The Meaning of Home: Spirituality and Domestic Space in Australian Home Birth Experiences

Emily Burns
The Meaning of Home: Spirituality and Domestic Space in Australian Home Birth Experiences

Emily Burns

Bachelor of Arts (Hons) 2008
University of Western Sydney

A thesis submitted in fulfilment of the requirements of the degree of Doctor of Philosophy, at Western Sydney University, 2016.

Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

...................................................
Abstract

The home and the hospital have become polarised sites in the discourse on childbirth. The hospital has been heavily critiqued as a site of childbirth since the 1960s, and scholars have interrogated the hospital within a broader framework of medicalisation. Oakley (1984), Kitzinger (2005), Reiger (2000) and Davis-Floyd (2003) have been particularly critical of the increasing medicalisation of childbirth, and argue for the importance of childbirth knowledge beyond the technology-fuelled medical institution. Research on homebirth has in many ways echoed the medicalisation thesis, with a focus on the ways home birthing women attempt to gain autonomy over their bodies by birthing outside of the medical system. What is missing in this critique, however, is an analysis of the space home-birthing women have chosen in their pursuit of autonomy - the home.

This thesis draws on interviews with 58 Australian home birthing women, doulas and independent midwives from New South Wales, Queensland and Victoria. Via a series of publications, I argue that during the bounded time-span of pregnancy and childbirth, these women renegotiate the meanings and relationships with their home environments, infusing them with the spiritual dimensions of pregnancy and childbirth. This is facilitated by the social nature of natural birth (Mansfield, 2008) and the perception of women’s ‘innate knowledge’ of how to birth naturally. As a result of the biological and gendered experiences of spirituality (King, 1995; Rose, 2001; Sointu & Woodhead, 2008), home birthing women create rituals like the ‘Blessingway’ (an alternative baby-shower), and ceremonies that memorialise the placenta as well as the birth itself, generating an albeit temporary, but nonetheless sacred home-space. The sacred home-space is reinforced by what I term the ‘nostalgic imagination’ of natural childbirth. Drawing on an imaginary mythology of birth and the connections between women throughout history, home birthing women are able to draw on an authoritative spiritual alternative to medical discourse.
Acknowledgements

My life as a student/mother/partner/sister/daughter/friend has been supported, pushed, and sometimes carried by so many wonderful people. I want to thank them here, in no particular order of value or importance.

Firstly, this PhD is for my children. They have only ever known their mother as a student, and without understanding why, have shared me with this thesis since they were born. I want to thank them for inspiring me in the first place, for without being pregnant, and planning my own hospital and home births, I would never have known the secret language of pain and love as one. This has fuelled me and fuelled this research, and for that I have Roman, Xavier and Addison to thank, so thank you, my darlings.

Because of my role as a mother, the role of childcare cannot be overlooked here. My selfless mother has been, in her own way, as committed to this project as have I for the last seven years. Thank you so very much, my children have one of the strongest bonds to a grandparent possible, which is a strength they will carry for the rest of their lives. I also owe considerable thanks to the Hazelwood Childcare Centre, not only for providing such a high standard of childcare, but for doing so with an energy and compassion that in turn have energised and nurtured my children. Having childcare has made this research possible, and having great childcare has made it possible without guilt.

My mentors, Cristina Rocha and Alphia Possamai-Inesedy, have been so much more than supervisors throughout this process. I am so fortunate to have had two such strong women to look up to. Thank you for your guidance, support, friendship, and most of all for pushing me, and demanding I do better with every draft. Thank you for seeing my potential when I could not, and for not letting me give up, even when I wanted to. Thank you for not accepting mediocrity, and via your own work, for showing me what great writing looks like.

My sister, thank you for pretending to be listening to so many of my thesis rants over the last seven years, the blank look on your face has made me realise time and time
again to snap out of it and re-enter the ‘real world’, my best friend, thank you for keeping me grounded, I love you so much. My Dad, Lois, Chris, and all of my wonderful in-laws, you have all listened, cared, supported, and I am so grateful to you all. Dad, I hope this makes you proud.

My friends, in particular Dane, Maree, Penny, Alanna, Shanna, Jacqueline, Emma, Dallas and Garth, thank you for the advice, support, proofreading, laughs, tissues, coffees, chocolate and wine, it has all been invaluable.

To Adam, I owe you so very much, including the push you gave me all those years ago to start an undergraduate degree in the first place. You always knew I needed more, and you have supported me as I have sought to find it. I have, and with you by my side. Thank you for making me lock my office door, and for giving me the space I have needed to get this work finished.

Last but certainly not least, I offer a heartfelt thanks to the women who invited me into their homes and shared such intimate stories with me. The time with you was enriching emotionally, spirituality and intellectually, and I hope this thesis does your stories justice.
# Table of Contents

Abstract iii
Acknowledgements iv
Publications x
1. Introduction 1
2. Methodology 5
   2.1 Ontology 5
   2.2 Narrative Interviews 6
   2.3 Power and Qualitative Research 9
   2.4 Rapport 10
   2.5 (Not) Gaining Access 13
   2.6 Research Design 15
   2.7 Limitations 16
3. Thematic Overview 18
   3.1 The Rise of the Medicalisation of Childbirth 18
   3.2 The impact of individualisation on medicalisation and religion 24
   3.3 Gendered Spirituality and Home Birth 29
   3.4 Summary of Findings 31
4. Conclusion 39
5. References 42
Appendix 1: Demographic Tables 55
Appendix 2: Project Information for Participants 57
Appendix 3: Participant Consent Form 60
Appendix 4: Participant Photographic Release 61
Appendix 5: Participant Counselling Service Information Sheet 62
Appendix 6: Research Ethics Approval 63
Appendix 7: More than clinical waste? Placenta rituals among
Australian home-birthing women 64

Appendix 8: The Blessingway ceremony: Ritual, nostalgic
imagination and feminist spirituality 73

Appendix 9: More than four walls: The meaning of home in home
birth experiences 88

Appendix 10: ‘Thanks, but no thanks’: Ethnographic fieldwork and
the experience of rejection from a new religious movement 99
List of Figures

Cover photo: Pregnant host and friend at a Blessingway (photo reproduced courtesy of participant)

Figure 1: Mandarin placenta tree 31
Figure 2: Potted placenta tree 31
Figure 3: Potted placenta tree 31
Figure 4: Native placenta tree 31
Figure 5: Native placenta tree 32
Figure 6: Placenta tree 32
Figure 7: Placenta tree 32
Figure 8: Apple placenta tree 32
Figure 9: Blessingway bead collection 34
Figure 10: Blessingway bead collection 35
Figure 11: Blessingway bead collection 35
Figure 12: Blessingway bead necklace 36
Figure 13: Hand-felted Blessingway bead 36
Figure 14: Mother/Daughter bracelets from a matrilineal wrist weave ritual 36
Figure 15: Three Blessingway bracelets 40
List of Tables

Table 1. Participants’ country of birth 54
Table 2. Participants’ age range 54
Table 3. Participants’ estimated yearly household income 55
Table 4. Participants’ self-identified religious affiliation 55
Table 5. Participants’ highest level of completed education 55
Publications


1. Introduction

The sites of childbirth are heavily politicised spaces. The home and the hospital, as sites for birth, have been polarised as two ends of a very narrow continuum of risk and safety respectively. As the most common site of childbirth in the West, the hospital has been heavily critiqued in recent decades, yet the home as a *site* of birth has not been afforded the same critical attention. Framed as the hospital’s Other, the home is constructed in both popular and medical discourse as a place of risk, or alternatively in the social research literature as a place of autonomy and control. Propelling these conceptualisations has been the critique of what has become known as medicalisation, now a well-known concept in sociology, anthropology, women’s studies, midwifery, nursing, and obstetrics. Medicalisation (Conrad, 1992a, 1992b; Foucault, 2003 [1989]; Illich, 1977) is broadly defined as the framing of non-pathological experiences, such as childbirth, but also menopause, obesity, even male-pattern hair loss, into conditions with medical definitions that require medical treatment. This critique has dominated the analytical framework of most social research on childbirth since the 1970s (Davis-Floyd, 1987; Oakley, 1980, 1984; Ruzbek, 1978), including home birth (Kitzinger, 1991; Morison, Hauck, Percival, & McMurray, 1998). What is missing in these critiques however, and where this thesis directly contributes, is an analysis of home space as an agent of childbirth practice. I argue that home space can facilitate an alternative, spiritual engagement with pregnancy and childbirth, one that relies on communities of women in particular, a nostalgic imagination and rituals that encourage the connections between the two. My research emphasises the spatiality of home birth by focusing on the material, symbolic, and ritual engagement with childbirth facilitated by ‘being home’.

Commonly, the home is conceptualised as domestic or ‘ordinary’ living space, and as a site for childbirth, the ‘risky’ option. The theorising of space and place has had a resurgence in recent years, propelled by cultural geography in particular, but can also be seen in midwifery and the health sciences, as well as religious studies. I mention these disciplines in particular because of the spiritual implications space has on health, including childbirth. This ‘spatial turn’ has not been widely embraced in social research on childbirth, which still largely echoes the medicalisation critique, with its emphasis on
the pursuit of autonomy and control (Dahlen, Jackson, & Stevens, 2011; Edwards, 2005; Moore, 2011), though there are some notable exceptions to this, which I will discuss below.

Geographers Able and Kearns (1991) discuss the importance of place in home birth experiences in New Zealand, arguing that the benefits are largely anticipatory for women choosing to birth at home. They contend that the relationship we have with potential birth places prior to birth may impact women’s choices and experiences. Also in cultural geography, Fannin (2003) has critiqued the domestication of birth suite décor in hospitals as superficial imitations of domestic space. Perhaps most notable of the exceptions is within midwifery, where work on birth and spirituality has become somewhat spatially theorised via concepts like ‘birth space’. Davis and Walker (2010) define birth space as that which is woman centred, where she feels “safe in the knowing that her choices will be respected. In this space, there is time for the process of childbirth to unfold in its unique way” (Davis & Walker, 2010, p. 606). The work of Seibold et al (2010) exemplifies a spatial rationale in midwifery research, with a discussion on the ‘ownership’, ‘lending’ and ‘holding’ of space for birth in Australian hospitals. For the 18 midwives interviewed in their study, the birth space was ultimately ’owned’ by the hospital, though via continuity of care, and in particular via case-load midwifery, this space could be ‘lent’ to a woman, who in turn would feel in control of her birth experience. If this was not possible, the midwife might ‘hold’ that space for her by way of keeping the room calm and relaxed when she herself could not be. These authors uniquely pair the theorising of space with childbirth, and the potential a spatial understanding of birth practice might offer.

This follows the growing interest of space in health care research on the importance of religion and spirituality in health care settings (Eckersley, 2007; Levin, 1994; Orchard, 2001; Robinson, 2003), particularly within geography (see for instance Cartier, 2003; Gesler & Kearns, 2002; Kearns, 1993; Kearns & Gesler, 1998) and nursing (Carolan, Andrews, & Hodnette, 2006). As the role and meaning of place and space has developed and expanded, contemporary social research on religion has engaged with space as a meaningful and dynamic area of study in religion (see, for example, Hume, 1998; McGuire, 2008; Williams, 2010).
This thesis responds to both of the above limitations of the literature, focusing not only on the home as an embodied space throughout pregnancy and birth, but also as a site of a specifically maternal spirituality. Spirituality is defined here as individualised practices of personal belief, informed by the work of Hanegraaff (1998, 1999), and discussed in more detail in section 3.2. For many participants in this study, birthing at home represented a search for an engagement with pregnancy, birth, and new motherhood that recognised a deeper, connective layer of experience they felt was not possible in the hospital system. By celebrating this experience via rituals such as the blessingway (distinct from a baby shower by a focus on rituals that draw on female spirituality and connection rather than gifts and games, discussed in more depth in section 3.3) and those that memorialise the placenta, a spiritual discourse of childbearing is enacted in, and facilitated by, home space. This has powerful implications for childbearing women and their communities, as they develop alternative discourses and practices to inform, engage and perform alongside and instead of those of the hospital and medicalisation.

It is important to note here that while this research does not focus on the rituals performed in hospital settings, the hospital environment does not preclude women from engaging in spiritual discourse. The rituals presented in this thesis may be particularly useful for those birthing in complex birth situations, including hospitals. While this is beyond the scope of this thesis, it would indeed be a rich area for further research.

There is a lack of critical engagement within the social sciences with discourses of childbearing that are not centred on the medicalisation critique, specifically the relationship/s between home space, spirituality, and childbirth. My central argument in this thesis is that there is a specifically gendered spirituality, intimately related to fertility, reproduction and domesticity present in home birth practices. This thesis contributes to the literature on spirituality and childbirth, and the scholarly engagement with alternative childbirth practices and spaces.

Research Aims
In this thesis, I aim to analyse an alternative childbirth discourse rooted in spirituality, ritual, and sacralisation of space. As such, the thesis will address three primary research questions:

1. How can we theorise home birth and spirituality against the backdrop of the heavily institutionalised maternity system in Australia?

2. How is the home-site engaged with when chosen as a space for childbirth?

3. In what ways is spirituality implicated during home birth ritual performances?

This thesis is presented as a series of publications, and as such the above questions are addressed in the four published articles, as well as in this overarching statement. These articles can be found in sequential order in Appendices 1-4. This accompanying overarching statement will demonstrate the contemporary relevance of these publications and their contribution to knowledge. It will also indicate the way the research has developed, and will complement the articles by providing the important theoretical rationale for the research as a whole. At the forefront of this is a discussion of the social trajectory of the medicalisation of childbirth as directly related to Beck’s (1994; Beck, Giddens, & Lash, 1994) and Giddens’ (Giddens, 1990, 1991, 1994) notion of reflexive modernity, and individualism (Beck & Beck-Gernsheim, 2002) in particular. This trajectory will draw on the work of Wallis (1983, 2006) in particular, and the gendered division of health-care delivery in Australia. This will directly feed into the final section on gendered spirituality and space in home birth experiences, which will also discuss the central findings of the published material.

In the following section I will outline the methodology for this research, which will include a discussion of my most recent publication on the complexities of gaining access to a research site, and the importance of ‘non-data’ during my preliminary fieldwork with a New Religious Movement (NRM).
2. Methodology

Still contentious in the social sciences are the means by which quality is judged, as much of the criteria for doing so remain rooted in the quantitative paradigms. Sociologists have argued for concepts such as goodness (Peshkin, 1993), validity (Koro-Ljungberg, 2008; Kvale, 1995), triangulation (Blaikie, 1991; Duffy, 1987), and reliability (Kirk & Miller, 1986; LeCompte & Goetz, 1982) as markers of quality. The employment of these markers, however, are as contested (LeCompte & Goetz, 1982; Smith, 1993) as they are espoused (Lincoln & Guba, 1979; Tobin & Begley, 2004). Rigour has emerged as a response to the need to develop strategies for quality assurance in qualitative research (Alasuutari, Bickman, & Brannen, 2008; Clough & Nutbrown, 2007; Cresswell & Miller, 2000; Lincoln & Guba, 1979).

The concept of rigour has developed as a way for qualitative researchers to engage with the discourse on legitimization of quality claims, without having to defend these claims against a positivist paradigm. While the measures for judging qualitative research are varied, the two criteria I will focus on in this section are based on transparency of logic and method. I will outline the ontology for this research, including a feminist epistemology, and the role of discourse. I will also outline and justify my methods of narrative-style interviews with a discussion of the importance and complexity of rapport. By being as reflexive as possible (Alvesson & Sköldberg, 2009; Mauthner & Doucet, 2003; Rose, 1997), I intend for this research as a process as well as an analytical product in itself to be transparent.

With specific reference to doctoral theses in the social sciences, completing this research as a series of publications is a novel way of ensuring methodological rigour by testing the research claims via four separate peer-review processes before these claims become part of the doctoral thesis.

2.1 Ontology
For Heidegger, ontology concerns the investigation and questioning of the nature of being (Heidegger, 1999). Social scientists have extended this pragmatically to refer to the insights social research gives to the nature of social reality (Blaikie, 1993; Layder, 1998). The ontology of a given methodology is important not only for highlighting the assumptions being made when using various research methods, but also as a way of maintaining a rigorous research practice.

As my research questions indicate, I clearly privilege the experience of childbirth at home as a distinct knowledge form. While our knowledge of childbirth is indeed discursive, the experience itself is material. My stance on this is reflective of a critical realist position that reality exists somewhere between language and materiality. Parker (1998) asserts that we know the experience of an event by the merging of our previous knowledge of that event as a phenomenological possibility, and the direct experience of the event itself. This brings to the fore awareness of objects and concepts as well as direct, conscious experience of them as the means by which we constitute knowledge of things.

Recognising the partiality of all knowledge, including that which I present here, I agree with Picking (2008, p. 27) who writes,

> Experience constitutes the meeting-place of individual perception and cultural meaning, self and symbolic forms, life-story and social conditions of existence. Experience occupies the contested territory between ways of being and ways of knowing.

At the same time I recognize that my world may only be known to me via the mediation of the real and the known (see, for example, Burns, 2015c for the personal context that preceded this particular project). My knowledge of others’ worlds or experiences, however, are only available to me via language, making narrative interviews the ideal method of data collection.

2.2 Narrative Interviews
People use narration to make sense of, and express, their everyday experiences (King & Horrocks, 2010; Mishler, 1986; Polkinghorne, 1988; Reissman, 1993, 2008), especially for major life events, including childbirth (Carpenter, 1985; Farley & Widmann, 2001; Keeler, 1984; Miller, 2009). I chose this style of interview because I concur with King and Horrocks (2010, p. 217) that “when we present versions of events we mobilize and draw upon familiar but constantly shifting discursive, cultural resources”. Narratives also reflect the complex relationship between language and experience of the world (Holloway & Jefferson, 1997; Murray, 2008).

Anecdotally, I knew before I started fieldwork that birth stories were a common feature of motherhood, and the literature reflects the ease and oftentimes eagerness with which women approach telling their birth stories to interested parties (Farley & Widmann, 2001; Pollock, 1997). By the time this research came into being, birth stories had become a normal part of my own social interaction with other women, from personal friendships with other mothers, to play-groups and even conversations with strangers in supermarket check-outs.

The narrative interviews I conducted are categorized by Flick (2000) as episodic narratives, or narratives that are focused on specific events and experiences. Episodic narratives are smaller scale, and “refrain from claims for ‘true’ data and focus instead on constructive and interpretive achievements by the interviewees” (Flick, 2000, p. 88). In order to elicit these narratives in the interview, it was crucial to design a set of questions I thought would best achieve this. The work of Holloway and Jefferson (1997) proved particularly useful in this endeavour. Their three principles of eliciting narratives guided my interview ‘schedule’. These strategies include avoiding ‘why’ questions (to avoid making the participant feel defensive), using open-ended questions, and following up using participants’ own ordering and phrasing (Holloway & Jefferson, 1997, p. 60). As such, I invited participating women to tell me their birth story, in their own words, structured however they chose. As these stories unfurled, I noted areas of interest, and asked follow-up, open-ended questions based on these. As the questioning depended on each individual birth story, the content of the interviews cannot be completely reflected in an interview schedule. The themes I covered however, included:

- The process of learning about home birth, and deciding to have a home birth.
- How the participant discovered she was pregnant, and how she felt about it.

- If pregnant and planning a home birth, what (if any) plans for the birth were in place, and how she felt about the birth.

- If the participant tells a birth story, how does she feel looking back on it.

- What, if any, prenatal testing/scanning was done, and how she felt about the decisions surrounding those options.

- What happened to the placenta after the birth, or, if pregnant, did the participant have any plans for it?

- Did the participant have, or was she planning to have a baby shower or blessingway or any other kind of get-together to mark the pregnancy?

- Where in the home the participant birthed, and what decisions were made about that.

As each of these questions was discussed, I asked more detailed questions, based on the stories and progress of each interview. In line with Marshall and Rossman (2006, p. 101), the “participant’s perspective on the phenomenon of interest should unfold as the participant views it…not as the researcher views it”. As such, the above ‘topics’ were considered guides, and usually came up in some form as part of each birth narrative. When they did not, I approached these topics at the end of the interview, but often found that the times they did not occur within the main narrative, they were not dominant features of the experience overall, which could explain their absence from the main narrative.

Another reason I chose to utilise narrative style interviews was to minimise the power imbalances between the participant and myself, a subject covered extensively in the literature on feminist methodology (Olesen, 1994; Reinharz, 1992; Ribbens & Edwards, 1998; Roberts, 1981). By inviting participants to ‘tell their story’, their stories could then be as reflective of their experiences as possible, and thus reducing (but not eliminating) the power imbalance between us (Letherby, 2011; Oakley, 1981). I shall go into more detail on this topic in the following section on power and qualitative research.
This thesis takes women’s own experience as authoritative, which is fundamental to feminist research. Here, however, lies a paradox of feminist methodologies, because while women’s experiences are treated as authoritative, these experiences still become ‘objects’ of our research. This is, as Stanley and Wise (1993) put it, “morally unjustifiable” and has become a chief concern of feminist methodological practice since the 1980s.

The paradox of feminist research, mentioned above, was certainly at play in the fieldwork of this project. As a middle-class white woman, and as a home birther myself, I was easily incorporated into the social milieu of the women I interviewed. As others have also experienced (Finch, 1993), I was mostly greeted warmly into participants’ homes, offered tea and coffee, and often snacks as well. In addition to these social niceties, there was a shared body of knowledge and understanding between us. Before each interview, we would introduce ourselves, and at some point in this exchange it would become appropriate to tell the interviewee that I had had a home birth and a hospital birth. During the interviews the participants would make comments like “you probably experienced this as well...” or “I don’t know if it was the same for you...”, indicating a shared knowledge and understanding that would not have been the same had I not been, at least partially, an ‘insider’ in the research.

The issue of trust was something I grappled with constantly in the field, especially during interviews where there seemed, at least to me, to be a genuine connection between myself and the woman I was interviewing. Sometimes conversation would flow so easily that at the end I had to ask myself whether I had crossed a line, contributing to a convivial rapport that meant the interviewee spoke about more than she may have originally consented to. The only way I can reconcile this is to recall the joviality of the interviewees, and their interest and excitement in the work I was doing, their curiosity about me, my family, and the reciprocal nature of the interviews themselves. In each interview, I answered questions about why I had been induced for my first pregnancy, or whether I gave my baby a pacifier, or if I co-slept. Being even
partially an insider adds an extra sense of responsibility for me to be as reflexive as possible in the analysis of the resulting interviews.

By distancing ourselves from scientific research that treat participants and their experiences as data, and taking a more integrative, personal approach, a potentially even more exploitative relationship can ensue (Finch, 1993; Oakley, 1981, 1999; Stacey, 1988; Tanesini, 1999). I will discuss this further in the section on rapport.

2.4 Rapport

Giving part of yourself to the interview process, and to those you are researching is an important element in rapport building. Knott (1995, p. 206) notes that “[y]ou can’t just expect that people will be willing to speak about themselves without knowing who you are, without also being free to ask you questions”. As such, I talked about myself, my children and husband, even friends and family, as well as placentas, perineums, birth-pools and a myriad of other birth, mothering- and family-related subjects. I enjoyed this reciprocity of the fieldwork, and was only too happy to answer questions and engage in pre- and post-interview talk (and mid-interview talk, if the interviewee asked a question then). I am also aware however, as discussed above, of how this would have an impact on the stories told.

It is not only biography or shared experience that impact fieldwork and rapport. Reinharz (1997) notes that we bring several selves into the field, and choose which ones are present at what time. I have at least several selves that make up who I am, including mother, sister, daughter, partner, friend, feminist, student, but also the many moods and nuances of my personality that I choose whether people see at any given time. I sometimes swear too much, I spend too much time on Facebook, I am a nervous city-driver, and I am a high-maintenance coffee drinker. These are parts of my Self that were not necessarily all present during fieldwork, but this is because I decided it was not appropriate to start venting to a participant about the bad coffee I had on the way to her house, or to start swearing about the inept merging of the blue sedan on the highway. I presented a Self in the interview that was certainly me, but it was a ‘me’ that I
constructed as appropriate for that setting. The same as we would for a job interview, teaching a class, going to the dentist. This point underpins the importance of reflexivity, and in being open about the process of knowledge construction, which begins long before the data analysis phase of research. Ultimately, the Self we take into the field heavily impacts the interviews and subsequent data, making transparency about this essential.

My identity as a white Australian, female researcher was clear from the beginning, as my name, a conventional female name in Australia, appeared on all initial expressions of interest. My biography was less obvious, although it became apparent in several interviews that it mattered. Some women told me they read the online call for participants and were unsure whether to contact me, because they did not know what my position on home birth was, and whether my research was aimed at denigrating or supporting home birth. When they discovered that I too had had a home birth, they felt comfortable enough to contact me and offer their participation. One participant told me explicitly she would not have had an interview unless I had had a home birth.

My enjoyment of the research process does not mean it was not, at times, fraught with anxiety. Hubbard et al (2001) extol the importance of paying attention to the emotional issues of the researcher during fieldwork. The importance of protecting respondents from emotional distress is well documented in ethical guidelines and literature, however researchers note that occurrences which evoke emotional responses from participants are likely to also evoke emotional responses from researchers (Hubbard et al., 2001; Wilkins, 1993). For these authors, emotions are not only legitimate responses to various fieldwork occurrences, they are also key indicators of potential analytical work.

I was, on several occasions, moved to tears during fieldwork. For instance, while watching a birth video that a respondent offered to show me (after the interview, off tape), I was in tears. At the time of writing this I can still recall the look on her face as she caught her baby in the birth pool, and the joy in her eyes as she brought her to the surface. At the time the participant became emotional as well, and we laughed about not being able to help but cry. Another time I was listening to a story about a blessingway, and the interviewee told me she sang a Hindu chant during a ‘laying on of hands’ ritual, and asked if I would like to hear it. I said yes and she sang the chant, which took less
than a minute, but as her soft speaking voice transformed into a deep, smooth sound that echoed around the dimly lit living room, it was an incredibly moving experience, and once again, I cried. She gave me a little hug and we chuckled together, and though I was a little embarrassed, I felt safe enough with her to be so.

Sometimes rather than pathos, there were strong connections to women and their stories which affected me, an experience shared by other researchers as well (Glesne, 1989; Wilkins, 1993). During the course of these interviews, which took place over five months, I had my own birth history validated. I thought I was the only one who experienced childbirth as alienating. I did not realise it was common, nor did I realise many of the women who had home births had previous trauma in hospital. I could identify with so many of the stories I heard, which in turn changed the way I thought about my own births, particularly the birth of my first child, who was induced in hospital. In some ways this was both healing and confronting. The interviews made me feel at times like I had made the best of a bad situation, and at others I felt duped by a system that I felt had not cared about me enough. It took some time to resolve these feelings, and in the meantime I took the advice of Glesne (1989) and Wilkins (1993) and wrote a journal, talked extensively with friends and my husband about all the feelings I was experiencing, and sought the advice of a counsellor. I admit that I did not confide in my supervisors about this, because at the time I thought my own personal insecurities were beyond the scope of supervisory responsibilities. In hindsight, both supervisors would have been valuable resources in dealing with the emotions of fieldwork.

Knott (1995) writes about the importance of *being* in the interview, and not just listening and trying to be objective, she writes “not being ourselves is a denial of the responsibility we take in hearing this person’s story” (p. 211). Interviews are context driven, and each one requires different appropriate behaviour, but this behaviour is also important when considering the data that comes from them. The above experiences are highlighted here because they reflect the ‘realness’ of fieldwork, which in turn affects the work itself. The context is important as the conversations and stories do not occur innocently, they “reflect, and cannot be decontextualised from, surrounding events and institutional circumstances” (Mauthner & Doucet, 2003, p. 422). As I will discuss in the
following section, rapport is not simply an issue within the interview setting, but also in the pre-access phase in ethnographic fieldwork.

2.5 (Not) Gaining Access

When I began this research in 2009, I planned to research the home birth practices of a new religious movement (NRM) in my local area. After several months of preliminary fieldwork with this group, they decided not to participate in the project. This experience is the topic of my most recent publication (Burns, 2015c, see Appendix 4). In this article, I discuss the experience of non-entry into the field, the tendency in the social sciences to see rapport as an achievement of the researcher, and the implications of an epistemological approach to failure and/or rejection.

It has become well established in the social sciences to view knowledge production as a collaboration between researcher/s and researched. So too the politics of fieldwork access involve many people, as well as dynamics that are completely beyond the researcher’s control. In the article I focus on the anthropological literature because I was pursuing an ethnographic project at the time, and ethnography relies so heavily on rapport and access. In the ethnographic methods literature, rapport is conceptualised as an achievement of the researcher. This assumes a power dynamic between researcher/s and participants that is unlikely to reflect the reality of the early research phases. Indeed, after my initial contact with this group, I had access to one family, and primarily one female member, Maria (a pseudonym), who served as my host. The decisions about my research and potential participation were made by a group of upper-echelon men whom I had no access to. I can only assume they read the research information I gave to Maria, but beyond that there was no scope for me to talk with them directly.

This situation is not necessarily unique, as the politics of access never only involve the researcher, but a range of other people. The methodological strategies in the social sciences literature provide only a partial insight into the issues faced during fieldwork, particularly pre-access fieldwork. By considering rapport an achievement of
the researcher, this literature overlooks the complex relationship between prospective participants and researchers.

The researcher in the pre-access phase is merely a ‘hopeful researcher’ in the research setting, and the would-be-participants “often have the upper-hand, acting as gatekeepers and defining the terms on which researchers can gather data” (Harrington, 2003, p. 598). Certainly in the case I present, my role in these pre-access interactions was not with an upper-hand, or even equal-footing. While I did have the power to leave the property whenever I wanted – a power I appreciate that many of the members themselves did not necessarily have - I wanted to stay, but the permission to do so was constantly precarious as I awaited acceptance.

The pre-research phase of ethnography is not merely the first step in successfully collecting data. As my article demonstrates, this phase highlights that power dynamics are rarely as simple as having or not having power, or even being an insider or an outsider. The power dynamic between researchers and participants has been critiqued heavily in the social sciences for decades now (Harding, 1987; Oakley, 1981; Olesen, 1994). While the literature often polarizes the power differences between researcher and researched (Oakley, 1981; Roberts, 1981), others see a paternalism in the way power is assumed to rest only with the researcher (Mishler, 1986).

In Burns (2015c) I argue that rejection and failure form part of the ‘non-data’ of research practice, and should be considered as epistemologically important as more conventional, ‘successful’ data. For doctoral students or early researchers, and indeed anyone in academia more broadly, the fear of rejection in professional life is commonplace. This article contributes to the social research methods literature by redirecting the social science lens inward toward the researcher, and addressing the taboo of professional failure and rejection. My article argues that pre-access fieldwork involves a complex network of agents that include more people than the researcher may have access to. Rather than a personal setback, rejection should be contextualised as part of the broader socio-political implications of the research project itself.

It was this rejection from the NRM that redirected this doctorate into a new phase. Given that I was interested in the literature on religion and spirituality and home birth, the focus of the research quickly became the spirituality of home birth more
broadly. These issues are the focus of the remaining three published articles for this thesis, the design and limitations of which I shall discuss in the following sections.

2.6 Research Design

Participants were recruited via web-based forums on the following Australian websites:

- www.birth.com.au
- www.essentialbaby.com.au
- www.naturalparenting.com.au
- www.bellybelly.com.au
- www.joyousbirth.info

In order to post in each forum, I was required to become a member, which gave me access to member posts, the ability to make forum posts of my own, and reply to others. I contacted the moderator of each forum for permission to recruit before posting a call for participants. As I wanted to conduct face-to-face interviews, I grouped prospective participants into geographical areas and decided to interview those in the most accessible locations.

While there were some women in remote areas wanting to participate, most were from capital cities. Hence I conducted 59 interviews in the three Australian cities of Sydney in New South Wales, followed by Brisbane in Queensland and Melbourne in Victoria. As I live in the greater Sydney area, within Sydney interviews were conducted in the Blue Mountains, the inner western suburbs, and the Illawarra. This was not deliberate, however, when some participants read the online posts, they then passed this

---

1 This project received ethical approval via the National Ethical Approval Form, approved by Western Sydney University in 2010. All participants received information sheets and consent forms before participating in the research, as well as a list of free counseling services specifically for women, should they become distressed. See Appendix 2-5.
onto members of their local mothers/parents groups, which meant there were clusters of interviewees in particular areas. After the interviews in Melbourne, I reached saturation point, and decided not to continue to any other cities. This decision necessarily excluded women from rural areas. Homebirth is also less predominant in rural settings because of the lack of midwifery services available (Australian Institute of Health and Welfare, 2005). After the interviews, recordings were transcribed, and then manually coded thematically. From this emerged broad themes including medicalisation, ritual, spirituality, home and family.

At each interview I collected demographic information, represented in the tables in Appendix 5. In summary, there were 43 participants who had recently birthed at home with an independent midwife, or were pregnant at the time of the interview and planning a home birth with an independent midwife. Six women were utilising a publically funded hospital home-birth program, three had had recent free births, or unassisted births, and seven were independent midwives or doulas. The average age-range of participants was between 26 and 35, average household income was between AUD $75,000 and $100,000+ per year, indicating a middle-class demographic. Participants mostly identified as having no religious affiliation, and almost half of participants had at least completed an undergraduate degree.

2.7 Limitations

This research has focused specifically on women’s experiences, and as such participants were all female. As I have discussed previously, I have privileged the experience of pregnancy and childbirth as a unique knowledge form, and only sought the participation of those who had experienced that themselves. An inclusion of partners and/or husbands would certainly yield a rich insight into the experiences we discussed in the interviews, however no participant suggested their stories would be richer with the inclusion of their partners.

This research cannot be generalizable due to the relatively small sample size of participants. As the participant demographics indicate, the largely urban, Anglo-Saxon,
middle class demographic does not represent the kind of reasons for choosing home birth or the experiences of home birth as those in rural settings, or the breadth and depth of the politics and complexities faced by Indigenous women birthing on country. Conducting qualitative interviews, as I discussed in section 2.4 meant that my relationships with participants would have impacted the interview material, though I have taken steps to be as reflexive as possible, both in this section and in the published material, to make that impact as transparent as possible. This research is perhaps also limited by a lack of engagement with how women formulate their knowledge of the kinds of practices discussed in this thesis.

Due to the nature of the research questions outlined above, the employment of a qualitative research design was appropriate, however a potential future direction of this research topic may benefit from the addition of quantitative methods, to continue to build our understanding of the field.
3. Thematic Overview

The following thematic overview forms the basis of the theoretical underpinnings for the accompanying published material for this thesis. It will situate the homebirth practices of the women I researched as spiritual experiences that connect women to a different understanding of their pregnancies and births, one that is not dominated by medicalised discourse.

In this overview, I will firstly discuss the rise of medicalisation in the eighteenth and the nineteenth centuries, paying particular attention to Willis’s (1983) historical analysis of this period and the gendered division of health care provision in Australia. I will then move on to a discussion of Beck’s (1992) notion of reflexive modernity, and in particular his theory of institutionalised individualism. These two sections will contextualise the contemporary maternity system and ‘birth choices’ in Australia, within which home birth exists. These sections also contextualise the central argument of this thesis that home birth needs to be seen beyond the lens of medicalisation, and potentially as a spatially and spiritually distinct practice that precedes and extends beyond the act of birth itself.

3.1 The Rise of the Medicalisation of Childbirth

Rather than a systematic review of the literature on the growth of medicalisation, this section will focus specifically on the institutionalisation of childbirth, the significance of the spatial shift from home to hospital, and the gendered division of health care provision in Australia.

The term ‘medicalisation’ broadly refers to a “process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad, 1992b, p. 209). Cahill argues that the expansion of medicalisation into previously non-medical problems indicates a “process which clearly serves the interests of medicine with its increasing focus on the indicators of disease rather than
the individual’s experience of health and illness” (Cahill, 2001, p. 339). The term has also been defined as the process of legitimising medical authority, specifically through “asserting and establishing the primacy of a medical interpretation of that area” (Freund, McGuire, & Podhurst, 2003, p. 207).

In the nineteenth century, health care delivery was structured as a hierarchy where biomedicine was placed above all other health occupations (Willis, 1983). This structure was social in nature because of the impact of gender, class and ethnicity on the power differentiation between biomedicine and ‘non-medical’ health professions, such as optometry, chiropractic, and midwifery, for example. At this time, higher education was a privilege predominantly of the white male ruling class. As such, students of biomedicine excluded women and ethnic minorities, as well as the working class.

It is this social division, and in particular a gendered division between biomedicine and midwifery, that Willis (1983) draws on in his historical analysis of health care provision in Australia. As the medical profession rose in political and economic power in the nineteenth century, there was a simultaneous decline in working class practitioners. These professions then entered into a subordinate relationship to medicine, occupations defined by Willis (1983, p. 92) as those with the content of their work “comprised of tasks delegated to them by doctors”. For midwifery, practiced solely by women until about the seventeenth century, this subordination was achieved “by its incorporation into nursing, an occupation which was already structurally located in a position of subordination to medicine” (Willis, 1983, p. 93).

Before the rise in the professionalization of medicine in the nineteenth century, however, Willis (1983) argues that the introduction of ‘lying-in’ hospitals for birthing women represents the beginning of the spatial shift in power dynamics in the mid-eighteenth century in the UK. The spatial positioning of this shift is also important here, as birth moved from the domestic sphere of the home, to the hospital, in which women had neither autonomy nor midwife to advocate for their welfare. This was the first successful attempt to bring parturition under professional medical management in a secular institutional setting (Versluyssen, 1981). These hospitals provided doctors with a constant stream of ‘patients’ upon whom to hone their skills, creating a new market for
doctors by expanding the pool of pathological childbirth experiences by shifting the parameters of pathology itself.

Willis (1983) argues that the relationship between midwives and doctors was one of subordination and dominance long before childbearing itself became medicalised. Technology has often been cited as one of the primary drivers of the medicalisation of childbirth, however Willis’s argument suggests a more complicated and political relationship between childbirth and medicalisation. The gendered and class divisions of healthcare provision as well as the growing institutionalisation of medicine played a much larger role in the early years of the medicalisation of childbirth than did technology. While the birthing shift from home to hospital can certainly be argued as an act of medical control, the medicalisation of childbirth as a discursively produced phenomenon did not start occurring until medicine began expanding its areas of expertise more broadly.

By the early to mid-twentieth century biomedicine’s authority was such that it was able to control the work of many other health occupations, including chiropractic, homeopathy and optometry (Willis, 2006). This dominance was legitimised by laws that granted a monopoly over these occupations, and in turn medicine had the power to limit or prohibit other kinds of health professionals (Baer, 2008). By using science to legitimise authority, biomedicine dominated the means by which other health occupations could compete for legitimacy. Indeed, in Australia the medical registration act of 1862 in Victoria was the first to differentiate between qualified and unqualified medical practitioners, an act which also excluded women altogether from being eligible to qualify for any health occupation. For Australia, this is a significantly gendered addition to the institutional power of medicine at the time. Until this point, despite the class and gendered divisions of labour, midwifery still had a relatively strong foothold in the country, particularly in rural areas (Barclay, 2008; Fahy, 2007).

The dominance of biomedicine over other health occupations created an increased reliance and deference to doctors for conditions that previously had not required ‘medical’ attention, for example childbirth. Thus biomedicine’s increasing attention to ‘normal’ bodily processes meant ordinary people quickly lost the ability and authority to manage these issues themselves (Illich, 1977). There was also a
dichotomising of the home and hospital in relation to hygiene, with the hospital able to reach levels of sanitation for a ‘cleaner’ and therefore ‘safer’ childbirth. This perception of greater sanitation was in part due to the surgical environment of the hospital, but was enhanced by the rapidly increasing reliance on technology by doctors in the 1960s, technology unrivalled by anything possible in the home space.

Oakley (1984) argues that the period between the 1960s to the 1980s was the ‘reign of technology’ for childbirth in America. In these decades, labour and birth techniques and obstetric procedures advanced exponentially, fuelled by what Brodsky (2008) describes as society’s newly found love-affair with science because of the 1969 Apollo 11 mission. Foetal diagnostic devices like ultrasound, amniocentesis and electronic foetal monitoring were standard practices by the early 1980s, and soon after came the escalation of the use of epidural anaesthesia.

Part of the way biomedicine achieved the level of success in childbirth practice it did in this period is via what Davis-Floyd refers to as the ‘technocracy’. Technocracy refers to a society that “organises itself in terms of its technologies and is bureaucratic, autocratic, and hierarchical” (Davis-Floyd, 1994, p. 1139). This framework utilises more than just biomedicine to explain birthing systems, but incorporates the force of technology and the specialised language used to understand it. More broadly, technology replaces human diagnostic processes, and in turn medical professionals rely on the results of those processes, and consumers rely on the interpretation of these results to manage their diagnosed conditions. Within this cycle there is little room for autonomy or informed decision making because all of the available options are shrouded in medical discourse, hospital policy, and certainly in the case of pregnancy, the power imbalance between the pregnant woman and the authority of the medical personnel.

One of the earliest points at which we can see this in practice is with the pregnancy test, which is now culturally as well as medically understood as the legitimised ‘proof’ of pregnancy, rather than any felt bodily sensations experienced by the woman herself. The confirmation of a pregnancy by a doctor also represents the beginning of the symbolic transfer of power from the pregnant women to medical professionals (Kitzinger, 2005). This process of legitimation continues via the need for regular
consultation with a doctor or midwife, and the various routine prenatal screening and diagnostic tests available.

All of these processes act to defer expertise from the pregnant woman, as well as to increase reliance on medical knowledge and discourse, and simultaneously create surveillance via the carefully recorded electronic medical history. It also marks the beginning of the need for the pregnant woman to continually stay informed, and of an ongoing search for expertise, be this through visits to a GP or midwifery clinic, but also via online and, increasingly, smartphone technology and the plethora of apps about you and your baby’s progress in utero. Thus while deferring expertise from the pregnant women, these processes also increase the pool of experts to be consulted, representing the kind of reflexive engagement with pregnancy and birth I will discuss in the following section.

Conrad (2005) argues that the definition of medicalisation has broadened from simply the authority of doctors and medical technology to include other players like pharmaceutical companies, bio-technology, and of course, politics. This also broadens the scope of the medicalisation critique, though does not necessarily counter its dominance as a paradigm. Challenges to this paradigm can, however, be seen in the shifting foci within the social research on health, with increasing attention on the health-care consumer (Ballard & Elston, 2005), childbirth embodiment (Lupton & Schmied, 2013; Walsh, 2010), as well as the body of work on cultural and religious birthing practice around the world (Callister & al, 2002; Callister & Vega, 1998; Campanella, Korbin, & Archeson, 1993; Klassen, 2001; Liamputtong, 2000; Schott & Henley, 1996).

Just as research has expanded the scope of our understanding of childbirth experience by looking beyond medicalisation, so too has hospital policy recognised alternative approaches to caring for women. This is particularly evident in the growth of more holistic, woman-centred approaches to birth (Brodsky, 2008). As such, there is a growing understanding of the benefits of doula participation (Gilliland, 2002; Mottl-Santiago et al., 2008), caseload midwifery programs that value one-to-one care (Williams, Lago, Lainchbury, & Eagar, 2010), and the recognition of the value of free-standing birth centres (Walsh, 2006; Walsh & Downe, 2004), or utilising domestic, ‘home-like’ décor (Fannin, 2003). While the biomedical model of childbirth practice is
still certainly dominant in Australia, the use of complementary and alternative medicine (CAM) in childbirth (Harding & Foureur, 2009), and holistic antenatal classes like hypno-birthing (Fisher, Esplin, Stoddard, & Silver, 2009) as well as the growth of alternative childbirth practices indicate a move toward individualised care. This refers to care that supposedly recognises the individual needs of birthing women. However, in practice it can be seen as the expansion of biomedicine to include that previously considered ‘alternative’, and increasing its authority in the process. Even the development of publicly funded hospital home birth programs in Australia can be seen in this light, particularly as their popularity builds (Catling-Paull, Coddington, Foureur, & Homer, 2013).

Research on the medicalisation of childbirth is vast, and while this overarching statement has not presented a systematic overview of this literature, suffice it to say that scholars have been highly critical of the intensively technological management of pregnancy and childbirth as well as the role of patriarchal systems of management of women’s birth experience (for instance see Beckett, 2005; Cahill, 2001; Crossley, 2007; Davis-Floyd, 1994; Katz-Rothman, 1994; Martin, 2003; Reiger, 1999; Rich, 1977). The gendering of medicalisation is no more evident than in contemporary home-birth politics. As discussed previously, struggles for legitimacy and autonomy have a long history in midwifery. Today, the lack of professional autonomy for midwives is a part of the genealogy of the historically complex relationship between medicine and midwifery.

While midwifery within the hospital system has been increasingly professionalised and has enjoyed the benefits and securities of an institutionalised setting over recent decades, the asymmetrical power dynamics between midwives and obstetricians within birthing suites is well-documented (see, for instance, Hunter, 2004; Keating & Fleming, 2009). Meanwhile, private practice midwifery has become a new target for dominance. Being able to practice without the overarching authority of obstetrics affords independent midwives a unique autonomy, albeit with many trade-offs, including the particularly precarious position of insurance availability, and the politics of collaborative arrangements (Newnham, 2010; Reiger, 2000, 2006).

While this thesis contributes to this body of literature, I have highlighted medicalisation in this section to contextualise the reflexive engagement with pregnancy
and childbirth in contemporary Australia. For over 99% of women in Australia, pregnancy will be at least partially medically managed, and birth will most likely occur in a hospital setting. Even those choosing home birth still engage with medical practices like blood tests, ultrasounds, or even the skill and knowledge of a medically trained, registered midwife. The concept of risk is particularly salient here, and will be addressed in the following section. Within the Australian maternity system there are now many ways women can tailor their birth choices, the majority of these options are structurally bound to the biomedical paradigm. The discursive construction of these options as ‘birth choices’ in the contemporary childbearing rhetoric indicates an institutionally individualised approach, typical of life in reflexive modernity (Beck & Beck-Gernsheim, 2002), which I will discuss in the following section.

3.2 The impact of individualisation on medicalisation and religion

Reflexive modernisation refers to contemporary life as distinct from ‘first’ modernity, or the period from the mid-nineteenth to the mid-twentieth centuries. This reflexive modernity, also known as ‘second modernity’, has transformed the institutions and social structure of the first modernity, in often unanticipated ways.

In the first modern era, the institutional structure was of a particular logic and order that left little room for ambiguities. Social structures like the nuclear family, class, and even gender and sexuality, for example, had very clearly demarcated and rigid boundaries of normativity. This is not to say that the lived experience of normativity was not complex, more that, as Beck and Lau (2005) clarify, in first modernity these complexities were not socially recognised. Today, in reflexive modernity, these complexities are recognised, and ‘normal’ is relative and exists on a continuum depending on geographical location, gender, sexuality, and a myriad of other factors.

For Beck, this recognition of complexity is possible because of a change from the ‘either/or’ logic of first modernity, to the ‘both/and’ logic of reflexive modernity. That is, for instance, from either work or family, to, both work and family. For Beck and Lau, “plural demarcations come to take the place of unambiguous dualities, standard
forms and distinctions” (2005, p. 527). For example, the decision to have a child at home in the ‘first’ modern period was not necessarily a complicated or controversial decision, nor did it require the attending midwife to navigate complex political, institutional, organisational and bureaucratic processes. However, in contemporary Australia one can have a home birth in four distinct ways. Firstly, and at one end of the ‘risk’ spectrum, one can plan to birth unassisted, or ‘free birth’. Secondly, and most commonly, one can hire a registered, privately practising midwife. Thirdly, if eligibility criteria are met, and there is one available in your local area, one can utilise a publicly funded hospital home birth program. Lastly, one can plan to give birth in a hospital but not make it there in time, having a home birth by default.

The most common of these examples, engaging the services of a privately practising midwife, initiates several interrelated processes. These include the midwife’s professional recognition, via the nursing and midwifery board of Australia. To be eligible for this recognition, the midwife will have needed to complete his or her education in an eligible institution, as well as complete a nominated number of hours of professional practice, with supervision, within a maternity hospital environment. The midwife will also require her own indemnity insurance, which is now a requirement for professional registration, and while the complexities of this are beyond the scope of this section, it remains a highly politicised issue for privately practising midwives (Newnham, 2010; Rigg, Schmied, Peters, & Dahlen, 2015). One of the key complexities of the indemnity insurance eligibility is the need to practice collaboratively with a GP (For instance, see, Hastie & Fahy, 2011; Kennedy et al., 2015; Lane, 2012).

While I have not provided a detailed overview of the current politics of home birth in Australia, the above example illustrates the shifting complexities between home birth in first modernity, and today. The current situation is the result of the culmination of events, policies, and shifting directions in midwifery and hospital practice, and is rather part of the larger context of second modernity. As Beck and Beck-Gernsheim (2002) illustrate, plurality in reflexive modernity is institutionally normalised and recognised. The kinds of pluralised means via which private practising midwives access education, resources, registration, insurance, as well as maintain their practice, has an impact on the range of choices women deciding on home birth have.
As a result of the increasing encroachment of institutions into our everyday lives, we absorb the rules and regulations into our biographies via our own actions (Beck & Beck-Gernsheim, 2002). This represents the categorical shift in the relationship between people and society (Beck, 1992). As such, for Beck and Beck-Gernsheim (2002), the individual is the defining feature of contemporary social life in reflexive modernity. Individualisation, as Beck presents, is bound to the previously unseen levels and expansion of institutionalisation and bureaucratisation of the late twentieth century. At the same time that individuals are expected to be self-driven and take responsibility for their lives, the plethora of possibilities for doing so are bound at every turn by institutional rules and bureaucratic regulations.

Individualisation, then, emerges in response to these changes in society, and institutions in particular, which are now geared almost exclusively to the individual, who has to access and interpret resources independently. The individual, for the first time, is constructed separately from traditional social formations, and is a distinct and independent form, ‘choosing’ their own life course. The process of individualisation occurs in three phases. First, there is a disembedding from traditional forms of cohesion. The changing roles of women in society provide an apt example of such disembedding. In modernity the nuclear family provided a basic gender structure for the role of women. Despite the constraints of these gender roles, social norms were at least clearly defined, which facilitated a sense of both social progress as well as individual lives progressing over time (Woodman, Threadgold, & Possamai-Inesedy, 2015, p. 1121). The sexual revolution of the 1960s and 1970s, for example, heralded significant change in the social status of women, not least of which included reproductive rights. These shifts meant women were no longer either wives or mothers, but could be, and were expected to desire, relationships and careers based on choice rather than expectation. The second phase of individualisation is a loss of security that comes from the disembedding, instituting general doubt in regards to expert knowledge, faith and social cohesion. Experts, writes Beck (1992, p. 137),

dump their contradictions and conflicts at the feet of the individual and leave him or her with the well intentioned invitation to judge all of this critically on the basis of his or her own notions.
As a result of this process, if we return to the earlier example of women in the workforce, individualization sees a ‘personalised contradiction’ (Beck, 1992) for contemporary women. Now, rather than gender roles prescribed by industrial society for life in the nuclear family, women are required to “build up a life of their own by way of the labour market, training and mobility, family, relations and friends” (original emphasis, Beck & Beck-Gernsheim, 1995, p. 6).

Thirdly, there is a re-embedding into new forms of cohesion, which are now built around the individual, but sustained via the increasing institutionalisation, as previously discussed. Social definitions like gender, class and family are increasingly complex. However, although they liberate us from the rigidity of social categories, they also impose equally complex and subjective categories to be navigated. This can be illustrated by the ‘birth choices’ discussed in the previous section, as the scope of ways to have a baby today is far more subjective than was possible in industrial society. While this means vastly decreased maternal and infant mortality and morbidity rates on the one hand, it also means options based on political contingencies, and systems that are heavily politicised and bureaucratic process today.

The maternity system represents an all-encompassing institution, offering services shrouded in discourses of biomedicine and risk. These services make up not only the medicalised maternity system, but also the social structure of maternal experience in Australia. We can see this in the number of services available to women prior to conception and during pregnancy and childbirth. For example, there is the pharmacist, who becomes an expert in prenatal (and pre-prenatal) vitamins, the over-the-counter urine test as scientific confirmation of pregnancy, and the General Practitioner as legitimiser of these results, who marks the beginning of the pregnancy medical record, and has the power of specialist referral. Then there is the obstetrician, sonographer, pathologist, those dealing with the various results of prenatal screening and diagnosis, such as the endocrinologist if blood glucose is too high, or the genetic counsellor if a screening test returns with anomalous results. There is also the midwife, perhaps a doula, a lactation consultant if required, a community nurse for regular newborn health checks, and later the more socially oriented roles of the
mothers/parents groups – both real and virtual, not to mention the role of the mass media at every turn along the way.

While this is by no means an exhaustive list of services, specialties and professions involved in the ‘average’ Australian pregnancy, birth and early-motherhood phases, they represent the kind of stimuli that pregnant/birthing women must cope with today. Among the participants in this study, for example, most women still engaged with at least one of the above services. The discourse of risk means that utilising these practices transfers responsibility from institutions to the individual. Women are expected to manage the maternity services and provisions themselves, as well as decide how to engage with the resulting outcomes. In this way, responsibility is not only medico-legal, but social and cultural as well, as the plethora of services means they are disseminated into the broader ‘field’ of maternal health and wellbeing, and not just in stasis with the act of birth. This means pregnant (and/or pre-pregnant) women incorporate this ‘to-do’ list of medical and social expectations into their lived experience of pregnancy, and do so as an enactment of responsible motherhood.

By attempting to deny at least some of the power of biomedicine over their bodies by choosing home birth, participants in this research have still performed this denial within the biomedical system. As previously mentioned, most have still engaged with at least some of the biomedical services available, including hiring a qualified, registered midwife. By utilising spiritual discourses, however, there is real potential at least to challenge the dominance of medical discourse. To understand this, I will discuss the ways reflexive modernity has signalled a shift in the meaning and experience of religion (Beck, 2010). Individualisation has had a similar, yet distinct, effect on religion as it has on the previous example on gender roles. Just as the expectations of women have expanded and become more complex, so too has religion. No longer a looming, disciplinary authority, religion instead is not only a choice for most people today, but has ceased to be the dominant, or indeed the only means by which we understand the world. The diversification of religious beliefs has given rise to an abundance of spiritual practices that exist outside traditional religion.

The concepts of religion and spirituality are not completely distinct, for most religious people see themselves as being both religious and spiritual (Chaves, 2011;
Possamaï, 2005), again referencing the reflexive shift. Hanegraaff’s (1998, 1999) distinctions between the two are particularly useful here. For him, religion is a social institution which embodies any symbolic system that ritually maintains “…contact between the everyday world and the meta framework of meaning” (Hanegraaff, 1999, p. 147). This contact is sustained via ritual practices. Spirituality, on the other hand, draws on the manipulation of these symbols by an individual (Hanegraaff, 1999). The commitment to common symbols is more important for religion than it is for spirituality, as these symbols take hold of popular imagination and personify the stories they represent, for example the Christian cross/crucifix (Hanegraaff, 1999). Thus religion is distinguished from spirituality by its close connection to organised forms of practice, while spirituality is more self-authored insofar as practices are individualised rather than structured by organised religion. Individuals may now write their own faith narratives by reappropriating symbols and meaning from the previously ‘fixed orbit’ of traditional religion, and do not even have to identify as religious or spiritual in order to do so. This can be seen in the rituals I will discuss in the summary of findings, as participants gathered a mixture of symbols to incorporate spirituality into their experiences, without necessarily identifying as spiritual.

The impacts of individualisation on medicine, midwifery and religion have a role in the politics of home birth. Home birth is the site where these different social and political trajectories meet. In this thesis I demonstrate that there is much more to home birth than simply being the backdrop of childbearing, or just another ‘birth choice’. There is a specifically gendered spirituality, intimately related to fertility, reproduction and domesticity present in home birth practices, which I will discuss in the following section.

3.3 Gendered Spirituality and Home Birth

In a diverse range of cultures, pregnancy and childbirth can be a particularly meaningful time, with women drawing closer to their religious and spiritual beliefs, and find a higher purpose for themselves as they become mothers (Callister & al, 2002; Callister & Khalaf, 2010; Hill, 1985; Kartchner & Callister, 2003; Liampittong, 2000). Jesse and
Read (2004, p. 740) argue that spirituality “should be considered as important as biophysical and psychosocial correlates and predictors of perinatal health”. Hall (2001, 2002, 2006, 2010), the most prolific contributor to the literature on birth and spirituality within midwifery, argues that the lack of widespread research on the topic is due to a research agenda focused on professional practice and education (Hall, 2004). Beyond midwifery, social research on the spirituality of childbirth is considerably lacking. Some argue the lack of research on spirituality and childbirth is because of the dominance of the medicalisation critique (Crowther & Hall, 2015; Jesse, Schoneboom, & Blanchard, 2007). Possamai-Inesedy (2009) agrees, but goes a step further to argue that, from a sociological perspective, there is a disjunction between the epistemological and methodological paradigms used within the sociology of religion and the sociology of childbirth respectively. For her, sociology of religion has the theoretical paradigm to engage with spirituality, but lacks the qualitative methodologies so well utilised by sociology of childbirth.

Despite this lack of research engagement with childbirth and spirituality, the importance of religion and spirituality to childbearing is recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) (2006) and the Australian Nursing and Midwifery Council (ANMC) (2008), both of which highlight respect for religious and spiritual beliefs in their codes of ethical practice. Hospital policy in Australia also takes seriously the importance of respecting religious and spiritual beliefs of those in their care, though some have argued that these policies are part of a ‘tick-box’ culture of care rather than evidence of a meaningful engagement with each concept and their relationship to birth (Crowther & Hall, 2015).

That there is a disjuncture between the recommendations and hospital policy, however, does not necessarily mean that hospitals cannot facilitate spirituality, though they do operate within a guise of medical and technological progress that supersedes spiritual needs. The home, on the other-hand, does not have the same restrictions, and as a site of birth transgresses clearly demarcated social and medical boundaries, and signifies a deliberate turn away from the technological progress achieved in late modernity. This progress is embodied by the contemporary maternity hospital, and
Accordingly, home birth represents an act of spatialised rebellion. The rituals I will discuss in the following section indicate a partial attempt of some participants to disembed from reflexive modernity, and re-embed (at least temporarily) back into selective aspects of traditional community. By turning away from biomedical dominance, making a specific effort to create woman-centred rituals that honour their bodies and maternal experiences and that draw on community, the participants successfully empower themselves to have the births they want. At the same time, their use of multiple symbols, rituals and denial of biomedical dominance is possible because of the kind of reflexive engagement with pregnancy and childbirth that is expected today.

3.4 Summary of Findings

In More Than Clinical Waste (Burns, 2014, see Appendix 1), I critiqued the notion of the placenta as clinical waste within a framework of the social construction of pollution (Douglas, 1995). The placenta is rarely discussed outside of medical literature, or the protocols for the professional management of the third stage within midwifery and obstetrics. In this article I analyse the placenta as an ‘after thought’ of social research on childbirth, as much as it is generally considered the ‘afterbirth’. In the home birth narratives of the women I interviewed, the placenta was an integral aspect of childbirth, and was revered, honoured and even ceremonialised. I found that participants consumed, buried (see figures 1 - 8), or did not separate baby and placenta at all, but allowed the cord to dry and come away naturally, a practice known as lotus birth. For women who had had previous hospital births, the burial of the home-birthed placenta was not only a celebration of the placenta as a life-giving organ, but also acted as a memorial for previous placentas that were discarded at the hospital. The placenta, once disconnected from the baby (or not disconnected, in the cases of those practicing lotus birth) was considered rich with spiritual significance, symbolising the links between the mother and the child, and the loss of the connection forged in utero.
argued here that the placenta rituals could be a meaningful way for women to engage with their birth experiences, including previous pregnancies and births. In light of these findings, I argued against the categorisation of the placenta as ‘clinical waste’, and argued for alternative ways in which particularly childbirth educators could present placenta treatment options.

Figure 1. Mandarin placenta tree
(Photo by Emily Burns)

Figure 2. Potted placenta tree
(Photo by Emily Burns)

Figure 2. Potted placenta tree
(Photo by Emily Burns)

Figure 4. Native placenta tree
(Photo by Emily Burns)
Figure 5. Native placenta tree
(Photo by Emily Burns)

Figure 6. Placenta tree
(Photo by Emily Burns)

Figure 7. Placenta tree
(Photo by Emily Burns)

Figure 8. Apple placenta tree
(Photo by Emily Burns)
The Blessingway Ceremony (Burns, 2015a, see Appendix 2) explores a ritual that can be described as an alternative baby-shower. Guests are asked not to bring gifts for the baby, but a symbolic bead to be threaded onto string for the pregnant woman to keep. Guests also participate in several smaller rituals to promote a connection between each other and the pregnant host. These rituals include the matrilineal introductions, the giving and threading of symbolic beads (see figure 9 - 12), and wrist weaving (see figure 13).

In each of these rituals the focus is on drawing participants’ attention to the connections between themselves and the pregnant hostess not only as friends or family, but also as women, as mothers and as daughters. While Davis-Floyd (2003) has observed a similar function of the more traditional baby-shower, participants in this research were quick to contrast the blessingway to the baby-shower by referring to it as superficial and consumer-driven. Women participated in this ritual partly to foster and celebrate an inter-generational connection between themselves and the women in their families, but also between themselves and ‘all’ women of the past, which I refer to as the nostalgic imagination.

I defined nostalgic imagination as an imagined time invoked via ritual that locates individual experiences within an allegorical past when ‘all’ women supported each other, did not have to be taught about birth, and birthed naturally. It was purportedly a time where birth was instinctive, communal and birth knowledge was ‘inherent’. The point of using an ‘allegorical past’ is that it enables women to imagine “different configurations of the past, present and future in order to challenge the fixity of the past and the stifling authority of history – or particular versions of it” (Graham, 2012, p. 59). It also enables participants to pick and choose the aspects of the past that are relevant to the natural birthing ethos being celebrated.

For Boym, nostalgia is a “sentiment of loss and displacement, but it is also a romance with one’s own fantasy…of home and abroad, of past and present, of dream and everyday life” (Boym, 2007, p. 7). She argues that nostalgia emerges when the pace of modernisation is felt most strongly, and people search for the “slower rhythms of the past” (2007, p. 13). Similarly, Bowman (1995) contends that the yearning for traditions represents a kind of ‘soft-primitivism’, the alter-ego of urban industrialisation, and a
glorification of the rural, pre-industrial every-day life. Nostalgia for tradition is a fitting retreat from the risks and responsibilities of life in late modernity. As we are expected to understand, navigate, and take responsibility for science and technology, particularly on the journey of maternity services, there is, for some, disconnection from the affect of pregnancy and birth itself. It is this disconnection that nostalgia speaks to, as it acts as a means for women to re-embed themselves into a simpler time of community engagement and fewer institutional complexities.

Figure 9. Blessingway bead collection (Photo by Emily Burns)
Figure 10. Blessingway bead collection (Photo by Emily Burns)

Figure 11. Blessingway bead collection (Photo by Emily Burns)
Via the Blessingway, this imagined past includes the communities of women who gather to celebrate pregnancy and impending birth/new motherhood. The Blessingway can be aptly described as an ‘invented tradition’, defined by Hobsbawm and Rangers (1984, p. 1) as “a set of practices, normally governed by overtly or tacitly accepted rules and of a ritual or symbolic nature”. He goes on to argue that invented traditions are responses to novel situations and that participants are establishing their
own past via myth and symbolism. Participants engage in rituals like the Blessingway because they represent an attempt to structure some aspect of social life as unchanging, in spite of the constant change and innovation of the modern world (Hobsbawm & Rangers, 1984). Certainly, as Giddens (1994) would argue, individualisation means producing, performing and piecing together one’s biography. Now that individuals have more agency to construct their ‘life-stories’ than ever before, for many this may include engaging in practices which send them ‘back’ in time.

While ‘history’ is often used as a legitimiser of invented tradition, and works to cement cohesion between participants (Hobsbawm, 1984), the blessingway ritual is specifically ahistorical, though it is this ahistoricism that is the source of cohesion. Ahistoricism in the blessingway context implies an infinite relationship between women and childbirth throughout time and space. Participants consistently discussed ‘the past’ and ‘history’ as non-specific periods, much in the same way they spoke about ‘women’ and ‘birth’ as un-specific and unchanging concepts. Without having to clarify their specifically situated history, the nostalgic past is utopian, and imagination serves to disrupt any sense of the inevitability of the present (Graham, 2012). For life in reflexive modernity, there is only certainty in the uncertainty of our times, but nostalgia puts that uncertainty temporarily on hold, shifting the linearity of time backward, if only momentarily.

As women perform these place-based rituals and engage with nostalgia, they reimagine the home-space, albeit temporarily, as sacred. In More than Four Walls (Burns, 2015b, see Appendix 3) I discuss the shifts in meaning of home spaces as women renegotiate their relationships to place as a result of planning and having home births. Constructing sacred spaces at the time of birth has been researched elsewhere (Crowther, Smythe, & Spence, 2015), but much like other research on home birth, place is considered just a backdrop to the main event. For instance, Crowther (2013) argues that it is not the place of birth that is important, but the quality of the space at birth; she writes “the physical place merely provides a locality for felt space to open at the right time” (p. 22). I would argue the physical space is being undervalued here. Following Fannin (2003) and Prescott (2009), I argue for the importance of a spatial consideration of the birth environment as an integral means of understanding birth experience.
Indeed, I found that the sacredness of home-space is accumulated throughout pregnancy, particularly via the rituals discussed in this thesis. The sacrality of the home in this context is one that is in a constant state of transition parallel to the transitions experienced by the participants themselves. The transitions, from not pregnant to pregnant, to planning a home birth, to labouring and birthing, and into early motherhood as well as the excitement a new member of the family brings, renders the relationship to home space particularly dynamic. It is this dynamism, I argue, that makes it possible for the sacred to emerge. For the women I met in this research, the sacred home space is constructed by the rituals of the blessingway, and reinforced post-birth by those of the placenta.

4. Conclusion

This research has developed from the experience of being denied access to conduct research with a NRM during early fieldwork. The non-data of rejection is still a taboo in the social sciences, but in Burns (2015c) I argue that non-data is just as useful and important as ‘successful’ data. Reframing rejection as data can epistemologically transform the experience of rejection. Methodological reflexivity has succeeded in turning researchers’ lens inward to our own impact in the field, though this move has not adequately recognised professional rejection or failure.

As this research developed from rejection into ‘successful’ data collection with women choosing to birth at home, the focus on spirituality became a productive way to analyse the experience of childbirth at home. This overarching statement has contextualised spirituality and childbirth via an analysis of reflexive modernity as a framework for the cultural shift in the twentieth century that saw maternity services in this country echo the framework of individualisation. Home birth represents the coalescing of the simultaneous processes of individualisation of religious and spiritual beliefs and practices, and ongoing maternity services. It is a practice that highlights the role of a subjective and highly fluid spirituality for some childbearing women as well as the active search for resources and experiences outside of the grip of biomedicine.
Home birth acts as a powerful conceptual space through which to examine the experience of childbirth, one that is not dominated by medicalisation dictating birth practice. I suggest that individualisation has produced an ironic situation for the politics of medicalised childbirth in Australia. By propelling a ‘birth choices’ agenda, the individualised maternity services consumer is encouraged to do her own research, make informed decisions, and be an active participant in her provision of care, as well as take full responsibility for her and her baby’s health and wellbeing. As such, medicine comes under more public scrutiny than ever, and doctors’ decisions, hospital protocols and standards become questioned. Thus the individualised and fragmented approach of maternity services has actually helped to produce the kind of active and critical participation that has seen home birth increase in Australia in the last ten years, despite the anti-home birth positions of RANZCOG, the Australian Medical Association, and the media.

Just as biomedicine feared losing control of midwifery in the nineteenth century, and sought to legislate in order to dominate, so too is biomedicine today recognising the need to provide home birth options under the same levels of medical control enjoyed in the hospital, via publicly funded home birth programs. While I would certainly argue for the benefit of these programs, and their continued and extended availability, I also suggest they are potentially another attempt to control privately practising midwives and the ‘vocal minority’ of home birthing women.

Thus in a system now designed for women and mothers to take as much personal responsibility as possible, some women will view it in their best interests to stay away from hospitals entirely. Our precarious trust in science is also implicated here, as women question the certainty of medicine, and use alternative discourses to support and maintain their decisions and confidence. Spirituality is one such discourse.

As such, rather than a deification of biomedicine, birth itself is deified, and home is the sacred space chosen to express it. The rituals of the blessingway ceremony, the memorialisation of the placenta, as well as the renegotiation of home space constitute the spiritual discourse of childbirth at home. My findings offer an alternative relationship between birth, women and space, by highlighting that women engage with home birth practices in a spiritual way. Such an engagement leaves open the possibility
that childbearing can not only be *experienced* outside of medicalised hegemony, but can be *pedagogically reimagined* outside it as well. This pedagogy is enacted via the rituals discussed in this thesis. They are an alternative system of birth epistemology. By engaging in these rituals, the women in this research participate in changing the culture of childbirth knowledge and practice.

Figure 15. Three Blessingway bracelets *(Photo by Emily Burns)*
5. References


Davis-Floyd, R. (1994). The technocratic body; american childbirth as cultural expression. *Social Science medicine, 38*(8), 1125-1140.


Appendix 1 – Demographic Tables.

Below is the demographic information collected at the time of the interview, and include information on participant ethnicity, income, education, religion, age and marital status. All questions were optional, and those left unanswered are represented by NR (no response). Other category abbreviations are as follows: IM: Participants who engaged the services of an independent midwife (also known as privately practising midwives), FB: Participants who had a free birth, HP: Participants engaging the services of a hospital home birth program, and MD: Participants who were midwives or doulas.

Table 1. Participants country of birth

<table>
<thead>
<tr>
<th>Country of Birth</th>
<th>IM</th>
<th>FB</th>
<th>HP</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>30</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>NZ</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Singapore</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UK</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>PNG</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweden</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NR</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 2. Participants age range

<table>
<thead>
<tr>
<th>Age</th>
<th>IM</th>
<th>FB</th>
<th>HP</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26-35</td>
<td>22</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>36-45</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>46-55</td>
<td>0</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>NR</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 3. Participants estimated yearly household income

<table>
<thead>
<tr>
<th>Income</th>
<th>IM</th>
<th>FB</th>
<th>HP</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>u25</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-39</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-74</td>
<td>12</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>75-99</td>
<td>9</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>100+</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>NR</td>
<td>7</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 4. Participant self-identified religious affiliation

<table>
<thead>
<tr>
<th>Religion</th>
<th>IM</th>
<th>FB</th>
<th>HP</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>10</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Pagan</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mormon</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bahai</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no religion</td>
<td>23</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>NR</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 5. Highest level of completed education qualification

<table>
<thead>
<tr>
<th>Education</th>
<th>IM</th>
<th>FB</th>
<th>HP</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Undergraduate Degree</td>
<td>17</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Postgraduate Degree</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vocational Training/TAFE</td>
<td>9</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>NR</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>3</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>
Subject: RE: HREC Approval H7737
Date: Wednesday, 3 March 2010 3:07:28 pm Australian Eastern Daylight Time
From: Kay Buckley
To: Emily Burns, Cristina Rocha

Notification of Approval
3 March 2010

Email on behalf of the UWS Human Research Ethics Committee

Dear Emily and Cristina

I'm writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

TITLE: Home Birth Experiences in Australia

H7737 Student: Emily Burns (Supervisor: Cristina Rocha)

The Protocol Number for this project is H7737. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:

1) The approval will expire on 2 February 2012. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer prior to this date.

2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.

3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report

4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

Associate Professor Janette Perz
Chair, UWS Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC  NSW 1797
Tel: 02 47 360 883
Appendix 2 – Project Information for Participants

Centre for Cultural Research
University of Western Sydney
Parramatta Campus Building EM
Locked Bag 1797
Penrith South DC 1797
+61 2 96859600

Home Birth Experiences in Australia.

Participant Information Sheet

Thank you for your interest in participating in my PhD research! Before you decide to participate it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information and discuss it with others if you wish. If anything is unclear, or you would like any further information, do not hesitate to ask me, Emily Burns, and I can be reached via e-mail at emily.burns@uws.edu.au or via telephone on 0422685354.

What is this study?
I am doing my PhD on Australian home birth experiences, including free-birth experiences, specifically to explore individual and collective spirituality, and the idea of a woman-centered childbirth experience. As childbirth in Australia becomes increasingly medicalised, the possibility of an empowering birth experience without utilizing medical environments as the place of birth is of great interest to me.

Who is conducting this study?
I am the Primary Researcher for this study, under the supervision of Dr. Cristina Rocha, and Dr. Alphia Possamai-Inesedy. I have had two children, one in hospital and one at home, and I’m a strong advocate for home birth.

Who is funding this study?
This study is a PhD project, with the Centre for Cultural Research at the University of Western Sydney. The research is being funded by the University of Western Sydney.

Why have I been chosen?
You may be involved in this study because you are pregnant and planning a home or free birth, or have recently had a home or free birth. You may have also been chosen to
participate in the study by attending a pregnancy/home birth related event that I am attending as a participant observer.

You may also have been chosen to participate in the study because you are a midwife or doula who attends home births.

**Do I have to take part?**

Participation in the study is voluntary, and you may withdraw at any time, without any negative consequences.

**What does participation involve?**

There are two components of participation. The first involves interviews with women who are pregnant and planning a home or free birth. If you have already had a home or free birth, I would also love to hear your birth story. These interviews may take up to two hours, at a time and place convenient for you. The second component of participation is attending various events and/or ceremonies that may involve home and free birthing women, like a Blessingway. On these occasions I will participate in the event like a guest, but may take time to make some personal notes. I will only attend these events as an invited guest of the host, and only with every guest’s consent.

**Are there any risks?**

There are no foreseeable risks involved in participating in this research, though all participants will be given a counseling information sheet, with access to free and paid counseling services. Should you feel concerned about any part of this research, please contact me for further information. If you do not feel comfortable participating in this study, you may decline to participate or withdraw at any time, without any repercussions.

**Are there any benefits?**

While I cannot guarantee there will be any direct benefits to you, the study aims to raise awareness for the potential benefits associated with home and free-birth.

**Will the information I give be confidential?**

All interviews will be taped and remain my property. They will be transcribed, and each participant will be asked to review the transcription and acknowledge it as an accurate representation of the interview. While my supervisors may have access to the information provided, it will only be to maintain a high standard of analysis. All identifying information, including all names (including those of children, partners etc), dates, and places of reference will be removed or replaced with pseudonyms. No other person/persons will have access to information provided.

**How will my information be stored?**

Taped interviews will be stored on DVD disks (as DVD have significantly more storage space than CD), and will be transcribed. The transcribed interviews will be stored on a secured portable hard drive in a lockable filing cabinet, along with any hard-copies that may be necessary for analysis.

I’m a midwife/doula, will you ask questions about my clients?
No, the questions will relate to your own practices. You should maintain client confidentiality at all times, though if you do tell personal anecdotes in your interview, all identifying information will be removed.

**What will happen at the end of the study?**

The results obtained in this study will be published in academic journals and presented at conferences; however no published material will include any information identifying individual participants. A results summary will be provided to all participants at the completion of the study.

**What if I have a complaint?**

This study has been approved by the University of Western Sydney Human Research Ethics Committee. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Human Ethics Officer, nominated as Complaint Officer (phone (02) 4736 0883 or email humanethics@uws.edu.au). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

**Thank You**

Thank you for considering being a part of this study. If you have any questions, or would like any further information, please contact:

Emily Burns  
Email - emily.burns@uws.edu.au  
Office ph – 02 47360188  
Mobile ph – 0422685354

**Research Supervisors**

Dr. Cristina Rocha  
Email – c.rocha@uws.edu.au  
Office ph - (02) 9772 6368

Dr Alphia Possamai-INESEDY  
Email – alphia.possamai@uws.edu.au  
Office ph - (02) 9772 6321
Appendix 3 – Participant Consent Form

Centre for Cultural Research
University of Western Sydney
Parramatta Campus Building EM
Locked Bag 1797
Penrith South DC 1797
+61 2 96859600

Home Birth Experiences in Australia.

Participant Consent Form

I, ......................................................................., have been invited to participate in the above study, to be conducted by Emily Burns. I understand that Emily’s PhD supervisors, Dr. Cristina Rocha and Dr. Alphia Possamai-Inesedy may assist and/or have access to the information I provide.

My agreement is based on the understanding that this study looks at the extent to which spirituality is utilised in pregnancy and the home birth experience. I understand the interview process may take up to two hours.

I have received and read the attached ‘Participant Information Sheet’ and understand the general purposes, methods and demands of the study. I have also been made aware of possible negative impacts of this study, and have been provided with a counselling services brochure.

All of my questions have been answered to my satisfaction. I understand that the project may not be of direct benefit to me.

I understand that I can refuse to consent or withdraw from the study at any time without any further repercussions, and that I can be withdrawn by Emily Burns from this study at any time, and this will not affect my relationship with her, or the University of Western Sydney in any way.

I agree that research data gathered from me for the study may be published on the condition that I cannot be personally identified as a participant.

I hereby voluntarily consent and offer to take part in this study.

Signature (Participant)

Date:                               Participant’s Contact Telephone No.
Appendix 4 – Participant Photographic Release

Photograph Release Form

I, ______________________________________, do hereby give my permission for Emily Burns to use this photograph/s or photographic image/s in the production of her PhD research on home birth experiences in Australia. I understand this may also include published items such as journal articles and conference proceeds.

It is agreed that the use of this photograph or photographic image shall in no way be used in any other forum other than for the research and publication purposes of Emily Burns.

I hereby waive any right that I may have to inspect or approve the finished product and the written material which it accompanies. I have addressed any concerns I may have with regards to the use of this photograph or image with Emily Burns.

Executed on the (date) ________________________________

_______________________________
Signature

_______________________________
Contact phone number _____________________________________________
Appendix 5 – Participant counselling services information sheet

Centre for Cultural Research
University of Western Sydney
Parramatta Campus Building EM
Locked Bag 1797
Penrith South DC 1797
+61 2 96859600

Home Birth Experiences in Australia.

Counselling Services Information Sheet

Birthline Pregnancy Support Services Inc

www.birthline.org.au

1300 655 156 (local call costs)

Lifeline

www.lifeline.org.au

13 11 14 (local call costs)

My Health Matters

www.myhealthmatters.com.au

0414 985 280 (local call costs or go online for free call-back service)

Sydney Women’s Counseling Centre

By appointment only

www.womenscounselling.com.au

9718 1955 (local/STD call costs)
Subject: RE: HREC Approval H7737
Date: Wednesday, 3 March 2010 3:07:28 pm Australian Eastern Daylight Time
From: Kay Buckley
To: Emily Burns, Cristina Rocha

Notification of Approval
3 March 2010

Email on behalf of the UWS Human Research Ethics Committee

Dear Emily and Cristina,

I’m writing to advise you that the Human Research Ethics Committee has agreed to approve the project.

**TITLE:** Home Birth Experiences in Australia

**H7737 Student: Emily Burns (Supervisor: Cristina Rocha)**

The Protocol Number for this project is H7737. Please ensure that this number is quoted in all relevant correspondence and on all information sheets, consent forms and other project documentation.

Please note the following:

1) The approval will expire on **2 February 2012**. If you require an extension of approval beyond this period, please ensure that you notify the Human Ethics Officer prior to this date.

2) Please ensure that you notify the Human Ethics Officer of any future change to the research methodology, recruitment procedure, set of participants or research team.

3) If anything unexpected should occur while carrying out the research, please submit an Adverse Event Form to the Human Ethics Officer. This can be found at [http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report](http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report)

4) Once the project has been completed, a report on its ethical aspects must be submitted to the Human Ethics Officer. This can also be found at [http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report](http://www.uws.edu.au/research/researchers/ethics/human_ethics/human_ethics_adverse_eventend_of_project_report)

Finally, please contact the Human Ethics Officer, Kay Buckley on (02) 4736 0883 or at k.buckley@uws.edu.au if you require any further information.

The Committee wishes you well with your research.

Yours sincerely

Associate Professor Janette Perz
Chair, UWS Human Research Ethics Committee

Kay Buckley
Human Ethics Officer
University of Western Sydney
Locked Bag 1797, Penrith Sth DC NSW 1797
Tel: 02 47 360 883
More Than Clinical Waste? Placenta Rituals Among Australian Home-Birthing Women

Emily Burns

ABSTRACT
The discursive construction of the human placenta varies greatly between hospital and home-birthing contexts. The former, driven by medicolegal discourse, defines the placenta as clinical waste. Within this framework, the placenta is as much of an afterthought as it is considered the “afterbirth.” In home-birth practices, the placenta is constructed as a “special” and meaningful element of the childbirth experience. I demonstrate this using 51 in-depth interviews with women who were pregnant and planning home births in Australia or had recently had home births in Australia. Analysis of these interviews indicates that the discursive shift taking place in home-birth practices from the medicalized model translates into a richer understanding and appreciation of the placenta as a spiritual component of the childbirth experience. The practices discussed in this article include the burial of the placenta beneath a specifically chosen plant, consuming the placenta, and having a lotus birth, which refers to not cutting the umbilical cord after the birth of the child but allowing it to dry naturally and break of its own accord. By shifting focus away from the medicalized frames of reference in relation to the third stage of labor, the home-birthing women in this study have used the placenta in various rituals and ceremonies to spiritualize an aspect of birth that is usually overlooked.

The Journal of Perinatal Education, 23(1), 41–49, http://dx.doi.org/10.1891/1058-1243.23.1.41

Keywords: placenta, childbirth, hospital birth, home birth, childbirth education

A first kiss with your favorite boyfriend. That mmm in your belly feeling. That’s how it was for me—like ping, big electric thing . . . (participant quote, Edwards, 2005, p. 243)

The placenta is the active interface of the most biologically intimate connection between two living organisms. The human placenta connects a mother and her baby physically, metabolically, and immunologically. (Power & Schulkin, 2012, p. 1)

The placenta has been of medical interest since the pre-Socratic Greek philosophers (De Witt, 1959). As the opening quotes of this article suggest, the “definition” of the placenta depends on the particular discourse being employed. Experientially, it is an electric, sensual thing, and medically, it is an endocrine organ that acts as the transfer agent of oxygen and nutrients between a mother and her fetus. Around the world, various traditions, customs, rituals and beliefs surround the placenta, which are said to function as anxiety-releasing mechanisms, “restoring
In most western countries, the placenta is considered clinical waste and therefore given little to no attention at all.

the social and biological equilibrium disrupted by the birth process” (Davidson, 1985, p. 75). From being the sibling of the newborn (Long, 1963, p. 234), to part creator of the sun and the earth (Knapp van Bogaert & Ogunbanjo, 2008, p. 45), to “essential for travel by the soul of the deceased into the spirit world to rejoin ancestors,” as it is for the Hmong (Helsel & Mochel, 2002, p. 282), the placenta is a powerful element of childbirth throughout the world.

Social research on placentas is limited, and that which is available is midwifery practice-oriented (Bastien, 2004; Fahy et al., 2010; Fry, 2007) or historical (De Witt, 1959; Long, 1963). This may be because in most western countries, the placenta is considered clinical waste and therefore given little to no attention at all (Birdsong, 1998; Callaghan, 2007).

This construction of the placenta as clinical waste, however, is symptomatic of a broader understanding of childbirth within a biomedical discursive framework, similar to that found in the United Kingdom and the United States (Hillier, 2003). Medical language “dominates and constricts perception of the birth process . . . uterine contractility and cervical dilation are often discussed as if they occurred on a laboratory bench rather than in a woman’s body” (Kitzinger, 2005). Within this framework, pregnancy is defined as pathological—a clinical crisis worthy of active intervention (Cahill, 2001; Freund, McGuire, & Podhurst, 2003), resulting in the categorization of women in terms of risk (Possamai-Inesedy, 2006). It should come as no surprise then that the third stage of labor (the birth of the placenta) is actively managed, as recommended by the Australia Department of Health, unless the laboring woman gives informed refusal (Fahy et al., 2010). Active management refers to an injection of Syntocinon into the laboring woman’s thigh to speed the birth of the placenta.

One of the ways the placenta is understood within this medicalized context is as an extension of the “mess” or “dirt” (Callaghan, 2007) of childbirth, a mess that must be contained to maintain the sterile environment of the hospital. Within the hospital system, the blood, amniotic fluid, and other bodily “waste” products of childbirth are not considered to have any value outside the body and indeed once they are outside the body, take on contamination status (Callaghan, 2007). Within a medical context the placenta is akin to dirt, defined by Douglas (1966/2002) as “matter out of place,” the idea of which “is compounded of two things, care for hygiene and respect for conventions” (Douglas, 1966/1995; p. 8). The conventions at play here include hospital protocol for the management of contaminated items and indeed the very definition of contaminated.

The Australian legislation on the placenta is ambiguous. The recent national guidelines set up by the National Health and Medical Research Council (1999) explicitly referred to human tissue from childbirth, and recommended incineration as primary means of disposal, but fell short of specifying the placenta in this category. These guidelines were rescinded in 2005 and were not replaced, leaving no national waste guidelines in place. Each hospital has its own set of guidelines and protocols for managing clinical waste, although the Australian standard on which most current hospital policy is based refers to the placenta as human waste, but when discussing how to implement the standard notes cultural, religious, and spiritual sensitivity should be recognized as part of the “patient needs” regarding disposal. As such, should a woman wish to take her placenta home, she may do so; however, it is double-wrapped in clinical waste bags and placed in a sealed container which is not to be opened on hospital premises. Callaghan (2007) notes that the symbolism of the clinical waste bag used for the placenta “ . . . with its official label, the Health Department and the medical profession through the actions of the midwives, are demonstrating their power by shaping the communities world view of the placenta” (p. 15).

A major Australian hospital, The Royal Women’s Hospital in Victoria, has a fact sheet on their website (The Royal Women’s Hospital, 2013), designed specifically for women wanting to take their placenta home for burial, which is itself indicative of the increasing popularity of at-home placental practices. Should a woman who has birthed in a hospital setting want to take her placenta home, a placenta release form needs to be signed, which includes criteria for safe burial practices designed to minimize the spreading of bacteria. There is also an instruction on these forms to contact local councils upon returning
home, so further advice can be given on local rules and regulations regarding the burial of clinical waste.

The discursive construction of the placenta as human or clinical waste in hospital environments contrasts starkly with the findings from my research with Australian home-birthing women. The placenta was overwhelmingly spoken of as having important meaning beyond its physiology, becoming a site for spiritual reflection. Medical discourse was rarely employed in these narratives. Instead, the placenta was understood in alternative ways which constructs it as a useful and ultimately integral part of the birthing experience.

METHODS
The interviews for this research took place between May and August of 2010, during which period, I conducted 54 interviews across the Australian states of Queensland, New South Wales, and Victoria. A National Ethics Application Form was submitted to the University of Western Sydney and approved by the appropriate review board. Participants were recruited through an invitation posted on various Australian-based childbirth forums, and snowball sampling occurred from there. Participants were women who were at the time of interview pregnant and planning a home birth or women who had had a home birth in the last 3 years. The category of home birth included women who were hiring or had hired an independent midwife, women using publically funded hospital home-birth programs, and women choosing to free birth or birth unassisted—that is, birth at home without a midwife present. For this research, 45 women had hired an independent midwife, 3 had free births, and 6 used hospital programs. Out of the 54 participants, 40 women had two or more children, and had birthed in hospitals previous to their home births, and of these, 6 had had previous cesarean surgeries.

RESULTS
The three placenta rituals presented in this article are placenta burial, placentophagy (eating or consuming the placenta), and lotus birth (leaving the umbilical cord attached until it dries and comes away from the baby naturally). Of the 54 participants, 15 were pregnant and planning a home birth at the time of our interview. When I asked them about their plans for their placentas, 11 planned to bury it, 2 planned a lotus birth, 1 planned to consume it, and 1 did not know what to do. Of the 39 participants who had already had a home birth, 30 buried it, 3 had a lotus birth (two of which were later dried and buried, and 1 was later consumed), 3 consumed it, 2 gave it to their midwives, and 1 could not remember.

A common theme of hospital narratives involving the placenta was a sense of loss some women felt when it came to the placenta, and their missed opportunity to respect or honor it in some way. Tania, who has two children, the first born via cesarean surgery and the second born at home, spoke about sharing her home-birthed baby’s placenta with her older child:

*I don't have [baby girl’s] because she was a cesarean and they just threw it away so I am going to give half to [baby girl] and half to her.*

That Tania could use the home-birthed placenta to reconcile the loss of her first one indicates the potential healing possibilities offered by acknowledging the placenta as more than clinical waste. Perhaps had Tania and women like her been given more of an opportunity to reflect on, or keep their placentas, at least one element to their hospital births could have been improved.

Other women, however, showed little or no interest in their placentas in hospital settings, emphasized by Adele, who at the time of our interview had a previous cesarean surgery and was pregnant and planning a home birth. She said,

*[That] placenta’s gone but you know what? I had no attachment with that placenta. When I was pregnant with him, I was extremely mainstream and I didn’t, it was gone, I never saw it so it wasn’t a big deal, you know? I didn’t know what I was missing so it didn’t matter to me.*

Adele and Tania represent two ends of the spectrum of placental attitudes. However, what they highlight is that in hindsight, the placenta mattered. Adele told me of plans to bury her new baby’s placenta under a fruit tree in her garden, to honor its importance.

In home-birth settings, all decisions about the birth are made by the birthing woman and her support network. In the home, there is no preexisting “placenta protocol,” so the woman needs to make a decision about what happens to the placenta. All of
All participants who spoke about placenta burial chose a specific tree or shrub in their yard or bought a specific tree or shrub for it, usually fruit bearing.

the pregnant women I interviewed spoke about their plans for the placenta, even if it was only to store it in a container in their freezer until they made up their minds about what to do. No participants said they intended to throw it in the bin, although some did say they gave it to their midwife who then used it as education material in childbirth education classes, recycled it into placenta pills for other women, or used it in their compost.

**PLACENTA BURIAL.**
The burial of the placenta is by far the most common use of the organ. All participants who spoke about placenta burial chose a specific tree or shrub in their yard or bought a specific tree or shrub for it, usually fruit bearing. The actual burial was considered an occasion to ceremonially birth in some way, even if few people were present. Many women spoke of the burial as a completion of the birthing journey, as the final act of birth.

Amali lives in Queensland and has three children, the third being born at home. At the time of our interview, her son was about 9 months old, and his placenta was still in a container in the freezer. I asked her if she was keeping it for any particular reason, and she said,

I'm going to bury it or invite some women that I love and trust and do a ceremony to complete my birthing, like a ritual around ending my birthing journey and completing that so that I can move on and start the new phase of my life now that I'm not going to [be] birthing any more babies and feeding babies which is quite a hard thing to come to terms with if you love birth like I do . . . It's a ritual. And it's giving it back to the earth you know with my participation, so I feel that that's respectful to the process for my baby and for me is to say something and mark it somehow, and it's such a connected thing I guess with that nurturing and nourishing element of the placenta. It's a life giving thing, so giving it back to the earth feels symbolic in some way. Its sits better inside me.

Organic discourse featured strongly in burial narratives, with statements such as “giving back to the earth” common conceptualizations of placenta burial. This idea draws on an ecological consciousness common in the home-birthing ethos, which includes natural birth, natural parenting, and an awareness of our environmental impact. The burial not only represented an end to the birthing cycle and the final separation between the child and her mother’s body but also, for some, a separation between the woman and childbearing itself.

The theme of respecting and honoring the placenta emerged from many of the stories as well. Wendy had three children, the second and third born at home, and although her youngest child’s placenta was still in the freezer, her second baby had his buried beneath a mandarin tree in the backyard. I asked if there was a reason she chose to bury it, and she said,

I think after giving birth there’s—as wonderful as the new baby is and all these new beginnings—there's also an ending to the pregnancy, and it's such a special time, I think for a woman's life, but I wanted to do something for myself to mark the end of the pregnancy. I wanted to honor the pregnancy in itself. I remember reading somewhere that with the birth of the baby that's in your arms is a loss of the dreamt of baby in the womb because who this person might be and all the journey from conception to birth. I wanted to do something to honor that and that's what appealed to me about keeping the placenta was that it was the shared connection with my baby at that time and it’s unique; it’s the only time you share your physical body with someone in that sense. We like the idea of planting it too as a symbol of new life and nurturing you know to nurture the baby, and now it’s nurturing our fruit trees. And we choose fruit trees because they bear fruit or that reason . . .

Referring to burial as a sign of respect for the organ that nourished your baby was a repeated theme in many of the interviews and echoes research on ecologically conscious burial on the whole (Feagan, 2007). This also reflects research done on the importance of burial rituals in miscarriage experiences (Brin, 2004) and the legitimizing function of burial in the grieving process (Kuller & Katz, 1994). The personified placenta deserves respect, as Amali said,

I think it deserves more respect than that—you know, it's an incredible thing. It kept my baby alive and me. It allowed that relationship to occur between
me, my body, and my baby. I don’t know. I just feel a sense of connection to it; like the thought of putting it in a plastic bag right now and throwing it into my wheelie bin is just, I don’t really understand why. It’s just a feeling like I just cannot bear that thought . . . I just can’t, and I guess that’s why so many women have them in their freezers because instinctively, it just feels dishonorable or it’s not giving it or not respecting it. It was part of us, my body and my baby.

The tree or shrub chosen was commonly fruit bearing, specifically so the placenta could contribute to the nourishment of food that would in turn nourish the family. Native plants, such as Wollemi Pines, were also common. Helen, an independent midwife and mother of four home-birthed children, spoke about choice of plant:

I liked the idea of giving life to something that then she could then still see, so it’s a Mulberry bush that we planted on it, so that placenta that had given her life could then be feed to give life to something else that still bears fruit and continue to nourish her.

Burial of the placenta is commonplace among cultures throughout the world. From Maori customs (Cairns, 2005; Panelli & Tipa, 2007), Samoan rites (Avegalio, 2009) or Navajo (Schwartz, 2009), home-birth placenta burial draws on a wealth of cultural discourse that constructs the placenta as an important and meaningful part of childbearing.

The discursive link between placenta burial and death is particularly strong and connects to discourses of memorialization, highlighted by the deliberate choosing of plants. Davies (2002) notes that “physical death is such a powerful force in human experience that it has been extensively employed as a symbol for other cultural events” (p. 145). The burial becomes a memorial, also common in the human bereavement experiences (Vale-Taylor, 2009). The placenta becomes a personified, embodied part of childbirth, symbolizing the links between women, childbirth, and nature (Klassen, 2001; Mansfield, 2008) and also the relationship between childbirth and spirituality (Callister & Khalaf, 2010; Hall, 2002) and the spiritual link between birth, death, and the unborn (Hall, 2004, 2006, 2010).

Lotus Birth

Lotus birth refers to the practice of not severing the umbilical cord after the birth of the baby. The cord is left intact, the placenta is generally wrapped in something breathable such as a cotton piece of fabric, and kept on or near the baby until the cord dries and breaks on its own. Although most participants went on to bury the placentas once they had come away from the baby, some continued to dry them and have kept them. The reasons to have a lotus birth vary slightly, but generally, it is because of a perceived spiritual connection between the baby and the placenta (Buckley, 2002). Lotus birth is very rare in hospital settings (Hanel & Ahmed, 2009). Elenor, a doula and mother of two home-birthed babies, practiced lotus birth for both of her children, and she tells me of the first time she saw a lotus birth as a doula to her friend:

I actually had a lotus birth with my babies, and I thought it was the weirdest thing to have a lotus birth but then I went to [friend’s] birth and I saw that she didn’t cut the cord, and I thought that feels right anyway she didn’t, and you know, her friend washed the placenta, we salted it and put it in a bag, and she pretty much carried it around.

Commonly, lotus birth is seen as the baby’s right and that to cut the cord is to take control over something that is not yours. Brook said,

. . . for me, it just felt it would be her decision to let go of her placenta because it isn’t mine; it’s hers and I’d rather she had the choice than have it cut.

Cassandra echoes this sentiment:

I heard babies can play with their placenta and the umbilical cord inside the womb and it’s their source of comfort and familiarity. So I felt like it was gentle and respectful to let that be the next transition rather than say right, we’re going do this now. I just, I couldn’t stand the thought of scissors cutting something so beautiful and connecting us, and I felt like there could be grieving from the baby and a grieving from me . . .

The placenta is seen as having such an important role in pregnancy that the natural drying of the cord and its eventual breaking is seen as the baby letting
The placenta was consumed primarily via dehydrating it, and grinding it into a powder, and put into capsules to be taken when energy was low.

Marcia cooked her child’s placenta using traditional Chinese medicine:

. . . so it was steamed with chillies, and I can’t remember now, but it was with chillies and things and then it was dried out and then crushed up and I just put it in some gelatin tablets and I took them; I started off with three times a day, and then I think by the time he was 6 weeks, I was down to one a day . . . I still had them right up to 10 months ‘cause I would just take them. Yeah because you don’t need a lot, you only need a little bit . . . I [would] just take it if I was sick or if I was run down or if I was feeling really overwhelmed, so I went back on them.

Cassandra recalled how much of an energy boost eating her son’s placenta gave her:

I actually kept some of the placenta, and I was eating it for about a fortnight. Which some family members found it really confronting that we had a lotus birth and I ate the placenta. But it felt right for me, and I felt that’s what animals do, they eat the placenta, it’s a natural thing and its full of nutrients, of zinc and iron, and I had to stop having it because I mixed it in up into fruit and nut smoothies, I had to stop taking it at night because I was just buzzing.

Although Cassandra makes the connection between nature and animals and eating the placenta, she was the only participant to do so because usually these references were used when discussing burial or the desire to do something respectful with the placenta. Many participants spoke about the healing qualities of the placenta, and I learned about several ways to prepare it for consumption. Some women put it into a food dehydrator and dried it out, then crushed it into a powder and put it into empty capsules you can buy from the health food store and took them like that. Others semi-froze it and then cut it into capsule-size pieces and froze them and took the frozen pieces like capsules as they needed them. Others froze chunks like Cas-
The bulk of our current knowledge of the placenta remains discursively in our technological birthing culture. This research strongly suggests a gap between what we know about the placenta and its biological functions and how the placenta is experienced by the women in this study. The stark contrasts between these discursive constructions offer the possibility that the hospital protocol may not be the only effective way of “dealing” with the placenta. The medical view of the placenta as clinical waste, however, is not something that policy alone will necessarily change because the compounding of the placenta as the clinical waste “afterbirth” requires an ideological shift.

What this research indicates is the possibility of conceiving of placenta decision making outside the confines of medicalization and clinical waste. Within much medical policy, there is little room to conceive of possibilities of difference. The women participating in placental rituals in the home-birth setting represent such difference and as such highlight the tension between women’s bodies and the treatment of these bodies through the medicalization of childbirth. None of the rituals presented in these findings are limited to home-birth practices, and women in all birth settings may find placenta rituals an enriching addition to their birth experience. Further research on placentas in hospital settings would further strengthen our knowledge of this part of the birth process. As yet there is research on how the third stage occurs (Fahy et al., 2010; Fry, 2007; Gyte, 1994), although the placenta is rarely discussed beyond this.

The implications for childbirth education include the facilitation of placenta treatment options that are not disposal-focused. By presenting suggestions that offer the possibility of a spiritual connection to the placenta, there is great potential for the third stage of labor to be a meaningful component of labor, birth, and the postpartum period. Many women may choose to leave their placentas behind, to be incinerated in accordance with hospital policy. Some, however, may not have known they had a choice to make an active decision. As one of the first and most trusted childbirth resources pregnant women encounter, childbirth education is a prime

The placenta is a key site of spiritual meaning for some birthing women, embodying the link between woman, child, and transformation of pregnancy and birth.
opportunity for the facilitation of placenta talk that can move beyond the usual medical boundaries and consider alternatives for the often overlooked third stage of labor.

In the home-birth setting, the symbolic value of rituals associated with the placenta suggests a rich insight into the potential for this organ to be more than a site of contamination. Placentas are an integral element of the home-birth experience, in part because it is the woman and her family who are required to make the decisions surrounding it. Whether it is consumed, buried, or left intact to separate from the infant naturally, the placenta in a home-birth setting offers an alternative to the dominant biomedical framework that positions it as clinical waste. The women in this study have created alternative ways of knowing and appreciating their bodies and what comes from them, and this has far reaching implications for women in all birth settings, including the majority of women who birth within the hospital system.

REFERENCES


Vale-Taylor, P. (2009). “We will remember them”: A mixed-methods study to explore which post-funeral remembrance activities are most significant and important to bereaved people living with loss, and why those particular activities are chosen. *Palliative Medicine*, 23(6), 537–544.

EMILY BURNS is a PhD candidate at the University of Western Sydney, Australia.
The Blessingway Ceremony: Ritual, Nostalgic Imagination and Feminist Spirituality

Emily Burns

Abstract There is an increasing interest in the role of spirituality on the experience of health, wellness and illness, as well as the role of spiritual practice in health care provision. For pregnancy and childbirth, this focus has tended to concentrate on hospital birth settings and care, and religious forms of spirituality. The blessingway ceremony can be described as an alternative baby shower, popular with home-birthing women. Its focus is woman-centred and draws on the power of ritual to evoke a spiritual experience for the pregnant host and her guests. This spirituality is experienced as a strong connection between women, their relationship with ‘nature’, and forged via the nostalgic imagination of women through time and space. This article will draw on data obtained in 2010 during doctoral fieldwork with 52 home-birthing women across eastern Australia and will examine the blessingway ceremony and its significance as a site of potential spiritual empowerment for pregnant and birthing women.

Keywords Birth · Homebirth · Blessingway · Ritual · Spirituality · New age

Introduction

The importance of spirituality and childbirth ‘...should be considered as important as biophysical and psychosocial correlates and predictors of perinatal health’ (Jesse and Reed 2004, p 740). Many women find a depth of spiritual meaning in their pregnancy and birth experiences (Balin 1988; Moloney 2006; Hall 2004, 2006; Stockley 1986; Callister et al. 2002; Hall 2002; Taylor 2002; Possamai-Inesedy 2009), including those who participate in unconventional means of expressing this spirituality (Burns 2014). For health care providers, a greater understanding of the kinds of spiritual practices that women engage into
gain a spiritual awareness of their experience should be part of the cultural sensitivity that is a standard consideration in much health care practice.

While doing fieldwork for a larger project on home-birth experiences in Australia in 2010, I heard many beautiful stories about the blessingway. It was described to me as a kind of alternative baby shower, rich in spiritual significance. At a blessingway, there are rarely gifts exchanged and rarely are there light-hearted games that are both common at baby showers. While a baby shower generally involves a gathering of women to celebrate the pending birth of a baby, the blessingway was described as a ceremony that spiritually celebrates the beginning of motherhood. During one of the interviews, I saw an invitation to a blessingway that included a brief description of the blessingway as a Navajo ceremony, which ‘blesses the way’ for the mother-to-be. I now know that while the name blessingway does indeed come from a Navajo tradition, the similarities end there.

A Navajo historian, Wyman (1970) writes that the blessingway is a system of chants and songs, considered to be the backbone of all Navajo ceremonies and rituals. These are not restricted to pregnancy and/or childbearing, but rather cover many aspects of domestic life. These songs and prayers are invoked for any number of transitional life phases, which require blessing, including marriage, adolescence, weddings, new homes, and childbirth. Others have noted that the customary purpose of the Navajo blessingway is ‘to restore an individual to a harmonious relationship with the physical, social and psychological worlds’ (Frisbie and McAllester 1978, p 1).

It is not my intention here to unproblematically accept the use of the blessingway name; as scholars like Sheridan-Jonah (2010) warn, taking a blasé attitude to cultural appropriation only further silences already marginalised communities. While the popular literature and online information (Cortlund et al. 2006; Maser 2004; Stewart 2006; Winder 2002–2012; Palmer et al. 2005; BubHub 2012) on blessingways acknowledge the name comes from the Navajo tradition, the borrowing falls short of appropriation by not taking on any aspect of the Navajo tradition itself, thereby not claiming or contesting ownership. Despite not claiming ownership, however, the appropriation of cultural practices remains a highly contested area of cultural exchange (Owen 2008).

Rather than cultural appropriation then, the incorporation of the Navajo name reflects a broader trend of new-age cultural consumption (Possamaï 2002; Welch 2002). This trend sees new-age believers and practitioners as subjectively creating a personal spirituality based on various ideas, mythologies, histories and cultures that revive perceptions of ancient spiritual wisdom (Hanegraaff 1998; Hammer 2001). This goes some way to explain the presence of the blessingway among women who may or may not identify as spiritual or religious, but incorporate this practice as a way of heightening the spiritual experience of pregnancy and childbirth. The blessingway then may be situated within the ‘free market’ of new-age spiritual practice in Australia and the growing diversity of alternative spiritual practices that do not necessarily conform to any particular set of spiritual or religious beliefs (Hughes et al. 2008; Bouma 2006).

While I cannot trace the use of the name blessingway in the home-birth context to one particular moment, I would argue that, because of the Navajo connection, it originated in the USA and, via the growth of the internet as an ‘information highway’, has disseminated from there. This positions the blessingway as an alternative baby shower as a relatively recent phenomenon.

This article will begin with a working definition of a blessingway, as discussed by the participants, primarily in relation to the more popular baby shower. The baby shower was a common theme when women explained what the blessingway was not. I will then discuss the focus on women explicit to the practice, moving onto the importance of ritual, outlining
three of the most common rituals performed. The creation of sacred space and the use of
the nostalgic imagination will then be discussed. This article will illustrate that the
blessingway contributes to an increasing interest in the spiritual discourses of pregnancy
and birth, contributing to the wider interest in the role of spirituality in health care.

Methodology

The data presented in this paper were obtained in 2010, across the eastern Australian states
of Queensland, New South Wales and Victoria. Participants were either planning a home
birth for a current pregnancy, had had a home birth within 3 years of our interview, or were
practicing doulas or independent midwives. In Australia, home births can be achieved in
three distinct ways. Firstly, a pregnant woman may give birth unassisted, that is, without
the assistance of a midwife, obstetrician, or any childbirth professional. This is referred to
as unassisted childbirth, or free birth. Secondly, she may hire an independent midwife, for
a fee of between $3,000AUD and $5,000AUD. This midwife will usually oversee all
antenatal care, will attend the birth, and provide postnatal care as well. Thirdly, depending
on the geographical location of the pregnant woman, she may be eligible to participate in a
publically funded hospital home-birth programme, operating in some hospitals around
Australia since 2009.

Once appropriate ethical approval was sought and granted, participants were recruited
using online parenting and childbirth forums, and snowball sampling occurred from there.
Semi-structured, face-to-face interviews were conducted, ranging between 1 and 3 h each.
I invited each participant to tell me the stories of her homebirth and/or pregnancies.

Of the 52 women in this study who had had recent home births or were pregnant and
planning one, 30 had or were planning a blessingway while pregnant, 8 expressed regret
for not having had one, and said they would, were they to have more children, 1 had a
traditional baby shower, and 13 did not have a blessingway or a baby shower, and either
were not planning more children or did not express a desire to have one in the future at all.
Demographic data were collected at the beginning of each interview, including any
spiritual of religious affiliation participants had. Participants were asked if they affiliated
with any particular religion, and the below table summarises the responses to this, in
relation to and their blessingway participation (Table 1).

<table>
<thead>
<tr>
<th>Religions</th>
<th>Had/Planning blessingway</th>
<th>No blessingway</th>
<th>Regretted no blessingway</th>
<th>Baby shower</th>
</tr>
</thead>
<tbody>
<tr>
<td>No religion</td>
<td>16</td>
<td>8</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Christian</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ba’hai</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mormon</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pagan</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>13</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>
The Anti-Baby Shower

One of the principle ways blessingways were described was by comparison with the more traditional baby shower. All participants, regardless of whether they had a blessingway or not, spoke derisively of baby showers as consumerist, superficial and baby-focused. Of the women who did not have a blessingway, baby showers were not an appealing substitute. Baby showers were discussed as a particularly ‘mainstream’ way to celebrate pregnancy and childbirth. Indeed, those who did not have blessingways often cited their more ‘mainstream’ friends and family as their reason why. One such participant was Ruth, who was pregnant with her second child, her first born in hospital. Ruth was planning her home birth using a publically funded local hospital programme when we met. After deciding to plan a home birth, she found information on the internet and discovered blessingways. She mentioned she went to a blessingway for a friend, and I asked if it was something she had considered for herself, she said

I just sort of considered having a blessingway because I love the idea of the support and encouragement that comes with that but I don’t really think many of my friends, family or whatever would really be into it, so I haven’t really worried about it…I think the concept sounds really nice, but it only works if the people that you’re with are receptive to that and I think, I don’t really think mine are because they’re practical and that sort of thing.

Similarly, Suzanne for example, a mother of two children and pregnant with her third, also using a hospital programme, said she had heard of blessingways and liked the idea, but said ‘it’s just not who I am’. Despite no one in this hospital group having a blessingway while pregnant, there is, however, a conceptual consensus of what the blessingway is, and a reflection on how well their friends and family would respond to that.

Almost all participants noted a general disdain for baby showers. One such respondent was Diane, a mother of two children, her second born at home with an independent midwife, and planning the birth of her third with the same midwife when we met said,

I’ve never had a baby shower. I hate things with any sort of attention. I can’t think of anything more horrifying than having a blessingway.

Carol, a mother of four, her fourth child recently born at home with an independent midwife when we met said,

Baby showers aren’t really my kind of thing. I love the idea of blessingways and such and most of my friends will never have heard of a blessing way let alone be able to organize one or appreciated the significance…I just like the spirituality. I just love the fact that it’s a gathering…And to have the strength, the knowledge and the wishes and thoughts of the people around you, who care about you and your baby, and want nothing but the best, that just seems to be a very special celebration, rather than just playing games and giving presents. That just doesn’t appeal to me, personally.

Only one participant had a planned baby shower. Molly, a mother of three, who home-birthed her third child with an independent midwife had a baby shower thrown for her by her friends, she told me

I ended up having a baby shower because my friends [said] “a blessingway sounds really stupid, why would you do that? That’s really stupid” So I ended up having a
baby shower, which was alright, I tried to ask them to not bother with presents and all that, but they went all out. It wasn’t what I was after, but they couldn’t understand...It was just the normal silly games and stuff, and not getting a chance to spend time with all women, and getting to honour it all. I’ve been to plenty of blessingways since I’ve had [third child]. All the women sitting around, who honour births, and respect birth, and are able to discuss it openly and honestly. Being able to respect the woman who’s going to birth soon, and her wishes and all that, there’s something special about all that.

Baby showers were spoken of by all with at least a small degree negativity, a common theme in talk about baby showers was the understanding of them as baby, gift and game focused, echoing research by Fischer and Gainer (1993), compared with blessingways, which are perceived as woman and birth focused. In this way, the baby shower mirrors Davis-Floyd’s [1993], (2008) analysis of technocratic birth cultures, where the focus is on the baby. The blessingway, on the other hand, was spoken of as a way to honour and nourish the pregnant woman and make her feel special and loved.

Myra, a mother of three children, her first and third born unassisted at home, her second in hospital, said,

There’re no gifts [at a blessingway]. Like the gift is the bead and the blessing and being together...You can’t give more than yourself... all these gifts might be useful—they’re really easy to give—but having to think about a picture or a poem or some words, that takes a lot more energy.

Similarly Ruby, a mother of four, her fourth born at home with an independent midwife and a practising doula said,

God I hate [baby showers]—they’re so consumeristic and it’s all about the baby—I think that’s one of the reasons I dislike them so much, it’s all about the baby and it’s not about the mother at all and I think that’s what the blessingway is, it’s all about the mother, which is what it should be about. I think the baby showers become about the baby... yeah it just emphasizes I guess that it’s all about having a healthy baby and not about what the mother goes through to get that...I think at a blessingway—that’s why it’s different because it’s about the mother. It’s celebrating the mother and supporting the mother rather than the baby shower which is really just ignoring the mother’s role in the whole process.

The point Ruby makes about the blessingway being for the pregnant woman, rather than for the child, was echoed by others as well. Shari, a mother of four home-birthed children using independent midwives, and also a doula, said

[The blessingway is] much more grounded and earthier I think than some of the more conservative baby showers where people bring gifts and everything, but there’s nothing real, there’s no real depth to it, no real acknowledgement of the mother. I found it really empowering and acknowledging that just everyone was there you know, wishing the best for me and my baby, you know saying words from their heart in the hopes that everything will go well, just that encouragement and support which was really great. The lighting of candles and just a real spiritual essence energy to it, just beautiful. There’s just nothing like it.

This brings the spiritual comparison between blessingways and baby showers to the fore, which is perhaps the most important distinction between the two ceremonies for these
participants. Blessingways appear to confirm the connection between women, birth and spirituality, while baby showers do not foster that connection and focus rather on light-hearted fun.

**Secret Women’s Business**

Specifically gendered ‘energies’ were a common theme in blessingway narratives. Blessingways were almost exclusively women-only events, with the only exception being the young sons of guests. Only one participant invited couples/families to her blessingway; however, it was made clear during the gathering that the men would go outside and the women would start the ceremony inside, with privacy.

Of all the women who spoke of having had, or having been to, or wanting a blessingway, all of them said it was for women only. The reasons for this were similar to those of Genevieve, a mother of three children, who was telling me about the pregnancy of her third child, and first homebirth with an independent midwife. She said:

I actually think the process of what happens to a woman’s body during pregnancy and birth is a female domain. I do think it’s nice to have our partners with us these days, but to me I just think, this pregnancy I really got in touch with that importance of femininity and female friends, and I sort of got back in touch with some women in my life… and I just really [felt] how important women are to me. Yeah, we should just be celebrating our femininity and how wonderful womanhood is and these beautiful things that only we get to experience.

Similarly, Rosemarie, a mother of four, her first child born in hospital and her next three born at home with an independent midwife said

I think dads needs to have themselves as their own support, and I think it’s just one of those occasions where, as awesome as my husband has been in my labours or whatever, he knows as much as I know that he understands in a different way than I do, and obviously his experience isn’t anything like my experience, so to have the blessing way, yeah we decided to sort of separate the sexes. I think these days where there’s so much in our society about men and women being equal and sharing every role and doing everything that the other can do and all of this thing, birth is one of those times where no matter what you say or how hard you try the guys and girls are never on the same plane, they never can be. So I think it’s good for men to support each other and for women to support each other.

When I met Bettina, she was pregnant with her first child and planning a home birth with an independent midwife, and her blessingway had been the week before our interview. When I asked who she had invited to her blessingway, she said

I wanted that feminine energy. I’ve got some absolutely beautiful men in my life, but I just wanted an afternoon of feminine energy around, and mothering energy around, and that felt really right.

Differentiating spiritual energy in this way leads to an essentialised understanding of the female body. ‘Woman’, then, becomes a unified, ahistorical category. While it can be argued that this is a unified category that the white, middle-class participants can afford to identify with, it also serves the unspecified ‘past’ that makes up the nostalgic imagination. Discourses of female bonding and a mythology of birth spirituality were constantly drawn
on in blessingway narratives. For Levi-Strauss, mythology appeals to our group instinct and makes us aware of our roots in society (1964, p 28). It is this group instinct that the blessingway cultivates, and its rituals reinforce.

Ritual

There are many rituals that shape the blessingway, and while I heard about many, the three most common that came from the respondents were the matrilineal introductions, wrist weaving, and bead threading. Other rituals include belly plaster-casting, creation of birth altars, pampering such as foot massages or hair brushing, sage smudging, and painting henna designs on the pregnant woman’s belly. The ‘laying on of hands’ ritual involves the pregnant woman laying/sitting down and the guests are invited to put their hands on her, and channel positive, loving energy into her through the power of touch, for her to draw on for strength during her labour.

The three rituals outlined below were the most common, occurring in almost all of the blessingway narratives, as well as stories about other blessingways the women had been to, heard or read about.

Matrilineal Introductions

This ritual usually occurs at the beginning of the blessingway and acts as a way for the women to introduce themselves to each other. Each guest takes turns saying who she is the mother of (if anyone), and then who she is daughter of, then granddaughter of, going as far back in her maternal line as she is able. If this is not possible, she may say ‘sister of’, ‘niece of’, etc. The purpose is to emphasise one’s position as one of the women in your family, rather than listing the extent of your family lineage. Matrilineal introductions invite female ancestors to be spiritually present at the ceremony. Rosemarie said

We did a maternal introduction because not all my family and friends knew each other and I wanted to do something. To connect with all the ancestors who had been mothers and birthed before us.

The focus and honour extended to female ancestors is one of the features of matrifocal religion (Sered 1994). While the other features of matrifocal religion do not necessarily apply to the practices of the blessingway, I identify them here as matrifocal spirituality. Matrifocal spirituality relies heavily upon ritual and, in this case, the production of the nostalgic imagination, a key theme in blessingways, to be discussed in more detail further in this article.

Wrist Weaving

This ritual takes place in a circle, with the guests usually seated. A ball of wool or string is passed from one woman to the next, and each takes the wool and wraps it around her wrist a couple of times before passing it to the next woman. After each guest has had a turn, the circle of women are all joined by the wool. Someone, sometimes the pregnant woman, sometime’s someone else, says a few words about the symbolism of being connected. Nina, a mother of two, her first child born via caesarean, and her second born unassisted at home, has often hosted blessingways for women in her home-birth mother’s group. She explained this symbolism,
I’ll usually say a few words about how we’re here in our continuum and we are a community and this symbolises how we are bound together, and that even if you feel alone when you’re birthing you won’t be because we will all be here for you, and how this binds us to all the other women who have ever birthed for a hundred thousand generations, how incredibly powerful that is, and I try to introduce things that women will hold in their mind around the perfection of their body and how evolution has perfected this system.

Scissors are then passed around the circle, and the wool is cut between each person, and each is left with the wool wrapped around her wrist, which is then tied together, forming a bracelet. This bracelet is generally left on as a reminder to send positive thoughts and energy to the pregnant woman and is removed after you know she has birthed, and she is well and no longer needs the thoughts.

**Giving and Threading of Beads**

The invitations to a blessingway usually include the request for guests to bring a bead and a blessing for the pregnant woman. Like the other two rituals, the giving and threading of beads involves sitting in a circle, with each guest taking turns threading her chosen bead onto some cord or string, and telling the group why she has chosen that bead. This ritual also often incorporates the ‘blessing’ part of the ceremony, where the bead represents that guest’s blessing towards the pregnant woman, her birth and baby.

Myra described to me the beads she received at her blessingway, which she made into a wall hanging. The beads hung together in a long strand, and she took them off the wall during our interview and lay them on the table we were sitting at. She touched each one and smiled as she remembered the women who had given her each bead. She said,

Well, all of the [guests] picked them and they all had reasons for picking them… the big one was made with felt, by my friend and she makes everything in felt, so that’s why she did that, ‘cos it’s her thing. But one of them has a spiral on it ‘cos the girl who gave that is really into spirals. There’s a handbag shaped one that my friend picked because she thinks that she’s prissy, there’s the one that’s got three flowers on it and [friend] said ‘Oh I picked this one ‘cos I think you’re gonna have three girls’. Some people picked blue ones ‘cos they thought I was gonna have a boy…I really like mermaids and stuff, one of them picked one that looked, made them think of water, and um, there’s three plastic ones on there that my friend picked from her daughter’s broken necklace, from my daughter to your daughter sort of thing. So yeah, they all had a story behind their beads.

Similarly, Elenna, a mother of two, her second child born at home with an independent midwife showed me her beads and described some of her them to me, saying

What was really interesting was some of the woman who know me really well, had really beautiful intentions for some things. [One friend] gave me this one which was a symbol of support because she felt that support would be really important, to allow myself to be supported…My midwife gave me a wooden bead, cause she knows I love it, it had faith written on it, she wrote faith on it, to have faith in myself. And this one was from [another friend], which was a woman I haven’t seen much but she’s a beautiful Fijian Indian woman and she gave me a piece of her jewellery that she wears all the time. It was really amazing to listen to different ideas that people had of me and about birth and what they thought it would be like.
Most blessingway narratives I heard that involved beads were shown to me, and the vivid memories of each one and the stories behind them were touching to hear. Van Gennep notes that the exchange of gifts has ‘a direct constraining effect: to accept a gift is to be bound to the giver’ (1960, p 29). This resonates in the bead ceremony, for what is recalled is the intention and words spoken by the giver of the bead. None of the participants spoke about what those particular beads meant to them; they were intimately connected to the woman that gave it. For Van Gennep, this exchange creates ‘a continuous social bond between them in the same way that a “communion” does’ (1960, p 31).

The production of the sacred space of the blessingway is collective and co-participatory (Lauver 2000). More recently, McGuire (2008) notes that spirituality involves people’s material bodies, not just their minds or spirits (p 97). Within the temporal space of the blessingway, women’s material bodies, and the material, ritualised objects, embody the sacredness of the divine. It is through embodiment, McGuire writes, that we confirm the reality—not just the symbolic idea—of the ritual act (2008, p 101).

The work of Julian Holloway (2002) is of particular interest here. Using empirical data from new-age men and women, Holloway theorises that sacred space is ‘corporeally enacted and physically sensed as sacred’ (p 1965, original emphasis). Sacred space can, for Holloway, become physically embodied, the room and its atmosphere becoming a sensory and visceral experience.

Embodiment plays another role within the blessingway, related to the nostalgic imagination. McGuire (2008) argues that our experiences of religion and spirituality are embodied via all of our physical and social senses, including memory. This is activated by rituals, which invoke ‘a chain of embodied practices, each link having the potential to activate deep emotions and a sense of social connectedness, as well as spiritual meanings’ (McGuire 2008, p 100). The blessingway participants themselves embody the sacred, for its manifestation (and interruption) is corporeally sensed and felt, and expressed as ‘atmosphere’ and ‘vibe’. Holloway (2002) contends that as well as embodied sacred space, the relationship with the surrounding, physical and mundane space should not be overlooked. He argues that objects like televisions, mantelpieces, etc., are ‘creatively woven into and coinvest in a field of emergent sacralisation’ (Holloway 2002, p 1968).

Nostalgic Imagination

As I heard women talk about the blessingway, a theme that emerged repeatedly was an evocation of an entirely creatively constructed past, based on a patchwork of history, rhetoric, romance and imagination. I have used the term nostalgic imagination to describe this, as it refers in a romantic sense, not a specific period in history, nor a specific place, but a past that functions as a mythology in which the blessingway, and to an extent, home birth as a whole attempts to return. The use of an imagined past is not at all a way to denigrate the subsequent mythology as make-believe, but rather it performs the function of locating individual experiences within a broader context of childbirth through space and time. The primary way this nostalgic imagination is drawn upon is via ritual.

The nostalgic imagination or, collective, mythological ancestry, is actively engaged during pregnancy and birth (Dwinell 1992) and is directly called upon in the matrilineal introduction ritual of the blessingways, which sets the matrifocal tone for the rest of the ceremony. This ritual evokes a community of women past and present. Social psychologists have argued that collective memory for particular social groups represents an endless chain, ‘…a body that transcends us not only in space, but also, and perhaps more
importantly, in time’ (Sani et al. 2007). By naming other generations, the blessingway participants simultaneously call upon and co-create a childbirth mythology, a fictional time ‘in the past’ where ‘all’ women supported each other, did not have to be taught about birth, birthed naturally, at home—and importantly, without mention of complications or infant and maternal morbidity rates. Birth was instinctive, communal and birth knowledge was ‘inherent’. Most importantly, birth during this time was by default natural and normal, rather than technocratic and risky. This time, of course, is not a specific period in history, nor a specific place or group of people. Myra told me about her blessingway, and why it was important, she said:

I reckon in ages and ages ago, when women were all in the red tent together and they all talked about it candidly…you saw your mum have babies—you were around pregnant women and stuff, you kind of understood the process.

The reference to the ‘Red Tent’ refers to the red tent of Judeo-Christian tradition, particularly made popular by the novel by Anita Diamant, The Red Tent (1997), which tells the fictional story of Biblical character Dinah, daughter of Jacob. This literal tent is symbolic as a place where women could be candid and share knowledge and oral history and overlooked as the place they were segregated to because they were considered ritually unclean. These details are of little importance, however, because the time, space and culture are imagined, the details shifting between each woman, ceremony and context. The group instinct noted by Levi-Strauss (1964) is reflected by Grace, mother of three, her third child born at home with an independent midwife. While talking about her own blessingway, she said:

I wanted, craved actually, that women connection this pregnancy. I wanted it, I wanted that feeling of sisterhood, mother to mother, woman to woman, that old way when they use to years ago. Grandmothers would tell their daughters who would tell their daughters, and there was this sharing of knowledge, this handing down of knowledge that’s missing culturally and socially now. We go to hospitals and it’s defragmented and broken and so I wanted to feel that feeling, that sharing and the wisdom, those ancient wisdom that are in us all I believe.

Here, the link between this nostalgic past and home birth is made, with reference to the ‘defragmented’ system within the hospital—a system that is counteracted via the blessingway. The blessingway, for Grace, supports women’s ‘ancient wisdom’, unlike the ‘broken’ hospital system. When asked, Leah, a mother of two, her second child born at home with an independent midwife, reinforces this belief in the ancient wisdom of home birth. For her, the difference between her home and hospital experiences were, she said:

It was so lovely. Like it sort of tuned me into I guess that ancient women’s wisdom I guess… and all the strength of all the women you know who have come before me, as well as the ones that are around me at the moment. It’s sort of that feminine, that strong, strong feminine energy.

Myra, Grace and Leah highlight the return to the past; however, the ‘memory’ being called upon does not involve personal memory. It is the particular ideology of the event itself that is important, which for home birth include natural, drug and intervention-free birth, breastfeeding, and extend beyond birth into natural parenting and a myriad of other family-oriented decisions. It is also focused on community, and the links between women, or a shared ‘sisterhood’ (Daly 1978).
Blessingway rituals act as a way to re-enact, or interpret the mythology of birth located in the nostalgic imaginary. The imagery created by this can then be a source of connection and strength for moments outside of the blessingway, such as labour. Kristin, a mother of three, her third child born unassisted at home, spoke about a moment in her labour, she said:

I had a bit of a cry, well not a cry but just a moment of ‘I wish someone was here with me’ you know…and I saw a spider outside my window that was actually building a web, and I had never seen a spider like that, and I [en]visioned her to be a female spider building her web and, I don’t know. [It] linked me with all the women before me who had given birth…You know I just felt there was a camp fire of women around me at that moment.

That biology and gender feed into experiences of spirituality (Rose 2001; Sointu and Woodhead 2008; King 1995) is no surprise when considering pregnancy and childbirth. With our knowledge of pregnancy and birth being so medically driven, the emphasis this biological discourse feeds into the spiritual. Pregnancy and childbirth seem to at least temporally amplify the biological differences between men and women, emphasised by Genevieve and Kristin, and may be part of the reason why these differences feature so prominently. The explanations for the gendering of the blessingway which Genevieve and Rosemarie put forward above, which were also echoed in other narratives, are not about the blessingway itself. What is foreground, however, is the primacy of relationships with other women, and the shared, spiritual connection between them, in part constituted by the exclusion of men.

For Levi-Strauss (1964), the ambition to achieve an absolute ‘truth’ behind a particular myth is meaningless, ‘…since we are dealing with a shifting reality, perpetually exposed to the attacks of a past that destroys it and of a future that changes it’ (p 3).

The ahistoricism of the nostalgic imagination is problematic, as the use of umbrella terms like ‘sisters’ and ‘women’ must be contextualised within the participant profile of predominantly white, middle-class voices. Using ‘women’ as a broad category in this sense further elevates this hegemonic status, silencing marginalised groups, and overlooking the importance of racial, socio-economic, and socio-political experiences of women throughout space and time (Graham 2012). What subsequently manifests is a homogenous history and politics of women and childbirth that does injustice to all groups it is supposed to represent.

In a feminist analysis of the allegorical past presented in a popular television series, Graham (2012) writes that allegorical histories subvert the taken-for-grantedness of the status quo. The point of using an ‘allegorical past’ is that imagines ‘…different configurations of the past, present and future in order to challenge the fixity of the past and the stifling authority of history—or particular versions of it’ (Graham 2012, p 59).

One such reconstructive step is developed by Eller (1991) who argues that ahistoricism is typical of feminist spirituality, arguing ahistoricism denies linear history, that the Goddess ‘belongs to nature, to timelessness, to the matriarchal eternities that stand at the beginning and end of history’ (p 293). Without having to clarify their specifically situated history, the nostalgic past is utopian, and the imagination serves to disrupt any sense of the inevitability of the present (Graham 2012).

By using an ahistoric model of the past, the nostalgic imaginary can choose to honour only aspects of the past that are relevant to the ethos being presented. What is excluded in these mythological birthing histories then is not necessarily a political exclusion of marginalised voices, nor an attempt to dominate history with a white middle-class world view.
but a symbolic resource to represent contextually situated ‘present values and intentions so as to shape and motivate…present actions’ (Knapp 1989, p 130).

Conclusion

When I began writing about the blessingway, I was hesitant to use the term feminist spirituality over women’s spirituality, because the two are distinctly different in their meanings and politics. In working towards defining these terms, feminist spirituality was chosen because of the emancipatory possibilities that the blessingway seemed to evoke. Finson (1987) argues that feminist spirituality is categorised by socio-relatedness, and that spiritual awareness is not reached in isolation but through our connections with other women. For the participants who had a blessingway, it was very clearly a powerful vehicle with which to connect with ‘womanhood’ and embrace an idea of childbirth that is rooted in the female psyche. While this is of course an incredibly essentialist way of viewing the female body, in this context, it operates as a way of denying the scientific discourse of childbirth knowledge, handed down by male experts that have, since the beginning of the twentieth century at least, convinced the public of being conceptually ‘uninformed’ and lagging hopelessly behind medical innovation and knowledge (Lane 1995, p 54). With this broader context of a system of patriarchal knowledge-making (Cahill 2001; Henley-Einion 2003; Jacobus et al. 1990; Fox and Worts 1999) in mind, the blessingway creates an environment of innately female authoritative knowledge.

For Martin, feminist spirituality ‘…is rooted in a sense of connectedness with the past made present in remembrance and with the future made present in hopeful struggle’ (Martin 1993, p 118). That connectedness in part is founded by rituals like the blessingway, where the past in the nostalgic imagination is, in a way, re-enacted. This perpetuates the story of the imagined past, creating new pathways to make sense of women’s experiences (Yates 1983), especially pregnancy and childbirth.

What rituals present us, according to Turner (1969), is an ordinary life ‘structure’, and the ‘anti-structure’ of ritual time. As a structuralist, Turner is referring to the properties of life in society that is hierarchical and systematically differentiates the positioning of people using politico-legal discourse. In contrast to this is the anti-structure of ritual time–space, in which these structures are at least temporarily suspended. What occurs in this space is some recognition ‘…of a generalised social bond that has ceased to be and has simultaneously yet to be fragmented into a multiplicity of social ties’ (Turner 1969, p 96). Here Turner himself refers to an unidentified past in which the ‘generalised social bond’ existed outside of ritual time–space. It is this idea, the basis of the nostalgic imaginary, that the blessingway draws on, however, locates it specifically in a matrifocal space, where the experiences of the maternal body are valued above all others, representing a significant shift from ‘everyday’ reality. The rituals that make up the blessingway perpetuate these ideas, reinforcing the themes of female bonding and spirituality.

The symbolism of the connections between women and generations past, as well as between women and nature that are drawn out in blessingway ceremonies mirrors the importance of symbolism in religion and spirituality more broadly. Writers like Sered (1994), Ochs (1997) and Neu (1995) argue for a spirituality that specifically privileges women’s experiences and values these as sacred as they become part of the theological and ritual focus of the celebration of womanhood. Feminist spirituality privileges the importance of the cyclic rhythms of human life and nature, rather than the linear time of calendar dates, and the utmost importance of the sharing of stories between women (Martin 1993).
Within this feminist spiritual framework, women are at the centre of spiritual reflection and practice, honouring ‘...the goodness of women’s bodies and their functions’ (Lauver 2000, pp 79–80).

Turner developed the notion of communitas, in relation to, but distinct from the idea of community. The difference, he argues, is to do with the presence of the sacred, and ‘giving recognition to an essential and generic human bond, without which there could be no society’ (1969, p 97, original emphasis). The blessingway draws on this recognition, though paying specific attention to women, pregnancy and childbirth.

For the blessingway, this recognition is created via attention to the present’s debt to a history of women who have come before. This history is constructed as a categorical ‘past’, which, although problematic, allows a perception of history that in many ways is personified by the blessingway. ‘History’, then, becomes a particularly pliable concept, nostalgically imagined, infused by the spiritual appeal of generations of women being proud of us in the present (birthing) moment.

Through the use of ritual and the production of an imagined, collective ancestry, the blessingway offers a uniquely spiritual ceremony to pregnant women. The blessingway contributes to the spiritual milieu of pregnancy and childbirth. This supports the argument that unconventional childbirth practices have the potential to open up modes of knowing the pregnant and birthing experience outside of a medicalisation framework. In the push for a greater understanding of the role of spirituality in a variety of health care settings, childbirth has been primarily examined via mainstream birthing modes. By broadening this to extend to unconventional birthing practices like the blessingway, a larger scale of potentially rich spiritual practices and possibilities for empowerment are possible.

References


Article

More Than Four Walls: The Meaning of Home in Home Birth Experiences

Emily Burns

Religion and Society Research Centre, School of Social Sciences and Psychology, University of Western Sydney, Penrith, NSW 2750, Australia; E-Mail: emily.burns@uws.edu.au

Submitted: 1 November 2014 | In Revised Form: 11 January 2015 | Accepted: 13 January 2015 | Published: 9 April 2015

Abstract

The “home versus hospital” as places of birth debate has had a long and at times vicious history. From academic literature to media coverage, the two have often been pitted against each other not only as opposing physical spaces, but also as opposing ideologies of birth. The hospital has been heavily critiqued as a site of childbirth since the 1960s, with particular focus on childbirth and medicalisation. The focus of much of the hospital and home birthing research exists on a continuum of medicalisation, safety, risk, agency, and maternal and neonatal health and wellbeing. While the hospital birthing space has been interrogated, a critique of home birthing space has remained largely absent from the social sciences. The research presented in this article unpacks the complex relationship between home birthing women and the spaces in which they birth. Using qualitative data collected with 59 home birthing women in Australia in 2010, between childbearing and the home should not be considered as merely an alternative to hospital births, but rather as an experience that completely renegotiates the home space. Home, for the participants in this study, is a dynamic, changing, and even spiritual element in the childbirth experience, and not simply the building in which it occurs.

Keywords

birth; home; hospital; medicalisation; place; space

Issue

This article is part of the special issue “Housing and Space: Toward Socio-Spatial Inclusion”, edited by Dr. Dallas Rogers (University of Western Sydney, Australia), Dr. Rae Dufty-Jones (University of Western Sydney, Australia) and Dr. Wendy Steele (RMIT University, Australia).

© 2015 by the author; licensee Cogitatio (Lisbon, Portugal). This article is licensed under a Creative Commons Attribution 4.0 International License (CC BY).

1. Introduction

In popular and medical childbirth discourse the home is not only constructed as “other” than the hospital (Homer et al., 2014), but also as the place of risk as opposed to safety (Lane, 1995; Possamaï-Inesedy, 2006). While much of the research on home birth focuses on why women choose to birth at home (Catling, Dahlen, & Homer, 2014; Moore, 2011), this article demonstrates that their experiences can tell us much about the negotiation of power and the management of bodies within the spaces that home birthing is performed. Indeed, the medicalisation of childbirth is now a well-known and widely used concept in disciplines and sub-disciplines from sociology, anthropology, women’s studies, midwifery and nursing. The medicalisation thesis has become so dominant that its importance has overshadowed the need to be equally as rigorous in analyses of the dynamics at play in home birthing space.

Most commonly, the home is conceptually understood within domestic or “ordinary” living space. In the birth literature, it is often regarded as the “backdrop” in which birth takes place, though there are some notable exceptions to this (Fannin, 2003; Michie, 1998). Indeed for Putnam (1999), when a new mode of living is mapped onto a house or a new house mapped onto an existing mode of living, the meaning of domestic space is redefined. In this light, what we know about the home, and about women’s relationships with the
home, will undoubtedly be entirely different from what we need to know about the home when remapped for childbirth, and the impact this experience has on the home and the birthing woman and her family thereafter.

That the focus of the home/hospital debate is centralised around place, and the spatial differentiation between the two, indicate clearly not only the pragmatic differences between the two sites as birth places, but the ideological distance that can so easily be epitomised by two discursively oppositional terms. The home and the hospital have become polar opposites in the discourse on childbirth (Powell Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009; Reibel, 2004).

Cresswell (1996) writes about the construction of ideologies, the most important ingredient of which, he argues, is the differentiation by place (p. 153). This is clearly evident in the home/hospital birth dichotomy, primarily because the hospital is what Cresswell (via Bourdieu) refers to as “doxa”, meaning it has become part of everyday common sense rather than critical decision making. At the opposite end, then, home is specifically differentiated as “abnormal”, and the spatial differentiation comes to personify this oppositional relationship, signifying ideological differences as well, specifically through the focus of safety and risk, which both sides of the debate used to defend their position (Michie, 1998).

This article will move beyond notions of safety and risk, and present findings on home that focus on the intimate and complex ways the home is reimagined in home birth experiences. I argue here that the home is far from merely the backdrop of childbirth, nor is it a site that simply opposes medical intervention. The role and importance of place attachment and the new meanings and boundaries that home birth instigates renegotiates the way birthing women relate to their homes and in turn, their births.

2. Background

Because reproduction is said to form the nexus of nature and society, the way a culture handles birth is strongly indicative of its core values (Blaaka & Shauer, 2008; Davis-Floyd, 1993/2008; Rapp, 2001). Davis-Floyd (1994) sees these values played out in the ritualistic procedures of birth, particularly in hospital settings. The hospital has been heavily critiqued as a site of childbirth since the 1960s, and scholars have primarily drawn on medicalisation as the framework for interrogation. Medicalisation can be defined here as,

the expansion of medical jurisdiction into the realms of other previously non-medically defined problems...a process which clearly serves the interests of medicine with its increasing focus on the indicators of disease rather than the individual’s experience of health and illness (Cahill, 2001, p. 339).

It is important to note however, that in the context of childbirth not all medicalised experiences are necessarily negative ones, however the assumption of control by medicine results in an implicit hand-over of bodily agency, which in turn can lead to disempowerment (Cahill, 2001; Davis-Floyd, 1993/2008; Williams & Umberson, 1999). The biomedical preference for understanding women ignores the inescapable psychosocial elements of birth (Mansfield, 2008), and the important transition to motherhood (Cahill, 2001). The dominance of medicine has resulted in a feminist response to the configuration of the contemporary childbirth model as a paradigm of power and control. This paradigm positions pregnant and birthing women at one end of this continuum and male dominated institutions (hospitals) and professions (medicine) at the other. One of the primary ways this is achieved is via authoritative knowledge. For any particular domain, writes Jordan (1997), several knowledge systems exist. Some of these knowledge systems come to carry more weight than others, “...either because they explain the state of the world better for the purposes at hand...or because they are associated with a stronger power base” (Jordan, 1997, p. 56) and usually both.

Power is a direct result of systems of authoritative knowledge, with medical professionals automatically having more power and control than patients and birthing women, simply because they hold medical knowledge (Crossley, 2007), and because medical knowledge is so highly valued in Western countries (Foucault, 1989/2003). Technology goes hand in hand with medicine in this regard, for in the hands of medical professionals, technology—and the authority to use it—is an extension of their power (Suchman & Jordan, 1997).

One of the ways a birth in the biomedical system is categorised from the early stages of pregnancy is in terms of risk. “Risk” is not a neutral term, and assumes the body is always on the brink of failure irrespective of circumstances, and almost always includes negative consequences for women (Lane, 1995, p. 57). The authoritative knowledge of the medical model of childbirth means that “normal” is defined in medical terms, and is often only used in retrospect, thus making every pregnancy “at risk” until after the birth (Skinner, 2002). The routine assignment of risk to pregnant women occurs without taking into account structural and social conditions, which individualises the risks, and in turn legitimises the routine of interventions (Lane, 1995, p. 55). This has seen the routine use of interventions like induction and foetal monitoring, which has done little to improve the outcome of “high-risk deliveries”, and that some say can only be explained by the practice of defensive medicine (Cahill, 2001; Davis-Floyd, 1993/2008; Skinner, 2002). More recently however, the medical model of hospital birth has increasingly included the recommendation of doulas (birth attendants), and complementary and alternative medicine in
pregnancy and labour (Harding & Foureur, 2009; Hastings-Tolsma & Terada, 2009; Wiebelitz, Weyert, & Beer, 2009), expanding the medicalised model to incorporate a variety of practices that might contribute to a more positive birth experience.

There is an obvious dichotomy set up in the child-birth literature between “medicalised” and “natural” definitions of childbirth. These two concepts however, rely on each other in a birthing context. What counts as medicalised depends on which elements of nature are being dominated, and similarly what counts as natural depends on what elements of medicine are excluded. A common understanding of “natural” is a birth without technological intervention, including spontaneous labour without anaesthesia, and a vaginal delivery. Crossley (2007) extends this definition, seeing “natural” birth as a subjective re-enactment of nature, which produces a physiological rather than pathological experience. Discursively there has been a move toward using terms such a physiological birth and normal birth, rather than natural birth (Downe, 2004).

There is an increasing body of literature that focuses on childbearing and broader issues of space and place, rather than with a focus on medicalisation. Hospitals and birth have been critiqued in relation to geographical (Abel & Kearns, 1991), spatial (Fannin, 2003; Michie, 1998; Seibold, Licurghis, Rolls, & Hopkins, 2010), and design (Foureur et al., 2010) frameworks as well. The focus for much of the research on homebirth is focused on the importance of issue such as gaining autonomy by birthing outside of the medical system (Dahlen, Barclay, & Homer, 2008; Edwards, 2005; Jackson, Dahlen, & Schmied, 2012; Nolan, 2011). Perhaps one reason for this is the high representation of midwifery scholarship in home birth research.

In Australia, home births can be achieved in three distinct ways. Firstly, a pregnant woman may birth unassisted, that is, without the assistance of a midwife or obstetrician, or any childbirth professional. This is referred to as unassisted childbirth (UC), or free birth. Secondly, she may hire an independent midwife, for a fee of between AUD$3000 and AUD$5000. This midwife will usually oversee all antenatal care, will attend the birth and provide postnatal care as well. Thirdly, depending on the geographical location of the pregnant woman, she may be eligible to participate in a hospital home birth program. These programs typically operate via a “case-load” model, where two or more midwives are assigned women to oversee their care from initial enrolment into the program, antenatal care, childbirth in the woman’s home, and postnatal care. The antenatal care takes place in the hospital, and the assigned midwives attend the birth in the woman’s home. These programs are government funded, and have strict eligibility guidelines (see Catling-Paull, Foureur, & Homer, 2012), which the pregnant/birthing woman must comply with or her participation in the program will be cancelled. These programs are relatively new in Australia, the first being established in Perth, Western Australia in 1996, but most since 2005 (Catling-Paull, Coddington, Foureur, & Homer, 2013). These programs are becoming increasingly popular, with 12 hospitals nation-wide offering publicly funded programs (Catling-Paull et al., 2013). While the efficacy of such programs is beyond the scope of this article, the research on these programs offers compelling evidence of their success (Catling et al., 2014; Catling-Paull et al., 2012; McMurtrie et al., 2009).

The safety of home birth for low risk women has been long-established, and has been used as the primary rationale for the implementation of publicly funded hospital home birth programs in Australia (Catling et al., 2014; Catling-Paull et al., 2012). While research on the experience, impact, and importance of space when it comes to childbirth is growing, the focus remains primarily on hospital space (Fannin, 2003; Foureur et al., 2010; Hammond, Foureur, Homer, & Davis, 2013; Smyth, Payne, Wilson, & Wynyard, 2013).

For the Australian women I interviewed, having a birth in the home necessitated an at least temporary re-shaping of the meaning of home. The existing ways the home was used by those living within it, and those visiting, needed readjusting to allow for the changes a home birth would instigate. These changes were as temporal as pregnancy and childbirth, but were important to creating balance for the participants. The home for home birthing women is indeed a physical place in which they live, but it also becomes a space that embodies various imaginings, and becomes intimately connected to the experience of pregnancy and childbirth.

For childbirth, part of what defines the home is its ideological distance from the hospital, meaning the hospital is a necessary component in the discussion of the home in home birth. There also needs to be caution when conceptualising the home, so as to not represent it as an entirely positive place or experience, as some of the participant narratives in this paper will show. Recent conceptions of home go beyond the configuration of a physical, spatial entity and into more “...an idea and an imaginary that is imbued with feelings” (Blunt & Dowling, 2006, p. 2). The imaginary in question includes a nostalgia for the past (Chapman & Hockey, 1999), our expectations of the present, and our dreams (and fears) for the future (Blunt & Varley, 2004).

Significantly, there are a myriad of ways in which being “at home” could be alienating. The geographical literature on home is right to criticise definitions that rely on notions of sanctuary, security, and safety. For many people home is not, as they say, “where the heart is”, but a place of alienation, discomfort or violence. Home, therefore, requires a contextually based definition, one that works for specific situations and groups of people with whom that definition may be
relevant. The home as a place of birth may only seem relevant to a small group of families who can afford it and for whom this is their reality, but it is nonetheless an important way to indicate the ways in which definitions and pre-existing ideas of home may be reshaped depending on the context.

While the home would ordinarily be considered a private sphere of social life, the influence of public life is keenly felt at home. Since the nineteenth century, the home afforded the possibility of retreat from public view, despite it not, in practice, being a place escaping the public gaze (Chapman & Hockey, 1999, p. 10). Blunt and Dowling (2006) write that the home is best understood “…as a site of intersecting spheres, constituted through both public and private” (p. 18). In the case of home birth, public discourse, which includes legislation regarding midwifery and home birth, heavily impacts the experiences of childbirth in the home. The public realm of policy seeps into the intimate spaces of the home, producing a home that has become politically, socially and even morally contentious and very, very public.

The emergence of publicly funded home birth programs, and a continuing critique of medical knowledge is indicative of Giddens’ (1991) assertion that in high-modernity multiple discourses compete for authority. The very fact that these knowledge sets compete at all is only possible in contexts where each set is considered equally ideologically valid. As such, it is not just home birth consumers questioning the authority of medical discourse and birth choices, but hospitals are increasingly encouraging and facilitating the use of more holistic birth approaches.

3. Methods

The data presented here forms part of a larger study on spirituality and home birth experiences. The themes presented here are from a small cohort of participants who spoke about their homes in their narratives as key sites of renegotiation. While the number of participants presented here is small compared to the number of women interviewed for the larger study, they speak directly about the gap in the empirical knowledge base outlined above, namely; space and the role home spaces play on pregnancy and birth experiences.

Participants were recruited via online parenting forums, where the author contacted the administrator with information about the research, and asked permission to write a post in an appropriate thread to recruit participants. This post included information about the research, eligibility criteria, what participating would involve, and the author’s contact details. Eligible participants would be both currently pregnant and planning a home birth, or would have had home births in Australia in the last three years, or be a practicing doula or independent midwife. Snowball sampling also occurred as a result of these posts, and within a period of 30 days over 200 eligible participants from around the country had contacted the author. While most of the participants lived within three hours of a capital city, it was decided for reasons of time and travel convenience that participants in QLD and VIC would be relatively central to Brisbane and Melbourne, while Sydney, where the author resides, was more spread out, and as a result there were participants from the Blue Mountains, the Illawarra, and various suburban Sydney areas. The number of eligible participants who lived in these areas and were available for face-to-face interviews on the travel dates arranged totalled 58.

In-depth interviews took place in 2010, and participants were asked narrative-style questions, including “can you tell me about the day you found out you were pregnant” and “can you tell me your birth story?” Interviews were recorded and transcribed, and coded initially for thematic results and then for a more detailed discourse analysis (Tonkiss, 2004). All names in this paper appear as pseudonyms. I interviewed all but four women in their homes, and for the other four one was in a local café, and three others were in the homes of their friends, also participating in the study.

Of the 58 women who participated in this study, 51 were pregnant and planning or had had a home birth in the last three years. The other 7 were professional doulas and independent midwives. Of the 51 home birthing women, 41 had had previous hospital births, and of those hospital births, 5 were caesarean births. The participant demography in this study is reflective of those found in other western countries, including the United States (Klassen, 2001), Sweden (Anthony, Buitendijk, Offerhaus, van Dommelen, & van der Pal-de Bruin, 2005), and New Zealand (Abel & Kearns, 1991). The participants could be described as predominantly middle-class, self-identified as Caucasian Australians, many were tertiary educated, all had access to the Internet and were widely read when it came to childbirth literature. Below are tables (Tables 1–4) indicating age, household income, education, and religion.

White women occupy a privileged position in birthing culture, and it is within this privileged position that Australian birthing discourse rests. The voices of this research are also predominantly white, though the value of this research has implications for childbearing more broadly. By better understanding the complexity of the experiences of home birth, broader childbirth discourse can begin to expand and take into account the myriad of peripheral experiences.

The aim of this study is not to provide generalised results or findings, but rather to move the theoretical debate beyond the home/hospital dichotomy. Further studies could expand the sample size to address the lack of ethnic and cultural diversity of participants in this study.
4. Findings

During the data collection and early analysis phase of the research, it became clear that, as previously discussed, the home is a taken-for-granted concept in home birth research. For most of the participants, home was spoken of as a relatively stable concept, however in a small number of narratives there was a clear renegotiation of the experience of home as a result of pregnancy and birth, and it is on those narratives this paper is based. This is not to generalise the experience of home, but rather to illustrate the more conceptual issue of the importance of space and place to childbearing beyond the experience of hospital space.

The central themes of place and space, and the experience of boundaries were common themes in the interview data. I have chosen only 5 of the 58 narratives for this paper, and have done so on the basis of the rich description they provide about the relationship between home and childbirth. The participants spoke as passionately about home birth as a choice as they did about their homes in relation to their births. Invariably, every woman I spoke with discussed the decision to birth at home, and while these decisions were so subjectively distinct, they involved issues like previous birth experiences, friends’ birth experiences, what they had read, online data and statistics about childbirth, and issues of cost and practicality. The central issue among the many discussed was always whether home was right. The importance of place in this decision was particularly strong, especially during the early, decision-making phase of planning a home birth. Secondly, the comparison between home and hospital environments were often discussed by women who had had previous births in hospitals, however it was the need for, and implementation of, previously un-required boundaries in and around the home that was a key concern leading up to the birth. Spaces that had not previously required monitoring suddenly needed rules, and those in their lives who had not previously had restricted access to their homes, were given, and expected to respect, new boundaries. Home spaces took on sacred significance within the home, heightening the intensity of feeling for previously usual living space.

4.1 Place and Space

Having a home birth is not as simple as birthing “at home”. Place is of the utmost importance in the decision to birth at home. Where women reside at the time of their pregnancies can often be reason enough not to have a home birth. Birthing at home should be seen as part of a broader social and cultural movement in Australia toward sustainability and environmental awareness, culminating toward a general consensus that the more natural something is, the less mass produced, the more local, the better it is.

As the below narratives will indicate, the decision to birth at home includes considerations of the home space and ones connection to it. Where that connection is strong, the decision seems easy, but when it is not, it is fraught.

Rachel was pregnant with her second child when we met. Originally from New Zealand, Rachel and her
The relationship between place, home and value are brought to the fore here. The $4000 cost of a home birth with an independent midwife becomes a question of value, a value that is not, for Rachel, met in her Western Sydney apartment. Her connection to New Zealand however, would make the value of home birth worthwhile. It seems clear that for Rachel, New Zealand is home, and her apartment is just where she lives. It is unclear whether Rachel would have pursued a home birth had the hospital program not been available to her.

Several women expressed a deep attachment to place, and value are brought to the fore here. The $4000 cost of a home birth with an independent midwife becomes a question of value, a value that is not, for Rachel, met in her Western Sydney apartment. Her connection to New Zealand however, would make the value of home birth worthwhile.

Nina told me she had spent a lot of time in pregnancy visualising going into labour, and doing relaxation breathing based on those visualisations, and the rental house was always the place in which she visualised. Via spiritual practices such as meditation and visualisation, Nina made a psycho-spiritual connection between her pregnant body, her baby, and the rental home, a connection that, after the months of pregnancy, was particularly strong. This connection was interrupted with the purchase of the new house and moving plans, causing a clearly fraught decision making process when she went into labour early. Despite birthing in the rental house, as she had planned, Nina said:

I feel really sad in a way that it wasn’t our home that we own, it was in our rental place. I feel really sad every time I drive past there, like a real kind of connection to that house, and I feel sad that he’s not going to grow up in the house that he was born in. But at the same time I kind of can see why I needed to birth there...that had been the plan until we suddenly bought this house, so that had been the plan most of the way along. And that’s where I pictured myself when I was doing visualization and stuff...and also [baby] knew that was the plan.

Decisions about birth and space are complex and involve interplay between practical, emotional and spiritual factors and perceptions of birthing women. For Nina, having two homes when she actually went into labour dislodged her planning—both practical and emotional/spiritual planning, and the decision no longer became one of birthing at home, but birthing in the place that felt most like home at the time, her rental. Here the space between home and house is particularly strong, and it is clear that for Nina, she was planning a home birth, and as such feeling connected to the surrounding space was the most important thing.

Similarly, the conflict between home and connection to place was also played out with Fenay, who had a free birth for her first child, and when she became pregnant the second time, she was living in a different town, several hundred kilometres away. In talking about the birth of her second child, she said:

We ended up out in [small town] which is a hole! Living in an awful flat that looked out into the bins of the supermarket, so I didn’t want to have a baby...
there, so we went over to the hospital.

The juxtaposition between contamination and cleanliness is at the forefront here, as Fenay recalls the view from the flat overlooking the supermarket bins, which is said together with calling the town a hole, and describing her flat as awful. These emotive descriptions of this space are given as the reasons she went to hospital. The hospital, in this context, “solves” the problem Fenay has with the town and the flat, and the contamination of the flat by the proximity to the supermarket bins. The hospital becomes the symbol of cleanliness, a pure, sterile environment that trumps the home when the home is contaminated. Fenay illustrates that it is not simply being at home that is important for home birth, but being in a space one can feel safe in, and a space that is worthy of the importance of childbirth. Dirt, it would seem, or proximity to the dirt of consumerist waste—the supermarket bins—has little place in this scenario.

Fenay lived in a town near a world heritage national park in New South Wales when she had first and second children. When pregnant with her first child, she said:

I used to really like sitting on rocks and sitting. Just sitting in nature. And I liked to be out in the bush a bit when I was pregnant, too...that kind of spiritualness, that connection to the earth kind of spiritualness, your understanding of the world.

Living there was a source of spiritual connection for Fenay, a place of nature and thoughtfulness. This directly contrasts to the way she describes the small town of her second pregnancy. This makes clear it was not only the “awful flat” that contributed to her feelings about not wanting to have a baby there, there was a bigger picture of the importance of feeling a connection to place as a way of justifying birthing at home. The concept of home itself is expanded beyond the physical and into the broader geographical space, and also the psychic realm of connection. Certainly, for van Muren (1990), the experience of lived space is largely pre-verbal, and thus difficult to describe and/or explain.

The home Fenay birthed her first child in, unassisted, contrasts greatly to where she lived while pregnant with her second child. For her third child, Fenay and her family were once again in the National Park setting of her first birth, where she once again birthed unassisted. The contamination of her flat while pregnant with her second child could be extended to the distance from the more nature-based spirituality reflected upon in the narrative of her first and third children’s births.

The importance of nature is a strong element in home birth discourse, with “natural birth” being one of the tenants of home birth rhetoric. Indeed the term “natural” on its own has become an umbrella term for a critique “…aimed at various crises of modern Western society, from industrialism, capitalism and materialism, to urbanisation and mass culture” (Moscucci, 2003, p. 168). Natural birth is a strong theme in home births—as a concept it is used much in the same way as home is to hospital, it is perceived as the opposite of medicalised experiences. “Home birth” has become discursively synonymous with “natural birth”, and thus much of the critique Moscucci mentions can be readily extended to include hospitals and medicalisation. In this sense, “home birth” as a movement can be seen as part of a growing social continuum that prioritises an ecological, sustainable worldview, which influences decisions surrounding pregnancy, childbirth and parenting as well as social life more broadly.

As part of this rhetoric, the importance of place is expanded from the expectations of home as the place to give birth to knowing whether the home is right for birth. One of the ways this is achieved is by introducing new ways to interact with the home space. The next sections will explore the changing dynamic that is created when birth takes place at home.

4.2 Boundaries

None of the women in this study had accidental home births; they were all carefully planned or in the process of being planned. This deliberacy also extended to the space within the home that they hoped or intended to actually give birth, many literally altering part of their home for it. Many of the women interviewed referred to the place of birth as a space rather than a room. Many of these areas had functions other than birthing, such as the room usually designated as the office, or bedroom, or even the dining or living rooms. With new configurations, new uses and new meanings, there comes the need to find new ways to protect such spaces, with a focus on the temporality of birth, and the heightened need for protection during this time. As such, a recurring theme in participant narratives was the need for respected boundaries. Ordinary means of ensuring the boundaries between the world and the home space become insufficient and there is need for something more intimate, private and specific for birth.

Laurel lives in Brisbane, Queensland. She has three children, the youngest was only a few months old at the time I interviewed her. Her first child was born in hospital with intervention, and with her second child she was looking for something more woman-focused and natural, so she went to a local birth centre. For her third pregnancy, she started going through the birth centre again, but found it was no longer the one-to-one care she felt was important, so she hired an independent midwife and started planning a home birth. When talking about the sort of things she did to get ready for the birth, she said:

I knew that I wanted it to be dark, and to be private, and I didn’t want anyone to—I was concerned about
my mum turning up, or someone turning up, so I just did everything to avoid me being disturbed. And I put signs up on the front step and the door saying “if anyone comes and we don’t come, we’re busy having a baby” or, “we’re in bed with our baby—we love you and we’ll call you later”. So just to put a boundary in place so I could let that feeling go and just get on with having a baby.

The shift between speaking for herself, and speaking for the family indicates at least her perception of the family’s mutual instigation of boundaries to protect their privacy during the birth. In a hospital environment, the policing of boundaries are largely governed by predetermined rules. Visiting hours create clear and often strict guidelines between the rest and privacy of new parents and visitors. At home, these boundaries are less clear and need to be instigated and enforced by the families themselves. This requires new methods of not only relating to the space of the home itself as a site of safety and security, but also of relating to others within the home.

These issues were reiterated by Taren, who told me the story of the birth of her second child, her first home birth. She described how she felt in the days after the birth,

At home, in one way you can feel a bit protected because it’s your home, but other times you feel like [family] just walk up the back, and I kinda feel a bit exposed, and so I am aware of that as well. And I know I need to be a little more assertive this time around and [husband] needs to be more assertive too in saying what feels okay for us at the time, whether we have visitors or not and how long they might stay. Cause I did find that tiring, with certain people kind of staying a bit too long just only after a day or two and thinking, well you know, other people would still be hospital right now having bed rest—not that I feel like I need to be treated like a patient—I felt kind of pressured to like be dressed up with makeup and making cups of tea and hosting people cause it was my house, whereas in hospital you wouldn’t be expected to do that. You would just be lying in bed with your pyjamas on cuddling the baby. But at home I kind of felt a bit sort of guilty in some way that I wasn’t up making everyone cups of tea and lunch

The switch between first and second person narration here is reflective of the narrative shift between personal experience story-telling of the former and the generic truths of popular attitudes, beliefs and values of the latter (Georgakopoulou & Goutsos, 1997/2004, p. 27). For Taren, this narrative begins with the situat-ed truth of feeling protected in one’s home, but then moves to contrast this feeling when “[family] just walk up the back”, the “just” here indicating a culturally specific, “common sense” boundary—a boundary not only understood in the context of cultural home-making in Australia, but also the shared understanding between Taren and I at the time of the interview. She then moves into a more personal account of her post-natal experience at home, then shifts again into a shared understanding of what would be expected of a new mother in hospital. This is not only reflective of Taren’s knowledge of cultural birthing norms, but also of the shared knowledge between us in the interview setting. Taren speaks to me comfortably in the assumption that I, too, would not expect a new mother to be wearing make-up and playing host. She then switches back into first person, admitting her guilt for not living up to the expectations that she knows are unreasonable.

The conflict illustrated here between the expectations of a female host, and the experience of having just birthed a baby at home, and the lack of understanding from her family regarding this suggest that it was the expectations that were in need of boundaries rather than the visitors themselves. Taren directly implicates her husband’s role in this also, saying he needs to be more assertive in what he thinks is OK. The authority of policing these boundaries is on him, while the burden of the expectations is on Taren.

Narratively it is noteworthy that this passage comes after the actual birth story of her son, and after she spoke about the ways she created her birth space and the way in which the literal construction of this space was influenced by her birthing prerogatives. The power and authority over her home before birthing decreased once the space converted back into usual living space, post-birth.

The contrast between home and hospital in this passage is unique; it was one of the few times I encountered positive representations of hospital space. What Taren is referring to here however, is not the hospital space per se, but rather the protection of hospital boundaries, and the acceptance of hospital authorised visiting time protocol within a maternity ward, which often have strict visiting hours. At home, however, there are no such protocols in place.

Though not in reference to visitors, Rachel’s story also reflected the need for authority over the home, as she spoke about the plans for the birth of her baby. Two midwives were assigned to her via the hospital program, and Rachel was unsure how “hands off” they would be, considering they were used to hospital births. She said

If they really annoy me then I could just say—just leave and go and wait in the car until I call you, you know because I think there is that power in your own house that it, it’s actually your space and you have that whereas when you’re in the hospital and you’re in kind of their space but yeah.
Here the boundary is a perceived, anticipatory one. Rachel was still pregnant during our interview, so she is talking about what she could say should the midwives “annoy” her, but Rachel indicates a boundary between her space and her authority in that space. Her reference to being annoyed clearly indicated that Rachel has a set of expectations that contrast with her perceptions of midwives behaviour in a hospital setting. Should these expectations not be met, as she has anticipated, she has a plan in place.

Rachel uses the first person when talking about these plans, reflecting the independence with which many women plan their home births. While partners are certainly part of the decision making process, ultimately the woman organises and plans most of what will take place. From buying/acquiring the items needed to the preparation of the birth space, women are the primary decision makers (Lindgren & Erlandsson, 2011). For childbirth in hospitals, research with midwives has argued that the birthing space for women does not belong to her in the moments of birth, but is “lent” to her by the hospital (Seibold et al., 2010). In home birth however, a birthing woman takes ownership of the space she holds while in labour, regardless of the usual “owner” of that space—whether it be joint ownership of communal living spaces, children’s play spaces, or a partner’s office space. She has prearranged with the family to be able to move freely around the space that has been dedicated to her and the birth.

5. Conclusion

Whether boundaries are physical, domestic or hypothetical, they function to reinforce balance between the pregnant/birthing woman and her home space. The cultural transgression of childbirth at home in Australia brings with it new challenges for women and their homes, challenges that may not have been met before. Childbirth drastically calls into question the existing relationship between women and home, and both women and home undergo an at least temporary transformation in relation to the other. The home space comes to accommodate a new set of needs and expectations, and the birthing woman and her family renegotiate their positions within this space as well.

Viewing home birth in a broader social and cultural sense opens the possibilities of “knowing” the home and birth beyond the confines of residence and medicine respectively. The impact of a focus on space and place in home birth experiences directly responds to the growing literature on therapeutic landscapes, with places and spaces moving beyond geographical location/social contexts of places, and into a more holistic understanding of the meaning of place for people, and the impact these meanings have on health and wellbeing (Gesler & Kearns, 2002; Kearns & Gesler, 1998).

When medical language “dominates and constricts perception of the birth process...uterine contractility and cervical dilation are often discussed as if they occurred on a laboratory bench rather than in a woman’s body”. As part of medical discourse, this is a model of understanding that perceive women as victims of their reproductive systems and hormones, and it is one that defines pregnancy as inherently pathological—a clinical crisis worthy of active intervention (Cahill, 2001; Freund, McGuire, & Podhurst, 2003). This biomedical preference for understanding women ignores the inescapable psycho-social elements of birth (Mansfield, 2008), and the important transition to motherhood (Cahill, 2001). In home birth discourse however, the medical discourse is considerably overshadowed by holistic, even spiritual language (Davic & Davis, 1996).

Part of the reason for this is the ideological as well as geographical distance between the home and the hospital. That the home would impact childbearing language and experience is telling of the importance of pregnant and birthing women’s surroundings, and the impact place and space has on experience. This article really only begins to set out some of the conceptual tensions and complexities around the relationship between childbirth and home space, and more research is certainly needed to understand its intricacies.

The rhetoric of home birth as natural and woman-centred played out strongly in the narratives I heard during the interview process. When deciding on the home as the place for childbirth, the home is constructed as not only preferable to the hospital, but as the ultimate place to have a baby. For the women in this study, childbirth and home are intimately linked, and as such the meaning of home must be conceptualised to incorporate the complexities that come with childbirth.

The “return” to home for childbearing should be seen as existing within a broader social and cultural movement in Australia toward sustainability and environmental awareness, an idea that the more “natural” something is, the less mass produced, the more local, the better it is. Viewing home birth in a broader social and cultural sense opens the possibilities of “knowing” the home and birth beyond the confines of medicalisation. The impact of a focus on place and space in home birth experiences directly responds to the growing literature on therapeutic landscapes, with places and spaces moving beyond geographical location/social contexts of places, and into a more holistic understanding of the meaning of place for people, and the impact these meanings have on health and wellbeing (Gesler & Kearns, 2002; Kearns & Gesler, 1998).

Continued focus on the home space in flux as a result of planning, having, and remembering childbirth at home reignites the discussion on home birth beyond discourses of safety and risk, which dominate the current debate. The temporal redefinition of living spaces via birth at home imbued those spaces with spiritual awareness. It is the space that creates a sacred experi-
ence for childbirth, and not simply the decision to birth at home instead of the hospital. Drawing on the need to connect with the space in order to birth, as seen in the above examples, highlights the importance of space and place when it comes to childbearing, a discussion that extends beyond the hospital walls. By being as critical of the home space as we have been with hospital space, we can start to unpack the importance of the complex and intimate relationships with space, place and birth.

Acknowledgements

With gratitude, I acknowledge the helpful comments from Cristina Rocha, Alphia Possamai-Inesedy, Emma Waterton and Jacqueline Nelson on previous drafts of this paper, as well as the five anonymous reviewers for their feedback and suggestions.

Conflict of Interests

The author declares no conflict of interests.

References


About the Author

Emily Burns

Emily Burns is a PhD candidate at the Religion and Society Research Centre at the University of Western Sydney, Australia. Her research focuses on spirituality and home birth in Australia.
“THANKS, BUT NO THANKS”: ETHNOGRAPHIC FIELDWORK AND THE EXPERIENCE OF REJECTION FROM A NEW RELIGIOUS MOVEMENT

Emily Burns is a PhD Candidate at the Religion and Society Research Cluster, School of Social Sciences and Psychology, Western Sydney University. Her research interests include the spirituality of childbirth, and she has published on the rituals and ceremonies involving the placenta, the Blessingway, and the meaning of home in Australia home birth narratives.

Religion and Society Research Cluster
School of Social Sciences and Psychology
Western Sydney University
Locked Bag 1797
Penrith NSW 2751
Australia
emily.burns@westernsydney.edu.au

ABSTRACT

Rarely do researchers publicly divulge their experiences of failure and rejection during fieldwork. Negotiations for access with members of new religious movements (NRMs) can be particularly fraught, especially for new researchers, who are embarking on a rite of passage with their first fieldwork experience. This article offers the author’s experience of participant refusal during her doctoral research on a NRM in Australia in 2009, focused on the group’s home birth practices. It provides an analysis of the methodological literature on access, rapport and the importance of a reflexive approach to one’s positionality, and addresses the lack of scholarship on fieldwork rejection and failure. By engaging with the experience of rejection, this article argues that rather than a mere lack of rapport, it was the complex social and political context of the group, compounded by the politically charged topic of home birth, that generated the decline to participate. Using this experience as an example, this article argues that rather than embarrassment and shame, rejection and failure form part of the “non-data” of research practice, offering methodological and epistemological insights that come from a critical engagement with such experiences.

Keywords: ethnography; failure; fieldwork; home birth; parenting; rejection.
Introduction

On a beautiful late October day in 2009 I once again arrived at the picturesque property of the new religious movement (NRM) I was researching for my PhD. For months they had been asking me to bring my family along for a visit, so finally I introduced my husband, Adam, and my two small sons to the private and conservative group of people I had spent so much time with that year. At the time I did not know if I was doing the right thing, taking my family along, but after months of the group “getting to know” me before making a formal decision to participate, I wondered if this might help. Adam was nervous when we arrived, but was soon swept up in lively conversation with some other men about shared farming backgrounds and machinery knowledge. I sat with Maria (a pseudonym), my usual host, at a picnic table under a huge willow tree, and watched the children run on the grass by the stream that ran through the property.

The visit was a happy one, as usual. As we finished our lunch, with views to the large vegetable gardens that produced it, Maria’s husband asked Adam and me if we could see ourselves living in their community. We were silent for a moment, before I spoke for both of us and said that while I had enjoyed coming to the property, had learned so much from the group, and appreciated the sustainable lifestyle the group were propagating there, my interest in the group was more professional than personal and we were not in a position to consider joining the group. Inwardly, I was in shock: I had not expected that question. After several months of visiting the property and getting to know the members, and making it clear on my first (and subsequent) visits I was a researcher hoping to research the group’s home birth practices, I thought my intentions had always been clearly professional.

Maria’s husband nodded, not looking surprised to hear this, and said one of the younger members had Googled my name and was uncomfortable with something he saw. He had discovered my research project title in the University research centre’s website “list of new students.” While I already had given them participant information sheets and the project proposal, and we had discussed their participation several times, they were concerned I was already writing about them. I assured them that was not the case, but they replied that nonetheless they had decided not to participate in the research. It was made clear to me that were I to return to the property, it should be for personal and not professional reasons.

As we said our goodbyes, the mood was much more stifled than when we arrived. We were seen off by two members, while we were greeted by at least five. For the first time since I met them they did not walk beside me on the way to the car. I was devastated on the way home. I felt like new friends in the school-yard had told me to go away. It slowly sank in that nine months worth of work was spiralling down the drain.
It has now been six years since that day, and I have often wondered what happened, what went wrong? Was it something I did? Was it just the Google search result? Was it because I did not want to join the group? With the benefit of hindsight, I suggest that it was the complex social and political context of the group, compounded by the politically charged topic of home birth that I was pursuing as the subject of the research. The highly charged context of government and media discussions on home birthing at the time, the NRM’s own fear of the state’s power to shut them down, and perhaps also my refusal to join them, propelled them to decide against participating in the research.

This article addresses the lack of scholarship on fieldwork rejection, and possible ways researchers can navigate and make sense of prospective-participant refusal. Being rejected by a potential research site or group may indicate a failure to gather data, and while researchers may have indeed failed to gather the data they intended, the “non-data” of failure can lead to rich theoretical engagement nonetheless. The importance of “non-data,” writes Fujii, lies not in “what they tell us about the particular, but what they suggest about the larger political and social world in which they (and the researcher) are embedded” (Fujii, 2014: 2).

It is in this larger political and social world that the context of rejection and failure should be placed. Furthermore, when we fail to establish rapport and gain access to a prospective group, what we can learn about ourselves, the research context and the groups we (attempt to) research is immense. I argue that just as we recognize research success and the processes that lead to it, so too should we recognize failure, and the potential epistemological benefits of such experiences.

**Fieldwork with NRMs**

The researcher certainly relies on chance and improvisation in the early phases of fieldwork; even the best-laid plans may run into unforeseen contingencies (Becker, 1965). Far from the idealized conceptualization often represented in textbooks, fieldwork is often inconvenient, “sometimes physically uncomfortable, frequently embarrassing, and, to a degree, always tense” (Shaffir and Stebbins, 1991: 1).

Conducting fieldwork with NRMs presents a host of unique challenges to researchers (Richardon, Balch and Melton, 1993). Notoriously difficult to research because of their want for privacy and their need to proselytize, some researchers have adopted a position of pseudo-personal interest status as a way of getting close to a group (Wallis, 1973), and others have used a covert approach in order to get close (Lauder, 2003). Researching groups in which the researcher has insider status is also a possibility, with scholars McKinley-Brayboy and Deyhle (2000) drawing on their insider/outsider experiences in Muscogee communities in
North America, and Sherif (2001) discussing the benefits and challenges of having Egyptian and German heritage during her ethnographic research in Egypt.

For those without insider status, one considered approach specific to NRMs and the particular challenges faced by researchers in this field is discussed by Richardson, Stewart and Simmonds (1978) and later by Gordon (1991). They emphasize the blurring of lines by trying to “fit in” with a NRM’s esoteric beliefs and practices. More beneficial, they both concur, is staying somewhat distant, but open and honest about one’s questions and personal beliefs. There is a tenuous balance in this approach. For instance, Anthony (1990) was too distant and refused to engage with members at all about his personal beliefs, which alienated and angered members who in the end decided to disengage from the research entirely.

A more balanced approach is to take seriously the beliefs of the group by engaging (though perhaps not initiating) in discussion about differing beliefs or views on various topics raised with members. For Richardson (1991), this created an atmosphere of mutual respect and often led to considerable insight into the group.

The above approach can also curtail the possibility for researchers to become defined by members as merely potential converts, particularly when most religious groups are at least somewhat evangelical (Richardson, 1991). Classification of researchers by members as potential converts raises a variety of ethical questions with regard to positionality and rapport. Importantly, Richardson (1991) discourages researchers from taking advantage of this classification, even though it may seem like a good “foot in the door” as it increases the likelihood of tension and conflict when a conversion does not occur.

Moreover, when a NRM is structured hierarchically, researchers need to be careful to respect this hierarchy, regardless of whether or not they agree with the group’s politics. The movement I am referring to in this article had a small group of men at the local leadership level, and they made the important decisions for the group, including whether or not to participate in the research proposal I presented them. I did not get the opportunity to speak with the men in this group about the research, as I was assigned a female “host” in a lower position. Thus, despite discussing the research prospects at length with Maria and her husband over several months, the information about the research that the leadership group received was outside of my control.

**Access**

Unlike the terms “entry” or “rapport,” “access focuses attention on the social scientific goal of ethnography: access to information” (Harrington, 2003: 599). Sometimes “access” and “entry” are used interchangeably; this conflation assumes
that the emphasis is on the actions of the researcher, rather than a relational process (Feldman, Bell and Berger, 2003). In the case of NRMs, having “access” is to understand the tenuous nature of research with those who have the right to retract that access at any moment. “Entry,” on the other hand, overlooks this important ethical caveat, and assumes a membership-like role. The discourses we use to construct the fields we work in can have a crucial impact on our ethical judgements, and ultimately our success and failure.

While in the literature access to field sites is recognized as a process (Amit, 2000; Ezzy, 2002; Rossman and Rallis, 2012), there is rarely a discussion of this process ending in a denial of access. A series of tips or strategies designed to “win” the trust of potential participants (Gobo, 2008) are commonly included in access discussions. The metaphor of trust as a prize to be won at best oversimplifies the process and renders the social and political context of the often fragile relationships between researchers and researched completely invisible. Another common tip is that new researchers need to exercise determination and hard work (Bryman, 2012), as though access is a hurdle that will be overcome by the willpower and strength of the researcher, with little regard to the agency of those being asked to participate.

The differences between the researcher and researched will shape access, with acceptance more likely where these differences are minimal (Shaffir, 1991). For research with NRMs however, as previously discussed, the differences between researchers and researched can potentially be bridged with a methodologically agnostic approach and a respectful openness about one’s views.

Coffey (1999) recognizes the complexity of fieldwork relations, especially in the pre-access phases. Recognizing that the onus of rapport is on the researcher, Coffey sees fieldwork as a form of identity work because of the focus and importance of social relationships. I will discuss this in more depth in the following sections on rapport and positionality, though it is suffice to say that these relationships are unique to each research setting, and therefore the personal “negotiation tactics” employed by a researcher will uniquely shape access experiences (Rocha, 2009). At the foreground of access negotiations is the importance of interpersonal skills (Feldman et al., 2003).

If access is granted to a NRM, anthropologists such as Ayella (1990) have shown how important it is to be critical of the kind of access that is being granted. She writes that NRMs “vary in the kind of access they allow; ‘potential convert’ may be the only way they conceptualize outsiders, in spite of the researcher’s identification of self as researcher” (p. 571). A researcher may also be understood as a reporter. In the final meeting with the group I was negotiating access with, it was clear from the group’s questioning that I was considered a potential convert;
however the behind-the-scenes discussions regarding the younger member “Googling” me points to a more complicated cause for refusal than simply my unwillingness to convert.

**Rejection**

There is very little scholarship on experiences of rejection during early phases of fieldwork, yet the vast literature on access, rapport and the politics of research-site negotiation points to the known difficulty of gaining access to a group for research. For established researchers with wide-reaching networks, anecdotes of rejection may indeed be plentiful, but new researchers often have limited professional exposure to such tales, and when this is matched with the lack of scholarship on the issue, it leads to a perception of a 100% success rate for research negotiations. This creates additional burdens of embarrassment and shame when rejected by potential participants, which further contributes to the silence on the issue in the literature.

Gilliat-Ray (2005) offers a detailed account of her experience of non-access to four Islamic seminaries in the UK. In this instance, the *dar ul-uloom*, or Islamic seminaries in question refused to engage with the researcher, who details four attempts to gain access via three separate gatekeeper negotiations, as well as a formal letter of request, all of which were unsuccessful. Similarly, Peshkin (1984) writes about the denial of access to a pilot-study site of two fundamentalist Christian schools. Restricted access was granted by two other schools; however Peshkin and his research assistants were asked to leave early because he and his colleagues were not Christian. Both Gilliat-Ray and Peshkin highlight the power dynamics in the field, as well as the impact of the researcher’s identity on access negotiations, both of which I will discuss further in this article.

While not an outright rejection, there are also cases where researchers have left the field early, such as Reeves (2010), who left while researching a parole hostel because of a relationship breakdown with some of the participants. She does write however that, by the time this occurred, she had reached a data saturation point. Gill (Gill and Temple, 2014) also left the field early, though without gathering data; however this was of his own choosing and was due more to the institutional limitations of funding, and the financial and personal toll of researching at a site geographically far away from his home. The logistic implications of research are not just minor details; as this case highlights there are times when the research relationship is strained by more than just the researcher/researched dynamic, and can involve institutional and personal tensions as well.

There are cases of researchers expelled from the field, such as Anthony (1990) who researched a NRM in North America. As Richardson (1991) points out, this
was due to the tension caused by Anthony’s refusal to engage in discussion of his personal religious beliefs, leaving participants feeling misunderstood, or taken advantage of. Decades after her research on the prevalence of mental illness among young men in Ireland, Scheper-Hughes returned to the town in which she lived with her family during her research. At the time, her participants were deeply offended by the resultant monograph (Scheper-Hughes, 1979) which argued that the prevalence of mental illness among men was at least partially due to the social conditioning of the youngest sons. Youngest sons, Scheper-Hughes argues, were poorly educated compared to older siblings, and were conditioned to believe the best they could hope for in life was to take over the family farm and care for their aging parents. Scheper-Hughes then published her own account of the experience of returning to Ireland, including the humiliating scene of expulsion when she arrived at an ex-participant’s house (Scheper-Hughes, 2000).

There is no doubt that times of professional rejection are hardly ones we want to focus on for too long. For new researchers, particularly in anthropology, the first experience of fieldwork is a rite-of-passage. To fail in that first foray into fieldwork is to at least postpone any professional recognition as an anthropologist. Much more than just failing to gain access, the failure to research can indeed bring grave professional consequences. It may be one thing for new researchers to tell tales of rejection to peers, who may have their own tales to tell, and another to publish these stories and admit to that rejection publicly. While more established researchers may have more stories of research success than failure, the academic requirements of data collection and research output afford little time to wallow in self-pity, and it is easy to see how the experiences of “non-data” get pushed aside (Smith, 2014).

The following sections offer a breakdown of some of the elements that may have contributed to my experience of rejection. The researcher’s positionality, uneasy rapport and the social and political context of the research topic of home birth shape this particular context of rejection.

**Positionality**

The context in which knowledge is produced matters. This context includes the researcher’s own identity, and the interpersonal interactions between researchers and researched. How the two (or more) parties see each other is based on a vast array of variables and creates a highly charged context for interaction, often before permission for access has even been discussed. My experience of rejection has many facets, some of which I will never understand as I was never privy to any conversations members may or may not have had with each other about me.
or the proposed research. My knowledge of my own positionality and its impact is only partial, though I will attempt to be as reflexive as possible here.

When I first visited the farm, a friendly man with a beard and loose-fitting clothes escorted me from the car park at the front of the property, along a garden path to a small cottage. I took my youngest son with me, as he was still exclusively breastfed. I left my two year old son with my mother. Admittedly, I also thought it might help my rapport with the women if I presented myself as a mother. Between this first visit and the next, my son had started eating solid foods, and I felt confident enough to go without him, and so with the exception of the final visit, I then visited alone.

At the cottage, my escort opened the door and introduced me to Maria, who would show me around (she would become my host each time I visited the property from then on). She ushered me inside and asked me to take a seat. She offered me tea, and I gave her the research information pack I had prepared. While she read the information, I took stock of the room around me, relishing the hive of activity in the kitchen. I wanted a kitchen that big, and that busy. I wanted to help cook whatever they were cooking. I could smell cookies baking. I could tell the décor was mostly hand-made. I noticed the hand-made toys, the abundance of wood and natural colourings. Everyone wore loose-fitting, natural-fibre clothing. None of the women seemed to dye their hair or wear make-up, and I could see that some of my foundation had rubbed off on the collar of my shirt. My son sat beside me in a wooden high chair, and sucked and cooed on the bright, plastic play-rings I had in my handbag. I watched him, begging him with my eyes to stay happy, and silently chastising myself for buying plastic toys and not something more natural.

I was acutely aware of the differences between myself and the others in the room. I would like to say these differences did not bother me, but as I was still learning about motherhood (and research), I was still vulnerable to criticism, and I had a long history of comparing myself to others. I sat there, feeling incredibly uncomfortable, even hoping my son would not need a new nappy (diaper), for they might see that I used the disposable kind, and not the more natural cloth variety.

These kinds of self-conscious concerns are not unique to me, and have been discussed by other researchers who have taken their children into the field. Mose Brown and De Casanova (2009) discuss their experiences of fieldwork with their own children, and the ways their parenting felt very much on display for their participants. They too felt their parenting quality was exposed and critiqued by participants.

On each subsequent visit I was asked by Maria and at least one other member where my children were and if I would bring them next time. I replied with vague statements such as “they’re spending the day with my mother,” and “I might bring...”
them, I’ll have to see.” I found it too awkward to admit that I considered these visits to be part of my work, and therefore had childcare arrangements, but at the same time these visits usually consisted of a couple of hours’ worth of drinking cups of tea and walking around the farm, hardly the kind of “work” most people are accustomed to. During these moments I felt my status as a “good mother” criticized, as I left my children with others while I “worked.” I knew all the women who asked me about my children were with their own children all day, and none of the children in the group went to an outside childcare facility.

Because I chose to bring my son with me on that first visit, and because I openly engaged with questions about my family with members, my role as a mother became part of the way members got to know me. These issues may not have directly influenced the reasons the group ultimately decided against participating, but they certainly influenced the rapport between myself and the group members.

In addition to the unique issues that parenting in the field creates, for Gordon (1991) there are two primary potential problems for researchers undertaking research with proselytizing groups: subjective distress and potential expulsion. While expulsion is not what happened in my case per se, subjective distress was certainly an issue I dealt with while I worked to “get to know” this group. About two months into the period of getting to know them, I found it increasingly difficult to separate my thoughts between my time on the farm and what was said, what I saw, what I felt, and my everyday life. I began having trouble sleeping, I was unable to concentrate, and found myself questioning things I had long accepted in my life. I began wondering what members of the group might say or think about this.

At the time I remember thinking that having these issues made me weak, that I was unable to focus on the work as work. I did not confide in my supervisors, who in hindsight I now know would have been supportive and understanding; however I was still trying to impress them and did not want them to think I could not handle the job. Instead, I consulted the university psychologist, free to me as a student, and told her what was going on. We talked at length, and she gave me a variety of strategies to keep these two parts of my life separate. Others have also noted this kind of all-consuming nature of fieldwork (Behar, 1996; Shaffir, 1991), and the growing acknowledgement of the vulnerability of researchers in sensitive areas (Dickson-Swift, James and Liamputtong, 2008; Liamputtong, 2007).

The strategies I used to help me cope with my emotions in the field included reminding myself daily that although I was attracted to their rural, farming lifestyle, I did not share their religious beliefs. Rarely did the group mention these beliefs to me in detail, and I only knew about them from accessing the leader’s teachings online, which were readily available. I also practised mindfulness when I could not focus, or had difficulty falling asleep at night. This involved focusing
my attention on a specific element of the present moment, such as concentrating on the sensation of breathing in and out, for example.

One approach that follows from the above strategies is the practice of “methodological agnosticism.” Originally developed by Berger (1969) as “methodological atheism,” scholars have since argued that agnosticism is preferred to atheism in this context as the latter instructs the researcher not to “consider ’metahuman explanations’ of religious phenomena” (Porpora, 2006: 61). Methodological agnosticism, on the other hand, asks the researcher to at least temporarily suspend disbelief (Barker, 2010; Ezzy, 2004).

The power dynamic between researchers and participants has been critiqued heavily in the social sciences for decades now (Harding, 1987; Oakley, 1981; Ole-sen, 1994). While the literature often polarizes the power differences between researcher and researched (Oakley, 1981; Roberts, 1981), others see a paternalism in the way power is assumed to rest only with the researcher (Mishler, 1986), and argue that there is more to interviewing “than can be circumscribed by the dominance-resistance binary” (Scheurich, 1995: 248). Postmodernist critiques highlight that participants are not passive, but rather active agents in the interview (Riach, 2009; Scheurich, 1995, 1997). Scheurich (1995) even shares moments of fieldwork in which interviewees have turned interview questions into something they have been more interested in talking about.

Power dynamics in early phases of access, however, are less defined, and perhaps less definable. The researcher in these phases is merely a “hopeful researcher” in the research setting, and the would-be-participants “often have the upper-hand, acting as gatekeepers and defining the terms on which researchers can gather data” (Harrington, 2003: 598). In these phases, more often than not it is the participants who interview the researcher. During my time with the members of the NRM, there were far more questions asked to me and about me than I asked of them. My time there was very clearly an exercise in building trust, and ultimately I knew that I was the one auditioning for access. This dynamic shaped our interactions. Undoubtedly I wanted this group to like me, and looking back I was certainly vulnerable and insecure. I was not powerless, however. As Bondy (2012) notes, as the researcher I had the power to leave.

**Rapport**

In my first visit to the farmhouse, when Maria finished reading the research information, she looked up from the papers and asked me what a PhD was. I was completely unprepared for that question, and I nervously gave her an answer and mumbled and fumbled my way through a series of unexpected questions about what I was doing and why. Maria’s questions were all legitimate; I was just
unprepared for them. I had over-intellectualized this meeting, and had not considered the ordinary, everyday questions people outside the university might ask of my proposed work, let alone people who had no experience with tertiary education at all—indeed the younger members of the group had no experience with state education at all as all the children in the group are home-schooled.

Maria folded the information sheets in front of her and asked if I had birthed at home. I sighed an internal breath of relief. I told Maria (and her nine-year-old daughter, who wandered in and out of the conversation) about my recent home birth, and what I had learned about that experience. I told her about my other son, then two years old, who was spending the day with my mother. She told me she birthed both her children at home, as did all the women in the group. We talked about how wonderful these experiences were, and bonded over our shared disappointment with the hospital maternity system as we had experienced it. We each told anecdotes of anti-hospital sentiment; stories I had learned were common when sharing home birth narratives.

Berger (2001) argues that the reciprocal sharing of stories during ethnographic fieldwork reduces the hierarchical gap between researcher and respondent. This idea has been met with some criticism, namely from feminist researchers who argue that “faking friendship” leads to an unethical exchange, where participants potentially give more than they are willing to, under the guise of false friendship (Dumcombe and Jessop, 2002). Not all friendship in the field is fake, however. I genuinely enjoyed Maria’s company, though found my time with her primarily to involve listening, and answering her questions about the research and my family; however my questions for her were rarely personal, and stayed mostly on the group’s history, the farm, value system and practices. Perhaps our rapport was not strong enough to feign friendship in the way I experience it with my friends on the “outside.”

For others like Richardson (1991), being open about your own beliefs, including those incongruous with the group’s, may advance rapport. While certainly this seems a more ethical approach than refusing to discuss your own beliefs, as a new researcher, inexperience coupled with the pressure to succeed created a much more obliging interaction. At the time of this research I took a similar position to Gordon (1991) and answered all questions asked of me as honestly as I could, and welcomed an open dialogue about anything I said, though I did not initiate disagreements, and did not respond antagonistically when told something I did not agree with. When Maria told me about the group’s disciplinary approach with children, which included corporal punishment, I just sat and listened. I did not agree with her view, and was silently horrified by it, but did not see the point in telling her that, and did not want to be rude or instigate an argument. I was a guest in someone else’s
home, and drew on my own socialization of “good manners” in such situations. I was certainly not confident enough to engage in well-meaning debate about parenting and discipline, or religious views, as Gordon (1991) recounts as benefiting his rapport with participants.

Rapport is traditionally defined in research contexts as one of the strategic devices employed by researchers (Glesne, 1989). For Jorgenson (1992), the development of rapport is then “evaluated according to the flow of data from the respondent” (p. 153) and becomes something the interviewer, as an individual, accomplishes. Despite rapport being the interpersonal interplay between researcher(s) and participant(s), it is usually discussed in the methodology literature as a deliberate strategy that develops using various tactics. These include, as Berger (2001) argues, the use of personal narratives, but for others it includes the deployment of gender strategies (Mazzei and O’Brien, 2009). For instance, for Kawulich (2011), working with Muscogee communities in North America, her working-class, farming background was emphasized more in her meetings with participants rather than her middle-class status and educational background. Farm life provided the common ground for their rapport. In much the same way, gender and motherhood played a key role in rapport for Maria and me, providing a mutual identification as women, wives, mothers, and home birthers.

In the case of the NRM I was researching, much of this advice on the development of rapport amounted to rather little. Despite our bonding over home birth, Maria had been in the group for more than ten years with minimal exposure to life outside the rural property since, and hence our rapport was not necessarily an easy-going one. She was very literal, quietly spoken, and serious. At the time I often thought my time with the group would have been more successful had I been allowed to socialize more freely. This, however, was beyond my control. Campbell et al. (2006) argue that we need to move away from the notion that researchers can control relationships in the field, and that “exerting this control is part of being a ‘good’ researcher” (p. 118).

Thus the notion of rapport as something the researcher achieves irrespective of the people they encounter during fieldwork does little to account for research in more restrictive environments such as NRMs. The literature on gatekeeper negotiations (Campbell et al., 2006; Reeves, 2010; Wanat, 2008) in more controlled research settings like educational institutions and other government organizations paints a more realistic picture of the kinds of hurdles a new researcher in a NRM might face. For this kind of ethnography, researchers are faced with varying levels of organizational structure with formal and informal gatekeepers at each level, each of whom need to be negotiated with in order to gain access to the particular research site.
While these bureaucratic levels were not necessarily the case for the NRM I was hoping to research, prior research on the group told me there was a very rigid hierarchical structure to the group, consisting of several layers of authority. While I was at the farm, I was ushered only by Maria and her accompanying children, and other members did not give me more than a cursory glance and smile. It was made clear in these interactions that I was there as a guest of Maria’s, and so I needed to stay with her. Indeed it seemed that while she was with me Maria was excused from any of the work she may have ordinarily been doing, and was free to sit and talk, sometimes for hours at a time. This certainly fits within a framework of viewing me as a potential convert rather than a researcher, and so perhaps Maria was there to facilitate this, rather than in genuine interest in participating in the research. Though I cannot confirm that her husband was part of the upper-level leadership of the group, he did appear to have more authority than many others. I met him several times, and each time his interest in the research seemed genuine. His knowledge of the politics and recent media debates was current, and his interest made me feel that their participation was likely. He may have just as likely felt that my interest in the community and their lifestyle was an encouraging sign that I would convert.

Social and Political Contexts

There is a social, legal and political context to fieldwork relations that goes beyond the research topic itself. What is of utmost importance, however, especially for new researchers, is considering the impact of this context on potential participants, and the ease by which they contribute to one’s research, or indeed if they contribute at all.

When I undertook this research project in 2009 Australia was experiencing a highly politicized reassessment of maternity services. Debates about these services were rife in the midwifery community (Newnham, 2010; Wilkes, Teakle and Gamble, 2009), the medical community (Pesce, 2009; Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2014), and the media (Devine, 2009; Elder, 2010; Wingate-Pearse, 2010). Many shared the views of conservative commentator Andrew Bolt, who wrote at the time in the *Herald Sun* newspaper online that the “free birth” movement (home birth with no midwife present) was just “the most extreme manifestation of a cult of ‘natural’ birth that forces so many women to endure unnecessary birth agonies for no good reason” (Bolt, 2009).

While home birth at the time, as now, remained a legal option for birthing women, in 2008 and 2009 there were at least two high-profile cases in which free-birthed babies were tragically stillborn (Devine, 2009; Duff and Hall, 2008; Lawrence, 2009). The families dealing with these tragedies were dragged through very
public coroner’s inquests, and public debate included questions of whether or not women should be “allowed” to birth unassisted, or at home at all.

For individuals wanting to access independent midwifery, it was an uncertain time to be planning a home birth. This NRM utilized home birth as part of a broader religious philosophy, and were possibly going one step further by free-birthing, though my knowledge of this at the time was purely hearsay. It is easy to imagine why the group may have felt reluctant to discuss their practices to a researcher planning on publishing the material.

The context for the research, while timely for a researcher, especially a young and enthusiastic doctoral student glad to have my finger on the pulse of a topical issue, has bigger implications for the participants and the perceived, potential or unknown consequences of participation. Certainly, if the media campaigns against the families who lost their babies during this time were anything to go by, this group could very reasonably expect to be dragged through the proverbial coals should the media decide to make an example of them. Considering this context from their point of view has helped me to empathize with their position, and I have asked myself since: “If I were in their position, would I participate?” I am not so sure I would.

**Conclusion**

The inner-workings of a NRM and how they perceive the research and their role in it is not at all transparent. The tactics and strategies provided in methodological literature go some way towards preparing a researcher for fieldwork and the multi-faceted nature of interactions in the field, though it would be an over-simplification to consider these strategies recipes for success. Rapport, for example, is often considered something the research achieves, rather than a process involving two or more people, whose attitudes, opinions, prejudices and personalities a researcher cannot control. When we start seeing the access phase of research projects as having more agents than simply the researcher armed with strategies for success, then rejection and failure can be seen as part of a broader context of interpersonal relations during research, and not a personal humiliation.

The variables at play in fieldwork with NRMs also include careful consideration of the socio-political context of the research project itself, and how that might impact the potential participants. In the situation presented in this article, my topical research on home birth may have been exciting for me, though for a NRM with a history of negative press, the stakes may have just been too high. While my time with this group gave me preliminary data on their practices of home birth in the form of my field-notes, this data cannot be published as I do not
have permission from the group to do so. Ethical research practice means respecting the wishes of the group, even as they see you to the door.

Other issues such as the structure of the group in question and their hierarchical politics are also beyond a researcher’s control. The power dynamics of a NRM may not be apparent to a new researcher, or any researcher without inside knowledge of the group’s structure. Power is often assumed to rest with the researcher, though in early phases of research, certainly before the group has formally agreed to participate, the researcher is merely auditioning. While as the researcher I may have had the power to leave the community at any time, I wanted to stay, but they had the power to tell me to leave, which they did.

All of the surrounding circumstances form the “non-data” of research practice, particularly early-phase research. While rejection is certainly unpleasant, and for the new researcher professionally challenging, it can be an important vehicle through which to engage with the social, political and interpersonal dynamics of social research, both for the project at hand and more broadly.

References


Bolt, A.

Bondy, C.

Bryman, A.

Campbell, L., N. Gray, Z. Meletis, J. Abbot and J. Silver

Coffey, A.

Devine, M.

Dickson-Swift, V., E. L. James and P. Liamputtong (eds)

Duff, E., and L. Hall

Dumcombe, J., and J. Jessop

Elder, J.

Ezzy, D.
2002 Qualitative Analysis: Practice and Innovation. Allen & Unwin, Crows Nest, NSW.

Feldman, M. S., J. Bell and M. T. Berger
2003 Gaining Access: A Practical and Theoretical Guide for Qualitative Researchers. Alta Mira Press, Walnut Creek, CA.

Fuji, L. A.

Gill, P. R., and E. C. Temple


© Equinox Publishing Ltd 2016


© Equinox Publishing Ltd 2016
Scheper-Hughes, N.
Scheurich, J. J.
Shaffir, W.
Shaffir, W. B., and R. A. Stebbins
Sherif, B.
Smith, A.-M.
Wallis, R.
Wanat, C. L.
Wilkes, E., B. Teakle and J. Gamble
Wingate-Pearse, G.

© Equinox Publishing Ltd 2016