

AN ABSTRACT OF THE THESIS OF

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Abstract approved:

Rebecca L. Warner

In this paper, my aim is to call attention to the meanings women attach to their birthing experiences using the symbolic interaction perspective in conjunction with a feminist lens. I argue that the obstetrical model of childbirth defines the course of the relationship between the laboring woman and attendant, limiting the amount of control women have over a hospital experience. In 2001 I interviewed 12 women who gave birth between the years 1932-2001. I found that the social location of actors, setting, and interventions affected the level of control they had in guiding the interaction. I additionally learned that the decision making process of *where* to birth had as much influence as the experience of birth itself did on the meaning of childbirth for this group of women. For some of the women in this study, redefining the birth experience allowed them to negotiate their own reality.

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Birthing Experience: Feminism, Symbolic Interaction, and (Re) Defining Birth

by
Michele L. Roland-Schwartz

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APPROVED:

Major Professor, representing Sociology

Director of Interdisciplinary Studies Program

Dean of the Graduate School

I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

Michele L. Roland-Schwartz, Author

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Birth Experience: Feminism, Symbolic Interaction, and (Re) Defining Birth

INTRODUCTION

Over the past 500 years, a drastic shift has occurred in the way childbirth is practiced. It has moved from a traditionally physiologic, midwifery-attended experience to a more medicalized one that increasingly includes the use of medication and technological interventions in hospital settings. This shift did not occur by happenstance. Rather the medical establishment appropriated the practice during political and religious upheaval. As the attendants, settings and interventions changed or were introduced, women's views about childbirth and ultimately their experiences also changed. The introduction of obstetric interventions have provided women with a sense of security and a perception of reduced harm to their child and themselves, as well as options to reduce or avoid labor pain. However, the use of obstetric interventions has the potential of removing women from the center of their experience as the attendant who uses the intervention takes control. With the rise of medicalization, *autonomy* has been overshadowed by *risk*, a defining concept of medicalized childbirth (Hausman, 2005).

There have been recent attempts to place women back at the center of their childbirth experience. While some states restrict the practice of midwifery, women increasingly have alternative childbirth options, including birthing in the home or in a birthing center. Some women have opted to combine traditional and contemporary birthing practices; for example, they may choose a hospital where pain and risk reducing interventions are used while taking advantage of the presence of a doula or midwife to obtain the support they desire. Access to information about these services is not always

readily available, and mixed messages about the pros and cons of specific providers, and methods of delivery can be confusing and misleading. Rothman (2006) argues that women must negotiate their care while “living in a land of contradictions” as evidenced by the “return of the midwife and the rise of the cesarean section” (p. 6-7).

When I interviewed the 12 women in this study in 2001 I had no background in childbirth, holistic or medical. My knowledge stemmed from what I had read and heard throughout my life, having not experienced birth myself. My interest in women’s health was kindled during my graduate coursework, specifically while studying feminist theory and research methods. I was skeptical of the medical establishment and was troubled by how women were treated, viewed and were given limited access to information about their healthcare options. This, coupled with my interest in women’s reproductive capacity fueled my interest in childbirth. As I began research for this project and started the interviews, my skepticism of medicine and obstetrics increased. This has influenced the tone of my thesis which is explicitly pro-homebirth, pro-midwife. I am not opposed to a hospital birth attended by a physician, as long as women are given unbiased information about the technology available to them and then are allowed to make informed decisions about their course of treatment. The women’s movement has offered women more autonomy and power in many spheres of life—including childbirth. Women are better able to advocate for themselves in the hospital environment than they were 50 years ago. I however am concerned about the often biased information offered to women that influence the decisions they make and ultimately their experiences of childbirth.

Using symbolic interaction theory to guide my analysis of the constructed meaning shared between the attendants and laboring women is useful to understand women's childbirth experiences. Traditionally women and midwives shared a definition of parturition that trusted women's bodies and viewed them as capable of childbirth. As the field of obstetrics grew, childbirth was redefined by the obstetrical community as an event to monitor, govern and control. Symbolic interaction theory will allow me to examine how the interaction between the women and attendants, the interventions used and the setting of childbirth construct the meaning of childbirth for the women interviewed in this project. Understanding the history of childbirth, which reveals the changes in attendant, setting and interventions, is crucial to understanding how women perceive and make meaning of their experiences. A small qualitative study will address how the structure and process of contemporary childbirth in the US defines the experience for women. According to Hesse-Biber (2007), "experience is shaped by one's particular context – specific circumstances, conditions, values, and relations of power. Each influences how one articulates *experience*" (p. 9). The women in this study gave birth at various times and places in the twentieth and twenty-first century, approached birth differently and utilized different providers and techniques that all influenced their experience with each individual birth. In the first part of this project I will review the history of childbirth, how obstetrical knowledge is considered authoritative knowledge, as well as the contemporary trends in the US to provide a context for my analysis of the women's experiences in this project.

THE APPROPRIATION OF WOMEN HEALERS

For hundreds of years in virtually all human societies, women healers or midwives were the primary aid and attendant coaching and supporting laboring women during birth (Maternity Center Association, 1999). Childbirth was a social process whereby women could bond and skills were passed down from one generation to the next (Kitzinger, 2005). The fifteenth and sixteenth centuries, however, witnessed the rise of the medical establishment, as well as one of the most violent and devastating events in women's history, "the witch-craze." The European witch-craze, or what Mary Daly (1990) refers to as "the burning times," targeted women accused of heresy, who were tortured and eventually hanged or burned at the stake. Many disagree on the number of women executed for witch-craft: some estimate in the thousands, others argue in the millions (Barstow, 1994; Ehrenreich & English, 1973; Williams, 1995). Barstow (1994) points out that, "no matter the exact or approximate number of victims, this was an organized mass murder of women" (p. 21). This "women's holocaust" (Mitford 1992, p. 23) was significant in that it not only set a precedent for violence against women (Barstow, 1994; Daly, 1990; Dworkin, 1974), it literally changed the face of the healing profession.

Midwives who were branded as witches were at the heart of the witch-hunts. A text written by two German-Dominican Monks, Heinrich Kramer and James Sprenger, titled *Malleus Maleficarum* (1486) or in English, *The Hammer of Witches*, influenced the misogynistic landscape. *Malleus Maleficarum* was commissioned by Pope Innocent the VIII in 1484 (during his first year of service) as a crusade against infidels and a response

to schism. Against the backdrop of the Protestant Reformation, *Malleus Maleficarum* was used as a source of persecution of midwives and other healers for nearly three centuries and was used as the primary text by judges and witch-hunters (Ehrenreich & English, 1973; Williams, 1995). Women healers in particular were linked to using magic and copulating with the Devil (Barstow, 1994; Mitford, 1992). Kramer and Sprenger charged that “witch-midwives,” or *Hexenhebammen*, “killed babies at birth and blasphemously offered them to devils” (Kramer & Sprenger, 1971, p. 140). Midwives who were arrested were consequently interrogated and forced, through violence and torture, to confess to the crimes for which they were charged.

Fearing being branded a witch, many midwives were forced into hiding, hindering the advancement of their profession (Rooks, 1997). Ehrenreich and English (1973) point out that the timing of the witch-burnings coincided with the rise of the medical establishment and its partnering with the Church and State: “Witches represented a political, religious and sexual threat to the Protestant and Catholic churches alike, as well as to the state” (p. 7). The rise of the medical establishment, supported by the church and state, usurped the healing profession and over time created the medicalized (Riessman, 1998), technocratic (Davis-Floyd, 1992; 1993; 1994) birth practiced in contemporary obstetrics.

AUTHORITY, KNOWLEDGE, AND RISK

In similar ways that religion played an important role as an agent of control during the witch-hunts, medicine too became an agent of social control as social and cultural

attitudes shifted about the body, disease and science (Foucault, 1973). Obstetrics as an agent of social control significantly impacts pregnant and laboring women, which I will address later on in this section. Obstetrics has captured authoritative knowledge so successfully that it is rarely required to defend or justify the ideology behind its practices and its normalized routines are rarely called into question. Women come to expect the interventions because they are considered a tacit standard of care blessed by the medical community (Hausman, 2005). When women challenge the routine practices of obstetrics or choose to resist obstetrics completely, issues of *risk* and *responsibility for health* arise. Obstetrics exerts control over women by monitoring their alternative choices to healthcare, such as a birth at home or in a birthing center attended by a midwife which they deem unsafe.

Obstetrics as a mechanism of social control was developed out of the medical establishment's ability to govern and manage lifestyle and behavior. Stewart (2004) points out that the ability of medicine to monitor lifestyle is in large part due to the shift from religious institutions shaping world views, to medicine acting as the moral arbiter of our generation, as it relates to our bodies. She argues, "the notion of an unhealthy lifestyle resulting in ill health has replaced earlier religious concepts of sinful behavior leading to divine retribution" (p. 31). Responsibility and blame for unhealthy outcomes is placed on the individual as the public health community makes clear the message that individuals must take responsibility for their own health, and subject themselves to the *medical gaze* (Foucault, 1973; Stewart, 2004). Edwards (2005) argues, "Where obstetric

thinking dominates, a woman cannot help but view birth through its lens, no matter what she believes” (p. 91). As pregnant women learn to view their bodies and their healthcare decisions through the eyes of medicine, their choices are influenced by what is considered acceptable by the majority. This is particularly true of childbirth, where women who choose to birth in a hospital do so because of the expectation by others around them. The option to birth at home or in a birthing center is *risky* because obstetrics tells us it is, a concept I will explore later.

The introduction of obstetrical tools and techniques solidified the role of the obstetrician as the expert, evidenced by the creation and use of childbirth forceps. Invented by the Chamberlain family in 1588, (a family of barber-surgeons), the forceps were kept a secret for approximately 100 years by means of concealing the forceps from the laboring woman and excluding attendants from the birthing room (Mitford, 1992). Physicians would not teach midwives how to use the tool, requiring them to call on physicians when their *expertise* was needed (Rooks, 1997). This invention helped secure the perception that the obstetrician was the expert in the hospital, and a safety-net for women who decide to have home-births today.

During the twentieth century childbearing women experienced several obstetrical interventions during labor and birth, including: shaving the perineum, use of enemas, episiotomies, fetal heart monitors, epidural anesthesia and cesareans. Several drugs were used to reduce the pain of childbirth including scopolamine, morphine, ether and chloroform. The drugs assisted with dilation, helping ease the pain of contractions and

labor. The drugs however left a generation of women with very little, if any, memory of their childbirth experience.

The response to the increased use of tools and medicine was the natural childbirth movement headed by Grantly Dick-Read, an English obstetrician and Fernand Lamaze, a French physician. Dick-Read (1959) and Lamaze (1984) each provided their own recommendations on how to achieve a fearless and painless childbirth under the direction of an obstetrician. Their recommendations which were based on their individual research, positioned themselves as the foremost authority in the field of childbirth. While Dick-Read shows a genuine appreciation of childbirth, his focus on a supportive birthing environment, without the fear of childbirth was co-opted from the midwifery model of childbirth care, with the exception that he saw the “value of protecting women from fear,” rather than acknowledging that a woman could labor without fear on her own (p. 58). Dick-Read (1959) (whose work was dismissed by Lamaze) proposed in a paternalistic tone, that without fear in childbirth, women would experience little to no pain. Dick-Read contended that minimal use of anesthesia should be used during childbirth, emphasizing the importance of supportive birth attendants during labor, bonding between the newborn infant and the parents and the removal of fear during childbirth. Dick-Read argues that this should be done only under the advisement of the obstetrician.

The early methods of Fernand Lamaze (1984) whose work was originally published in 1956, cast himself, or that of the educated Lamaze specialist, in the role of

the childbirth expert. Lamaze argues that by using the “psycho-prophylactic method”

(based on Pavlov’s theory of conditioned reflexes, known in his work with salivating dogs), a laboring woman could essentially recondition her response to pain, ultimately experiencing the absence of pain during childbirth. Lamaze contends that the success of childbirth is ultimately under the control of the laboring woman and that, “she is responsible for the success or failure of her own childbirth” (p. 17). However, Lamaze positions the obstetrician as the “director” of the labor and the woman a mere participant:

The obstetrician is and must remain the only head in directing and controlling the preparation and the labour, as he is the only one conversant with the dynamic nature of the uterus, he alone can decide how such and such a labour is progressing...in no case, as some people are trying to affirm, will a prepared woman deliver herself painlessly without the advice of the obstetrician and the watchful care of the midwife. Teamwork is an essential; it may be a team of two to start with which will later expand, but, as in all teams, there can only be one leader- and this is the obstetrician. (p. 185)

How is the laboring woman responsible for the outcome or success of her childbirth when the obstetrician is positioned as the expert of her experience? If the woman feels pain during childbirth but the obstetrician is the leader, how can she be responsible for what is perceived as failing? It appears that the early Lamaze practice did not allow laboring women control over the events during childbirth, but rather to control their behaviors and accept the obstetrician’s decisions. The natural childbirth movement, while arguing that drugs and interventions are unnecessary fails to challenge the obstetrical definition of childbirth as something to monitor and control. Rather, Dick-Read and Lamaze argue that women must subject themselves to the expertise of the

obstetrician, and in a subtler way, to the expertise they offer under the guise of *natural birth*.

The field of obstetrics which views women's bodies as a risk to themselves (Martin, 1987; Stewart, 2004) impacts the care pregnant and laboring women receive, limits the choices women have in navigating their healthcare options and influences women's beliefs about their bodies and ultimately their childbirth experiences. Childbirth in the hospital introduces women to routine medical interventions, increases women's risk of experiencing a cesarean section and limits the continuous labor support necessary for a woman to have an optimal birth experience (Rosen, 2004; Simkin & O'Hara, 2002; Stark, 2006). The process of childbirth in the hospital is centered on the needs of the medical system rather than offering empowerment to women (Lorber & Moore, 2007).

Influenced by Cartesian dualism, that would regard the body as a machine or as a collection of parts separated from the mind, medicine consistently cuts the female body into functioning and malfunctioning parts that require constant monitoring (Martin, 1987). In the case of childbirth, women's bodies are a site of control by the medical community—monitors are used to track the fetal heartbeat as the contractions may cause fetal distress, scissors are used to cut the area between the anus and vulva (episiotomy) if the vaginal opening is not considered big enough for the fetus to pass through, forceps or a vacuum extractor are used to retrieve the fetus, if the woman's body is considered unable to expel the fetus on its own. In all of these examples, the physician's tools are a

means to fix the perceived failing or risky body.

The concept of *risk* in the US, which is defined as “the potential for negative consequences of an event” is largely based on our past experience, even though this is not a reliable predictor of future loss (Tierney, 1999, p. 217). Tierney points out that when estimates of risk are generated, no matter how “empirically sound,” they are viewed as an accurate reflection of a specific social or physical system (p. 220). The concept of risk in childbirth has significantly impacted the technological practices of obstetricians and healthcare decisions that pregnant women make. Hausman (2005) argues,

Contemporary women’s perceptions of the risks associated with childbirth have been manipulated through the historical shifts in the management of childbirth from female-dominated contexts to the medically defined hospital obstetric practice to produce new kinds of risks and new ways to approach, address and manage those risks. (p. 33)

Obstetrics has constructed the female body as something that must be managed by the medical community, and governed by a “physician’s authority to define the abnormal” (Weir, 2007, p. 102). The female body is regarded as “abnormal, inherently defective, and dangerously under the influence of nature” (Davis-Floyd, 1994, p. 4), therefore a risk to itself. The notion of risk for perinatal mortality is applied to the birth as well as the weeks leading up to and following the birth of a child. Weir (2005) describes this series of events as “the threshold of the living subject which constitutes the zone of transition into and out of human bodily substance” (p.1). This series of events is monitored by various medical technologies and practices in order to reduce the risk of perceived harm to the fetus and mother, although the primary concern is for the fetus.

Weir (2005) argues that women are pressured between making two choices: 1) “Be responsible managers of their own risk factors” or, 2) If they refuse the obstetric model of care, “women are ordered into involuntary medical treatment” (p.13). The latter

may appear drastic, but has certainly been witnessed in the case of court-ordered cesarean sections in the US and UK (Cahill, 1999; Kitzinger, 2005). Even if women are not ordered into involuntary medical treatment, rejecting the recommendations of the medical community casts them as irresponsible by putting themselves or more importantly their fetus in danger. The pressure from family and friends may elicit compliance with risk management. Hausman (2005) concludes that the compliant behaviors of mother’s as an obstetrical patient is influenced by “gendered experiences and their understanding of themselves as patients” (p. 37).

Dr. Joseph De Lee, a well established and well known physician and published author of obstetric texts in the early twentieth century encouraged regular medical interventions. He argued that “childbirth is a pathologic process from which many women could escape damage” (Rooks, 1997, p. 25). This pervasive view of childbirth as a risk influenced the routine use of interventions in obstetrical practice as well as women’s views that their bodies must be managed. Many women may perceive their bodies in the same manner as the obstetrical community as ideas about the body are shared culturally and are influenced by social structures (Lorber & Moore, 2007; Stewart, 2004). It is in this way that obstetrical knowledge is considered *authoritative knowledge*.

Its views are shared by the majority because that is the primary knowledge presented.

CONTEMPORARY MIDWIFERY

As discussed earlier, midwifery as a practice has been stunted over the past several hundred years, from the widespread witch-hunts, to the early twentieth century when a campaign by public health leaders nearly ended midwifery altogether. The public health leaders however, recognized that midwives were caring for poor and minority women and agreed to allow midwives to practice, but only within the strict guidelines and educational standards of the medical profession (Rooks, 1997). Many midwives have attempted to resist the confines of the medical community by defining their practice as “the care of physiologic/healthy/normal pregnancy and birth” (Weir, 2006, p. 78). This attitude about pregnancy and childbirth is a distinct contrast to the medical community’s version of childbirth as a pathologic process. The midwifery model trusts women’s ability to birth rather than viewing the body as a risk to itself. While I do not promote the view that the purpose of women is to reproduce and that their primary achievement is motherhood—I do believe that the midwifery model of care fosters empowerment and autonomy for women who choose this method of care. Unfortunately it is greatly underused by women in the US due to the many legal restrictions on midwifery practice (Midwives Alliance of North America, 2006) and the negative messages about midwives that currently persist.

These messages are evidenced by a recent case in Indiana where Jennifer Williams, a midwife, was convicted, not with causing or contributing to the death of a

new-born child in June of 2005, but with practicing without a medical license. The case makes clear the anti-homebirth sentiment from doctors, legislators and prosecutors in Indiana: “Home births supervised by midwives present grave and unacceptable medical risks” (Liptak, 2006). Dr. Kevin R. Burke, president of the Indiana State Medical Association argues, in a sentiment similar to his predecessor, Dr. De Lee: “routine things sometimes become very un-routine, the best environment for labor and delivery is in a hospital or in a facility that adjoins the hospital” (Dowdy, 2006). This case illustrates the push by medical leaders and their allies to create strictures of practice on midwifery and send the message that homebirths and midwives are unsafe.

Midwives are attempting to unite and create political change, but they cannot always agree on what that change will look like. While some midwives believe in the traditional midwifery model of childbirth practice—others believe that professionalizing the field will bring legitimacy and acceptance in the eyes of the obstetrical community as well as mainstream women. Midwives are seemingly caught between two different models of care, stemming from two different paradigms, causing a split amongst practicing midwives. This split is evident in Davis-Floyd’s *Mainstreaming Midwives* (2006) where she describes the inability for two professional midwifery organizations, the Midwives Alliance of North America (MANA) and the American College of Nurse Midwives (ACNM), to agree on the kind of training and education required for midwives to practice. This inability to agree has led to difficulty in legislating midwifery practice and bringing legitimacy to the field. MANA believes that apprenticeship is a sufficient

form of teaching, while ACNM argues that a “nurse-midwife” must have a college degree to acquire legitimization and rejects midwives who do not have a formal education. The disagreement has also left midwives arguing with one another on “what makes a good midwife” rather than challenging obstetrical ideology—in other words, focusing only on

legitimizing midwifery practice leaves obstetrics in a place of rarely having to defend its practice (Edwards, 2005).

CONTEMPORARY TRENDS

The National Vital Statistics Reports (NVSR) from the Centers for Disease Control and Prevention (CDC) reports that while 92% of births in 1997 were attended by physicians, they saw a steady increase in use of midwives from 3.7% in 1989 to 7% of total births in 1997 (Curtin, 1999). While the rate of increase is comparatively smaller, the use of the midwife increased to 8% by 2003. The use of a midwife may have increased, but the hospital setting is basically unchanged from 1989-1997 at 99%. Of the 1% of out-of-hospital births, 65% occurred predominantly in a residence while 27% were in a freestanding birthing center in 2003 (Martin et al., 2006).

According to the 2005 report from the CDC's NVSR, 27.5% of births in 2003 were cesarean section deliveries (Menacker, 2005). This percentage is not insignificant. Between the years 1989-2000 cesarean section rates fluctuated between 20.7%-22.9%. 2001-2003 saw a drastic increase from 24.4% in 2001, to 26.1% in 2002. In 2003, the rate increased to 27.5%, a 4.6% increase from 2000. The CDC's NVSR for 2006 show that cesarean sections have increased to 29.1% in 2004 (Martin et al., 2006), and "the 2006 rate will reveal that about one pregnant woman in three is giving birth by major abdominal surgery" (Sakala, 2006, pg. 16).

Many argue that the increase in cesarean sections is due to women electing to have the surgical procedure without medical reasoning (Spiesal, 2006). Childbirth Connection, a national non-profit organization (formerly the Maternity Center

Association) refutes this popular claim by reporting that nearly 10% of the women in their

survey who gave birth in 2005 reported feeling pressured by their medical provider to have a c-section (Childbirth Connection, 2006; Declercq et al., 2006). The increase in cesarean sections may be due to what Sakala (2006) calls *defensive medicine*, which is influenced by “medical, legal, social and financial factors, as well as changing attitudes and values that health professionals and pregnant women hold” (p. 16).

American obstetrics have employed a multitude of other interventions used during childbirth that have changed even during the late twentieth century. While research suggests that routine episiotomy provides no benefit and may be harmful to women (Hartmann et al., 2005), 17.5% of births in 2003 included the use of an episiotomy to assist with delivery. The CDC reports that during 1989-1997, the use of forceps has consistently decreased from 5.5% to 2.8%; however the use of vacuum extraction, which has replaced forceps as a routine practice, has increased from 3.5% to 6.2%. The CDC additionally reports that in 2003 the electronic fetal heart monitor was the most frequently used obstetrical intervention at 85.4% and that the rate of labor induction increased by 9.5% from 1999 to 2003 (Martin et al, 2005).

Simpson and Thorman (2005) argue that obstetric interventions are used as a form of *convenience* rather than medical necessity, and that interventions used for convenience often produce the opposite outcome. In response to the increased use of interventions, Simkin and O’Hara (2002), suggest that there is an advantage of using non-

pharmacologic methods, such as continuous labor support, baths, touch, massage, maternal movement, positioning, and intra-dermal water blocks for pain relief. They

argue that these methods may actually improve birth outcomes while reducing labor pain.

It is difficult to determine the level of safety in home, birthing center and hospital settings. Dr. Carol Sakala, Medical Director for Childbirth Connection states that “the CDC data is not a useful tool in determining safety risks for each category because, unplanned out of hospital births are often classified as home births and are very different from planned home births (and less safe)” (personal communication, September 11, 2006). Dr. Sakala pointed out the following article located online in the *British Medical Journal* from, The Northern Region Perinatal Mortality Survey Coordinating Group (1996). They argue that “any risk of mortality associated with a planned home birth are only quantifiable when the death is classified according to the planned site of delivery” (www.bmj.com). Their survey noted that only 3 out of 124 deaths were associated with planned home births during 1981-1994. The survey concluded that “perinatal hazard associated with planned home birth in the few women who exercised this option was low and mostly unavoidable” (www.bmj.com). Johnson and Daviss (2005) noted that a planned home birth attended by a certified midwife revealed lower rates of medical interventions, and similar intra-partum and neonatal mortality to that of hospital births.

Organizations like Childbirth Connection and Lamaze International are promoting care that is well-supported by evidenced-based, scientific research (Simkin & O’Hara, 2002; Maternity Care Association, 2004; Bingham, 2005; Declercq et al 2006). In a

series of topical guides, most notably *Women Supporting Women During Childbirth* (Maternity Center Association, 1999), they argue that continuous support during labor

offers many benefits and no known risks to women and infants. They add that women may feel less pain, experience less anxiety and experience more control during labor.

Rosen (2004) argues that women with continuous labor support will experience less anxiety, feel more empowered, and have less need for analgesia and other interventions.

Stark and Jones (2006) also point to the evidence arguing for continuous labor support as well as a trusting relationship between the woman and her caregiver as indicators for an optimal childbirth experience.

Davis-Floyd (1992) proposes a conversation that focuses on the perspective that women choosing technology in birth originates from a false consciousness. She argues that the childbirth choices women make are influenced by a “hegemonic cultural model of reality” (p. 5). She explains that this model is accepted because it is, “consistently presented to us through our most basic cultural rituals” (p. 5). The 2005 edition of *Our Bodies, Ourselves*, addresses the various kinds of care available to women; including the risks and benefits of particular settings, attendants and interventions in an effort to enable women to gather information and make the most well-informed health-care decisions for themselves. The Boston Women’s Health Collective acknowledges the life-saving opportunities that medicine can offer and the benefits that health care providers such as midwives and doulas can offer. Most notably, they acknowledge the immense effect that a childbirth experience can have on childbearing women.

CONSTRUCTING MEANING FROM EXPERIENCE

Following Barbara Katz Rothman's (1978, 1982, 1991) approach to studying childbirth, I am interested in the ways childbirth is socially constructed, and how the attendant, interventions and setting create meaning for the women in this study. I am also interested in how concepts of risk and authoritative knowledge influence the healthcare decisions women make and the care they receive. To discuss how the women in this study articulate or create meaning about their experience, I will employ an interpretive paradigm based on the symbolic interaction perspective given rise in the classic tradition in 1934 by George Herbert Mead (1962), but coined and developed in contemporary sociological theory by Herbert Blumer in 1962. Blumer, a student of Mead, "emphasized the social and interactive processes that allow individuals to construct their actions" (Farganis, 1996, p. 356). The symbolic interaction perspective studies how people make sense of the various situations or experiences presented to them in life. Symbolic interaction looks at how individuals approach situations or experiences, in conjunction with others—in essence, how we rely on each other to successfully complete the roles we play. Each of us play a role to define the situation, and that situation is validated by the props, the setting and the social location of the actors involved.

There are three basic assumptions grounding the symbolic interaction perspective which Erving Goffman (1959) sums up in his introduction of *The Presentation of Self in Everyday Life*:

When an individual enters the presence of others, they commonly seek to

acquire information about him or to bring into play information about him already possessed. They will be interested in his general socio-economic status, his conception of self, his attitude toward them, his competence, his trustworthiness, etc. Although some of this information seems to be sought almost as an end in itself, there are usually quite practical reasons for acquiring it. Information about the individual helps to define the situation, enabling others to know in advance what he will expect of them and what they may expect of him. Informed in these ways, the others will know how best to act in order to call forth a desired response from him (p. 1).

The first assumption of symbolic interaction theory is that humans define the actions of others based on the meanings and interpretations they attach to the action or reality, or in other words, “people act on the basis of meanings, so that one’s actions in a particular situation depend on the way that situation is perceived” (Hewitt, 2003, p. 19). Second, we learn the meanings of an object or situation from others by the way we see them act toward it. Rothman (1991) adds, “meaning is the product” of the interaction between socially located individuals and that “the meaning of an object lies not in the thing itself, but in the way people define it, and these meanings are shared between people in interaction” (p. 152). Last, we interpret and guide our own behavior and actions based on how we imagine others will respond. This allows us to interpret our own behavior as well as the behavior of others in a given situation.

Mead distinguishes this process through the acknowledgement of the self, whereby he separates the “I” (subject) and the “Me” (object) (Charon, 2004; Hewitt, 2003; Sandstrom et al, 2006). The “I” and “Me” that he refers to are the alternating periods of awareness that are experienced during interaction. Mead (1934) defines the “I” as the ability to respond as an acting subject on the events, objects or generalized others in a situation. The “Me” refers to the real or imagined actions of the self as an

object in a

situation. Mead states that, “the *I* is aware of the social *me*” (p. 173). This process is done unconsciously in every situation one may encounter with others—“the self is essentially a social process going on with these two distinguishable phases” (p. 178).

For the situation to unfold successfully all actors must agree upon the definition of that reality. To do this, humans must have a mutual understanding of a given reality. Emerson (1970) points out that “reality seems to exist out there before we arrive on the scene” as individuals have a sense of the structure of a given reality (p. 265). In other words, situations have been defined through previous and repeated interaction, so that an individual is able to predict the behavior and role of others, and therefore their own behavior and role in a particular situation prior to its occurrence. She adds that this reality exists because people tend to accept beliefs or meanings without question if it is believed, or if the meaning is agreed upon by everyone else. Definitions of reality are sustained by various features of a particular situation, such as the setting, the props used to help project the definition, and the social location of the actors (education, appearance, language, gender, etc.). Hewitt (2003) points out that, “people locate themselves—that is, they maintain a cognitive grasp of *where* they are relative to the situation and to the larger social context in which that situation exists” (p. 147). Individuals place others and themselves in social categories during interaction. What an individual brings with them to the interaction determines their social location and role within the interaction. This is done through the process of role-taking and role-making. Role-taking is simply being

able to view ourselves through the perspective of the other so that the individual can

grasp their perspective of how the interaction should take place. Role-making is the ability to refine our behavior in a situation that fits with other's expectations (Charon, 2004; Hewitt, 2003; Sandstrom et al, 2006).

Goffman (1959) elaborated on the concept of roles through the symbolic interaction approach called *dramaturgy* which describes social life as a theater or staged drama. Goffman argued that people are actors who, in an effort to control the responses of others towards them, control their own performance. Goffman adds, "When an actor takes on an established social role, usually he finds that a particular front has already been established for it" (p. 27). Goffman argues that individuals present themselves in a way that elicits a favorable assessment in the minds of others. According to Goffman, like the theater, performances have a front and back stage. Actors manage their behavior depending on where the action is performed to maintain the definition of the situation, and affect the other person's conduct (Charon, 2004). Goffman argues that through the interaction, individuals arrive at a *working consensus* about their definitions of one another and the situation. A working consensus avoids, "open conflict of definitions of the situation" (Goffman, 1959, p. 10) which occurs when an individual rejects their role (Charon, 2004).

Symbolic interaction theorists have often been criticized for assuming agency and autonomy of individuals during interactions, as if there are no constraints to behavior. While contemporary symbolic interaction theory discusses the constraints inherent in

social interaction; I find it useful to use a feminist lens and approach while using this

theory to acknowledge the limitations on how situations are defined, and *who* defines the situation. Even though feminists have criticized Goffman's work, West (1996) argues that his "greatest gift" to feminist theory is "opening up the possibility of studying the personal," no matter how trivial (p. 364). Goffman himself questioned "whose opinion is voiced most frequently and most forcibly?" during interaction, and "who makes the minor ongoing decisions required for the coordination of any joint activity?" (West, 1996, p. 365). His inquiry into the nuances that make up social interaction is central to the idea that people are, "limited in the definitions they consider and in the interpretations they make" (Hewitt, 2003, p. 147). When an individual controls a situation, they control and limit the behaviors of others.

Rothman (1991) points out that the, "process of limiting the behavioral possibilities for the other has been called 'alter-casting', or casting the other in a role" (p. 161). Casting another into an identity that serves one's plans for the interaction is controlling the situation. Power and privilege, or in other words—one's social location—plays a role in who defines the situation. Herein lies my concern for the hospital environment, where the situation is defined by the physician, ultimately limiting and constraining the acts of the laboring woman. When the physician takes the role as the authority or expert of the situation, they define the situation, and alter-cast the laboring woman in the passive role of being delivered. Delivery, as defined by obstetrics, "is an activity which women engage in, but a procedure which doctors do"

(Rothman, 1978, p. 124). This form of dominance and the ability to sanction behavior influences the actions

and perspective of women. In the case of obstetrics, Edwards (2005) argues that, “where obstetric thinking dominates, a woman cannot help but view birth through its lens, no matter what she believes” (p. 91). Edwards also contends that, “obstetrics is a manifestation of patriarchal values; it is in a position of control over women and their bodies” (p. 45). Within the hospital setting, an unequal power relation exists between the dominant ideology, or “authority” and the laboring woman, characteristic of what Sandstrom, et al. (2006) call an *asymmetrical relationship* whereby “one of the participants establishes control or dominance” which “determines the form and course of the relationship” (p. 130).

The physician can assert his or her role within the hospital setting and determine the course of the relationship and events with the use of props during labor and delivery as well as the overall set-up of the room. On a tour of a typical obstetrical ward in a teaching hospital, I took note of the delivery room: the bed, which is central to the room, can at the time of labor collapse at the foot, leaving the woman’s buttocks at the edge, allowing the physician easy access to catch the newborn baby. While the bed limits the movement of the woman, it has several features that allow ease during pushing and recovery between contractions. For instance, upon request (this is not routine), the laboring woman can have a bar placed at the foot of the bed upon which she can support herself in a squatting position while pushing. Between contractions, she can rest her legs

on stirrups that are located on the corners of the bed, maintaining the physician's convenient access to the expectant newborn.

The room itself limits the number of people that it can easily fit. The woman may have two or three social supports (partner, family, friend, midwife or doula), along with the nurse and the physician who enters when the woman is ready to push. The room is furnished with medical equipment, from the electronic fetal heart monitor, located at the head of the bed, to the incubator across the room, where the newborn is examined, treated, cleaned, and swaddled following delivery. Among other items in the room is a chair on the alternate side of the bed where a support person can rest, a stool for the doctor at the foot of the bed and a cart stocked with linens, towels, and other medical supplies and tools. A birthing ball is available, (although not in every room) for a woman who may request this as an aid during labor to reduce discomfort. The room also has a small bathroom with shower that can be used if the woman is able to disconnect herself from the electronic fetal heart monitor.

The use of props aids the physician to assert authority. For example, the roles of the physician and the nurse are to interpret the output of the electronic fetal heart monitor (the nurse monitors the output and reports the data to the physician). During labor, the nurse enters to check on the laboring woman. Their first task is to go directly to the monitor, whereby the monitor tells them the possible risk factors to the fetus. Initially the fetal heart monitor may be strapped around the mother's protruding stomach. In so doing, the mother's actions are limited by her attachment to the fetal heart monitor,

although she is able to remove it if she needs to walk around, squat or use the birthing ball. If the nurse detects any fetal distress, they may opt to insert a wire with two prongs into the woman's

vagina, whereby the prongs are clipped to the scalp of the fetus. The woman's movements are restricted to the immediate area of the monitor, constraining her to the bed, and reducing the options for alternate positions, movement or other techniques to ease pain (i.e. hot shower, walking, changing positions). If the monitor produces signs that the fetus is in distress, then the person in authority (physician) determines the next course of action and imposes his or her will (treatment by other interventions) on the laboring mother. The woman can refuse the use of medical interventions, but as identified earlier, she may come to expect the monitor or other tools as a standard of care. She may also experience pressure from others (social support and medical personnel alike) as the concept of risk is used to ensure compliance.

In contrast, a homebirth is experienced within the parameters of the laboring woman's home, where life goes on as usual. The options for parturition are not limited to the bed, but can occur in a birthing pool, on a birthing chair, or using the physical support of others present—all of which can be utilized anywhere in the home. The laboring woman is able to move around, take a hot shower, sit in a hot-tub, squat, kneel, sit, stand, rock, or sit on a birthing ball. The midwife's role is to encourage the laboring woman and her partner throughout the process, monitor dilation or complications, and assist with the delivery. The midwife may recommend alternate positions or the use of techniques

during labor, but typically defer to the laboring mother. The midwife will also listen to the heartbeat of the fetus by using a stethoscope to detect any fetal distress, and may recommend or insist on the transfer of the woman from home to hospital in the event of an emergency. The message is that the woman is capable of birthing on her own with the aid and support of a midwife or other attendant.

Throughout the interaction, either with the midwife at home or the physician in a hospital, the definitions are negotiated through shared symbols (a social object, language, or perspective) creating a shared meaning so that the woman and attendant can act together (Charon, 2004; Rothman, 1991). Yet, while in each situation the actors share meaning, they may not contribute equally to the parameters of the definition. Due to the social location of the actors involved, the situations are negotiated differently and unequally. The differences in power influence the amount of control experienced by the woman even if in both situations she has *some* power. Depending on the amount of power the woman has within the interaction, she will adjust her behavior based on the actions of others to maintain the interaction; in the case of childbirth there is so much at stake that the woman may concede to those who control the perception of risk. In the case of a hospital birth, it is the physician influenced by obstetrical ideology who may use the perception of risk to influence the definition of the situation, and it is the woman who can only react. Even though the actors may arrive at a working consensus, situations do not have to be accepted as they are defined. Emerson (1970) points out that some situations are precarious when “participants deliberately decline the current reality”

(p. 266). This is particularly true if the person is aware of another possible reality that contradicts the mainstream reality. In the case of childbirth, the laboring woman may accept the definition of reality in the hospital, home or birthing center, or reject these definitions. In some situations the laboring woman may redefine the situation completely.

I have discussed the historical influences that have redefined the situation of childbirth from that of a midwifery-attended birth at home to a physician-attended birth in a hospital environment. I maintain that the midwifery ethos of healthcare offers women the opportunity to form the course of the relationship and therefore define the situation, whereas a hospital birth attended by a physician is guided by the physician's definition of the situation, influencing the amount of control the laboring woman has over the course of their interaction. I argue that current obstetrical practice, while having the potential to save lives and offer advanced technology allows laboring women limited ability to define or control the situation. My aim here is that the birth stories shared by the women I interviewed will reveal the connection between social structure and the meanings they constructed from their experience, as well as the level of control the women had to form the course of the relationship in each situation.

METHODOLOGY

In 2001, I interviewed 12 women ages 19-83, covering a span of childbirth experiences from 1936-2001. I relied on a local midwife, a small health clinic and the snowball method to collect a sample of participants. The majority of my participants were gathered through the snowball method; others were referred to me by a local midwife while the health clinic did not refer anyone to me. My data collection consisted of one-on-one semi-structured interviews, which lasted between 30 minutes to 2 hours each and were transcribed immediately following the interview. To protect the privacy of the participants, they had the option of choosing a pseudonym to identify themselves. Each participant completed a brief questionnaire that elicited information about their age, educational background, race, etc. I have included in *Appendix A* the demographics of the participants in this study.

Each participant had the choice of setting for their interview. The interview setting varied from their homes to a park. I offered each woman the option of a second interview if they needed more time. I asked one broad question to start the interview, with several probing questions. I began the interview by asking the women to describe their childbirth experience(s) from the moment each birth began for them. While many probes were used, I asked three main questions to gain further information: What led you to decide on the setting and attendant? What was your relationship with the attendants? What would you have changed about the experience? During these interviews I paid attention to how the women described and made meaning of their experiences. I used an

interpretive approach to analyze the data collected for this study to help uncover the themes that resonate in each story.

While my study includes three different settings of birth (hospital, home and birthing center), two different models of childbirth care were experienced: the medical model of childbirth care (hospital) and the midwifery model of childbirth care (home or birthing center). *Setting* refers to the place where each woman bore children: hospital, birthing center or home. *Attendant* refers to the individual assisting the woman during childbirth: midwife, doctor or family/friend attendant. *Family/Friend* attendants include family, significant others, spouses, friends, and acquaintances. *Interventions* refer to specific obstetric instruments, technology, medication and medical/surgical practices used during childbirth. The participant's attendants varied (15 physician, 9 midwife, 3 family/friend) as well as the setting (15 hospital, 10 home, 2 birthing center), totaling 27 births and approximately 200 hours or over 8 days of labor. The interventions used during birth varied among the participants, from the use of consciousness-altering drugs to cesarean sections.

Hesse-Biber (2007) argues that, "feminist research must create knowledge that is for rather than about the people studied" (p. 184). She adds that the challenge of feminist research is, "to make the knowledge produced through interviewing applicable to the worlds that women live in" (p.190). My hope is that the stories documented here will illuminate the importance of studying lived experience through a qualitative method.

BIRTH STORIES

While sifting through the stories of the 12 women I interviewed, I found it helpful to sort their stories out chronologically from the first birth story in 1936 to the last birth in 2001. What emerged were cohorts, or groupings of women giving birth during a particular time period. I have grouped the women's births in specific cohorts based on the time period of the birth and any similarities within that time period. For the 12 women interviewed, they are placed in one of five sub-categories. Julie, Sue and Alicia are in the first cohort from the years 1936-1950 which I have dubbed the *twilight years*, a common reference for this time period when drugs were commonly administered during birth. The second cohort titled *expectations* dates births from 1961-1983. This group includes Lauren, Emma and Blythe who are grouped together for their similar decisions to have a hospital birth. While Emma decided to have homebirths for her subsequent children, I am including her in this group because of the time period and similarities she shares with the other women in the group. The third cohort titled *rejecting normative reality* includes Vida and Jo, who were having their children during the same time as Emma and Blythe. They were included in a separate cohort because they each approached their first childbirth as an event that should not happen in a hospital. The fourth cohort, *shifting expectations*, includes Lilly and Terri whose first childbirth experiences occurred in 1995 and had subsequent births through 2001. Lilly and Terri were not only grouped together because of time-period, but because of their decisions to give birth at home following a hospital birth experience. The final cohort, titled *at home*,

includes Willow and Noni who chose to give birth for the first time at home in 2000 and 2001.

THE TWILIGHT YEARS

Julie, Sue and Alicia, birthed when the use of scopolamine and ether were popular, the reason why these three women are grouped together. Many women during this time period have difficulty remembering much of what happened because they were drugged, which is true for Julie, Sue and Alicia. Their interviews were the shortest and most difficult to elicit information from because they were unable to recount many, if any details of what happened in the delivery room. I found that Julie and Alicia shared their stories with me as if they were visiting with a granddaughter—asking me when I planned to have children and offering up bits of advice and wisdom. Sue’s interview, while short because she did not remember much about her experience also hinted at our social distance as interviewer and participant—she simply may not have felt comfortable sharing intimate details of her experience with me.

All three shared why they decided to give birth in the hospital and the process of events that commenced when their contractions began. The concept of risk and how their physicians alleviated their concern for risk was a focal point—the doctor was considered the expert and someone they could trust to get them through their birth unharmed and without pain. They also discussed how they felt their experience was “easier” because of the reduced pain due to the ether or other drugs.

Julie, the first to deliver a child out of the group of women I interviewed was 16

years old when she had her son in 1936. Julie, who finished her schooling in the ninth-grade, stated that she was “too young” to know anything about childbirth, “but I knew I would be taken care of.” Julie was able to locate herself within the interaction. Her *location* was someone who was young and inexperienced, and understood the role of the physicians to care for her. Julie was unable to recall much of what happened during the childbirth, but had this to say about her experience:

(Julie) In those days, doctors used ether on you...so you were just kind of in and out. You didn't know everything that was going on. They didn't want anyone in the room, just the doctor and nurse. It was much easier than what my mother had...but also today is easier, women are pampered.

(Michele) What do you mean by in and out?

(Julie) Well, you can hear the doctor talking, but I didn't know anything. They just gave me enough to ease the pain.

(Michele) What did you think about the ether?

(Julie) I didn't like it...they just give it. I figured anything to ease the pain is ok with me.

(Michele) What made you decide on a hospital?

(Julie) I surely didn't want it at home, so that's what you did.

Julie's second child was a daughter born over 10 years later in 1947. Julie chose a hospital because, “everyone did that at that time . . . people didn't have babies at home so much.” Due to the ether, the childbirth experience for Julie was one that would not exist in her memory, but one that she experienced only *through* the memory of her husband who was listening outside of the delivery room:

(Julie) I must have had a hard time because my husband stayed out in the hallway...they wouldn't let anyone in at the time and he could hear the doctor slap me because I was holding my breath to make me come out of it...so I guess I was having a hard time with it.

(Michele) How did you feel about him slapping you?

(Julie) I didn't know it. I was too far out I guess.

(Michele) Can you talk a little bit about having a hard time at the beginning?

(Julie) I don't know. They took me in the delivery room and whatever they used on me, it made it easier. You don't know what's going on...you're just in and out. My husband asked about the slapping and the doctor said that I was holding my breath. You never know what they're doing when you're half out.

Julie offered me this bit of advice: "Just have confidence in your doctor. Don't be afraid."

Julie's indifference to being slapped by the doctor is indicative of her willingness to accept a passive position, which in this case was dictated by the fear of experiencing pain. The pain of childbirth for some is evidence of some abnormality, or something *wrong* with the childbirth. Her answer, "I didn't know it . . . I was too far out I guess" is cause for analysis. Rather than answering based on what she thought about the slapping after her husband shared her experience with her, or on what she thinks about it now, she can only answer the question as it applies to the moment itself. She is unable to conjure an opinion about the doctor's behavior and control over her body—even so many years after the fact—because the situation as it was defined at the time was so rigid and pervasive, so as to grant an amount of agency so minimal, that even to venture a belated judgment is inconceivable. The doctor is simply someone she could trust to take care of her, no

matter the means. She was alter-cast into the passive position of being delivered. While Julie did not care for the use of drugs, she believed that this was the only option available to her to reduce pain. The medication symbolized the physician's ability to reduce pain, which allowed Julie to interpret her physician as someone she could trust to care for her and help her out of "having a hard time."

My interview with Sue revealed the social expectation to birth in a hospital. Sue, an 83 year old mother of two children recounts her first birth in 1944 when her husband was away at war. Sue was having dinner with a friend when her water broke:

(Sue) We had to stop eating and go to the hospital. It took me all night to have her. It took all night long. They just waited for the baby to come and in those days they didn't sit through much to watch the birth. People weren't allowed to watch the birth. At that time, we stayed in a week and during the war it was hard to get nurses. I was the queen though because my nurse always gave me clean sheets everyday, and they weren't supposed to do that, so they called me the queen.

(Michele) Can you tell me more about the childbirth?

(Sue) The childbirth was well, it was hard, cuz it took me so long...they gave me drugs. I think I asked for them. They didn't use forceps with her.

(Michele) Can you describe what the childbirth was like?

(Sue) Painful, just like you'll never want to have another one.

When asked why she chose a hospital setting Sue provided a matter-of-fact reply, "well, we always went to the hospital." Of her second birth in 1950 she has this to say about why she chose another hospital birth:

(Sue) It was more or less the thing you did that day.

(Michele) Can you tell me about your second birth?

(Sue) It was practically the middle of the night. I had a breach baby. They had a hard time with that. They had to use the tweezers, or whatever you call them and that gave him a rash or infection...it irritated the skin. They got him turned around and had drugs. I wasn't completely out, but I was asleep.

(Michele) What did you think about the drugs?

(Sue) I don't remember. That was too long ago.

Sue refers to having a breach baby as something that "they had a hard time with," referring to their active participation and management of her birth. She speaks of her experience as if she were not there. The medical staff in this example established control by way of drugging Sue to manage her breach baby. They asserted their role so successfully that like Julie, Sue is unable to invoke an opinion of the doctor's use of drugs during the moment and it is even more inconceivable for her to judge their use now.

Alicia's story resonates with Julie's view of the physician as someone who can be trusted or viewed as the expert in childbirth. Alicia, a retired waitress and 80 year old mother of one daughter born in 1945, shared the day she began to have back-aches. Alicia had a tooth pulled that day and then saw her doctor because she had been having labor pains "on and off during the day." The doctor told her that it wouldn't happen for 2-3 days. Her reply to his prediction was, "I'll see you tonight", "And I did! Once the tummy part started it wasn't an hour after I'd been there and I had her...he came in and said, 'well you did see me tonight.'" Alicia talks about why she decided to have her baby

in a hospital:

(Alicia) My mother had it at home. I just felt more comfortable in the hospital, if anything went wrong, they had the equipment there to take care of it. I was kind of scared, and as soon as he showed up I was fine, women today should trust their doctor. It would be kind of odd if you didn't trust your doctor.

For Alicia, the decision to birth in the hospital was based on a shared definition that her doctor was someone she should “trust” and the interventions or equipment symbolized safety if anything “went wrong.” Alicia was concerned about the risks in childbirth, but her concerns were quelled upon the physician’s arrival. She had accepted the definition of childbirth as a risk that the physician would manage. The physician and his medications also represented something “better” than what her mother had experienced. While Alicia could not recount her mother’s experience for me, the imagined reality that Emerson (1970) discusses is evident—reality exists “out there” and is something she can compare her experience to.

Julie, Sue and Alicia experienced their births at the time of demise for midwifery and obstetrics rise as a specialty. They did not consider other options to birth, because a hospital birth was the only accepted option offered to them by society. This was the only reality that could exist because its meaning was agreed upon by everyone else, allowing Julie, Alicia and Sue to accept the beliefs and meanings without question. The thought of using a midwife or having a baby at home was seen as unsafe—it was assumed that “something could happen.” They perceived the physician as the only one who could fix a possible complication. They shared the belief that the doctor was the expert, the interventions were a necessary part of the experience and that no matter what happened,

the doctor would do what was in their best interest.

Their historical location also influenced their experience. This was years before the women's movement, during a time of limited options and access to education for most women. The social expectation of not only being a mother, but also to passively accept the treatment offered by obstetrics at the time was the foundation of their experience. This is true for the birth experience in the subsequent cohort, *expectations*.

EXPECTATIONS

For the following three women in this study, Lauren, Emma and Blythe whose first children were born during the sixties and seventies, the thought of choosing another mode or setting of childbirth was also not available—hospital births were considered the only option. Unlike Julie, Alicia and Sue, all three were awake and aware during their labor and delivery, allowing them to interact fully with hospital staff. While ether and scopolamine were out of style; spinal shots, enemas, shaving, labor induction and forceps were routine procedures. Their experiences paralleled the women's movement the growth of the women's movement, which influenced their ability to make choices about what kind of care they expected and shifted their ideas about who they were as women and mothers. For one, that meant choosing a different birth setting after a hospital experience. For the others, that meant having a greater sense of who they were as women and mothers, as well as the medical options available to them. They no longer tolerated being drugged, however the obstetrical community imposed other medical interventions on them.

Lauren begins this era from 1961-1964, having three sons in a hospital, attended by a physician and nurses. Lauren's first birth included what she called a "saddle-block...which is like a spinal". Her second birth included a "spinal shot...I couldn't feel it...at the time I thought it was good, but I don't think you should do it now". Lauren's perspective after experiencing her third birth shifted her view of the interventions used during the first two, "I wouldn't have had the shot during those...I don't agree with that and I wouldn't have done that, but you can't go back now." Lauren described her third birth in 1963 as "more meaningful" and that she was beginning to "grow as a person."

Lauren describes her third birth and the effect her physician had on her:

(Lauren) I went to the hospital two or three times because I was doing false labor, and I'd never done that before, so that was interesting. So when it was happening I knew that it would happen that day. I wasn't going to go to the hospital because they damn well was not sending me home again. It was obvious I was in labor, but I was only dilated to 3, so 'oh-gee', it's going to be a long afternoon. It was probably about 2:00 in the morning and it was hit-and-miss. I knew if I moved around I could make it. I just wanted to get this body in gear and have this baby.

At the hospital I started to cry. The doctor showed up and said in my ear shot, 'I'll be a son-of-a-bitch if I wait around here for her all day', so they broke my water with a knitting needle...they didn't do all the other fun stuff that they did in the first two, like the enemas and shaving. Well when they broke my water the baby decided he was ready to go, and the doctor was quite literally yelling at me, 'Don't bear down! Don't bear down!', because he didn't want the baby to come out because I was still out in the holding pen, you know, where us cows go through. So they decided they would get me in the delivery room, and the doctor is foaming at the mouth, because I'm messing up the whole day. So the doctor is helping me get ready for the enema and shaving business, and the baby is coming and we're going to have this baby whether the doctor decided to help or not. So the nurse is trying to help me breath so that I won't bear down, and he screams at her to get out of there. I know it crossed her mind to say no,

but she couldn't because he was not a nice person. It was made a scramble, as soon as the baby is born, he stitches me back up and he is gone...of course no body cared that he left.

With that birth, it was more meaningful, because I could see and feel, in spite of him. You know, it was special to me because I knew what was happening, because I could feel it, because they hadn't given me the spinal shot. That was better, that part of it. I was anxious, to me the knitting needle to break the water...to me that was kind of scary. The way the doctor talked made me apprehensive, because I didn't think the doctor would talk where the patients would hear. I could see the nurses around me, and they were definitely reacting to the way this man was ranting and raving like a maniac. It was the weekend and he didn't want to be there.

(Michele) What made you decide to have your three sons in a hospital?

(Lauren) I can't imagine not...

(Michele) What would you have changed about your third birth?

(Lauren) The doctor. He was an ugly man...he called the office one day and I got a knot in my stomach just from hearing his voice, and I knew who he was the minute he started to talk, cuz I could still hear that 'he would be a son-of-a-bitch!'

While Lauren could not imagine having her baby outside of a hospital, she was skeptical of the obstetrical interventions used, stating that she would not have had a shot during her first two births. Lauren recognized that the interventions were routine practice, "that was just part of it. I assumed it was anyway...so other than hating it, you know, I thought it was a necessary part." Lauren also verbalized her understanding of *who* defines labor when she stated, "they damn well was not going to send me home." Lauren knew she would have her baby when she started to experience what she called, "false labor." Lauren called it "false labor" because she believed that that is what hospital staff would call it. She decided to wait until she had progressed to a point where hospital staff would

define her labor as real labor, preventing her from having to go home. Upon her arrival the physician determined that her labor was not progressing, so induced with a “knitting needle.”

It was not until I attended a Lamaze childbirth course in 2007, that I understood the use of the “knitting needle” as she described it, or as the childbirth educator in the class called it, “the amnio-hook,” an instrument used to “break the water” to aid in speeding up a labor. I wonder if anyone had bothered to explain to Lauren what the amniocentesis-hook was used for, and that it had a purpose, if she would have felt the same sense of angst that she described. Instead, the hook was defined as something “scary” that the doctor “foaming at the mouth” used. I also find it interesting the blurring of the front and back stage, as Goffman defines it. Lauren was aware of the doctor’s discontent because she overheard him say something that would normally occur behind the scene. The conflict of roles occurred over differing perceptions of false labor, real labor and when it was time to push. In spite of the physicians, interventions, and expectation to have her children in a hospital setting—Lauren attempted to maintain a sense of autonomy during all three birth experiences, but especially during her last birth. Lauren described herself as someone who had grown a lot since her previous two births and had confidence that she could birth her son without the doctor’s assistance.

Like Lauren, Emma delivered her first child in the hospital because of other’s expectation to birth in a hospital, “I chose a hospital birth because that’s what everyone was doing at the time.” At the time of our interview, Emma was working full-time as an

instructor and had her master's degree. She however was 19 at the time of her first birth in 1961, "I didn't know to question...we were totally unprepared, I think we had one package of diapers." Emma recalls that the physicians made her feel "like a child".

Emma's mother, who was studying to be a nurse at the time of Emma's first birth, "was a big proponent of doctors and medicine." Emma woke up bleeding on the morning of the birth of her only son:

(Emma) I went to the doctor and they told me I was in labor. So I went to the hospital and I didn't even go into the delivery room. They gave me a spinal. His head was showing and they gave me a spinal. I felt really cheated about that. He didn't breathe right away and they whisked him away and I barely got to see him or hold him or anything and they kept him in the nursery, and brought him to me.

I did what I was told, but that was my experience with everybody at the time in the medical profession who was dealing with me when I was pregnant. I just did as I was told. They were treating me like I was a child. They all I'm sure thought I was far too young to be having a child, but the pediatrician was the same way, he treated me like I was stupid, and he treated me like I was a child. My relationship with my obstetrician was the same. I mean, he was fairly kind, but he still treated me like a child. I wasn't consulted really, I was just told what was going to happen and what I was supposed to do.

Emma grasped her social location relative to the situation as a subordinate to the physicians whom she did not feel she could question due to their social location as professionals, and aligned her behaviors to the expectations of the physicians she encountered. Hewitt (2003) discusses the "awareness context" by which each individual, "knows about the identity of the other as well as his or her own identity in the eyes of the other" (p. 118). Emma knew that the physicians were in a position of power over her and

that their perception of her was that she was young, inexperienced and needed direction—an example of an asymmetrical relationship. She and the physicians came to a working consensus of each other's role within the interaction whereby the physicians decided *who* would make the decisions that formed the course of their relationship. Part of their decision-making process included administering a spinal. Emma described feeling “cheated” because she wasn't allowed the opportunity to feel her son's birth:

(Emma) I wasn't asked if I wanted a spinal. I was just told and it was done. I wasn't given any options. They didn't say, 'oh well your baby is crowning and two more pushes and your baby is here'. They never asked me, they just did it. It was assumed that I would go along with everybody. I went along because I was so very young. It was a weird experience. I hated it. What it did was made my sensations stop. The sensations were not anything horrible, they weren't anything I could not have stood. I think, now this was a long time ago, 32 years—they should have assigned me a nurse to coach me through all of this, so I could have had him naturally, because it was going so well and so quickly...and I wasn't in obvious pain, and then boom I had drugs.

Emma is now clearly able to ask the questions she wished she could have at the age of 19. Emma went along with the intervention, but given her dissatisfaction of her experience decided to have her subsequent births out of the hospital. She, unlike Alicia and Sue is able to make a judgment, in retrospect about how she was treated and controlled by others.

When Emma was pregnant with her second child she felt she was “older and more educated”, and could make an informed decision about where to have her baby, “when I found out I was pregnant I read everything I could and educated myself. I decided I wouldn't do it in a hospital.” Emma, now in a better place to

ask questions, rejected the definition of a hospital birth, however maintained her skepticism of the “quasi-doctor” that she chose for her second birth, which she had filmed for a mini-documentary on homebirths in 1975:

(Emma) I was a good candidate to show people that childbirth can be calm, peaceful and serene, and not a horrible disruptive thing that we see on the media with the woman screaming and out of control.

(Michele) Why didn't you care for this doctor?

(Emma) I don't know why I didn't like him, but you know my mother was a nurse and she was very, very suspicious of a doctor who couldn't prescribe medicine, so she questioned his training. She had a back-up doctor, a clinic that would admit me immediately...she was doing some background stuff. And I knew this and while I appreciated it, it made me more suspicious of my doctor, so it made me more watchful. So my relationship with him was not completely trusting, but I didn't care, because all I needed him to do was catch the baby.

Emma describes her rejection of the hospital-setting and yet the pressure from others to conform to obstetrical practice which influenced her decision to have her child at home with a “quasi” physician. She felt uneasy about the attendant because of her mother's medical background and suspicions, which is indicative of the influence that a social system has on a woman's decisions and experience of birth. Emma's transition and gradual break from the medical-model of birth sets the foundation for Emma's choice to have her final two births at home, attended by a certified nurse-midwife. It is interesting to note how like Lauren who described her ability to sense autonomy in her last birth because she had grown as a person, that Emma as well felt more control. Emma talked a little about being challenged by others when she disclosed her choice to birth at home:

(Emma) In a subtle degree my mother challenged my choice, but not really. If I would tell people who were not close to me that I was pregnant, they would ask what hospital I was having my baby in. I would tell them I was having her at home, and then that would be challenged. But then when I had her, nothing was challenged...but there was nothing to challenge.

I was an old hand. It wasn't a control factor anymore. It was just doing what I was used to doing. I don't know how to say that any other way. I wish that everybody could have a childbirth experience like mine were, cuz mine were just so incredibly great. I will never forget having my babies and looking at them and falling completely in love.

Emma describes her latter births as something she was able to do, and that control was not a factor. I find this interesting because in her last two births, and even for her second, Emma was in control. For Emma, birth not being a control factor meant that she was in control, and not competing with another's definition of reality. She was able to decide how and where to have her children. The role of the midwives was simply to support and aid her, but she was able to birth on her own. Those around Emma had a specific definition of the reality—her disclosure that she planned to birth at home conflicted with the perception of others that she should birth in a hospital. Rothman (1991) argued that people can redefine a situation they do not accept to create a new reality. Emma successfully created a new reality by redefining her perspective of childbirth regardless of what other's expectations were.

Blythe, a 51 year old mother of five children were all born in a hospital between the years 1972-1981. Her experiences were much different than the hospital experience for Lauren and Emma. Blythe talks about her experience with the same manner of satisfaction as Emma's homebirths, "it was amazing. It separated me from the roots of my

life forever. It was sacred, real, visceral and bloody.” Blythe however made her decision to birth in a hospital because that was her definition of reality:

(Blythe) That’s how you did it responsibly...it was thought to be irresponsible to do it otherwise...it was fool hardy to put the baby at risk if there were any complications. Who did I hear the other day say that the difference between God and doctors is that God doesn’t think he’s a doctor [laughing]. It wasn’t even an option I thought.

As mentioned previously, obstetrics defines childbirth as a risk-laden event which influenced Blythe’s decision to not put her baby at risk. Blythe talked about the interactions she had with a nurse, who was particularly soothing, and the physician who took over that she described as “clinical”:

(Blythe) There was only one attendant that I remember, she came and sat beside me and rubbed my arm and rubbed my hand gently...she just sat there by me. There is something about labor that makes you vulnerable, but you’re genius sensitive to, to what? To goodness! And her goodness really got me, really helped. I remember thinking I owe this lady so much, she was the only drug I had. I was really attuned to kindness and appreciated it. The guy who delivered the baby was kind of a horse doctor, he was a good old boy, Mormon bishop, confident, and sure he was right and clueless. Not once do I remember him saying anything, no offering that way. He didn’t know that that was a shame, I needed personal interaction, cuz this is the most personal thing you’ll ever do, having a baby. It is so much more personal than sex...in fact, sex is like sneezing compared to having a baby...you’re split wide open. With this doctor, the most personal thing he told me was about cattle, and I remember thinking how I was as a Bovine! [laughing]...funny how we did that whole dance between professional, clinical and personal.

Blythe’s ability to identify the “dance” she and the physician acted out is significant in that she was aware of the roles each played in the delivery-room and the difference between the care she received from the physician and the nurse during that birth. Blythe

talked openly about how important it was that her attendant “care” for her and that she had an attendant that “knew that this mattered to me” which she felt in the following births. She, like Lauren and Emma also discussed her growing ability in subsequent births to feel confident, and as a “pro” who trusted her body. Blythe had positive birth experiences in a hospital setting. She felt safe and to some degree had control in the situation. The physicians present seemed secondary to the pain she experienced; however she was cognizant of their care and attitude toward her. For Blythe, her body was the source of wisdom and guidance she needed—she describes being able to “trust” her body and that she had “no fear anywhere around me.”

REJECTING NORMATIVE REALITY

My next cohort, Vida and Jo had their children between 1975-1979—the same time period as Emma and Blythe. I have separated their birth’s out from this time period because of *where* they decided to give birth for the first time and *who* they had attend their birth. For Vida and Jo, they described their decision to have a home and birthing center birth as based on what they didn’t want. They rejected the common definition of childbirth as an activity done in the hospital with clinically skilled physicians, and yet they had very different expectations of their attendants’ expertise as evidenced by their experiences below. Both were looking for a more holistic approach and experience for birth, certainly a sign of the times. Their rejection of the mainstream definition of birth created conflict as other individuals, or specifically the medical community reacted negatively to their choices.

At the time of Vida's pregnancy in 1975, she was a college student and described herself as a "strict vegetarian" who was very health conscious. Vida immediately began reading everything she could about pregnancy and childbirth, and changed her dietary habits by "eating fish, because I didn't want to mess up anything with the baby." Vida's decision to have a homebirth is not so much surprising as whom she decided to help deliver her first daughter. Vida's husband, who attended births while in the military during Vietnam, told her he knew what he was doing. That coupled with the books that Vida read to prepare her made her decide to have her baby at home. Vida enlisted the help of her "friend's grandmother," who ended up being ill on the day Vida went into labor, so Vida's friend came over to attend the birth:

(Vida) Having her there was comforting to me, it was relaxing. She has been around babies being born longer than I had, so it was a relief to talk to her.

(Michele) Tell me about your husband and friend? How were they involved in the birth?

(Vida) It is hard for me to separate what she did and what [my husband] did because they both knew what was going on, telling me how to breathe and when to breathe...talking me down on when to relax, when it wasn't and was time to push. [My husband] actually received the baby into his hands. [My friend] was there basically as a support. She'd make the tea I needed. She basically gave me everything I needed. If I needed a wet cloth across the forehead, she was the one who got the cloth, keeping track of time and that type of thing.

Vida is another example of the ability to redefine the situation of birth; however she rejected the typical reality of a home birth attended by a midwife. Vida preferred birthing at home, with attendants who may not have had formal training but whom she

trusted. Vida described for me the reason why she decided not to birth in a hospital:

(Vida) At that point I couldn't see why babies were born in hospitals full of germs and infections. I couldn't see why you have to have spinal taps and all of the those things if you didn't want them and when you go into the hospital everything becomes into the control of the Doctor instead of in your control and I just didn't want to be there, I was totally against that—that was the main decision.

This was in 1975 and 1977, in the midst of the women's movement. One day you would hear about a woman going to the hospital not wanting to have medication, and they doped her up anyway. I felt like the medical community had just taken control of women's bodies and decided 'this is the way this will be' and 'this is the way that will be' and 'no you can't do that' and 'no you don't know anything' and I just wanted to feel like this is my body, I wanted to live my way.

Vida had an inclination of the kind of care she would receive in the hospital, again—the reality existed out there and was confirmed in the articles and books she was reading.

This reality was validated when she discussed having a homebirth with her obstetrician whom she was going to for prenatal care:

(Vida) I did ask my doctor if he ever did home deliveries and he got mad and told me how stupid that was, and I said, 'OK we won't talk to him anymore', and I went to my doctor for all of my appointments. I called him and said it's a girl and he was pissed. He was not amused at all because I didn't invite him because he didn't do home deliveries and I didn't tell him what I was doing, I just stayed home.

Vida visited this same doctor following her childbirth because she had RH-negative blood, requiring a shot to prevent her body from attacking any subsequent fetuses.

During her visit she was reprimanded for her choice to deliver at home:

(Vida) He said that it was a 'stupid thing to do...do you know all the things that could have happened? You could have had this complication or that complication'? I said 'well I didn't', and he said 'well that's fine,

I'll give you the shot'. He said 'well you tore and it's too late now so I'm not going to stitch it up' because it was like the day after. He was just

nasty. He said, ‘after this I don’t want to see you in my office again’. And I said ‘fine’. He was through with me and didn’t want to treat me for anything.

Vida’s negative interactions with her physician during her first birth prepared her for how the medical community might react to her second homebirth plan. When Vida became pregnant again, she found a physician at the local health department, with the same intent to keep her prenatal appointments, but to birth at home, this time attended by her husband, mother, and a close friend who lived “three houses down from me.” Vida’s first birth experience provided her with the confidence to structure her second birth similarly. Vida gave birth during a time of great social and political change for women. Her access to an academic atmosphere also provided her with the know-how to do research and to educate herself about her options. Vida brought with her a confidence in her ability to birth and a level of trust in her attendants.

Like Vida, Jo’s decision to deliver in a birthing center, was based on her belief that women shouldn’t have babies in a hospital setting. Jo explained how in 1979, she went about finding a midwife who at the time had all been “run out” of the main city. Jo decided to use a midwife that lived approximately thirty to forty-five minutes away from her home. When asked why she decided to have her daughter in a birthing center with a midwife she had this to say:

(Jo) At that time, that was a hippie era, we were typical hippies. We believed in a simple life, and wanted to get back to the land and didn’t believe in doctors. I really believed that doctors didn’t know jack-shit about birthing babies. You know, my opinion, if you haven’t birthed one,

you ought not be in the delivery room, you know, and I still feel that way. At that time, I was pretty rabid about it and I was like, ‘I will not go to a hospital, I will not have that experience.’ I don’t like hospitals and I don’t

trust the people who work in them to this day.

For Jo, the birthing center was a compromise between a having clinical atmosphere and having an attendant that she trusted who offered the midwifery model of care. Jo shares two stories that outline her distrust of the medical field and her uncompromising expectation to have a competent attendant. While researching midwifery options, Jo visited a “kind of midwife cooperative...none of them had training as nurses; it was like the hippie midwife group.” When she visited their facility, she was “not happy”:

(Jo) I mean, there were flies. It was pretty primitive...it was very primitive quite frankly. And you know, as much as I thought childbirth should not be turned into some sort of medical spectacle, I also knew that it was important to have people that were very experienced that knew something about health. I also trusted my gut...my gut feeling was that I don't want to have a midwife that is going to get stoned before she delivered my baby.

Jo found a midwife who practiced out of a birthing center that provided a clinical environment she was comfortable with, “it was full of women, they had a nutritionist nearby as well, and so, I was sold on it.” Jo's appreciation for a midwifery model of care, coupled with a clinically based practice is evident in her articulation of her birth experience. Jo recalls the day she started contractions:

(Jo) The birth center was really neat; it was a small town office building. This was a birth home, which was something that I wanted because I didn't want to clean up the mess and I knew if I birthed at home I would have had to clean it up myself. So the birth experience itself was pretty clean, so that was ok. By then I was ready to push but the problem was that I was not completely effaced. I had to wait for almost an hour and it was terrible because they kept saying, ‘walk around the room, take a hot

shower, do this, do that,’ and I kept having the desire to push, it was constant with these big waves...so we started the process and actually my husband sat behind me on the bed, it was great because I would push against him. But I pushed, and pushed, and pushed for about a half hour,

the problem was she came out like a line-backer. So of course you know, we're trying to do it all naturally, no nothing...and finally my midwife says, 'you know, you're going to tear from end to end, I really think I need to give you an episiotomy and I want to ask you permission'. So she gave me a local, she cut about half of what she needed and started to assess the situation and said, 'I am going to have to make this big', she literally had to cut back into my asshole. So I'm trying to push and I was out of energy, so they gave me oxygen. Fortunately for me, Irene had just gone to Sweden and had trained in this new technique. It looked like a toilet plunger sorta, like a suction cup...so they put that on her head and helped me by pulling...the doctors would have given me a cesarean. So it was just like that, two pushes and she came, everything was hunky-dory and I was a happy camper.

Jo's preference for an atmosphere that provided space for her to make decisions, coupled with a "clean" setting and competent attendant redefined the standard home or hospital birth that some women opt for. This morphing of setting, attendant and model of care present a new definition of birth.

Both Vida and Jo had negative experiences with the medical community during their pregnancy. While Vida's negative experience was with the physicians she used for her prenatal care, Jo's negative experience was with the nurses who were supposed to administer a stress test ordered by Jo's midwife. The nurses insisted that Jo's pregnancy be induced and have the baby at the time of her visit. The interaction became confrontational, "the nurses were horrible":

(Jo) At first the nurses were horrible, they were so mean to me when they found out that I was going to use a midwife, they were just really mean. So they started to have me sign all of this paperwork, and I said, 'I'm not here to have a baby, I'm just here for the stress test'. They said you have to sign

it anyway. Then they hooked me up to an IV and brought in this stuff and I said 'what is that for?', and they said, 'as far as we're concerned, you're having that baby today. We're going to induce labor.' These nurses were like, 'you have no right to have your baby anywhere else but the hospital'.

Jo's rejection of the obstetrical definition of childbirth conflicted with the nurse's expectations that women should birth in the hospital. The nurses in this situation were not the soothing or humanizing support that Blythe experienced during her birth. Jo's refused to accept their attempt at 'role-making,' whereby they expected her to comply with their wish to create reality. The interaction ended when the physician, who supported midwifery entered the room and ordered all of the nurses out. The physician apologized for their behavior and created a humanizing atmosphere. Jo's experience with the physician is drastically different from Vida's experience in that the physician provided an atmosphere where Jo could regain some control of what happened to her.

Jo and Vida gave birth after years of being involved in the women's liberation movement in the 1960's. This not only affected how they approached where they would give birth, but provided them with a different set of expectations to consider as 'consciousness-raising' was at the heart of the women's movement. As a result of women's liberation, Jo and Vida were offered the opportunity to question gender norms and address unequal power. Like Emma, who began to question authority after the birth of her first child, Jo and Vida were skeptical of obstetrics and a system that limited the options and choices available to women. The resistance that they encountered was a backlash against feminist values that challenged societal norms. Jo and Vida were situated within the time-period they gave birth, affecting their options, decisions and ultimately their experiences.

SHIFTING EXPECTATIONS

My interviews with Lilly and Terri, both of whom experienced homebirths like Jo and Vida, were different in that they each had a previous hospital experience and decided to have their subsequent births based on what they did not want. Lilly in particular distrusted the hospital setting in the new town she moved to after her previous experience as a labor and delivery nurse in a different state; she had assumed that her hospital experience in the new town would mirror that of what she saw back in her home-state. Terri on the other hand had chosen a homebirth because of her previous hospital experience, and because of her interest in becoming a midwife. Lilly and Terri both had their first child in 1995 in different states, and their last child at the time of the interview (Lilly's third, Terri's second) in 2001 with the same midwife, in the same town.

During my interview with Lilly at her home, she described her background in the field, "I was already a professional in this area and had witnessed a number of births already." Lilly described her expectation of how birth would go for her and how, "every step of the way it turned out very different...my first experience if you were to ask was an awful experience, but it led me to my other two experiences which were incredible." Lilly recalls how at six months pregnant, and after finally overcoming a "very sick trimester," her husband was offered a job in another state, "so that was stress." When Lilly moved she "hooked up" with one of the practices in town, "and immediately realized the way they practiced was not how I had envisioned things." Lilly's perception of reality was incongruent with what she experienced at the new clinic. Lilly possessed information about how the situation should be defined and seeing that it differed from her

reality disallowed a working consensus within the interaction. Lilly experienced this incongruity in definition from the moment she visited her doctor on the day she went in to labor. She felt she was in labor, they defined it otherwise:

(Lilly) The labor started at like 3:00 in the morning and told him [husband] at 5:00am. I had low back pain, very intense and then we went we went into the office in the morning and they told me to go back home, that they were irregular contractions. In hindsight it was the classic posterior baby, but no one knew at the time. I was at home and during that time I got what I consider out of control. I wasn't able to handle the contractions. My husband, he was, well this was all new to us—he wasn't able to get me back into control. We went to the office at 5:00pm, and I had barely progressed. I think maybe I was dilated at 3 but they could see I wasn't handling it so they took me over to the hospital and it just went down-hill from there. I walked in and they started talking cesarean. I just you know, I went into my fight mode. My background kicked in and it was like 'No!'

So of course they put you right into bed and they start monitoring you. So I'm on my back. I'm now in bed. It's like the worst position to take on childbirth. Then it was just one intervention after another, and that's what bothered me.

So then they gave me Stadol, and I don't recall asking them to give it to me, or giving permission per se, that is getting foggy-ish. I acted negatively to it; I thought my head was floating off. They were running a bath for me and it took forever, and as I started getting into the tub I threw up. They had to drain it out and start all over. When I got in the tub, and we have a picture, my husband took a picture, I'm like kind of passed out, and he was holding me up because of the Stadol. Then they got me out and they were still talking cesarean and I was like 'No, No, No!' I just remember one of the nurses got into my face and helped me get back into control, I mean I'm like screaming this entire time, screaming at the top of my lungs, bloody murder. I think I was screaming a profanity or something and I just never was reeled back in, so things just kind of snowballed. The

next thing I remember is starting to push on my back, and this is the worst position to push in. So I push, and push, and push—nothing is happening.

The total time I pushed was probably for four hours. The doctor finally came in and he suggested forceps. He put the forceps in, and it hit a nerve

and my leg just kind of lost all sensation. He was frustrated and tired and just took them out quickly and said, 'we're done, cesarean!' It was close to 27 hours by then and I was just pooped, and I just sobbed and sobbed while they got the room ready and had a cesarean.

(Michele) You mentioned several times that you were out of control. What would *in control* have meant to you?

(Lilly) In control would have been, handling the contractions better. I think if I could have handled them better I would have been able to change things for myself, I could have just focused and said, 'well what do I need'...Walking in and having them bring up Cesarean right there set me off, and made me angry and put me in a very defensive fighting mode-which I think took away from what I was going through as a laboring mom, and then to break my water, I was already out of control.

The cesarean for Lilly was perceived as the hospital taking control and her failing to gain control. Lilly brought to the experience her own background in labor and delivery. She expected hospital staff to take on the role of support and to help her "get back in control." She notes the doctor's frustration that her leg went numb when he hit a nerve with the forceps, as if her negative physiological response to the interventions were an imposition on him. His response to what he defined as an inability to progress was the use of additional interventions. The conflict that arose from this asymmetrical relationship was the impetus for Lilly's decision to birth at home when she learned she was pregnant.

Lilly shares her next two experiences which were homebirths attended by the same midwife. Lilly described her growing confidence in herself after she teams up with a local midwife, "who answered all of my questions...every appointment lasted an hour of just talking and sharing. My confidence soared...I was just so darn excited about labor and delivery." During Lilly's second birth, the labor lasted "all day," and her third

was “two hours!” Lilly recalls feeling supported and encouraged while experiencing

bodily sensations for the first time in a manner that she could “control”:

(Lilly) I progressed through the day. We were going around and going around...it was pretty intense. What I loved the most, the one thing she said to me....at one time I said, ‘I can’t do this anymore, there is something wrong’ and she said ‘no, you’re fine...this is what it feels like to have a baby.’ I had not had that vaginal feeling, so it was like OH! And that was so reassuring, and I just got right back into it and said OK I can do this.

My noises started to change and it was so neat because she said, wow, you sound different, are you pushing? And I said, I think I am...and I loved that she didn’t have to tell my you’re at 10, you can start pushing, I loved that it was all about my body. So then I started pushing and it took about an hour and 45 minutes. It was look what you did...not what we did, but that they were there to assist. The approach is totally different, so the end result is very different. It was magical, it was Friday the 13th, it was a full moon, it was a lunar eclipse...I had a small tear. I look over and I saw a lady bug crawling across the pillow case and I’d never seen one in the house before. It was so magical. It was so wonderful.

The working consensus that Lilly and her midwife came to allowed Lilly to feel she had control over her labor and delivery. The midwives definition of labor, “this is what it feels like to have a baby,” allowed Lilly to feel more comfortable with her sensations and control over her experience. Lilly subsequently felt that the childbirth was something *she did*, not just in her second birth, but in her third homebirth experience as well. Lilly felt she was able to contribute equally to the definition of the situation because her behavioral opportunities were not limited by the midwife. Her ability to define the situation allowed her to “welcome the pain because my midwife welcomed the pain...it wasn’t pain, it was my body doing what it was supposed to do.”

My interview with Terri revealed the ability for women to create a new meaning

when multiple realities are experienced. Terri had watched her mother give birth to her brother when she was six and felt very comfortable with the idea of a homebirth. She however was informed during her first pregnancy that she was “high-risk” because of her kidney disease. She decided to opt for a physician-attended birth with a certified nurse-midwife present. “It was the best of both worlds...the safety of the hospital, but yet the personal attendant...I just felt really comfortable with that situation that time.” Terri was eight days overdue, so the doctor induced labor:

(Terri) At 6:00 that evening the Doctor came in and broke my water and then I went into labor and he was born at 9:00. I just immediately went into hard labor, and I think that had a lot to do with being on the Pitocin. It was really easy, no episiotomy, no stitches...the nurse midwife was wonderful. She was really good; she was there the whole time not just the very end.

(Michele) What was your relationship like with the midwife and the doctor?

(Terri) The Doctor induced the labor and we had just met him about maybe twice before. The nurse-midwife...I felt really comfortable with her. But it wasn't a real tight, close relationship...at the time I thought she was great, but now that I've had this birth it was a totally different experience

Terri described her hospital experience as “wonderful” because, “the hospital sort of would do what I wanted to do...there was a bunch going on, so they really made an effort to make me feel like I was the only one.” Terri recalled feeling “mortified” however

when the labor and delivery staff, “starting talking c-section. I was mortified—whatever it takes to have a healthy baby, but I really didn't feel like I needed it. I was mortified.”

The nurse-midwife in the hospital played an important role, making Terri feel

comfortable by her constant presence. Terri only talks about the physician in relation to the induction of labor and his suggestion to perform a cesarean section. Terri hints that she would have actively managed her behavior by conceding to a c-section to “have a healthy baby,” even though she did not feel like she needed it.

In 2001, Terri and her husband were living in a different state and searched for a local midwife they found through a friend. At the time Terri was considering becoming a midwife herself. Terri met with the midwife who completed a nutritional analysis, which put Terri at ease since her first pregnancy was dubbed as *high risk*. Terri labored in the water-tub set up for her, and described the last few minutes as “really scary” because of the level of pain she experienced. Terri described the pain as something she could not control:

(Terri) I had total confidence in the people who were attending me, I felt totally comfortable with them. It was just a fear of losing control. I am a person who likes to be in control and then I just didn't have control. Just those last couple of minutes...I've always been irritated with women who scream during labor, and sure enough that was me this time. Here I was with my six-year-old child there and here I am screaming. That was really hard for me, in fact I can talk about it easily now, but that was hard for me for a long time...I haven't wanted to relive that because it bothers me that I feel like I lost control.

While Terri felt that she lost control, she voiced her certainty that if she had delivered in a hospital, “I would have had at the very least an episiotomy, and probably a pretty large one, if they would have let me do that. I probably would have been a c-section immediately...it just would have been a different situation.” In retrospect Terri was able to compare her two experiences. While Terri had a definition of birth that the hospital

honored, she felt more control and freedom at home. Terri described satisfaction that the midwife, “encouraged us to take the responsibility for ourselves and put it on our shoulders...I really appreciated that.” Because of her previous hospital experience where there was “talk” of a c-section, Terri had some clue as to how the situation would have been negotiated for her second birth and *who* would have controlled the course of the relationship.

Terri and Lilly gave birth years after the women’s movement which strove to improve the social and political positions of women in society. Long-gone were the archaic interventions used during Sue, Alicia and Julie, which left them with no memory of their experiences and no control over who was present during their labor and delivery. Terri and Lilly were more conscious of the options they had available to them, which may have influenced the dissatisfaction they had of their hospital experiences where other interventions were used, including the use of drugs in Lilly’s situation, which did leave her with a traumatic memory of her birth. They expected to have options and control over the care that they received during birth in the hospital. The limited choices and imposing views of the medical staff, particularly for Lilly was what brought them to subsequent homebirths. They however were able to imagine another definition of reality—different from the reality of the hospital, without much resistance from the community or their social network.

AT HOME

The last cohort, Willow and Noni, delivered their first children at home with a

midwife. They both utilized the same midwife but came to their decisions in a very different way. Willow was 38 years old at the time of her childbirth, “if you’re over 35 the doctors treat you like a geriatric...the risk of having a c-section because I was older was high enough, plus the risk of having a c-section in general just by going to the hospital is really high...I just wanted to avoid that risk all-together as much as I could.” Noni was 19 at the time of her delivery. During our interview she reminisced about being a midwife assistant and doula, “Since I was 12 or 13.” Noni, like Terri, wanted to be a midwife as well. Noni reported feeling “scared to go to the hospital...I’ve been to other births in the hospital, just the attitude in the air there is really weird. It makes you tense.” Willow and Noni echoed nearly 25 years later what Emma, Vida and Jo felt when they were planning their homebirth experiences. Willow wanted a homebirth, “partly for the idea of having my decisions respected...I’ve dealt with doctors and most of them don’t have respect for your opinions. When it comes to childbirth, they think you know nothing at all.” Noni resonates, “I wanted to be able to do what I wanted to do. In the hospital I don’t think they would have let me run around...they usually restrict you to your bed and I wanted to try things.” The ability to try different positions and techniques was a focus for these two women.

Willow, an instructor with a master’s degree was working on some “major projects with the Green party and earth day stuff...I finished up the projects and thought to myself, ‘you can come anytime.’” She started laboring the next day. She opted for a water birth where she labored for about four hours:

(Willow) I labored in the tank, which is comfortable for the most part, but my contractions made me arch back. I felt like he [husband] had to hold my head up. The tank wasn't comfortable for my head. I laid down on the futon and labored there a couple of hours. [Midwife] said that I wasn't making progress so they had me get up and do some. I was starting to feel the need to push...she needed some gravity. My husband was behind me supporting and holding me. She started crowning—we watched her head go out, go in, go out, go in...there's hair, she's gone! My knees got tired, and I went from hands to knees, which I'd swore I'd never do, but it was comfortable. Most of it was extremely uncomfortable, but not unbearable. The actual exit of her head, the last part of her head, that hurt...I actually got to experience my birth, instead of one of my cousins. She made jokes in her announcement about having an epidural and these monitors hooked up. She would see blips where she was contracting and she and her husband would laugh and say 'well that must have hurt.'

(Michele) What did you think about your childbirth?

(Willow) It really let's you understand how strong you are, knowing that you can birth a baby not being drugged up.

Willow's rejection of a hospital setting and interventions was validated by a childbirth education class she took at the local hospital. Willow said the educator talked at length about preparing the women for what kind of drugs they wanted to ease the pain, "she then told us not to come to the hospital too early because the longer we're there, the more we'll be interfered with, and the more we're interfered with, the likelier we'll experience a c-section." Willow was in a place to ask questions and determine the kind of experience she wanted. Willow understood that her age was perceived differently in each setting—that she was a risk in the hospital and not risk at home. In fact, Willow went as far to say that because of her age, *the risk was the hospital*. She perceived the hospital as an environment that would force its will on her. Willow's ability to *role-take*, or imagine how hospital staff would perceive her allowed her to make a different choice for setting

and attendant. Willow brought to her interaction with the midwife a level of confidence that aligned with the midwife's perception that she could labor on her own, resulting in a successful definition of the situation. The midwife's role allowed Willow to successfully perform her role as an active participant in the labor and delivery.

Noni, a recent high-school graduate was in a very different place than Willow in relation to age and educational background. She however was able to negotiate her reality and subsequently felt confident and empowered after her delivery. While planning her homebirth, Noni faced some conflict with her husband and in-laws, "they were worried something was going to happen, that I would need a doctor. They thought I was stupid and didn't think I was educated." She and her husband compromised that, "he could have the baby circumcised if I could have it at home." Noni's husband remarked after the delivery, "He said that I made it look so easy!" When asked when the childbirth began for her, she stated:

(Noni) I was two weeks late and it was about 4:00 in the evening. I started to have serious contractions. It's not really easy, but it was easier for me than I think for most women, because I was prepared for it. Mentally I had prepared myself for it. I knew it was going to hurt, so I was anticipating it. It was a really nice experience. A lot of women say it was the worst thing and they scare a lot of other women. Childbirth for me was one of the best parts. It was a lot of pain, I didn't have any medication. So

I was constantly in and out of the hot-tub, running in the house.

Once I started pushing I totally blocked everybody out, I was totally concentrating on getting the baby out, and that was my goal. For me there was no body else in the room, it was just me and the baby and I was determined to push him out. Finally, 5:31am he came out. At first I was like, 'I'm not doing that again.' But after that I forgot the pain and it was really wonderful for me. One of the best parts was that I had a midwife, and I didn't go to the hospital, I had the baby at home and I had a

relationship with her for almost nine months. We got to know each other, we got personal, so when it came time to have my baby I was more relaxed, I was able to enjoy what was going on. And I'm really glad about that.

Noni had a definition of birth that she learned at a young age, "I've seen both home and hospital births." Her previous experience prepared her for what might happen in each setting and she opted for a homebirth, "that was what I was most comfortable with."

Noni describes her confidence giving birth because, "I do know so much. I've been around it so it's like second nature for me...one of the main keys for me was to stay relaxed and focused and know that I can do it." She, like Emma faced some conflict with others who had a differing perspective on how and where women should labor. Noni however found a provider whose perspective aligned with hers, allowing her control over her childbirth. Noni knew what to expect from the midwife and through their interaction they came to a working consensus. Noni felt that the midwife "knew" when to leave her be and when to intervene. Noni and the midwife created and shared meaning allowing them to act together successfully and contribute equally to the parameters of the definition.

Willow and Noni gave birth during a time of greater political and social freedom for women in the US. Willow and Noni operated with a greater sense of autonomy and power than were experienced by Julie, Sue, Alicia and Lauren, because of the time-period in which they experienced birth. Their historical location—giving birth in the 21st century, versus the expectation to give birth in a hospital during the 1930's-1980's—provided them with the freedom to make an 'alternative' healthcare choice without much

resistance or negative reaction from others.

DISCUSSION

For the purpose of discussion, I'd like to address the emerging themes in terms of the following categories: women who chose a hospital birth with a physician as the attendant, women who chose a setting outside of the hospital with a midwife, friend or family-member as their attendant, and women who changed the birth setting after an initial hospital experience.

Among the women I interviewed who chose a hospital setting—there was an overwhelming consensus among this group that a hospital birth attended by a physician was the only option- the only definition of birth that could exist. They all gave similar reasons as to why they chose this option: “we always went to the hospital”, “It was more or less the thing you did that day”, “That’s how you did it responsibly…it was thought to be irresponsible to do it otherwise…it was foolhardy to put the baby at risk.” There was a mutual understanding of reality shared among this group of women because the definition was agreed upon by everyone else.

The concept of risk and how their physician alleviated their fears was also a focal point. The doctor was considered the expert and someone they could trust to get them through their birth unharmed and without pain. There was a working consensus of reality that the doctor’s would manage the childbirth and that the interventions were necessary for the treatment of childbirth. Even for those who were skeptical of the interventions, they thought that the tools and procedures were necessary.

All of the women who experienced a hospital birth had a working consensus of

reality with the physicians that avoided open conflicts and maintained a successful interaction. Some of the women's behaviors were limited and the doctors made the ongoing decisions required for the joint activity of childbirth.

As we look at women who decided to birth out of the hospital, there are several variations in setting, and attendant, as well as themes that emerge. The women among these cohorts rejected the normative reality of childbirth and redefined birth for themselves on various levels. The primary theme for this grouping of women was their ability to form the course of the relationship and redefine the situation of birth. Their ability to redefine birth however did not occur without conflict from the mainstream. All four; Vida, Jo, Noni and Willow experienced criticism from others for their decision to birth out of a hospital, which influenced their experience. While they were able to negotiate reality during the time of delivery, conflict arose because they rejected the definition of birth that was agreed upon by everyone else. This is evidenced by, in particular, Vida and Jo's experience of the medical providers they encountered during their pregnancy. All four of these women were aware of the normative reality of birth which they rejected and redefined. They were able to negotiate their own reality during the interaction with their attendants allowing them to control the situation.

The final grouping of women delivered their first children in a hospital attended by a physician and then decided to deliver at home with a midwife for their subsequent births. They have the ability to compare their experiences, as opposed to relying on an imagined reality. Their initial experiences were influenced by what they brought with

them to the interaction—being inexperienced and young (Emma), a professional in the field of labor and delivery (Lilly), and having an interest in midwifery (Terri). These three women, dissatisfied with their initial hospital experience created a new reality at home with a midwife that allowed them more control and optimal birth experiences.

All of the women in this study, no matter what option they chose, had a definition of childbirth that was influenced by those around them and the historical period they gave birth in. They came to the situation of birth with an understanding of the roles that each member was to perform which guided their perspective. The reality of childbirth in a hospital, home or birthing center *existed*, even if they had not “arrived on the scene” (Emerson, 1970, p. 265). All of the women had a sense of what that reality was, even if they themselves had not experienced it. The women were also able to locate themselves within a situation based on their age and experience. Their ability to role-take allowed them to view themselves through the perspective of the attendant, whether or not that attendant was who they chose in the end.

When I set to the task of interviewing the women in this study, I thought that asking the general question, “tell me where the childbirth began for you” would uncover the meanings they associated with their childbirth. However, I learned that asking the question about what led them to decide on a particular setting provided me with how the women made sense of their childbirth experiences. Through this question I was able to learn how they defined birth and if that definition was sustained in the interaction with their attendants or if there was conflict. To some degree, all of the women had a

definition that was sustained throughout their interaction; however there were three distinct experiences that influenced the meanings women had about their childbirth experiences. These three experiences were Emma, Lilly and Terri who decided to birth at home following a hospital experience. The interaction with their attendants was constrained by the physician's definition of reality; therefore the physician formed the course of the relationship. Their homebirth experiences, in contrast to their hospital experiences confirmed my assertion that a midwifery-attended birth offered more autonomy. Not all of the women who experienced birth in a hospital had negative experience. They felt safer with a physician and having technological interventions available if there were any complications. They felt comfortable with a hospital experience as it was defined which prevented conflict within their interaction with others. Other's, particularly Sue, Julie and Alicia while feeling safe and confident that their physician's would care for them were limited in their ability to negotiate a reality due to the mere fact that they were rendered semi-unconscious during their experiences.

I found that to some degree, educational background may have influenced the women's decisions and allowed them to ask questions (seven out of the twelve women had a formal college education). For instance, I found that those with a master's degree or higher were more likely to give birth at home or in a birthing center with a midwife or family/friend attending the birth. Those with a bachelor's degree, high school diploma or less were more likely to give birth in a hospital attended by a physician. This is not to say that education influences what setting and attendant a woman will choose—I think

historical period has a greater influence on this. I however found it interesting that women with a graduate level education were more likely to give birth at home with a midwife. Those who earned a degree in higher education obtained their degrees during or following the women's movement. So with access to education came access to additional options that others in the study may not have had.

Limitations of this study include the homogeneity of this sample. Of the twelve women interviewed, one was African-American while all others were Caucasian. Social location is an important factor in interaction—*what* the actors bring with them influences *how* the interaction will be defined. Variables such as age, race, ethnicity, ability and class are important factors to consider. The stories of women of color and in particular, native or indigenous women need to be studied to determine how colonization has impacted traditional practices and experiences. The stories of lesbian women and women with disabilities need to be included to illuminate cultural attitudes of *who* should be a mother and how this impacts the care they receive. I also think that studying the experiences of women in prison will uncover ideas about *who* should be mothers and how the mother and newborn baby are treated and cared for during pregnancy, labor, delivery and the post-partum period.

There were no homebirth/birthing center stories prior to 1975 and no hospital birth stories after 1995 in this sample. A broader sample with different experiences would have been useful to compare and contrast within the different eras, although the limitation to finding a homebirth experience prior to 1975 may be indicative of the era

itself. While the last four women in this sample were referred by the same midwife, the two other women who experienced birth's with a midwife offset the bias of the four recruited by my gatekeeper. None of the women I interviewed had a negative homebirth experience that then prompted them to seek a future hospital experience. This is not to say that women have not had negative experiences at home or in a birthing center.

Including this story may reveal further how one's social location influences the meaning of the experience for them. Including this story would also help reveal if homebirth's are more likely to offer women control of the situation. Further qualitative study is merited to capture women's experiences in an effort to bring forth more conversation and debate about the state of obstetrical care and women's healthcare options in the US and internationally.

As I mentioned in the beginning of project, I have no background in childbirth. I have neither experienced nor witnessed birth which affected the questions I asked and quite simply prevented me from knowing that I should have asked additional questions. In the example of Lauren, I did not know to ask more about the "knitting needle" because I had no background in childbirth. By educating myself more about pregnancy, labor and delivery through reading, attending a childbirth education course, attending a Lamaze International conference, and touring an obstetrical facility, I am better able to understand more fully the stories this group of women shared with me.

I would have liked to delve more into the reasons why Julie, Sue, Alicia, Lauren and Blythe did not consider a homebirth. They briefly alluded to the fact that risk and

expectations of others influenced their decisions; however I did not have them elaborate further. My focus on highlighting how a hospital-setting reduced the control women had prevented me from seeking more information about why some of the women rejected a home or birthing center birth as an option. This however has not prevented me from being able to learn how the women in this study created meaning from their experience.

My location as a white, middle-class, heterosexual woman also influenced and limited the questions I asked and the participants that were included in this project. As mentioned previously, the homogeneity of the sample limits the findings of my project to a specific socio-demographic group. Had I included women from different backgrounds and experiences, the questions I asked may have been broader and included variables such as age, race, class, ability and sexual orientation. My social location as a young, educated and middle-class woman also influenced the comfort level of my participants which may have caused some of them to censor themselves, or provide answers they hoped I was looking for (particularly for the older women in the study).

REDEFINING BIRTH

How might contemporary women redefine the reality of birth for themselves to produce greater autonomy and control over their own lived experience? I believe this redefinition is occurring on many different levels. On a macro-level, state laws restricting the practice of midwifery are being challenged, as noted earlier in this project. Research abounds on the necessity to change obstetrical practice to reduce potential harm caused by interventions, and improve birth outcomes for women. Advocacy and educational groups like Childbirth Connection and Lamaze International are refuting the common claims of obstetrical ideology and supporting evidenced-based research that supports normal birth methods, continuous labor support, and advocates for women to be adequately informed of their healthcare options by providers.

On a micro-level, women who approach their first births have an opportunity to redefine the experience of birth. Like Vida and Jo who made very different choices on setting and attendant, women can decide for themselves how their birth experience is defined. Childbirth can also be redefined by women who decide to have a different setting for multiple births, as indicated by Emma, Lilly and Terri. The symbolic interaction perspective recognizes that a situation does not have to be accepted as defined and that individuals can decline a current reality. This can only be true however if the individual is aware of a converse reality, which is difficult in the arena of childbirth. As I pointed out early on, Rothman (2006) argues that women are living in a land of contradiction where the “dominant mental picture of birth is a woman lying flat on her

back, crying or screaming, as a doctor rescues her baby” (p. 7). While women may be aware of a converse reality, the information they have about that reality may be skewed by what the dominant ideology tells them. Access to unbiased information and awareness about limitations on women’s behavior is necessary for women to attempt to redefine birth, particularly in a hospital setting. Bingham (2005) contends that when women begin to insist on their right for normal birth options will hospitals respond and change happen (p. 39). I contend that when women who choose a hospital birth can define and control the situation, and women who make the decision to birth at home or in a birthing center no longer face negative reactions from others, will birth be truly redefined and truly woman-centered.

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APPENDIX

APPENDIX A: PARTICIPANT DEMOGRAPHICS

Name	Age	# of birth(s)	Year of birth(s)	Place of birth(s)	Attendant	Highest level of education	Racial/Ethnic identity
Julie	81	2	1936 1947	Hospital Hospital	Physician Physician	9 th grade	White
Sue	83	2	1944 1950	Hospital Hospital	Physician Physician	12 th grade (diploma)	White
Alicia	80	1	1945	Hospital	Physician	12 th grade (diploma)	White
Lauren	59	3	1961 1964 1969	Hospital Hospital Hospital	Physician Physician Physician	12 th grade (diploma)	White
Emma	52	4	1960 1975 1978 1981	Hospital Home Home Home	Physician Physician Midwife Midwife	Graduate School (Master's degree)	White
Blythe	51	5	1972 1975 1977 1980 1983	Hospital Hospital Hospital Hospital Hospital	Physician Physician Physician Physician Physician	College (Bachelor's degree)	White
Vida	48	2	1975 1977	Home Home	Friend/Husb and Friend/Husb and	Graduate School (PhD)	African- American
Jo	43	1	1979	Birthing center	Midwife	Graduate school (Master's degree)	White
Lilly	37	3	1995 1998 2001	Hospital Home Home	Physician Midwife Midwife	Graduate School (Master's degree)	White
Terri	27	2	1995 2001	Hospital Home	Physician/C NM Midwife	College (Bachelor's degree)	White
Willow	39	1	2000	Home	Midwife	Graduate School (Master's degree)	White
Noni	19	1	2001	Home	Midwife	12 th grade (diploma)	White

