the final stretch of my eighteen months of fieldwork. It captured the visionary spirit that I had found so intriguing since I started this project: the idea that changing how birth happens will ripple outward into some form of utopia, that the problems of the world start in poor childbirth practices and therefore need to be remedied there. Many of the birth workers I spoke with insisted that birth practices have broader consequences than the health of mother and baby, or even than their more capacious "well being," and this idea suffused alternative sorts of magazines and websites. The premise of the BirthKeepers' Summit was that if the well-being of *all* mothers and babies were actually prioritized, all the problems of the planet would start to be cured (of course, this statement begs its own inversion: only if fundamental, curative social shifts were starting to be enacted *could* the well being of all mothers and babies be prioritized).

Ariel Martin,[3] the initial organizer of the event, said as much when I asked her why she was present at the demonstration in front of the ACOG convention. She rhetorically posed

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[2] The only person from the ACOG conference that engaged with the group was a doctor from Brazil, who stepped outside to casually investigate and chatted with the organizer a bit; she told me he agreed with lowering caesarian rates, which in Brazil are some of the highest in the world.

[3] Pseudonym

the question, "What would happen if the first consideration was MotherBaby, MotherEarth? There would be no more violence against women, no more violence against children, no more violence against the environment. There would be care and compassion as the new definition of human beings." I don't intend to hold up the BirthKeepers' Summit as particularly unique or successful, but it did epitomize an idealist spirit and a practical dedication to translating ideals into actions, and as such, is a window onto the possibilities and pitfalls of the activisms that cling near birth. It was an attempt at "staying with the trouble," as Donna Haraway enjoins in her 2016 work of that title: that when we run up against the difficulty of co-creating a jointly respectful vision a better society, we must keep engaging that difficulty and not let it turn us away.

I first heard about the BirthKeepers via a postcard laid out on the entrance table of the Bay Area Doula Salon, which met that month in someone's loft-commune space in a cramped side-street in San Francisco, across from a tangled community garden enclosed by chain-link fencing. It offered the provocative motto: *Save birth, Save the world.* When I signed up for the list serve and contacted the organizer, offering to volunteer, we set up a meeting in a Berkeley cafe. Ariel Martin arrived with close-cropped grey curls and neat business casual, and over tea lattes in the leafy open-air back patio, explained her expansive vision for a "BirthKeepers' movement" that would unify all social justice causes, from environmentalist groups to anti-racist and anti-military groups to the people who had been active in Occupy a year or two prior. She was not a birth worker of any sort, but a mother who was seized by a sense of

culpability for perpetuating environmental harm into her now-grown children's bodies, and for bringing them into an unsafe and toxic world.[4]

She shared with me her awe at the knowledge that her body, and therefore her children's bodies, were made of (and therefore compromised by) the material that had surrounded her grandmother in her youth. She told me about epigenetics and APPPAH, evolutionary biology and ecofeminism, and how the "motherbaby" must be thought of as a being irreducibly in relationship. She named numerous like-minded people she had learned from and been in contact with, citing their ideas as evidence that this was a matter of widespread interest.[5] Martin told me how her personal background was laced with privilege that she said she actively sought to recognize. She had just retired from working in corporate sales when she had a kind of awakening, in which she was appalled to realize her own complicity in structures that destroy the environment and oppress people. When I interviewed her after the conference, she said "I did not consent for this to happen in my body. It turns me into a perpetrator and I do not want to perpetrate harm to my children and my grandchildren... this is an intimate story, this is an intimate endeavor for us."

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[4] She mentioned the short film *Birth Day,* which she told me midwives show their clients to give an idea "what natural birth looks like" (the film's website says it will give "understanding of the true meaning of birth" https://www.midwiferytoday.com/videos/birthday.asp). This led Martin to bemoan the rarity of "natural birth" rather apocalyptically, as "you can't go somewhere where there's an untouched culture," but moreover "there is so much pollution" that "there's NO place you can see a natural birth anymore." This short film was eventually screened at the Summit.

[5] Martin explained how she understood the oppression of women to be inextricably linked to the oppression of the Earth, invoking the witch hunts, colonialism, and male desire to control the reproduction of the work force. See Federici's compelling 2004 polemic, to which Martin referred me.

That the feeling of intimate violation was a shock is a condition of her privilege. But she didn't want the BirthKeepers' Summit to represent privilege, she told me, and over the next ten months of organizing she and the other members of the team went to lengths attempting to not have white, well-off voices dominate in the planning or the ultimate conversation.

Martin recognized that "the women on the front lines, suffering the most from the things this movement is opposing, are poor women of color, so they need to be included." A number of speakers from less privileged backgrounds had to be pleaded and cajoled into attending; one black feminist doula said she fought Ariel for a long time over being part of BirthKeepers (presumably because she assumed it had a rather narcissistic agenda), but that in the end she was glad she consented. The organizers offered scholarships for attending the conference, in an attempt to make it accessible -- Martin noted how it can be "farther" to get poor women in east Oakland to the conference than an eminent speaker on black rights from Mississippi. An early organizing email stated: "The goal of the BirthKeeper Summit is a deep transformation in the paradigm of birth, and life, on this earth. Voices from diverse

demographics and disciplines are needed to make this happen."[6] In order to "model the society we want to create" while recognizing that "we don't necessarily have the skills to do that," she was considering using NVC (non-violent communication) trainers and consensus-based methods among the organizers. Martin insisted that mothers are in denial about their responsibility for this burden of cellular-level intergenerational transfer; she wanted to make them understand that they "are culpable as a mother for this toxicity," but recognized that "the last thing mothers need is more guilt and responsibility." Her solution was that moms need to

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[6] A full recruitment email:

Dear Friends, Supporters and Activists for a better world:

What would our world be like if we put our first consideration on the immutable relationship we have all been born into -- * MotherBaby MotherEarth? * We would have healthy, caring humans and a healed earth home. We would act in solidarity with all who are endeavoring to change the systems of destruction in our culture, becoming *BirthKeepers *and *Beloved Ancestors.* Join us for the first BirthKeeper Summit, a convening of those who care about the future of life on our Mother Earth into a focused grassroots movement. We are taking a stand and withdrawing our consent from a culture that commodifies and privatizes our Mother Earth and intervenes with MotherBaby.

... We have almost a year to plan, strategize, collaborate and coordinate a social movement that understands the need for life-producing systems in our world today and works hard to produce it... Who wants to help create this vision? Who should we collaborate with so we include our frontline communities enduring the largest impact, the activists who can teach us how to develop a social movement, the youth whose energy must be supported, and the elders who can teach us?

... This is the time to take on the role of BirthKeeper, the one who guards our most precious birthright -- being born healthy and loved into a flourishing and just world. This is the time to choose to focus on the treatment of mothers who are the first environment for life, birthing the future generations of happy, thriving humans, who are fully capable of caring and protecting our beloved MotherEarth.

... *At the first BirthKeeper Summit, 2015, we will learn the essential work needed to change the current harmful societal paradigm. We will hear from Black activists, Indigenous elders, youth leaders and birth workers on what steps we can take to move forward to create a world of care and compassion. We will be inspired by the confluence of grassroots movements from diverse segments of our society--rights activists, environmental health proponents, social justice advocates, grandmothers... all understanding the connections we hold together and the responsibility we have to support and love our precious babies and the future of our beloved MotherBaby MotherEarth.*

be in a community where everyone supports and nurtures mothers; if they don't have to carry the whole burden, they won't have to deny the whole burden.[7] Creating such a community was the goal. Together, she thought we could "midwife the birth of a new culture, a new consciousness for society."

The four-day long BirthKeepers' Summit took place ten months later, during the final stretch of my fieldwork. It was focused on (but not limited to) the United States, and the 350 attendees included parents, midwives, doulas, doctors, nurses, activists, artists, policy makers, and alternative-care providers; most fit within more than one of these categories. Panels and workshops dealt with a wide range of topics, including racial disparities in care and outcomes, embodied historical traumas, indigenous birthways, postpartum depression in fathers and mothers, perinatal psychology, the social impact of new reproductive technologies, environmental effects on fertility, feminist intersections with birth and abortion, and LGBTQ experiences with reproduction. The emotional tenor of the event vacillated between fascination with the depth and miracle of the birthing process, and impassioned anger at the indignities and abuses birthing people suffer. Speakers included Kathi Valeii, author of BirthAnarchy.com and furious about the ongoing control of women through shame, and Dr. Shelley Sella, third-trimester abortion provider who does so in the style of midwifery and who worked with Dr. Tiller before his notorious murder. Others spoke about how to educate one's elected officials and run for office, about toxic chemicals in consumer products, about health equity, institutionalized racism, and perinatal substance abuse, and about how capitalism perpetuates fear through language. In the many panels that grappled with sensitive topics,

[7] While in my opinion such recognition is important and admirable, I will note that it is exceedingly difficult in practice to present such messages without eliciting feelings of guilt and responsibility from individual mothers.

touching and enlightening dialogs ensued: the patient who felt wronged and the nurse who asked what could have been done better; those with a deep mistrust of hospitals confronting those who experienced poorly managed home births; or midwives who fought for professional legitimation honoring the perspectives of indigenous midwives who gathered knowledge and skill in unofficial ways. Even though differently situated mothers and children suffer unequally, the conference presentations repeatedly stressed that the well-being of all mothers and children is linked. A healthy new generation is imperative to everyone.

The motto that had first attracted my attention -- "Save birth, Save the world" -- begs several questions. "Birth" and "world" are clearly metonyms, but what do they stand in for? Who is included in those seemingly expansive terms? Furthermore, save them *from what?* Presumably, these capacious placeholders need saving from poor cultural priorities; by necessity, if a major shift towards better cultural priorities occurs to "save" birth, then these better priorities would heal "the world" from its traumas and dysfunction as well. This is partially a fetishization of human origins -- that the problems of the world start in poor childbirth practices, because that's where people begin. But it also recognizes birth as a site where interconnectivity is obvious -- between bodies, generations, materialities, communities. Toxic affective connection was memorably evoked when speakers in the introductory panel introduced themselves by remarking on the oppressions and violences that darkened the generational chains leading to their own births: born into legacies of slavery, rape and incest, genocide, famine, abuse, scopolamine and caesarian trauma. Much of the BirthKeeper materials discussed "the Primal Continuum" as a critical period that starts before conception and continues through infancy, in which the dispositions and aptitudes of the next generation are cultivated in the "Mother-Baby" as "one biological system." Implicit throughout the

conference, including in its premise, was the recognition and interpolation of childbearing as the site of a deep wellspring of passionate concern, care, anxiety, and love.

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"White women, understand that your having babies is part of a settler colonialism project!" enjoined reproductive justice activist-scholar Loretta Ross on the warm May Saturday of the BirthKeeper's Summit, to the largely but far from exclusively white audience gathered in the Berkeley City College auditorium.[8] "Not that you shouldn't," she added in a lighter tone, "but examine that." The forthright Ross began her talk by saying that since she only had one baby and then was sterilized against her will, she thought she "mightn't be a good fit to talk at BirthKeepers'," but was convinced otherwise. She also pointed out the irony of talking about "choice in birthing when you didn't even have a choice about the sex," as her child was conceived by incest. Yet her attitude was resolutely practical and purposeful: "I don't care who fucked up, I'm here now." She talked about how she was born at home unassisted, and was unaware for a long time of how rare that was. When she feels treated unfairly she thinks of her mother raising eight kids while cleaning houses on her hands and knees and not complaining. Someone at this conference had offered her a wider chair to sit in onstage, as she's a woman of ample proportions; she didn't have to ask for it. "*That's* what paying attention to women's lives looks like," she said. Later on, she led a session called "Appropriate Whiteness" about alliance building. She asked the audience to consider whose motherhood is

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[8] Loretta Ross is a notable and respected figure in the reproductive justice movement, recipient of honorary doctorates, subject of much media coverage, and leader of the March for Women's Lives.

valued, and whose is disciplined, and proposed that it's impossible to talk about birth without talking about genocide. "If we weren't living in a context of genocide, 'Black Lives Matter' wouldn't need to be uttered."

Ross is emphatic that reproductive justice was *not* a response to the framework of reproductive rights, familiar from the "pro-Choice" movement that grew from 20th century privileged white feminism.[9] "That would mean black women couldn't get white women off their minds; no, we did it for ourselves." Ross was instrumental in founding SisterSong, the pre-eminent reproductive justice organization, created by and for women of color in 1997, and based in the South.[10] It is a collective of 16 organizations of women of color from "four mini-communities" (Native American, African American, Latina, Asian American, and recently Arab American/Middle Eastern) who "recognized that we have the right and responsibility to represent ourselves and our communities, and the equally compelling need to advance the perspectives and needs of women of color." SisterSong's website defines reproductive justice as "the human right to have children, not have children, and parent the children we have in safe and healthy environments... the human right to bodily autonomy from any form of reproductive oppression." Reproductive justice is expansive in scope, because to truly parent in a safe and supported environment would encompass the prison pipeline, environmental

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[9] Reproductive justice is often contrasted to reproductive rights. The latter is based on championing individual choice and often falls into the frame of neoliberal consumer politics. Thinking in terms of choice ignores the compulsion and constraint many marginalized women face, and there are problematic class assumptions in naturalizing consumer choice as a model. The approach of reproductive justice, on the other hand, attempts to account for and rectify racism, as well as any other form of oppression, as it manifests in a group's ability to reproduce itself and thrive.

[10] See SisterSong's mission statement on their website, http://sistersong.net/mission/, accessed March 10, 2016

toxins, climate change, deportation, militarized police, gentrification, hunger, and any number of social-systemic problems.[11] "Reproductive justice applies to *everybody*. Everyone has reproductive potential," Ross claims. "It's more universal than anything I've ever heard feminism talk about."

Other reproductive justice activists who spoke that day at the BirthKeepers' conference included Samsarah Morgan and Linda Jones, East-Bay based doulas of color who explained their work supporting vulnerable mothers. Morgan advocates for young pregnant women in foster care, defending their need for resources: "They are wards of the state, which makes us all their parents, and they are receiving abuse and neglect. Yes, *any* woman who makes the choice to bring children into the world needs lots of help, that's normal, that's human." She connects them with doulas without premising that provision on judgment, and explains that mothering is learned so there's no shame in not knowing what you're doing. She focuses on primary skills like cooking meals to feed themselves: "You need to have three square meals in your body to fight for social justice, or even to care about it." Morgan explained that these women often fire their doulas, and that that's ok, because it's the first time in "the poor young lady's life she gets to fire someone -- you can't fire a social worker." They usually make up; it's the process, the right to complain and be listened to and acknowledged and have power, that is transformative, she said.

Jones used to own a baby shop in upscale North Berkeley called Waddle and Swaddle, which I remember from my days as an undergraduate student there. She said she started it

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[11] A score of recent media articles have taken up this rhetoric, describing Flint's leaden water crisis, police brutality, and access to public services as reproductive justice. For example, "#FlintWaterCrisis Is a Reproductive Justice Issue," *Ebony*, February 2, 2016; "The Murder of Black Youth Is a Reproductive Justice Issue," *The Nation*, August 13, 2014; "'Water, Water Everywhere': Racial Inequality and Reproductive Justice in Detroit," *Rewire*, July 22, 2014.

because she saw women "wandering the street" pushing $600 strollers, crying because they had no one to listen to them or help them care for their babies. So the store began as a kind of community space, where she hired moms who walked in looking for something more than a purchase, and they worked there together with their babes in Moby wraps on their backs, she recounted. Jones co-founded Black Women Birthing Justice (BWBJ, which published the 2016 anthology *Birthing Justice*) and was instrumental in organizing a recent grant-funded initiative, called the East Bay Community Birth Support Project, to train sixteen formerly-incarcerated women and other women of color as doulas to serve in their communities, and make a living providing those services. This was the joint endeavor of BWBJ and the Birth Justice Project, which provides doulas for women in the San Francisco County Jail.[12] BWBJ has collected over a hundred birth stories from women who don't often get to tell them. Jones said emphatically, "I want people who are not afraid to be around black people to help black people have their babies. And I want them to get paid for it." Her present doula clientele is primarily wealthy white women from the Berkeley Hills, but "they need help too, and I'm ok with that", she said.

[12] When the Alameda county public health department solicited proposals for assisting adult reentry in 2013, the Birth Justice program received a $191,000 grant. They partnered with Black Women Birthing Justice to form The East Bay Community Birth Support Project. Jones explained in her talk that partnering with BWBJ enabled participants to avoid being stigmatized as formerly incarcerated, since other low-income women of color also participated and "no one knows who is who." Their first cohort of 16 trainees is now practicing as doulas, and they've received crowdsourced community financial support to continue with another cohort. Jones said: "I don't feel right training another group of people if we can't give them a way to make a living doing it. They can't volunteer, they have kids, they have to get paid for what they do." See the Birth Justice Project's website (http://birthjusticeproject.org/east-bay-community-birth-support-project), and an evaluation article published in the *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* Stanley et al 2015.

Reproductive justice engages the social conditions that constrain and enable choices one might make. It uses a frame of widespread enablement instead of individual control; a reproductive justice framework considers not just access to abortions, for example, but access to the material conditions for both fetal and maternal life to thrive, so that the decision to abort is actually a choice. Abortion, often the centerpiece of reproductive rights, is de-centered in justice discourses. The ability to have children and be supported in childbearing has historically been contentious in non-white communities, due to non-consensual sterilizations and coercive use of birth control such as Norplant, as well as through longer histories of slavery, poverty, genocide, re-education, disempowerment, and imperialism that sully the prospect of bearing and raising a new generation (Davis 1983, Roberts 1997).

Ginsburg and Rapp discuss "stratified reproduction" in which some women are empowered to nurture and reproduce while others are disempowered/constrained in doing so (1995). Lack of adequate social services for childcare, healthcare, and education are ways of restricting poor and marginalized women's reproduction, and police violence against whole populations of young people is reproductive violence that implicates their parents and their future children. Reproductive justice involves not only the ability to bear and raise new life, but the ability to do so *well.* This includes being treated respectfully, equitably, and with compassion in facilities that provide reproductive care, whether that is a birth or an abortion. It might mean having people you recognize as part of your community take care of your reproductive needs, or being empowered with knowledge enough that you can take care of yourself and not be dependent on institutions. It includes being able to support your

household and provide for yourself and your children without undue mental or physical stress.[13]

Reproductive *rights*, as a movement historically focused on the right of privileged women to *not* bear children, has a complicated relationship with childbearing.[14] Much second-wave feminism framed motherhood as repressive and detrimental to a feminist lifestyle, politics, and civic engagement, yet government sponsored childcare was a major component of the women's movement in the '60s and '70s.[15] The natural birth movement of this era was part of the women's movement and certainly saw itself as feminist, but differently oriented feminists found the premise of La Leche League, for example, a woman-founded community-based organization which has advocated for breastfeeding since the 1950s, backward and repressive. This contentious history within white feminism has bled into popular (mis)conceptions and appropriations of reproductive justice, as well, and differing assumptions and convictions about which titles could be attributed where were recurrent at the Birth Keepers' Summit.

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[13] I encountered reproductive justice projects (Sea Change and Core Align) concerned with reducing *stigma,* including its classed and raced dimensions, around issues like infertility, LGBTQ conception and family-making, abortion, intentional childlessness, teen pregnancy, adoption, sexually transmitted infections, and single parenting (but rarely polyamorous or community parenting). It was less focused on considering structural disempowerment or the childbearing process, i.e., what kind of treatment by what kind of providers under what kind of conditions.

[14] I am simplifying the history of what might be called a "reproductive rights movement" here; one common genealogy traces itself back to Margaret Sanger and Planned Parenthood in the early 20th century, though this heritage was implicated in eugenic projects and not simply about the "right" to access abortion and birth control. Another more recent genealogy looks to activism around Roe vs Wade, such as the Jane project in Chicago. Like feminism itself, reproductive rights -- and reproductive justice -- are not cohesive/homogenous discourses.

[15] Congress actually passed a bill that would provide this, which President Nixon vetoed because it rang too much of socialism, and "we want our women to take care of their own children." See Dore's documentary film about the feminist movement of late 1960s, *She's Beautiful When She's Angry*.

There was a poignant moment in a Q+A after a panel on feminism in which the young speakers insisted that birth needs to be added to the feminist agenda, "merging birth justice with reproductive justice." A much older woman stood up and said she was "deeply saddened" that the panelists thought "this is the first time birth is being raised as a feminist issue. It came up even in the suffragists, with the desire for pain relief." She enjoined the group to "not dismiss the work getting us here, so we can take this to the next level!" The panelists responded that they were aware, "but the reality is that in 2015 childbirth is NOT mainstream as a feminist agenda. People think 'reproductive justice' means contraception/abortion." A similar, inverted moment happened later that weekend when an older white midwife whom I knew as one of the founding activists in the Santa Cruz natural birth movement, stood to respond to a young woman's comment. "You forget", she said, "that all the birth activism of the past decades was done by feminists." At a different point, there was a cascade of interruptions insisting on specificity in evoking "feminism", wherein someone protested "excuse me, you mean *white* feminism" and a further person added "you mean *conservative* white feminism." Explicitly on the table were the questions of whose feminism counts and whose perspective and history is recognized.

Slippage between kinds of activism/politics was both an opportunity and a frustration. Not only is the word "rights" not indicative of or coextensive with the limits of "choice" frameworks, but "access" can be used to both aggrandize and limit activist aspirations. At the 2012 MANA conference, midwife and therapist of color Tamara Taitt discussed the "right to health" vs the "right to *access* health": the latter implies access to healthcare, she argued, which at its most inclusive might mean access to preventative care, "which is disease screening." A right to health *itself* would have to be so much more, she said -- a clean environment, a

nurturing social group, nutritious food. A right to health would be truly revolutionary. Across birth worlds, a patchwork of terms and their relevant concepts was being built, variously and piecemeal. An international movement for "human rights in childbirth" used rights language to demand greater reproductive options, while re-inscribing individualist/masculinist contract ethics across the globe and overlooking locally nuanced conditions. It's not coincidental that advocacy for access to low-tech care happens in contexts with overabundant access to technology; much international women's rights activism focuses on access *to* life-saving technology in poor regions. Consumer rights discourse persists across more conventional birth world activism, with its concomitant blindnesses: the right to choose providers presumes access to healthcare, the right to make informed decisions about one's body presumes time, education, self-confidence, and access to information (Craven 2010). MANA increasingly recognized that it is not enough for midwife-overseen home births to be legalized as a "choice;" they must be covered by insurance and medicaid, and insurance and/or medicaid must be available to all (though there is a strong historical precedent for midwives of all genres to "buck the system" entirely and explore modalities like barter, instead). Yet even the whitest and most privileged midwives are still persecuted for practicing home births; two cases in Northern California went to court as recently as 2014,[16] in which the CNMs practiced home births without physician supervision, even though the rule requiring such nominal oversight (which was impossible to obtain for liability reasons, and thus a legal gray zone) was supposedly lifted that year. The summer of 2013, I attended a protest at the capital building in Sacramento calling for ending this law, said to be patronizing by home birth midwives and their devoted clients.

[16] The defendants in these two 2014 cases were Yelena Kolodji/Kavita Noble and Dena Moes.

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Near-birth activism I encountered during fieldwork was hardly limited to, or represented by, the BirthKeepers' Summit, though the fact that that event was generated in the Bay Area speaks to the richness of activist narratives circulating there. The Bay Area Doula Project met monthly in the East Bay or San Francisco, gathered around topics such as:

Countering stigma in the abortion clinic
Sex, love and herbal medicine
From fetal bodies to babies (processing pregnancy loss of desired babies)
Chinese medicine for menstrual health
An evening with Hatch (organization supporting young/teen parents)
Sea Change's "Untold Stories" project
Home abortion care
Adoption from perspective of birth parents
Mental health training for doulas
Racism and disparities in reproductive care
Sex during labor and childbirth

BADP hosted evenings with reproductive justice activists, "Resistance Art Parties" and game nights, and biannual full-spectrum doula trainings. During fieldwork, I encountered activist projects from around the country that circulated through Bay Area birth worlds, and were enriched by them. I learned about annual "Labor Day" demonstrations held in most states since 2011 to draw attention to inadequacies in childbirth practice and policy. I heard about polemical documentary films like *Guerrilla Midwife*, which follows a midwife through post-Tsunami refugee camps in Indonesia and "demonstrates why we must change our protocols for pregnancy and childbirth, and return to a gentle, natural method if our planet is to survive

the dominance of mankind," and *Freedom for Birth,* which is a "campaigning film" that reframes restricted autonomy in birth as a pressing international human rights issue.[17] New anthologies were published at the nexus of scholarship and activism, including *Revolutionary Mothering: Love on the Front Lines* (Gumbs et al 2016) and *Birthing Justice: Black Women, Pregnancy, and Childbirth* (Oparah and Bonaparte 2016). I encountered an infinity of blogs such as Birth Anarchy, which features a header of a genderqueer pregnant lion in chains, and Outlaw Midwife, chronicling the opinions and trials of an "out of system, out of compliance" midwife of color. *SQUAT: An Anarchist Birth Journal* was a reproductive justice magazine founded in 2010 and published quarterly until the volunteer editors retired it in 2016. It aimed to be "a radical celebration of midwifery and birth," and the community of contributors convened in person at an annual "SquatFest."[18]

Miriam Zoila Perez, a doula who self-describes as a queer and gender-queer Latina of Cuban descent, wrote the *Radical Doula Guide* (2012) in which she defines reproductive justice as "building a world where everyone has what they need to create the family that they want to create." She was delighted with the community spearheaded by Squat, and praised it on her Radical Doula blog:

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[17] According to the *Freedom for Birth* website: "In many countries around the world, women are being denied the most basic human right of autonomy over their own bodies. They cannot choose how and where to give birth. Those that persist in their desire to have a normal, physiological birth are sometimes forced by judges to surrender to surgery or threatened with having their babies taken away by child welfare services." The film's subtitle is "The Women's Revolution: Women will take back Childbirth" www.freedomforbirth.com and www.guerrillamidwife.com. The midwife protagonist in *Guerrilla Midwife*, Robin Lim, was a featured speaker at the Birth Keepers' Summit. Both films referenced in Chapter 5, *Microbirth* and *In Utero*, were other such polemical niche documentaries.

[18] Outlaw Midwife critiqued it for being an updated "hipster" version of *Midwifery Today*, an iconic natural-birth publication that's been going since the '70s and very much represents white revival midwifery. She wanted more leeway to be angry and found Squat unsupportive.

> Needless to say, I no longer feel alone. Instead I'm in awe of the incredible growth in the doula movement, and particularly in the movement of doulas who see their work as part of a broader social justice vision. For so many of us, this work isn't just about improving a few select people's experiences with pregnancy and birth–it's about changing the systems altogether.[19]

For Perez and others involved in birth world activism, doula work is not just about reproductive experience but about building a just world. Her blog features numerous profiles of self-identified "radical doulas" from around the country, who are all actor-theorists of reproductive justice. They critique racism, capitalism, institutionalized medicine, institutionalized violence, and fear. They advocate things like non-judgment, strong communities, evidence, sex positivity, recruitment of doulas from underserved communities, healing trauma via birth, and reimagining the language of birth. They imagine childbearing as an activity wherein the qualities of humans and their world are shaped. Below, I have excerpted some of the profiles and italicized portions I wish to highlight, as they echo themes I have discussed above.[20]

Maggie, San Francisco:[21]

> *The first few moments of life are so precious and so important* to to our beliefs that we are loved, worthy, safe, and whole in the world... I would ensure everyone got the support they needed and that birth was once more looked at *not as a medical experience of pain, but a community experience of power.*

Sarah, St Louis:[22]

> The phrase 'bread and roses' comes from a 1912 textile strike in which Rose Schneiderman said "The worker must have bread, but she must have roses, too." This

[19] http://radicaldoula.com/tag/squatfest/

[20] All grammar and spelling irregularities in these excerpts are copied from the originals.

[21] http://radicaldoula.com/2016/02/10/radical-doula-profiles-maggie-weber-striplin

[22] http://radicaldoula.com/2016/01/27/radical-doula-profiles-sarah-michelson/

phrase has been used for over a century by feminists and activists, meaning that *we want our sustenance but we also want beauty and we want both without compromise.*

Birthwork is the fight for autonomy over normal life processes, specifically during the childbearing years... The first step I would take to create safer and healthier experiences of pregnancy and birth would be to start universal comprehensive sexuality education programs that are inclusive of the LGBTQQIIAA spectrum, that *focus specifically on sex positivity and healthy relationships, and that lead to more open gender roles*, especially during the childbearing years.

Alana, San Francisco:[23]

Radical birth work for me begins with the recognition that birth, and actually all reproductive processes, are both deeply personal and highly politicised events. *We cannot separete the "personal" from the "political" in birth.* How we birth, and how we support others through birth, is a direct reflection of society's politics.
Radical birth work also requires confronting systems of privilege that run throughout society. Some continue to benefit whilst others continue to be harmed. What is unique about doulas in this case, is that while we work (most often) within hospitals, we work for ourselves. This enables us to bring a degree of institutional critique to our practice... leaving us with the potential to confront and redress institutional forms of violence that are inflicted upon reproductive and birthing bodies. *A radical doula is a caregiver whose activism holds the ability to literally reimagine lifes beginnings.*

...Economically disadvantaged communities, communities of colour, queer and gender nonconforming communities, in particular, bear the brunt of *institutional forms of violence.* Breaking cycles of oppression means directly engaging these systems in order to *reimagine a language of birth* that creates room for all birth givers to feel heard, affirmed and respected.

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[23] http://radicaldoula.com/2016/01/13/radical-doula-profiles-alana-apfel/

Becca, Orange County, CA:[24]

Doula work is about way more than having babies. It's about helping people have access to information and choices and to their own voices and power. In a realm where that isn't always encouraged, it's radical.

...I also consider myself *radically evidence-based.*

...I would take away all the horror stories pregnant and birthing people hear. For providers, I'd take away the fear of being sued and the fear of doing something outside the norm. *If everyone was less afraid,* the whole experience of pregnancy and birth would feel less antagonistic and more like the amazing phenomenon it is.

Cat, Virginia[25]**:**

Radical comes from the Latin word radicem, which means root. It means to form the roots, to grow, to change, to become. What better word to describe *a doula, who helps guide women and partners as they form their own family roots, as they change and become?*

I believe doulas are there to support families in whatever informed decision they would like to make. I don't believe in imposing my own fantasy birth on them or making judgments. I feel like families will make the choices that are right for them when provided with the right information and emotional support... *I wish we would all recognize that other people are experts in their own lives.*

Torrey, undisclosed location:[26]

My doula practice has evolved into *a trauma healing practice.* In the past 10 years [150 births], I have only had 4 clients who were not survivors of childhood sexual assault, nor survivors of military sexual trauma. Two of those 4 were survivors of domestic violence.

...I work hard to locate women in underserved communities and encourage them to pursue doula training. I try to find representatives in each community to apprentice with me *so they can take the knowledge back into their communities.*

And I try to *get folks comfortable talking about sex,* anywhere. Because if women can reclaim their sexuality, and their autonomy, they can reclaim their birth experience. Radical, right?

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[24] http://radicaldoula.com/2016/01/20/radical-doula-profiles-becca-spence-dobias/

[25] http://radicaldoula.com/2016/02/03/radical-doula-profiles-cat-ennis-sears/

[26] http://radicaldoula.com/2016/01/06/radical-doula-profiles-torrey-moorman

I believe *every birth offers a healing experience.* I believe every infant needs to have its autonomy respected, and be allowed to birth itself as it needs... Just as *our culture fails to recognize an infant's autonomy, we fail to recognize and respect the autonomy of women, minorities, survivors, and anyone who is "other".* I fight to shine light on these issues.

[I would change things so that] homebirth mommas who say "something just doesn't feel right" would be honored by hospital personnel instead of shamed. *A woman's intuition should be celebrated, nurtured and cultivated. Not shamed.*

Simiya, St Louis:[27]

I am called to birthwork because of the dire need of culturally competent birth services. I am a firm believer in *accessible, culturally relevant birth services as a means to eliminate racial and health disparities* in underserved communities. I've seen first hand how race and income can negatively impact childbirth... I became part of the growing statistic in the U.S. of women of color subjected to unnecessary c-sections. During my 3 days of labor in the hospital I experienced racism, lack of informed consent, forced medical procedures from nurses and a resident, blatant disrespect and inhumane treatment.

I am a radical doula because I believe that *birth support is a right and doulas should be accessible to all communities*. I identify as a radical Black feminist and I understand the impact that the intersections of race, class, sexuality and gender identity have on access to healthcare, education and resources. I understand the impact those intersections can have on pregnancy outcomes and the health of a birthing parent and their child. *All birth outcomes deserve compassionate support.* I am dedicated to supporting families through miscarriage, abortion, loss, stillbirth, adoption and full term birth and making my services available to low and no income families. My doula work is an essential part of my feminist and social justice praxis. ...Positive change starts with recognizing and honoring the bodily autonomy of birthing parents and *trusting pregnancy and birth.*

Liz, Baltimore:[28]

I identify with the term radical doula because *my work is firmly grounded in my ideals of social and reproductive justice.* I am fiercely pro-choice and work hard to make my services available to everyone, regardless of funds. *I believe in growing communities not profits,* and believe that this work is both sustainable and important.

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[27] http://radicaldoula.com/2015/11/04/radical-doula-profiles-simiya-sudduth/

[28] http://radicaldoula.com/2015/10/28/radical-doula-profiles-liz-jones/

In Bay Area birth worlds, information also circulated about activism from Indigenous communities across North America, particularly in Canada, who are reclaiming their traditional healers and "being allowed" to have spiritual practices at their births in hospitals. Two Navajo midwives are starting the first native birth center in the US, in the Southwest.[29] People talk of returning birth to the community, envisioning "an alternative community-based Aboriginal childbearing model that integrates western expertise and knowledge" (Hiebert 2003) and "looking back towards the future" in which "traditions must lead" (Martin-Hill 2007). In addition to advocating reproductive autonomy and incorporation of traditional practices, these groups often emphasize the problems of environmental/ecological violence, vulnerability, and trauma, comparing and connecting ecological violence with genocide.[30] There is a notion of the mother's body as the "first environment" in First Nations cultures, and indigenous reproductive justice champions the right to a non-toxic environment as a basic reproductive right.

Katsi Cook, an indigenous reproductive justice advocate from the Akwesasne community (Northern New York, Southwestern Quebec and Southeastern Ontario), works to share and improve indigenous experiences of damaged abilities to reproduce due to toxicity and stress. She founded the Woman is the First Environment Collaborative that supports community-based health projects seeking to empower Native women of all ages and increase knowledge concerning reproductive health, and the Mother's Milk Monitoring Project that launched

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[29] See Perez's 2015 *Colorlines* article and Pearson's 2015 *Huffington Post* article.

[30] Indigenous midwives were active in protesting the Dakota Access pipeline, and articulated their concerns in these ways; Democracy Now! ran a story on them in November 2016 (Goodman).

major studies on heavy metals contamination, while serving her community as a traditional Mohawk midwife. She is also a researcher and lecturer in environmental health, toxicology, and alternative/complementary medical therapies at SUNY, UCSF, and other institutions, where she weaves her work with "Mohawk visionary epistemes."[31] She spoke at MANA conferences and is on their Advisory Council of Elders, one of whose responsibilities is to function as the committee to represent the MANA Traditional Midwife[32]. She writes:

> That the woman is the foundation and carrier of life is central to Native American thought. Therefore, the integrity of our reproductive power, and that of all female life, including the Earth, our Mother, is the basis of our real health. Sterilization abuse and the ecological impact of industrial development on the reproductive health of Indian communities cannot be understood outside of the historical reality which makes these most obvious threats to the survival of the Indian generations tantamount to genocide (Cook 1982).

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Whiteness, racism, and "diversity" were topics of much attention in the birth worlds where I circulated. The vast majority of trainings and conferences I attended included workshops on white privilege, allyship, and structural bias. The BirthKeepers' Summit began with an "optional" day-long Thursday workshop on race issues, with solidarity groups for people of color and educational meetings on white privilege and racism. Indicating both

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[31] See Follett 2006, as well as "Women's Heath - 'Women is the First Environment'" http://indianyouth.org/news/detail/womens-health

[32] http://mana.org/about-us/advisory-council-of-elders. I do not know to what extent these star personalities from marginalized groups, including those speaking at BirthKeepers, were recruited because they're palatable to people from outside those groups and fit a preconceived ideal, versus stars within those marginalized communities themselves.

successful initiation of conversations and ongoing need for conversations, tensions bubbled up regularly when the plenary sessions were opened up to audience participation. The work of allowing, acknowledging, and reconciling different perspectives, histories, and needs/desires is complex! "Calling out" white privilege and hashing out differences in priorities were common themes. For example, when a young white audience member "self-lauded" for working as a low-cost doula for poor migrant people in her Southwestern town, other audience members responded: "If you want to help, sponsor a Latina doula." There was a lot of educating, accusing, and specifying that vacillated between tense and generous, and passionate expansion on the responsibility for ignorance and the erasure of history (Ross exclaimed, "There's so many white people allergic to history, I can't even fathom that!"). There was contentious evocation of different feminisms as inflected by generation, race, and ideology (including over abortion, about which there is often a tacit agreement not to speak in birth worlds, as it can be incredibly divisive between people who otherwise think and practice very similarly).[33] Frequently, people reassured each other that "disagreement" doesn't mean "dislike," presumably in efforts to bolster largely female-socialized egos trained to avoid conflict and seek approval, and to refocus on respectful collaboration.

The imperative to recruit providers from marginalized backgrounds was a recurrent theme among white organizations, as was an often-anxious bemoaning of lack of diversity. Doulas of North America (DONA) offered scholarships to people of color to become certified doula trainers, and the Midwives Alliance of North America (MANA) did likewise for people

[33] When contemplating starting a full-spectrum doula practice with a friend in Santa Cruz, I remember our conversation in which she enumerated as a matter of obviousness which midwives, doulas, and doctors would be open to a conversation and which should be avoided, noting the unlikeliness of some of the attributions!

to attend their conferences. UC San Francisco had a robust scholarship program for members of marginalized groups to attend its midwifery program. At one Bay Area Doula Project meeting in San Francisco, where I perched on the kitchen steps of the living space where it was held among an overflow of other bodies, a black midwifery student from UCSF declared that "affirmative action for midwives of color is the answer!" -- the answer to racial perinatal health disparities, and indeed the answer for a good many social ills that overflowed the birth experience. Over the three years of my fieldwork, I witnessed this imperative to promote diversity become more and more emphasized, and I saw how "helpful intentions" from privileged/white people were increasingly met with insistence to "help communities help themselves" through financial donations and affirmative action.

This is a bumpy transition for people and organizations that took certain privileges for granted, and there have been a number of blunders along the way. During pre-fieldwork, at the MANA conference in 2012, I interviewed a woman who worked with MEAC, the accreditation organization for midwifery education, and she voluntarily expounded upon how MANA was having a "big controversy over midwives of color," calling it a timely issue and a hot and delicate topic within the organization. At that conference, workshops and speakers addressed institutionalized racism and announced a scholarship program and book donation drive to support training midwives of color. Disparities in perinatal health outcomes and access to various kinds of care and resources were held up as reminders of issues about which "we" should be concerned. At that conference, there was a planned fireside vigil for health disparities one evening, which became a singing circle featuring songs largely from the white natural birth movement in the 70s. The next morning, some of the organizers issued an awkward and confusing public apology for a "slip up" in focus, for, I gathered, drifting from

the intention of inclusion and appropriating the event into a more comfortable and precedented genre. Listening to everyone puzzle out this rather vague "announcement" was interesting, and I sensed an overall feeling of "thanks for mentioning that, that's how progress is made." The road away from narcissism is long and winding. Such attempts by white organizations, in both their failures and successes, are a mirror for what is happening more broadly in white American culture: realizing that good intentions are important but inadequate, struggling to accept that abstinence and ignorance are not innocent, trying to learn from and include others and thereby counter individual and group narcissism.

For the past 5 or so years, at least since this 2012 conference, MANA has been going through what might be called "diversity pains." These are manifest in attempts to reshape itself to be inclusive and representative of marginalized groups and their concerns, but also to consider how birth is at the center of a whole nexus of broader issues. My notes are full of what seemed a sort of unofficial motto, "We need to get our eyes off the perineum!" The perineum, the tissue between the vagina and anus that stretches (and often tears) to accommodate the passage of a tiny human, and which is intimately observed by the attending midwife during this event, is a metonym for parturition or "birth proper." Midwives are struggling with the idea that it is problematically limited and limiting to think only about how babies literally come into the world; it is necessary to also consider what kind of world they come into, and how this world limits what kinds of entrances are possible for a given baby. Like the perineum, white midwifery and privileged "birth worlds" are stretching -- and confronting the possibility, perhaps the inevitability, of tearing -- to accommodate the birth of a new social order.

But this push for "diversity" begs the question of how much change will be required to account for "other" perspectives (as I will argue below, the requisite amount is greater than the gravity holding these privileged worldviews together). There is a kind of "evangelism" in much childbearing activism, and not just that of white people, that often copes poorly with difference, finding it "wrong." It was popular among more "radical" birth workers to explicitly claim non-judgment and/or to specify their own biases, indicating that other birth workers often had implicit expectations and values, likely towards "natural birth" and hetero-feminized motherhood.[34] There is a definite tension in such activism between the "freedom" evoked in discourses of autonomy, and prescriptive ideals of proper practices and the futures and beings they produce. There is likewise a tension between the desire to claim universal goods and to respectfully account for identity politics.[35]

Class-based identify politics invites a particular kind of judgment, with what seems to me less allowance for difference (or said otherwise, less inclination to write people off as incomprehensibly other). The questioning of hegemony that underlies anti-institutional birth discourse is a form of privilege -- poor and otherwise marginalized birthing people aren't concerned so much with questioning hegemony in trendy ways, perhaps because they were

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[34] A doula colleague in Santa Cruz was very intentional about using queer-inclusive language on her website and talking about family making in ways that didn't imply marriage or motherhood or two partners, for example, and was explicit about supporting all pregnancy outcomes including terminations and high-tech births, but she could not allow herself to participate in births with infant male circumcision, which she found abhorrent, and was clear about this to potential clients when they were "shopping."

[35] Although here I am largely talking about race and, to a lesser extent, class as identity politics, those of gender and sexuality were also present in my field sites, though less politicized. BWBJ consistently includes trans people with black people when they talk about birth oppression. Less interestingly, Birth Keepers hosted sessions on supporting lesbian fertility as midwives and doulas, and on using non-hetero, gender-neutral, trans-positive language on websites and promotional material.

never fully part of the hegemonic group in the first place. For someone who has always been kept at a distance, it's not so destabilizing when cracks are found, as compared to the passionate indignation and disillusionment that often accompanies privileged people's birth traumas.

At the maternity home for vulnerable women in Santa Cruz, where I volunteered during fieldwork, the residents were more concerned with how they would manage to sustain their own lives and the new little ones in their care, than they were with optimizing them or making them resemble a certain thing.[36] Nonetheless, breastfeeding was persistently encouraged by the organizers and the volunteer doulas, with schemes to cultivate the internal house culture and group dynamics toward a "tipping point" where breastfeeding became "cool" and self-perpetuating.[37] The volunteers talked about hosting "spa nights" to pamper the residents and promote self-care so they could be in an affective space to give to their children. We doubtfully wondered if they would like (or tolerate) going to "Wombsong," a women-only weekly singing circle for childbearing people and birth workers, as some of them met even house recycling bins with disdain, dismissing them as "so Santa Cruz," i.e. hippie-liberal.

[36] The residents were mostly white, with some Latinas. As such, class elements were more easily disentangled from race.

[37] Breastfeeding is far less expensive than formula, and thus in this way more accessible, especially since many of the home's women were not working or were on maternity leave. Working away from one's baby with little or no accommodation for pumping makes it logistically near-impossible. There are other cultural reasons that people practice formula or breast feeding.

Much "natural birth" discourse has implicit class bias. For example, the appeal of home birth is based on home being a place of comfort and autonomy.[38] For this to make sense, one needs to have a stable home in reasonable cleanliness and good repair, money to stock it with useful and pretty things, and loving, reliable, respectful people to occupy it. For many, many people, these items cannot be taken for granted, and homes can be stressful, unsanitary, abusive, ugly, and ill-equipped. We volunteer doulas were told that the maternity home residents rarely wanted to labor at home as long as possible before going to the hospital, a standard component of more privileged birth plans. When I was in a childbirth class at the large local hospital with one of my clients, Grecia, the instructor was asking everyone if they had stockpiled the various postpartum supplies in their home cabinets, and I realized with a shock how awkward that moment might be for Grecia, who had neither cabinets nor money for supplies. Being taken care of in a hospital could be seen as a luxury (indeed, even one of my solidly middle-class interviewees explained her desire to birth in a hospital with this rationale). It is also in some historical ways an achievement for marginalized groups to access professional care, particularly care of the same sorts and in the same places where wealthier others go.

Yet though tenets of "natural birth" have been "revived" by privileged white groups, they are not "just a white thing" (though many activists and practitioners of color must dispel this idea among their communities). Black and indigenous groups advocating for midwifery, breastfeeding, and unmedicated or ritual birth often articulate this as reclaiming their

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[38] Home birth is also, paradoxically, a very expensive and inaccessible option because medicaid certainly does not cover the midwife's few thousand dollars of fees (neither does much private insurance), even though it costs far less overall than hospitalization.

traditions. A new term, "birth justice", evolved out of black feminist reproductive justice work. The website of Black Women Birthing Justice, mentioned above, asserts:

> We believe that Birth Justice exists when women and transfolks are empowered during pregnancy, labor, childbirth and postpartum to make healthy decisions for themselves and their babies. Birth Justice is part of a wider movement against reproductive oppression. It aims to dismantle inequalities of race, class, gender and sexuality that lead to negative birth experiences, especially for women of color, low-income women, survivors of violence, immigrant women, queer and transfolks, and women in the Global South.
>
> Working for Birth Justice involves educating the community, and challenging abuses by medical personnel and overuse of medical interventions. It also involves advocating for universal access to culturally appropriate, women-centered health care. It includes the right to choose whether or not to carry a pregnancy, to choose when, where, how, and with whom to birth, including access to traditional and indigenous birth-workers, such as midwives and doulas, and the right to breastfeeding support.[39]

Is this evangelism? BWBJ promotes "natural" birth for black women, including breastfeeding, doulas and midwives, birthing at home or birth centers, against over-medicalization and fear-based media images. It is tempting to see such efforts as prescriptive and controlling in a reactionary way against medical and institutional abuses; to the extent that this is true, do they not go against principles of non-judgment and autonomy? Not when one considers the barriers to accessing these "natural" things, already great among the privileged, and far higher for those marginalized by race, class, and non-heteronormativity. There is no "choice" over which one can have autonomy until options are equally on the table. The mind-shift that some of the "natural birth" movement of the '70s promoted is highly relevant to the reproductive empowerment and well being of all communities, even if much of that energy has been re-channeled into neoliberal consumerist responsibilization. Is birth justice the new face of (white) natural birth? Does it co-opt something people of color have

[39] http://www.blackwomenbirthingjustice.org/#!what-is-birth-justice/crh4 accessed March 10, 2016

championed, reproductive justice, into more narrow privileged concerns? Is it a subset of reproductive justice, or a distraction from it?

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The variety of frames in which activism takes place near birth can be understood as gravitating toward two poles. On the one hand, there is the possibility for the BirthKeeper vision to come to pass, or that of radical Reproductive Justice as articulated by black feminists: to profoundly reimagine the colonial, heteropatriarchal, violent and destructive lifeways that underpin so many aspects of contemporary infrastructures, ecologies, and socialities. On the other hand, there is the continual and inevitable cooptation of the possibility for different modes right back into neoliberal frames based on individuals, consumption, extraction, and profit.

As with the other polarities I have proposed and engaged in this work, actual practices always fall somewhere in between. Any "activist" discourse near birth has the potential to enact/engender difference and the potential to re-inscribe sameness; often both potentials are actualized, sometimes simultaneously. It is incredibly difficult to think/act outside of paradigms that Margot Weiss calls neoliberal citizenship (2008), and Lauren Berlant calls the intimate public sphere (2007, 2008). Political repression in contemporary American society is closely related to normative ideals of private life that revolve around consumption and the family. Moreover, any kind of activism (particularly for those with young children!) is constrained by the necessity of material survival and logistical compromise in a world structured by disposable consumer products, alienated supply chains, out-of-control chemical

proliferation, dispersed communities, civic disillusionment, and various kinds of demographically-distributed precarity. Yet political imaginations do flourish near birth, perhaps fueled by the passionate, protective love that babies often inspire, perhaps driven by a nexus of other emotions, aspirations, frustrations, and longings.

In her examination of sexual politics in San Francisco, Weiss distinguishes between two versions of "equality" in use by activist organizations: equality as sameness with normativity, or equality as freedom to deviate from the norm, which implies a more radical and uncomfortable politics. She explains that the former is much more palatable because it aligns with the neoliberal focus on the private sphere of consumption that renders dominant class-based domestic norms so powerful. Neoliberal ideology promotes the idea that a "free" market characterized by individual entrepreneurialism, strong private property rights, and consumer-oriented lifestyles is both the solution to social ills and key to the thriving of the individual.[40] Citizenship becomes defined by "consumption, rights, and family values." Weiss writes, "In this newly privatized setting, it is the relationship within families, structured through

[40] David Harvey (2005) defines neoliberalism as a global economic doctrine, developed and implemented in the United States (and elsewhere) in the late 1970s and early 1980s, that "proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade".

consumption, rather than a civic relationship between individuals and the state, that serves as the locus for engagement."[41]

Berlant discusses this privatization of citizenship in more detail (2007), describing how American politics became centered on the intimate space of the family during the "rise of the Reaganite right," when the unborn child became the ideal citizen.[42] This conservative cultural politics aimed to dilute the far more oppositional politics of the '60s and '70s that exposed the historical and present oppressions of stereotyped groups, highlighting differences and iniquities instead of patriotic assimilation. The "privatization of citizenship" changes legitimate claims for redress from a frame of historical wrongdoing to one of present loss. Within a frame of historical wrongdoing, the claims of African Americans, women, gays, etc were justified. A frame of present loss legitimates the nostalgia of those who "lost" the American Dream and the freedom to feel unmarked. This latter, Reaganite frame enables "A scandal of ex-privilege... a desperate desire to return to an order of things deemed normal, an order of what was felt to be a general everyday intimacy that was sometimes called 'the American way of life'" (2).

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[41] Similarly, Cathy Cohen (1997) argues that single-issue activism -- in her case, that for gay rights -- excludes all sorts of people who experience intersecting oppressions, and only liberates those who don't experience other oppressions in addition to being gay (or, in the case of reproductive rights, in addition to being a woman). Cohen claims that gay rights activism opens the normative "Pottery Barn lifestyle" of white, upper-middle-class family making to gay people, but leaves out homeless queer teens and black "bulldaggers" on welfare, among many others. By contrast, "queer politics" recognizes intersectionality and advocates for acceptance of non-normativity, rather than making normativity a bit more inclusive. Queer politics is to "homonormative" gay rights what reproductive justice is to reproductive rights. These rights discourses remain within the frame of consumer-oriented activism that does not offer a fundamental challenge to colonial-capitalist priorities and values.

[42] Federici (2004) compares this Reagan/Thatcher crackdown against the idealistic alternative thinking of the 60s and 70s to the witch hunts in 1600s that cracked down on the heretic visionaries and empowered artisans/peasants who were gaining momentum against the established order. In each, a period where "anything seemed possible" ossified into acceptance of an even-worse norm.

This intimate politics reserves citizenship (and by extension the ability to make claims on the social contract) for members of families, and poses private life as the core of politics. Berlant claims that in this situation, to be "American" is to be un-conflicted, unconstrained by identity. The nation is no longer conceived of as a state, but a culture, to which one belongs via an anti-federal patriotism. Shaping and interfacing with the social order is thus not done primarily through political struggle, but through a core of "personal acts and identities performed in the intimate domains of the quotidian" (4). Public good is only found in simultaneous private worlds that are homogenized via mainstreamed media, where images of vibrant national life do not feature adults in civic interaction, but children in domestic contexts.

Berlant's theorization of US public culture illustrates one answer to why birth is the site of so much cultural investment in the future. If it no longer makes great cultural sense to "take to the streets" with grievances and aspirations, and if childbearing is the core of heteronormative domestic familial life, then there is significant gravity pointing those who believe we need to transform our society so that all life can thrive towards individual infants and the context in which they come into being. Private cultivation of desirable qualities and personal empowerment in the domestic realm, including by buying products and services (even those that should be public goods in classic liberal societies, like healthcare and education), seem more believable and relevant as ways to shape collective life than gathering publicly or petitioning government. While some activism near birth advocates and initiates lobbying, protesting, and running for public office, the majority looks to "empower," "inform," and "support" individual moms and babies in their private contexts, or at best their local

communities. The fact that fewer than ten percent of the BirthKeepers' Summit attendees showed up for the ACOG demonstration is illustrative of this.

On a different note, the infant citizen is a stand-in for anxieties about *whose* bodies/interests/desires/subjectivity will be the future, and be supported in/by that future. This abstract future is generative of present crises; it is an alibi for horrifying present political crack-downs on immigration, women, black lives, queerness, and all religio-racial otherness. The politics of birthrates, specifically declining birthrates among colonial populations and the "high" birthrates of poor, non-white "others", have precipitated national crises across Europe, notably in Italy and Spain, particularly with regard to refugees from the east and south of the Mediterranean.[43] In the United States, such panics center on Mexican immigration and economic relationships with East Asia, featuring accusations of "thievery" of resources like jobs, investment opportunities, and tax-funded services, and calls to rethink/revoke birthright citizenship. (California, of course, is a paradigmatic site of both stereotypes.)

Yet projected futures are also generative of progressive vision and action. Michelle Murphy's politics of alterlife calls for "differently distributed futures" (2017). She links this to a frame of radically articulated reproductive justice that considers which relations, structures, and beings get to have a future and which are destroyed, as opposed to the hegemonic colonial frame of population, which she argues is a thinly-masked and abhorrent form of eugenics. Alterlife requires questions other than how to maximize opportunities for personal choice; it asks us to consider where the benefits of violence are concentrated, and at what cost. Murphy asserts that a cosmology that posits the individual, human, and body as distinct and isolatable

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[43] Italy's government ran a widely criticized national campaign to promote Italian fertility by mobilizing stereotyped gender norms. See Piangiani's 2016 *New York Times* article.

from "conditions of becoming with the many" is what enables elite, consumptive, low-fertility lifestyles that are supported by the exposure to violence for others. She argues that the kinds of toxicities I explored in Chapter 5 demonstrate an indistinction between ecologies and infrastructures, both of which are now implicated in and constituted by uncharted chemical-technological realities. She advocates a politics of dismantling, persistence, and relation-making.

The question for white, heteronormative near-birth activism should not be how to "diversify" and be "inclusive," which falls into the trap of multiculturalism, by which what seems like progress is really just pouring different colored plastic into the same mold, leaving the underlying categories, assumptions, and options un-interrogated and unchanged. Rather, the question should be how "we" people of privilege can decentralize our own complaints to join and support *their* movements. This is the (only?) way to resist neoliberal cooptation of the radical potential clinging near birth, and begin to develop and enact a new social paradigm.

Such decentralization of hegemonic perspectives provides a "third option" out of the problem of calling for state involvement in reproduction. Championing the social need for free provision of reproductive healthcare, accessible and quality childcare, and expansive parental leave is, on the one hand, a way of out of the neoliberal politics of privatized individuals, but on the other hand, it advocates giving a concerning amount of power to a state formation that is fundamentally and perhaps irredeemably racist, humanist, and heteropatriarchal. American suspicion and distrust of government (at least as presently constituted) is bi-partisan and widespread. Standard liberal claims on government provision of social services are becoming incoherent and perhaps dangerous in Trump-era politics wherein gross misogyny and white supremacy are intensified manifestations of the fundamental problems noted above; the

opposite sorts of concerns are manifest in conservative complaints that "big government" provides a leg up to those who are not "American" in Berlant's affective, unmarked sense.

Thinking with alternatives to both neoliberalism and the liberal state requires (and is enabled by) thinking otherwise than about individuals, particularly autonomous ones. The American fantasy of the autonomous individual, exaggerated from its European Enlightenment roots by "rugged individualism" and the historical importance of the settler frontier, has been a foil throughout this dissertation. The obsessing over origins that happens near birth can both re-inscribe and circumvent this fetishization of the individual. Importance placed on origins can be used to individualize responsibility, to enact what Nikolas Rose calls neoliberal "responsibilization" that bypasses traditional liberal institutions and fortifies Foucauldian discipline with a Protestant entrepreneurial spirit. Mothers are being held responsible for their children's well-being before they are even conceived, and in more and more demanding, extensive, and "intensive" ways.[44] But no individual can be responsible for her *own* origins, when she didn't exist as such but only in process and in relationship with the person who bore her.[45] Babies and children do not make contracts, metaphorical or otherwise. Thus the idea of responsibility in birth can be used to evoke responsibility for/to a relationship, community, or environment; it invites thinking about relations and mutual implication instead of self-ownership and contractual ethics.

In an anthology about childbearing, Rosalind Petchesky (1997) proposes "a feminist re-vision" of the idea of property (and thus "self-ownership") to involve imperatives to care for

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[44] See Trnka and Trundle 2017 on contemporary regimes of responsibility.

[45] Or people, as such bearing might include gametes, the doctors who manipulate gametes, wombs, nursing/feeding, intentionality, and care in various combinations, as well as often including a second parent or extended family.

resources and share them among dependent parties, drawing from the idea of the commons and opposing "ownership" as a right to destroy versus a right to access and a responsibility to tend. While her argument has concerning resonance with ideas about male/social access to women's bodies and labor as "natural" resources, she attempts to use the concept of ownership to think outside the idea of autonomy entirely, for all beings, which is of necessity at odds with those who champion women's autonomy as liberating. Indeed, Petchesky is not concerned with "liberation" in the sense of being unconstrained or "free"; her proposed re-valuation argues for liberation of quite a different sort through socially instituted connection and interdependence. This is not unrelated to Murphy's alterlife politics of relationship (though they are hardly coterminous).

In its 21st issue, the "anarchist birth journal" *SQUAT* ran an interview with black midwife Claudia Booker.[46] In it, Claudia discusses how structural racism impedes access to healthy, supported birth, and considers such birth as the property of a community:

> Claudia was astonished by a community where, "no one births in fear... For me, that opened up a whole new way of thinking about birth and a community's ability to create a different birth-reality than the community I lived in and served. *I understood that a community that cannot birth itself will not survive.*" [My italics].

Claudia was impacted by hearing her mother's story of spending her entire labor frightened, alone, and in pain, making it the "worst day of her life." She sees such near-birth experiences as having implications far beyond the individual.

> "This isn't a one time thing that happens to one person once. What happens to us is not an accident, *it's the system working the way it has been designed,*" Claudia realized. ..."We can see how the continual stress of generation after generation of racism, poverty, disempowerment, and marginalization negatively impacts not only a woman's overall health and body, but also the baby she is carrying and her future children, her family, her

[46] See Rose 2015.

> community, and *the whole epigenetics of her tribe!*" she says. "We don't yet fully understand the depths of irreparable damage it does." [My italics].

As seen via communities of activists, American birth is becoming the site of all kinds of different levels of investment, and the bearer of anxieties about what life is, and what it could and should become. Bodies are seen as endangered, transformed by stress, chemicals, and the lack of intimacy, at the same time as their resilience is trusted to get us out of this mess. Anxieties and aspirations about the past and the future are projected onto this beginning. Structural and ecological inequalities are understood to be perpetuated through the physical and affective experiences in the first moments, days, months of life. This originary period can retrospectively explain adult outcomes, from illiteracy to diabetes to violent temperaments and callous moral judgments. Reproductive justice is concerned with not only the life and death of particular groups, but with making/enabling them to live in a certain way, to thrive, and thereby prevent the very extinction of one's community. Birth is a screen on which people are projecting all sorts of fantasies about alternative futures, and a different kind of human is engineered through birthing practices. Though such projections are all-too-easily reincorporated into dominant social narratives and categories, their potential for difference is real.[47]

[47] Utopian dreaming and utopian projects have an important history within feminist thinking. See Johnson 2002 and Cooper 2013.

Epilogue:

Glimmers of the Possible

It happened relatively inconspicuously, at a regular meeting of the Bay Area Doula Project, held that month in a downtown Oakland business center -- and yet it etched an imprint on my memory. During discussion, one of the doulas stood up with a child wrapped on her back, long bright skirt and tall bun accenting her dark skin and regal bearing, and said, clear voiced and unapologetic, "I refuse to make choices based on fear." This simple statement was the basis for an approach to life, babies, and everything, as the doula went on to explain with an elegant economy of words that seemed appreciatively received. I find that this attitude undermines the framework for much of the anxiety, dissatisfaction, and aspiration near birth that I have been discussing. Discourses of risk and safety lose their power (though of course, to not be afraid is not to be reckless). Negotiations of trust and control become simplified, their angst reduced. Judgmental tensions with peers and professionals lose their bite and grip, and a barrier to bold, transformative, near-birth activism is removed. Adopting a philosophy that (re)claims one's decisions from fear does not prevent fear, of course, but frees one to use other considerations as guides for action -- indeed, to the extent that fear-based decisions are

an unspoken default in hegemonic American culture, it requires intentional self-positioning around alternative values and affects.[1] By rejecting outright an imperative to be afraid of what might go wrong or to be anxious about "doing it right," this woman implicitly raised the question of what such alternative values and affects might be. This departure from hegemonic birth discourse opens up possibilities for idiosyncratic choices, community solidarity, and powerful anti-colonial political positioning.

In moments like this, I believed I saw transformative social potential near birth. These were moments that transcended the personal transformation so often hailed in birth-story narratives of trauma, empowerment, or feminist galvanization. Although such personal experiences are implicated in and instrumental to social shifts, the "transcendent" social is more than the sum of its parts. Personal awakenings are more accessible manifestations of this potential; what I found remarkable, and deeply alluring, were these glimmers of radically different sociality and the ways of knowing and being that might underpin it. This potential is what drew me near birth as a researcher, and to the California Bay Area. It is not so much that Californian practices near birth are different from elsewhere in the country (though this is to some extent the case), but rather that the discourses and imaginaries that surround those practices are remarkable. These include narratives about what reproduction is and does that both implicitly and explicitly mobilize utopian and dystopian fantasies. They include hyperbolic rhetoric, and ideals that can be visionary, polarized, and innovative. Sometimes such ideals are flickering and fragmented, and sometimes part of grand activist narratives. Sometimes they are creatively anti-hegemonic and other times they creatively re-entrench

[1] See Glassner 1999, Davis 1999, and Masco 2014 on the American relationship with fear and related emotions/affects.

heterosexist values and extremes of racist, exploitative, neoliberal capitalism -- moreover, the two are not mutually exclusive. These imaginaries act out social, political, and ethical questions that are latent in larger US contexts.

The past five decades or so have entailed significant cultural shifts in the United States. A new race politics has evolved with civil rights and the "browning" of the US population, and the queering of social life has posed questions and possibilities about what family and intimacy might be. Class narratives of an attainable American dream or egalitarian middle have been de-masked as illusory and exclusionist. Political apathy and reactionary political horror are two sides of the same distrust and disaffection, signaling the dominance of the neoliberal private-consumer mode. Heteronormative, white, middle class people are reacting and adapting to this swirl that de-centers their collective perspective and privileges, and in many ways this is reflected in this group's childbearing practices, which are a mirror for a host of new anxieties. Thus looking near birth -- as opposed to other spheres of heightened anxiety, instability, and scholarly and popular attention pertaining to reproduction, notably abortion and assisted reproductive technologies -- allows us to see the broader contemporary moment and the future of "unmarked" American culture.

Contemporary contests over childbearing practices and discourses braid together consumer worlds, professional stakes, gendered politics, racial tensions, histories of discrimination, and environmental degradation, change, and threat. They braid together many of the threads that wind through the contemporary historical moment. Birthing, and what clings near it, is an increasingly ambitious space, where people's aspirations for what to find or do in the experience are proliferating and aggrandizing. While one possible approach to birth is as a moment to endure and move on from, my research shows that this is not at all what is

happening in the Bay Area, where even those who do attempt to endure and move on do so in an environment swirling with literal world building. Near-birth practices are (re)building a class system, a race system, a biology, a sexuality, a chemical order, a gendered order, a spirituality, a myth-history, an ecology. The *possible* stakes couldn't be higher, or implications wider. At its best, this world building grasps at ways of being and knowing that are incommensurate with hetero-patriarchal colonial capitalism and privatized professional expertise. Such moments of possibility are elusive and often unarticulated, easily co-opted; yet I argue that their presence makes near-birth worlds important areas for inquiry and attention.

By looking specifically near birth, and not at the inflamed abortion debate or eerie sci-fi possibilities of assistive reproductive technologies, those more publicly contentious and ethically murky areas of reproductive worlds, we can see other social questions and possibilities come to the fore.[2] Rather than mirroring standard concerns "near reproduction," such as kinship, women's autonomy, or the use and abuse of "life", worlds near birth show us the social implications of interconnectivity and contextual attunement.[3] They grapple with the

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[2] Abortion and reproductive technologies have received more recent scholarly and journalistic attention than birth, despite affecting fewer people. The recent fluster around (comparatively *quite* uncommon) transnational surrogacy and its ethical, raced, classed, colonial implications is an excellent example. Perhaps birthing seems uninteresting because it is common, and perhaps birthing among hegemonic and privileged groups seems narcissistic and un-implicated in the futures of marginalized people - I argue otherwise.

[3] The concept of "life" is deployed to political ends in popular and some academic discourse, and has come under critique by academics like Angela Willey (2016), who argues that through the category of "life," genealogies of materialism in Western thought smuggle a power-neutral conception of the human into critical theory. Neither conceptions of human life nor of matter, that false binary critiqued by material feminists, are outside power relations. Neither category is obvious, and within both are highly uneven attributions of value and meaning. As I suggested in Chapter 4, thinking with a processual idea of personhood, derived ethnographically near birth, instead of a life/non-life binary, offers a way out of the "life" stalemate in current political debates and shows that "life" and the "material" (or contextual, practical) are inseparable.

fact that all fates are always already intertwined and mutually implicated, and not even just those of humans (though especially those of humans). Childbearing in the Bay Area demonstrates the fallacy -- and appeal -- of many kinds of divisions, including ontological/epistemological divisions underlying what I have called regular physiology, political divisions sustaining distracting media wars, and temporal divisions between past purity and imminent pollution. Birth worlds show how qualities of life are profoundly *in common* and *in process,* even while opportunities for living are vastly disparate, and seemingly rigidly so. In doing so, birth worlds destabilize conceptions of the liberal individual, and the colonial-capitalist ontology/epistemology and ethics he sustains. Birthing is a tightly controlled and heavily contested space where discord and transformation in the social order is latent.

By examining birth worlds, we can see that reproduction is not a niche concern shaped and influenced by knowledge systems, categories of social organization, and gendered/classed/raced orders, as it has largely been treated in social science literature. Rather than being "far" from such overarching problematics, or subordinate to them, reproduction is dangerously near them, impinging upon them, speaking back to them, belying their inevitability. From the vantage point of childbearing practices, things like funerals for fetuses, adoptions of embryos, and rentals of wombs seem like symptoms of more profound social instability rather than instances or negotiations of instability themselves. Birth worlds as an object of investigation make clear that the contemporary politicization around reproduction is not about how a pregnancy should end -- i.e., whose rights are at stake and what "life" is -- but about what a pregnancy is (an opportunity for) in the first place. Unruly and uncharted conception technologies introduce questions of kinship, unequal access, regulation, and the heteronormative order, but such questions are underlied by a colonial-capitalist

epistemological/ontological order and its concomitant ideas of personhood, ethics, materiality, and efficacy. This "deeper layer" is what agitation near birth is grappling with and attempting, in piecemeal ways, to alter. I do not intend to reify such metaphorical layers, as discussions around abortion and ART are also entwined with those near birth, nor do I wish to trivialize the important and interesting work done in other studies of reproduction, but I do argue that controversy near birth raises questions that are more fundamental, and speaks to potentials that are more widely resonant and that ripple outward from reproduction with more ease.[4]

Looking more recently than the fundamentals of capitalism and colonialism, to the past few decades in the United States, we see that the transformation in ambitions for birthing has taken place in a context of parallel politicizations of women's bodies. It is quite relevant that the multigenerational project to de-authorize abortion and the proliferation of ways to technologically assist conception took place simultaneously with the movement to reclaim "traditional" or "natural" childbearing practices. The past forty or fifty years have seen simultaneous revolutions in the laws, technologies, and practices involving women's bodies, and the resulting tumult has had great resonance and trenchancy -- whole presidential campaigns have been run on the issue of the nuclear family and reproductive politics. The 2016 presidential debates featured not only abortion and Planned Parenthood as key issues, but paid family leave and birthright citizenship. Prior, President Obama controversially

[4] This analytical perspective for which I'm arguing is itself difficult to categorize, and thus this work straddles and draws from cultural and medical anthropology, American studies, STS, gender studies and feminist philosophy, and political-economic critique. It exceeds the bounds of the anthropology of reproduction, properly defined. This breadth of conversational interventions and connections is its strength. In it, rather disparate conversations cohere because the implications and questions I write about are produced by a particular cultural-historical-regional moment, in which all of these conversations have a stake.

promoted access to childcare, preschool, and medical care, which are reproductive essentials in a contemporary liberal society.

Simultaneously, childbearing has become more complicated, its stakes more loaded. While the center of gravity has moved away from the mother's experience to that of the fetus or infant, the possibilities for being a "bad mother" have increased, and mothers, as an archetypal figure, are being held responsible for things no individual can control. The past decade has featured intense climate change conversations and we are now confronted with an anthropocene in which every environment is changing, wherein engineered environments are enabling life to continue in conditions that are going "elsewhere" -- it is thus probably quite true that the womb environment is shifting. Given the post-WWII reality of hundreds of synthetic chemicals shot out into environment, it is a fact that global conditions have already shifted, and therefore every being and body in it has already been altered and implicated. As information and anxiety about this situation spreads in birth worlds, there is the assumption that by knowing these things, an individual -- a mother -- can do something about them. And morally must, as a person who loves and protects her child. Consider Sandra Steingraber's call to be petrochemical "abolitionists", and Ariel Martin's seizure of culpability that launched the BirthKeepers -- both felt the individual pressure as mothers, and reacted to it by drawing in others and calling out social situations. But like the "hysterical" women of privilege in the nineteenth century, only a few are able to grab their diaphanous oppression/depression and go

public with it, turn it into something, while many more tolerate, to their detriment, having impossibility heaped on their shoulders.[5]

On both these fronts of reproductive politics, there is an increasing interest and investment in the origins of persons. This is a moment of emancipatory potential that could be seized, because given the interconnectedness of life conditions and qualities, for anyone's birth to be "saved," "the world" would need to be saved as well. Yet this radical potential for co-implication is easily co-opted, because we are ultimately dealing in imagination: imaginaries about what someone (or I, or we) *ought* to be getting versus what that person is *actually* getting. And this discrepancy can yield resentment, indignation, and anger as easily as, or more easily than, it can yield recognition and communality. As choices near birth proliferate, the imaginations of what the experience could be also get more weighty and complicated. That more than two thousand books on childbearing were published in less than a decade speaks to anxiety about its potentials![6] There are enormous disjunctures between aspirations, fears, and realities near birth. Such disjuncture signals instability, and with it the possibility for significant movement and stubborn re-entrenchment.

Throughout this dissertation, I have elaborated on the various fantasies at work in the disjunctures between aspiration, fear, and reality near birth. By "fantasy" I mean a situation that is imbued with highly positive or negative affects, a utopian or dystopian imaginary. To

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[5] Note: I am here discussing the situation of people privileged by race, class, cisgender, sexuality; I am doing so to make a point about how anxieties, double binds, and responses circulate in hegemonic discourses. As described in Chapter 6, black, LGBTQ, and otherwise marginalized groups are feeling pressures and taking actions in different, though not unrelated, ways.

[6] An Amazon search of the "pregnancy and childbirth" category of books published since 2010 yields 2100 entries, accessed in May 2017. This is of course not an accurate count, but a rough estimate, considering duplicate entries and relevant titles in other categories.

point to this affective investment is not to deny the situation its reality. Chapters 1 explored fantasies of autonomy from institutions and institutional expertise, enabled by a fantastic contextual-intuitive physiology and the silver bullet of empirical evidence. Such dissatisfaction with institutions is manifest in fantasies of relationships, such as between birthing people and doulas or midwives, or within nuclear families. Yet relationships are also mobilized in disturbing fantasies of war, judgment, isolation, and being controlled, discussed in Chapter 3. Fantasies of non-mediation were explored in Chapter 4 as nostalgic searches for an elusive "natural" and romanticized sorts of intensity and immediacy. These are closely related to a utopian idea of primacy and a fantasy of human origins, and are foils for the fantasy of techno-medical triumph over pain, death, and uncertainty. Chapter 5 developed fantasies of peril, toxicity, precarity, and degeneration, fueled by the impossibility of isolating and controlling origins. The fantasy of a "root" movement occupied Chapter 6, a search for a cause that would link all injustices into a grand sweeping Solution, which is in its way also a fetish of origins, seeking a problem from which all others stem and around which diverse coalitions can agree and align. Historical fantasies of various pasts and legacies circulate throughout birth worlds: claims to connections with early-modern European peasants called witches, indigenous and African traditional practices, communally-oriented female sociality among Euro-American settlers, and the beneficial progress of scientific rationality and professional medical knowledge. "Right wing" and "left wing" fantasies meet near birth, where radical doulas and birth anarchists cry out against the patriarchy while Christian fundamentalists find purpose in domestic utopias, where both link spirituality with "nature" and find political-ideological passion in the details of everyday embodiment. There are progressive and conservative

versions of dissatisfaction with neoliberal alienation and regularity; there are socialist and libertarian fantasies of birthing different social orders.

Such fantasies are almost never engaged as such, wholesale, explicitly; their utopian/ dystopian character makes them more affective and imaginary than practical, and as I've emphasized throughout, people "on the ground" constantly make hybrids and make bricolage and make do. Yet these fantasies are the terrain through which they navigate, the visions around which they orient. The questions raised near birth are nothing less than what is the future of society, and what kind of human is being built for this future society? Both the infrastructure and the kinds of people who will rely on it are being (re)invented in the contemporary moment. Certain arrivals and new norms make both former and potential ways of being unthinkable or impossible, while universalizing claims and projects capitalize on such foreclosures. The universal scope of fantasies near birth is manifest in hyperbole and polarization. The world appears to need reinventing, and in quotidian hybrid ways, people are doing so, near birth.

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