

Spring 2016

What Makes a Good Birth? A Qualitative Study on Choices and Experiences Among Women in Greater Boston

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**What Makes a Good Birth? A Qualitative Study on Choices and Experiences
Among Women in Greater Boston**

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Spring 2016**

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Introduction

We are all born; therefore it stands to reason that this universal truth warrants significant discussion on how women give birth. And yet, it is a topic that garners little attention in the media, and is hardly a topic of social conversation. This also holds true for my own experiences with the topic of childbirth. My mother delivered me at the hospital, without pain medication, and for that I am proud of her. But why? It was not until my first year in college that I realized there was a whole birth-related world out there that it seemed many people did not know about, even women in the birth process themselves. In a class on the sociology of gender, I learned from Professor Theresa Morris that the birth experiences many women had might not be the best that their healthcare providers could have given them.

In class, we watched *The Business of Being Born*, a documentary that explores the maternity care system and how the natural process of birth has been turned into a business, and it opened my eyes to the multitude of options women have. The problem is that women may not know of or be exposed to these options while they navigate themselves through the pregnancy and birth process, leaving them with only one path—directly to the hospital. I undertook this thesis to understand and try to answer the question: what makes a good birth? Tapping into a network of women willing to share their stories with me has allowed me to uncover some of the aspects that women feel are key in having a good birth. I believe that the importance of this research lies in its qualitative approach, because there is no other way to define a successful birth than by going directly to the women who experienced it.

I begin in Chapter 1 by discussing women's prenatal choices and values, which arguably dictate how the pregnancy and delivery process is going to proceed. I looked for women who had the financial ability to choose whichever birth options they wanted because if they were able to afford any and all available options, I could understand exactly what they wanted, what they ended up getting, and whether or not they were happy with their delivery decisions. I describe four categories of births available to women: planned hospital births, midwives attending hospital births, high-risk hospital births, and planned home births. In general, women who chose to deliver in the hospital were either comfortable with the medical model of delivery, or were unaware of or uncomfortable with more non-traditional methods of delivery. These women wanted medical assurance in case they needed an intervention, or because they chose to have a medicated birth (often by receiving an epidural). In addition, I discuss the unique case of high-risk women, who have no choice in where to deliver.

On the other end of the spectrum were women who made a conscious decision to attempt to stay away from the medical model and sought the comfort of their homes to provide them with more "natural" deliveries. With a strong belief that the body is able to birth naturally, these women avoided the hospital because they felt that if they chose to deliver there, their births would be interfered with in some way. In the middle of this spectrum were women who chose to use midwives and/or doulas in their hospital births. Midwives bridged the gap between the medical aspect of a hospital delivery and the comfort, support, and control of a home delivery. Women who chose to do this wanted the comforting aspects of home

with the medical assurance of the hospital in case of emergency. I conclude this chapter with the impression that the medical model method of delivery could be shifting, indicated by the increased number of women seeking the comfort of home deliveries in the hospital as well as the avoidance of medical interventions .

Chapter 2 highlights women's reported risks, concerns, and expectations before going into labor. The literature on the risks by location is unclear, but from this data I conclude that what matters is what women perceive the risks to be. For example, a woman who does not want interventions will view delivering in the hospital as risky because her definition of risk is receiving interventions. On the other hand, women who want medical interventions available will view delivering at home to be risky because interventions are not readily available. All reports of risks, concerns, and expectations included some aspect of medicalization whether focused on its acceptance or rejection.

In terms of expectations, women who delivered in the hospital without a midwife and/or doula reported that they did not know what to expect, while women who did use these resources (whether at home or in the hospital) reported that they had a good idea about how their deliveries would progress. This chapter also highlights the aspect of support in receiving prenatal information. While hospital birth women heard "horror stories" about undesirable hospital deliveries, home birth women were surrounded by the support of others and encouraged with positive birth stories. The aspect of support is one that clearly differentiates home and hospital experiences. As discussed in the final chapter, the women I interviewed at a birth circle (where women gather to share birth stories and experiences) were

able to use the circle as a form of support and comfort, a resource that hospital women did not report having at their disposal.

Chapter 3 examines the outcomes of the women's births, which included various criteria, as well as the ways in which they told their birth stories. This is an important discussion because it generates a conversation about how women feel about the entire birth experience, as opposed to the statistical data that is often found in the literature on outcomes. Although many women commented at the outset of their pregnancies that they did not want any medical interventions, many ended up receiving them because they chose to at the last moment, or because of complications with the delivery. While some women expressed being traumatized by their births, they differed in the ways in which they accepted or dealt with these aspects of trauma. Some reported that delivering a healthy baby was enough for them to accept their less-than-perfect deliveries, but other women still dealt with aspects of trauma much later, during the postpartum period.

Women in the birth circle who were encouraged to accept their trauma and share their stories with others who had experienced traumatic births found this experience empowering. Many of these women sought home births for their subsequent deliveries, and or made sure to include midwives and or doulas in the process. As opposed to hospital birth women, the women in the birth circle, perhaps given the supportive environment, were able to share all aspects of their stories, whether they were positive or not. I argue that telling a "real" story (acknowledging aspects of trauma) as opposed to a "good" story (with no trauma) is a crucial part of the storytelling process and needs to be available to all women, regardless of

experience. Discussions of significant life events such as birth are important for self-expression, understanding, and healing.

By structuring the thesis in this way, I hope to explore the entire process of pregnancy, labor, and delivery and how these stages are important in defining what it means to have a successful birth. In addition, my goal is to highlight the fact that although no birth story is exactly the same, it is crucial that women are able to make their own choices and decisions as well as have an opportunity to express their feelings about their experiences, especially in cases of trauma. By using stories as my data source, I encourage other researchers to do the same in order to fully understand what women desire in terms of the ideal experience, as well as how these experiences can be accessed and achieved.

A Review of the Literature

Women in the United States have used many different birth and delivery procedures over hundreds of years, using varied methods, locations, and care providers. It is only within the past fifty years, with the advancement of modern medicine, that giving birth has opened up a wide discussion among scholars, doctors, feminists, and others who debate issues such as choice, delivery location, and health. Women who are able to afford non-traditional (out of the hospital and/or using a midwife or doula) choices now have many options for delivery location and the type of care they hope to receive. Current conversations on this topic highlight how American culture as well as social class determines choice and decision-making, which reflect personal ideas about medicine and the body (Tuteur 2010). With the growing contemporary power of biomedicine has come the idea that a medicalized birth is the most effective in terms of ensuring good outcomes (Wagner 2000). While some take this view and trust only what is now seen as a traditional hospital birth, others push back and examine the power of the body to birth naturally without medical intervention.

Debates on this issue now take two sides: one argues that hospital births promote unnecessary intervention, while the other side argues that hospitals are the safest place to give birth, and giving birth outside of the hospital only unnecessarily increases risk (Wagner 2001). A big component of this debate surrounds the rate of Cesarean sections and whether or not they are viewed too casually and therefore occur too frequently (Morris 2013). People who promote

non-traditional births argue that doctors are not paying enough attention to the fact that a C-section is a major abdominal surgery, and should only be performed in the event that there is absolutely no way the baby can be born vaginally. On the other hand, doctors and others who promote the medicalization of birth argue that a C-section can ensure a successful birth of a healthy baby and healthy mother, to which critics respond that post C-section not all mothers are healthy. In general, obstetricians emphasize the dangers of delivery and what could go wrong while midwives stress that birth is a natural process that requires only facilitation (Klein 2004).

Amidst this discussion are women who are fighting against medicalization and intervention in an attempt to create their births the way they want them, in whatever way they know how. These non-traditional options may include the use of a midwife, doula, or delivering at home, to ensure women are able to make decisions and choices aimed towards providing them with the best experience. Giving birth is both part of and literally what makes us human, and therefore it is important to examine how we give birth and the factors that allow women to create their own birth experiences.

This chapter will discuss the history of how women have given birth in the United States, and how the location of birth influences their overall birth experience. In addition, I will examine trends among middle and upper-class women whose finances allow them to create their delivery experiences in any way they wish, and the impact the American culture of choice, decision-making, and privilege has on these decisions. Given that medicalized and non-traditional birth options are

available to these women, investigating their decisions will give insight into what women find important about the birth experience and how that influences where they decide to give birth.

History

Midwife use has fluctuated significantly over the past two-hundred years. Notably, in Massachusetts, where I conducted my research, midwifery was banned in 1907. This was after the case of *Commonwealth v. Hanna Porn*, a midwife who was charged with “illegally practicing medicine and holding herself out as a practitioner of medicine without a license” (Declercq 1994, 1024). This case demonstrates the strong opinions that existed on both sides of the argument for the best birthing method, and highlights the struggle faced by midwives to assert themselves as professionals to those who argued otherwise, as well as prove they could provide positive outcomes.

Despite this time of discord in Massachusetts, up until the early twentieth century in the United States, midwifery dominated the methods of giving birth, and was also a female occupation. In 1910, fifty percent of babies were delivered by midwives (Ehrenreich and English 1973). Midwives were considered professionals, and were paid well for their services by all women, urban and rural, rich and poor. However, technological changes shifted the domain of birth from women in the home to male doctors in the hospital. The body began to be seen as something that could be medically manipulated instead of something natural and untouched (Merchant 1980). As society progressed further in terms of technology, this

underlying idea became stronger, and the belief that the body could be manipulated medically became standardized practice as well. The “body-as-the-machine” idea and medical hegemony led to the depiction of women’s natural bodies as defective, and in need of “superior” medical intervention (Davis-Floyd 2004).

The notion that interventions guarantee success over the natural processes of the body permeates the literature explaining why birth became medicalized. The natural body is not as trusted as it once was, and proponents of medicalized births, as discussed by Shumaker and Smith (1994), argue that medicine is the only way to produce guaranteed success that includes a healthy mother and baby. Robbie Davis-Floyd explains birth as a rite of passage, and argues that “our technocratic society's extreme fear of the natural processes” allows us to view intervention in a positive and almost natural way (Davis-Floyd 2004, 2).

Despite the general medicalization of birth, there have been moments in U.S. history that focus on non-traditional methods of delivery. Barbara Ehrenreich and Deirdre English discuss the changes that occurred in the feminist movement of the 1970s that brought choice and decision-making back to women and away from the medical field. By that time, “midwives had been virtually eliminated within the United States” and by 1969, almost one hundred percent of births were hospital births (Shumaker and Smith 1994, 193). Feminists became aware of the way the medical system subordinated women by giving them limited choice in delivery options, asserting that the best way to give birth was in a hospital with medical professionals (usually male doctors). Women were not entitled to make choices about their own bodies, and women who requested non-traditional options, such as

natural childbirth, were called “uncooperative or neurotic” (Ehrenreich and English 1973, 8). References to times when midwives dominated deliveries were described as primitive, an obviously negative connotation that favored the medical technologies that so many women had grown accustomed to.

The shift to accept midwifery as an option for delivery came with feminist activists who gathered information on midwifery and other practices and distributed it among women interested in non-traditional options (Ehrenreich and English 1973). This information often took form in pamphlets and meetings. Also in response to medicalized births was the alternative birth movement of the 1970s and 1980s that promoted non-traditional births to decrease the “unnecessary procedures” and “technological interventions” that had become staples of the American birth (Mathews and Zadak 1991, 44). Following the trends of other countries such as Japan, Denmark, Sweden, and the Netherlands, supporters of non-traditional births promoted the use of midwives and home birth as safe options.

However, in the early 1990s, midwives only attended four percent of births, despite the steadfast women and increased conversation surrounding non-traditional birth and delivery choices. Smith and Shumaker (1994) explain this by saying women lacked knowledge and were largely unaware that out-of-hospital births were as safe as hospital births.

More Recent Trends

The fact that national data on the number of midwife-attended births is only available from 1989 on demonstrates just how recent the acknowledgement and

acceptance of this growing non-traditional trend is, especially with regards to time spent on data collection. Data since 1989 show a steady increase of births attended by midwives, reflecting a change in attitudes among women both physically and financially able to afford them. In 2012, an all-time high of 8.66% of babies were delivered by midwives (Declercq 2015). Considering that midwives do not perform C-sections, the proportion of vaginal deliveries by midwives increases even more to 12.1% of deliveries, or one in eight women (Rochman 2015). In addition, Declercq presents the fact that certified nurse-midwives (CNM) attended almost 1 in 12 of births in the United States, and 1 in 8 vaginal births. The amount of CNM attended home births doubled from 2004 to 2012 (Declercq 2015).

Declercq explains this trend by emphasizing that midwives and doctors take different approaches throughout the pregnancy and during delivery. Midwives are described as having more patience, and take a more holistic approach. Midwives have also become a trend not just among “hippies” but among the upper classes as well, and using a midwife is viewed as “trendy.” Sylvie Blaustein, the founder of Midwifery of Manhattan, a sought-after midwifery practice, attributes this trend to quality of care and the status associated with getting the best for one’s children (Rochman 2015).

Declercq also argues that the healthcare system has been telling women for years that birth is a dangerous thing, which makes them inclined to seek medical intervention for safety and assurance. There is an ideological difference between doctors and midwives because doctors have been trained to identify everything that could go wrong, while midwives instead focus on the natural and normal

progression of birth. However, Declerq argues that if mothers start with the belief that they can deliver without intervention, they will begin to question the existing system. He believes that the midwifery and home birth trends are proof that women are questioning the system and not depending as much on intervention (Kingsbury 2015).

At the other intervention extreme is the C-section, present at increasing rates in hospitals all around the country. In 2005, one-third of all births were delivered by C-section. In 2013 every state had at least a 20% C-section rate, and five states had rates above 36% (“Birth by the Numbers” 2015). The Leapfrog group, self-described as the “national nonprofit watchdog” that advocates for hospital transparency, equality, and safety, set a 2015 target rate of 23.9 percent of all births delivered in a hospital. This standard comes from the initiative labeled “Healthy People 2020.”

By releasing the first national C-section rates for specific hospitals, The Leapfrog Group hopes that women who wish to deliver in hospitals can make informed choices, implying hospitals with lower C-section rates. Leapfrog hopes to make hospital care providers more aware of women’s birth plans, which usually list C-sections as appropriate only if medically necessary, to help reduce the number of unnecessary C-sections. They argue that the increasing rate of C-sections is “not safe,” supported by statements made by both The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine that C-sections are “too common.” In addition, they argue that C-sections are not cost effective and

impose fifty percent more cost to all associated payers than vaginal deliveries (The Leapfrog Group 2015).

Following the sentiment of important health organizations that C-sections are too common is their argument that obstetricians are “forced to practice defensive medicine” (C-sections) so as to avoid lawsuits (Morris 2013, 31). Women who have negative outcomes may sue their physicians, resulting in more physicians practicing the safer (for them) mode of delivery. The Leapfrog Group assertions are indicative of the larger picture being painted by current literature, which shows that C-section rates are increasing and despite higher costs, are easier and faster for hospitals to perform. Critics of non-traditional births argue that nothing is safer than delivering in the hospital, contrary to the “too common” abdominal surgery that occurs at shockingly high rates.

In her article “*Fish can’t see water: the need to humanize birth*,” Marsden Wagner argues that because of the medical model of birth, care providers are ignoring the women giving birth, treating them instead as machines and “containers for making babies” (Wagner 2001, 25). She states that medicalized births take the mother away from her environment unnecessarily, and make healthcare providers unaware of what an un-medicalized birth looks like. While most literature discusses the medicalization of birth, some describe how women are treated as the medicalized object, as mentioned above.

In her book *Woman in the Body*, Emily Martin uses the analogy between factory workers and women giving birth to highlight the ways in which women’s bodies are viewed as objects and therefore subject to a “means of production” found

in hospital deliveries (Martin 2001, 143). Martin argues that delivering at home is the equivalent of “opening up your own shop or becoming your own boss” because this makes women in charge of their own bodies and able to make decisions as they please (Martin 2001, 143). In addition, she discusses the aspect of machines and how they detract from care providers’ knowledge in the hospital; doctors and nurses rely on machines to help women deliver. This is in opposition to midwives, who are able to depend on their own delivering skills and the natural power of women’s bodies to birth.

The differences between care providers in both locations is highlighted in an article entitled *Doctors Versus Midwives: The Birth Wars Rage On* published in *Time Magazine*, where anthropology professor at Oregon State University and practicing midwife Melissa Cheney argues that one of the only times midwives and obstetricians interact is when a midwife’s patient is rushed in for hospital care. Doctors do not see the uneventful home births, only the troubled ones when a transfer to the hospital is necessary. Cheney argues that this does not portray non-traditional deliveries as positive experiences, and instead makes doctors view themselves as forced to take on both someone else’s patient and someone else’s problem (Kluger 2009). This makes it difficult for doctors to view home birth as a safe and effective method of delivery, and this backlash from medical professionals is one of the reasons home birth is not as widely accepted as it once was.

However, in the “birth war” between doctors and midwives, research shows that doctors have a slight upper hand when it comes to outcomes in planned home versus planned hospital births in the United States. The literature on these

outcomes varies immensely, with some sources claiming home births result in infant death two to three times more often than hospital births, while others claim much smaller disparities and posit that both are safe options. For example, researchers recently found that although home births have a slightly higher risk of infant death than hospitals, the “absolute risk of death was low in both settings” (Snowden et al. 2015, 2642). There is a lack of professional consensus about whether giving birth at home is safe (Wax et al. 2010). Given the low risk for both home and hospital deliveries, most care providers accept a woman’s choice to deliver at home if she is in good health and if there are no foreseeable complications (Cheyney, Burcher, and Vedam 2014).

In addition, the birth war represents two categories found in the literature in terms of theory. The first is the medical model, which has become stronger over time and now dominates the West in terms of childbirth (Martin 2003). This model can be examined in a sociological context, “the medical models that emerged in a patriarchal culture construct pregnancy, labor, and birth as abnormal conditions needing technological treatment” (Martin 2003, 56). As previously mentioned, birth in the medical model is the idea that it is not a natural process and instead something to be facilitated by medicine. By contrast, the feminist perspective views birth as a natural process about which women should be able to make their own choices. This perspective is also applied to research on birth and focuses on women’s oppression, their voices, and their ability to make their own choices (Keating and Fleming 2009).

The discussion around interventions is particularly relevant, given the heightened number of C-sections. While interventions are available to all women who deliver in the hospital, some women strongly prefer not to receive them, while others are more open. Echoing the medical model mantra, delivering in the hospital is supposed to be risk-free because of the medical interventions available. However, because some women do not want interventions, delivering in the hospital can include aspects of risk. Risk is relevant to birth because “where control over one’s life has become increasingly viewed as important, the concept of ‘risk’ is now widely used to explain deviations from the norm, misfortune, and frightening events” (Lupton 1999, 3). Lupton states that this is the definition used in contemporary Western societies, in which we believe that humans have the ability to prevent misfortune, an idea that can be applied to the use of interventions. Delivering in the hospital could be defined as risky if women feel that receiving interventions strays from the norm of a natural birth and would leave them uncomfortable and physically or emotionally harmed.

Another perspective, by anthropologist Mary Douglas, is that the perception of risk is defined culturally and is dependent on social factors (Douglas 1986). She posits that the public tends to overestimate the dangers of rare events, and underestimate those of common events, an idea that is applicable when analyzing hospital births. Since birth is so common, women may feel that the risks of delivery are lower and choose the most common delivery location, the hospital. However, given that more women are slowly gravitating away from the medical model present

in hospital deliveries, the risk of delivering in the hospital (and of receiving interventions) is being addressed more often (Wagner 2001).

One of the main arguments promoted by non-traditional delivery care providers as well as mothers who have delivered at home is that hospitals do not leave women with much ability to make decisions or choose what they want to do when interventions are involved. They argue that women in hospitals may find themselves receiving interventions they had not planned on or do not want, that they would not receive in a non-traditional setting. The topics of choice and decision-making permeate much of the literature on birth and delivery locations (VandeVusse 1999).

How Women Choose to Deliver

Americans have a great deal of choice afforded to them, and being allowed to choose constitutes a large part of American identity. Being able to choose gives people a sense of agency that allows them to have control over their own lives and in their decisions. Choice is the ability and power to choose while decision-making is the analysis and elimination of possible options (Mertz 2012). With regards to birth, choice can be applied to where women decide to give birth while decisions are the choices they make within the context of their deliveries.

The middle and upper classes are especially privileged to make choices. Women who are wealthier are more able to choose more non-traditional options than poorer women because they can decide which options work best for them, as well as afford them (Lazarus, 1994). These women view birth in two ways: some

view taking total control as medicalizing their births so as to ensure good outcomes, while others view control as examining all of their options and picking the ones that work best for them, making sure to avoid medical interventions because it takes control away from them (Ginsburg and Rapp 1991). For the latter women, rejecting medicalization is a way, and a privilege, to create a part of their identities by asserting themselves and their abilities to choose (Tuteur 2010).

Lazarus (1994) says that knowledge of childbirth is more than an awareness of the biological process of birth. It includes social knowledge as well, such as the health care system and different choices a woman can make about her pregnancy and birth. This knowledge is limited to upper class women, who are able to afford and obtain information about the choices they have. Poorer women may be unemployed, unmarried, have less education, and have more unplanned pregnancies, while wealthier women are generally more stable and can afford both socially and financially to focus on choices and decision-making (Lazarus 1994).

However, women are not the only ones who construct how they deliver. Their care providers play crucial roles in the level of care they receive, any interventions (such as inductions or epidurals), and any advocacy for women's desires and choices. Birth is still defined and widely seen as a medical process. A medical hegemony surrounds birth, especially defining it as fraught with risk and therefore better dealt with in hospital settings where any problem can be treated (Lazarus 1994). The hospital setting and care providers within it can sway a woman's original birth plan: doctors have incredible power and influence over birth

and delivery choices and decisions, and many women rely on their professional knowledge (Declercq et al. 2007).

Lazarus argues for changing the role of the obstetrician, and especially how they are trained. She asserts that little time in medical school is spent on bioethics, informed consent, professional responsibility, and communicating with patients, and “residents are expected to develop these skills on their own” (Lazarus 1994, 41). A more recent opinion from the American College of Obstetricians and Gynecologists stresses that patients should be more involved in their care and that “involvement of patients in [decisions about their own medical care] is good for their health—not only because it is a protection against treatment that patients might consider harmful, but because it contributes positively to their well-being” (ACOG 2009, 3). However, they do not mention that better training of obstetricians also could help foster patient well-being.

The role of obstetricians is apparent in the case of women electing to have C-sections and doctors readily accepting. Doctors earn as much as twice more for a C-section than for a vaginal delivery, and the World Health Organization reports, “In the United States the profit motive explained hospital-specific cesarean section rates that were high even by United States standards” (Wagner 2000, 1678). This specific situation demonstrates the need to make birth focus on the woman and her baby instead of rapid and high profits for the doctor and hospital.

When a woman chooses to have a midwife and/or doula in a hospital delivery, for example, it is less likely that interventions will be used because midwives usually view birth “as a natural process that needs to be facilitated” (Klein

2004, 163). Wagner writes, “Midwifery uses a different paradigm by focusing not on the potential for abnormality but on the normality of pregnancy. To a midwife a breech delivery is a variation of the normal; to a doctor it is a pathological condition” (Wagner 2000). Following the same practices as home births, midwives in hospitals focus on the woman and what she prefers in terms of delivery options as opposed to the “necessity” of medical interventions (Klein 2004). In addition, women who use midwives and/or doulas in hospitals are comforted by the fact that they have someone who can assert their wishes while she is in labor (a vulnerable state). They are able to help the woman resist the medical model of birth if she so chooses, and help foster better communication with obstetricians and nurses (Keating and Fleming 2009).

In addition, birth-related policies also affect soon-to-be mothers and the choices available to them. Since they are consumers in the process of deciding where to deliver and with whom they deliver, their voices should be heard in the policymaking associated with maternity care (De Vries et al. 2002). In Massachusetts in 2012, a law was passed that enabled certified nurse-midwives to work in the state without the supervision of a physician, and required them instead to practice within a health care system and have a clinical relationship with an obstetrician-gynecologist (Barr 2012). In addition, many hospitals now offer the choice to have a certified nurse-midwife deliver babies, an option brought on by consumer interest in midwife-assisted births. In 2013, certified nurse-midwives and nurse midwives attended 7.8% of all hospital births, which is an 8.3% increase from 2005 rates (JA Martin et al. 2016). The trend of including midwives in the delivery

process by women and hospitals is another indication that women are moving away from the medical model and traditional methods of delivery.

Choices Applied to Delivery

As discussed in the above sections, the main divide between a planned home birth and a planned hospital birth is the availability of medical interventions. However, women choose either location for many other reasons. The earlier literature on reasons why women deliver is written from a feminist lens and focuses on the patriarchal medical institution that women who gave birth at home attempted to push away (McClain 1987). More recent literature focuses on the political divides between people who choose home birth versus hospital birth. Declercq reasons that for liberals, home birth is appealing because it allows them freedom of choice in maintaining control over their bodies and the experience of birth for themselves and their families, while for conservatives, home birth appeals because of its “family-centric nature” (Declercq 2012). However, Declercq also argues that the issues of home birth specifically should not be considered political so as to avoid the “gridlock” that accompanies partisan issues. He suggests that all political parties should “approach birth less as an ideological mission and more as a health policy challenge” (Declercq 2012, 281).

Boucher et. al (2009) conducted a study that surveyed women on why they decided to give birth at home, and their responses are representative of those found elsewhere in the literature. Among twenty-six themes, the most common included avoidance of medical intervention, negative previous hospital experiences, control,

comfortable environment, and trust in natural birth. The women in this study felt that they would be active participants in their home births, and that they could choose what they wanted to do without backlash or refusal from hospital care providers. In addition, they trusted their bodies' inherent abilities to give birth on their own, without medical intervention, and in a comfortable space of their choosing (Boucher et al. 2009). More specifically, women may choose home birth to be more comfortable physically, which can take many different forms: being able to eat, wearing their own clothes, showering, moving around, and birthing in a position of their choosing (Mayo Clinic 2014).

The reasons for choosing a midwife resemble the reasons for choosing home birth. Midwives allow women to make their own choices, and guide and facilitate them through their options instead of telling them how they are going to deliver. In the hospital setting, midwives are able to help the mother communicate with the hospital staff to ensure the mother's desires for her birth are being met, and to help open dialogues if the obstetrician or nurses think a medical intervention is necessary. The relationship between the mother and the midwife is crucial because the midwife is the most important person present during the birth and helps facilitate it in all aspects. Women "shop" for midwives and choose the one they connect with the most, and they have to have a trusting relationship so the woman knows she is in the best hands for the kind of care and birth she wants (Cronk 2000).

A noteworthy trend is the growing number of doctors, nurses, and midwives who choose to deliver their babies at home. In a 2016 documentary titled "Why Not

Home?” these women explain their decisions to deliver at home, despite the fact that their careers are based in hospitals. They discuss the training they received in medical school in which “it was drilled in my head during training that [home birth] was not appropriate for anybody” (Moore 2016). They argue that because we associate technology with delivery, our fears surrounding childbirth make us more inclined to intervene with the “normal physiology” of birth. They comment on their choice of home birth by saying that the social support and comfort it provided made them feel like they had more control. This is an especially provocative documentary because if people who work in hospitals are choosing to deliver outside of the hospital, they are rejecting the hospital methods of delivery.

Women who plan to give birth in the hospital are exercising the same intent to maintain control as women who choose home birth. Women who decide on a hospital birth are following the medical hegemonic script and believe a hospital birth will prevent anything from going wrong, and believe they are securing a positive outcome no matter what. These women view medical interventions as maintaining control over the birth, while women who choose home birth view these interventions as giving control away. One of the differences in location noted is that women who choose hospital births have a “psychological advantage” by not having to deal with the backlash that faces some women who choose home births (Johnson and Daviss 2005). Because giving birth in the hospital is the norm, most women who decide to deliver in the hospital are not questioned about issues of safety or risk as women who choose home birth may be.

Women who choose hospitals might want to receive pain management, such as an epidural, or need Pitocin to speed along their labors. In addition, mothers-to-be may be concerned about the baby's health, and want to be close to a neonatal intensive care unit (NICU) in the event that something goes wrong. The security of a hospital may provide women with a sense of safety and comfort: they and their babies will have access to medical care if needed (Declercq et al. 2007).

The biggest intervention, only available in hospitals, is a C-section, which, as I mention above, is more recently occurring at alarming rates. The title of Theresa Morris' book *Cut It Out: The C-Section Epidemic in America* points bluntly to the fact that the current rates of C-section in this country can be defined as an epidemic. Morris discusses the Listening to Mothers II survey, which details reasons why women have C-sections. Ninety percent of the women in this survey had C-sections because it was recommended by their care providers for reasons such as a breeched baby or the baby being too big for a vaginal birth (Declercq et al. 2007).

Another aspect of this conversation is the elective C-section, in which women choose to deliver via C-section for no medical reason. Marsden Wagner discusses the dilemma of allowing a woman to choose a C-section and "the degree to which the procedure is doctor-friendly" (Wagner 2000, 1677). Women may choose to have a C-section to avoid any pain (a false assumption because the recovery time and severity of pain are greater after a C-section than after a vaginal delivery), or want to maintain "vaginal tone." However, C-section opponents argue that "little weight is given to the empowering aspects of vaginal birth or the impact of mode of birth on over-all maternal health" (Klein 2004, 161). Not only is a vaginal delivery the

avoidance of a C-section (abdominal surgery), it also has health benefits for the mother and child. For mothers these include a quicker recovery time, shorter stay in the hospital, and an increased rate of breastfeeding. For babies delivered vaginally, benefits can be categorized under their “natural physiological adaptation to the external environment” which includes their respiratory, hematologic, and immunologic systems (Gregory et al. 2012, 12).

In addition, going to the hospital in the first place can lead to what is described as the “cascade” of interventions (Tracy and Tracy 2003). That is, when a woman goes to a hospital to deliver, she may be provided with interventions that increase her risk for other, more serious interventions. The extreme end of this chain is a C-section, which Morris describes as more common when “women who have epidurals and receive a low dose of Pitocin to augment labor, like those doses advocated by the patient safety movement, have an increased risk of c-section” (Morris 2013, 71). This exemplifies the standardized care that hospitals are legally obligated to provide, although this care can also lead women to deliver using unwanted interventions, especially C-sections.

Women’s Views on Life After Delivery

The literature on birth outcomes focuses mostly on medical outcomes, but is sparse on whether or not women are happy and satisfied with their delivery outcomes. What literature does exist on the topic focuses on issues of trauma and the importance of women telling their birth stories to help themselves and others. Women do experience trauma in some aspects of the birth experience. Telling birth

stories is a positive step to help women understand their own births. This can also help other women understand their options and which decisions could provide them with their ideal birth experience.

The choice to deliver in a certain place in a certain way has an effect on how the mother gives birth, her postpartum health, and the baby's health. How mothers feel about the birth, whether positive or negative, can influence postpartum depression, breastfeeding, and the use of pain relievers, which all impact mother and child (Green 2012). Although this is an emerging trend in the literature, one study found that first-time mothers considered their births positive, but found that because they did not know what to expect, their expectations did not match their outcomes (Gibbins and Thomson 2001). Many expressed distress that they were not able to talk to their care providers after they had given birth to go over the delivery and clarify some of the hazier parts. This was especially true of mothers for which the delivery took an unexpected turn, often in the form of medical intervention.

Women get social and emotional support by sharing their stories because they are able to learn practical information and strategies, have their stories validated by others, and testify to how powerful the experience was for them (Goding, Bolding, and Simkin 2008). Other sources comment on the fact that giving birth is a major life event that should be discussed as such. In her article "Making Meaning: Women's Birth Stories," Lynn Clark Callister argues that the benefits of sharing birth stories include

"the opportunity for integration of a major event into the framework of a mother's life; the opportunity to share a significant life experience; the opportunity to discuss fears, concerns, "missing pieces" or feelings of inadequacy or disappointment; the opportunity for the woman to gain an

understanding of her strengths; and the opportunity to connect with other women” (Callister 2005, 508).

She also argues that failure to share and express these stories could lead to postpartum mood disorders, especially in the event of a traumatic birth. Sharing birth stories allows women put their fears or disappointments in context and is helpful to them in understanding their experiences and postpartum feelings. Talking in a supportive environment can also help women feel a sense of empowerment in knowing that they have accomplished something meaningful and that their efforts are valued and legitimate.

A photo series project started in 2015 called “American Childbirth: Exposing Silence,” empowers traumatized women to share their birth experiences and create a conversation among other mothers who have had bad experiences “from difficult stories of emergency C-sections to miscarriages to claims of abuse by medical professionals” (Bologna 2015). Another example of empowering women to share birth stories is the podcast called “The Birth Hour” in which two women each week are profiled and tell their delivery stories, which take all different forms. The podcast’s mission is to “inform listeners about birth while also providing a safe place to talk about the issues and emotions surrounding birth and motherhood” (Huntpalmer, 2015). The Birth Hour also has an active social media presence, in which pictures are used to advocate for successful deliveries in any way the mother chooses. They discuss issues such as delayed umbilical cord clamping, breastfeeding, water births, and skin-to-skin contact with newborns, and the stigma surrounding C-sections.

These are just some examples of the types of advocacy and support groups, communities, and networks available to women that allow them to discuss their birth experiences. These groups highlight the growing trend of women expressing their birth stories in unique ways that are meant to include others and create dialogues and conversations. In this thesis I will describe my experiences at a birth circle, where women met to share stories, good and bad, about their birth experiences as well as learn from other women's stories. The need for more conversation surrounding how women give birth and their experiences, especially traumatic ones, seems strong, and discussing these topics could help women make more informed choices about their births as well as allow women who have traumatic experiences to express themselves in supportive environments.

Conclusion

Looking at how the natural process of birth has progressed (or by some standards, regressed) and assessing where mothers decide to give birth and why can open a discussion about how caregivers and health providers can adjust their practices to be safe and accommodating for soon-to-be mothers. In Massachusetts specifically, where the doctor versus midwife debate was heated in the late 1800s to early 1900s, my analysis of more current trends shows that the debate continues, and rates of C-sections as well as non-traditional options have grown in tandem. By analyzing interviews with women who have recently given birth, this thesis aims to bring to light what is important to these women about the choices they make, the outcomes of their births, and the issues they and their care providers face. I hope to

demonstrate the power inherent in sharing and expressing thoughts about delivery experiences and given the universal and essential nature of birth.

Methods

Introduction

I first became interested in this topic after taking a class my sophomore year with Theresa Morris about the sociology of gender. Professor Morris, whose own work focuses on birth, explained to us the lack of knowledge women have about the birth process, and the injustices they often face in the delivery room. I was immediately hooked on the topic as well as on the idea that something needed to be changed.

The next year I was presented with the opportunity to submit a proposal written in the junior seminar for Anthropology to the Student Initiated Research Grant at Trinity. From my interest in birth in general, I was able to narrow my topic to whether or not women were satisfied with their births. After receiving the grant, I began my research on women's birth experiences with the hopes of answering the question: what makes a good birth?

Finding Interviewees

Over the course of the summer of 2015, I looked for women in the Boston area who were pregnant or who had recently given birth and who were also middle to upper class. I hoped to interview women who had the financial means to choose whichever birth options they wanted, because this would show their true values about their deliveries instead of how they wished they could have delivered. Talking

to women who had all of the options available to them meant that they could choose and speak freely about their decisions without the burden of finances.

I sent emails to and spoke on the phone with many yoga studios that offered pre and post-natal yoga, and organizations that offered classes for soon-to-be or new mothers about delivery, breastfeeding, and parenting. With little success, I finally received an enthusiastic response from one of the leaders of a well-known Boston organization, offering to send my request for interview letter along to the women who attended her classes. The letter I sent to women included information about what the research was about, why I was doing it, and asking them to contact me if they would like to participate. I got most of my interviews from this connection, and from there I was able to tap into new mothers groups in the area, specifically in Jamaica Plain, Boston. The second part of my interviewing was done in a birth circle, a get together for women to tell their birth stories, in a far Western suburb of Boston.

Location

Many of the women I initially interviewed were from Jamaica Plain, and were helpful in connecting me with other mothers in the area. Jamaica Plain is a culturally diverse area filled with young people and young families. It is a very politically liberal area, and I found that trend to be consistent among my interviewees in their thoughts about birth. I was initially skeptical about interviewing so many women (six) from one specific geographic location, but as I interviewed women from other surrounding Boston towns (four from Newton and four from Milton, Belmont,

Concord, and Boston respectively) I realized that this general ideology was present no matter where the woman was from.

The birth circle I attended was held at a facility that offers many resources for expecting and new mothers such as prenatal and parenting classes, breastfeeding consultations, and massage therapy. I found that this group of women was especially dedicated to sharing positive aspects of non-traditional births, and this provided me with an interesting contrast with women who had given birth in hospitals. Many of the women there had had positive non-traditional birth experiences, while others attended the circle to hear about these experiences and decide if they should try non-traditional methods, especially home birth, for their next or upcoming deliveries.

Interviewing

I conducted fourteen interviews with women in their homes over the summer. The interviews were semi-structured and consisted of thirty-two set questions (See Appendix B), as well as follow up questions as necessary. Only one of the women I interviewed was pregnant at the time of the interview so I followed up with her via phone about her birth outcomes and her postnatal reflections. The average time for an interview was thirty minutes, and none ran less than twenty-five minutes or over sixty-five minutes. I divided the questions up into categories that included location, resources, values, expectations, non-traditional options, and outcomes. I usually did not need to ask all of the questions, as the interviewees answered them in the process of answering other questions. In addition to

recording the interviews, I also took some brief notes about comments that stood out to me or follow-up questions I would ask later.

After doing a couple of interviews, I added two questions. The first was “Did you feel like you had control in the process?” and the second was “If you were to tell someone what the ideal birth experience would be, what would you say?” The first additional question I felt was being touched upon in the interviews but not explicitly addressed. I added the second for the same reason, and asked it last to wrap up the interview and get a final idea about what the women considered to be the best birth practices after detailing their own.

The birth circle was a five-hour event where women discussed their birth stories in a very casual and open environment. Sixteen women were there, including three women who were certified as midwives, doulas, breastfeeding consultants, or a combination of the three. All of the women introduced themselves and gave a quick background about their birth experiences, and then seven women told their full birth stories. I recorded and took notes the whole time and asked some clarifying questions at the end to make sure I was clear about all of the information the women provided.

Analyzing Data

After uploading the recorded interviews onto my computer, I began to transcribe them using software called InqScribe. I transcribed all fourteen interviews and the birth circle recordings word for word into InqScribe, then transferred the transcriptions into separate Microsoft Word documents. While

transcribing, I took notes in another Word document about answers or statements that stood out to me in each interview, and general ideas I had while listening back on the interviews. When writing specific sections of the thesis I used the search function in Microsoft Word to look for specific quotations were pertinent to the topic I was discussing.

Ethics

Before starting my research, I sent a proposal to the Institutional Review Board at my home institution, Trinity College (See Appendix C). The proposal included information about the nature of my research, who I would be interviewing, and how I would ensure their confidentiality. I did not begin to research until I had IRB approval in May. I also took an online certification necessary for IRB approval called “Protecting Human Research Participants” through the National Health Institute’s Office of Extramural Research. I provided each interviewee as well as all of the women at the birth circle with an informed consent form (See Appendix A), explaining the purpose of the study, their role in the study, the benefits and risks of their participation, and the fact that I would maintain confidentiality throughout my research and report.

Chapter 1: Women's Prenatal Choices and Values

All of the women I interviewed had the financial ability to choose both their delivery locations and care providers, such as midwives or doulas for their births. Prenatal values about the delivery experience dictated where women chose to give birth: at home or in a hospital. The choice of where to deliver is the first step that set the rest of the experience up, and determined and informed subsequent pregnancy, delivery, and birth experiences. This initial choice (an extension of a woman's values) predicts expectations about the method of delivery, the use of any interventions, and the composition and role of the delivery team.

The literature illustrates that prenatal values are one of the most important criteria that guide a woman to certain birth choices, experiences, and expectations. For example, women with liberal ideologies will be more inclined to choose non-traditional options (Declercq, 2012). Examining these overarching values is important in understanding women's choices and therefore how they intend and hope to have the best birth experiences. The values the women I interviewed had and the prenatal choices they made shape their expectations, deliveries, outcomes, and how they chose to tell their stories. This chapter will discuss four situations: planned hospital births, midwives attending hospital births, high-risk hospital births, and planned home births. Each section will explain why the women in these categories chose (or did not choose) certain locations and methods for their deliveries as well as how these choices dictated subsequent delivery decisions and outcomes.

Planned Hospital Births

Women who chose the hospital were comfortable with the medical model and therefore more likely to accept the hospital setting and the interventions that accompany it. As discussed in the literature review, the medical model in terms of birth focuses on delivery as a process that should be fostered by medical monitoring and intervention. Many of the women I interviewed expressed how lucky they felt to live in the Boston area, where a multitude of delivery options were available to them, allowing them to customize their birth experiences as they chose. Women who opted for delivery in a hospital valued safety above all, first for their babies and secondly for themselves. They felt secure knowing that if something went wrong or they wanted a medical intervention such as an epidural, these options were available to them in the hospital and would be provided to them upon request. One woman said that she preferred a hospital in case she “needed an intervention,” indicating that women who chose hospitals felt that interventions could be necessary (which is in contrast to the midwife model and their views on women’s natural birthing abilities). However, sometimes women received interventions that they did not want, an issue I will explore in the next chapter on Expectations.

Women also valued hospitals with neonatal intensive care units (NICUs) in case their newborn needed extra support. As noted in the “Choices Applied to Delivery Section” of the literature review, Declerq et al. (2007) found that women wanted the security of the hospital both for themselves and for their newborns in the event that their babies needed extra care. The presence of a NICU in the hospital setting provided reassurance that any need could be met and guaranteed success in

the form of “healthy baby and healthy mother,” a phrase used by hospital-based interviewees. This “guaranteed” success is rooted in the idea that because hospitals treat deliveries as medical procedures, the outcome will always be positive as medicine prevails (Davis-Floyd, 2004).

While selecting which hospital to use for their delivery, many women reported that they followed their primary care doctor’s recommendations or did their own Internet research. While some women looked for hospitals with low rates of intervention, others looked for the best doctors available, especially if they had high-risk deliveries. One woman who delivered twins via C-section commented, “My whole philosophy is to get the best doctor you can for whatever you have, listen to them, and if it makes sense, just do what they say.” Trusting medical care providers such as obstetricians and nurses because of their medical knowledge was a strong factor in women choosing to deliver in the hospital.

In addition, a few women cited convenience of hospital locations as reasons why they chose hospitals to begin with. This is connected to the aspect of safety in that women felt more comfortable knowing that they could get to the hospital in five or ten minutes as opposed to thirty, and feeling like they could more easily visit their obstetricians for regular appointments as well as for any concerns they had during their pregnancies.

Women who chose hospitals expressed a prenatal interest in medical interventions such as Pitocin and epidurals. One woman stated that she was “not interested in feeling pain the first time around” and wanted an epidural early in her delivery. While pain was something the women discussed, it came up only a few

times in discussions on prenatal planning. This could be because the interviews were conducted after they delivered (and after they had been through the pain) and labor pain seemed more tolerable postnatally. Women discussed interventions only in terms of labor and how the baby was going to come out (with help from Pitocin or other interventions). While women did think about pain prenatally, many wanted to try for natural births, knowing if they desperately needed relief, they could find it in the hospital in the form of an epidural. One new mom mentioned that although giving birth was “horribly painful” she wanted to wait out the pain to see if she could do it naturally (which she did), with the epidural as a last resort. Having these interventions as options made women feel more relaxed about enduring labor pains, and more secure knowing that if they reached their tolerance levels there would be options for reducing the pain.

Women who were having multiple births at hospitals reported they knew there was a good chance that they would need interventions if they had used them before, so planned on receiving them. For example, one woman planned on having her third child in the hospital aided by Pitocin. “I always get stuck at, like, four centimeters [during dilating] so I knew I was gonna need Pitocin to keep me in labor and speed it along.” Having previous birth experiences prepared women more for what to expect in terms of subsequent births, explaining their prenatal preferences for medical interventions they had found useful.

Many of the women who articulated an early desire for medical interventions also discussed choosing hospitals because they could give control to the doctors and nurses, knowing that they were in good hands. These women were the only ones I

interviewed who prenatally valued relinquishing control of their deliveries and decisions made during labor to doctors and nurses. Upon expressing this, one woman who works as a nurse worried that she had not given enough thought to her choices, and quickly tried to justify her desire to let her doctors and nurses handle all aspects of her birth. She said, “I don’t know, I just think what do I know about birth? I knew I wanted a hospital just in case something happened, so it’s like, just let someone who knows what they’re doing handle everything, and I can tell them if I don’t want something.” This shows that women readily put doctors and nurses in charge of their deliveries because they believe their care providers will be able to provide them with whatever they need to deliver successfully, which in hospitals often includes type of medical intervention.

This view is consistent with the medical model, but the specific knowledge women have dictates their views on the right way to deliver or which care providers they want to use. Since knowledge about birth for women who deliver in hospitals usually comes from professionals in the field (traditionally doctors or nurses), women who are guided by these professionals are more inclined to choose to deliver in hospitals. Women trust the advice and guidance they get from these people, and this trust carries over into the delivery room.

Women reported that they had strong relationships with their obstetricians, explaining that these relationships made them feel completely supported and helped them trust that they would be a part of the decision-making process—allowing them to make their own decisions throughout labor. Relationships with obstetricians are rarely described like this in the literature and instead, the

literature supporting medical interventions and hospital births refer to the medical capabilities of doctors to provide services to women. Some women I spoke with described very similar strong and trusting relationships with their OBs, referring to them by their first names and describing how attentive and supportive they were. These values echo the description of the close personal relationships women have with midwives and doulas. The relationship between a woman and her midwife needs to be a trusting one, viewing the midwife as the medical professional who will help facilitate all aspects of the birth. Women expect that they will be in the best hands with midwives who will be able to provide them best birth experience (Cronk, 2000).

All relationships with care providers are based on the assumption that the care provider will ensure that the woman is safe at all times, feels comfortable, is aware of what is happening to her body, and can ask questions about the process. One comment made about doctors and nurses assisting births was that being in the hospital gave them power because “they’re in their domain, this is what they’re good at, these are the tools they use, and they have the full support of the hospital and their colleagues.” This assured women that since their care providers were comfortable in the hospital environment, this comfort would translate into better care for the women.

The Best of Both Worlds

Even women who valued a “less is more” ideology preferred to give birth in a hospital for safety reasons. Some of these women researched the intervention rates

at different hospitals to decrease the chance of being pressured to have an intervention, but also wanted interventions to be available if they were “medically necessary.” While this echoes the benefits of the medical model and guarantees of success, women also decided to avoid the medical model while in the hospital setting by introducing other non-traditional delivery choices.

This option has been an increasing one in past years, with hospitals including midwifery practices associated with the hospital, allowing women to choose both options. The demand for this two-in-one option was present both in the numbers of increased births delivered with certified nurse-midwives as well as the number of women I interviewed who opted to have a midwife deliver their babies in hospitals. With women viewed as the consumer in terms of picking the place and people that will deliver their babies, hospitals responded to this demand in order to keep women delivering in hospitals with the addition of trending non-traditional options.

While these women could afford any option, some commented that their choices were swayed by what their insurance covered, or if there were midwives practices associated with their chosen hospitals. For example, one new mother commented, “my practice delivered at either [Hospital A] or [Hospital B]. You can also choose to have an OB or midwives, and I went with midwives both times.” This exemplifies that the options the women were presented with within their choice of home or hospital as well as in terms of care providers impacted their final decisions on where and with whom to deliver.

Women used midwives and doulas in hospitals to get the “best of both worlds.” Women who chose to have non-traditional care providers in hospitals

valued the relationship they had with their midwives and doulas, and felt more comfortable knowing who would be delivering their babies. One woman said, “Midwives are way more attentive than doctors, and you spend so much time building a relationship with them. You know they’re going to deliver your baby instead of a random doctor who happens to be working when you deliver.”

Midwives and doulas tend to be associated with home births, and the literature on midwives in hospitals is almost non-existent, while this research shows that many women opt to have the best of both worlds by including midwives and doulas as well as the option for medicine in their deliveries.

The decision to have a midwife or doula present at a hospital birth indicates that care providers mattered a lot to women who took extra measures to bring someone they were comfortable with into the hospital setting. By doing this, women were able to support their values of a natural, comfortable birth with the option of medical intervention if necessary. By employing the “midwife model” into a hospital delivery, women reported feeling that their births were in their own hands as well as in the hands of their midwives. The strong relationship between a woman and her midwife was crucial because it made women comfortable knowing that they could rely on the midwives to give them the delivery they hoped for.

In addition, women who wanted the medical comfort of a hospital worried that they would be pressured to get interventions they did not want. Having the midwives there ensured that a medical professional was there just for them to support them in every decision they made, even when they could not make decisions themselves (for example, while enduring extreme labor pain). One woman

commented, “to be able to be in a hospital and be left alone to let nature take its course is a really nice thing, and I think my midwife completely made that possible.” Having the midwives there allowed women to experience birth how they wanted to, despite being in a setting that often promotes medical intervention.

While women valued having the midwives there so they could oppose the medical model present in the hospital setting, others used their midwives as translators to better understand what was happening to their bodies or procedures being done to them. When midwives were present in the hospital, women reported that the nurses backed off a little bit, possibly because they knew that the woman wanted a more natural birth that the midwife would try secure for her. This included refusing interventions and not even being offered interventions at all. One woman who used a midwife explained,

“I knew I wanted to try for a natural birth, and my midwife was totally on board with that. I wasn’t even offered an epidural, no one said the word epidural, and I think that’s because my midwife was there. Her being there made sure that I wouldn’t be offered or pushed to have anything I didn’t want.”

The midwife acted as a barrier between the medical model and her client, ensuring to the best of her ability that the woman was able to have the birth of her choosing.

One woman commented that her midwife “told the nurses why I didn’t want to be checked [for how many centimeters she was dilated]. I didn’t want to explain every time why I didn’t want certain interventions and my midwife made that so much easier.” Having a trusted ally there to convey this information to hospital staff was something the women did not have to worry about doing themselves, and allowed them to concentrate on labor. Midwives were also able to effectively convey

information that the woman may not have received otherwise. When a baby was whisked away to the NICU right when she was born, the mother's midwife was able to communicate information between the doctors and nurses as well as the NICU to the mother on what was happening to her newborn.

None of the women I interviewed who delivered in a hospital wanted a C-section. The larger discussion on C-sections (for example, Marsden Wagner's position that C-sections are more "doctor friendly") reveals that women who choose to have hospital births have more interventions, including C-sections. Being in a hospital to begin with puts women at a much higher chance of having a C-section than does giving birth at home. While some women who did not want C-sections ended up having them, others knew they had to have C-sections because their pregnancies were considered high-risk. The idea of being high-risk immediately meant that women should and would deliver in the hospital so any complication could be dealt with safely and effectively. Even with women who would not have preferred to deliver in the hospital, the "high-risk" label was a scary one, and women felt that a hospital delivery was the safest and therefore best option.

When Women Have No Choice

Four of the women I interviewed knew almost certainly that they would need to deliver via C-section. All of these women were "older" (35 and over), one had diabetes, two were delivering twins, and the last had a repeat C-section following unforeseen complications with her first child. When I asked these women where they had been planning to give birth when they were pregnant, without hesitation

they said the hospital. Being labeled as “high-risk” had a big impact on them, and because of this, none of them wanted anything other than a hospital birth supported by doctors and nurses. The label of high-risk does not force women to deliver in the hospital, as taking a risk is still a choice, but all of the high-risk women I spoke with took that label to mean that their deliveries were in danger if they did not deliver in the hospital. Women could be labeled as high-risk and choose to deliver at home, but it would not be medically advised. Following the medical model, the high-risk label takes the choice of delivery location away, and women feel they need to choose planned hospital births where interventions can be obtained if (and probably when) necessary.

Despite knowing that they were going to have C-sections, these women still had decisions to make in terms of which obstetrician they chose, at which hospital they would deliver, and the postpartum services they would utilize. For example, one woman having a C-section said she wanted to experience skin-to-skin contact with her son as soon as he was born in the operating room. Another said that she chose the hospital with the best anesthesiology department. While the literature covers the “C-section epidemic,” little attention is paid to other choices women can make even when they do need C-sections. Allowing women to make these choices and decisions allows them to feel some form of control in a non-ideal situation that often takes much of that control away. Since women cannot see, feel, or really experience C-sections other than what they are told by anesthesiologists, doctors or nurses while it is happening, they assert their presence in other ways that gives them more control and connection to the delivery experience.

Planned Home Births

The women I spoke with who chose home births were able to afford non-traditional delivery options. Home births cost upwards of \$5,000, and all of the women said that this was something they would go into debt for if they could not afford it. Among the women I interviewed, women who delivered at home had the strongest prenatal feelings and values about where they wanted to deliver, and this shows in their willingness to go into debt for their ideal of the home birth experience. These strong views also emerged in their discussion of why they wanted to give birth at home, and there were many common themes among their stories.

In terms of resources, most of the women turned away from the medical model and toward other women who had used non-traditional options to deliver. Home birth women attended prenatal classes like natural birth, prenatal parenting, or even hypnobirthing (the use of hypnotic techniques during labor to reduce fear and pain) that promoted non-traditional delivery options. The sources of information for women delivering at home came from more communal resources than for women delivering in hospitals. The birth circle I attended, in which women met to discuss past and upcoming deliveries, confirmed that women who delivered at home cherished the connection they had with other women, and that they viewed themselves as a small but strong subgroup of women who held similar values and beliefs about what birth should be. By sharing stories and information, the women collected and strengthened their own knowledge about nontraditional birth options. Some of the women were there to learn about nontraditional birth options and if those options would be best for their upcoming deliveries. Women who had home

births shared what they valued most about the experience, and how their experiences contrasted to common hospital experiences.

The word that best sums up what women value about the home birth experience is comfort. This comfort manifested into the freedom to decide how the birth was going to go and knowing that prenatal choices would be adhered to during the delivery. This comfort also included being in control and staying away from medical interventions. The nonmedical model presented by these women included their thinking that birth was something they and their bodies could do on their own, without medical intervention or a hospital setting to guide or help them. One woman who had her first child in the hospital and her second at home commented that her “experience in the hospital was so uncomfortable, the pain was incredible because of interventions. And the other one [her home birth] felt like natural pain, it felt normal. Like it was supposed to be that way.” This woman is representative of the differences in the medical versus nonmedical model, because she had both experiences, one negative and one positive. The choice to deliver at home after having an unpleasant hospital experience is indicative of the sense of control she felt in her home birth, which felt more natural and normal. The women I spoke with who delivered at home felt that because they were making all of the decisions (with assistance from their midwives), that they would have successful births. While the choice to deliver in the hospital could have unintended consequences (such as unwanted interventions), home deliveries are tailored by the women and for the women—leaving every choice and decision up to the person who will be experiencing them.

These women valued being able to have a natural birth in all aspects. They did not want the option of medical interventions, except in the case of emergency transfers to the hospital, for which they wanted midwives to be prepared. The physical space of the home was something that fostered women's values and experiences of comfort. For example, they wanted to be able to labor at home, to eat and drink whatever and whenever they wanted, to have family close by, and to spend lots of time skin-to-skin with their newborns. They noted that being in a hospital meant that they were on someone else's turf and therefore had to follow someone else's rules. One woman explained that "I didn't wanna be in a bright, white room surrounded by people I don't know who are offering me interventions I didn't ask for and don't want." These women equated giving up control with going to the hospital, and maintaining control in their choices to stay at home.

The aspect of control and comfort at home echoes literature on why women choose to deliver at home, as well as the connection women have with their midwives. A study conducted by Boucher et. al (discussed in the Choices Applied to Delivery section of the Literature Review) found that common reasons for women who wanted to deliver at home included avoidance of unnecessary medical intervention common in hospitals, a previous negative hospital experience, more control in a comfortable environment, and trust in the natural birth process (Boucher et al., 2009). They also determined that midwives were crucial in facilitating these wishes, and were able to provide women with the ability to make their own, supported choices.

The expectations for midwives' and doulas' roles by women who delivered at home were very similar to the expectations of women who gave birth in the hospital. Women wanted them to be supportive, attentive, and readily available. The difference between midwives at hospitals and midwives at home was that at home they did not have to advocate for women in order to maintain their choices and decisions; the women were guaranteed that their choices and decisions would be respected and supported.

Women who delivered at home reported intimate relationships with their midwives and valued this close bond. They were able to text message their midwives, have the convenience of the midwives come to their homes, and get postpartum advice. Whereas doctors were only there for some prenatal appointments and the delivery (though not always), midwives and doulas were available throughout the process, and were available for postpartum services at home such as breastfeeding help, infant checks, and checking up on the mother's healing. Women who had midwives in hospitals did not report the same level of intimacy that midwives shared with women at home, possibly because midwives provided more services and more time to home birth women. Women who delivered at home commented on the fact that midwives were a "one stop shop" and liked that everything they needed was in one person, and that they did not have to find lactation consultants or parenting classes in addition to someone to deliver their baby.

All women valued their own safety and the safety of their babies during their deliveries, but measured safety in different ways. While women who chose or were

forced to choose hospitals had the assurance that they would have successful births, they also had the opportunity to choose medical interventions. Women at home valued the comfort and control of their deliveries, and looked for care providers who could help them safely achieve these goals. While the literature is consistent with most of the choices and values associated with either hospital or home locations, it fails to successfully account for deliveries that fall somewhere in the middle, such as when women have midwives or doulas in the hospital. While birthing centers bridge the gap between the nonmedical and medical models, having non-traditional choices in a traditional setting means that the medical model in terms of deliveries could be shifting, an idea that I will explore in the next section on Expectations.

Chapter 2: Risks, Concerns, and Expectations

While prenatal choices and values dictated the outcomes of most deliveries, women's risks, concerns, and expectations also played roles in determining the success of the birth. There are risks associated with delivering at home and at the hospital, but women's perceptions of these risks is what shaped the concerns and expectations they and how they prepared to deliver. The literature is unclear about the definitive risks in both locations, with some studies asserting that home birth is risky, while others arguing that hospital births are. Examining what women saw as the risks of delivering in particular locations is helpful in ascertaining their concerns about delivery and perceived risks of their chosen location (largely absent from the literature) as opposed to the current statistical data present in the literature on risk. Recommendations from delivery healthcare providers have changed over time, especially with regards to which locations or practices are or are not safe. Due to this uncertainty, women had to decide for themselves which risks or uncertainties they were willing to accept. In addition, the definition of risk varied woman to woman, and this also determined the prenatal choices women made in how they prepared for delivery.

As discussed in the literature review, risk is socially constructed concept, and can be used to define deviations from the norm (Lupton 1999). Risks reported by all women I interviewed included some aspect of medicalization. While the medical model accepts medicalization as the norm, not all women fully accept the medical model. Women who delivered in hospitals were worried about receiving either some or many interventions they did not want, while women who delivered at home

were worried about being transferred to the hospital. However, women who delivered at the hospital had less of an idea of what to expect than did women who delivered at home, possibly because of the chance of getting intervention in the hospital. This was especially the case for women who planned hospital deliveries without interventions because receiving an intervention in the hospital was always a possibility. Women at home said that they anticipated successful births in all aspects because they felt they had control of how they were going to deliver with the help of their midwives and/or doulas.

This chapter will analyze the perceived risks, concerns, and expectations women had before they delivered at home or in a hospital. In turn, these three aspects of prenatal preparation relied on obtaining information, preparing physically, and trusting the delivery team. This chapter will also discuss how women obtain information about delivery risks, and what they do to address their risks and concerns. While responses varied between the two locations, it is clear that women gave thought to these determinants and attempted to tailor their births as best they could to be able to birth the way they wanted.

Hospital Deliveries

Women who chose to deliver in the hospital were the ones who talked most about the risks of delivery. Intervention seekers as well as intervention avoiders (unless absolutely necessary) both voiced concern that the interventions could exceed what they wanted. Hospital birth women voiced concerns about pain management, and wanted the option to use epidurals if the pain became too much to

handle naturally. However, they worried about the increased chance of having the “chain effect” or “snowball effect” upon receiving initial interventions. One woman described it like this, “I’ve heard stories of women who go into the hospital wanting natural births and come out with C-sections. It’s like, if you get Pitocin, you need an epidural and on and on... the snowball effect. You have to be ready for that when you deliver in the hospital.”

This illustrates what many women were worried about when making the choice to deliver in the hospital: the seemingly inevitable chain effect that many women encounter during hospital deliveries. As discussed in the literature review, in its basic form, this chain begins with Pitocin to start or progress labor, and moves on to an epidural to manage the more intense contraction pain brought on by the Pitocin. The more extreme outcomes of these early interventions end with removal methods like a vacuum or forceps, or, the ultimate intervention, a C-section. One woman relayed the story of her sister’s birth,

“she ended up in a situation where her labor stalled so she had Pitocin and then she needed an epidural to handle the Pitocin contractions. Then ultimately, when she tried to push her baby was stuck and she had to have a C-section. So doing everything I could to have a vaginal delivery was really important to me.”

Even women who wanted interventions did not want C-sections. None of the women I spoke with would choose to have a C-section in an ideal birthing situation.

This is an interesting finding because it contrasts with the literature on the medical model and the idea that delivering in a hospital gives women a guaranteed successful birth. The risk associated with delivering in the hospital stems from the fear that women who do not want interventions will end up receiving them.

Although they like to have interventions available for emergencies, they also know that delivering in the hospital increases their probability of receiving an intervention they did not plan for. To many women, the hospital is supposed to be a risk-free place, but defining risk as the chance of receiving an unwanted intervention makes the hospital fraught with uncertainty.

When women did receive interventions, they were worried about the physical repercussions, such as recovery time, that inevitably accompany interventions. For example, women reported that if they chose to have epidurals or Pitocin, they would have to stay in bed so the interventions could be monitored. Heart rate monitors were also cited as an annoyance that women did not want to be constricted by. Many women wanted the freedom to move around the room during labor, be able to use the bathroom by themselves, and generally not feel confined to stay in bed because of interventions. This physical freedom was not explicitly mentioned in the form of prenatal concerns, but ended up being significant when women spoke about their deliveries and how interventions hindered them from doing what they wanted, such as moving while laboring, pushing in different positions, and eating.

Also mentioned with regards to being physically constrained was autonomy and control of the delivery. While women understood that being physically uncomfortable was part of receiving interventions, many reached points where they felt trapped (literally) and powerless. One of the high-risk women who initially tried to deliver her twins vaginally said “I had spent so much time in this room and I was hooked up and on all of these IVs... I did not leave my room for 4 days, I wasn’t

eating and I was like I'm ready to start eating and going to the bathroom myself and get these monitors off." These were often the points where women felt that they were no longer able to control what was going to happen with their deliveries, and also the times that they most felt they wanted control and autonomy to make delivery decisions.

One woman who delivered in a hospital did not want to have an episiotomy, where the perineum is cut (as opposed to the woman tearing naturally) to allow the baby to come through more easily. About the procedure she said, "I wasn't expecting that [getting the episiotomy] and that was the one thing I didn't wanna have but the doctor said she needed the baby out. I was kind of crushed I had to have that done because I know it's harder with the healing and everything postpartum." This highlights the fact that the one intervention she did not want, she got, and that because the doctor "needed" to do it, it was done. This exemplifies the medical model at work as well as the complete trust women have in doctors, who, as women described, often act out of sync with the woman's prenatal wishes. Women expect doctors and nurses to do what is best for them and their babies, whether or not this ultimately leads to an unwanted intervention.

Women who chose to use midwives or doulas in the hospital did so partly because they wanted someone who would support them in their opposition to interventions. They worried that if they did not have the midwives and doulas there, they would be put under pressure to get interventions and be unable to effectively refuse them. The midwives provided a buffer from interventions, and decreased the probability that women would receive them. As mentioned in the previous section,

women felt comfortable with midwives in the hospital because of the strong relationships they had with them. These relationships ensured that the mother would not receive anything she did not want unless absolutely necessary. Women who did not have midwives or doulas may have been pressured into receiving unwanted interventions, without having the support of an advocate who could help them find other ways to deliver effectively.

In addition, women who delivered in the hospital with midwives or doulas reported that they knew what to expect. Instead of being prepped by the nurses and doctors, whom they often met at the time of the delivery, women who had midwives and doulas had been preparing with these exact care providers for months. They knew both what they wanted, which the midwives could help them achieve, and also what to expect in terms of birth because of the prenatal relationship and discussions with the midwives and doulas. This was a key distinction between hospital birth women with versus without non-traditional care providers. While women who did not use midwives or doulas said that they had little to no idea what to expect, the women who did use these extra services felt more comfortable and prepared for their deliveries. This kind of support was not mentioned as much by women who did not choose to use midwives or doulas. Instead of addressing concerns, they went not knowing what to expect and hoped for the best—relying on themselves to advocate for their wishes and hoping doctors would respect them.

Women who most clearly knew what to expect were those who knew that they needed to deliver via C-section. As mentioned in the previous chapter, these women were labeled “high-risk”. This term is often defined as a condition and is

therefore stigmatized, because women assume that it leaves them with no choices or decisions to make on their own. Although these women were aware that they would probably if not definitely need C-sections, they still went into their deliveries with few expectations. Two wanted to try for vaginal deliveries, despite warnings from their doctors that this could be difficult and probably would not be how they delivered. However, women expected that their doctors would be willing to try to deliver the baby or babies vaginally, and only resort to a C-section if a vaginal delivery was deemed impossible after a good attempt. They were nervous about the C-sections themselves, acknowledging that although it is a safe procedure, it is still considered major abdominal surgery and could therefore come with risks.

Expecting a C-section left them with few other choices and decisions to make. Women wanted their doctors and nurses to inform them at every step of the way, explaining the role of the anesthesiologist, how the C-section was performed, and the recovery process. This information made them feel more in control of the process and treated more as a subject instead of an object. About her first emergency C-section, one woman said “I wished that there had been just a moment for somebody to say its OK to just take a deep breath before we do this. Just someone there to say everything is alright.” She talked about the fact that since it was an emergency, there was no time to go into detail about the procedure, and, not expecting to have a C-section in the first place, she did not know in detail what a C-section entailed.

The main concerns that C-section women reported having were spending time with their newborns right after they were delivered, and being able to care for

them effectively while recovering from surgery. Since these women were largely unable to make choices about their deliveries, they expected doctors and nurses to give them the opportunity to make other kinds of decisions, such as immediate skin-to-skin contact with their newborns.

Home Deliveries

While it may seem that women who deliver at home cannot know what to expect, they reported that it was the opposite, and that they knew almost exactly how their deliveries would go. As I explained in the previous chapter, being at home meant that the women had control and freedom to customize their births with the help of midwives and doulas. This ensured their values and choices would most likely be carried out in the ways they wanted and expected them to. Being at home meant knowing what to expect, and they had high expectations for positive deliveries given the heavy preparation and attention to detail that went into planning home births.

As opposed to women who delivered in the hospital with minimal expectations and planning, women at home were on their own turf and therefore felt they could largely dictate how they would experience birth. Women also reported that they did not feel like they had to advocate for themselves because their midwives and doulas knew what they were looking for and were there to provide it. The function of the midwives and doulas was described as the same for any woman who used them; they were sources of information, comfort, protection, and advocacy if necessary.

One woman who attended the birth circle mentioned that her two births at the hospital before her home birth did not include any conversations, and that her care providers made all of the decisions for her. She said the preparation for her home birth was filled with conversations about different options and that these conversations made her feel better prepared and more comfortable. Specifically, she said that at the hospital the tears from her vaginal delivery were stitched immediately after she gave birth, something that was done without her consent, but something she could not stop. At her home birth, she had the option to heal without stitches. She said, "Overall at home, the minor details are very different. At the hospital, the aftercare details are dictated by the hospital but at home, they're dictated by you. I wasn't as concerned about having something done to me that I didn't want done to me [at home]." Many women who delivered at home discussed the greatly reduced chance of having unwanted interventions, even minor ones, and this comforted them greatly and made them feel better prepared to effectively labor and deliver without having to worry.

Women who delivered at home said that the information the midwives provided was crucial, especially with the ultimate risk of home birth being a transfer to the hospital. While this thought was kept in the backs of their minds, women and their midwives had conversations about what happens if the woman needed or wanted to be transferred to the hospital. This soothed many women who worried that transfers would happen too late, or that they would immediately be subject to interventions when they got there. Going to the hospital was the one thing women who gave birth at home did not want, as was apparent in their choice to deliver at

home. They worried about being in an environment dictated by the medical model, and leaving the hospital traumatized by a birth they did not want. In addition, women acknowledged being worried that doctors who cared for home-birth transfer patients would feel that they were being forced to take a patient in an emergency situation that could have been prevented had the woman delivered at the hospital as she's "supposed" to (as discussed in the literature review). They feared that in the case of a transfer, the hospital environment and staff could be unfriendly to a home birth woman and her midwife. Ultimately, women understood that transfers were sometimes necessary and would mean straying from their birth plans, although this was not something they expected to happen.

Preparing for a home birth with midwives required a description of what the midwives were able to do in case of an emergency. While women who delivered at home were not expecting to have anything out of the ordinary happen (trusting that their bodies would be able to birth naturally and safely), they felt comfort in knowing that the midwives were prepared with many of the tools and technologies used to deal with unexpected delivery situations. The midwives at the birth circle explained that they are able to deal with almost any problem that doctors at the hospital are able to handle, including pain relief, tearing, hemorrhaging, and care for the baby after it is born.

One midwife at the birth circle answered a concern about transfers to the hospital from an expecting mom and said, "most births are very straightforward. The most common concern is mom bleeds too much afterwards and we manage the hemorrhage at home. It's very unusual where everything is going fine and then

everybody crashes.” In addition, in cases of hemorrhages she mentioned that an ambulance is not equipped to stop the bleeding but it can transport the woman to the hospital. In almost all cases, she said the bleeding can be managed at home, so staying at home is a safe option. She commented, “911 is not super useful because they’re not as equipped as we are. I only manage your hemorrhage if you need it, at the hospital they do prophylactic Pitocin [to manage bleeding] but we only use that in a home birth if it’s necessary.” The fact that the midwives have the same methods used in hospitals is comforting to women who are worried about complications and the availability of the necessary tools to deal with them.

The midwives at the birth circle explained that when women do get transferred to the hospital, they can be sure that their delivery team from home will accompany them and advocate for them. The relationship between mother and midwife protects the woman from having an unwanted experience. This relationship is especially important when it comes to discussion about transfer to the hospital from home (Cronk, 2000). If home birth deliveries have to transfer, women feel assured knowing that they will not have to advocate for themselves in an uncomfortable setting. As with all women who chose to have midwives in the hospital, this choice provided them with assurance that the pressure to get interventions would be off and they could just focus on labor. In addition, women who delivered at home mentioned that they felt comfortable knowing that prenatal choices they made would be followed through despite location, given the presence of midwives and/or doulas.

Addressing Concerns and Getting Information

Hospital birth women and home birth women addressed their concerns and risks with similar resources in general, such as prenatal classes or support groups, but used these resources to different extents and received different messages on how to prepare and what to expect about delivery. While many women used prenatal classes, women who delivered in the hospital without midwives or doulas typically just attended one-day classes offered by the hospital. The women who used this resource reported that these classes included touring the labor and delivery unit, addressing any questions or concerns women had about delivery, and teaching soon-to-be parents about caring for the newborn (such as breastfeeding and diaper-changing lessons). Women who used midwives and doulas in the hospital commented that they felt that these providers were constant sources of information, so they felt that additional preparation in the form of classes or extensive reading were unnecessary. While these prenatal classes were themselves more general, the women felt that the midwives and doulas could answer questions specific and personal to them and their births.

Home birth women were more inclined to take prenatal classes, and these classes often included non-traditional aspects of birthing. For example, instruction on how to birth naturally, techniques for dealing with pain, and new mothers groups were components of prenatal preparation that they mentioned. These women were more concerned with the prenatal preparation for birth, especially in preparing for natural births, and sought information and reading material that would help them best prepare. This reflects the desire of women who delivered at home to be

involved and active in their births, so this reading was deemed a necessary prenatal step in effectively preparing for home birth delivery.

However, some women who delivered at home did not rely on any prenatal classes for information and instead depended on information from their midwives and doulas about preparing for birth and managing pain naturally. Women who delivered at home were more likely to say that they read prenatal material intensively (such as books, articles, and studies done on delivery methods) than were women who delivered in the hospital. The difference in preparedness between the two groups of women was defined mostly by care providers—if women in either location had midwives or doulas, they did not feel as inclined to use other resources (although some home birth women did use them in order to work in tandem with their midwives) as opposed to women in the hospital who relied on and trusted doctors and nurses to be in charge and make the best decisions.

Another component of birth preparation is the support and information from other women about birth and how to prepare for it. While the support networks for both groups were largely informal, the networks for women who chose non-traditional birth options were described as far more extensive and supportive than for women who gave birth in the hospital. Women who delivered in the hospital reported hearing more horror stories of hospital births than positive stories. One woman decided to use a midwife in the hospital after hearing friends' experiences, "hearing about people that went to a doctor and what happened to them made me totally rethink my birth. After hearing so many stories about trauma at the hospital it's like, OK what can I do differently to make sure this doesn't happen to me?" This

was the sentiment among many women who chose non-traditional options to make sure they did not have these “horror story” experiences. Women who chose to deliver in the hospital did not mention having supportive networks of other women on whom they could rely as sources of information or comfort as they prepared for their deliveries.

On the other hand, home birth women found that they had a strong, supportive network of women who shared positive stories about their home births and use of non-traditional options. The existence of the birth circle alone attests to this, as women were able to share their stories and provide information to pregnant women who were navigating their prenatal delivery choices. The women who had delivered at home commented that before they gave birth they were able to tap into networks of women who had done the same and could help them decide which options were best for them. They reported that women who choose non-traditional options are a small but strong group who are willing to share intimate and personal details about their births and help others do the same. Women who attended the birth circle shared stories about relying heavily on other women to inform them about delivery options as well as help them through the delivery and postnatal processes. While this information came from friends or acquaintances, it also came from groups such as the birth circle, whose purpose is to share stories and inform women about all of their options—traditional or not.

Women at both delivery locations reported being nervous or worried about potential risks, and most of these can be classified as medical or interventionist risks. While women at the hospital worried about unwanted interventions, women

at home worried about being transferred to the hospital and the repercussions transfers could have for how they had planned their births. However, all women recognized that interventions were sometimes necessary and helpful in achieving a safe delivery.

In preparing for delivery, women relied on similar sources of information such as friends, midwives, doulas, reading material, and doctors. The biggest difference between the two locations in terms of support networks was that women who chose non-traditional options found that they could reach out to others to hear about positive experiences more often than could women who delivered in the hospital, who heard mostly about hospital delivery horror stories. Expectations for delivery differed, with hospital birth women conveying that they were not as sure what to expect, as opposed to home birth women who felt they did know what to expect. These expectations were sometimes accurate, and sometimes women had to change their outlook and definition of a successful birth in the process of delivery. The next section will examine what the outcomes of these women's births were, as well as how they talked about their experiences.

Chapter 3: Outcomes of Delivery and How Women Told Their Stories

All of the women I interviewed provided similar descriptions of their delivery outcomes—while the births were successful, something about the labor and delivery process was not as they had expected or planned. Nonetheless, while all women reported that some aspect of their delivery was unexpected, all were happy with their outcomes overall. Similarly to the literature on risk, the literature on outcomes is reported in terms of statistics, whether it's infant mortality, C-section rate, epidural use, or others. While the women I spoke with did talk about these components of delivery outcomes, their conversation and definitions of success centered mainly on their primary goal: delivering a healthy baby.

In addition, women reported that they would endure whatever would give them a baby in the end, even if the delivery process was not as they had planned or expected. When women summarized their experiences of labor and delivery, they portrayed successful and happy births (often in the form of a healthy baby) even if they had previously mentioned they had not always felt that way. I encountered this discussion and acceptance of traumatic birth experiences more often in the birth circle, where women were encouraged to share all aspects of their births, good and bad.

This chapter will discuss the outcomes of hospital and home deliveries, and whether women's expectations matched their outcomes. It will also explore how the availability of medical interventions (or lack thereof) influenced deliveries, and why they were used. Delivery outcomes also depended on the delivery team, especially

midwives in the hospital and at home, as discussed in the previous chapters. In each section I will highlight the delivery outcomes within each location, including what these women reported as the ideal birth and how they would advise other women about where and how to deliver. Lastly, this chapter will examine what it means to tell a good birth story, and how women chose to talk about and share the stories of their delivery experiences.

Hospital Delivery Outcomes

Most of the women who delivered in the hospital without a midwife and/or doula received interventions during their deliveries. While their hesitations about interventions were not as strong as other women's, because they had chosen to deliver in the hospital in the first place, they were happy that interventions could be provided to them. The most common interventions women received were Pitocin and epidurals. Many received them in succession, echoing the chain effect of more painful contractions mentioned in the previous chapter.

Since many of these women were giving birth for the first time, they reported labor was a longer process, and after many hours of stalled labor, Pitocin "made sense." The choice to intervene was made by women and their doctors together, usually with the doctor's initial suggestion. Natural birth for incredibly long labors was draining and women reported that labor became more effective—they were able to push better—after receiving these interventions. Many women said that they did not realize how painful it was going to be until they were experiencing it. One woman on her decision to use an epidural said,

“I was pretty exhausted and there was a lot of pain but I was only 5 centimeters [dilated]. So if I have 5 centimeters to go I gotta get the epidural. It was the best decision I could have made because it allowed me to relax in a way I wasn’t able to without it...being numb allowed me to push without fear. I think if I felt myself tearing it would have been really scary, but I couldn’t, it was like just go for it. It was great.”

Many women shared the sentiment that after trying unsuccessfully for natural births (oftentimes for many hours), interventions seemed to be the best option.

In addition, some hospital birth women reported going into the delivery process not wanting to feel any pain and expecting to receive epidurals. Given the number of women who chose to deliver in the hospital, the number of women who planned to have epidurals was small. One woman commented, “I wasn’t really interested in a natural birth, feeling it was not something I needed. I had good pain control [with an epidural] so I didn’t really feel much of it.” Another said, “I didn’t know what to expect so I didn’t wanna pigeonhole myself and say ‘You have to do this naturally’ but I just felt more comfortable with the idea of being in a hospital if I wanted the epidural.” Many of the hospital birth women reported that a natural childbirth was not important to them, and in general, the delivery process was simply a means to an end—a healthy baby was the main goal. Interestingly, women who strongly reported this sentiment had backgrounds in health, whether they were doctors, nurses, or had other roles in health care. These women acknowledged that having a health occupation made them more comfortable in the hospital setting, as well as more understanding or accepting of receiving interventions, which they often did.

Delivering in the hospital meant these women were not strongly opposed to interventions and readily made use of them when delivering naturally became too difficult or painful. One woman who received an episiotomy said,

“I never thought in my life someone would tell me they were gonna cut my nether regions and I was gonna say ‘Yes, do it!’ but you try so hard and you can feel it’s so close and then it just isn’t coming through and you’re like ‘Do whatever you need to do to get this baby out!’ It was unexpected that it had to happen and then it was unexpected at how little I cared that it happened.”

Again, this was a case in which the doctor deemed an unexpected intervention necessary. Because it helped progress the labor and ultimately led to the baby being born, the woman was more than willing to have it.

Hospital birth women without midwives or doulas were also the ones who reported being unsure of what to expect, and when these women realized what delivery was like, they were more inclined to let medicine intervene. Having few concrete expectations made them more open to changing their prenatal choices about delivery while they were delivering, including the use of interventions.

On the other hand, hospital birth women who used midwives and/or doulas reported that they were not as accepting of interventions. These women had stronger views about wanting natural births and were therefore more opposed to interventions, planning on relying on them only in emergency situations. Only a few of these women received interventions, and while discussing their reasons for this, many seemed defensive, and explained in detail why their initial strong will and opposition changed during delivery. One woman explained that she felt she let herself down, because

“It just wasn’t what I expected. Since I came in strong with all of these expectations for a natural delivery, no medicine, I set the bar too high. Then

when you need to get them, you feel disappointed but it's like, you're getting it because it's going to help you. I felt bitter for a while but now I've kind of come to terms with it because that's what got my baby out."

Going in with expectations for delivery left some women disappointed when they needed or wanted to receive interventions during delivery. Interestingly, this contrasts with findings discussed in Chapter Two, where I reported that many women I interviewed had strong opinions about how they wanted their births to go, especially with regards to no interventions. When women ended up receiving interventions, either for medical reasons or personal choice, they pushed away their prenatal values in order to deliver how they wanted or needed to in the moment.

Only one woman went into birth expecting a vaginal delivery and ended up with a C-section.

"I wouldn't say I was depressed, but my expectation was not going into the OR, lie on a table, have people around me chit chat about their Thanksgivings while I'm being cut open. Then there's this baby that they say is my baby but I didn't feel it come out of me...Disconnected, that's exactly how I felt. It took a long time for me not to feel really, really bitter."

When she first found out she was pregnant, this woman had considered doing a home birth (that her husband was not on board with), and having a C-section was most distant from what she considered the ideal birthing situation.

However, her sentiment about feeling bitter echoes what many women felt postpartum about receiving interventions. While unexpected and unwanted, after the delivery and into the "whirlwind" that one woman described as early motherhood, many women were able to get over the fact that their births did not go as planned or expected. However, the sentiment I gathered from the women I spoke with is that there is a stigma surrounding receiving interventions, especially

delivering via C-section. Given the amount of women who deliver via C-section, as discussed in the literature review, it is interesting that women stigmatize it. One woman who needed an emergency C-section reflected on this stigma, "I think that women who have C-sections are kind of shamed by the mommy patrol and I think it's really unfortunate because with Maya if I hadn't been able to have a C-section we could have both died." This is indicative of both the stigma surrounding interventions as well as the absolute importance and necessity of receiving them, as this story clearly exemplifies. Women reported that receiving interventions sometimes made them feel badly about themselves because it made them appear weaker or unable to handle a natural childbirth. They compared themselves to women who were able to deliver naturally, and who thought all birth should be natural, although natural birth is not always possible.

As mentioned in the previous chapters, women who knew they were delivering via C-section did not have the same choices as women who planned on vaginal deliveries, but those who planned C-sections still expected to make their own decisions related to the postpartum experience and to receive a high level of care. Even though they all expressed feeling some sense of disconnection, they had time to prepare emotionally for a C-section and knew that it was the safest way for them to deliver given their health concerns.

One woman who delivered her twins via C-section explained how she "rationalized" this delivery method, "My philosophy for things in general, if you know you're going in for a C-section, great, if it's unplanned, people are traumatized by it. But I don't feel traumatized... I have two super cute babies and that just

happens to be how they were delivered.” She mentioned that although being disconnected from birth is strange, the sense of comfort and relief she had from knowing she was delivering safely overcame her sense of discomfort and disconnect. In addition, this woman requested immediate skin-to-skin contact with her newborns, and this decision was one that the delivery team upheld. This was another factor that helped her accept her C-section, because her prenatal wishes were met even in a situation that took most choice away from her.

In terms of care providers, women reported that midwives and doulas were there to provide emotional and physical comfort as well as help them navigate the medical aspects of hospital deliveries. Doctors and nurses provided women with some comfort, but mostly attended to medical needs and explanations. Women who had expectations about the level of care from their care providers reported that their expectations were met. Women who used midwives and/or doulas commented that having non-traditional care providers in the hospital worked. They felt they got the best of both worlds because of these positive and supportive relationships.

Women described midwives and doulas as providing help with laboring, such as reminding them of breathing techniques as well as using massage to combat labor pain. In general, these providers were able to support the woman and her partner through labor in whichever ways they had planned or needed in the moment. Women reported that midwives and doulas had good relationships with doctors and nurses, who let midwives take the reins of the delivery and stepped in only when helpful or necessary.

Women who did not use midwives or doulas overall reported that they were happy with the level of care they received from doctors and nurses. However, some wished that they were a bit more comforting and that the doctor-patient relationship was friendlier and less centered on the medical aspects of delivery. For some, this relationship was a balance, “I was comfortable with my OB but he isn’t that warm and fuzzy which I maybe would have wanted a little bit more of for my first pregnancy but I felt comfortable medically in his hands.” Using a doctor as her care provider made this woman comfortable with the fact that he was going to deliver her baby, but less comfortable with her own relationship with him. She also said,

“He’s not the best communicator. If I asked a question he would answer it but he didn’t really volunteer a lot of “This is what to expect and this is how it’s gonna be’ so I had to figure it out a little bit on my own. But I took solace in the fact that million of people do this everyday and I’m gonna be just fine.”

This is another instance of a not-so-ideal situation being accepted: because her doctor was providing her with a successful delivery, she was fine with him not being as “fuzzy.”

In terms of the ideal birth situation, hospital birth women fell into a mix of categories between idealizing similar experiences to their own, different experiences from their own, or just having a healthy baby. Women who said that they would recommend deliveries dissimilar from their own had often received unwanted interventions in the hospital or were high-risk and therefore planned to deliver via C-section. These women were quick to share cautionary words, advocating for the most natural options but also defending the necessity of

emergency interventions and their overall acceptance, because they had relied on interventions for their own deliveries.

High-risk women, who as I mentioned above were very limited in choosing their ideal experiences, suggested that women make as many of their own decisions as possible. They often created their own advisee, or an idealized image of themselves to whom to give advice. One woman imagined herself as “25 [years old] and totally healthy. I would say have the most natural birth you can. If you’re young and healthy and have no complications, why not?” Another high-risk woman said she would use choose a vaginal delivery with an epidural because “They invented those drugs for a reason. Why try and tough it out when they’re completely safe?” Since these women had C-sections, their conceptualizations of the ideal birth experiences were important to them and revealed their feelings about receiving C-sections. While they expressed thankfulness that they were able to deliver safely, they wished they could have delivered another way and been provided with more choices.

Hospital birth women who used midwives and/or doulas most frequently said that they thought they had ideal birth experiences. Similar to home birth women, these women said that delivering naturally was one of the most amazing experiences, and they supported other women who sought natural births. One woman mentioned that she felt guilty when she heard about women who had negative birth experiences. Since she felt her birth was ideal, she would not hesitate to recommend that other women make the same delivery choices that she did.

Home Delivery Outcomes

All of the women who delivered at home reported being incredibly happy with the delivery and birth process and would not change much about it. Many gushed about how delivering at home was the most amazing experience of their lives and how eager they were to do it again. Knowing generally how the birth was going to go (naturally, with midwife support, using a birthing tub, etcetera), home birth women felt that they could relax and let nature take its course, and be comfortable not knowing what every minute of their delivery and birth would entail. There were no medical interventions, save one case of a minor hemorrhage in which Pitocin was used. Their descriptions of home births provided intimate and detailed accounts of each step and delivery method.

No account of home birth was the same, and women used many different methods to help them manage pain and push comfortably and effectively. Many women had long labors but felt in no rush: because they were staying at home, every process could take as long as necessary. As opposed to the fast paced hospital environment, starting with the decision to go to the hospital, and then the pressure to have a quick delivery, home births were long events, often lasting more than one day and using many different delivery methods.

In many cases, women went into labor and alerted their midwives via phone call or text message. Depending on the length of time between contractions, the midwives would either ask the woman to let her know when they got closer together, or would come over if the labor seemed to be progressing quickly. Once there, the midwives (women always had at least two) would set up and assess how

the woman was progressing. Oftentimes they would use fetal heart rate monitors to check how the baby was doing as well. Because the midwives were available to them and only them whenever they needed them to be, this gave women a sense of control. As discussed in the literature review, the intimate and direct connection women had with their midwives provided both a sense of control as well as constant support.

Home birth women commented on the fact that since they were at home, they could do whatever they wanted in their own time and space. As opposed to hospital deliveries, home deliveries depended on the mother's body and mind as opposed to the potential scenario of a doctor or nurse setting the pace of and dictating methods for the delivery. Since labor usually took many hours, women expressed happiness that they were able to shower, eat, walk around in a familiar and comfortable environment, and be with family. In terms of having family at the birth, one mother of two commented that "I liked having a large amount of people because for me it was normalizing natural birth and it was showing them it can be done without being in a hospital setting." In addition, her five-year-old son was with her for the labor and delivery and even joined her in the birth tub to rub her back.

Most women expressed that being at home made them relaxed and better able to cope with pain. A woman at the birth circle mentioned that she was not as stressed when she labored at home as opposed to laboring in the hospital, "I really do think when you're calmed down you're less likely to have such intense pain even with back labor and I think that vomiting is pain induced. The less stress you have, the fewer side effects and the easier time you have delivering." This was what all of

the home birth women reported: delivering at home was stress-free and they were able to effectively manage their pain and relax before they started pushing.

Home birth women also felt this way about the recovery process, and thought that being relaxed at home and having the midwives come to them made them able to recover faster and be more active. A mom who delivered her second baby at home was much happier with her home recovery than her hospital recovery and said “ the first time I was not relaxed at all in the hospital, but at home it [recovery] was so much quicker and shorter, even my postpartum bleeding, I could just feel myself healing faster.” She attributed this to both the comfort of home and not needing to separate between her delivery room and recovery room. In addition, many women stated that having midwives and doulas so available and accessible to them made this process much smoother.

As mentioned in the previous chapters, relationships with midwives and doulas were strong, intimate, and enduring. For almost every prenatal appointment, midwives would come to the home of the expecting parents to talk about the delivery as well as the mother’s health. During the delivery process, women reflected on the fact that the midwives were there but only as much as the mother needed them to be. One woman described their presence and compared it to her hospital birth experience,

“In the hospital they were all up in my grill about everything, they wouldn’t let me be. At home, I remember I was screaming in the bathroom just because I was in a lot of pain and it’s not like they ran over and made a big deal they were just like ‘Oh, normal birthing sounds, that sounds great.’”

Women reported that whatever they asked of the midwives, they were able to do or help with. They did not heavily intervene in the process, an aspect of home birth that women liked. In these situations, birth was viewed as natural and was subsequently treated as such in that heavy interventions were avoided.

After the delivery, midwives provided healthcare to mothers and their babies as well as childcare tips. Women commented that since the midwives and doulas had been coming to their houses for prenatal appointments, having them there postpartum was completely normal and made the process easier. In addition, the midwives at the birth circle said that part of the intimacy comes from being in someone else's home for so many months, which makes everyone involved more comfortable when the time comes to deliver as well as in the postpartum stage.

Many women commented on the fact that the midwives were able to help them breastfeed, which none of the women found immediately easy. Since the midwives were already very comfortable in the home, and the parents were comfortable having them there, this continued care was smooth and provided parents with an extended resource. One woman was grateful that the midwife was a "one-stop shop,"

"It was nice having her there to help change diapers and help me breastfeed initially... it just seems a lot harder finding all of those people when you've just had a baby. Having these people we already knew really well who were just coming to our house regularly was so smooth and easy."

Since the midwives were able to help with all aspects of prenatal and postpartum care, women were able to use them as consistent, accessible, and reliable resources throughout the process.

Women who chose non-traditional methods in any sense (whether at home, or with a midwife or doula) explained their descriptions of ideal birth with a rejection of the medical model. As described in the literature review, women were able to assert their identities and sense of control in their rejection of medicalization (Tuteur, 2010). Many women at the birth circle who delivered at home commented unfavorably on the rates of interventions, especially C-sections, and felt that this was not the best way to deliver. They supported this argument by saying that most women and their bodies had the ability to deliver naturally, and if that were the case, then they had the ability to deliver at home. The midwives and doulas at the birth circle made similar points, and although all would advocate for natural births at home if possible, they also knew not all women felt comfortable or were able to deliver this way.

On the other end of the spectrum were women who removed themselves and their own experiences from their descriptions of the ideal birth. Many women from both delivery locations who used different methods of delivery explained that in the end, it did not matter how a woman delivered, and that the arrival and health of her baby was the only important thing. One woman commented,

“I think part of the ideal birth has to deal with realizing that this is what’s at the other end, this little guy [her baby]. It doesn’t really matter how it happens, like if you end up having to have a C-section that’s OK and we shouldn’t beat ourselves up about that. If you have a healthy baby, that’s the ideal birth experience.”

This sentiment reflects what many women felt about the ideal birth experience—that it was simply a means to an end, and however the woman got there, she was met with a baby on the other side. This begs the question of why delivery location

and choice in that location matter in the first place. The next section will expand on this question by discussing the important role that storytelling played and still plays.

Telling the Story

Birth stories are forms of personal narratives, and each woman is able to tell the story of her pregnancy and delivery how she wants. With the power to construct the story of her experience, each woman is able to choose what to reveal and how to tell her story. This is another aspect of the birth process that gives women power and control over their experiences, because each woman has her own unique experience that she can share as she wishes. By interviewing these women about a very intimate and personal aspect of their lives, I was privy to their sharing. The more I interviewed, the more I understood how their answers were formatted, scripted, and filtered. Even though women were responding to questions, the way they answered them varied person to person. While some answered with only a few sentences, others provided in-depth answers that extended beyond the question and added additional information of their choosing. In addition, the level of intimacy in each interview varied, but women who used non-traditional options often provided the most intimate answers.

The way each woman told her story varied immensely. Furthermore, the act of sharing their stories meant something different to each group. For hospital birth women without midwives and/or doulas, the information they shared was very straightforward and clinical. They were not as comfortable sharing intimate details

about the physical aspect of their deliveries, and shied away from “taboo” words or topics such as parts of the body or interventions. While sharing her story, one woman stopped herself, “So I ended up needing an episiotomy [episiotomy]—is this too much information?” Others felt uncomfortable using the word “vagina,” so instead used words like “nether-regions,” “down there,” or “below the waist.” These word choices and concerns about over-sharing were consistent throughout interviews with hospital birth women, and were confined to this group.

In addition, women who received interventions were quick to defend themselves as if I would judge them for receiving them, again highlighting the stigma associated with interventions as mentioned in the previous section. A woman who tried to deliver naturally but ended up getting an epidural explained, “it was just so painful. I’ve run marathons, I’m in good shape so I thought I would be fine but I had to get it eventually, my doctor recommended it so it just seemed medically necessary at that point.” In this case, she puts blame for the epidural on her doctor, possibly in an attempt both take blame off of herself to make herself look stronger or to try to explain just how painful childbirth was (especially to someone who had never experienced it). Given the trend of women avoiding interventions as discussed in the literature review, the need to defend getting interventions could be a result of this trend as well as the stigma associated with it.

This also relates to experiences of trauma, which women did not explicitly express but briefly acknowledged and then dismissed. For example, one anti-intervention woman who ended up receiving Pitocin, an epidural, and an episiotomy commented

“I was pretty upset for a while afterwards, like I really didn’t want that to happen to me, so I was a little shaken because I wasn’t expecting my birth to be like that. I guess I was traumatized initially... But then I was like, I have this amazing baby so all of that kind of washed away.”

Hospital birth women who had traumatic birth experiences (as defined by them) did not seem to accept this trauma as much as other women did. They were able to look past initially unwanted experiences and be comforted by the delivery of a healthy baby, expressed most explicitly by one woman who said “It’s about how you are as a mother, not how you delivered your baby.” This allows women to dismiss trauma by focusing on motherhood instead of their traumatic birth experiences. In addition, because trauma is a sensitive and stigmatized topic, talking about trauma did not make for the “good” birth story that people expect to hear. In that sense, the devaluation of traumatic experiences could have been attempts to provide the expected happy birth story rather than a negative discussion of traumatic birth experiences.

As opposed to hospital birth women, women who used midwives and/or doulas, or who delivered at home shared their experiences in a much more intimate way. My knowledge of birth was limited before I talked to these women in particular, who did not hesitate to share intimate details of their delivery experiences. Women who chose non-traditional options seemed generally more concerned with the emotional and mental aspect of delivery and did not hesitate to share these types of birth experiences candidly with me. One woman confessed that “It was honestly more grueling than I thought it was going to be, but that’s what I liked about it. The fact that it was hard both emotionally and physically made it an even bigger accomplishment and it really had a positive impact on me.” These types

of answers were not as prevalent among hospital birth women, who focused on the clinical and physical aspects of delivery.

In addition to the stories shared in one on one interviews, the women who attended the birth circle were willing to share every aspect of their birth experiences. Women discussed very intimate physical details such as losing mucus plugs, having bloody show as they went into labor, vomiting while in labor, and delivering the placenta. I never would have known about these aspects of delivery had it not been for the women who shared at the birth circle—there were no limits on what was discussed. Perhaps it was the supportive atmosphere and the comfort women felt in openly sharing their stories, as well as every aspect of them. The idea of no-limit sharing is supported in the literature on women telling their birth stories and the almost cathartic experience is one I recognized at the birth circle (Callister, 2005).

For women who had received interventions, the main difference between interviews with one on one hospital birth women and with women at the birth circle was the acceptance of trauma. While hospital birth women attempted to cover up, defend, or downplay their experiences of trauma (mostly in the form of unwanted interventions or many interventions), women at the birth circle not only accepted that they were traumatized by hospital births, but used storytelling and sharing to inform and heal. In addition, most of the women shared that they experienced trauma at for their first deliveries in the hospital, and if they chose to have more children, they delivered with midwives and/or doulas at home or in the hospital. These women began their stories with a description of their first birth and then

ended on positive notes by describing their second, “ideal” births. Each woman was given an opportunity to share her story, and was encouraged and supported by the other women throughout its telling.

All of the birth circle women were able to accept that sometimes trauma is a part of the birth experience, but that there are ways to accept trauma and also improve subsequent birth experiences. These women did not feel the need to provide the positive, good story that birth experiences are “supposed” to be if they did not feel that they had positive stories. As opposed to hospital birth women, the women at the birth circle were there to share their stories in their purest forms, which sometimes included aspects of trauma.

While other women with traumatic experiences did not explicitly say that they considered their births to be traumatic, the women at the birth circle talked about trauma as a way to call attention to the fact that it happens and show women that they were not alone in their experiences of trauma. In addition, these women were less inclined to say that the arrival of the baby and entrance into motherhood completely erased a traumatic birth experience, although many said that it helped. The existence of the birth circle and other groups like it points to the need for women to tell their stories, traumatic or not, in an environment that will support them and encourage them in a therapeutic and healing way.

It is important to examine the outcomes of deliveries especially in comparison to prenatal expectations to understand whether or not women feel that their births were successful. These reports are crucial parts of improving practices to ensure that women do not feel traumatized by unwanted or unexpected practices

or methods. Delivery outcomes depend on expectations, location, delivery team, and also discussions of trauma and storytelling. As discussed in the literature review, many women and doctors believe that medical interventions can guarantee a successful birth in the form of a healthy baby. However, definitions of success vary. Other women take into account the road they took to get there, placing more emphasis on trauma and the importance of a real rather than a good birth story.

Conclusion

My conclusions about women's birth experiences rely on the understanding of every step women encounter when making choices and decisions about their births. It is important to acknowledge each of these steps, from beginning to end, to be able to understand how women view the birth process and in turn provide them with access to their ideal births. By examining births at the hospital and at home, popularly viewed as opposite locations, I have been able to show their similarities and differences in terms of prenatal choices, risks, choice of care providers, and outcomes. In addition, the findings from this research suggest that midwives and the availability of interventions or medicalization play large roles in the formation of birth experiences and outcomes. I can conclude that it would be helpful for women to have access to and information about all birth options and methods to ensure that they have positive experiences and be able to look back on childbirth as the joyful experience it is. In addition, women should be able to express feelings of concern, discomfort, or distress in situations of less-than-ideal births, and the creation of and advocacy for support groups is necessary in order for them do be able to do so.

My first deduction is that the initial decisions made about delivery have an impact on and predict which methods will be used and how the process will evolve. For example, by deciding to deliver in a hospital setting, women put themselves "at risk" for receiving interventions, wanted or unwanted. Alternately, the decision to use midwives and/or doulas also largely impacts delivery outcomes in terms of care and support. I argue that it is important for women to have access to comprehensive

information on each of these choices, so that whatever method they choose, it will result in a meaningful and pleasant delivery experience. Information and planning are key components for women who would like to try to create and understand their deliveries.

The increased use of non-traditional options suggests that the reliance or comfort with the medical model could be shifting, largely demonstrated by the number of women in my study who chose to use non-traditional options and methods and the difference that location made in terms of women reporting traumatic experiences. Midwives made a huge difference in the experiences reported by women who used them. They could assist women who did not want interventions either at home or in the hospital. In the hospital especially, midwives were able to provide women with the comfort and support of a home birth, but with medical intervention at the ready, if necessary.

The medicalization of many of these births is indicative both of choice of location and in receiving interventions. Hospital birth women were split on the use of interventions, with some (usually those with midwives) opposing them and others expecting to receive them. Midwives were also important in this sense in that they provided women with an extra layer of support against interventions when in the hospital. Women who did not have midwives present in the hospital were more likely to receive interventions, even when they were unwanted.

Outcomes were also split in women's postpartum feelings about receiving interventions. The most surprising reports in my research were those from women who expressed being strongly opposed to interventions before they went into labor,

but who ended up receiving them anyway—and readily accepted this change of plan postpartum. However, while most women who experienced unexpected situations reported some aspect of trauma, not all could point to the delivery of a healthy baby as acceptance that their births had not gone as planned. While the literature discusses some aspects of trauma, such as the trauma itself and its aftermath, the discussion of acceptance and support for women traumatized by their births is not prevalent (Tatano Beck, 2004). The general taboo surrounding both trauma and birth make this a difficult topic to discuss, especially given the fact that birth is supposed to be a beautiful and life-changing event. When women do not feel this way about their births, they are put in a position where they can feel discouraged and disheartened.

By using the birth circle and the women who shared their stories there, I hope that I have demonstrated the power that storytelling has, especially for women who feel they had traumatic birth experiences. Many women had hospital births for their first child and used non-traditional options for their subsequent deliveries. However, being able to talk about their first experiences was helpful to them in both expressing their trauma and recovering from it. With the support of the other women, they were able to describe their experiences and recognize exactly what about these experiences was uncomfortable for them. In addition, these stories also helped other women who were deciding on where to give birth. Hearing other women's stories gave them some clarity and helped them determine what they valued about their own upcoming delivery experiences.

This research is exploratory, but it opens up many topics for discussion and indicates the need for further research, including the study of women who cannot afford to choose the birth location or method they would like, leaving them with no choice but to deliver in the hospital. Studying women who have been able to afford whatever option feels like the right one for them has given me the opportunity to understand the aspect that planning your own delivery has on outcomes of birth, and if these are congruent. This begins with examining how women access information about delivery methods, and if some women have better access than others. Some of the women I spoke with were unfamiliar about midwives and doulas, and unsure what they would be able to bring to the birth. Even the existence of some non-traditional options are unknown to some women, making it difficult to customize the delivery experience, given there are many options available.

Until all women are able to make informed decisions and have access to the birth experiences they want, there must be resources as well as research on traumatic births and the healing aspect of recovery in all forms (mental and physical). The current literature demonstrates that there are healing qualities of storytelling, but these ideas should be examined in the context of birth. Further research could examine the impact that groups such as the birth circle have on women, who uses them, and the ways in which they are used.

It is my hope that as women become more educated about and invested in their childbirth options—and as the methods of delivery continue to improve and change—the discussion of “how we are born” becomes more mainstream, both in the media and in everyday conversation. It is important not only for women, but for

their families, health care providers, and policymakers to understand what women value about the delivery experience and how successful births can be accessed and achieved for all women. After all, birth affects every single human being, so it more than deserves a place in public discourse.

Appendix A: Informed Consent

INFORMED CONSENT

I, _____ (please print name) hereby consent to my participation in this research project.

This study will investigate where women decide to give birth and why, focusing on three delivery sites: home, birthing center, and hospital. Given the nature of the topic, I understand that I will be asked questions that may be sensitive or personal. These include where I decided to give birth and the values I have that drew me to choose this location. I understand that my participation in this project is voluntary and that, with no penalty, I may withdraw my participation at any point or refuse to answer any questions that I do not want to answer for whatever reason.

I understand that the use of a recording device is not required for participation in this study and I am free to ask that my interview not be recorded. If I allow the interview to be recorded, I understand that I am free to ask that it be turned off at any point. I also understand that Katie Dimond, the principal investigator, will be the only person who will have access to this recording. It will not include my name and upon completion of the interview, it will be transferred onto a secure server and deleted from the recording device. I understand that this recording will be used for research purposes only and any transcripts of the recording will change my name and the names of any other identifying places or people.

The purpose of this research is to understand the decision-making process behind choosing a delivery location and the values associated with this decision. This research could benefit both pregnant women and their possible providers in giving them insight into this process and help them achieve the best and desired birth experience for women. As all identifying information will be kept confidential and available only to the principal investigator, I understand that there are no potential risks.

If I have any questions regarding this project or wish to have further information, I am free to contact Katie Dimond, a student in the Anthropology Department at Trinity College, (617) 872-7406, kathryn.dimond@trincoll.edu.

Signature

Date

Appendix B: Interview Questions

Location:

Where are you planning on having your baby?

Resources:

Even before you became pregnant, were you thinking of where you would want to give birth?

Have you done research on different birth options?

Where did you get information about which location would be best for you?

What was the most persuasive source of information for you in making your decision?

Will the cost associated with your childbirth be covered by your insurance?

Did you take any prenatal classes? Support groups? Helpful? Guide you in any direction?

Values:

What drew you to choose the option you're considering?

What do you value in the delivery experience?

Are there any aspects of your chosen delivery option that give you concern? Are you doing anything to address these concerns, if so, what?

Do you feel that your provider is including you in decisions about your delivery?

Have you had support in your decision? From family, friends, doctor.

If it turned out that your insurance did not cover your preferred delivery option, would you consider paying out of pocket for it?

Do you consider your delivery experience to be one worth paying for?

Would you assume a debt in order to achieve the ideal experience?

How do you feel about women who have scheduled birth through C-section? (for non-health reasons)

Expectations:

What are your expectations for how it's going to go?

Are you planning on a natural birth or do you anticipate wanting to have an epidural or other pain medication?

What are you expecting from the people who help you deliver?

What are you looking for in a delivery team?

Do you feel like you have control in what's going to happen?

Non-hospital options:

How much do you know about non-hospital deliveries?

Would you feel comfortable delivering outside of a hospital? Why or why not?

Would you feel comfortable using a midwife?

Would you consider using a doula?

If you are using a doula, why did you choose this?

Outcomes:

Was your delivery as you expected it to be? Were there any surprises?

Did you feel you were well-informed? Would you have wanted anything to go differently than it did?

Was the team responsible for your delivery responsive to your needs?

If you have another pregnancy after this one, would you do the same thing or something else? Why?

Did you feel like you had control?

Final

If you were to tell someone what the ideal birth experience would be, what would you say?

Appendix C: IRB Approval

Date: June 16, 2015
To: Kathryn (Katie) Dimond
James Trostle
From: James J. Hughes, Chair
Trinity College Institutional Review Board
Federalwide Assurance: FWA00013955
Re: Approval of Research Proposal 2015-077



I have reviewed your request for IRB approval of your research project "Choosing a Delivery Room: Expectations and Outcomes of Birth Among Middle- and Upper- Class Women." Your proposed project meets the ethical standards for research involving human participants with respect to obtaining informed consent, assuring confidentiality of participants' responses, and posing little or no risk to participants. Your project is hereby approved under expedited review and you may proceed with your research when you wish. If the need arises for any further communication about this proposal, please use the identifier number above.

Please note this approval extends for a period of one year from the date above. Should you continue your research beyond that period a new IRB application is required.

If you change your research methodology in any way, please contact me so that I can verify that your research still meets the appropriate ethical standards.

cc. Richard Prigodich, IRB Administrator

Sincerely,



James J. Hughes
Chair, Institutional Review Board
Trinity College

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