

**Adam Rafalovich**  
Pacific University, U.S.A.

DOI: <https://doi.org/10.18778/1733-8077.12.3.05>

## **Pain Is the Club: Identity and Membership in the Natural Childbirth Community**

**Abstract** Based upon interview data collected from 50 respondents, this study examines how expectant mothers navigate the divide between natural and non-natural childbirth when faced with the dilemma of using chemical pain management. The vast majority of participants in this study had strong intentions of delivering without any type of chemical pain management, but when faced with intense physical pain and/or coaxing from medical authorities, made the decision to use an epidural. Respondent accounts illustrate that the decision to use an epidural effectively removed them from membership in the “natural childbirth club.” In order to better understand this process of group inclusion/exclusion, I draw upon the symbolic interaction frameworks of George Herbert Mead (1934) and Norbert Wiley (1995), paying special attention to their theories of the self. This study concludes that the decision to use chemical pain management in the childbirth process is often done so at the expense of changes in identity with respect to the Generalized Other of the “natural childbirth” community.

**Keywords** United States; Natural Childbirth; Medicalization; Epidurals; Pitocin; Gender; Club Membership

**Adam Rafalovich** received his Ph.D. in Sociology from the University of British Columbia in 2002. His doctoral dissertation was a social analysis of the response of adult authorities to children suspected of having Attention Deficit / Hyperactivity Disorder. This research became the backbone of his book *Framing ADHD Children* (Rowman and Littlefield-Lexington Books, 2004). Dr. Rafalovich has published widely in the area of medical sociology, with articles appearing in *Sociological Quarterly*, *Journal for the Theory of Social Behaviour*, and *Deviant Behavior*, and in issues of *Sociology of Health and Illness* and *Symbolic Interaction*. Dr. Rafalovich is an Associate Professor of Sociology at Pacific University in Forest Grove, Oregon, U.S.A.

**email address:** rafalova@yahoo.com

Although a variety of social contexts influence childbirth decisions (Fox and Worts 1999; Miller and Shriver 2012), it is well established that childbirth in contemporary Western society is situated within the milieu of medical social control (Oakley 1980). Of particular note is Western medicine’s advocacy for drug-induced pain management. Focusing upon how childbirth contexts impact individual identity (Levesque-Lopman 1983; Zadoroznyj 1999), this paper addresses women’s unexpected decisions to use chemical pain management in the childbirth process. Below I examine how mothers who used such pain management defined their birth experience as “non-natural” vis-à-vis mothers who delivered their children “natural-

ly,” that is, without any chemical pain relief. The “natural/non-natural” dichotomy in childbirth is an extension of childbirth narratives that interrogate the increasing presence of Western medicine in the birthing process. Given the prevalence of this dichotomy in defining the birth experience, it is important to examine the literature addressing both the medicalization and de-medicalization of childbirth.

### **Childbirth and Pain Management**

Childbirth in Western societies is commonly overseen by medical experts yet is still entrenched in many facets of “folk medicine,” making childbirth a socially negotiated process (Rothman 1978) between expectant mother, the world of lay wisdom, and the medical establishment. These social negotiations lead to a wide variety of approaches to childbirth (Nelson 1983), falling somewhere upon the “non-medical-medical” continuum. In cases of uncomplicated childbirth, the decision to adopt medically invasive approaches usually involves pain relief. A major theme in accounts of the childbirth process (Norr et al. 1977; Barnes 2011), decisions about pain management depend greatly upon an expectant mother’s social network (Sargent and Stark 1989; Dillaway and Brubaker 2006). As childbirth connotes fear of pain and the unknown for expectant mothers (Fisher, Hauck, and Fenwick 2006), pain relief through chemical means has proven to be a crucial part of conventional medicine’s hegemony in childbirth practices (Guillemin and Holmstrom 1986; Davis-Floyd 1994; Stockill 2007). For many women, the experience of childbirth is often characterized by the ability to

navigate within a brief timeframe the implications of such interventions (Akrich and Pasveer 2004).

One intervention that has attained prominence in American society is spinal anesthesia, commonly known as an “epidural.” According to the Centers for Disease Control, approximately two-thirds (61%) of American women who had singleton, vaginally delivered babies received an epidural in 2008 (Osterman and Martin 2011). The wide use of epidurals is a touchstone of modern obstetrics (Arney and Neill 1982), and often serves as the medical intervention that distinguishes “natural” from “non-natural” childbirth.

### **De-Medicalization and Natural Childbirth**

Countering the hegemony of Western practices which seek to medicalize childbirth, or place it within the province of modern medicine and treat childbirth more like an illness than a natural phenomenon, natural childbirth narratives de-medicalize the childbirth process (Nash and Nash 1979; Monto 1997; Brubaker and Dillaway 2009). Embracing a natural childbirth approach involves a willful re-appropriation of the birthing process from the dominance of the Western medical model. Although the term “natural” is socially constructed, and by definition, subjective (Westfall and Benoit 2004; Mansfield 2008), it generally denotes childbirth as a process with no chemical pain management. Natural childbirth is also said to be more readily achieved through social support (Morton 2003) and many healthcare organizations adopt flexible approaches to the birthing process, including those that are

non-medical or “naturalistic” (for an example of this, see: Walsh 2006).

De-medicalizing childbirth narratives partially stems from expectant mothers who fear medical intervention (Christiaens, Van de Velde, and Bracke 2011) and embrace social support to achieve a natural delivery of their children. The re-emergence of midwifery, for example, in the childbirth process (even in medical settings, like hospitals), demonstrates an embrace of a de-medicalized approach (Weitz and Sullivan 1986; Allen 2001; Walsh and Kitzinger 2007; Fowler 2009). The combined fear of medical intervention and the expressed need for social support from “birthing experts” like midwives can be seen in the steady increase in “home birthing,” indicating a rising skepticism towards strictly medical approaches (Wheeler 1980; Moore 2011).

Given the context of this rising skepticism, this study will examine how expectant mothers navigate this divide between natural and non-natural childbirth when faced with the dilemma of using chemical pain management, usually in the form of an epidural. The majority of participants in this study had strong intentions of delivering without any type of chemical pain management, but when faced with intense physical pain and/or coaxing from medical authorities, made the decision to use an epidural. Respondent accounts illustrate that the decision to use an epidural effectively removed them from membership in the “natural childbirth club.” In order to better understand this process of group inclusion/exclusion, I draw upon the symbolic interaction frameworks of George Herbert Mead

(1934) and Norbert Wiley (1995), paying special attention to their theories of the self.

### Methods and Data

Data for this study were collected from 50 respondents initially recruited through an informal stay-at-home mom’s club located in a metropolitan area in the Pacific Northwest. Additional respondents were recruited through “snowball sampling” (Birnacki and Waldorf 1981; Marshall 1996) in which the sample size grew as respondents referred me to potential participants. The respondent profile was mostly comprised of white women, between the ages of 26 and 49. Approximately half of the 50 respondents described themselves as strictly “stay-at-home” moms, whereas the remaining participants had employment outside the home. Several respondents who defined themselves as stay-at-home parents offered a caveat that their employment status was due to their children being quite young at the time of the interview.

Subsequent to pre-testing, I simplified my instrument to an eight question, open-ended interview schedule, which served as a general guide for data collection (see: Appendix). After each participant read and signed my university IRB-approved consent form, I began the interview. Interviews were audio recorded and took on a conversational tone, typifying the principle of dialogue between researcher and participant (see: Fontana and Frey 2000). Each interview took, on average, sixty minutes to complete, which translated to roughly fifty hours of recordings that were later transcribed to provide the raw data for analysis. To avoid “waiver-

ing calibrations” (Webb et al. 1966:22) in data collection, I carefully read each interview transcript and followed up with respondents regarding statements that were unclear or inaudible during the transcription process.

Once interviews were transcribed and clarifications made with respondents, I applied a grounded theory coding scheme (Glaser and Strauss 1967; Glaser 1978; Strauss and Corbin 1990) to the data set. I began by indiscriminately reading each interview transcript while writing and audio recording analytical notes based upon my preliminary findings. This culminated with an open coding (Glaser 1978:55) scheme to identify some of the salient themes in the raw data. These codes were applied to the interview transcripts, which were then categorized for the most prevalent themes in the data set. I then began selective coding (Glaser 1978:61), in which I placed specific analytical focus upon the most emergent themes in the data set. As my analysis of the raw data became more precise, I focused upon two interconnected themes which form the backbone of this paper. The first concerns the extent to which the definition of natural childbirth constitutes a form of de-medicalization of the childbirth process. The second theme focuses upon the experience of pain in the childbirth process as a rite of passage into the community of women who delivered children naturally. Although these two themes do not constitute a “theory unto themselves” in the classic sense of grounded theory, I feel that this approach in coding the qualitative data provided important clarity for the application of the symbolic interaction theories of George Herbert Mead (1934) and Norbert Wiley (1995). Stat-

ed differently, I use the analytical approaches in grounded theory to distill major themes from the data and expand upon an already established body of theory.

### Findings and Analysis

Data analysis revealed two interrelated themes. The first concerns a strong de-medicalizing sentiment and a concomitant subscription to natural childbirth. The second concerns the specific role that pain and pain management play in distinguishing between natural and non-natural childbirth. Both of these types of accounts shape the knowledge, expectations, and practices of childbirth and provide a backdrop to the experiences of most women in this study. It is important to situate the themes from the data within a broader body of theory in sociology. Two theorists that are indispensable in this conversation are George Herbert Mead (1934) and Norbert Wiley (1995).

A major departure from Freudian understandings of personality that postulate identity as a result of innate processes, Mead’s *Mind, Self, and Society* (1934), emphasizes identity as a reciprocating symbolic process between the self and greater social environment. For Mead (1934), the role of language is crucial in shaping who we are and typified by his concept of the “I” (the creative, spontaneous part of self) and the “Me” (the socially conscious part of self). As foundational concepts in symbolic interaction, the “I” denotes social dynamism and individual creativity, whereas the “Me” illustrates social stability. The “Me” is the linguistic manifestation of the “Generalized Other,” or greater community

by which an individual evaluates his/her social role. According to Mead, the relationship between I and Me is a constantly evolving social process. Importantly, the Generalized Other within the context of this study denotes the greater community of women who have avoided invasive medical intervention in the delivery of their children and collectively identify as having birthed their children naturally.

Norbert Wiley's *The Semiotic Self* (1995) extends Mead's conversation in a very important way by adding the concept of the "You" to the process of self. According to Wiley (1995), the process of self is not dialogical in the sense that "I" and "Me" have an ongoing, insulated, symbolic relationship, but is instead "triological." In the sense that the "Me" is socially conscious, it is also socially reflective, temporally situated in past social experiences. As the source of creativity and social change, the "I" represents the present self. Finally, the "You" demonstrates a projected future self. The triologue is a three-way conversation, in which the I (present self) and the You (future self) converse with each other about the Me (past self). My application of Wiley's work is particularly relevant when I discuss how medical agents often appropriate the discourse of the natural childbirth community in an effort to console women who chose chemical pain management despite their initial intentions to avoid such medical intervention.

### The De-Medicalizing Self

Participants in this study overwhelmingly agreed that a natural delivery was optimal (even for the mothers in the sample who never seriously consid-

ered natural childbirth), but also prepared for the necessity of medical intervention in the event of complications. Such sentiment demonstrates how the availability of information to expectant mothers has shifted cultural perceptions of childbirth. Indeed, the medicalization of childbirth has given rise to concomitant alternative discourses supporting the practice of natural childbirth. Such alternative viewpoints presented in books such as *Birth From Within* (England and Horowitz 1998) and the documentary film *The Business of Being Born* (Epstein [director] 2008) assert themselves vis-à-vis the perceived insensitivity and physiological harm caused by unnecessary medical intervention in the childbirth process. Wont to offer theories on the way babies should be born, these sources of information and those who espouse their benefits shape a cultural narrative of the childbirth experience and form the landscape of childbirth expectations.

For mothers who defined themselves as having delivered children naturally, information from these sources galvanized them against the medical establishment. As one respondent who had a home birth states:

I definitely prepared by reading a lot, learning about other birth experiences, and I think really being committed to the self-belief that I can do this because millions of women have done it, and the desire to be strong and to feel proud of myself and strong that I did it...we [she and her partner] did attend a workshop that was based upon this book that I read, called *Birth From Within*, where...there are pain management techniques that are...based in sort of a mind over matter type of idea. [Respondent #6]

Based upon the knowledge she gained from studying proper techniques for natural childbirth, she discusses the need to separate oneself from a medical environment:

...at the hospital it's common for them to kind of push the epidural, they want you to have the epidural because they want you in the bed and they want you just to relax and not be screaming, so that's a common thing, so when you have a lot of pressure from the outside, "Maybe it's time for that epidural now, sweetie," and you're in a lot of pain and it's getting really bad, sometimes it's easy to just, "Okay, fine, give it to me," and you can kind of give in to that pressure and because, like I said, the pain can be so intense that it'd be hard to say "No" when it's right there, somebody's got it right in front of you, "I can give you this magic injection and everything will go away," and right in the moment I think that...[it] is hard to resist. [Respondent #6]

The above illustrates the belief that administering an epidural is not only for pain relief, but also for compliance and the maintenance of a calm hospital atmosphere. Reflecting a common facet of the natural birth narrative, several participants in the study explain how their reticence to deliver at a hospital is not based upon aesthetic reasons, but rather because of the cascading effect of medical intervention:

...hospitals are for sick people and hospitals are riddled with interventions and then one intervention leads to another intervention...They usually want the easy way out which can get you the results quick. And I really didn't want people to tell me what to do...being stuck in a...hospital. [Respondent #13]

Another respondent describes this cascading effect with respect to the increased probability of a cesarean section:

...my birth plan was really detailed and I think my biggest fear about giving birth was this image of the big bad hospital taking over...I was like no episiotomy, no this. I took a sample of one of natural books I was reading and basically...there's just a lot of talk about. The Cascade Effect: you do one intervention and then you have like ten follow, you know?...I think my biggest fear was that they were going to take power out of hands, and I was going to end up with a cesarean, because I hear that one in four births [it is actually one in three, approximately 32%—author's note] in America are cesarean. So I was determined that it was going to be natural. [Respondent #19]

Due to extenuating circumstances, a few respondents who were educated in the natural childbirth process and wished to deliver at home were unable to do so because of insurance reasons. One respondent who delivered without any medications or surgical procedure describes her consumption of information, and the compromise she made between her desire for home birth and the necessity of a hospital setting:

...I read lots and lots of books and talked to lots of people. In that process, I decided that, and I knew enough about myself, that environment was really important...Originally, I had wanted a home birth. I wanted to do a water birth, but that wasn't an option through my insurance, so I decided to have a hospital birth, but found a nurse midwife that would deliver

in a hospital. So I felt like that was kind of my compromise. I could still have a more of a holistic natural birth process, but in a hospital setting. [Respondent #42]

In order to protect herself against possible pressure to take medication in the hospital environment, she describes the completion of her birth plan once labor begun:

Then I remember that I went into labor...I started to feel...this intense nesting feeling because the car seat still hadn't been installed and my birth plan hadn't been written. I told [partner's name], I said, "Okay, you have to go out to the car and install the car seat right now. I'm going to the coffee shop and I'm going to finish writing the birth plan and print it out. I want everything ready to go." [Respondent #42]

The perceived correctness of natural childbirth is partially based upon the belief that invasive medical intervention in the childbirth process poses increased risk to both mother and child. The use of an epidural (often through lidocaine injected into the spinal column), or other forms of intravenous pain management (Stadol, Demerol, and so forth) are seen as potentially toxic, even if the specific effects of such drugs are not explicitly understood. For example, in defining natural childbirth, one respondent states:

It meant that I did not want to use any drugs because of how they affect the baby. And actually, mostly—mostly because it starts nursing off badly. And I really felt that nursing was going to be a real important part of that, and if babies don't latch on immediately be-

cause they are lethargic or—that's a strong word, but, you know, not as alert as they may be...it can start nursing off on a bad step. So that was my big concern. [Respondent #19]

The above accounts illustrate that the childbirth process, which is almost entirely medicalized in Western society, is characterized by a tremendous power asymmetry between medical experts that oversee childbirth and the mother-to-be under their care. Hence, the push towards de-medicalization is as much a decision about the health of mother and child as it is an expression of the desire to connect to a Generalized Other that has reclaimed a significant portion of the childbirth process from Western medicine. This Generalized Other is an internalized composite of texts, documentaries, and the directly conveyed experiences of family and friends. The presence of this Generalized Other runs directly counter to the asymmetry in power between modern medicine and the natural childbirth community, manifested in a variety of ways—through official clothing, credentials, medical jargon, and so forth—but perhaps what is most significant is the way that experts articulate medically necessary interventions.

### A Self That Embraces Pain

In addition to the perceived risks of physiological harm through medical intervention, the data indicate that the ethic surrounding natural childbirth is cultivated by social relationships. Several respondents spoke about friends, parents, or other family members who had delivered their children naturally, never used chemical pain management, and ar-

ticulated a "magical" experience with the process. Without question, most respondents felt a degree of social pressure to share in this experience. Medical intervention, in this sense, first, symbolizes social exclusion from those who had never experienced such intervention in their own deliveries and, second, one's inability to withstand physical pain.

Most women in this sample equated natural childbirth with eschewing chemical pain management. However, the definition of natural childbirth does not exclude all types of medical intervention in all cases. For example, some respondents argue that Pitocin—a drug used to intensify contractions and speed up the labor process—can be administered and still allow a "natural" birth. This brings up important questions about the ontology of natural childbirth and connection to the Generalized Other of those who are a bona fide part of the natural childbirth community. For example, what specific components of the birth experience (irrespective of medical intervention) are necessary conditions to define it as natural and therefore, maintain the desired identification with this Generalized Other? As the data point out, the use of medical interventions that intensify pain does not necessarily serve to prevent identification with the natural childbirth community.

The below excerpt from a respondent who went through thirty hours of labor before finally taking an epidural sheds some light on this question. In this conversation, she describes how the experience of physical pain, perhaps more than a lack of medical intervention, allows one to have membership in the natural childbirth "club":

**Interviewer:** Talk a little bit about that club.

**Respondent #28:** I think it is a little bit of a club because, well, [friend's name], she had the same, completely naturally with no drugs at all...And it's so intense that I think you have to have experienced it to really relate with somebody else who's done it. Because I can relate with the labor pains, but I certainly can't relate with the actual delivery part of it.

Our conversation then turns to her aunt who did not have an epidural, but used Pitocin for all three of her deliveries:

**I:** Have you had any...conversations with people where even though it wasn't explicitly stated you're not a member of the club, where you felt as though you weren't...given full membership?

**R #28:** ...Well, actually, yeah, probably my aunt. My aunt...is kind of like my mom. She was there [at the birth] and...for all three of her babies, she had had Pitocin...

**I:** ...So you can use Pitocin and still be in that club?

**R #28:** Right. Yeah...I think...the pain *is* the club part.

**I:** What does that mean?...let's talk a little bit about why that pain would give someone membership.

**R #28:** I think because it is so intense...I dated a guy who was an Army Ranger...And the rangers have to go through ranger school, which is like this intense, you know, sleep deprivation and like just grueling, I don't know how long that was, but it separates them from the regular Army like having gone through that kind of exhaustion and those sorts of things. I think as a short experience, they feel morally because of that, that they've done that. And, I guess that's maybe what I can compare it to.

**I:** ...in this sense, we can say the Pitocin actually adds to the pain?

**R #28:** Yeah...But, they didn't tell me that before they started me on the Pitocin, but everyone who has had it said, "Oh, yeah, the labor is a lot worse with the Pitocin, at least the contractions part of it."

Another respondent who identified as delivering her son naturally offers a similar viewpoint, describing her use of Pitocin in the delivery of her son—a decision that did not exclude her from membership in the natural childbirth club:

...I was terrified about having Pitocin because I heard: "Oh, if you have Pitocin, then you're guaranteed you'll have to have the epidural, you know, Pitocin is so painful." Twenty hours...into it nothing was progressing because my uterus was exhausted and they were like, "We'd like to give you a little Pitocin," and I was just terrified, but my older sister was right there and convinced me that a little bit would be okay because she had Pitocin, and I agreed, and I'm really thankful 'cause they did, they just gave me a little bit. It was just a kick-start. [Respondent #19]

For many respondents, to be included or excluded from the club defines, in part, the importance of the childbirth experience. Although the interview accounts illustrate that having a healthy baby trumps all other outcomes, it is clear that in many cases succumbing to medical intervention produces feelings of failure and social isolation. Describing the delivery of her children (in which she used an epidural) vis-à-vis the experience of her relatives, one respondent explains:

**R #1:** Well, I'll admit with the epidural I felt a little bit like I was cheating because it was so virtually pain free, and so I was surprised by that. I expected there still to be a fair amount of pain once I chose the epidural, and so, I mean, I felt like I was barely participating in the delivery of both babies. Like I was there and trying to follow directions on what I should be doing, but honestly just felt like, "Am I doing it?"

**I:** It's interesting that you would use the word "cheating"...

**R #1:** Yes...my mom didn't have an epidural for any of her babies [respondent's mother had 10 children—author's note], so I just felt like I wasn't fully experiencing what I should be as part of bringing a child into the world should include all of these certain bullet points...It just seemed like, a lot of the people that I respect, most who became moms before I did, including my mom, aunties, and just other older women in my life. It just seemed like they all had this similar experience and maybe...it just seemed like maybe I was skipping a step.

The above explains the experience of natural childbirth along generational lines. "Skipping a step" denotes a generation gap and a detachment from the Generalized Other of the natural childbirth community. Further, this respondent, like others in the sample, describes her epidural experience as one that separates her from the essence of the birth experience—"barely participating" in her words. This theme repeatedly emerges from the data. Because an epidural numbs the body from the waist down, therefore removing a significant amount, if not all, of the pain of childbirth, it is the Rubicon which precludes "club" membership.

In other instances, exclusion from the club occurs as a result of succumbing to clinician pressure. The below excerpt further articulates this sense of disappointment and separation in the face of unexpectedly intense pain and a physician who continuously badgered her to take an epidural. Ultimately conceding to having the epidural, she explains her feelings afterwards:

**I:** Can you describe a little bit of...your feelings when you had made the decision to...follow what the doctor had suggested?

**R #3:** Complete disappointment, in myself, not understanding why I couldn't do it. Not realizing that it maybe had nothing to do with me physically, or it had everything to do with me physically, and nothing to do with me as a person *per se*. I had good intentions, blah, blah, blah, but for whatever reason physically, I couldn't do it. But, it was still a big let-down. I still wish I could have had that experience...I have seen natural childbirths and just wanted to have that feeling.

Membership in the club is certainly not free. As these and other examples from the data illustrate, respondents describe the childbirth process as an extraordinary confrontation with physical pain. Indeed, several respondents (either through having gone through childbirth previously or using other sources of information) explain childbirth as the most painful experience a person can ever encounter. Yet, in reflection upon their childbirth experience, most women in this sample described themselves as "up to the task" prior to the point of labor:

I guess because, again in looking back at it, I think it was that I had always thought of myself as a strong

woman, always been very athletic, always been very independent, I'm goal-oriented and I usually achieve those goals, so to have had a goal for natural childbirth and to not achieve that I felt like a failure. It also felt like I was weak, I couldn't do it. There are certain friends in our community that are very much into just more natural ways of doing things...I was fearful of their perception of me and my inability to do that without drugs. [Respondent #15]

The above excerpt illustrates how the feeling of failure correlates with belief in self efficacy. As this respondent explains, natural childbirth is a goal not only for personal achievement, but also to fit in better with her community.

Continuing with this theme, respondents almost uniformly discussed how the decision to take or not take an epidural was based upon the perceived limitations of their own bodies. If a mother-to-be can withstand the pain of childbirth, she will deliver naturally, but if the pain proves to be too great, she may opt to use an epidural. Sometimes the blinding and unexpected intensity of labor pain is simply too great a burden. One respondent who was steadfast in her expectations for a natural delivery, but chose to use an epidural at the onset of heavy labor articulated the experience this way:

Oh, it just felt like somebody was just tearing your insides out. I mean, it was just ripping on things, you know your sensitivity of your body, just each part, just really hurt. [Respondent #43]

Given the vulnerability of women in the childbirth process, and the intense desire for the delivery of

a healthy baby above all other outcomes, respondents' accounts repeatedly illustrate how a woman determined to deliver a baby naturally "gives in" to the wishes of medical practitioners.

Take the following statement from a respondent who was particularly adamant about delivering her child without the use of any medication:

...I think that *really* [read: without drugs] giving birth can be a great touchstone for a woman's experience. [respondent #19]

This clear expression of belief that childbirth can be a defining moment for a woman's identity leads with the "I" or present self. The "I" sees the social benefit of the "pain club," or the Generalized Other, and wants membership in it. It is also known that this conviction is influenced by other social factors—in this case, family members who delivered children without medication. Hence, as with any definitive "I" statement, there is the spectre of "Me," illustrating the symbolic internalization of the Generalized Other. Given the conviction of this respondent, her support from family members who had delivered children naturally, and the absence of any medical emergency, it would not be unreasonable to expect that this respondent would deliver her child without medication and achieve that "great touchstone." However, her account continues:

...I had asked them deliberately not to ask me if I wanted any drugs...I was asked eleven times if I wanted drugs during that period of time. Crazy. I mean, that's a lot. And it just—it tears away at your self confidence and your ability to deal with this. [Respondent #19]

Ultimately, and likely as a result of succumbing to this pressure, this respondent did use an epidural approximately an hour-and-a-half before delivering her child. Although the baby was in no distress, the constant offering of pain relief through medication ultimately wore down her conviction about delivering naturally:

...she kept saying...you're not a bad mom if you do this. It was really just somebody pushing constantly about it. [Respondent #19]

### Natural Childbirth Identity and the Consolation Prize

The previous excerpt is an example of how medical experts adopt the role of the Generalized Other and anticipate what a mother-to-be would think of herself should she use the epidural. In Wiley's (1995) terms, they anticipate the "You" of this respondent. In assuming that this respondent would see herself as a bad mother, medical practitioners attempt to establish themselves as credible members of the Generalized Other.

The mode of entry into the realm of credibility, and hence, a part of the Generalized Other that can effectively anticipate the "You" is largely contingent upon the legitimacy of Western medicine. As several respondents point out, many of their anxieties surrounding the childbirth process are already anticipated by the medical staff caring for these mothers-to-be.

Following the fact that there is no canonized definition of natural childbirth, a small number of respondents who used an epidural explained how they ex-

perienced enough physical pain and exhaustion to warrant at least partial membership in the natural childbirth club. A respondent who delivered twins explains how she had a natural delivery because her labor was so protracted that her epidural had effectively worn off:

...also for the second delivery I also had an epidural. I was in hard labor just right off the bat. There was no lead up, too, it was just all of a sudden hard back labor hit. So I was in pain several hours before we actually even went into the hospital. So then they had to stop, they tried to stop my labor. That was several days worth of being in the hospital. So they gave me the epidural so that I would be comfortable for those couple days. Turns out when I actually gave birth to the twins I'd had the epidural for a day and a half and it was taking in some places, but not in the place where it really could have done the most work. That I definitely feel that one was, even though I had an epidural, the twins were a natural birth because I can tell night and day between the two different births. The twins were much, much smaller than my first. I kind of feel like I've had both worlds, even though technically I had an epidural the second time around. [Respondent #18]

Another respondent reflects upon two contradictory interpretations from the nursing staff, where one nurse states that the delivery was not natural, whereas the other, in understanding that the epidural had worn off hours before the actual birth, offers an interpretation that allows inclusion into the natural childbirth club:

The doctor got straight to work on sewing up the large tears inside and out. When she left, she men-

tioned that she wouldn't be in this business if every birth was that intense. The nurse who was helping with the clean up heard me say, "Well, I wasn't able to deliver naturally after all." I felt like a failure, but with the trauma of the birth and how close we were to having an emergency c-section, I was relieved to have a healthy baby. I knew that my friends who had delivered with no drugs would be asking if I had opted for an epidural. The fact of the matter was that I never had more doses of the epidural drugs and it had worn off hours before the actual birth. The nurse rubbed my arm and said, "Actually, honey, you had your natural birth!" [Respondent #50]

It is important to note that the validation of a natural delivery is generally provided by medical practitioners. As respondents in my sample repeatedly state, they have made their expectations of natural childbirth apparent to medical staff that oversees the delivery of their children, such a redefinition of the childbirth situation is offered as a type of consolation. There is, without doubt, significant asymmetry here, not only with respect to physical control over the body, but also with respect to the way that medical practitioners leverage medical discourses. This is not to imply that medical practitioners automatically assume that expectant mothers who are set on natural childbirth are going to feel a sense of despair and separation should their natural childbirth expectations not pan out, but rather, this asymmetry is a clear indication of the socialization of medical practitioners. After all, that which is a defining life experience for an expectant mother is "all in a day's work" for a medical practitioner. Such a stark contrast between the subjective experience of expectant mothers and the professional obligations of those

who work in Western medicine illustrates, in part, why expectant mothers experience such a tremendous amount of pressure to embrace medical interventions when they enter a hospital setting.

Given this analysis, let me return to a previous excerpt (recall Respondent #19's "touchstone" comment), and add hypothetical text that illustrates the social pressure experienced in the hospital:

...I think that naturally giving birth can be a great touchstone for a woman's experience, *but will this be possible for me?*

This addendum to the above statement illustrates a tearing away of self-confidence, and the erosion of belief in one's ability to deal with the pain of childbirth. The "Me" component of this statement included here illustrates the presence of a new Generalized Other influencing this reflective part of self. As the achievement of an ideal, natural delivery symbolizes a cherished entrance into the natural childbirth club, and the waning possibility of natural delivery has dramatic implications for self-concept. The italicized part of this hypothetical question pits an expectant mother against her own limits of pain endurance. The experience of pain without chemical intervention is a gatekeeper evidenced by reflection upon the Generalized Other. In this sense, the Generalized Other includes people who are a part of the natural childbirth club, but as medical intervention intensifies, the Generalized Other may also include medical practitioners who offer an "easier, softer way" to deliver children. Operating in this capacity, medical practitioners manipulate the "You" in an emotionally favorable way.

## Conclusion

I hope that the accounts presented in the study offer some insight into the social psychological processes of inclusion in, or exclusion from, the natural childbirth club. As many of these accounts illustrate, natural childbirth, although an ideal situation for most expectant mothers in this sample, is a process that requires significant social navigation. For instance, mothers who are determined to deliver naturally repeatedly express the need for a willful "push-back" against medical social actors who offer the promise of pain relief, and a more "medically safe" childbirth experience. Further, despite being armed with the knowledge that medical practitioners will likely pressure expectant mothers into medical interventions such as the use of Pitocin, epidurals, and so forth, many respondents in this sample explain that such social pressures, when coupled with the unexpected turmoil of childbirth, are often too daunting a barrier into the natural childbirth club. In these cases, exclusion from this club may be a troubling part of a mother's birth story.

This stark dichotomy between expectant mothers and the medical establishment does not tell all of the story when it comes to membership into the natural childbirth club. For women who experienced unanticipated pain, and opted for an epidural, respondents' accounts demonstrate a mutually understood exclusion from the natural childbirth club. However, for women who used an epidural that had worn off prior to delivery, delivered vaginally, and with significant pain, the accounts demonstrate the flexibility of membership. The same also goes for the use of Pitocin which, as at least one respondent

mentions, intensifies the pain of delivery and therefore still allows natural childbirth club membership. In this sense, medical intervention is a necessary, but not sufficient condition to exclude one from the natural childbirth club.

Although it is clear that the childbirth stories in this sample which involve the use of an epidural exclude a respondent from membership in the natural childbirth club, there remains a significant amount of flexibility to the standards of club membership. Anticipating the emotional impact of succumbing to medical interventions such as epidurals, medical practitioners, who may know very little about the biography of an expectant mother, may mitigate the gatekeeping that excludes mothers who use such medical intervention. This leads to some very interesting questions for further research: Is the anticipation of a mother's expectations on behalf of medical practitioners a natural

outcropping of the professional medical environment? Or, is this part of a discursive strategy that solidifies the hegemony of modern medicine in the childbirth process? Future research that focuses upon the way that medical actors anticipate and respond to the social network of expectant mothers may shed some light upon these important questions.

On a final note, it is important to add that, although this research sheds light upon some important questions, the study also has limitations, primarily in the profile and size of the sample itself. As the bulk of women who participated in the study were white and largely middle-class, it would be inappropriate to extrapolate these findings beyond the nuances of the sample. This is a great place, I believe, to encourage further research in this area, perhaps through the cultivation of larger and more diverse respondent samples.

## Appendix: Interview Schedule

1. Can you generally describe for me some of your experiences in the prenatal and delivery phases of your pregnancy?
2. Overall, can you describe the role that medical practitioners played in your prenatal care, as well as the delivery of your baby?
3. Can you describe for me any point during the prenatal and delivery process where you felt that medical practitioners were overbearing, or discounted your opinions? Any specific examples?
4. Can you describe for me any point during the prenatal and delivery process where you felt that medical practitioners were accommodating and clearly listening to your individual needs? Any specific examples?

5. Can you describe for me some of the moments leading up to the birth of your child? For example, what specific changes had occurred that led you to believe that the moment to deliver the baby had arrived?
6. (Relating to Question #5) Can you describe for me how the people around you responded to these particular changes? For example, your birth partner, family, friends, physician, or other significant people?
7. Could you describe for me any moments through the delivery process in which the expectations you had of the experience of delivering your child were different from what was actually happening during the delivery? In other words, did you experience a disconnect between what you expected to experience versus what you actually experienced?
8. Did you take any medications prior to and during the delivery process? If so, can you describe some of the circumstances that led to your taking of the medications?

## References

- Akrich, Madeleine and Bernike Pasveer. 2004. "Embodiment and Disembodiment in Childbirth Narratives." *Body & Society* 10(2-3):63-84.
- Allen, Davina. 2001. "Social Perspectives on Pregnancy and Childbirth for Midwives, Nurses, and the Caring Professions." *Sociology of Health and Illness* 23(3):386-396.
- Arney, William R. and Jane Neill. 1982. "The Location of Pain in Childbirth: Natural Childbirth and the Transformation of Obstetrics." *Sociology of Health and Illness* 4(1):1-24.
- Barnes, Hayden H. 2011. *The Ring of Fire: The Psychological Purpose of Pain in Childbirth*. MA Thesis. Pacific Graduate Institute.
- Biernacki, Patrick and Dan Waldorf. 1981. "Snowball Sampling: Problems and Techniques of Chain Referral Sampling." *Sociological Methods and Research* 10:141-163.
- Brubaker, Sarah J. and Heather E. Dillaway. 2009. "Medicalization, Natural Childbirth, and Birthing Experiences." *Sociology Compass* 3(1):31-48.
- Christiaens, Wendy, Sarah Van de Velde, and Piet Bracke. 2011. "Pregnant Women's Fear of Childbirth in Midwife- and Obstetrician-Led Care in Belgium and the Netherlands: Test of the Medicalization Hypothesis." *Women & Health* 51(3):220-239.
- Davis-Floyd, Robbie. 1994. "The Technocratic Body: American Childbirth as Cultural Expression." *Social Science and Medicine* 38(8):1125-1140.
- Dillaway, Heather and Sarah J. Brubaker. 2006. "Intersectionality and Childbirth: How Women From Different Social Locations Discuss Epidural Use." *Race, Gender & Class* 13(3-4):16-41.
- England, Pam and Rob Horowitz. 1998. *Birthing From Within: An Extra-Ordinary Guide to Childbirth Preparation*. Santa Barbara, CA: Partera Press.
- Epstein, Abby, director. 2008. *The Business of Being Born*. U.S.A.: Barranca Productions.
- Fisher, Colleen, Yvonne Hauck, and Jenny Fenwick. 2006. "How Social Context Impacts on Women's Fears of Childbirth: A Western Australian Example." *Social Science & Medicine* 63(1):64-75.
- Fontana, Andrea and James H. Frey. 2000. "The Interview: From Structured Questions to Negotiated Text." Pp. 645-72 in *The Handbook of Qualitative Research*, edited by N. Denzin and Y. Lincoln. Thousand Oaks, CA: Sage.
- Fowler, Alexandra. 2009. *Moms, Midwives, and MDs: A Mixed-Methods Study of the Medicalization and Demedicalization of Childbirth*. Doctoral Dissertation. Duke University.
- Fox, Bonnie and Diana Worts. 1999. "Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth." *Gender & Society* 13(3):326-346.
- Glaser, Barney G. 1978. *Theoretical Sensitivity: Advances in the Methodology of Grounded Theory*. Mill Valley, CA: Sociology Press.
- Glaser, Barney G. and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine.
- Guillemin, Jeanne H. and Lynda L. Holmstrom. 1986. "The Business of Childbirth." *Society* 23(5):48-54.
- Levesque-Lopman, Louise. 1983. "Decision and Experience: A Phenomenological Analysis of Pregnancy and Childbirth." *Human Studies* 6(3):247-277.
- Mansfield, Becky. 2008. "The Social Nature of Natural Childbirth." *Social Science & Medicine* 66(5):1084-1094.
- Marshall, Gordon. 1996. *The Concise Oxford Dictionary of Sociology*. Oxford: Oxford Press.
- Mead, George H. 1934. *Mind, Self, and Society: From the Standpoint of a Social Behaviorist*. Chicago: University of Chicago Press.
- Miller, Amy C. and Thomas E. Shriver. 2012. "Women's Childbirth Preferences and Practices in the United States." *Social Science & Medicine* 75(4):709-716.
- Monto, Martin A. 1997. "The Lingering Presence of Medical Definitions Among Women Committed to Natural Childbirth." *Journal of Contemporary Ethnography* 26(3):293-316.
- Moore, Sara B. 2011. "Reclaiming the Body, Birthing at Home: Knowledge, Power, and Control in Childbirth." *Humanity and Society* 35(4):376-389.
- Morton, Christine H. 2003. "Doula Care: The (Re)-Emergence of Woman-Supported Childbirth in the United States." Doctoral Dissertation. University of California.
- Nash, Anedith and Jeffrey E. Nash. 1979. "Conflicting Interpretations of Childbirth: The Medical and Natural Perspectives." *Urban Life* 7(4):493-512.
- Nelson, Margaret K. 1983. "Working-Class Women, Middle-Class Women, and Models of Childbirth." *Social Problems* 30(3):284-297.
- Norr, Kathleen L. et al. 1977. "Explaining Pain and Enjoyment in Childbirth." *Journal of Health and Social Behavior* 18(3):260-275.
- Oakley, Ann. 1980. *Women Confined: Towards a Sociology of Childbirth*. New York: Schocken Books.
- Osterman, Michelle J. K. and Joyce A. Martin. 2011. "Epidural and Spinal Anesthesia Use During Labor: 27-state Reporting Area, 2008." *National Vital Statistics Reports* 59(5):1-16. Retrieved April 05, 2016 ([http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59\\_05.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_05.pdf)).
- Rothman, Barbara K. 1978. "Childbirth as Negotiated Reality." *Symbolic Interaction* 1(2):124-137.
- Sargent, Carolyn and Nancy Stark. 1989. "Childbirth Education and Childbirth Models: Parental Perspectives on Control, Anesthesia, and Technological Intervention in the Birth Process." *Medical Anthropology Quarterly (New Series)* 3(1):36-51.
- Stockill, Clare. 2007. "Trust the Experts? A Commentary on Choice and Control in Childbirth." *Feminism & Psychology* 17(4):571-577.
- Strauss, Anselm M. and Juliet Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Measures and Techniques*. Newbury Park, CA: Sage.
- Walsh, Denis. 2006. "Subverting the Assembly-Line: Childbirth in a Free-Standing Birth Centre." *Social Science & Medicine* 62(6):1330-1340.



Walsh, Denis J. and S. Kitzinger. 2007. "A Birth Centre's Encounters With Discourses of Childbirth: How Resistance Led to Innovation." *Sociology of Health and Illness* 29(2):216-232.

Webb, Eugene J. et al. 1966. *Unobtrusive Measures: Non-Reactive Research in the Social Sciences*. Chicago: Rand McNally.

Weitz, Rose and Deborah A. Sullivan. 1986. "The Politics of Childbirth: The Re-Emergence of Midwifery in Arizona." *Social Problems* 33(3):163-175.

Westfall, Rachel E. and Cecilia Benoit. 2004. "The Rhetoric of 'Natural' in Natural Childbirth: Childbearing Women's

Perspectives on Prolonged Pregnancy and Induction of Labour." *Social Science & Medicine* 59(7):1397-1408.

Wheeler, Eunice L. 1980. "The Demedicalization of Childbirth." *North Central Sociological Association*. Retrieved April 05, 2016 (<http://search.proquest.com/docview/61729225?accountid=13047>).

Wiley, Norbert. 1995. *The Semiotic Self*. Chicago: University of Chicago Press.

Zadoroznyj, Maria. 1999. "States of Health: Health and Illness in Australia." *The Australian and New Zealand Journal of Sociology* 25(1):136-137.

Rafalovich, Adam. 2016. "Pain Is the Club: Identity and Membership in the Natural Childbirth Community." *Qualitative Sociology Review* 12(3):100-116. Retrieved Month, Year ([http://www.qualitativesociologyreview.org/ENG/archive\\_eng.php](http://www.qualitativesociologyreview.org/ENG/archive_eng.php)).