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ECSTATIC PAIN AND A LABOR OF LOVE:
EMOTIVE PRAXIS OF THE MIDWIFERY MOVEMENT

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

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In the United States, childbirth is the number one cause for hospitalization, and the authoritative status of biomedical knowledge obscures other ways of birthing. Childbirth is contested terrain, however, and the independent midwifery movement offers a safe alternative to the culturally dominant rational-technological approach. Because birth uniquely bridges the biological and the social, contention over ways of birthing is likely to have significance at the level of emotions. This is especially so given the routine use of electronic fetal monitors, epidural drugs, lithotomy tables, and episiotomies in hospital birth and the oppositional midwifery view that birth is a healthy state of personal and family transition.

In this study, I use the midwifery movement as a case to examine how social movements create and legitimize new emotion knowledge and normative frameworks. Through a running exchange between existing theory and empirical research, I integrate cultural approaches to social movements (Eyerman and Jamison 1991; Melucci 1989, 1997) with relevant ideas from the sociology of emotions (Hochschild 1975, 1979, 1998; McCarthy 1989; Perinbanayagam 1989) to generate a new model that joins recent work (Goodwin, Jasper and Polletta 2001; Aminzade and McAdam 2002) that treats emotions as central to political protest.
Data from intensive interviews, secondary sources, and movement documents reveal that the midwifery movement's contention with established political authorities is best understood as an attempt to legitimize alternative knowledge about childbirth. I find that central to the movement's alternative knowledge are feeling rules and interactional resonances that replace fear with trust, pain with pleasure, and the supposed neutrality of impersonal material reductionism with love. Through constructing and disseminating alternative feeling rules and interactional resonances, the midwifery movement transforms specific emotion interests into new emotion knowledge. Analysis of the distinctive goals of the midwifery movement therefore offers support for a new and expanded conceptualization of social movements as emotive praxis.
dedicated to Anthony Vigorito,
my True Love

AND

dedicated to my mother
and her sisters
who are also mine
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Last, but certainly not least, I am humbly grateful in the presence of Divinity.
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CHAPTER 1

CONTENTION OVER CHILDBIRTH

Birth, a physiological process with certain universal characteristics, is at the same time an individual experience totally unique to each woman who experiences it and a profoundly significant cultural event, as the future of society (still) depends on women giving birth to babies who will grow up to perpetuate that society. Thus, all human cultures take an interest in birth, stamping this physiological and individual experience with a distinct cultural imprint.

—Robbie E. Davis-Floyd (2001:viii)

Nearly all of the 4 million babies born every year in the United States (93%) arrive under the authority of an obstetrical surgeon (Ventura, Martin, Curtin, and Mathews 1998). Childbirth is the single most common cause for hospitalization (U.S. Bureau of the Census 1998), and there is a national trend toward surgical delivery—even though the majority of cases are vaginal births with no complicating diagnoses (Agency for Health Care Policy and Research 1997). Because the hospital is a “thoroughly rational service institution” (Goffman 1961:347) with a mission to treat sickness and disease, “once the decision is made to give birth in a hospital, it is difficult to avoid the complexity of medical technologies routinely used” (Guillemin and
Holmstrom 1986:49).\footnote{Because biomedicine\footnote{Biomedicine is primarily focused on human biology, physiology, and pathophysiology (Hahn and Kleinman 1983) and is legitimized under the guise of “scientific medicine” (Berliner 1985). I use the term to distinguish from other approaches to medicine, defined more broadly as “the art or science of restoring or preserving health” (Webster 1975).} exhibits a general neglect for emotions (Baker, Yoels, and Clair 1996), hospital birth tends to be as impersonal and routinized as any other hospital procedure (Ritzer 1996). The similarities are, in fact, striking.

As described by medical anthropologist, Robbie E. Davis-Floyd (1992a), the typical uncomplicated hospital birth begins with a wheelchair ride to the “prep room” where the mother is separated from her partner, dressed in a hospital gown, shaved, and given an enema. She is brought to bed, administered an IV to compensate for the food and drink she does not receive during her labor, as well as a pitocin drip to stimulate uterine contractions and analgesia/anesthesia to relieve tension and pain. Whether to speed her labor or to insert an internal electronic fetal monitor, her membranes are artificially ruptured. If an external fetal monitor is used instead, she is attached to the machine by large belts strapped around her abdomen. She is subjected to cervical checks at regular intervals to monitor her progress and issued commands about when to push and when not to push. If she is transferred to a separate delivery room (during which time she must not push), the mother is wheeled down a hall on a high flat table to a sterile environment where, although her hands are no longer strapped down,\footnote{This practice was common until the late 1970s.} her bottom is scrubbed and she is covered with sterile drapes. As the baby’s head appears, the mother’s perineum is cut to enlarge her vaginal opening. Once out, the baby is separated

\footnote{Hospital birth is characterized by a level of efficiency, calculability, routinization, and technological control that ultimately generates irrationality (Ritzer 1996).}
from the mother for quantitative assessment, washing, prophylactic eye treatment, and a vitamin injection. The baby is handed to the mother for a brief period of "bonding" before being removed to the nursery and a plastic bassinet or radiant warmer for 4 to 12 hours. After mother and baby are reunited, there is a second wheelchair ride out of the hospital.4

While not every hospital birth incorporates every procedure in this typology, most childbearing women in the U.S. undergo most of the above procedures most of the time (Davis-Floyd 1992a). Because biomedical knowledge is granted authoritative status (Jordan 1997), the possibility of other ways of birthing is obscured (Davis-Floyd and Davis 1997) even to obstetricians themselves (Wagner 1997). Nevertheless, there is at least one feasible alternative to hospital birth.

Home birth has been shown to be cost-effective (Anderson and Anderson 1999), and in comparison with hospital based physicians, independent midwives have been found to have better outcomes in terms of complications and overall neonatal health (Mehl, Ramiel, Leininger, Hoff, Kronenthal, and Peterson 1980). Because the midwifery approach diverges from the biomedical approach in both principle and practice (Davis-Floyd 1992a; Rothman 1979, 1982), the existence of independent midwifery renders childbirth contested terrain (Declerq, DeVries, Viisainen, Salvesen, and Wrede 2001; Rothman 1978; Suarez 1993). In contrast to the rational-technological biomedical approach, the wholistic midwifery approach holds that birth is a normal, natural, intimate,}

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4 Repeated international randomized controlled trials of perinatal care show every aspect of the routine hospital approach to be scientifically unwarranted (Enkin, Keirse, Renfrew, and Neilson 1995).
woman-centered process involving a great deal of physical and emotional effort on the part of the mother (Chester 1977) but working smoothly in the vast majority of cases.

Birth is a unique bridge between the biological and the social (Crouch and Manderson 1993), and contention over ways of birthing is likely to have significance at the level of emotions. Previous research suggests that while hospital birth enacts the culturally dominant value of technological separation, home birth enacts the culturally subordinate value of organic interconnection (Davis-Floyd 1992b, 1994, 1996). These divergent value orientations seem to be accompanied by different emotion orientations as well. For example, mothers interviewed by Davis-Floyd (1992b) clearly communicate distinct attitudes toward pain. One woman, a hospital-birther, reported that, “Out of the birth experience itself I wanted no pain. I wanted it to be as simple and easy and uncomplicated as most everything else has been for me” (1992b:70). In contrast, another woman, a home-birther, stated that, “Even though during labor I remember feeling it was almost unbearable, it never entered my mind to wish I had ‘something for the pain.’ …[There is] wonderful physical and emotional stuff going on at the same time as the pain” (1996:86). Inspired by the possibility that midwives resist biomedical birth because of the way emotions are constituted therein, this research asks: 1) What are the distinctive goals of the midwifery movement?, and 2) What does this case illustrate about social movements and emotions?
1.1 **Purpose of this Research**

This inductive study draws on, integrates, and extends theory in the sociological subdisciplines of social movements and emotions. I was first motivated to apply the sociological lens to midwifery over 7 years ago by scholarship on gender and power. For reasons that were unclear to me then, however, I found the gender-power framework limited in its capacity to satisfy my curiosity. I went on to study social movements theory, political sociology, theories of social change, and cooperative organizations. The latter brought me to the sociology of emotions, and it was there that I found what had been missing years before.

I was initially interested in the fundamentally woman-centered character of midwifery – its emergence from women, its focus on women, and its attention to an activity performed solely by women. In a course on gender, I read Acker's (1990) arguments about the gendered nature of organizations, which enabled me to distinguish between male biomedical practitioners and the masculinity embedded in the biomedical profession as well as the organization of the hospital. I was puzzled by the question of

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5 Organizations are gendered in at least five ways: 1) there exists a division of labor along lines of gender, 2) symbols and images reinforce that division, 3) interactions enact dominance and submission, 4) this produces gendered components of the self, and 5) gender is embedded in the conceptualization and creation of social structures (Acker 1990). It is the last observation, discussed in detail by Smith (1987, 1990), that I find most intriguing.

6 While I hesitate to risk biological essentialization of gender, social history has produced at least one split that is signified by the terms “masculine” and “feminine.” For lack of better language at this time, I use those terms heuristically in this paper. I do so with full knowledge that there are many masculinities and femininities (e.g., Connell 1987), and that gender is cross-cut with sexuality, race/ethnicity, and social class (among other distinctions).

7 While few studies explicitly analyze the gender embedded in biomedicine (e.g., Ehrenreich and English 1973; Morantz-Sanchez 1985), the exclusion of women from the creation of both the profession and its structural manifestation are well documented (Baer 1989; Berliner 1985; Borst 1990, 1995; Brown 1979; Donnison 1977; Duffy 1993; Friedson 1970; Litoff 1986, 1990; Starr 1982).
what distinguishes the “feminine” approach to birth from the “masculine.” What does the midwifery approach offer that biomedical birth does not? Given the existence of male midwives, what is it exactly that defines midwifery?

As I read the social movement theories of Melucci (1989, 1997) and Eyerman & Jamison (1991), I made connections between their distinct yet complementary approaches and what I already understood of midwifery (see Chapter 3). Conversely, the contours of a midwifery movement clarified as I read about submerged networks and cognitive praxis. In this inductive study, I combine those conceptual frameworks to examine how social movements produce new culture and knowledge. As scholars have recently pointed out, however, even culturally oriented social movements theory tends to neglect emotions (Goodwin and Jasper 1999), and it took exposure to the sociology of emotions for me to consider the way “feelings themselves and their social expression are differently constituted for people whose social relations and social worlds are marked by difference relative to the worlds of others” (McCarthy 1989:57, original emphasis).

Because most women (60-80%) report negative feelings after their babies are born (Taylor 1996), and because many specifically attribute their intense dissatisfaction with birth to the treatment they received in the hospital (Kitzinger 1992), I wondered whether emotions were differently constituted in the social world created by home birth midwives. Recent work in the sociology of emotions suggests an interesting question for social movements scholarship — as Thoits (1990:182) asks, “How do subcultural and

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8 McCarthy (1996) argues that knowledge is best understood as culture.
protest group members create and legitimize new emotion norms...?9 More broadly, how do social movements create and legitimize what McCarthy (1989) calls emotion knowledge?10 Turning to the existing literature on social movements and emotions, I found that scholars have begun to explore this dynamic (Britt and Heise 2000; Groves 1995; Jasper and Poulsen 1999; Taylor 1995, 2000; Taylor and Rupp 1999). Because existing studies tend to focus on movements where the transformation of feeling rules is a means to some other (more obviously political) end, however, to date no one has sufficiently explained the process whereby social movements create and legitimize new emotion knowledge.

Drawing on culturally oriented theoretical perspectives on social movements (Eyerman and Jamison 1991; Melucci 1989, 1995, 1996, 1997) and relevant ideas from the sociology of emotions (Hochschild 1979, 1983, 1990, 1998; McCarthy 1989; Perinbanayagam 1989), this research aims to determine the extent to which change in emotion knowledge is a goal of the midwifery movement and to use that unique case to explain the process by which social movements create and legitimize new emotion knowledge. Specifically, this research asks:

1) What are the distinctive goals of the midwifery movement?

2) How does the movement create and legitimize new emotion knowledge?

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9 Thoits (1990) uses the terms "emotion norms" and "feeling rules" interchangeably. At times I do as well, although I consider feeling rules to be indicative of underlying emotion norms.

10 i.e., knowledge about emotions embedded in people's interpretations of reality and thereby fostering particular kinds of experiences (McCarthy 1989).
Through a “running exchange” between existing theory and empirical analysis (Burawoy 1991:11), this inductive study generates a new analytical model that extends theory on social movements and emotions.

1.2 Importance of this Research

This inductive study draws on and extends sociological theory on social movements and sociological theory on emotions. Because independent midwifery is a health-related movement that emerged from women and for women, findings may also be of interest to scholars of gender, power, and health policy.

Scholars of social movements have recently turned their attention to the role of emotions in collective contention (Jasper 1998). Existing empirical studies show emotions to be central to the motivation to join a social movement (Britt and Heise 2000; Jasper and Poulsen 1995; Taylor 1995), as well as the creation of collective identity and solidarity (Britt and Heise 2000; Taylor 2000; Taylor and Rupp 1999). The latter may be the result of emotional capital raised by activists (Britt and Heise 2000) or emotion labor performed by activists (Taylor and Rupp 1999). Additionally, movements have been shown to transform the feelings of their participants through redefinition (Britt and Heise 2000) and through the provision of alternative feeling rules (Taylor 1995).

The emerging literature on social movements and emotions seeks to reconcile images of a rational actor consciously engaged in cognitive processes with the equally present emotional dimensions of human life. To date, however, no one has studied emotions as the goal of social movement activity. Doing so enables the synthesis and
extension of complementary cultural approaches to social movements (Eyerman and Jamison 1991; Melucci 1989, 1995, 1996, 1997). Integrating those useful but incomplete approaches with relevant ideas from the sociology of emotions, this inductive study generates a new analytical model to explain how movements create and legitimize new emotion knowledge. This research thereby contributes to an “interdisciplinary renaissance in interest in emotion” (Hochschild 1998:3), which history shows to be much needed.

From its inception, Western civilization has promoted a conceptual dichotomy between reason and emotion (Emirbayer and Goldberg working paper), with emotion denigrated as uncertain and irrational (Barbalet 1998). The perpetuation of that bias has been linked to the gendered11 history of scientific knowledge, wherein the men who practiced science in its formative years12 presented manhood as rational and intellectual and womanhood as irrational and emotional13 (Rowland 1988). Science came to exclude not only women, but all things defined as “inferior” and/or feminine (Schiebinger 1989). Emotion was thereby marginalized as unworthy of scholarly attention.

Still, although a systematic sociological approach to emotion was not begun until the end of the 20th century, the classical theorists all touched on emotion-laden aspects of social life. Durkheim considered shared sentiments of collective effervescence to be the

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11 Gender refers to social relations that separate people into differentiated statuses that signify power relations (Lorber 1994). These statuses are linked to the binary opposition of biological sex and are inextricably influenced by cross-cutting racial, sexual, and class-statuses.

12 Women were historically excluded from the practice of science (Rowland 1988), as were most men.

13 Not all men were granted the status of manhood, however, and binary oppositions regarding differences across boundaries of race and social class regardless of sex were also promoted by early practitioners of science (Schiebinger 1993).
foundation of social cohesion. Marx viewed the alienation of workers from their productive activity, the product of their labor, their fellow workers, and their human potential to be the very condition that would eventually undermine the capitalist system. Weber considered charisma to be one of the most powerful forces for political revolution. None of these men used language that would today be used to signify emotions, but it is nonetheless evident that they recognized the importance of emotions in social life.

Collective effervescence serves to bond people because it feels good. Alienation is problematic because it feels bad. Charisma is an elusive quality precisely because it taps into a level of consciousness that scholars are just now beginning to explore systematically.

Only after the rise of the psychological and mental health industries in the 19th century did people come to hold the vocabularies with which we understand and experience emotional states in our current age (McCarthy 1989). These vocabularies are still being constructed, and research in the sociology of emotions has helped forward our understanding through application of the sociological viewpoint. Most existing sociological research on emotions draws from existing psychological and physiological research, and thereby neglects to seriously engage in “an autonomous sociological perspective on mind, self, and emotion” (McCarthy 1989:52); i.e., one based purely in sociological theory. This inductive study advances sociological understanding of

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14 A simple exploration of the dictionary shows such understanding to be much needed. Webster’s (1975) defines emotion as “an affective state of consciousness distinct from the cognitive and volitional states of consciousness.” Unfortunately the term affective is defined as “causing or expressing emotion.” This circularity belies the dearth of understanding about emotions and the significance they hold for human social life.
emotions by integrating contemporary social movement theories with ideas from the sociology of emotions to explain how new emotion knowledge is created and legitimized by goal-oriented collective action.

At a more pragmatic level, health policy research has recently called attention to the need for studies that investigate the underlying pathology of existing systems (Davies 2001), as well as the need to focus on women’s own understanding of health-related issues (Crooks 2001). The gender-power dynamic of biomedicine has often been detrimental to women (Ehrenreich and English 1979; Fisher 1986; Scully 1980; West 1984), and in the case of childbirth in the U.S., the pressure to conform to the biomedical approach has been referred to as “emotional blackmail” (Kitzinger 1992). By giving voice to woman-centered activists resisting biomedical birth, this study illuminates a specific critique of the underlying pathology of the dominant system.

Previous studies of midwifery have examined the historical shift in control over childbirth from midwives to obstetricians (Litoff 1990; Bogdan 1990; Leavitt 1986; Oakley 1984; Donnison 1977), the complex web of gender inequalities in which this shift was embedded (Borst 1990; Litoff 1986; Donegan 1978; Ehrenrich and English 1973), and ongoing gender bias in the biomedical approach (Witz 1992; Romalis 1981; Scully 1980). Scholars have viewed midwifery as feminist praxis (Rothman 1989; Kay, Butter, Chang, and Houlihan 1988) and have explored some of the challenges midwifery poses to the biomedical approach (Kitzinger 1988; Sullivan and Weitz 1988; Rothman 1989; DeVries 1996; Chester 1997). Existing research also addresses the effects of ongoing professional conflict on the structure of midwifery practice, the lived experience of
midwives and their clients (Weitz and Sullivan 1986), and the state of public health (Wagner 1995; Stephenson and Wagner 1993; Sullivan and Weitz 1984). This study is the first to examine midwifery through the dual theoretical lens of social movements and emotions.

1.3 Scope and Limitations of the Study

Chester (1997) identifies three distinct types of midwives: grand midwives, certified nurse-midwives (CNMs), and independent midwives. Grand midwives represent an unbroken line of hereditary birth knowledge and community-based practice that survived among indigenous and immigrant populations as childbirth was medicalized. Few grand midwives remain in practice today. CNMs are biomedical nurses with additional training in the ancient art of midwifery. With origins in public health service to the urban and rural poor, CNMs have attended healthy middle-class women in hospitals since the 1970s. There is reason to believe the provision of CNMs in hospitals was a response to the economic threat posed by the re-emergence of

15 These categories are not mutually exclusive. For example, many midwives start out as independent practitioners and eventually become credentialed as certified nurse-midwives for a variety of reasons including political pressure.

16 For more information on grand midwives or traditional community-based midwifery, see: Bovard and Milton 1993; Buss 1980; Susie 1988; Logan 1989; Holmes 1990; Smith and Holmes 1996.

17 As Mary Breckenridge, R.N, pointed out in 1927, “The midwife’s calling is so ancient that the medical and nursing professions, in even their earliest traditions, are parvenus beside it” (Breckenridge 1927:1147).

18 Although many CNMs would like to offer home birth services, currently 95% work in hospitals. CNM home birth practice requires written consent of a physician, and few physicians are willing to deviate from professional norms. For a discussion of intraprofessional dynamics see Wagner 1997.
independent midwifery (Mitford 1992), which also dates to the 1970s, as women attended
the home births of those disillusioned with hospital care.

While all forms of midwifery may be viewed as based on some sense of solidarity
among women, and while midwives share a collective identity unconstrained by
credentials or lack thereof (Chester 1997), this study considers only independent
midwifery to be a social movement. Melucci (1997:262) defines a social movement as
"a form of collective action (a) based on solidarity, (b) carrying on a conflict, (c)
breaking the limits of the system in which the action occurs." Grand midwives are not
actively carrying on a conflict, and CNMs do not break the limits of the biomedical
system. Only independent midwifery, which advocates home birth for normal labor,
breaks those limits (Suarez 1993). In addition to rejecting routine hospitalization for
childbirth, whereas the biomedical model exhibits a normative demand for a neutral or
cool emotional stance from personnel (James 1989, 1992), independent midwives are
reported to "love women; they know how to listen; they are intuitive; they explain things;
they are emotionally accessible" (Cohen 1991:163). This research aims to determine the
extent to which change in the emotion knowledge surrounding childbirth is a goal of the
midwifery movement and to use that unique case to explain the process by which social
movements create and legitimize new emotion knowledge.

Because this study is concerned with movement goals, the research centers on the
personal experiences and accounts of midwives themselves. This study does not address

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19 This study defines the midwifery movement in terms of the collective action of independent midwives,
and hereafter, any unqualified mention of the midwifery movement, midwives, or midwifery is intended to
refer to midwifery that is practiced independent of biomedical control.
the experiences and accounts of birthing women and their families. Because this study is concerned with the goals of independent midwives, the research also makes no assertions regarding the goals or practices of grand midwives, CNMs, obstetricians, or general physicians who attend birthing women. Additionally, due to space and time constraints, this study does not address questions pertaining to the rise or maintenance of the midwifery movement. \textsuperscript{20} Likewise, the safety of independent midwifery has been addressed elsewhere (Beesley 1995; Mehl \textit{et al.} 1980; Wagner 1994), as has its cost-effectiveness (Anderson and Anderson 1999), and its non-medical nature (Suarez 1993). Here, the focus is on the distinctive goals of the midwifery movement and what that movement can show us about how emotion knowledge is collectively created and legitimized.

1.4 Overview

In this chapter, I have described ongoing contention over childbirth in the U.S., and I have presented two questions that guide this research: 1) What are the distinctive goals of the midwifery movement?, and 2) What does this case illustrate about social movements and emotions? I have proposed that analysis of the midwifery movement’s distinctive goals can reveal the way social movements create and legitimize new emotion knowledge. I have discussed how this analysis extends existing social movements theory by supplementing longstanding cognitive bias. I have also discussed the importance of

this analysis for understanding the social shaping of emotions and for providing insight about substantive issues of gender, power, and health policy.

In Chapter 2, I provide a detailed discussion of the theoretical perspectives and ideas that both inform and are informed by this inductive study. Specifically, I present Melucci’s (1989, 1995, 1996, 1997) two-pole model of social movements, Eyerman & Jamison’s (1991) conceptual framework of cognitive praxis, and relevant ideas from the sociology of emotions (Hochschild 1979, 1983, 1990, 1998; McCarthy 1989; Perinbanayagam 1989). In Chapter 3, I describe the research methods that I use in Chapter 4 to analyze the midwifery movement’s visible and latent cognitive praxis and in Chapter 5 to analyze the midwifery movement’s pursuit of emotion interests. In Chapter 6, I summarize this inductive study and discuss the implications of the new analytical model it generates to explain how social movements create and legitimize new emotion knowledge.
...instead of proving a theory by corroboration or forsaking a theory because it faces falsification, our preferred approach is to improve theories by turning anomalies into exemplars.

—Michael Burawoy (1991:10)

Scholars of social movements have recently begun to explore the role of emotions in all aspects of movement dynamics (Jasper 1998). This emerging literature shows emotions to be central to the motivation to join a social movement (Britt and Heise 2000; Jasper and Poulsen 1995; Taylor 1995), as well as to the creation of collective identity and solidarity (Britt and Heise 2000; Taylor 2000; Taylor and Rupp 1999). Activist have been shown to raise emotional capital (Britt and Heise 2000) and engage in emotion labor (Taylor and Rupp 1999). Participation in a social movement has been shown to transform people’s feelings through redefinition (Britt and Heise 2000) and through the provision of alternative feeling rules (Taylor 1995).

Arguing that structural approaches tend to downplay the importance of such factors, scholars interested in social movements and emotions suggest the usefulness of so-called new social movement approaches (Goodwin and Jasper 1999). New social
movements approaches question rationalist assumptions underlying structural approaches (Taylor 1995) and offer a vocabulary for examining collective challenges that do not fit conventional understandings of the political. By focusing on symbolic challenges and the construction of new meanings and knowledge, new social movements theorists provide a framework for understanding social movements and emotions.

This inductive study draws on theoretical treatments by three prominent new social movements scholars — Alberto Melucci, Ron Eyerman, and Andrew Jamison. In order to determine the distinctive goals of the midwifery movement, I draw from Melucci's (1989, 1995, 1996, 1997) two-pole model of social movements as sources of cultural innovation and Eyerman and Jamison's (1991) conceptual framework of social movements as cognitive praxis. In order to determine what the midwifery movement can show us about how emotion knowledge is collectively created and legitimized, I also integrate relevant ideas from the sociology of emotions. This chapter provides a detailed discussion of each theoretical perspective, how these perspectives fit together, and what theoretical questions remain. This chapter concludes with the proposal of a new analytical model explaining how social movements create and legitimize new emotion knowledge.

2.1 The Meaning of Social Movements

The earliest approaches to social movements focused on various psychological stresses caused by structural strains and considered collective action to be irregular and irrational (Buechler 1993). In contrast, resource mobilization (RM) theories downplayed
emotional elements and emphasized that collective action was a rational strategy for achieving valid goals (Jenkins 1995). RM thus shifted the scholarly discourse to conditions which facilitate the emergence, growth, and decline of social movement organizations (McCarthy and Zald 1977), as well as strategies for mobilizing resources and participants (Zald and McCarthy 1987). RM was extended by political process models (PPM) that focused on the role of changes in the political opportunity structure (McAdam 1982). Both RM and PPM theorists recognize that cultural processes are involved in social movements, but neither explore that dimension as a site of political contention. Primarily, RM and PPM approaches define social movements as collective actors engaged in ongoing contention against elite opponents for political goals at the level of the state (e.g., Tarrow 1998).

Conversely, new social movements (NSM) theorists point out that culture is the locus of contention for many contemporary social movements (Castells 1997; Eyerman and Jamison 1991; Giddens 1991; Melucci 1989, 1995, 1996, 1997). These emerging cultural approaches stress the need for inquiry that goes beyond the structural and conventionally political aspects of social movements (Goodwin and Jasper 1999). Cultural approaches emphasize that movements bring elements of their preferred future into the present life of movement participants (Melucci 1989). Although not political in the conventional sense of the word, such activities are seen to have important implications for power relations and social change.

Melucci (1989), for example, defines a social movement as collective action characterized by solidarity, conflict, and breaking the limits of the system. Solidarity is
defined as the recognition of actors that they are a shared social unit. Conflict is defined as the struggle between adversaries for goods or values which lay between them. Breaking the limits of the system is defined as “pushing the system beyond the range of variations that it can tolerate without altering its structure” (29). In other words, a social movement is comprised of actors with a shared identity struggling for goods or values in a manner that cannot be accommodated without some degree of change in the existing system.

For Melucci (1997), contemporary social conflicts affect the cultural production of a system through the two-pole demonstration of alternative cultural patterns (Figure 1). In his view, the public political activity of a movement — the dimension that gives a movement visibility — is a temporary and relatively infrequent necessity. When groups emerge in visible confrontation with established authorities over particular issues, opposition to the logic of public-policy making is communicated to society.²¹ That, however, is not the entirety of a movement’s significance.²² In displaying public opposition, visible political activity is an attempt to legitimize alternative cultural patterns that are produced and enacted in submerged networks of everyday life. Visibility and latency reinforce each other, and it is through both that social movements offer to society the possibility of something different. Cultural alternatives offered by social movements push the dominant system to defend its logic — thus revealing the weaknesses therein.

²¹ The dimension of visibility is oriented toward what political scientists call “third parties” (Lipsky 1968; Turner 1969), as well as toward those capable of granting goals.

²² As visibility is the dimension of activism studied by most scholars of social movements, Melucci’s model suggests the existence of far more social movement activity than is currently acknowledged in the research literature.
Melucci’s model enables analysis of the way social movements produce change at the level of culture, but the process by which visibility and latency reinforce each other to produce cultural alternatives remains unspecified.

Eyerman and Jamison’s (1991) conceptual framework of social movements as “cognitive praxis” offers one possible specification for that process. Like Melucci (1989, 1995, 1996, 1997), Eyerman and Jamison refuse to reduce a social movement to its visible organizations, focusing instead on the collective creation of identities, ideas, and ideals, as well as public space for interest articulation. From their perspective, the historical significance of a movement is defined by its creation of new kinds of social identities in combination with its relations to knowledge, including the movement’s worldview assumptions and specific issues of concern.

Cognitive praxis directs our attention to the way movements contribute to the production of knowledge by developing new ways of thinking (Figure 2), particularly through the construction of speeches, essays, articles, and books that articulate distinctive knowledge interests and cognitive identity. For Eyerman and Jamison (1991), the historical meaning of a social movement therefore lies in its potential to mediate “both in the transformation of everyday knowledge into professional knowledge, and, perhaps even more importantly, in providing new contexts for the reinterpretation of professional knowledge” (Eyerman and Jamison 1991:52). In other words, the cognitive praxis of

\[23\] In fact, Eyerman and Jamison (1991:48) themselves note that “perhaps closest to our position among contemporary students of social movements is the Italian sociologist Alberto Melucci…”

\[24\] To Eyerman and Jamison “knowledge” refers specifically to concepts, ideas, and intellectual activities which combine to breed innovations in thought and the social organization of thought. I argue, however, that knowledge is intrinsically located at the intersection of thinking and feeling.
social movements produces new guidelines for thinking, including the ability to think outside the parameters of the dominant system. Cognitive praxis is defined as a creative learning process that takes place on multiple levels, including interaction between movement activists and interaction between movement groups and their opponents in the public sphere. These levels parallel Melucci’s concepts of activity and latency, and I therefore argue that the process of cognitive praxis helps explain how visible and latent activities reinforce each other (Figure 3).

2.2 Evaluating Social Movement Theories

Social movement scholars offer multiple avenues for analyzing goal-oriented collective action. The ideas presented here are derived from cultural frameworks and present conceptualizations of social movements that do not depend of conventional definitions of politics. This does not mean they deny the dimension of state-oriented collective contention, but rather that they do not prioritize the state in their application of the sociological lens.

Melucci’s (1989, 1995, 1996, 1997) emphasis on social movement visibility and latency enables the extension of analysis beyond the realm of politics as conventionally defined, but his two-pole model does not explain the process by which visible and latent activities reinforce each other to produce alternative cultural patterns. Overlaying his model with Eyerman and Jamison’s (1991) conceptualization of cognitive praxis offers a partial explanation for movement dynamics. I say partial because use of the term
“cognitive praxis” to denote the transformation of knowledge interests into new knowledge, or the production of new cultural patterns, creates an incomplete view of knowledge as bereft of emotions. Still, the synthesis of Melucci’s perspective with Eyerman and Jamison’s is an important starting point for this analysis.

If we consider social movements to be knowledge producers that create new knowledge in submerged networks of everyday life (latency) and legitimize new knowledge in the public sphere (visibility), we can see that activities at both levels reinforce each other through the process of cognitive praxis. This view begins to account for the process of reinforcement between visible and latent movement activities, but another explanatory gap remains. As sociologists of emotions remind us, humans are both thinking and feeling creatures (Hochshild 1975).

To say that social movements produce alternative cultural patterns solely through cognitive praxis would perpetuate a view of knowledge as purely cognitive — a shortcoming of Eyerman and Jamison’s (1991) approach. For the term “knowledge” to have meaning distinct from “thought” or “ideas,” it must not be reduced to mere cognition. For the term “knowledge” to have meaning, it must be mapped at the intersection of thought and feeling, cognition and emotion. One may think a thing, but until it is also felt, it is not known. In order to make sense of the way social movements produce new knowledge, we must therefore consider whether such a thing as emotive

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25 The word “emotive” has a very different connotative meaning than the word “emotional,” and I choose the former term for its specific definition as “characterized or pertaining to emotion” as well as “productive of or directed toward the emotions” (Webster 1975).
praxis exists. To that end, this study also draws from theoretical perspectives from the sociology of emotions.

2.3 The Social Shaping of Emotions

Systematic application of the sociological perspective to the study of emotions is a relatively recent theoretical development, and scholarship in this newly emerging subdiscipline exhibits a variety of epistemological approaches (Franks and McCarthy 1989; Kemper 1990). These range from the positivist stance on emotions as objective phenomena (Kemper 1987) to the constructionist stance on emotions as social emergents (McCarthy 1989). The former suggests that sociological studies of emotions must accommodate a priori physiological foundations. The latter suggests that no aspect of emotions exists uninfluenced by sociocultural factors.

Because theoretical conceptualization of emotions occurs within a socially variable cognitive and linguistic framework (Franks and McCarthy 1989), it is important to consider the relationship between emotions and cognitions. Not only are emotions shaped by sociocultural context, but cognitions are shaped by a context of emotions (Collins 1986). Bringing emotions from margin to center, then, is the overarching project of the sociology of emotions. Although there is a risk of reifying the distinction between cognition and emotion, the analytical value of such heuristic distinction remains. In particular, by considering emotions as distinct from cognitions, we are able to focus the sociological lens on that which has been neglected in scholarly work and thereby supplement existing cognitive bias.
Ideas generated by sociologists of emotions whose work derives from symbolic interactionist and social constructionist perspectives are most relevant to this study. Noting that emotions have meaning only in relation to specific sociohistorical contexts (Hochschild 1975; McCarthy 1989), these scholars assert that although feelings pervade human life, they are subject to variation across time and space. From that perspective, interpretation plays a central role, as does the cultural backdrop against which feelings are felt.

Hochschild (1979:522), for example, asserts that humans are profoundly socialized “to pay tribute to official definitions of situations with no less than their feelings.” She notes that when people talk about feelings they often make reference to rights and duties associated with them. Specifically, people offer rule reminders in the form of linguistic claims about how one should feel, call for accounts of feelings, and extend verbal sanctions such as teasing or scolding each other for feeling particular ways. These dynamics highlight the existence of feeling rules, which subtly stipulate the appropriate extent, direction, and duration of a feeling given the context of its situation. Hochschild suggests feeling rules are a fundamental component of ideology and asserts that shifts in ideology are accompanied by changes in the rules for both thinking and feeling reactions.

To explain how culture shapes feeling, Hochschild (1998) suggests the metaphors of an emotional dictionary and an emotional bible. The dictionary is a collectively shared set of ideas about what feelings are feel-able, like a book listing all the feelings one could possible have under particular circumstances. The bible is a set of prescriptions which
designate ideals about when to feel certain things, who one should feel certain things
toward, and how strongly said feeling should be felt (all buttressed by beliefs concerning
how important said feeling should be). The emotional dictionary enables the matching of
inner experience to a collectively shared sense of reality. The emotional bible lays out a
set of feeling rules. Together these form the emotional culture (Gordon 1989), which
interacts with social context to result in emotional experience for the individual. As the
emotive component of ideology, feeling rules embedded in emotional culture are subject
to defiance and contention (Hochschild 1979).

Similarly, McCarthy (1989) argues that the emotions of any given age conform to
that age’s forms of knowledge. In addition to telling people what their feelings mean, the
forms of knowledge that characterize any historical period provide the framework
through which people feel any particular emotion in the first place. Because humans
exist in relation to a social world, emotions have an emergent quality that arises within
specific acts and group processes (McCarthy 1989). From this perspective, emotions are
cojointly fabricated by humans and are “rendered meaningful only within a society’s
forms of knowledge” (67). It is important, therefore, to analyze the construction of
“emotion knowledge” and its institutional and expert dissemination.

That such dissemination is itself suffused with emotion is suggested by
Perinbanayagam (1989), whose concept of “interactional resonances” directs our
attention to the subtle yet articulatory (though not necessarily verbalized) existence of

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This parallels Hochschild’s (1998) metaphor of the emotional dictionary.
emotional exchange. From this perspective, emotions are not to be contrasted with cognitions, but rather understood as inseparable aspects of human being, seeing, and doing. They are inescapable presences that permeate interaction and enable a shared energy exchange or mood. Recognizing that emotions are immediately framed within particular cognitive structures linked to signifying terminologies, this view maintains that emotions are socially defined and situated — that they are “occurrent states.” From this perspective, emotions suffuse all social acts, and emotional experience emerges in an ongoing emotional context within which individuals take the role of the other (Shott 1979). Ambiguity shifts into identification, display/expression, and ultimately experience through reflexive process (Rosenberg 1990). The sum of each interactant’s individual reflexive, role-taking process constitutes interactional resonance. The term “interactional resonance” labels the subtle yet articulatory exchange of emotional energies (Collins 1981).

2.4 Evaluating Emotion Theories

Sociologists of emotion offer multiple avenues for including emotions in sociological analysis. The ideas presented here derive from symbolic interactionist and social constructionist frameworks and present conceptualizations of emotions that do not depend on a priori physiological states. This does not mean they deny the physiological dimensions of emotional experience, but rather that they do not prioritize the biological in their application of the sociological lens.

Hochschild’s (1975, 1979, 1983, 1990, 1998) ideas about feeling rules provide a useful starting point for assessing the relationship between social movements and emotions, and, in fact, much research on that topic draws from her ideas (e.g., Groves 1995; Taylor 1995). Because this study analyzes changes at the level of emotions as the goal of the midwifery movement, this research offers an innovative approach. Here, the notion that feeling rules are subject to contention enables the construction of a conceptual parallel to the “thinking rules” that social movements challenge through cognitive praxis. In other words, consideration of emotions as goals leads to consideration of the possible emotive praxis as well as cognitive praxis of a social movement.

McCarthy’s (1989) emphasis on the construction and dissemination of emotion knowledge by institutions and experts parallels Eyerman and Jamison’s (1991) sense of movement intellectuals articulating a movement’s cognitive interests. In other words, just as movements have cognitive knowledge interests, they have emotive knowledge interests, or emotion interests. Additionally, her sense of emotions as emergent and tied to forms of knowledge directs our attention to the inadequacy of an approach to knowledge that focuses only on its cognitive components. Likewise, Perinbanayagam (1989) directs our attention to the subtle interactional exchange of emotional energy. Suggesting that emotional forms permeate human affairs and that any given circumstance can give rise to particular occurrent states of emotion, this idea allows us to focus on the way emotions resonate among individuals in ongoing experiences of everyday life.
Bringing ideas from the sociology of emotions to bear on this study’s research questions enables the extension of existing social movements theory. If feeling rules are subject to contention, and if interactional resonances vary depending on the stance of individuals involved, then movements activities that produce alternative feeling rules and/or alternative interactional resonances are ultimately concerned with producing alternative emotion knowledge. If, for the purpose of addressing cognitive bias, we think of knowledge as “emotion knowledge,” then efforts to produce alternative emotion knowledge may be thought of as emotive praxis (Figure 4).

2.5 Summary

In this chapter, I have presented theoretical perspectives from scholars of social movements and scholars of emotions that both inform and are informed by this inductive study. Through a running exchange between existing theory (Eyerman and Jamison 1991; Hochschild 1975, 1979, 1983, 1990, 1998; Melucci 1989, 1995, 1996, 1997; McCarthy 1989; Perinbanayagam 1989) and empirical research, this inductive study seeks to determine the distinctive goals of the midwifery movement and explain how social movements create and legitimize new emotion knowledge.

McCarthy 1989; Perinbanayagam 1989) enables empirical analysis of the way social movements create and legitimize new emotion knowledge (Chapter 5).

Melucci’s model (Figure 1) explains the production of alternative cultural patterns as the result of latent and visible movement activities reinforcing one another. That process of reinforcement is partially explained by the addition of Eyerman and Jamison’s (1991) conceptual framework of social movements as cognitive praxis (Figure 2). Cognitive praxis — such as the collective creation of new identities, ideas, and ideals — transforms a movement’s knowledge interests into new knowledge (i.e., shifts in thought and in the organization of thoughts). Combining these two approaches generates the model in Figure 3.

As will be discussed in Chapter 4, empirical analysis of the midwifery movement shows that a movement’s visible activities can be understood as an attempt to legitimize alternative cultural patterns created by a movement’s latent activities. Substitution of the terms “creation” and “legitimization” for the terms “latency” and “visibility” gives greater motion to the model by transforming nouns into verbs. The explanatory power of the two-pole model of cognitive praxis (Figure 3) is therefore enhanced by that alternative signification. Synthesizing the enhanced model (Figure 4) with ideas about feeling rules and interactional resonance generates a new analytical model to explain how social movements create and legitimize new emotion knowledge (Figure 5).

Figure 5 presents the new analytical model of emotive praxis generated by this inductive study. Like cognitive praxis, emotive praxis directs attention to social

\[28\] Worldview assumptions, technological concerns, and organizational forms (Eyerman and Jamison 1991).

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movements as knowledge producers. Rather than allowing the theoretical reduction of knowledge to cognition, however, the new analytical model generated by this inductive study offers a sensitizing supplement to existing theory that directs attention to emotions. As I will show, empirical analysis of the midwifery movement supports the notion that just as social movements produce knowledge through a process of cognitive praxis (Eyerman and Jamison 1991), so do social movements produce knowledge through a process of emotive praxis. To view social movements as emotive praxis is to focus on the construction and dissemination of emotion knowledge (McCarthy 1989).
CHAPTER 3

RESEARCH METHODOLOGY

What was center is now decentered; what was margin and border is now taking center stage.


This inductive study examines contention over U.S. birth principles and practices to determine whether and how social movements produce new emotion knowledge, not as a means to some other (more obviously political end), but as an end in itself. In addition to extending sociological theory on social movements and emotions, this inductive study advances understanding of the range of choices available to childbearing women and their families. Beginning with analysis of the distinctive goals of the midwifery movement and moving to the development of a new analytical model, this inductive study draws attention to previously marginalized processes and substantive issues.

To pursue these theoretical and empirical aims, qualitative research methods are the most appropriate (Burawoy 1991). Qualitative methods enable analysis of meanings and characteristics (Berg 1995), allow research subjects to describe their worlds (Rubin
and Rubin 1995), and facilitate critical understanding of social phenomena (Kincheloe and McLaren 2000). Most important to this research, because qualitative methods allow for an iterative process of data collection and interpretation (Blee and Taylor 2000; Charmaz 1983), they promote the extension of existing theory (Burawoy 1991).

3.1 Research Standpoint

Before I discuss the data used in this inductive study, I find it necessary to position myself in relation to the research. Knowledge is always discovered from some vantage point (Smith 1987, 1990), and my experience of the midwifery movement is both abstract and situated. Like many contemporary sociologists, I value both kinds of knowledge. I recognize that were it not for the latter, I most likely would never have come to the former. Given that intentional home births comprise less than 1% of all births in the U.S., the activities of the midwifery movement are marginal indeed. As the daughter of a midwife, I have a lifelong familiarity with something the vast majority of the U.S. population isn’t even aware of—midwife attended home birth.

For most of my life, midwife attended home birth was not an “alternative cultural pattern.” It was the job that drew my mother off to another family’s home for days at a time or to the realm of sleep when she finally returned. It was the identity that gave my mother a seductive mystique a “wise woman” who would have been targeted during the European witch hunts. It was the deviant behavior that positioned my mother in opposition to the doctors, the rules of the hospital, and the law. Because my father is also
a deviant health care provider (an acupuncturist), the politics of medicine are deeply embedded in my familial culture. At an early age, I internalized a fairly sophisticated critical perspective on the biomedical profession.

3.1.1 Valuing Situated Knowledge

That we rarely acknowledge our parents’ influence on our thinking points to how little our society values the act of parenting. That we rarely acknowledge the act of our birth points to how little our society values life. Although I recognized the sociological significance of contention over childbirth during my first year of graduate school, I was hesitant to devote my energy to a research topic easily dismissed as a “women’s issue.” That we rarely acknowledge “women’s issues” points to how little our society values women.

My mother is a midwife for many reasons, not the least of which was her own hospital birth experience — the one we shared in 1972. I have no memory of that event, although I’ve recently wondered the degree to which my amnesia is due to the drugs they administered against her will. She remembers. They wouldn’t let my father in the room. They told her they were just giving her oxygen as they were knocking her out. She was screaming and pushing the mask away from her face as my father was pushing at the door. Three years later, she let a small underground school of midwives assist her in birthing my sister at home. It changed her life.

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Like most of the midwives I interviewed for this research, my mother felt called to help people enter this world in the best possible way. Her experiential (situated) knowledge originated through comparison of my (hospital) birth with my sister’s (home) birth. It was verified through more than a decade of independent home birth practice followed by more than a decade of hospital-based and biomedically controlled nurse-midwifery practice. Today my mother still touts the superiority of home birth midwifery. As she puts it, “I mean, how much easier is it to relax in an environment where you can do really and literally what you want to do as opposed to: you’re in bed with an IV, with a monitor strapped around your belly, and the bed’s not even comfortable, and the sheets aren’t comfortable, and it’s plastic under the pillow.”

To even consider the role of relaxation in childbirth requires attention to situated knowledge. To the extent that contention over birth principles and practices is focused on the birthing woman’s comfort, it can be thought of as a women’s issue. But, the birthing woman’s every experience is shared by her baby, who is physically situated in the same body. Rather than two individuals, the birthing woman and her baby are a commingling presence (Simms 2001), referred to in Swahili as mamatoto. Thus, the way a given culture patterns birth has implications scholars are only beginning to consider (Feher 1981; Janov 2000; Klaus and Robertson 1982; Klaus and Kennell 1982; Macfarlane 1977).

Because we all start out as mamatoto, contention over childbirth is fundamentally an issue of human rights. At a substantive level, this inductive study seeks to determine

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30 The socio-cultural factors behind this switch from independent midwifery to nurse midwifery is worthy
the extent to which emotions lie at the core of that issue. At a theoretical level, this inductive study seeks to explain how social movements create and legitimize new emotion knowledge.

3.1.2 Considerations

I was brought up to see midwifery as a calling, but I have learned to view midwifery as a social movement. Bringing my familial knowledge of midwifery to the study of social movements, I have learned to make sense of theories and concepts that might otherwise have remained incomprehensible to me. I have also learned to see conceptual intersections and analytical relationships that might otherwise have remained unaddressed.

I believe my personal relationship to the midwifery movement has shaped this study in the following ways: I am sympathetic. I have no fear of birth, and from experience, I know that under normal circumstances a healthy woman is fully capable of birthing her baby into the world. I would never choose to give birth in a hospital. I personally find the notion absolutely horrifying. I understand, however, that many women do make that decision, and I firmly support the human right to choose among bodily experiences. I suspect, however, that such decisions are often made without fully informed consent.

The authoritative status of biomedical knowledge (Jordan 1997) is evidenced by the acceptance of biomedicine as medicine and biomedical birth as birth. Unlike most

\[\text{of a study in itself. For now, suffice it to serve as a comparative viewpoint.}\]
U.S. citizens, I am highly cynical about biomedical knowledge. Formal study of biomedical history and professionalization, combined with scientific training as a sociologist, have only strengthened my critical view. I am therefore personally motivated to give voice to groups offering alternatives to the culturally dominant approach to health and healing. My motivation goes beyond the mere personal, however, as I believe the study of cultural alternatives is key to making knowledgeable decisions as a society.

3.2 The Data

The situated knowledge I bring to this inductive study serves only as a foundational starting point. My abstract knowledge of the movement derives from the systematic combination of different qualitative data-collection techniques. Triangulation is “a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation” (Stake 2000). Triangulation (Berg 1995; Lofland and Lofland 1984) serves to increase detail and counteract threats to validity (Denzin 1989). It is not intended to validate the objectivity of a phenomenon, but rather to secure in-depth understanding and accurate representation (Denzin and Lincoln 2000). To accurately represent the goals of the independent midwifery movement, this research is based on: 1) semi-structured telephone interviews with midwives across the U.S., 2) content analysis of secondary sources that study the U.S. midwifery movement from a
variety of perspectives, and 3) key movement generated texts analyzed for comparison with my emerging interpretation of the movement’s significance.

3.2.1 Interviews

Methodological scholars have found that semi-structured interviews: 1) provide rich data, 2) enable understanding to proceed from respondents’ points of view, and 3) are “the best method for probing deep emotional issues” (Blee and Taylor 2000:6). Because this research seeks to determine whether and how the midwifery movement aims to change the emotion norms surrounding childbirth, I found it necessary to gather rich data from the point of view of those involved. Because this research seeks to determine how social movements create and legitimize new emotion norms, I also found it necessary to probe deep emotional issues. I therefore conducted 25 semi-structured telephone interviews with midwives across the country, based on a purposive snow-ball sample (Berg 1995) of midwives chosen for their ability to act as movement informants. While families and mothers who choose midwifery care can be viewed as movement participants, this study focuses on those most central to the movement — midwives themselves. Midwives are best qualified to answer questions about the distinctive goals of the movement as it is they who share the oppositional collective identity of midwife.

I used intensity sampling (Morse 1994) to select information rich experiential experts for semi-structured interviews through initial referral by members of the

31 This is so because they provide demand for midwifery services and because they often lobby on behalf of the right to choose midwifery care.
Midwives Alliance of North America (MANA). My sample of movement informants were chosen to secure saturation and to attain dissimilarity as well as similarity (Rubin and Rubin 1995). Indices of saturation included repetition of information and confirmation of data previously collected (Morse 1994). Dissimilarity was ensured by conducting interviews with midwives of varying length of experience, midwives credentialed as CNMs, midwifery educators, and midwives of different ethnicities and sexes.

All interviews were conducted by telephone, and respondents gave verbal consent for the interview to be tape recorded for later transcription. I transcribed all of the data from these interviews myself, verbatim and in their entirety. The interviews were basically guided conversations, and I strove for balance between covering the topic as pre-determined and allowing the emergence of unexpected topics and new directions (Blee and Taylor 2000). Due to time and space constraints, many topics addressed in the interviews are not explored in this report. These interviews serve as my primary source of data.

3.2.2 Sampling and Data Collection

I initially gained entrée to the midwifery movement through an e-mail list of Midwives’ Alliance of North America members. Initial contacts referred me to other

32 Founded in 1982 to facilitate communication, support, representation, education, research, and women’s right to choose midwifery care (http://www.mana.org), MANA is the core national organization for the independent midwifery movement. Other national organizations include the North American Registry of Midwives (NARM), the Midwifery Education and Accreditation Council (MEAC), and Citizens for Midwifery (CfM).
midwives, including midwives who were not members of any formal organization. Most of the individuals I interviewed have been practicing midwifery for over 20 years. Most are white, female, currently in practice, educated at least to the level of some college, and have more than two children. Most are married and have formal midwifery credentials of some kind. Due to differences in spousal employment and region of practice, there is a wide range of incomes from over $200,000 to under $20,000, although most report a total household income between $30,000 and $50,000.

The midwives I spoke with live and practice in a variety of geographical settings (urban, rural, suburban, urban/rural, urban/suburban, rural/suburban), and report different political climates in terms of biomedical tolerance. Nearly all strongly self-identify as feminists, although a few specifically reject that label. All self-identify as spiritual, and most (though not all) describe their spirituality as eclectic and distinct from conventional religion.

In responding to my questions, there was a tendency for informants to group together accounts derived from their personal birth experiences, those of their clients, and those from other sources such as movement texts. Additionally, many expressed frustration with the biomedical establishment, but most were careful to preface or conclude such statements with a disclaimer expressing the desire to work in conjunction with biomedical practitioners. Overall, respondents communicated a preference to practice in an environment where biomedical technology is available for emergency backup and biomedical practitioners respect the unique knowledge and skills derived from the embodied experience of giving birth.
Many themes that emerged during the early interviews became inspiration for later interview questions. As new themes arose, over time, the main questions shifted slightly, and I used new follow-up questions for further clarification. Through an iterative process, emergent themes were tested and modified (Rubin et al. 1995) throughout the interview portion of data collection. I framed each interview the same way, however, by telling respondents that I was particularly interested in the emotional dimensions of childbirth and midwifery.

Often respondents anticipated questions before I asked them, and many new questions and answers arose that I had not originally considered when starting this project. All together, the thick descriptions generated by these interviews provide a rich data source from which to understand the distinctive goals of the midwifery movement, particularly the alternative emotion knowledge it offers. In order to add breadth, complexity, and depth (Flick 1998), as well as to help explain the more abstract process of how social movements create and legitimize new emotion knowledge, interviews were supplemented with content analysis of secondary sources and key movement texts. It is important to note, however, that triangulation is less a tool of validation than a means of adding greater rigor and richness to qualitative inquiry (Denzin and Lincoln 2000).

3.2.3 Secondary Sources

To increase data detail, clarify meaning, and secure in-depth understanding, I first turned to secondary sources offering representations of midwifery. During the literature review process, I discovered several scholarly studies that hinted at but did not analyze
the way midwives focus on emotional aspects of childbirth. Several journal articles (e.g., Rushing 1993; Weitz and Sullivan 1985, 1986) and books such as *Sisters on a Journey: Portraits of American Midwives* (Chester 1997), *Birth as an American Rite of Passage* (Davis-Floyd 1992a), and *Labor Pains: Modern Midwives and Home Birth* (Sullivan and Weitz 1988) provide secondary representations of particular themes that emerged during my interviews. Additionally, newspaper and magazine articles reporting ongoing developments in the legal arena (Botos 2002; Powell 2002; Granju 1997) provide another perspective from which to draw analytical comparison with themes emerging from my primary data source.

### 3.2.4 Movement Texts

Guided by Eyerman and Jamison's (1991) emphasis on the role of movement intellectuals in articulating the knowledge interests of a movement, I also conducted content analyses of key movement texts. My aim was to find expressions of the midwifery movement's distinctive knowledge interests and emotion knowledge, and to determine the extent to which visible movement activities reflect latent attempts to change emotion knowledge surrounding childbirth. For each textual source, I recorded and coded relevant passages (Krippendorff 1980) along thematic lines discovered through analysis of my primary data source.

Before conducting the interviews, I decided to code passages from *Immaculate Deception: A New Look at Women and Childbirth* (Arms 1975) and *Spiritual Midwifery* (Gaskin 1977), and was pleased to find that most respondents mentioned one or both
sources without direct questioning. Repeated unprovoked references to these texts confirm their centrality as movement documents.

Originally published in 1975,33 Immaculate Deception was written as “a statement that grew out of [the authors’] need to understand and explain [her] own birth experience” (Arms 1975:xiv). Most of the midwives I interviewed mentioned the influence of this text on their personal change in consciousness and/or their interest and participation in the midwifery movement.

Likewise, most of my informants referred to Spiritual Midwifery, which was released in 1977 through “a group of midwives who deliver babies and provide primary health care for [a] spiritual community of eleven hundred long-haired vegetarians” (Gaskin 1977:14), otherwise known as “The Farm” in Tennessee. Part treatise, part collection of birth stories, and part handbook on midwifery skills, Spiritual Midwifery is distinctly oriented toward women’s own reclamation of birth.

I also coded segments from organizational websites,34 including the contemporary document, the Midwives Model of Care™ brochure, found on the CfM website. The brochure is disseminated nationally and was created by an umbrella organization comprised of members of each of the national movement organizations.35 The document is intended as an educational and promotional tool, and it thereby provides a formal philosophical statement of the 30-year-old social movement.

33 Arms’ published Immaculate Deception II in the late 1980s. The updated version rings less of a clarion call, but still articulates specific knowledge interests.

3.3 Data Analysis

This inductive study entailed an iterative process of data collection and analysis (Charmaz 1983), with interpretation at all stages. I began with a broad interest in the distinctive goals of the midwifery movement and collected data that led me to extend existing theory (Burawoy 1991). In wholistic fashion, I continuously moved between data collection and analysis, as well as between analysis and existing theory. I confirmed data adequacy through saturation and confirmation of previously collected data, while carefully noting negative cases (Esterberg 2002). Gradually, an image of the distinctive goals of the midwifery movement emerged (see Chapter 4), as well as a new analytical model of emotive praxis (see Chapter 5).

As the theoretical and empirical significance of the midwifery movement unfolded, I adjusted my analysis accordingly. In the initial phase, I sorted data into broad general categories such as "rejecting biomedical birth," "defining midwifery," "childbirth meanings," "feminism," and "spirituality." Through the use of NUD*IST qualitative software (Coffey and Atkinson 1996), the general coding categories morphed into distinct themes as I developed processual analysis (Charmaz 1983). In the second phase, I added specific emotional themes such as "pain," "pleasure," "fear," "trust," and "love." Finally, I drew theoretical conclusions within each category based on common findings and themes that emerged.

The Midwifery Task Force is comprised of members of MANA, NARM, MEAC, and CfM.
In the following chapters, I present my analysis with enough detail to show what people said without risking their confidentiality. In keeping with human subjects protocol, I have neither identified respondents by name nor used any information that would disclose their identity.

3.4 Summary

In this chapter, I have described and specified the appropriateness of the methods used in this research. I have chosen qualitative research methods because they are the best for generating in-depth understanding (Rubin et al. 1995), for analyzing meaning and characteristics (Berg 1995), and for engaging in the iterative process of data collection and interpretation (Blee et al. 2000; Charmaz 1983) necessary for the extension of existing theory (Burawoy 1991). I have explained how this research is based on a combination of semi-structured interviews, secondary sources, and key movement texts.

This empirical triangulation provides rich data for determining the extent to which contention over U.S. birth principles and practices is centered on emotions and developing a new analytical model to illuminate the way social movements create and legitimate new emotion norms. Chapter 4 presents analysis of the distinctive goals of the midwifery movement. Chapter 5 presents empirical support for a new model of emotive praxis. Chapter 6 provides a detailed discussion of that model and suggests some implications of this research.
CHAPTER 4

VISIBLE AND LATENT COGNITIVE PRAXIS OF
THE MIDWIFERY MOVEMENT

[Social movements] question definition of codes, nomination of reality. They don’t ask, they offer. They offer by their own existence other ways of defining the meaning of individual and collective action. They don’t separate individual change from collective action, they translate a general appeal in the here and now of individual experience.

—Alberto Melucci (1997:270-1)

Like other contemporary social movements (Melucci 1997), the form of the independent midwifery movement is the most direct expression of its message. By offering an alternative cultural pattern — midwife attended home birth — the movement communicates to society that the experience of birth can be different. Viewing the movement as a two-pole action system (Melucci 1989, 1997) directs attention to its visible struggle against established political authorities and its latent enactment of alternative birth philosophy in submerged networks of everyday life. Melucci’s two-pole model (Figure 1) exhibits an explanatory gap, however, and the process by which visible and latent movement activities reinforce each other to produce alternative cultural patterns remains unclear.
Viewing the midwifery movement as cognitive praxis (Eyerman and Jamison 1991) directs attention to its transformation of knowledge interests into new knowledge (Figure 2) through the collective creation of new identities, ideas, and ideals. Adding the concept of cognitive praxis to Melucci's (1989, 1997) two-pole model offers partial explanation for the process by which visible and latent movement activities reinforce each other to produce alternative cultural knowledge (Figure 3). Viewing the midwifery movement as two-poled cognitive praxis directs attention to the movement's visible struggle to construct new social identities and the movement's latent enactment of alternative ideas and ideals.

In this chapter, I analyze the midwifery movement's visible and latent cognitive praxis. I show that the movement transforms knowledge interests into new knowledge through visible political activities that construct new professional identities. I show that the movement also transforms knowledge interests into new knowledge through latent political activities that enact new ideas and ideals. Finally, I show that the construction of new professional identities can be understood as an attempt to legitimize the enactment of new ideas and ideals. To the extent that the movement's visible activities can be understood as an attempt to legitimize the movement's latent activities, substitution of the terms "creation" and "legitimization" for the terms "latency" and "visibility" extend the explanatory capacity of the two-pole model of cognitive praxis.

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36 McCarthy (1996) argues that knowledge is best understood as culture.
4.1 The Construction of New Professional Identities

At the visible level, the midwifery movement is engaged in struggle against the established political authority of the biomedical profession. This struggle manifests as contention over scope of practice laws and over the codification of "expert" identities. In general, laws protect prevailing systems "by defining power relationships, thus establishing who is superordinate and who is subordinate in any given situation" (Vago 2000:1). Thus, collective challenges to prevailing systems often involve attempts to change the legal codification of power relationships. In the case of contention over childbirth, the power to define and control principles and practices is currently held by the biomedical profession (Suarez 1993). It is therefore no surprise to find the midwifery movement engaged in visible efforts to secure legal recognition through the construction of professional identities.

Over the past 20 years, national midwifery organizations have been assisting state-level associations in pursuit of licensed and certified professional identities. Recently, for example, the Midwives Alliance of North America (MANA) successfully attained endorsement of the American Public Health Association (APHA), through adoption of the resolution, "Increasing Access to Out-of-Hospital Maternity Care Services Through State-Regulated and Nationally Certified Direct-Entry Midwives."

Due to visible tactical efforts, independent midwifery is currently sanctioned by law in 28 states. Strategic activities continue at the national level and in states where the practice

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37 MANA, NARM, MEAC, CfM, etc.

38 49 states currently have state-level midwifery associations of some kind (http://www.cfmidwifery.org/states/grassrootslist.asp).
of midwifery is prohibited by law;\textsuperscript{39} where it is legal by statute, but licensure is unavailable;\textsuperscript{40} and where it is neither prohibited nor legally defined.\textsuperscript{41} In many cases, however, even states that do legally recognize midwifery maintain the superordinate positioning of biomedicine through regulatory boards dominated by doctors and nurses.

The establishment of a biomedical knowledge elite with the power "to define and construct particular areas of social reality, under the guise of universal validity conferred on them by their expertise" (Larson 1977:xiii), is historically intertwined with the rise of American capitalism (Rueschemeyer 1986). In the early 19\textsuperscript{th} century, those claiming special medical expertise were able to create and dominate a market for their services. The American Medical Association (AMA) was founded in 1847 by middle-class men distinguished solely by their ability to offer clients the prestige of being treated by a "gentleman" (Ehrenreich and English 1973). Through class connections, members of the AMA succeeded in establishing licensure laws (Duffy 1983), and by 1906 only graduates of schools approved by its Council of Medical Education were granted license to practice medicine (Baer 1983).\textsuperscript{42} Through claims to esoteric knowledge, the right of self-regulation under the protection of the state, and special power and prestige for

\textsuperscript{39} Independent midwifery is prohibited by statute, case law, or stricture of safe practices in the District of Columbia, Illinois, Indiana, Iowa, Kentucky, Maryland, Missouri, North Carolina, Virginia, and Wyoming.

\textsuperscript{40} Independent midwifery is legal by statute, but licensure is unavailable in Alabama, Delaware, Georgia, Hawaii, New Jersey, New York, and Rhode Island.

\textsuperscript{41} Independent midwifery is neither prohibited nor legally defined in Connecticut, Nebraska, Ohio, South Dakota, West Virginia, and Wisconsin.

\textsuperscript{42} This process began before the acceptance of scientific findings applicable to medicine (Duffy 1983) and is perhaps more accurately explained by the social class, race, and gender inequality that characterized society as a whole (Baer 1989; Borst 1995; Ehrenreich and English 1973; Larson 1977).
appropriately credentialed members (Abbott 1988; Larson 1977; Macdonald 1995; Rueschemeyer 1986), professionalization enabled specialized knowledge claims to be leveraged into social and economic rewards. Professionalization thus created a new form of social inequality based on knowledge expertise (e.g., Gaventa 1993).

Because experts must be consulted even on legal issues pertaining to their field (De Vries 1985), outside challenges are extremely difficult. The biomedical profession is highly territorial (Wagner 1997), and as participants in the midwifery movement have found, physicians are often unwilling to collaborate with outsiders. As one midwife describes, “here in my own rural area, where we have a small community hospital, I can't apply for privileges there. Because there's only one practice of obstetricians, and they won't agree. Because, of course, that would bring competition to them.” While some contemporary midwives are fortunate to work in areas that have come to accept childbirth alternatives (a point I will return to), the competition midwives represent is often greeted with outright hostility.

Professions are political organizations (Rothman 1978), and contemporary biomedicine is the most clear-cut profession (Friedson 1970). Previous research shows biomedical resistance to outside challenges can manifest in dangerous ways. In emergency transport cases, hospital personnel sometimes punish women for attempting home birth “by inflicting unnecessary pain on them during examination and treatment” (Weitz and Sullivan 1986:171). As one midwife describes a recent transport experience:

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43 Past attempts to challenge the dominance of biomedical definitions have been largely unsuccessful (Baer 1989; Wolpe 1985).

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The doctor who was on call started suturing her, and just as he finished suturing her — and now, just imagine the position she was in to be sutured, you know, with her vagina wide open, her legs open, and he stands between them — proceeded to call her stupid — he actually called her stupid, "What are you an idiot? Staying home when you're having contractions and you're 35 weeks? If you had gone to a doctor, this never would have happened...you are a dumb, dumb, dumb, little girl."

It is hard to imagine a professional care-giver speaking to anyone with such a tone, let alone while they are physically vulnerable. It is important to note that many midwives express positive relationships with biomedical professionals, but it is also important to note the centrality of power relations in the midwifery movement's visible efforts to secure legal recognition through the construction of professional identities.

That the movement's struggle for formal recognition challenges biomedicine's power over childbirth is evidenced by the ongoing legal persecution of practicing midwives (Wagner 1994). At the time of this writing, for example, the State of Ohio was about to hold committee hearings on HR 477, a bill that would establish scope of practice and enable self-regulation of midwives as independent professionals. Two days before the first hearing, an award-winning midwife was charged with practicing medicine without a license. Similar to other instances around the country (Granju 1997), charges were brought not by the parents who hired the woman in question, but by a hospital-affiliated obstetrician (Botos 2002; Powell 2002).

In contrast to the "criminal-practicing-medicine-without-a-license" identity projected by the biomedical profession, the midwifery movement visibly seeks to attain independent professional identity through promotion of certification and licensure.
While many midwives support this effort, others explicitly reject it. As one midwife explains, “every time you get legal, you become more and more under the auspices of the medical establishment.” As mentioned above, licensure often involves formal submission to a biomedical regulatory board. This is problematic because, as another midwife explains, that board, “tells us what to do, how to do it, and if you don’t, your license will be revoked. So you’re always walking under that threat.” Rather than a movement victory, then, some midwives suggest that attainment of licensure is a form of capitulation to the existing system. As another midwife emphasizes:

At least we don’t get arrested for practicing medicine without a license, which is what happened here about 15 years ago, before we got licensed. [That’s] what stimulates licensure among people who really would not voluntarily go there on their own — the reason they’re midwives is that they don’t buy the party line — …at some point its very personal, and you would rather work licensed than be arrested.

This comment points to another level of social movement activity — that which takes place in the space where midwives “don’t buy the party line.” I will address that dimension in detail below. Here, it is important to note that in addition to lack of consensus over visible activities, the movement’s own history suggests that the struggle for professional identity is best understood as an attempt to legitimize alternative cultural patterns created and enacted in submerged networks.

During the 1970s, the practice of attending another woman during her out-of-hospital birth often occurred without any sense of engaging in a particular occupation. For example, after successfully assisting in the complicated home birth of a friend, one of
my respondents was informed she was a “midwife” by the new mother’s grandmother.

As she explains:

It just really blew me away. I hadn’t even thought about that. It was like, no, I was just helping. Anything I could do — wash rags, whatever. And then I got home, and my husband…went and got Webster’s dictionary. And he flipped it open to the word, “midwife,” and he said, “Read this.” He said, “Isn’t that what you’ve been doing?”

As this woman communicates, the re-emergence of midwifery in the 1970s was oriented toward friendly caregiving during non-medicalized birth. The midwifery movement originated as an attempt to provide an alternative birth experience. People who did not want to birth in the hospital sought support for their decision, and people who were interested in helping others through their labor were willing to give that support. As another midwife, who started out as a childbirth educator, explains:

I used to go to the hospital a lot with people in my classes and labor with them. I loved working with people in labor and helping them to find their way through — through the labor. And then when things changed here where childbirth educators were no longer welcome in the labor and delivery units unless they were hospital employees — this was the beginning of the transition from people going to classes taught by community instructors and people going to a class sponsored by the hospital. That transition was starting and so, for a while I wasn’t really allowed to go into labor and delivery anymore, and right at that time, I had two different people in my childbirth class who were planning a home birth with a midwife. And that’s the first I’d ever heard of that. I was fascinated by the idea, and I got invited to their birth as a labor helper, you know? And I met their midwife, and that’s when I saw what birth was supposed to be like — what I had been trying to see for so long, that was just not getting there in the hospital. It was at home. That’s where it happened. That’s where birth was the incredibly spiritual experience that I consider it to be — was at home, in a non-interventionist manner that midwives
have. The midwives' model of caring for women in labor is so different.

As this comment relates, the midwifery movement seeks to provide an alternative model of care during birth. That model is at the core of the movement regardless of occupational credentials.

In fact, empirical analysis suggests that the movement's visible efforts to construct professional identities can best be understood as an attempt to legitimize alternative ideas and ideals enacted in submerged networks of everyday life. As one midwife explains:

"Depending on the community that a midwife serves in, she can have a lot of resistance, and opposition, and bad feelings by the medical community, no matter how hard she tries. And so, I can understand why someone would want to do that [attain legal status] — just for the ability to practice without so much opposition."

Those midwives who spear-headed the visible struggle for professional identities did so in reaction to opposition from established political authorities, i.e., the biomedical profession. As another midwife relates, "In my area, because we have been licensed for a long time, we have not had quite as much hostility from the medical profession." In other words, licensure brings at least some legitimacy to the movement's alternative birth philosophy.

The movement's visible activities are viewed by many midwives as necessary for the preservation of the movement's latent activities. As a midwife working with the North American Registry of Midwives (NARM) explains:

"The goal of this credential is to preserve the credential as created by midwives and for midwives. This is midwives
defining midwifery. Midwives defining what knowledge and skills are necessary to be competent. This is not physicians or health department administrators saying, "This is what you can do and not do." This is midwives — midwives also not saying what you can do and not do, but midwives saying, "These are the kind of things you need to know to be able to practice on your own." And I think that that's an incredible responsibility that we've got to take seriously, otherwise we either become regulated by the medical profession or outlawed by the medical profession.

As this comment indicates, the midwifery movement is engaged in visible efforts to construct professional identities in order to prevent biomedical regulation or prohibition.

That credentials are less important to midwives than the quality of care itself is evidenced by comments about biomedical practitioners' capacity to approach birth with a "midwife heart." Suggesting the midwifery movement is characterized by distinctive emotion interests, one midwife describes the biomedical practitioner with a midwife heart as follows:

They still intuitively trust the process of birth. They don't come into the room with a lot of fear and the need that they have to manipulate it and do a lot. And they have that more spiritual quality to their medical practice...it's just the trust in the natural process and the natural functioning of the body and a softness and gentleness to them as a human being.

Trust, lack of fear, a spiritual quality, softness, and gentleness — these are some of the qualities of a "midwife heart." These qualities and their importance communicate a distinct worldview (explored below), and in Chapter 5, I present an in-depth analysis of the emotion interests of the midwifery movement. For now, let us consider that visible movement activities oriented toward the production of new social identities do not constitute the goal of the movement, but rather a means of legitimizing the ultimate goal.
According to Melucci (1989, 1995, 1996, 1997), the public political activity of a social movement is but a temporary and relatively infrequent necessity. While the midwifery movement is visibly engaged in efforts to secure legal professional identity, I argue that the visible level of activism is best understood as an attempt to legitimize the alternative birth principles and practices created and enacted in the submerged networks of everyday life. Recent bumpersticker slogans such as *Birth is as Safe as Life Gets* and *Every Woman Deserves a Midwife* evidence the movement's continuing focus on providing a unique type of care to birthing women. Viewing the public struggle for professional identity as temporary and infrequent relative to the actual practice of midwifery care, I turn next to the everyday life activities legitimized by attainment of professional identities.

4.2 The Enactment of Alternative Birth Philosophy

At the latent level, the midwifery movement enacts alternative childbirth ideas and ideals in submerged networks of everyday life. Prior research (Sullivan and Weitz 1988) shows that the midwifery approach to birth differs from the biomedical approach along at least five dimensions: 1) bureaucratization, 2) scientism, 3) medicalization, 4) intervention, and 5) locus of responsibility. Whereas biomedical care is routinized, reductionist, disease-oriented, actively managed and hierarchical, midwifery care is individualized, holistic, wellness-oriented, and passively managed under shared responsibility. These differences can be traced to the movement's distinctive knowledge interests. Viewing social movements as cognitive praxis directs attention to its
distinctive cosmological, technological, and organizational knowledge interests (Eyerman and Jamison 1991). Through its cosmological dimension, a movement articulates its attitude toward nature, society, and their interrelationships. Through its technological dimension, a movement articulates its critique of technological application and its search for alternative technologies. Through its organizational dimension, a movement articulates its critique of elitism and its specific emancipatory project.

4.2.1 Cosmological Interests

The midwifery movement’s distinctive attitude toward nature, society, and their interrelationships is characterized by naturalism, wholism, personalism, and flexibility. As they articulate the movement’s cosmological ideas and ideals, midwives often contrast their attitude with that of biomedicine, which they see as characterized by pathologization, segmentation, impersonality, and rigidity.

Midwives describe birth as "miraculous," "powerful," "healthy," "beautiful," "marvelous," "magnificent," "amazing," "natural," and "normal." As one midwife describes, "It’s fundamentally so basically a healthy, normal part of a woman’s life if she’s blessed to have children. It’s not a disease or a medical condition." The definition of birth as a state of health is at odds with the dominant view. As another midwife explains, "The medical establishment, because they basically deal with illness, injury, and disease, take on the responsibility for seeing a problem and fixing the problem." While midwives value that approach for actual sickness and disease, they find its routine application to childbirth problematic. As another midwife clarifies, "The inherent
philosophy behind medicine...is that pregnancy is a pathological process.” Contrasting their philosophy to the pathological philosophy of the culturally dominant system, midwives emphasize that they approach birth from an entirely different perspective. As another midwife asserts, “Midwives believe that birth works and that birth works best if you leave it alone and support it, but you're ready to handle anything that might take it off track. Whereas, I think an obstetrician honestly does perceive birth as a medical disaster waiting to happen.” While biomedical practitioners might share some of the awe that midwives articulate, the view of birth as natural, normal, and healthy challenges the dominant assumption that birth inherently requires hospitalization.

Viewing birth as normal and natural, midwives reject the “diseasing of reproduction” (Todd 1983:84) and emphasize that nature has designed the process to work perfectly. As one midwife describes, “it’s something that the body is — the human female body — is created to do.” Midwives respect the natural process, and consider anthropological history to be on their side about the matter. As another midwife explains, “If birth didn’t work, none of us would be here. If the process didn’t work, we’d have died out.” This view of birth as a well-functioning process gives midwives a different perspective on the physical rigor of birth as well.

Midwives accept that birth can be hard, but they compare it to other worthwhile physical activities. As one midwife states,

It's something like taking a hike out the Grand Canyon. You do it one step at a time, and it gets hard. Those calf muscles and those thigh muscles start to ache after a while, but it's not something that's pathological. It's something that's normal.

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Similar to hiking the Grand Canyon, midwives see birth as requiring endurance and enabling the individual to muster internal strength through physical challenge. That challenge is not viewed lightly. As another midwife describes, "Birth is a lot like death in that they’re emotional experiences that are very, very intense. And until you’ve actually experienced them, you do not comprehend the intensity of the experience.” That intensity is understood by midwives to stretch beyond the mere physical. As another midwife explains, “Our thoughts, our beliefs, our emotions are much more a determinant of successful childbirth than the size of our pelvis or the position of the baby.” In other words, just as hikers can psyche themselves up or psyche themselves out, so too can birthing women.

This understanding stems from the wholistic worldview midwives share. As another midwife asserts, “The birth experience — or even pregnancy — it's a wholistic experience. Your body goes through it, your mind goes through it, your emotions go through it, and your spirit goes through it. And this is also true for the baby, when the baby is born.” This perspective on birth is at odds with the segmented and reductionist approach of biomedicine. Moreover, midwives not only see the act of birth as a wholistic experience for the individual, they also see the act of birth as one component of a larger life context. As another midwife explains, “This has everything to do, I believe, with our physical, emotional, intellectual, and spiritual health. That having a good start has everything to do with all of that...I think it probably has a whole lot more effect than anybody realizes.” The birth experience is understood to be a part of the ongoing life of the birthing woman and her family, including the new baby.
The quality of the birth experience is therefore seen to be very important and something that needs to be approached in a personalized manner. As another midwife asserts, “I think it’s a life changing experience to find your way through labor…and to know that you can find that strength in yourself.” Again, just as a major hiking experience can stimulate personal growth, midwives see childbirth as potentially self-actualizing. Unlike hiking, however, birth marks a change in social status regardless of how it is experienced. As another midwife explains, “The birth is a time when the mother and the father are becoming parents. You know, they're becoming a mother and a father. The nine months of pregnancy is that transition into parenthood.” That transition into parenthood is a highly meaningful personal experience, and something midwives believe the dominant approach tends to neglect.

Approaching birth with an eye to its naturalness, wholism, and personally transitional qualities, midwives advocate flexibility in caregiving. The desire for flexibility stimulated the rise of the movement in the first place, and it is midwives’ understanding of the need for flexibility that underlies their advocacy of home birth. As one midwife explains:

I think it's a peak experience in the mother's life that she'll retain with her forever. And she'll influence others around her in her experience. Either seeing it as a tremendous joy or a horrible, to-be-dreaded experience. I, myself, I've had four babies. They've all been born at home. Peak experiences in my life.

A woman’s ability to experience birth as a joyful peak experience is believed to be directly related to the amount of flexibility she is given during the process. If caregiving
is flexible enough to meet her needs, she will carry that experience for the rest of her life.

As another midwife adds:

You never stop experiencing your birth — in the same way as you can never stop experiencing your people's creation story. You get what I mean? Your whole psychological make-up is based in the creation story you were raised with — in the creation story you ascribe to and believe in. That's how you see your world — based on that.

In other words, the powerful experience of birth is understood to serve as a foundational framework through which other experiences are interpreted. Birth is viewed as having the potential to completely shape one's psychological make-up. Another midwife stated that birth is the re-enactment of creation, and as this comment suggests, the movement's cosmology places birth in a divine light. As another midwife describes:

To be present when another human being is born and takes their first breath and looks at us, I just think that's a really incredible experience... I mean, the innocence of a newborn taking his first look at us, taking his first breath — for me it's just a holy, incredible, spiritual place. I don't know how to describe it other than that.

This comment brings us back to the movement's perceptions of birth as not only natural, normal, and healthy, but miraculous, powerful, and magnificent. From the midwifery perspective, birth is a process to be revered. Such ideas are at odds with the culturally dominant approach.

4.2.2 Technological Interests

The midwifery movement's distinctive critique of technological application and its search for alternative technologies is characterized by a rejection of what they see as
the meddlesome interference of biomedical protocols, an emphasis on personalized support, and a substitution of alternative modalities for the high-tech hospital approach. As midwives articulate the movement's technological ideas and ideals, they often contrast their approach with that of biomedicine, which they see as unreasonable and dangerous.

Because home birth is not rigidly regulated, midwives see themselves as better able to occupy a "holy, spiritual place" as the baby first enters the world. In contrast, as one midwife describes:

A minute after he's born in the hospital, there are people just waiting to take the baby away so they can move it along an assembly line...They have to dry the baby off and they have to clean it up, and they have to put it in a blanket — you know, put all the trappings on it that are expected.

The assembly-line processing of the baby as if he were a product of the hospital rather than the woman's own body (Rothman 1978), is seen as the first step in a larger institutional separation of babies from their parents. As I discuss in greater detail below, midwives reject the way babies are treated under the dominant approach. As another midwife describes, "First look at the new planet — you know, the kid arrives — and we torture them! When you go past a nursery...you're going to see a bunch of little prisoners in plastic boxes crying." That hospital routines leave little time or space for pondering the miracle of life is seen as problematic. As another midwife states, "Doctors are very good technicians. They're very good at the technical aspect of it. But on the other side, do they truly understand what's going on? I don't think so." Biomedical overemphasis on
technical aspects of childbirth is viewed by midwives as obscuring important dimensions of natural reality.

Midwives view the technical manipulation of normal childbirth as fundamentally altering the process itself, beginning with the requisite trip to the hospital. As one midwife explains, “If you take a woman from her natural habitat and put her in the zoo, she’s not going to be able to birth right...if you take the woman and move her — that’s an intervention. Right away.” While that intervention may seem minimal, it is understood to be the first in a long line of potential interventions. As another midwife describes:

When you go to a hospital, the first thing they do is do a vaginal exam. Okay, that's done by a person you've never seen before. And, I've never quite figured out why they have to be so rough,...They're very impersonal, and they work to stay very impersonal...they put them in bed — laying in bed is just a big taboo. It slows your labor down. It also makes the contractions more exerted towards the back, which is not what momma wants to feel at all. It directs the force of the baby...on the wrong part of the cervix. Instead of aiming out the vagina, he's kind of aiming out the wrong place. It also makes mother more tense. I mean, she's just laying there watching somebody's clock tick by, and she's not mobile, and she's not active.

That a woman’s labor might “stall out” after a rough internal examination by strangers, uncomfortable confinement in a position that works against gravity, and bored clock watching, is hardly surprising. That hospital protocols continue to create such circumstances is a central concern of the midwifery movement.

The movement expresses a non-interventionist stance, and midwives critique the drastic degree to which early interventions can escalate. As one midwife asserts, “[In]
the majority of those situations where you begin to meddle with birth, you start a
snowball effect. If you introduce one intervention, it usually leads to another and on and
on and on — ultimately the woman ends up with a C-section. We have a pretty
appallingly high C-section rate in this country.” While this comment may seem alarmist,
midwives point out that once a woman chooses to have her baby in the hospital she is
subject to the decisions of biomedical experts operating under institutional protocol. As
another midwife describes:

For instance, let's say a mom's good, but her membranes
are ruptured. She hasn't started contractions or the ones
she's had, according to the machine, aren't acceptable.
They don't come in and say, "Well, you know, if your
membranes are ruptured, you'll have your baby in a day or
so." They come in and they give a woman a — they
usually start out with something along these lines, I've
heard it a billion times — "It's been however many hours
since your membranes were ruptured. The baby really
should be born within 20 hours, and we need to start pitocin
to help give you contractions." They use the words, "we
need," — sometimes they say, "we're going to," — but
usually those are the words they use. It's not presented as a
choice for the mom, and when it is presented, it's as if she
really has no choice. It may be, "The risk of infection is so
high, your baby could die if we don't start pitocin right
now." Now that's not a choice. So there you are. And
you're already hooked up to the IV anyway.

Midwives warn that because the hospital is designed around the possibility of pathology,
the worst-case scenario often becomes a self-fulfilling prophecy. That the birthing
woman has already been defined as a patient is seen as exacerbating this tendency.

Rejecting dominant definitions of birth as a condition and obstetricians as experts,
midwives express concern over the culturally distorted understanding most Americans
have of birth. As another midwife declares, “I think a lot of the pain that’s associated
with childbirth has to do with what we do to women in childbirth — you know, because they’re in the hospital.” Midwives’ alternative stance on pain is addressed in Chapter 5, but here it is important to note that midwives suggest biomedicine is the very cause of the problems it claims to solve.

Like other normal, natural biological processes, midwives define childbirth as something the body knows how to do. Therefore, they believe it is inappropriate to micro-manage the process. As one midwife explains:

It sounds crude, but — it's very similar to having a bowel movement or any other natural function. If we let our bodies do things at their own rhythm, and you know, we just do it, that's one thing. But if we — we can make any natural function very complicated if we obsess with the process. If I had to sit around and try to figure what state of peristalsis my system's in and whereabouts in my abdomen, you know, the contents were, and at what point should I consider moving to the other room — I mean, you know what I mean. [laughs] It could become quite an experience.

That even the simplest intervention, such as moving a laboring woman to another location, can interfere with the natural process was articulated by many midwives.

Routine hospital birth generally involves a great deal of intervention, however, and prior research shows that one procedure does increase the likelihood of others (Davis-Floyd 1996). As another midwife describes:

Think about feeling the urge to have a bowel movement, and going into a room, and having the door open — you know, sitting on the toilet having the door open — in a strange place, you know, that's not your home. Not your place. And you have 20 people telling you how to do it. The urge can go away pretty quickly. And I think that happens with birth. And then we try to make it happen, but
it's almost like we're mainstreaming giving enemas to people...

In contrast to the biomedical tendency to try to "improve" the process, an approach rooted in definitions of pathophysiology, midwives express the need to provide the comfort, security, and freedom to allow the process to unfold. Again, hospital routines inherently define the woman as a patient. They also serve to distance her from her partner. As another midwife describes,

I think that when fathers are in the hospitals a lot of times they're afraid to touch their wife because they don't want to dislodge a machine or pull out an IV tubing or...They're intimidated by all of that. And out of the hospital, their wife is much more free of all that stuff.

Midwives critique such unnecessary interference with what they consider to be a powerful and potentially self-actualizing experience. As one midwife notes, "There's a lot of things that are done in medicine just because that's always the way it's been."

While biomedical birth has not "always" been around, historical amnesia has led many once controversial practices to become taken-for-granted habits.

One such practice is the blase administration of epidural drugs. Most hospital births include "pain medication," and many women choose to birth in the hospital specifically to have access to such drugs. The midwifery movement sees that as problematic, and challenges hospital protocol that not only encourages the use of such drugs but actively discourages alternative treatment. As one midwife describes:

44 The administration of epidural drugs is a 20 minute procedure of spinal injection and catheter placement that renders a woman "numb" but alert.

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One of our local hospitals — the standard for nursing is that they are to come in, and they ask the mom to rate her pain or her discomfort on a scale of one to ten. If she reports discomfort of four or above, they are to offer medication. If they don't — if they offer encouragement, or a back rub, or whatever — they can be put on report. Guess what? Their epidural rate's like 98%.

While epidural drugs may seem to be a relatively simple intervention, there are risks associated with any technological procedure (Wagner 2000). In the case of epidurals, the risks are compounded by other hospital protocol. As another midwife explains:

A very well known side effect of an epidural is that the mother may run a fever. If the mother runs a fever, the baby has to have a full septic work-up. That's a big deal. That means the baby is off to an NICU — usually it's two rounds on different kinds of broad spectrum antibiotics. Oftentimes it means a spinal tap and a lot of separation from the mom and a tremendous amount of trauma for the newborn.

At first glance, the increased chance of fever may seem like an insignificant side-effect, but in the wider context of hospital protocol we see that a "normal" birth can very easily become a major medical event. The midwifery movement draws attention to that dimension of biomedical birth.

The movement also offers alternative methods for helping women through labor and childbirth. As I discuss in Chapter 5, the feelings of birth are highly variable, but in those instances where women experience pain, midwives draw from alternative modalities. As one midwife explains:

For pain management there are lots of different tools. Laboring in water and hypnobirthing. There's visualization, there's massage, there's herbal teas and

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45 For a discussion of the profitability of neonatal crisis management, see (Guillemin and Holmstrom 1986).
homeopathics, acupressure, touch, prayer, movement, walking around, dancing, keeping the environment supportive. There are lots and lots of things that you can use.

Such methods are more feasible with home births than hospital births due to differences in personalization as well as the economy of scale. At the hospital, as another midwife describes:

You don't have control over who's on call as a nurse — who's working, who's on duty as a nurse. So, sometimes the labor and delivery nurses are great, and sometimes they're terrible. And you also don't have control over how busy it is. So if you've got ten other people, or even six other people, in labor, your nurses are going to be overwhelmed. And it's going to be very difficult to help somebody who's having an unmedicated birth...And then if the anesthesia is right there, you know.

Because hospital birth is characterized by pathologization, segmentation, impersonality, and rigidity, there is little room for working with individual women on the basis of their emergent needs.

The demands of the institution therefore come to outweigh the demands of the birthing woman and her family. As one midwife describes, “The tendency of obstetrics is to jump to the most profound way of dealing with the situation quicker…” In contrast, with midwifery, as another midwife states, “the philosophy of your care giver is to allow your body to do what it’s gonna do and watch it unfold as opposed to trying to manage it and speed things up.” The pace of care giving derives in part from the structural

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46 See Ritzer 1996. Also see Habermas.
differences in home and hospital birth, but also from the cosmological differences described above.

Because midwives respect the natural process and view birth as a state of health, they are less rushed and less inclined to apply high-technology "solutions." Rather than intervene with machinery and drugs, midwives tend to build personal connections. As one midwife describes:

   I would take someone's hands in mine. Look them in the eyes. Acknowledge them. Tell them I'm there for them in whatever capacity they need me, that they're safe, that I will make it as safe as I can for them. I won't leave them frightened. I won't abandon them. I will do my very best for them. Things like that.

Acknowledging the woman's individuality and her humanity may seem like simple things, and they are, but midwives assert that it is precisely the simple things that are neglected under the dominant approach.

Human connection is viewed by midwives to be the most important "technology" one could bring to a birth. In place of electronic fetal monitors,47 lithotomy tables,48 and episiotomies,49 midwives use education, conversation, and encouragement to help women birth naturally. As one midwife states,

   I really encourage them to listen to their bodies and get in touch with their bodies and move, sing, dance, march up and down the stairs, go outside and play in the yard and

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47 External fetal monitors penetrate the woman's uterus with ultrasound waves to record the baby's heartbeat. Internal fetal monitors are attached directly to the baby's scalp by electrode (needle) insertion.

48 The supine lithotomy position, while forcing the mother to labor against gravity, is most conducive to obstetrical intervention and therefore routine in hospital birth.

49 Episiotomy is a 4-inch surgical incision (cut) across the perineum. In the hospital, it is performed on over 90% of first-time mothers (Thacker and Banta 1983).
swing on the swings, get into the birth pool, go and have sex with their husbands if that's what they want to do, whatever. They need to get in their own space and find what level they need to be on in order to get the baby out. And I'm basically an insurance policy sitting in the corner in case there's a problem. Ninety-nine times out of a hundred, I don't even need to be there. And that's exactly the way it should be.

Because they view birth as normal, natural, and healthy, midwives see their role as one of “insurance” rather than “deliverer.” Their avoidance of unnecessary instrumentality is accompanied by an expressivity the dominant approach lacks. As another midwife explains, “There's a lot of counseling skills that go on too. Just back and forth being able to really be there for somebody in an advisory kind of way. Basically, midwives mother the mother.” That alternative techniques such as counseling, caring, comforting, and nurturing are excluded from the dominant approach is not surprising given the gendered history of biomedicine (Ehrenreich and English 1973; Morantz-Sanchez 1985). Nor is it surprising that midwives advocate these techniques. As another midwife adds:

I ask who's going to be present. Who do they plan to have there? And what's their relationship, and what would their role be? And what are those people's view of childbirth? And childbirth outside the hospital. So we talk that over, because I find that people there influence mother and dad a lot.

Recognition that the people present influence the way birth proceeds is entirely outside the realm of the dominant approach. Hospital birth is inherently unable to personalize care to that degree. To the extent that midwives focus on such concerns, their enactment of alternative birth philosophy serves as a critique of the dominant system.
Midwives are highly concerned with the energetic influence people have during birth, and the implications of that focus are discussed in greater detail in Chapter 5. Here it is important to note that the midwifery approach is qualitatively different from the biomedical approach to birth. As one midwife describes:

You give them the resources and you encourage them on a step by step and day by day basis, and hour by hour basis in labor, to encourage them to give birth and use the kinds of techniques that would be non-pharmacological — warm water and aromatherapy and herbs and massage and heat and things, relaxation techniques and positioning and all those kinds of things to help to facilitate the normal birth...

Midwives give women resources, teach them skills, encourage them, guide them through alternative modalities, and help them to get in touch with their own bodies. This distinctive approach reveals dimensions of the birth experience that are obscured under the dominant approach. As another midwife relates:

If the mom, for instance, is bleeding more than your happy with — I will frequently tell moms, "I need you to concentrate on your baby and breast-feeding your baby, and I want you to visualize your uterus clamping down. All those blood vessels are now shut off. They don't need to bleed anymore, and the placenta needs to come out," and I have literally had moms just kind of...they'll walk along that path with me, and then they're done. They just, they got kind of emotionally stuck with being open to the baby and they haven't allowed them to come out because that's the end of the process. The birth is over.

This story illustrates a point suggested earlier — that birth is more than just a physical experience, that the woman’s body, mind, emotions, and spirit all go through it together. Such a view is rooted in the wholistic worldview of the movement, and as I will show, it
is central to knowledge interests that are unaccounted for by a purely cognitive theoretical perspective.

The midwifery movement’s search for alternative technologies brings to light important non-physical dimensions of childbirth. As one midwife explains:

One of the things that we use at home quite a bit is immersion in warm water... The other thing is just loving support. There's not a bunch of machines around that everybody's looking at and distracted with, but everyone is actually looking at the woman. The woman knows the people well that are there with her at home. They're people that she's chosen, and she's on her own territory. She can go to her own refrigerator. She can be in her own bed. She can be in her own shower or — and so, that's something that's different than being in a place that has, you know, certain policies and guidelines that the woman has to go by. And then, what I've seen is that there's a level of preparation there, by the entire family, that provides a level of support for the woman that is real integral to her — to serving her needs.

Rather than replace one set of material technologies with another, the midwifery movement shifts attention from instrumental technology to expressive technologies.

Away from the machines and the mass institution, surrounded by people she knows, the woman who births under the care of independent midwives is given “loving support”50 and a freedom that is only possible in her own home.

4.2.3 Organizational Interests

The midwifery movement’s critique of biomedical elitism, the movement’s emancipatory project, centers on issues of time, relationship, power, treatment, family

50 See also, Taylor (1996, 2000).
relations, experiential knowledge, and comfort. As they articulate the movement's organizational ideas and ideals, midwives often contrast their approach to birth with that of biomedicine, which they see as characterized by anonymity, manipulation, maltreatment, objectification, pathologization, and displacement.

The personalized approach of midwifery care both motivates and is made possible by a different relationship to time. Midwives spend far more time with their clients than the dominant approach exhibits. As one midwife describes:

Midwives...spend a lot more time with women. I figure for every five minutes an obstetrician would spend with a woman, I'll spend an hour. So obviously in that time period, you're offering not only health care, but you're offering emotional support, guidance, advocacy, education — you know, to again, enhance her capability regarding her maintenance of her own health care.

Extended visits are considered important because midwifery care addresses far more than just the physical aspects of childbirth. As another midwife adds:

What we provide is the time during the prenatal care to really listen to the family and to get to know them — get to know the woman — and to find out what her needs are. She might be a woman who needs more privacy. Then there might be a woman who needs more social support. But each hour of prenatal care, each month, and then several times in the seventh and eighth month, and then four or five times in the last month, you know, spending an hour at each visit, you get a really good chance to really know what that family is about and get a chance to help them prepare in the ways that they need to prepare.

Extended visits are also considered important because midwifery care is centered on meeting the woman's personal needs. One need that midwives tend to approach from a more standardized perspective is the need for education. As another midwife relates, "It's
important to me that she feels informed and that she makes informed and educated
decisions about her care.” By definition, midwife means “with woman,” and midwifery
care is organized along collaborative principles that encourage the education of the
birthing woman and her family.

In contrast to the dominant organizational approach, under midwifery care, the
woman is an equal participant in the decision-making process. As one midwife
expresses, “I see midwives as being in service to woman. And when I get an image of
that, it's like we are sitting at her feet. We collaborate with the woman to bring forth that
which she wants.” This characteristic is related to the movement’s cosmology of
personalism, as well as the relatively small scale of midwifery practice. As another
midwife explains, “I'm going to be so much more immersed in the individual experience
versus a multitude of people's experience. So that I'm much more likely to be able to
empathize, I think, with that individual, versus the doctor with his patients.” The
importance of empathy is discussed in greater detail in Chapter 5. For now, it is
important to note that midwifery is inherently and purposefully organized on a small
scale.

That small scale creates a social world very different from that exhibited under
the dominant approach. As one midwife describes:

Typically, a woman...goes to either a health care clinic or
obstetrical practice, and they're seen by a succession of
people who will do their charting and their vital signs, and
then the doctor will come in for five minutes and listen to
the heartbeat and talk to them and run out of the room, and
they might be someone they've never seen before. The
person who takes care of them in labor is going to be the
nurse at the hospital, who they've never seen before, and
the doctor who they may or may not have had a relationship with in pregnancy, is only going to show up when it's time for the baby to come out.

Large-scale organization, which characterizes the dominant approach, fosters impersonality and segmentation. In contrast, as another midwife explains, “I'm staying in the room the whole time... Midwifery is where you're part of the whole process.” This wholistic organizational approach derives directly from the movement’s worldview and is related to the movement’s critique of biomedical technology.

According to midwives, under the dominant organizational model not only are caregivers brief and impersonal, but they make decisions based on the needs of the institution rather than the needs of birthing women, babies, or families. As one midwife describes, “They're usually not there except for five or six minutes at the end to catch the baby, take the placenta out, cut the episiotomy, stitch her back together and say, ‘Congratulations,’ and go out the door.” The vast number of births performed in the hospital, combined with the normative demand for emotional distance, creates a dehumanizing birth experience. As another midwife explains, “From the perspective of the obstetrician, as soon as he cuts the umbilical cord the baby belongs to somebody else. It's the pediatrician or the pediatric nurse practitioner who then takes over the care of that baby.” Another midwife adds, “they clamp the cord right away, because then they're no longer responsible.” In an impersonal mass institution, liability concerns can usurp the kind of sensitivities advocated by the midwifery movement.

In contrast, the movement constructs an approach to care that is not only time intensive, but consistent. As one midwife explains, “One of the huge differences is the...
continuity of care...I've known women who've gone through their entire pregnancy seeing their doctor once.” Because the movement values wholism and personalism, midwives organize their practice in a very different way. As another midwife describes:

The same person sees you every month. The same person comes to labor with you, and sit between your legs, and help catch your baby, and does all your postpartum care, and assists you with lactation and adjusting to the new baby in the household. You know, that continuity of care is an extremely integral piece of midwifery care.

Given the intimate nature of childbirth, midwives assert that the development of a personal relationship has a positive effect on the overall process — a point that is explored in greater detail in Chapter 5.

In addition, by providing access to home birth, the midwifery movement reveals new knowledge about the process of birth itself. As one midwife describes, “we learn from home birth, what is the real — what woman can really do. And out of that knowledge, we could help the other types of birth, not the other way around.” This comment illustrates that the midwifery approach inverts the dominant assumption that biomedical knowledge of birth is superior and applicable in all circumstances.

Home birth is also seen as providing an alternative to the anonymity and dehumanization that characterize hospital birth. As one midwife describes:

When you leave your home, and you go into somebody else's space, and you're one of — how many thousands of people are in that hospital that particular day? You know, I'm in a big city. I think if you took the census of the hospital — all the workers, all the cleaners, all the patients, all the doctors — that's a lot of people. You're one of an anthill. And you walk up into your room — which is on the umpteenth floor of some building, you know, down the
hall — and you're in their space, and in a way you're at their mercy. Now, this may feel like a really safe place for you to be, and a choice that you made. You wanted to be there because you feel safe having your baby in a hospital. But it's not your space. And you can do what you want to try to make it that way — some people throw their own pillows on the bed — but all the decisions are no longer going to be made by you, and many of them aren't even going to be made with your consent.

Midwives assert that the very structure of the hospital is inherently disempowering. Not only are birthing women and their families moved from the familiarity of their own home to the sterility of a multi-leveled building, they are also moved to a rigidly hierarchical bureaucratic institution at a time when they are quite vulnerable. As another midwife states:

The institution creates an immediate hierarchy that's disempowering to the client. And then you take the client and put them in labor, which is a vulnerable situation — a woman's not always able to advocate, she's not able to process information in the same way that she can if she's not in labor. And you end up with, like a chasm between — the parents lose a lot of their power. And you lose a lot of negotiating power.

To midwives, the organizational structure of the hospital is inherently and unavoidably disempowering. In addition to the hierarchy of decision-making power, hospitals are characterized by countless rules that regulate the behavior of those inside. As another midwife explains:

You are essentially at the mercy of their rules as to whether or not you're going to be allowed to have a nice, normal, non-interfered with birth. Even the things as subtle as a bed in the room — and, well now they say you should put an easy chair — and that's all the furniture. It tells you that you're supposed to be in the bed. I mean, where else are you going to be?
By virtue of moving to an institutionalized setting for childbirth, woman and their families enter an environment that exerts great control over their behavior (e.g., Goffman 1967).

The organization of the hospital is seen as exerting both overt and subtle constraints on the birthing woman and her family. Because midwives understand birth to require flexibility and freedom of movement, this is seen as highly problematic. As one midwife relates:

In a hospital system, where a mom is in a relatively cold, boring, non-hospitable room that isn't her own environment and isn't nurturing, and she's not allowed to eat or drink, and she's supposed to make sure to stay — maybe not laying down so much anymore nowadays, but certainly in a position where they can get the stupid heartbeat the whole time with the monitor, which pretty much means laying down — and that to me is suffering, because that isn't allowing the process to unfold naturally.

Rather than allowing the process to unfold naturally, the organizational form of the culturally dominant approach is seen as inappropriately molding the birthing woman's experience to the needs of the institution. As another midwife states, “medical model of birth is really the worst kind of rape. Because it's the kind where women don't even know that it's happening to them. And at the end of it they oftentimes say thank you — and go back.” The imposition of institutional needs is seen as a major violation of women’s integrity, and one that remains invisible to many women (e.g., Kitzinger 1992).

Again, the dominant system’s organization operates at overt and subtle levels. While the hospital appears to offer safety and security, midwives assert that in fact the
hospital constructs or intensifies a fear-based attitude toward birth. As one midwife illustrates:

Most hospitals...you're in a room that's designed around the possibility that something could go wrong, and that at any moment something disastrous could happen. I mean, the electronic fetal monitor is there...which unconsciously screams at you, "Your baby could die between one moment and the next, between one heartbeat and the next. It could die. So it needs to be monitored every second while it's inside you." That's what a fetal monitor says. A fetal monitor doesn't give people reassurance. It sets up a tremendous negative fear in the back of the woman's head.

The machines, the drugs, the beeps, the white-coats — all the trappings of biomedical expertise combine to form a symbolic message that birth is dangerous and very likely to require emergency treatment. At the same time, the birthing woman has already been transformed into a patient. As another midwife describes, "in the hospital setting, they put on the hospital gown, they're hooked up to various machines, they have timelines."

Should her birth go past the pre-established timelines, as described above, the transformation from normal birth to surgical procedure is already begun.

The dominant organizational form therefore serves to define the birthing woman as a docile recipient of whatever services are eventually deemed fit, regardless of their possible iatrogenic sources. As one midwife describes, "Psychologically, she becomes managed. She's not managing her labor. Someone else is. And that, I think, is incredibly disempowering to women. And the father. And the father, in no small way. Fathers are hideously displaced and disempowered in the hospital."

The effect on interpersonal relations is most evident if we turn our attention to the role of fathers.
The alternative organization of childbirth enacted by the midwifery movement centers in large part on the inclusion of fathers and the facilitation of the family bond. As one midwife explains:

I think that most fathers, when they go into the hospital, see that there's this other person — man or woman — who is the authority — the one who's in charge of things, and his role is — has to be mediated through this other person. Where, when the couple is in their own home, their relationship doesn't have to be mediated through the expert.

Here, we see that a key emancipatory aim of the movement is to free childbirth from the mediating influence of authoritative expertise — defined by movement philosophy as misguided, inappropriate, and even dangerous. The alternative organization of birth under the midwifery model seeks to reinstate the displaced father. As another midwife relates:

What I hear from dads themselves, who've experience hospital and birth center or home birth — the difference in them is they say, "With the hospital birth, I always felt like I was kind of in the way and I couldn't do anything to help. This is really different." Dad's are free, with a midwifery assisted birth, to do as much as they're comfortable doing. And we encourage them to do — like, "Look, look. Hold her back this way." Or just pass them a cool cloth for her forehead, you know, kind of give them a cue to do stuff. Rather than just stepping in and doing that kind of caretaking thing for them.

Because midwives are unconcerned with perpetuating a hierarchical relationship with the women they care for, their position in relation to birth is not threatened by the inclusion of the father. As another midwife adds, "A good midwife...never replaces the father. You know, they're always making sure — inviting the father to be kind of the main

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support person. You know, if anybody's making eye contact, as long as the father's available and able, it should be the dad.” Inclusion of fathers is also easier under a system where the main technologies are those of interpersonal interconnection. Coming from a naturalistic worldview, many midwives see no reason why the father himself shouldn’t catch the baby. As another midwife relates, “I'll always say, "Would you like to catch the baby?" And they say, "Oh, yes, I'd love it. Could I?" And I say, "Yes. Technically, your hands should be the very first ones to touch our baby.” Not all midwives share that aspect of the experience. Those who do not, however, still make a point to include the father right away. As another midwife describes:

> When the baby comes out, first it goes to the mom, always. That’s the way it’s supposed to be. And the baby can smell her and be with her. But then we really believe that the next person to hold the baby should be him. So that at some point, when we’re getting ready to do the newborn exam or look at her bottom or help her to the shower whatever, we say, “Dad, you want to hold the baby while we do — this?” And then he takes up the baby.

The significance of this approach to fathers is discussed in greater detail in Chapter 5. Here it is important to note that midwives take a distinctive approach to the moments directly following the birth itself.

As mentioned in Chapter 1, hospitals are organized on rational principles of efficiency, routinization, calculability, and technological control (Ritzer 1996). The midwifery movement challenges the logic of the resultant organizational form. As one midwife specifies:

> I think that when babies are born — what needs to happen immediately after birth, ideally to feel calmed, and connected, and embraced by their parents. And when
they're taken away from their parents, and they're handled roughly by doctors or nurses — they're put in warmers, not in their mom's or dad's arms. When they're taken directly out of the birth canal and to a warmer or to a nursery versus being kept with their mom and their dad, I think that places a tremendous amount of stress on that newborn. And I think that interferes with normal emotional development, and normal intellectual development, and possibly even normal physical development. I think it's a very traumatic, very unnecessary, very unnatural, very alien, and in my estimation, very damaging effect upon the newborn. And I don't think that we fully understand what a bad thing we do to babies when we take them away from their moms and dads.

Whereas hospital birth removes newborns from the unpredictable human context and places them in the controlled environment of the nursery, home birth signifies that such practices are unnecessary. As another midwife explains:

All hospitals have some protocols that require that the baby be removed from the parents and taken for some period of time into a nursery and subjected to a battery of tests and so forth. And the very few tests that are necessary immediately at birth can be done right in the parents' arms, right on the bed with the parents.

The image of a midwife surreptitiously checking a newborn while it rests in the arms of a mother who is cradled by a father in their own bed at home is almost the exact opposite of the image of a doctor stitching up a routine episiotomy cut into a woman laying on a lithotomy table under surgical lighting while her baby cries in a plastic box in another room and her husband waits in the hall.

The midwifery movement's critique of the dominant system communicates to society that there are choices to be made. It also communicates that different options create different social worlds which manifest completely different birth experiences. As
one midwife expresses, “I think it's a very liberating thing — when you feel that nobody
else is going to impose something on you that you don't want — that it's a great feeling of
security.” Offering freedom from constraint and interference, the midwifery movement
challenges biomedicine's authoritative knowledge (Jordan 1997). As another midwife
asserts, “Throughout time, women have attended women. I mean, I don't think anybody,
no matter how much they read about birth could really know about birth if they hadn't
been through it.” That experiential knowledge of normal birth is superior to objective
knowledge of medicalized birth is a central message of the midwifery movement. That
supportive care is more important than technological gadgetry is as well. As another
midwife relates:

I often encourage women to have another woman friend at
the birth — a close family member that's female or a
girlfriend who they really trust, who they can get literally
naked with — physically and emotionally — to be there as a
comfort person if they feel that they need that. And not
expect their partner to do all of that when he can't possibly
know what they're going through.

That a woman can choose to stay at home, be surrounded by loving friends, give birth
naked rather than in a hospital gown, and experience the entire process as a joyful state of
health is communicated to society through enactment of alternative birth philosophy in
submerged networks of everyday life.

4.3 Summary

In this chapter, I have identified the midwifery movement's visible and latent
cognitive praxis. I have shown that the public struggle for professional identity is an
attempt to legitimize the alternative birth philosophy enacted in submerged networks of everyday life. These findings offer empirical support for the analytical model presented in Figure 4. Important social movement dimensions remain unexplained, however.

Analysis of the midwifery movement’s latent activities (its creation of new knowledge) points to the existence of knowledge interests obscured by a purely cognitive approach. I have shown that the movement communicates distinctive attitudes toward nature, society, and their interrelationships (cosmological interests). I have shown that the movement communicates a distinctive critique of technological application and a search for alternative technologies (technological interests). I have also shown that the movement communicates a distinctive critique of elitism — a specific emancipatory project (organizational interests). Embedded in each, however, appears to be a set of knowledge interests that are more accurately described as emotive, that is, characterized by emotions, pertaining to emotions, and/or directed toward emotions.

The movement’s cosmological interests center on a perception of birth as natural, normal, healthy, miraculous, powerful, magnificent, and something to be revered. Midwives view birth as an intense, transformative, powerful, transitional, spiritual and life changing experience with the potential for self-actualization and joy. The movement’s technological interests center on a critique of the dominant approach as dehumanizing interference that distorts the birth process and creates self-fulfilling prophecies of pain and complications. In place of the dominant assembly-line approach, midwives advocate spiritually grounded, personalized care that employs alternative modalitites such as education, counseling, relaxation, positioning, breathing, heat,
aromatherapy, hypnosis, visualization, herbs, homeopathy, acupuncture, massage, touch, prayer, movement, dancing, singing, kissing, personal interconnections, and a supportive environment. The movement’s organizational interests center on a critique of the dominant approach as depersonalizing, disempowering, manipulating, objectifying, pathologizing, exclusionary, and disruptive. In contrast, midwifery care emphasizes personalized collaboration, empathy, continuity, empowerment, autonomy, experiential knowledge, family bonding, liberation, comfort, and support. While many of the above knowledge interests pertain to thoughts and the organization of thought, many others pertain to feelings and the organization of feeling.

An accurate representation of the midwifery movement's distinctive goals therefore requires consideration of its specific emotion interests. In the next chapter, I use the midwifery movement as an empirical case to explore the process by which social movements transform emotion interests into emotion knowledge.
CHAPTER 5

EMOTION INTERESTS AND KNOWLEDGE PRODUCTION OF THE MIDWIFERY MOVEMENT

One can defy an ideological stance not simply by maintaining an alternative frame on a situation but by maintaining an alternative set of feeling rights and obligations.

—Arlie Russell Hochschild (1979:567)

The distinctive knowledge interests of the midwifery movement suggest the inadequacy of a purely cognitive approach. As discussed in Chapter 4, the movement does exhibit cosmological, technological, and organizational concerns (i.e., knowledge interests) that fit the two-pole model of cognitive praxis (Figure 4). The movement also exhibits particular feeling and expressive concerns (i.e., emotion interests), however, that existing theoretical approaches do not explain.

In this chapter, I use the two-pole model of cognitive praxis as a theoretical base, and draw relevant ideas from the sociology of emotions to extend existing theory. Beginning with a view of the midwifery movement as cognitive praxis directs attention to the production of new knowledge. Relocating knowledge as a bridge between thinking and feeling directs attention to the way existing perspectives fail to adequately address
the complexity of knowledge. Specifically, it highlights the erasure of "emotion knowledge" (McCarthy 1989) among conventional approaches. Considering the place of emotions in knowledge, directs attention to social movements as important sources of new emotive developments. Rather than contrast emotion knowledge with some kind of cognition knowledge, however, my intent is to supplement the heretofore incomplete (and cognitively biased) understanding of social movements as knowledge producers.

In this chapter, I combine relevant ideas from the sociology of emotions with the two-pole model of cognitive praxis (Figure 4) to analyze the midwifery movement’s construction and dissemination of alternative feeling rules (Hochschild 1979) and alternative interactional resonances (Perinbanayagam 1989). I also use analysis of the midwifery movement’s transformation of emotion interests into new emotion knowledge to generate a new analytical model of social movements as emotive praxis (Figure 5).

5.1 The Two-Pole Model of Cognitive Praxis

In Chapter 4, analysis of the midwifery movement’s visible struggle against established political authorities and latent enactment of alternative birth philosophy in submerged networks of everyday life revealed two important findings. First, the movement’s construction of new professional identities legitimizes the movement’s enactment of new ideas and ideals. Second, the movement’s transformation of knowledge interests into new knowledge is only partially explained by its dissemination of new ideas and ideals.
The reduction of "knowledge" to cognition is problematic, however, as knowledge interests can be emotive as well as cognitive. While the first half of this inductive study provides support for the two-pole model of cognitive praxis (Figure 4), it also reveals the inadequacies of that model. Specifically, the model in Figure 4 does not explain how social movements create and legitimize new emotion knowledge.

5.2 Feeling Rules

Childbirth is an embodied experience that occurs within a social context. While theoretical considerations of the body are beyond the scope of this research, it is important to note that "it is through emotion (feeling/sentiment/affect) that the links between the body and the social world are clearly drawn" (Lyon and Barbalet 1994:48). Previous research shows that hospital birth is a traumatic and disempowering ordeal for many women, but most refrain from verbalizing their distress because such emotions are perceived by others as trivial (Kitzinger 1992). While the effect that has on women's inner lives is beyond the scope of this research, it is important to note the powerful process of matching one's felt experiences to the set of emotion prescriptions embedded in one's culture (Hochschild 1998).

Official definitions of the situation are generally accompanied by specific feeling rules articulated through verbal claims, accounts, and sanctions (Hochschild 1979). Once internalized, feeling rules regulate when one should or should not feel a certain way, whom one should or should not feel a certain way toward, how strongly one should or should not feel a given feeling, and how important or unimportant a given feeling is
Different sets of feeling rules produce different kinds of "emotion consciousness" (McCarthy 1989:64).

Because emotion is "a means through which we know the social world, our relation to it, and how we frame ourselves within it" (Mamo 1999), social movement activities that expand or alter emotion consciousness are political activities. In this chapter, I show that through alternative emotion claims, accounts, and sanctions, the midwifery movement translates specific emotion interests into new emotion knowledge.

5.2.1 Emotive Claims and Sanctions

Through enactment of alternative birth philosophy in submerged networks of everyday life, the midwifery movement constructs and disseminates specific knowledge interests regarding the emotive stance of care providers, the emotive stance of society in general, and the emotive stance of the birthing woman. The specific emotion interests of the movement are transformed into new emotion knowledge through expression and enactment of claims and sanctions regulating the feelings and expression of feeling surrounding childbirth.

Midwives claim that care providers occupy a position of emotive responsibility. As one midwife asserts, "You're supposed to be helping the woman cope, with whatever she has to endure, and giving her the confidence that she can do this." Helping the woman and giving her confidence are understood to be crucial emotive activities. As another midwife adds, "The care provider needs to be there and just to approach the whole experience — and I mean pregnancy through postpartum, the whole experience —
with a great respect for the family they're serving. And that's with trust and confidence in the natural process themselves. The care provider needs to have that.” Respect for the family and trust in the natural process are also understood to be crucial emotive qualities. As discussed in Chapter 4, midwives advocate personalized care based on collaborative relationships. Here, we see that embedded in that knowledge interest are important concerns about emotion. As one midwife explains:

If you don't have a handle on who she is and how she lives her life and how she approaches her sexuality, you know, her interconnectedness with her extended family — I think you miss out on being able to foresee any problems if you don't know a woman well, if you don't know what her body image is and her past grievances. Even in my small practice, about one fourth of the women that I serve have been sexually assaulted in some fashion. And if you don't deal with that and discuss it, it can come up as a problematic impasse in a woman's labor.

Viewing childbirth as an intimate and complex process involving transformation of the body and subjective states of mind, the midwifery movement articulates that deep psychological and emotional issues are likely to arise during the process. For that reason, the movement claims that care providers must work to build respect, trust, and personal relationships with their clients.

Most midwives also express that while respectful relations are necessary, they are not sufficient. As another midwife emphasizes, “When you see a newborn baby come out, or when your hands touch a new baby, ...you're in the presence of God, and that needs to be recognized.” Whether they use the word “God” or not, midwives claim that birth must be approached from a place of awe and reverence. As another midwife explains:
You know how the trees change colors? I mean, sometimes when you're driving down the road, if you like open up your heart, and like look at the miracle that happens — with those trees changing those colors. Okay, yeah I know there's like a whole scientific explanation, blah, blah. But it's just so great! And it happens again and again. And like in the spring, those bulbs that you put in there last year — they come up into these fabulous flowers, you know. And if you'll let yourself feel how good that feels, and like really wonder about it and look at that for the amazing thing that it is — a birth is like the big show. You know?

Advocating reverence of God or Nature, the midwifery movement constructs and disseminates a renewed sense of wonder about the miracle of birth. In contrast to biomedicine's normative demand for a neutral or cool emotional stance (James 1989, 1992), the movement claims that caregivers should be emotionally affected by and involved in their work. As another midwife emphasized, "that's what makes it really, really, really good is the fact that you know and love and care for the person that's having the baby, let alone the child that's coming out."

Claims for reverence extend beyond the caregiver to the whole of society. As one midwife asserts, "When you're pregnant, you're in a whole other realm...I don't want to get too spiritual on it, but it's a really blessed state to be in, and it's one that needs to be acknowledged. It needs to be honored." That the movement articulates a need for pregnancy to be honored highlights the lack of such emotive stance in the dominant cultural system. Rather than honor, pregnancy in the U.S. often evokes horror. As one midwife describes:

[It's] one of the most basic — not just feminine, but female functions — and it's looked at with kind of like — almost like a yucky, kind of creepy thing by a lot of men, and
actually a lot of women. A lot of young women don't just see birth as something that's painful and frightening, they see birth as something that's gross. And that's their word. Yucky. Gross. Even disgusting.

Cultural perceptions of birth as painful, frightening, gross, and disgusting suggest a widespread aversion to childbirth that pre-exists experiential knowledge of the event. As one midwife states, "American women are raised to be afraid of birth..." The implications of birth fear and aversion will be discussed shortly, but for now it is important to note that midwives understand birth fear to be based in cultural (mis-) perceptions of birth pain.

As movement intellectuals point out, the "knowledge" that birth is painful has roots in Judeo-Christian scripture. Among other relevant passages, the Book of Genesis (3:16) specifies that, "in great sorrow shalt thou bring forth children," and the Book of Isaiah (21:3-4) states that, "pangs have taken hold upon me, as the pangs of a woman that travaileth" (Arms 1975:15). Such deep-seated notions can be difficult to counter, but a central aspect of the movement, as one midwife states, is working "to dispel the cultural fears we have surrounding birth — pregnancy and birth." To that end, the experiential knowledge of midwives is highly valued. As another midwife explains, "Nobody can understand it unless they experience it themselves, so they're very fearful of it. And those people who've done it, aren't." From personal experience, either as birthing women or care providers, midwives have constructed new knowledge of birth as a wholistically intense experience that manifests along a spectrum from bearable pain to ecstatic pleasure.
At one end of that spectrum, midwives claim that birth is painful but that the pain is not inherently aversive. As one midwife states, “I don't see the pain as a bad thing. In medicine, pain is a bad thing, patients shouldn't feel pain. If they're feeling pain, get them a pill.” Rather than a feeling to be avoided, the midwifery movement claims that birth pain serves an important function. As another midwife explains:

I think getting in touch with the — and I don't know if I like to use the word pain, but it is painful — I know, I've had six children — that — through the physical sensations of pain, I really know my body is working. And if you really tune in to where you’re feeling the pain, you can really feel your baby moving down.

From this perspective, pain can be a means of self-assessment. Moreover, as another midwife states, “The pain...serves to put a woman into a place where visions are possible...If a woman can get to that point in her being where she surrenders to what's happening in her body — the pain serves a psychological function, serves a spiritual function.” The movement claims that birth pain has a practical purpose, and that such feelings are not only bearable but desirable. As another midwife adds, “I think Mother Nature has designed the system so that it blocks out your attention of things that are superfluous...Most people can handle the intensity of the contractions, and it is a very intense physical sensation, but they don't describe it as pain.” As these two comments show, midwives hesitate to apply the word “pain” to the intense feelings of birth. The use of that word is understood to obscure a qualitative difference between the pain of birth and the pain of injury. As one midwife explains:

I broke my finger once, and I've also stubbed my toe really hard — and really created some horrible bruising on it —
and I've also slammed my finger in a car door. And so, I've compared that kind of pain with the pain of labor, and for myself, the pain of labor is not at all like that. It's uncomfortable, it's pressure, it's something that I need to stay relaxed with and focus on, but it's not the extreme pain that sends me wailing and crying and screaming because I just broke my finger.

Because midwives emphasize that birth is a state of health, they distinguish between the intense sensations of birth and feelings of pathological pain. This view challenges the logic of the routine treatment of pain with anesthetic drugs, something many midwives consider completely misdirected. As one midwife relates:

It astounds me that in our culture, you know, if a woman wants to be a marathon runner and run a 26 mile race, we think it's great. And, you know, when she's at that 25th, 26th mile, we're like yelling, "Come on! You can do it! You can do it!" Right? And, you know, you get these women in labor — and I don't see it as being much different than that — and everybody wants to rescue her from the experience. You don't see like anesthesiologists running on the track offering a runner an epidural. It's insane. Or some sort of anesthesia, so she doesn't feel her experience. And I'm telling you, I'd have a baby in a heartbeat. I'm not afraid of birth at all. But I ain't running a 26 mile marathon.

The claim that birth pain is an important dimension of the overall process, one that ought to be felt, is embedded in alternative ideas about birth. As discussed in Chapter 4, the movement views birth as an intense and transformative experience with the potential for self-actualization and joy, much like hiking the Grand Canyon or running a marathon.

In the middle of the spectrum, midwives claim that birth pain exists in combination with birth pleasure. As one midwife states, "Not everyone experiences it as pain. Some people really don't. They really experience it as — it's a tightening, but it's
wonderful, and it's pleasurable for some people. It doesn't have to be — it's not always pain.” The notion that birth is inherently an unbearable experience is understood to be based on cultural misconceptions and cultural practices. As one midwife explains:

> When you go to the hospital to have a baby, all you're really focusing on is your contractions. People around you are focusing on your contractions and on a machine to register your contractions, and on the IV with pitocin, which makes the contractions harder, and the drugs they give you to make the contractions more bearable. That's the entire focus of your existence in the contractions, and in our words, of course, means the pain of childbirth.

In other words, the dominant cultural approach is understood to create the very thing it claims to treat. Because midwives are engaged in creating new ways of birthing in the submerged networks of everyday life, they are able to produce new knowledge about the emotions of birth. As another midwife emphasizes, "Most people can handle the intensity of the contractions, and it is a very intense physical sensation, but they don't describe it as pain." Other midwives claim that "it's kind of like there's pain and pleasure occurring together," or that the pain itself is actually pleasurable. The following metaphor offered by another midwife serves to illustrate:

> When I talk to husbands, and they say to me, "Why in the world would my wife want to experience all that pain?" And I say, "Well, what do you get out of a football game?" And they say, "What do you mean?" And I'm like, "When you're running around, banging into the guys, does that hurt?" "Well, yeah, but I get this rush," and I'm like, "Exactly."

As this comment shows, the notion that pain and pleasure can co-exist is not completely new to the dominant culture. That pain and pleasure co-exist in childbirth, however, is.
Knowledge about positive birth feelings is at odds with the dominant culture. As one midwife explains:

I don't think very many people are set up to recognize that childbirth can be pleasurable. I think that in our society that's considered...I think it's not only considered that women aren't going to be able to feel pleasure in childbirth, but I think that if women feel pleasurable sensations associated with birth and with breast-feeding, in our society we confuse sensual pleasure with sexuality, and that can be very scary to her.

This comment underscores the overlapping nature of childbirth and sexuality, a point that I discuss in the following section. It also suggests the dominant culture has created a "Catch-22" for women. Birth pain is scary. Birth pleasure is scary. That birth can be anything other than scary is itself a major knowledge contribution. As I show in the following section, however, the midwifery movement makes even more significant emotive claims.

At the other end of the spectrum, midwives claim that birth can be an ecstatic experience. Whether ecstasy is understood to follow birth pain or to exist independent of physical discomfort, the movement disseminates emotion knowledge that is overwhelmingly absent in the culturally dominant approach. As one midwife describes:

There's definitely that ecstatic release, and I think many women when they watch the videos of their birth or they listen to an audio tape of their babies being born, they realize that the sounds that they make very closely simulate the sounds of orgasm, because it is such an all encompassing, physically overpowering sensation, and it's designed to be that way so you have to pay 150 percent of your attention to what's going on. Some people are a little taken aback by that, but I've had women who just turn to

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51 See also Richardson 1977.
me right after they got their babies and say, "I could do that again." [laughs]

New knowledge about distinctly pleasurable childbirth is discussed at the end of the following section, but for now it is important to note that specific emotion interests are embedded in the movement's alternative birth philosophy. Many midwives initially rejected the dominant approach after their own disappointing and sometimes traumatic hospital births. That a woman can feel like "doing it again" right away is counter to the feeling rules exhibited by the dominant approach. As I show below, it is also unlikely to result under circumstances where birth is micro-managed. Midwives claim that control in inimical to a good birth experience. As another midwife describes:

You must completely surrender to the forces that are surrounding your labor, that are in your body, that are part of you. You have to completely surrender to it. You can't be in control of your labor. You have to let it happen. And that's a very, very spiritual thing. That surrendering.

Beyond the spiritual significance of surrender, acceptance of the process is understood to shape the experience itself. That point is explored in the following section. For now, it is important to note that midwives construct and disseminate new knowledge about the highly individualistic feelings of birth.

5.2.2 Emotive Accounts

Through enactment of alternative birth philosophy in submerged networks of everyday life, the midwifery movement expresses specific knowledge interests regarding the relationships between fear and pain, trust and pleasure. The specific emotion interests of the movement are transformed into new emotion knowledge through expression and
enactment of accounts describing the feelings and expression of feeling surrounding childbirth. These accounts are understood to provide an important corrective to dominant cultural perceptions about birth. As one midwife states, “if you look around our culture today, all you see on childbirth is fear-based.” Midwives turn the cultural aversion to birth around. They suggest that rather than birth fear being the result of birth pain, birth pain is the result of birth fear. As another midwife explains:

We generate chemicals in our bodies by the emotions we feel. We feel joy, we have one kind of chemical in our bloodstream. We feel grief, we have another. We feel terror, we have yet another. And the terror — the adrenaline, and other hormones and chemicals that circulate in response to the emotion of terror, are counterproductive to labor. It makes it harder to dilate. It makes it much more painful. It makes it much more unpleasant. Conversely, the more relaxed and secure and safe she feels, the easier the process is.

The relationship between emotional states and physiological sensations is confirmed by objective scientific accounts. Recent neurophysiological studies, for example, show that in different contexts vaginal, cervical, and uterine sensory activity can induce a variety of perceptual responses ranging from pain through analgesia to pleasure (Komisaruk and Whipple 2000). Before the advent of such studies, however, midwives were constructing and disseminating experiential knowledge that a woman's emotional state (and the emotional atmosphere of her environment) influences her subjective birth experience.

It was precisely that knowledge that led many midwives to reject the dominant model in the first place. As one midwife describes, "At that time, you had your baby at home because you wanted things to be natural. You didn't want the interference in your birth. You wanted that emotional aspect of it. You knew that was missing in the
hospital.” Where the hospital provides an impersonal atmosphere of readiness for emergencies, home birth midwifery provides personalized comfort to ease fear and smooth the process of birth. As another midwife explains, “If somebody who's been on a journey takes you and is your guide on the journey, even when it gets hard...it's very, very beneficial. It’s very comforting. It takes a lot of the fear away.” Midwives understand "taking the fear away" to be central to a naturally pain-free birth experience.

At the same time, just as midwives understand that pain can serve a function, so do midwives understand that fear can serve a function. Emphasizing that courage is the act of going forward in the face of fear, one midwife explains:

> When you have faced the fear and the uncertainty, and you've gotten through it,...you can face a lot of other fears in your life, not necessarily knowing how you're going to get through it. Not necessarily having the plan of action. But, knowing that you can deal with whatever you have to deal with, and that you're not afraid of things that are hard, things that are difficult, things that are unknown, uncertain.

This comment explains one source of birth’s potential for self-actualization and joy. Precisely because it is intense and uncertain, birth can provide the kind of pressure that forces one to draw on deep and previously unacknowledged sources of strength and courage. Movement accounts indicate that overcoming fear and other negative emotions is central to overcoming birth pain. As another midwife explains, “I think the more progress we make in reducing the fear — and the shame that's still there, there's still shame involved with this bodily process as there is with all bodily processes in the modern world or the postmodern world — today — I think the more we might be open to interpreting some of the sensations as pleasurable.” The role of shame in childbirth is
beyond the scope of this paper, but it is important to note that reducing the cultural fear of birth is understood by midwives to be a complex undertaking.\textsuperscript{52}

Knowledge about the relationship between fear and pain is constructed and disseminated by the midwifery movement in a manner that locates the problem at the level of culture. Midwives account for the way fear leads to pain by directing attention to socialization processes. As one midwife describes:

Many times, women who are in America are very frightened of birth because of the socialization and the information that they've been given surrounding birth...and with that fear comes a greater fear of the process, fear of the pain, and therefore maybe even a greater sensitivity to the pain...they get the idea of tearing or just all these pathological things happening instead of thinking of it as pressure, and stretching, and opening, and that kind of thing.

Because dominant cultural knowledge about birth derives from the culturally dominant approach to birth, midwives consider American women to be culturally predisposed to experience birth as painful. That predisposition is rooted in fear, and midwives are aware that fear can creep into the process at any time. As another midwife describes:

It's amazing how psychologically fear is tied in to pain. So if you start to lose them on that slippery slope — usually the moms will start to express, you know, some uncertainty and doubt. And then the dad, if he's not in a strong place, then he starts to slide with her. And when she sees him starting to doubt — that just sends her further. Then you've got this ball rolling that's really hard to stop rolling.

\textsuperscript{52} For future work, see Scheff and Kemper on shame and social movements, as well as Taylor (1995).
In addition to accounts of doubt creating a slippery slope to fear and ultimately pain, midwives suggest the process can work in the reverse. Crucial, however, is the role of outsider influence. As another midwife states:

I see women who are very comfortable in labor. They're really doing fine. And they want to know if they're like one centimeter, two centimeters, because everything's so comfortable and it's just beginning, and somebody checks them and they're like seven centimeters, and then they go, "Uauuh!" and start hawing with the same contractions they've been having earlier. Because they think now that they must be in pain. And I've seen it go the other way too.

Rather than trust her own subjective experience, American women have been socialized to accept the objective account as the accurate account. If childbirth is objectively considered to be painful, and a woman is objectively considered to be in active labor, then a woman who might otherwise experience very mild sensations at that time can be influenced to feel something different. As Hochschild (1979:522) points out, people "pay tribute to official definitions of situations with no less than their feelings."

I argue that the midwifery movement strives to change the official definition of childbirth in order to change the emotive definition of childbirth. In other words, the movement seeks to create and legitimize new emotion knowledge. As mentioned above, midwives claim that birth can be an ecstatic experience. Midwives' accounts of ecstatic pain and unadulterated ecstasy reveal an important relationship between trust and pleasure.

As discussed in Chapter 4, drug-free childbirth is more difficult to accomplish in a hospital setting. For most women, truly natural childbirth (i.e., free of technological intervention), can only take place at home. Because home birth is a deviant way of
birthing in the U.S., women and families who make that decision must have a certain amount of trust to begin with. As one midwife describes:

> When a woman has decided to have a baby at home, the first step in her decision is, "I'm not that fearful. I think everything will go well." And that tells her that she has a certain amount of trust in her body, and just in general nature, and in her midwife's abilities to detect a problem, if there really is one, and to render aid or get her to aid if she needs it.

As this comment indicates, emotion knowledge is a self-reflexive process (Rosenberg 1990) wherein the individual indicates certain thing to her Self. If trust can be understood as a state of self-comfort, then midwives' attempts to enhance the birthing woman's comfort can be understood as a means of allowing the experience of trust. As another midwife explains:

> When a woman has a faith of some kind, I acknowledge that and even ask her to use that...if you believe in a Higher Power, or you believe in Mother Earth and Father Sky, you know, if you believe Buddha, whatever it is that inside makes the energy grow and feeds your compassion and makes you love people? That — whatever it is that's inside you — that goodness? That we like to call God. When a woman acknowledges that to herself, it gets bigger and bigger, and it feeds her. You know, it makes her be more open — be more able to open up and accept what's happening — not fight against the birth, but go with the birth. To be able to walk that line — to get into that state where she can just let everything go and go back to her primal self and just trust, trust, trust.

The culturally dominant approach does not tend to acknowledge that thing that makes us love people. Midwives' accounts place love in a central position. As one midwife declares, love is "the essence of midwifery." This notion will be discussed in the
following section. For now, it is important to note that midwives' construct and disseminate distinctive knowledge regarding the centrality of trust to good birthing.

According to midwives' accounts, if a woman comes to birth from a place of trust, and she thereby avoids the interference of drugs, then any pain she might feel is transformed into ecstasy. As one midwife describes:

If you look at lots of sets of birth pictures, you'll notice in a great many instances, there's a shot of the mother within moments after birth...you'll see them in a pose with their heads thrown back, and this look of absolute ecstasy and bliss on their faces. That comes partly just from the thrill of knowing that it's over, but also from the endorphins — the runner's high, there's a correlation there. The endorphins that have kicked in to get you through this labor — when the labor is over — rush through your body in such a way that it really is transporting.

In other words, even if a woman experiences pain during birth, under drug-free circumstances, the process ends in a rush of pleasurable endorphins that immediately transport the woman into an ecstatic realm. As another midwife adds, "she goes directly from — as the baby's head's crowning — she's "Aaaahaahooohoooo, my baby." I mean, it's an instantaneous switch...to this incredible ecstasy..." Ecstatic pain is accounted for by the thrill of the baby's arrival, but also, as another midwife explains, "from the endorphins — the runner's high, there's a correlation there. The endorphins that have kicked in to get you through this labor — when the labor's over — rush through your body in such a way that it is really transporting." Midwives' accounts reveal that birth outside the culturally dominant approach inherently exhibits an ecstatic release.
According to midwives' accounts, while some women experience birth as ecstatic pain, others report only pleasure, or even ecstasy. As one midwife relates:

A lot of women describe pushing — and I'm in that camp - pushing was very pleasant for me. It felt good to be able to do something, to feel the baby moving, the sensation of opening and the head being born. You know, it's stretching and burning, but a lot of women like that — like the feeling of giving birth to the head. And the feeling of the rest of the baby slipping out — you know, the shoulders and the rest of the baby kind of coming flooq out. Oh, it feels so good! [laughs] And it's such a relief knowing that you're done. And the baby's there, and you're holding the baby. That's a wonderful feeling.

Midwives' accounts reveal the potential for pleasure through active involvement, the progression of labor, and the actual physiological process of giving birth. This knowledge is unrecognized by the dominant approach. In addition, through construction and dissemination in submerged networks of everyday life, the midwifery movement produces new knowledge that birth can even be an ecstatic extension of sexual pleasure. As one midwife relates:

I have seen women experience contractions as an extension of sexual pleasure and just really be in their bodies and have it be a part of who they are and what their bodies were designed to do, in terms of having pleasure with the whole reproductive process — whether that's an orgasm during intercourse or during labor. I mean, the same hormone is secreted... I certainly have seen some women just really — really get into it. It's amazing to watch.

Knowledge of the potential for orgasmic childbirth could only have been generated through enactment of alternative birth philosophy. Under the dominant model of birth as a pathological process requiring hospitalization and routine technological intervention, the notion of an orgasm has no place. As another midwife adds:
There is something very sensual about home birth — about birth — that is masked — again, it's not that it can't happen in the hospital — it has for me on rare occasions. But, that I think happens routinely with birth out of the hospital. You know, when it's allowed to physiologically unfold. And it's very sensual. It is almost sexual. And it feels that way when you're in the middle of it. It's amazing.

This is not to say that every home birth is orgasmic, but rather that the midwifery approach is uniquely suited to allow childbirth to be whatever the individual woman wants it to be and/or is capable of making it be. As another midwife describes:

I've seen some women who — and in general, you can tell they have a pretty comfortable, shall we say, sexual life with their husband...I've seen more than one where the — you know, she's starting to push, that's pretty overwhelming. And they're really giving in to it — I've seen more than one woman put her hands down on her clitoris and uh, um, well find a way of relaxing [laughs]...And during contractions, you know, I've seen a few that actually experience it as orgasmic contractions...

More than a mere curiosity, the capacity for orgasmic childbirth has important implications for the overall birth process. Specifically, as that same midwife continues:

It goes very fast. You get a first time mom who pushes 15 minutes, and you can see — getting technical here — if a woman is doing that, you can see where...almost immediately, the vaginal area becomes — well, we use words like, "loose," you know. It becomes — it's more open. It begins to bulge slowly into — the baby begins to move on down, rather rapidly. It's as if all the tissues inside are just relaxing and changing. You know, it's a whole hormonal output that happens normally in birth, but...when a woman is having an orgasmic labor, you see that happen quite rapidly.

In Chapter 4, I presented one midwife's assertion that the study of birth should begin with home birth rather than hospital birth. As these comments show, such an approach would
likely render very different knowledge about birth. That the midwifery movement takes such an approach evidences the movement's production of alternative emotion knowledge.

5.3 Interactional Resonance

Because all social encounters are suffused with emotions, even those that are ostensibly emotion-free generate some kind of interactional resonance (Peribanayagam 1989). Far from biomedicine's "emotional abstraction" (Daniels 1960) and normative demand for a neutral or cool emotional stance (James 1989; 1992), the midwifery approach is distinctively attuned to the quality of interactional resonance between the caregiver and the birthing woman, and between the birthing woman and her family. Through enactment of alternative birth philosophy in submerged networks of everyday life, the midwifery movement constructs and disseminates distinctive interactional resonances — distinctive emotional forms of interaction. The movement's distinctive emotional energy exchanges both derive from and generate the cosmological, technological, and organizational knowledge interests discussed in Chapter 4.

The kind of interactional resonance the movement is oriented toward creating is in direct opposition to that which characterizes hospital birth. As one midwife describes:

The holiness of birth gets lost in a hospital delivery. I forget about that until I'm over there. Just when the woman's ready to push and birth is immanent, in the hospital, suddenly the light's really bright — the big overhead light that focuses on her bottom. The clanky tray gets unwrapped. People come in. It gets really busy. And it gets very noisy. And there's the whole thing of exhorting her to push, non-physiologic pushing.
As discussed in Chapter 4, the structure of the hospital creates a very different social world that the one created by home birth midwifery. As another midwife adds, "They ignore the spiritual thing. They don't encourage the father to be involved." The midwifery movement's interest in facilitating the family bond manifests as critique of the way fathers are displaced in hospital birth. As another midwife describes, "Fathers are oftentimes — right outside, you know, totally disconnected from the process. And they're to the side, they're sitting in a chair in the corner of the room...but they're not together — not the three of them together." As discussed in Chapter 4, midwifery practice seeks to integrate the father. Many midwives even have him catch the baby — a very different kind of emotional energy exchange.

Likewise, the movement is critical of the effect hospital resonances have on the birthing woman and her capacities as a mother. As one midwife describes:

She goes to the hospital...she's strapped to the monitor the whole time. Once again, it's sending her that message, "Your baby's in extreme danger. We have to monitor it every second." The baby's born, and I have to wonder if that sense of, "the baby could die at any minute," ever really goes away.

The fear that midwives see as leading to painful childbirth is also seen as undermining one's confidence as a parent. Because the hospital is so highly geared towards pain and fear, midwives assert that an entirely different interactional resonance is created. As another midwife explains:

When you go to the hospital to have a baby, all you're really focusing on is your contractions. People around you are focusing on your contractions and on a machine to
register your contractions, and on the IV with pitocin,
which makes the contractions harder, and the drugs they
give you to make the contractions more bearable. That's
the entire focus of your entire existence is the contractions,
and in our words, of course, means the pain of childbirth.
Labor pain takes over your whole mentality. At home,
being in labor and having a labor pain or a cramp or
contraction now and then — it's just part of your normal
life. It puts it back in a much lower perspective. By the
time things are really intense and strong, when you're really
concentrating on, wow, relaxing, because things are really
picking up, you're almost through labor, and your baby's
going to be coming.

At the hospital the degree of attention given to the potential for pain is understood to
heighten the experience of pain. At home, pain is less severely emphasized and therefore
less severely experienced.

In contrast to hospital birth, the degree of personalization enabled by a home birth
can facilitate a more celebratory atmosphere (after all, it is a birthday). Rather than a
birth plan specifying what procedures a woman does not want (epidural, episiotomy,
etc.), under home birth, midwives work with women to construct a birth plan that
enhances the sensual dimensions of childbirth. As one midwife describes a typical birth
under her care:

We frequently will use music of her preference. Some
people...I have them create what their ideal environment is
going to be to relax in. And probably about half the births I
do these days are water births, so many women will relax in
the heated tub that we have, which is heated to 98.6,
basically her temperature. It's not a hot tub or anything.
But I have them concentrate, when they're pulling their
birth plan together, on things that make them feel good.
Setting an atmospheric tone that is pleasing to the birthing woman and that makes her feel good is one way midwives facilitate a distinctive kind of interactional resonance. That midwife continues:

I encourage them to have food available that is comfort food to them, as well as easily digestible — they often go hand in hand. Lots of liquids. We use aromatherapy. We'll often use scented candles or different kinds of massage oils with aromatherapy. Basically she gets to be Queen for the Day...we'll use a lot of massage. I do use a big labor ball. I have a birth stool. We use chairs in different positions. I will encourage people to keep changing positions. Lots of hands-on therapy, because I find that it really keeps the energy moving.

In addition to sounds, midwives recognize the importance of tastes, smells, touch — all the senses — to the overall experience of birth. This is very different from the clunky tray in the crowded hospital delivery described above. That midwife continues:

Most of the time it's the husband or the support person that's doing the hands-on stuff. Because their touch means more than mine. I'd like to facilitate that. That's the energy that got the baby in, as Ina May says, and that's the energy that's going to get the baby back out. It is. Kissing. They can even have sex if they want to, as long as their water's not broken, that's okay with me if you need to do that in order to get a labor going a little bit.

Ultimately, the kind of interactional resonance that midwives want to create is one that “gets the baby back out,” but midwives know that comfort is what does that the best.

Midwives work to facilitate comfort, a quality understood to be intricately interwoven with trust and the potential for pleasure. As one midwife relates, “My job is focused on keeping the mother comfortable. And trying to get a sense of what that is for her. Because some women, you know, maybe they want their back rubbed every
moment, and somebody rubbing their feet. Other women just want somebody to joke
with them while this goes on.” Because comfort is a highly personal and variable thing,
midwives must get to know each woman very well. As another midwife explains:

If you get to know somebody prenatally, you can pretty much sense — you know, like if this is somebody who's real huggy and touchy and makes a lot of eye contact and has a lot of fear coming into the birth, you might expect that they're going to want a lot of eye contact, physical contact, and want you right there saying kind things. But if this is somebody who doesn't like a lot of physical contact, not a hugging person, you know, is very interested in the physiology around the birth, kind of left-brain type of person, then you're not going to be trying to do a lot of massage or make a lot of long eye contact, because you can kind of — of course, you would take your cues from the laboring person, but generally speaking, women don't change their personality when they go into labor. They're still the same person. And I think a good midwife has established enough of a relationship where she knows who she [the laboring woman] is going in. And then she's sensitive enough to who she is and what she needs during the labor.

As this comment reveals, midwifery entails unique knowledge skills including intuition,
constant observation, ongoing adjustment, and overall sensitivity to the needs of the birthing woman. Midwives know that there is not a one-size-fits-all set of needs that can be formalized in some protocol. As another midwife relates:

I've been in births where I maintained eye contact with clients almost the whole time. And held their hand and talked them through every contraction. And then I've been at births where, you know, she was into being with her partner and it kind of seemed like they wanted privacy. And then I've been at births where they didn't seem to need much at all — or, I've actually been at the birth of a 16 year old where she told me she didn't want to hear me talk anymore. [laughs]
Not only is each woman different, but the same woman will exhibit different needs at
different times during her labor. As another midwife explains:

Even within a labor, those cycles go — when they need to be touched, when they need their backs rubbed, when they need their hands held, and times when they need to stand up, and they don't even want to look at you, they want you behind them. And you have to feel through that by watching and by really paying attention to what you're doing, how that effects her. And that's mostly what we do. Stay real tuned in to how what we're doing effects her and what seems to make it work.

So midwives must “stay tuned” to what works. By virtue of that aspect of midwifery care alone, a unique interactional resonance is constructed.

Under the midwifery model, the care provider remains continuously attuned to the emotional needs of the birthing woman and her family. As one midwife states, “I give them whatever I feel that they’re needing. And quite a bit of it is nonverbal when it gets to that intensity level.” Attunement to the clients’ needs is something that occurs at the emotive level. Midwives give women what they feel those women need. As another midwife explains:

You're aware of the energy, and you have a perspective on the energy and the flow of energy. And, again, what that would be is the energy that's working with the mom, the energy that's working with the baby, and the dad, and whomever and whatever is in your space. So it's helping to keep the energy flowing, keep the energy moving.

To say that one is working with “the flow of energy” is to specifically articulate that one is facilitating a certain kind of interactional resonance — one that feels good to all interactants, particularly the mom, the baby, and the dad. One that is aware of and attuned to the feeling of love.
As discussed in Chapter 4, the midwifery movement seeks to integrate the father into the birth experience. As one midwife describes:

I see the man as the lover of the woman at the birth...there are so many ways to make love, and that's up to the couple how they do it. Some people love kissy-kissy, and that's good. [laughs] Some other people are kind of rubby, some other people talk and whisper to each other. Some of the times he's rubbing her. Some of the times, actually, he wants to cook and do something else sometimes, like get into the water with them. Sometimes they get to catch the baby, sometimes they just want to be at her head, sometimes at the butt, whatever. Every couple is kind of a little bit different. In how they are as lovers and companions to each other.

As this comment illustrates, midwives encourage the father's involvement out of respect for the love he has to give. Midwives also express the benefits to fathers and to families when the man is witness to the work his partner does to bring forth new life. As one midwife elaborates:

With that father's integration into the care and support of that mother during the birth, a couple of things happen. First of all, his respect for her and for the work that she's doing to give birth to this baby, increases a lot. [laughs] And then, second of all, her ability to depend on him, makes him a real integral part of the process. And so, in that, comes like a bonding. And then when that baby is born, they're just both so excited, and so relieved, and so tired, and so happy, and all of those things, and they share that together. Then they become parents, and they do that together. I think that it helps, in most circumstances, to provide a stronger bond between that father and that child.

This comment suggests that the movement's philosophical emphasis on family bonding (Chapter 4) is ultimately intended to create a specific kind of interactional resonance among family members.
Finally, the midwifery approach also seeks to create a specific kind of interactional resonance between the care giver and the client, one that is very different from the dominant approach. As one midwife explains, "midwives...love women, and they love babies, and they love life. And if they don't, they shouldn't be a midwife." In place of rigid protocol, drugs, and surgery, as described in Chapter 4, the midwifery model seeks alternative techniques for facilitating childbirth. Chief among these, as I have shown, is the interpersonal relationship. Helping women to relax, maintaining a stance of reverence, and providing greater freedom for individual experience, midwives construct and disseminate new knowledge about the emotive significance of environmental factors. Central to the alternative pattern the midwifery movement produces is love. As one midwife states, "love is the drug, you know? You have to give it." The personal relationships midwives construct with the clients they serve, combined with their reverent and trusting approach to birth creates a distinctive "labor of love." As another midwife describes:

Every time that I attend a birth, I see a woman go from, like maiden to a mother. And that transition in her life is hard—depending on the birth, of course, and depending on the issues that she faces. And so, to see a woman use her body in ways, to open up, that she never thought would be available to her. To see women focus in to the eyes of her partner and open up in ways that she thought would never be available to her. To just stand by and watch a family support a young mother and give her blessings, and rub her back, and just be totally, totally there for her and supportive of her, so that she can find the strength to keep on going when she's tired, when she's exhausted. To see a woman tune into and focus on a way of breathing that allows her to relax so completely, when two hours before she was struggling and kind of fighting. Just dozens of things like that, that, I mean, we're just so privileged to be able to see
those miracles in the transformation of women, and to see them find their strength. It's just an incredible privilege to be a part of that.

As described in Chapter 4, midwives view birth as a foundational experience that has lifelong impact. That idea undergirds midwives' work to facilitate a labor of love. As another midwife explains:

> By giving the baby a good start — a start where the baby feels safe, and feels loved, and feels supported and nurtured. Versus being torn from their mother's arms. Versus having their needs unmet. Versus crying and being unheard, and unanswered, and their needs not met and possibly — you know, having this very early imprinting of frustration, and anger, and anxiety, etcetera. Versus having that early imprinting — having an imprinting that's a positive imprinting, so that maybe by feeling safe, and nurtured, and warm, and secure from the very beginning, hopefully that carries over into our psyche.

In other words, midwives intentionally work to facilitate a loving resonance during childbirth in the hope that a loving resonance can be fostered in the world. This sense derives from midwives' own experiential knowledge. As another midwife describes,

"Some part of me grew, as a woman and as a mother, in terms of how loving I became...and I think you can get that much easier at a home birth...there's a much more, a flow of love that goes back and forth." In particular, the moments immediately following birth — those moments where under the dominant cultural approach removes the infant for "processing" and "testing" — are considered by midwives to be of utmost emotive importance. As another midwife expresses, "the baby is a sentient being and is a totally innocent sentient being and deserves all of our love and all of our gentleness, because as each experience builds on the other, the best we can do to create a gentle experience for
the baby, is very important." Not only the baby as an individual, but the family as a unit is considered to be emotionally vulnerable at that time. As another midwife relates, "I think when the baby first comes, and all the senses are opening up and they're finding out the new world, I think that's the time that the baby falls in love with the parents. And the parents fall in love with the baby."

5.4 Summary

In this chapter, I have identified certain knowledge interests unaccounted for by the two-pole model of cognitive praxis (Figure 4). I have shown that through enactment of alternative birth philosophy in submerged networks of everyday life, (i.e., the creation of alternative cultural patterns) the midwifery movement translates specific emotion interests into new emotion knowledge. I thereby find support for the new analytical model presented in Figure 5.

Because emotions are products of human activity and interaction, they have an emergent quality that arises within specific acts and group processes (McCarthy 1989). Just as doctors define emotional experience in hospital birth (Kitzinger 1992), midwives define emotional experience in home birth. Through specific emotive claims, sanctions, accounts, and interactional resonances, the midwifery movement constructs and disseminates new emotion knowledge. Through analysis of the midwifery movement's construction and dissemination of emotive claims, sanctions, accounts, and interactional resonances I show that in addition to the production of innovation in thought and the organization of thought, the movement is engaged in the production of innovation in
feeling and the organization of feeling. Specifically, the movement creates new knowledge pertaining to the feelings of the caregiver, the feelings of the birthing woman, and the feelings among family members. In particular, the movements creates new knowledge pertaining to trust, fear, pain, pleasure, and love.
CHAPTER 6

CONCLUSION:
SOCIAL MOVEMENTS AS EMOTIVE PRAXIS

One of the great advantages of modeling is that it allows representation of complex relations among many variables in a reasonably parsimonious fashion.


6.1 Review

I began this study with a personally driven interest in the fundamentally woman-centered character of midwifery — its emergence from women, its focus on women, and its attention to an activity performed solely by women. Starting from the perspective of gender as an institution, I was puzzled by what seemed to be a distinctively “feminine” approach to childbirth. Moving beyond the framework of gender, I wondered what lay at the core of the midwifery approach. What is the social significance of midwifery?

Social movement scholarship directed my attention to the solidarity, conflict, and system breaking (Melucci 1989, 1995, 1996, 1997) knowledge production (Eyerman and Jamison 1991) that form the contours of a midwifery movement. In the first half of this
study, I showed how the movement is engaged in visible confrontation with established authorities over the issue of professional identity. I showed how the movement practices in the present the changes it seeks for the future through the production and enactment of alternative birth philosophy in submerged networks of everyday life. I showed how the two poles of the midwifery movement's cognitive praxis (latent and visible) constitute efforts at cultural creation and legitimization. I showed that an accurate representation of the movement's distinctive goals requires the inclusion of ideas from the sociology of emotions.

Scholarship on the sociology of emotions directed my attention to the social shaping of emotions. It sensitized me to the way acceptance of official definitions of the situation includes acceptance of a particular set of feeling rules. It also sensitized me to the way emotions are differently constituted in different social worlds and the way emotions are socially defined and situated through negotiation of subtle energy exchange. In the second half of this study, I showed how the midwifery movement is engaged in the collective shaping of emotions. I showed how the movement's alternative philosophy is characterized by distinctive emotion interests. I showed that through a process of emotive praxis parallel to Eyerman and Jamison's (1991) conceptual framework of cognitive praxis, the midwifery movement is engaged in the creation and legitimization of new emotion knowledge.

Taken together, the two halves of this study generate a new analytical model to explain an important relationship between social movements and emotions. In the

53 See also Taylor 1999. In addition to the approach taken by this study, the movement can be understood
remainder of this chapter, I provide a detailed discussion of the theoretical and empirical foundations of the new analytical model, the new model itself, and the sociological significance of the model.

6.2 Theoretical and Empirical Foundations

Melucci's (1989, 1995, 1996, 1997) two-pole model of social movement as a reinforcing system of visible and latent collective action that produces alternative cultural patterns (Figure 1), offers a theoretical base from which to explain how social movements create and legitimize new emotion knowledge. In the first half of this analysis, I showed that the midwifery movement offers support for Melucci's two-poled model. I showed that the movement is engaged in a (visible) struggle against established political authorities. I showed that the movement is also engaged in the (latent) enactment of alternative birth philosophy in submerged networks of everyday life. Melucci's model contains an explanatory gap, however.

What is the process by which visible and latent social movement activities reinforce each other to produce new cultural patterns? For an answer to that question, I draw from Eyerman and Jamison's (1991) cognitive approach to social movements. Their explanation of social movements as cognitive praxis (Figure 2) suggests a knowledge-producing function of social movements that offers a theoretical base from which to explain the process by which visible and latent social movement activities reinforce each other to produce alternative cultural knowledge. In the first half of this
analysis, I showed that the midwifery movement offers support for the addition of Eyerman and Jamison's (1991) conceptual framework to Melucci's (1989, 1997) two-pole model (Figure 3). I showed that the movement's production of alternative birth knowledge is reinforced by new social identities constructed through visible movement activities and new ideas and ideals enacted through latent movement activities. I also showed that the construction of new identities can be understood as an attempt to legitimate the enactment of new ideas and ideals.

The latter finding suggests that the social forces Melucci designates "latency" and "visibility" can be understood as "creating" and "legitimizing" (Figure 4). That conceptual transformation forwards Melucci's (1996) representation of social movements as action systems. To signify a movement's "latent activities" and "visible activities" with verbs rather than nouns gives greater motion to the analytical model. It also clarifies the process by which these two dimensions of movement activity reinforce each other. Once participants create new cultural patterns, those same participants or other participants can engage in collective action to legitimize them. Through visible legitimizing acts, others come to know that something different can exist and they can, in turn, become submerged participants enacting new cultural patterns in their everyday lives. And so on.

In the case of the midwifery movement, participants enact alternative childbirth ideas and ideals in the realm of everyday life, thus creating a new cultural pattern — midwife attended home birth. Movement participants seek to legitimize that alternative of the dominant medical system (Crooks 2001) through its resistance to biomedical birth (Davies 2001).
cultural pattern, which can be thought of as new knowledge, through the production of new social identities — Certified Professional Midwife, etc. These collective acts of creating and legitimizing reinforce each other to produce an alternative to culturally dominant birth principles and practices. At the level of ideas, ideals, and identities, this process is captured by the concept of cognitive praxis. As this analysis of the midwifery movement shows, however, the cognitive approach to social movements and knowledge is incomplete.

6.3 The New Model

Human sentience is comprised on both thinking and feeling (Hochschild 1975), and the very meaning of “knowledge” lies in the way it bridges those two dimensions of consciousness. One may think a thing, but until it is also felt, it is not “known.” For the concept of knowledge to remain useful, it must not be reduced to mere thought or cognitions. The place of emotions in knowledge must be recognized. As evidenced by the language of the preceding sentence, emotion and cognition are intricately interwoven. Each functions within the context of the other, and each is intrinsically social (Franks and McCarthy 1989). In other words, emotion is not experienced or understood in the absence of cognition, and cognition is not experienced or understood in the absence of emotion. As we have not yet reached a historical moment where we can take the integrated and inseparable nature of “emoticogni” as a given, however, any representation of knowledge that emphasizes the cognitive dimension to the exclusion of the emotive dimension is theoretically problematic.
To provide a more complete approach to social movements and knowledge, I therefore draw relevant ideas from the sociology of emotions. In particular, McCarthy's (1989) concept of "emotion knowledge," while linguistically awkward, serves as a heuristic device that supplements the heretofore cognitively biased analytical model explaining how social movement activities of (latent) creating and (visible) legitimizing reinforce each other to produce new knowledge (Figure 4).

In Figure 5, I have substituted McCarthy's (1989) concept of emotion knowledge for Eyerman and Jamison's (1991) cognitively biased use of the term "knowledge" in order to highlight the dimension of human consciousness signified by the term "emotion." I have also substituted a new concept of emotive praxis for Eyerman and Jamison's (1991) concept of cognitive praxis. The conceptual framework of emotive praxis is not meant to replace the conceptual framework of cognitive praxis, but rather to signify and draw attention to a missing dimension of collective knowledge-production. The language is admittedly awkward, but Eyerman and Jamison's (1991) definition of knowledge as comprised solely of cognition erases the equally present dimension of emotion, and thereby necessitates specific signification of emotion knowledge. At the risk of reifying the binary opposition of cognition/emotion, this new model offers a supplemental perspective from which to align the feeling dimension of human consciousness with the thinking dimension.

Previous research shows that just as the emergence of a movement depends upon the articulation of a cognitive theme (Eyerman and Jamison 1991), so does the emergence of a social movement depend on the construction and dissemination of emotional
resonance among potential participants (Britt and Heise 2000; Jasper and Poulsen 1995; Taylor 1995). While Eyerman and Jamison (1991) assert that cognitive praxis enables us to see knowledge creation as a collective process, I argue that such vision is but partial without a complementary framework of emotive praxis (Figure 5). Just as cognitive praxis focuses attention on a movement's production of new thoughts and new organizations of thought (Eyerman and Jamison 1991), emotive praxis focuses attention on a movement's production of new emotions and new organizations of emotion. Just as cognitive praxis refers to the transformation of largely taken for granted knowledge interests into new knowledge, emotive praxis refers to the transformation of largely taken for granted emotion interests into new emotion knowledge. Just as cognitive praxis reveals that social movements are important sources of new cognitive developments, emotive praxis reveals that social movements are important sources of new emotive developments.

In the second half of this analysis I showed that the midwifery movement offers support for a new model of social movements as emotive praxis (Figure 5). I showed that the movement is engaged in the construction and dissemination of alternative feeling rules (Hochschild 1979) and alternative interactional resonances (Perinbanayagam 1989). I also showed that these knowledge-producing activities transcend the cognitive approach to social movements and knowledge.

Figure 5 presents the new analytical model of emotive praxis generated by this research. It's basic shape is that of Melucci's (1989, 1997) two-pole model of social movement visibility and latency (Figure 1). It's basic process is a mirror image of
Eyerman and Jamison's (1991) cognitive praxis (Figure 2). It reflects the conventionally neglected realm of emotion, and thereby provides a supplement to the two-pole model of cognitive praxis created by combining Eyerman and Jamison's conceptual framework with Melucci's model of social movements as action systems (Figure 3). Whereas Figures 1 and 3 divide social movement into dimensions of latency and visibility, the new model uses the verbs "creating" and "legitimizing" (a substitution made in Figure 4). Figure 5 thereby provides a visual answer to the question of how social movements create and legitimize new emotion knowledge.

6.4 Conclusion

Like the conceptual framework of cognitive praxis, emotive praxis directs attention to social movements as knowledge producers. Rather than allowing theoretical reduction of knowledge as cognition, however, the new model presented in Figure 5 offers a corrective supplement to existing theory. To view social movements as emotive praxis is to focus on the construction and dissemination of emotion knowledge.

McCarthy (1989) defines emotion knowledge as knowledge about emotions embedded in people's interpretations of reality and thereby fostering particular kinds of experiences. Forms of knowledge (including emotion knowledge) provide the framework through which people interpret reality and thereby experience reality. One aspect of that framework is specified by Hochschild's (1979) concept of feeling rules — socio-cultural prescriptions that shape individual emotional experience. Another dimension of that framework is specified by Perinbanayagam's (1989) concept of
interactional resonances — subtle, yet inescapable and articulatory, shared moods. As this analysis of the midwifery movement shows, changing the framework through which people interpret and thereby experience emotion can be the goal of social movement activity.

Western civilization has historically denigrated emotion as uncertain and irrational (Barbalet 1998), and formal scholarly attention has therefore been lacking. Nevertheless, from its inception, sociological theory has addressed emotion-laden aspects of social life. Although the current vocabulary of emotions was unavailable at the time, Durkheim's interest in collective effervescence, Marx's interest in alienation, and Weber's interest in charisma were all rooted in concern for human feeling. Likewise, contemporary scholarship on the social shaping of emotions (Collins 1981, 1986; Franks and McCarthy 1989; Hochschild 1975, 1979, 1983, 1990, 1998; McCarthy 1989; Perinbanayagam 1989; Thoits 1990) suggests the centrality of emotion to sociological understanding. Additionally, social movement scholars' renewed interest in emotions (Britt and Heise 2000; Jasper and Poulsen 1995; Taylor 1995, 2000; Taylor and Rupp 1999) suggests the centrality of emotion to goal-oriented collective action. Understanding change in emotion knowledge as the goal of social movement activity extends our understanding of social movements as well as our understanding of emotions. Just as "social movements articulate new historical projects by reflecting on their own cognitive identity" (Eyerman and Jamison 1991:165), the new model of emotive praxis generated by this study suggests that social movements articulate new historical projects by reflecting on their own emotive identity. The term "emotive identity" signifies identity
characterized by emotions, pertaining to emotions, and/or directed toward emotions. To
the extent that reflecting on cognitive identity leads to historical projects of thought, the
new model generated by this inductive study suggests that reflecting on emotive identity
leads to historical projects of emotion.

Scholars of social movements have recently called for expansion of the concepts
and distinctions used to analyze social movements (Goodwin and Jasper 1999). This
inductive study suggests the usefulness of several concepts derived from the sociology of
emotions. In particular, emotion interests, emotion knowledge, emotive praxis, and the
just noted emotive identity, can all be used to broaden contemporary social movements
research. Just as cultural approaches to social movements (Castells 1997; Eyerman and
perspectives from which to view more than structural and conventionally political
aspects, emotive approaches (such as the one I propose herein) provide theoretical
perspectives from which to view more than the cognitive dimensions of human sentience.

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54 I am aware the Goodwin and Jasper (1999) also called for the abandonment of invariant models. Rather
than an invariant model, I consider the analytical model of emotive praxis generated by this inductive study
to be a sensitizing framework that addresses an issue of shared concern — the conventional exclusion of
emotions (Jasper 1998).
APPENDIX A

FIGURES
Figure 1. Melucci's (1989, 1997) two-pole model of social movement as visible and latent collective action reinforcing to produce an alternative cultural pattern.
Figure 2. Eyerman and Jamison's (1991) conceptual framework of social movement as cognitive praxis transforming knowledge interests into new knowledge.
Figure 3. Overlay of Eyerman and Jamison's (1991) conceptual framework of social movement as cognitive praxis onto Melucci's (1989, 1997) two-pole model of social movement as visible and latent collective action reinforcing to produce an alternative cultural pattern — in this case, new knowledge.
Figure 4. Substitution of the verbs "creating" and "legitimizing" for Melucci's (1989, 1997) concepts of collective action at the levels of "latency" and "visibility."
Figure 5. New two-pole model of social movements as emotive praxis generated by substitution of McCarthy's (1989) concept of "emotion knowledge" for Eyerman and Jamison's (1991) cognitively biased use of the term "knowledge" and substitution of "emotive praxis" for Eyerman and Jamison's (1991) concept of "cognitive praxis."
ABBREVIATIONS


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