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Perceptions of Control in Midwifery Assisted Childbirth: A Qualitative Examination of the Midwifery Assisted Experience of Childbearing

Sarah Jordan Keels

University of South Carolina - Columbia

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PERCEPTIONS OF CONTROL IN MIDWIFERY ASSISTED CHILDBIRTH:
A QUALITATIVE EXAMINATION OF THE MIDWIFERY EXPERIENCE OF
CHILDBEARING

by

Jordan Keels

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Accepted by:

Jimmy Sanders, Director of Thesis

Shelley Smith, Reader

Erica Gibson, Reader

Lacy Ford, Vice Provost and Dean of Graduate Studies

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ABSTRACT

This study looks to uncover some of the reasons that the sub-group of women who give birth outside of a hospital setting, and the midwives who serve them, choose to have an alternative birth plan and are willing to undergo social criticism for their decision. This is a qualitative analysis based on interview data with women who utilized midwifery care and midwives themselves. In-depth interview questions focus on the decision to use a midwife, definitions of control in the prenatal and birthing experience, and any kind of facilitation midwifery is seen to give expectant mothers in relation to these concepts. Through analyzing these interview responses, I found an emerging theme work in the midwifery model of care. Women who participated in this model, whether it be mothers or midwives themselves, emphasized ideas of control, autonomy and achievement in the childbirth experience. I also found a heavy emphasis on respect for the mother in this model of care. Furthermore, many of the respondents spoke about the emerging social movement of alternative birthing plans and their relationship with conventional medicine which I feel is worthy of examining through a sociological lens. Finally, an interesting theme regarding masculinity and the role of fathers in the childbirth experience developed from the data.

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CHAPTER 1

INTRODUCTION AND RESEARCH OBJECTIVES

Approximately 1-2% of American women give birth with a midwife at home, in hospitals, or in birthing centers. As they are so against the “norm”, these women face substantial obstacles by making this decision. The goal of this research is to explore the reasons women chose to have a midwife-assisted birth and the ways in which these women and their midwives articulate their understanding of the needs of the mother in childbearing. Specifically, I set out to focus on themes of agency, control, and achievement in the narratives of mothers and midwives. Additionally, after conducting and analyzing the interviews, other interesting themes began to emerge: ideas about education and social movements, midwifery’s relationship with conventional medicine, and modern masculinity’s impact on the role of a father in the childbirth process.

The focus on experiences of midwife-assisted birth is novel in sociology. Medical sociology and the sociology of gender have largely neglected the topic of childbirth (Fox 1999). This is surprising, given the importance of the entry into motherhood as a transition point in the life course. Motherhood is a shaping factor in a woman’s identity and social relationships. It can give a sense of purpose or meaning to a woman’s life. With a few exceptions, research on

midwife-assisted births, critiques of medicalized birth, and exploration of the social aspects of childbirth have largely occurred in medicine, public health, psychology, anthropology, policy analysis and other fields outside of sociology (Fox 1999, Davis-Floyd 1994, 2001, Wendland 2007, Rosenthal 2006, Barker 1998, Bassett 2000, Leavitt 1996). Little is known about the maternal perspectives on the choice of birth attendant and what the expectations of proper and satisfying prenatal care are. This research seeks to offer a sociological perspective on the perceptions of childbirth among women who choose midwives. As this subculture continues to become more vocal in their opposition toward the conventional model of birth, it is important to examine it in greater detail sociologically, especially as the drawbacks of the conventional method become more and more apparent. It is vital that those in the medical field learn about and respect these alternative options in order to ensure that prenatal care is acceptable to all women's expectations.

In confirmation with the literature, my sample of mothers consisted largely of women who have a high socioeconomic status. As opposed to midwifery users pre-1960, who tended to be poor, minority, rural, or inner-city women, women who utilize midwives today tend to be patrons of private offices, birthing centers, and managed care organizations (Raisler 2005, Stone 2000). A large percentage of midwifery users tend to be well-educated, white, and high achieving individuals of the middle class (MacDonald 2006). In general,

practitioners of alternative medicine are well-educated women (Bishop 2010). These women are more likely to value such things as perceived control, agency, notions of achievement, and respect, as indicated in the literature. Because of this, I expected to see a high level of reference to these concepts in the mother's narratives. I predicted that these women would opt to use a midwife and an alternative birth plan because it addressed their need to feel "control", however they define it, in this important life experience more than the conventional option would.

I also expected midwives themselves to value such ideas highly. In reference to literature regarding the practice of midwifery, there seems to be a sharp distinction between the facilitation a midwife sees herself giving a pregnant woman and that which she sees conventional medicine as giving (Davis-Floyd 1996, Hyde 2004). The midwife traditionally positions herself in opposition to the conventional/technocratic birth model, though more recently there has been increased pressure to conform to it (Hyde 2004, Annandale 1988). In doing so, she distinguishes herself by means of the difference in the services she provides the mother. I believed midwives would vocalize this by explaining the ways in which they facilitate pregnant women to have more control in the birthing process. I expected that midwives would see themselves as sources of empowerment, respect, and true connection during this very special time in the mother's life.

In setting up my research, I allowed myself the space for hypothesis-generating or interpretive themes that could potentially emerge from my data. I believed that it was important to address anything that became apparent in my data that was not expected and that seems worthy of further exploration, and my analysis process allowed for that.

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CHAPTER 2

BACKGROUND OF MIDWIFERY

When seeking maternity services, women are confronted with a complex array of choices and social orders. The 'choices' women make reflect the variety of discourses that surround and idealize possible birthing experiences (Zadoroznj 1999). For much of American history, childbirth was almost exclusively a women centered event consisting of self-help networks, with midwives performing the majority of all births. However, in the late 19th and early 20th centuries, medical authority came to rest the hands of obstetricians. Through a series of technological and cultural developments, the importance of this "scientific" version of childbirth manipulated women and increased the power of doctors while at the same time subduing the voices of mothers themselves. (Leavitt 1996).

The traditional practice of midwifery underwent a rapid and drastic change in the twentieth century. In 1900, less than five percent of all women gave birth in a hospital setting. However, by 1960, less than five percent of births occurred in the home. That number has held steady over the last 50 years, although midwifery as a practice seems to be experiencing some resurgence over the last decade (MANA). It is culturally more visible, as seen in such popular

documentaries as actress Ricki Lake's "The Business of Being Born" (2008).

Perhaps this is in reaction to the biomedical model and the increasing induction and cesarean section rate nationwide.

Exact statistics on midwifery are difficult to locate, perhaps due to the fact that there is a variation in titles, licensing, and training of those in this occupation. Currently in the United States, there are certified midwives, certified nurse midwives, certified professional midwives, licensed midwives, and lay midwives (MANA). With such an array of titles, training can range from the informal and largely self-taught knowledge of lay midwives to up to five years of training for certified nurse midwives (CNM) who must train in both the fields of midwifery and traditional nursing. Since the onset of the biomedical model, an increased pressure for accreditation and licensing has been placed on the occupation, since accreditation is a basis by which proponents of technocratic births assert their authority. Occupational societies, colleges, and boards, such as the American College of Nurse Midwives, the American Midwifery Certification Board, the Midwives Alliance of North America, and the Midwifery Education Accreditation Council have also been formed in recent years in order to increase the presence and professionalism of the institution.

The general midwifery ideology is also important to examine here. The "Midwives Model of Care" is the best example of the overall ideology of midwifery. It is as follows (CfM):

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes. It includes:

- *Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle.*
- *Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support.*
- *Minimizing technological interventions*
- *Identifying and referring women who requires obstetrical attention*

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Representatives of the Midwives Alliance of North America (MANA), the North American Registry of Midwives (NARM), the Midwifery Education Accreditation Council (MEAC) and Citizens for Midwifery (CfM) collaborated to provide this working definition for all groups to use consistently in communicating with health care decision makers. It is clear that the focus is on the mother and that the partnership between the mother and her caregiver is highlighted. In midwifery, mothers are treated as capable decision makers, in control of their bodies and their pregnancies. In this definition, understanding and communication are key and the role of technology and interventions are minimized.

Sociological and anthropological research on midwifery generally looks at this ideological stance in some fashion. There is concentration on illness prevention and health promotion, concentrating on the individual mother's experiences, feelings, and expectations for her childbirth (Howell-White 1997). The research Fraser (2007) conducted with midwifery students reveals the most

important reason for going into the field was the issue of wanting to empower women. Hyde (2004) found that midwives saw themselves as liberating the autonomous subject of the mother, most importantly through communicative action; that is mutual negotiation of decisions of actions to be taken as a result of communication. Davis-Floyd has asserted that midwifery actually forms its own type of authoritative knowledge within that birth community, commonly guided by intuition (1996). The deep value that midwives place on connection “leads them to listen to and follow their ‘inner voice’ during birth, rather than operating only according to protocols and standard parameters” (237). Intuition thus becomes a salient source of authoritative knowledge, emerging out of the deepest bodily and spiritual aspects of a midwife’s being; this extends to a mother’s encouragement to trust her own intuition in the birthing practice as well.

2.1: Midwifery in South Carolina

In the state of South Carolina, in order to become a licensed midwife (the type being interviewed in this research), one must be licensed by the state Department of Health and Environmental Control (DHEC). To do this, one must apply and complete an apprenticeship, provide evidence of education in line with department standards, pass various medical checks, provide recommendations from other midwives, and sit for an exam. Once the license is obtained, the midwife must complete continuing education requirements as set by DHEC. Her practice is also restricted the obstetric or prenatal care only of

women in South Carolina. There are also strict conditions under which a licensed midwife must refer a patient over to an obstetric physician (DHEC).

Unlike many other states, South Carolina has deep historical roots in the tradition of midwifery. Interestingly, there has been no period of time during which midwifery was prohibited from practice, as in most other states. While elsewhere, the numbers of midwives began to decline drastically in the early 1900's, in the 1920's in South Carolina there were still 4,000 lay midwives practicing and attending 80% of all births (Ott 1991). They were mostly "grand" or "granny" midwives, which refers to the Southern African American tradition of experientially trained older women attending births in the community (Kollath 2012). By 1940, however, there were just 1,400 registered and practicing lay midwives in the state of South Carolina (Bowie 1988.). Seventy years later, the number has shrunk to 33 currently licensed midwives, minuscule compared to the past (DHEC).

It is hard to say whether South Carolina is supportive of the institution of direct entry midwifery. On the one hand, we are one of the few states that provides licensing and regulation procedures, so midwives do not have to battle for legal recognition. However, this same regulation means there are many rules that midwives have to follow, and these rules can seem very arbitrary because there are many definitions of risk in pregnancy and childbirth. The freedom of a

midwife to make her own intuitive decisions can be drastically curtailed with these regulations.

It also worth considering how South Carolina supports midwifery economically. Medicaid has covered licensed midwives since 1993, however the reimbursement rate is only 65% of what Medicaid pays physicians, which is the lowest in the country (Kollath 2012). Additionally, Blue Cross/Blue Shield, primary insurer of state employees, has plans that include licensed midwives, but they are poorly covered. Even though state insurance options cover licensed midwives, it is extremely limited and inconsistent. This restricts access to midwifery care and alternative birth options for many women. On the other hand, insurance coverage is much better for certified nurse midwives, which no doubt results at least partially from their more “mainstream” formal education, training, and practice settings. Taking these issues of insurance coverage into account, it seems South Carolina does not support the institution of direct entry midwifery (Kollath 2012).

It is also worth noting some recent developments in midwifery in the state of South Carolina. In 2013, a bill was introduced that would potentially negatively affect licensed midwives in the state. It would change the way the institution is regulated by making it much harder for the women to practice independently. The bill is still awaiting action.

Additionally, due to a bad birth outcome in the Upstate of South Carolina, birth centers were shut down in December of 2013, and will be shut down again in June of 2014 if they fail to meet the vague standards set by DHEC concerning on call doctors and transfer regulations.

CHAPTER 3

REVIEW OF THE LITERATURE

3.1: The technocratic/biomedical birth model

Today, most births are performed by physicians trained in the biomedical model of care. Biomedicine represents hegemony in health care delivery in the United States. It corresponds to what Robbie Davis-Floyd (2001) describes as the technocratic paradigm of health care delivery. This paradigm emphasizes rationality and technology. As such, it resonates with the Western orientation toward science, technology, economic profit, and patriarchally governed institutions (Davis-Floyd 2001). Our medical system reflects these values, thus, the scientific justifications for the way pregnancy is treated in our culture are a guise for the means by which it makes cultural sense. Among the most salient characteristics of a technocratic model is the treatment of the body as machine separate from the mind, the treatment of the patient as object, and the authority/responsibility falling to the practitioner, not the patient (Davis-Floyd 2001).

Approximately 98% of all births in the United States reflect this “evidence-based” (Wendland 2007) model of care. In this model, the obstetrician is in

control, making most decisions about labor and delivery interventions (Leavitt 1996). Critics of the biomedical model argue that biomedical rhetoric treats pregnancy as a disease, a “faulty and untrustworthy process” (Davis-Floyd 2001). Obstetricians have legitimized themselves by claiming they have the cultural authority with which to treat such a malady (Barker 1998). The metaphorization of the female body as defective machine lead to the working premise that birth will be ‘better’ when this defective birthing machine is hooked up to other, more perfect diagnostic machines (Davis-Floyd 1996). Fox (1999) asserts “medical professionals, acting on a definition of childbirth as hazardous, intervene in what is essentially a natural process. Their managements of birth decreases the control of the birthing woman, fails to improve the physical and emotional outcome of birth, and even alienates the woman from a potentially empowering experience” (328).

In contrast to the maternal-centered mindset prevalent in earlier times, the introduction of the biomedical model to prenatal and maternal care resulted in the shift of focus away from the mother and toward the fetus. The rise of malpractice lawsuits and the development of defensive medicine further fueled this trend. Bassett (2000) defines defensive medicine as the “dialectical relationship that mutually defines, substantiates, and expands both disciplines [medicine and law] over time” (524). In other words; biomedicine influences law by developing clinical standards, and law also influences medicine through the

litigation process and the outcomes of trials. This affects the behavior and decisions of individual physicians; the threat of a suit is constantly present. The fear of litigation spurred a drastic increase in cesarean sections, fetal monitoring, and a “standardized” version of labor that focused on averages and statistics. For example, in 1965 the U.S. rate for cesarean sections was 4.5 per 100 deliveries whereas in 1991 the rate was 23.5 per every 100 deliveries (Lazarus 1994). There is an alarming lack of prenatal counseling, and even consent, before certain procedures and tests are undergone in a hospital birth setting (Rosenthal 2006). As Wendland (2007) notes, “the mothers body disappears from analytical view; images of fetal safety are marketing tools; technology magically wards off the unpredictability and danger of birth” (218). The mother becomes invisible and inaudible, even as her cries of pain become subsided with pharmaceuticals.

Understandably, many women feel dissatisfied and frustrated with the biomedical standard of care. Novick’s research (2009) reveals that a substantive group of pregnant women’s expectations are not being met; namely they perceive prenatal care as mechanistic, dehumanizing, or harsh. Many feel that there must be an alternative to their long waits, rushed visits, and dismissive attitudes of doctors. They long to experience a real connection with their health care providers, and to be treated with the respect that they have been taught they deserve (Davis-Floyd 2001). These concerns are among the potential reasons that

lead some pregnant women to seek such alternatives as midwifery, home birth, and other “natural” birth options.

3.2: The Natural Birth Model

Although it is not to be equated with midwifery, the natural childbirth model is often portrayed as an alternative to the biomedical birth. Many women give birth naturally (without the intervention of drugs) using a midwife, however many women may also give birth naturally in a hospital setting. In Davis-Floyd’s (2001) typology, natural childbirth resonates with “humanistic” and “holistic” approaches to healthcare. Humanism is “relational, partnership-oriented, individually responsive, and compassionate” (6). Humanism recognizes the mind-body connection, and insists that it is impossible to treat physical symptoms without addressing their psychological components. The holistic model of care is founded upon the oneness of body-mind-spirit, the individuation of care, the drastically reduced reliance on technology, and the authority and responsibility resting inherently in the individual patient (Davis-Floyd 2001).

Using a content analysis of pregnancy self-help books, Mansfield (2007) sought to better understand what is meant by “natural” childbirth, or an experience without the intervention of drugs. She uncovered that the three themes included activity during birth, preparation before the birth, and social support. Being active helps the mother avoid the role of the patient and stay

confident and in control. Preparations before the birth include acquiring information and attending to mothers' physical and emotional health. All of these techniques also stress the autonomy of the mother and the responsibility for the birth outcome lying inherently in her hands.

The theme of control emerges as critical in most narratives on natural birth. MacDonald (2006), for instance, argues that the promotion of natural birth "posits women as naturally capable and strong, their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting" (236). It is in this way that natural birth becomes a source of empowerment to the women who choose it; here they experience a sense of control and accomplishment that positively informs their sense of self "not only as women and mothers, but also as persons" (236).

MacDonald (2006) points out that the ideal of the natural birth is a rhetorical strategy not unlike that of the biomedical model. Natural equates to a normal birth, and thus carries "a kind of cultural weight that goes beyond this latter term" (236). The women who choose a natural birth feel strongly about its necessity and its empowering abilities for mothers everywhere. Since the majority of midwifery assisted births are natural as well, for the purposes of this research, the ideas of control and autonomy reflected in the natural model are important to examine.

3.3: Concentration on the Individual Mother

Another aspect of the natural birth model, especially prominent in the institution of midwifery, is the emphasis on the individual mother in the pregnancy and childbirth process. Howell-White (1997) specifically looked at the ways in which women who chose certified nurse midwives over obstetricians for their prenatal care expressed a desire for a client-oriented professional philosophy. Since the midwifery philosophy advocates informing and educating patients so that the women themselves participate actively in the decision-making process, this would make sense, and Howell-White's researched confirmed it (1997). In the midwifery model of care, the mother and birth attendant work together and individual qualities of birth are expressed, i.e. no two births are exactly alike, and there is no routinization or "normalization" of pregnancy. I feel that this model of care would work best for a woman who desires more information from the provider, such as education and support on diet, exercise, lifestyle issues, and preventative medicine. It would also better serve a mother who desires more control and power over the interactions and experiences of the childbirth process.

Howell-White's study revealed that women who "believed physicians gave less quality care are more likely to select a certified nurse midwife" (1997: 932). Women who want a more personalized and less medically focused relationship with their care provider can better find it in the institution of

midwifery. Howell-White's (1997) respondents who chose to use a midwife articulated such desires as increased time of prenatal visits, a desire to make them feel important, respected, and heard, willingness to discuss emotional concerns, and an emphasis on education and information. It seems that the extra time and effort taken in the midwifery model "seems to build personal relationships between the women and the certified nurse midwives that naturally lead to selecting them for the intimate event of birth" (1997: 932).

3.4: How Midwives See Themselves

Fraser & Hyde's research (2007) echoed similar findings on what midwives see themselves as providing the prenatal and childbirth experience. Specifically focusing on women who were studying to become midwives, the researchers found that the desire to empower women was found to be a major influencing factor in the decision to enter the field. Secondly, a belief that it is a privilege to be part of such a life-changing experience fueled many of the women's choices to become midwives (2007: 312-13).

For women who were studying to be midwives and were also already mothers, there were also interesting findings. For those women who had positive birthing experiences using midwives, there was a desire for other women to experience that same level of support and care. On the other hand, women who had negative experiences wanted to ensure that others did not suffer the same fate; "their aim was to help mothers to have the rewarding experience that they

had not experienced” (314). Overall, the need to make birth a positive experience for all women was a major desire for midwifery students, and thus midwives themselves. These women see themselves as facilitators and co-creators of positive experiences of pregnancy and childbirth, “being with the woman to support, empower, and care for her, and to create the right environment for their positive images of birth to be fulfilled” (314). Being “present and involved” when a new life enters the world is one of the greatest honors a person can have, and the midwifery model of care reflects this approach in its philosophy.

3.5: Social Class and the theme of Control

Lazarus (1994) examined the ways in which social class affected pregnant women’s definitions of control in their pregnancy. Knowledge and access to knowledge became a central focus in the analysis and she found that the more knowledge a mother had access to, the more they were able to articulate their choices and thus control their experience. The middle-class women in her study “wanted to believe that they had control over the process as a part of control over their lives” (36). She focused on women who were all pursuing biomedical birth plans, however, but I believe this research could be extended by applying these ideas specifically in a population who are choosing to participate in alternative prenatal care and birth experience and may define control in a similar way.

Howell-White (1997) also looked at the ways in which control factored into prenatal care, and as mentioned, this research incorporated the idea of differing definitions and ideals of childbirth and how it impacts the decision of birth attendant: obstetrician or midwife. Her research noted a strong relationship between women who define childbirth as a normal and natural experience and the selection of midwife. She found unexpectedly, however, that a lower desire for control was related to selecting a nurse midwife as well. I believe her conceptualization of “control” did not accurately reflect the idea of autonomy or capability, as it was a Likert scale measurement and not a qualitative question. I believe that a qualitative analysis along with a focus on women who choose only to use alternative birth models lends itself better to address such questions. As Howell-White notes (933), “One possible explanation could be that what these women wanted control over was the pain, duration of labor, and any possibly complications that may have occurred.” In other words, the woman’s personal sense of control was not reflected in this conceptualization, rather control by the doctor over the events of the birth.

Zadoroznj’s research (1999) focused on social class and its role in shaping concerns over birthing experience, and it found as well a markedly different approach between working and middle class women. She also made the distinction that across the board middle class women value control in prenatal care, however the ways in which they define such a concept vary. This is why

this research specifically focuses on women who have chosen a more “natural” and less interventionist approach to childbirth. Like her, this research sets out to investigate the role childbearing women themselves play in negotiating the terms of their birthing experience, not the disempowerment of birthing women as a result of the medical model (Zadoroznyj 1999). Her research also noted the power of the experience of childbirth itself in giving women a sense of empowerment that makes them more likely to seek control in subsequent pregnancies.

Social class has an impact on the subjective evaluation of the experience of birth and even on the actual character of the birth itself. Socially structured differences in attitudes, orientations, and even the cognitive ways of thinking about one's health affect the empowerment and control one feels over it, and thus health care experiences such as childbirth (Zadoroznyj 1999). Blaxter argued for example that working class individuals tend to be much more fatalistic in their orientation, while middle class individuals tend to be more activist (1990). In terms of childbirth, this could be seen in the preparations women make for labor, both physically and mentally, or expectations for the circumstances surrounding the labor.

For Zadoroznyj, an important indicator used to measure control is the construct locus of control (LOC), which measures “the extent to which the cognitive perception of what happens in one's life is seen as the results of one's own actions (internal LOC) or is seen as beyond one's own control, and in the

hands of fate, chance, or other people (external LOC)" (271). Internal LOC has become associated with better-educated, higher income people in non-manual occupations (Blaxter 1990). In other words, middle class women demonstrate a stronger sense of their own part in determining the outcome of health care experiences. It is important to note that these differences are not essentialist, but that the styles of control an individual adopts can change in response to life events (Zadoroznyj 1999).

Lazarus (1994) wrote about control in terms of institutionalized knowledge. She argues that knowledge filters, and thus constructs, medical experiences. It is inseparable from social relationships and social experiences, and is thus connected to matters of power and control. She too found that middle-class women wanted to participate actively in childbirth and to avoid interventions, while working class women wanted more interventions; i.e. less pain and reduced labor (30). This research uses the work of Anthony Giddens to describe how there is an "interdependence between knowledge, one's ability to act on such knowledge, the social institutions that constrain actions, and one's position in the larger structure of a society" (30).

3.6: Giddens and Agency

The work of Giddens focuses on the ways in which individual agency and social structures have a hand in shaping the social self and social action and will serve as a theoretical perspective for this research. People, as Giddens describes,

“reflexively monitor their conduct via the knowledge they have of the circumstances of their activity” (1979:254). In other words, actors are constantly balancing the power of their own agency with social structures in order to form their self-identity; neither is more powerful than the other. People make society, but are at the same time constrained by it. In this period of “high modernity”, (Giddens 1991) self-identity is best examined as a set of biographical narratives, social roles, and lifestyles that is created, maintained and revised by actors. These personal narratives must continually integrate events that occur in the external world and sort them into this ongoing story of the self. “High modernity is distinctively future-oriented, a society of abstract systems, with no foundational truths, a society of experts...and a world of risk in which we need constantly to remake ourselves” (Zadoroznj:273).

This was an important perspective to incorporate into the analysis of the interviews in this research, as the context of contemporary childbirth embodies a variety of discourses that actors must make sense of, exemplifying “high modernity”. Even as Giddens acknowledges that structure can be constraining to actors, he believes the importance of structural constraints have been overstated through the years in the social sciences. He stresses that agency of an actor is possible and will demonstrate itself in some social form even in the face of constraining structure. With regard to this research, agency continues to exist in the face of the overwhelmingly powerful biomedical structure of our healthcare

system. Midwifery as a social institution posits itself against the biomedical institution and demonstrates a way in which social actors engage their own agency in order to form their identities as women who are in control of their bodies and their social selves. Analyzing the “personal narratives” of the women who subscribe to this model of birth reveals the ways in which these women establish self-identity and inform their future behavior as social actors. To me, it was important to determine if the women who use midwives and the midwives themselves value this sense of agency or freedom from constraining social structures, and to explore the way in which their decisions and lifestyles may be reflections of this.

3.7: Leininger’s Cultural Care Diversity and Universality Theory

Although this theory technically belongs to the field of nursing, it bridges sociocultural perspectives and medical care and is thus important to this research. Leininger offered this unique theoretical perspective as both an anthropologist and a nurse. She advocated for a new definition of medical care that took into account cultural differences in patient expectations; a blend of medical care and cultural knowledge. The central purpose of this theory is to discover and explain diverse and culturally based care factors influencing the health, well-being, illness, or death of individuals or groups (190). In other words, it extends Giddens’ idea of the duality of structure/agency further as it takes into account the way worldview and cultural/social factors such as

education, economics, religion, politics, language, and technology both influence and are influenced by medical care expectations and practices of different communities or institutions.

These concepts can and should be applied to examine midwifery-assisted childbirth. With so few women utilizing midwifery as a model of care for their pregnancy and labor, they should be considered as a group with distinct cultural differences and a unique set of expectations of care. Looking at the practice of midwifery through this theoretical lens will offer a sociological perspective of these women as a subcultural group navigating their way through “high-modernity” and a variety of discourses surrounding childbirth. It is important to examine these women’s cultural expectations in order to answer larger questions about midwifery as an institution and what it offers women culturally that the biomedical model is lacking.

CHAPTER 4

METHODS

4.1: Data Collection and Respondents

This research study is qualitative in nature and based on semi-structured interviews. The interviews focused on midwives (n=6) themselves and women (n=6) who have had children using a midwife only, no conventional deliveries, within the last two years but who are at least six weeks post-delivery. I believed it was important to speak with both midwives themselves and the women who utilized their practice in order to get a well-rounded idea about what the practice offers in relation to a more conventional treatment.

My decision to interview newer mothers was an effort to capture an experience that is still very fresh and salient to these women in their everyday lives. However, I also believe it is vital that participants were at least six weeks post-partum for the very same reason; so that the childbearing experience has had time to synthesize for the new mother and she can talk about it as objectively and honestly as possible. The participants were recruited via snowball sampling. In September 2010, I began the process by contacting local midwives in the area that I knew personally. I informed these women that I was beginning research for my master's thesis and wanted to focus on the practice of midwifery and the

women who used midwives in their birthing process. These midwives then recommended others for me to contact in the area and mothers whom they knew from their practice and thought may be interested in participating in the study as well. I then followed up these leads via email or phone contact. I also obtained the list of all statewide licensed midwives and birth centers available on the website of the Department of Health and Environmental Control (DHEC). Again, I made telephone and/or email contact with the midwives. Upon contacting these women, I informed them of my research objectives and sent them a copy of my letter of invitation/consent when possible stating the details of my study, including the criteria of the mothers I was looking for, as previously mentioned above.

By using “purposeful sampling”, a recruitment technique based on targeting participants with interests in line with the topic under study, it is possible that some biases could exist within the data (Westfall 2004). However, the strengths of the method outweigh the risks, as they allow for extremely information-rich cases in which one can learn about issues central to the purpose of the research (Westfall 2004). Also, this informal method of sampling is logical, as midwives and the women who use them are a very small and close-knit subculture.

I am not a member of this sub-culture. In fieldwork, as Lofland and Lofland explain, in order to be successful as an outside researcher, it is best to

“enter negotiations armed with *connections, accounts, knowledge, and courtesy.*” (1995: 37). I have used my limited *connections* to a few midwives in the area to gain access to my subjects, I have given them an *account* of the objectives of my research in such a way that makes sense to them, I have positioned myself as an eager *learner* about the practice of midwifery, and I have been *considerate* with these women as I contacted them and recruited them as participants, working around their schedules.

The interviews took place at a time and location mutually agreed upon by the participant and myself during the early months 2011. There was only one meeting with each participant, and that meeting consisted solely of the respondent and me (discounting any children present). If any interview required follow-up or clarification on my part, I had the preferred contact information of the participant and thus was able to get in touch with them to clarify.

The interviews are semi-structured in nature. I compiled a list of questions and topics that I wanted to address with my subjects, what Lofland and Lofland (1995) call the “interview guide”. I placed the more formal and demographical questions first on a “facesheet” for the respondent to fill out by hand, and the more open-ended conversational questions after. I asked the respondent these questions aloud. There was a separate paper copy for each respondent to refer to as well. Depending on the level of comfort and vulnerability the respondent demonstrated in speaking with me, I up took their responses and replied

accordingly to steer the conversation in a way that addressed my research questions as specifically as possible without being overly leading. These uptakes of interview responses according to ideas I want to know more about as the researcher are called “probes”. This on the spot tool allows for spontaneous amplification or clarification of responses.

The hope for this research was that the interviews became “narratives” of experience (Zadoroznj 1999). This approach allowed these women to “tell their stor[ies] in ways that ‘make sense’ to them and hence brings into view their reflexivity as well as highlighting shifts in their subjective and lived identity” (274). Lofland and Lofland (1995) describe this method of fieldwork as “intensive interviewing”, or “a guided conversation whose goal it is to elicit from the interviewee...rich, detailed materials that can use used in qualitative analysis.” (18). Intensive interviewing seeks to “discover the informant’s experience” (18), thus it was the appropriate methodology for this research.

Lofland and Lofland also suggest that a successful investigator presents herself as non-threatening and acceptably incompetent (1995: 56). By being non-threatening, it is meant that the investigator takes on an attitude of interest, sympathy, and support and leaves behind any ridicule, disinterest, or self-confidence. By the same token, an acceptably incompetent researcher is one who is constantly watching and asking questions because she or he is ignorant on the subject and needs to be taught. It is with this attitude that I conducted my

interviews and hopefully got the richest and most honest responses from my participants.

The interviews themselves were recorded using a simple audio recorder (Coby 1GB Digital Voice Recorder), which the respondent was made aware of in the letter of consent/invitation to participate. The participants were all assured in the same letter that their recordings will be heard by no one other than myself and that the audio data will be destroyed after the transcription process and analysis is complete if they so choose. The subjects' anonymity was also guaranteed.

Simple field notes were also written to assist with the data analysis process. These were either taken during the interviews themselves or immediately following the fieldwork. Researchers have suggested that field notes enable extra-interview details such as time of day, characteristics of the respondent, emotional tones of the interview, and personal feelings, insights, or reflections to be jotted down and later incorporated into the data if relevant and enriching to the analysis (Lofland and Lofland 1995).

4.2: Transcription, Coding, and Analysis

I used the *thematic analysis* method derived from grounded theory. Thematic analysis starts with identification of themes built into the interview questions (control, autonomy, agency, achievement, independence, respect). Then, deeper analysis looks into themes that were not built into the interview

questions, but rather emerged from the data. Constant comparative analysis of these themes lead to the emergence of categories of data (Glaser and Strauss 1967). To be more precise, the first step in this methodology was to code the data, classifying individual pieces into as many categories it fits into as possible. These categories emerged through the experience of collecting and analyzing the data. As I made generalizations about the data and was able to state that a specific entity/interview comment was an example of a specific category or *theme*, I took note of it. As my analysis continued, categories were created and further and further refined.

Qualitative data on the topic of birth and midwifery, such as the interviews conducted in this study, is frequently analyzed via this methodological framework (Westfall 2004, Hyde 2004, Fraser 2007, Lazarus 1994, Zadoroznyj 1999, Fox 1999, Shuval 2008). One of the strengths of this method, as Westfall states, (2004:1401) “is its ability to bridge positivist (hypotheses-testing) and interpretive (hypotheses-generating) methodologies by translating qualitative data into forms that can be interpreted and evaluated by ‘hard’ scientists”. The following chapter will be devoted to thematically exploring the findings of the interview analysis process.

CHAPTER 5

FINDINGS

The following chapter will be devoted to examining the findings of the interview analysis process. Specifically, each theme will be presented in its own sections, with subsections devoted to examples of that theme in nuanced ways.

5.1: Control

5.1.1 - CONTROL BY CHOICE: The primary aim of this research was to look at how this sampling of women talked about control in the pregnancy and childbirth experience. It quickly became clear to me while analyzing the data that control is a many faceted word, defined differently by each individual. The first common way that control seemed to be referenced in regards to the midwifery childbirth experience was in this idea of choosing the circumstances surrounding pregnancy and childbirth, specifically labor and delivery. Many of these women believe they enacted their agency against larger structural restraints, i.e. the conventional hospital birthing system, by choosing alternative birth plans. For example, this mother of one, Amy, was great at articulating what she didn't want her in birth experience: "Well, I definitely wanted more control and I knew, in the hospital...they have lots of rules...and policies and protocols, and I knew I

did not want to follow them." She wants to avoid all those features described earlier in the biomedical model, with the authority resting in the practitioner and not the patient. This follows Novik's research (2009) that a substantial group of pregnant women perceive standard prenatal care to be dehumanizing and harsh.

The same mother also mentions that these policies and protocols come from people outside of the immediate situation but who hold power in the institutional setting: "Being able to kind of make my own decisions and not have to be forced to try...arbitrary...policies that come from the higher ups...based on...power, you know." Giddens' idea about individual agency and social structures truly resonates here; this mother is balancing the power of her agency, her choice to use a midwife and deliver in a birth center, with the larger social structure of the biomedical model in order to shape her identity as a social actor. She has been constrained by her lack of options in conventional prenatal care, but she has demonstrated her identity as a woman who is in control of her body and social self by choosing to participate in this alternative birth system.

Another mother of one, Rachel, echoed similar sentiments when she was asked about what control meant to her in her decision to use a midwife:

"To me, the biggest control was choosing to go to the Birth Center. I felt like I was in control of my birth in that I decided that that was where I was going to go with the midwife that I had researched and the research that I had done, so I felt very much in control that this is the choice I was going to make."

She has used the power of her choice to give herself the pregnancy and birth experience she wants. She has done the work of researching her options, and her

ability to follow through with the one that she prefers is once again how she enacts her agency. This confirms Lazarus' (1994) findings that a mother's knowledge and her access to it had a direct effect on her ability to articulate her choices and thus control her childbearing experience.

An extremely interesting idea began to emerge in the data; when a mother enacts her agency/control and chooses the circumstances surrounding her birth, she could then let go of control once the process of labor began. For example, as Rachel puts it: "I felt very much in control because I chose to be there and then I was willing to then turn it over to somebody else to tell me what to do." So, this woman's deliberate choice in designing how and with whom she would birth her baby resulted in her fully being able to relax and allow the person with whom she has built trust guide her through the experience.

Along those same lines, Rachel says that when the experience of labor began, she became vulnerable because of the lack of control she felt, and looked to the midwife for assistance in the process. She trusted in the midwives experience and knowledge of childbirth and leaned into them when she needed to:

"The control that I felt was that I went in there 100% confident that that was where I wanted to go and where I wanted to be but, once I got there, I think I gave up control and let the midwife [control when] to get out of the tub, stay in the bathtub...and I just kept yelling at them to tell me what to do."

"I wanted control over my choice to use a midwife. It was empowering to me. Once I made that choice, I was willing to give up a little more control to the midwife because I trusted them."

Because the mother feels confident and safe in the situation she has created via her agency, she can relinquish the need to control the immediate situation.

Howell-White (1997) had an unexpected result when the mothers in her study who had a lower desire for control were more likely to select a midwife as a birth attendant. I believe this can be explained via the different conceptualizations of control. It seems that nuanced shift takes place in terms of control in the choices surrounding childbirth and control in the actual labor and delivery process itself. Mothers who use midwives desire more control in setting the circumstances of their birth, but they are ok with having less control in the labor process itself, i.e. control over pain, control over their bodies, control over nature itself.

5.1.2 - FACILITATORS OF CONTROL - The midwives interviewed in this study also made it very clear that one of their most important roles was to support and facilitate the mother's maintaining a sense of control in the prenatal and labor experience.

"The mom has most of the control. As midwives...unless it is something totally unhealthy or against our regulations...we pretty much let them do whatever they want to and we are just kind of there to oversee and watch and help them, if they need help."

Obviously, this midwife, Anna, sees the ultimate authority resting in the mother in terms of the labor process, exceptions only being made in the case of dangerous or illegal circumstances.

When the mother is in the most difficult parts of labor and finds herself feeling very vulnerable and unsure of herself and her abilities, however, a midwife steps into her role as an emotional facilitator and a pillar of strength for the mother, even an advocate, as illustrated in the second passage:

"They are so proud of themselves for having done this and sometimes they need us to be strong for them...we can encourage them and say, you can do this. And you wanted this, and here's why...sometimes all they need is that verbal encouragement and they are fine." (Kathryn - midwife)

"Control is...a really delicate issue when you come to birth because there are moments...when you cannot physically move yourself because you are in the thralls of labor. I think respect is almost more important because there is a point at which you do relinquish control. You can't actually speak...you have to trust that your husband or your partner...maybe a doula...someone can advocate for you and fully understand." (Elizabeth - mother)

I believe Kathryn's comment above about reminding the mothers that this is what they wanted, and this is the childbirth experience that they chose, reveals that in this subtle way, midwives are in fact giving control back over to the mother herself. They are also empowering the mothers with their encouragement and strength, proving they have confidence in the mother's ability to come through the experience successful. The second passage above comes from a soon to be mother of two, Elizabeth, who mentions the physically confining nature of labor itself and the idea that her midwife was a trusted advocate for her in those moments. Again, it seems that these women who use the midwifery model have chosen to surround themselves with people who will literally advocate for them and help protect their wishes and best interests when they become vulnerable and compromised by the labor process.

5.1.3 - THE BODY TAKES OVER: Along those same lines, there emerged from the data this theme that once the mothers are in labor, the body literally takes over the control. For the most part, these women are prepared for this experience, however, because they have put themselves in a situation where they feel safe in allowing the body to call the shots, and they have faith that their bodies are capable and knowing:

“My mind was not in control at that point. My body really took over, and I let that happen and felt safe enough to let that happen...there were things that were happening and I...I was just trying to let them happen. In terms of decision making, though, I still felt like I was in complete control of my decisions in labor.”

Anna, who is both a midwife and a mother who gave birth using a midwife, is quick to point out that she still felt able to make decisions for herself, however, even amidst the chaos of the labor experience. I did find it interesting that the distinction is made between the body and the mind, because it connects back to the idea that the body is a machine, but not a faulty one as it is seen in the biomedical model of care. Instead, here the female body is celebrated as having the innate knowledge to handle the childbirth process, and this perspective posits these women as naturally capable and strong, as in the natural childbirth model (MacDonald 2006). This soon to be mother of two, Katie, explains:

“The thing is...our bodies are in control, so, I mean, its not even like...its not even us as a woman. It's literally my body was in control...You are along for the ride. So your body is in control, so no midwife, or even you really, can control what is going on because it is just going to happen, You are having a baby.”

The data was full of example of midwives reminding these mothers to trust the body, to remain flexible once labor began, and to let go of the need to control every detail of the birth plan they may have envisioned:

“So, I credit my midwife of doing a good job of taking me away from thinking that I was going to control the situation and...I would be dishonest if I did not say that I was going to, like, have a picture-perfect birth, but I think my midwife did a good job of reminding me regularly...that I might not have control over all of this.” (Rachel)

This is important to take note of because it again highlights this nuanced shift in the way control is thought of in the midwifery model; many of these mothers have a strong internal LOC as mentioned in Zadoroznyj’s research (1999). They believe that what happens in one’s life is the result of one’s own actions. So, it may be hard for them to begin to allow the body to take over as labor begins. The midwives assist in gently reminding them to be more flexible and allowing of the labor process to handle things. It also highlights the power that the midwives have in the relationship and the power that their expertise has in assisting the mothers:

“It took my body breaking me down a little bit from that too because I was very much in my head, you know, like I thought I was in labor and they told me I was only one centimeter dilated and I was mad...I had a couple of midwives in [the room] at the time...[saying] nothing is changing. [I said] Give me something to do to make this change. I wanted to have more control over the situation than I did.”

Rachel specifically says that she was “in her head”, or that she was having trouble with feelings of powerlessness and allowing in labor and delivery. She references her body as “breaking her down”, or softening that strong internal

LOC. It is also noteworthy that she looks to the midwives to offer her options to feel involved and purposeful in these moments of vulnerability. The options that midwives give mothers in order to help them feel more control are an important feature of the midwifery model and will be further discussed in the section on active participation.

5.1.4 - NEGOTIATIONS: Sometimes in the pregnancy and childbirth experience, situations arise and decisions have to be made that require both the mother and the midwives' input. When looking at the data, it became clear that there was a process of negotiation involved in these interactions; a give and take of control between mother and midwife:

"One of the first things I say to moms is, I need for you to be flexible. Please do not come in with an agenda...Most women are very...understanding about it and they want suggestions. They want ideas. I see, probably someone who came in that needed to have a tremendous amount of control over everything would not be a good client for us to work with because I am willing to be very flexible. If they are not willing to be, it is probably not going to work."

This midwife, Mary, expressed the need to set the boundaries up front, during prenatal consults, clearly outlining the expectations she has of their shared understanding and power for the decisions that lie ahead in the pregnancy and labor events. She articulates that she will be flexible in her role as caregiver and she fully expects the mother to be flexible in her needs as a client. She goes so far as to say that mothers who are clinging tightly to control would actually not be good clients for her to work with. This was an interesting comment because it was initially expected that the mothers who chose to go the midwifery route

needed to have a heavy amount of control over the birth. It is becoming more clear that their control, however, was expressed again in their choosing an birth attendant who would be receptive to their opinions and needs, and treat them with respecting and trust in their choosing responsibly based on the facts midwives give them.

Furthermore, Mary and this midwife, Kathryn, reference the idea that mothers are hungry for midwives' knowledge and suggestions when it comes to decision making, and they respect that these midwives are experts in the areas of pregnancy and childbirth:

"We educate them, we give them the facts, and we do give them the ultimate control. They call the shots based on being given a clear picture of the facts. That's not to say we can't influence one way or the other because absolutely we will...but the decision ultimately lies with the mom."

"Letting them feel like they have the choice and yet they do understand if we feel it is important and that is not usually an issue, but we give them that power back...we follow mom's leading...what does she want, you know, and encourage her. We are going to make a lot of suggestions, but you do what is right for you. If it is a need, you are going to know the difference...we are going to say we need you to...and because of the relationship and the trust we have built, they understand and they do it."

So, Kathryn puts the ultimate power or control of the situation back in the mother's court when it comes to making decisions, and states that midwives will make lots of suggestions, but mothers should do what serves them first and foremost. However, she explicitly states that if there is a need that arises, the rhetoric used to describe the situation will change, and the mother will understand the difference. She also alludes to the power that midwives can

potentially have if they choose to use their expertise to influence a mother's decisions.

5.1.5 - EMERGENCY SITUATIONS: Along these lines, sometimes there are emergency situations that do arise in home birth or births at birth centers. In these instances, decisions have to be made that can potentially directly impact the health of the baby and the mother. Respondents were asked about who has control in emergencies and how these important decisions are made, and most answered that because of her expertise, the midwife would be relied on in times of need to make the call to transport to a hospital or call an ambulance.

"I would have relied on [the midwife] to say, you know, its time...or if [the midwife or my husband] had...said...we are worried..I really would have relied on them. If you are in labor...you can't really make an informed decision, I don't think. I think its hard to." (7)

Anna also references the idea that in a vulnerable time or an emergency, she may not have felt confident or comfortable with any decisions she had made. She would have relied on trusted others, the midwife or husband, to have her and her baby's best interests in mind.

One midwife, Mary, spoke specifically about a very dangerous situation that arose when a mother she was working with refused to transport to a hospital at both her and her husband's urging. When speaking about the situation, this midwife was physically showing symptoms of anxiety; breathing heavily and wringing her hands; obviously it was a very emotional moment for her. She spoke about how the situation could have been "catastrophic" and that

they could have lost the baby or the mother. EMS was called and yet still, the mother could not be transported to the hospital until she consented to it or passed out. Mary clearly stated that this is a very extreme and rare case, but it has made her aware of how she handles negotiating control when she takes on new clients now:

“Her refusing to transport made everybody really uncomfortable, so when I sit down the first time with couples, I tell them, you know, if we see a problem, then if you are going to be in my care, then we are going to agree to transport if there is a problem.”

She now explicitly states up front that if such an emergency arises, the mother will agree to transport to the hospital, thus negotiating control in the childbirth experience.

5.2: Achievement, Autonomy, and Independence

5.2.1 - COMPETITION: The second theme that emerged in the data answered questions about the characteristics of achievement, autonomy and independence in mothers that choose midwives as birth attendants. The respondents were questioned about any notion of competitiveness within in the midwifery model. Not competition with other mothers necessarily, but competition with themselves; the idea being that achievement oriented or type A individuals would be more likely to choose a model of care where more responsibility and participation is demanded on their behalf, from lack of pain medication to more direct involvement in prenatal care and decision making. The data did show

some of those characteristics, but also a much deeper understanding of a woman's trust of her capabilities in labor and delivery:

"[The] thing I often hear is...you must have a high tolerance for pain, you must be competitive. That wasn't really it...from a feminist perspective...we are made to do this, we can do it. So, its not I think competing..." (8)

This mother of two, Sam, did not feel like she was being competitive or achievement oriented in her decision to use a midwife and have a home birth. Instead, she articulated that she was simply doing what she was made to do and was completely capable of handling. She is exploring the limits of her strength as a woman and empowering herself with her decision to use an alternative birth plan. Just as in Howell-White's research (1997), women selecting to use a midwife here viewed childbirth as a normal and natural experience.

Specifically, Anna mentioned a story she had read in her undergraduate studies of women in Africa who went off by themselves to give birth, completely unassisted, and then returned to their village. She then said, "If they can do it, I can do it." She was empowered by other women's experiences, and allowed those stories to shape the expectations she created for herself. She believed herself capable of achieving this ideal birth: "Yeah, I did it. I did it. I did it without the pain numbing medications that everybody uses. I did it...the way they did it a million years ago...I did the same way they did with nothing but a friend, a midwife..." As MacDonald (2006) noted, natural birth becomes a sense of empowerment to these women, here they experience a sense of

accomplishment that positively informs their sense of self “not only as women and mothers, but also as persons” (236).

On the other hand, there were some mothers that were interviewed who spoke about using a midwife in a more competitive manner:

“I wanted to defy the expectations and have it all just go perfectly...I mean, I knew I would have been disappointed in myself if I caved in or if I had transferred...There was a little bit of, I wanted to walk that talk because I had been talking about it so much.” (3)

Rachel admits that had something gone awry in labor or if she had “caved”, clearly referring to weakness on her behalf, she would have felt embarrassed because she had been so vocal about her decision to participate in the midwifery model. This echoes research by MacDonald (2006) when she takes note of the rhetorical strategies of the ideal of natural birth carrying a “cultural weight” for these mothers. Another mother, Katie, shared a similar opinion in her interview:

“It breaks my heart when a woman has to have a C-section because she has decided to limit herself...Most women don’t want to hear it who are not educated in the beginning...Its hard to educate people who want someone else to think for them, and that is the culture. That is our culture.”

Again, mothers who have chosen to participate in the biomedical mother (or perhaps are forced to for the health of them or their baby) are seen by those opting for midwifery as “limiting” themselves, or not stepping fully into their potential. There is this shared understanding that the mother’s autonomy lies in the responsibility for the birth outcome lying inherently in her hands. I found this theme of competition with one’s self, the idea of being your best version of you in response to the major life event of childbirth, to be relatively widespread

in the women I interviewed. However, I do think that despite this idealism, both mothers and midwives do a wonderful job of keeping the safety of both baby and mother the top priority.

5.2.2 - KNOWLEDGE AS POWER: Another means by which mothers who choose midwives as birth attendants expressed this theme of autonomy and independence is by using their knowledge as power. Even midwives themselves remarked on general characteristics of the mothers they care for, noting:

"I guess that you have to have a...bit of an independent nature...you are expected to have a degree of knowledge and skills...I think you have to be a lifelong learner..." (Jamie)

"When I think of midwifery clients, generally, those are the ones who have researched and researched, and they just want a different outcome...for their labor and their pregnancy experience." (Anna)

These midwives both described their clients to be highly motivated in acquiring knowledge; they have done research on the experience they are about to embark on and are willing to take ownership and responsibility for their part in making that experience successful and live up to the ideal they are hoping for. When Lazarus (1994) examined the ways social class affected pregnant women's definitions of control in pregnancy, knowledge and access to knowledge played a central role. Along those same lines, here it seems that the more knowledge a mother has access to, the more they are able to articulate their choices and control their childbirth experience. Knowledge filters and contracts medical experiences. This knowledge is inseparable from social relationship and experiences, and thus connected to the idea of power. Rachel's response reflects

this idea as well: “They knew I was a bit of a control freak. They knew that I was over educated and was going to ask them a ton of questions.” She openly and even jokingly refers to her high knowledge level as a significant factor in what brought her to the midwifery model of care. She believed it was her duty and a reflection of her competency as a mother to educate herself on all the issues surrounding pregnancy and childbirth. Howell-White confirmed that midwifery users gravitate towards the practice because its philosophy advocates informed and educated clients who want to participate actively in the decision making process.

On the other hand, these women depict the biomedical model as a philosophy that puts knowledge back in the hands of the providers and treats women and incapable and incompetent of acquiring knowledge on their own. The conventional birth models philosophy, in words of Katie says: “Let us think for you, we’ll give you the drugs.” So, as Wendland described (2007), the mother becomes invisible and inaudible as a result of this dismissive attitude towards her and her capabilities.

5.2.3 - ACTIVE PARTICIPATION: Along those same lines, perhaps one of the most noticeable differences between the biomedical model and the midwifery model of care is the amount of emphasis given in midwifery to active participation by the mothers in the pregnancy and labor process. Rachel’s response captures this idea very well:

“If you are choosing a midwife, you are...an active participant in your birth process because you are saying, I want to trust my body and trust myself that we are going to get through this together. We do not need a lot of external assistance ...There is so much at the hospital that becomes passive. You lie there and things were given to you, done to you. You get checked every hour...You do not need that kind of thing. There is an incredible sense of empowerment [in midwifery], and you made the choice to be empowered.”

When Mansfield looked at natural childbirth (2007), she also found the theme of activity during birth to be very prevalent. Being an active participant enables the mother to be empowered and avoid the role of the passive patient. Instead, mothers feel confident and in control of their experience because they actively and autonomously sought out the circumstances of their birth experience, from an increased role in preparations before birth to being given processes by which to actively increase the success of labor and delivery. This midwife, Anna, characterizes many of her clients' desires here:

“Sometimes they have an lot of ideals of what they want and an awful lot of times they have more of an idea of what they don't want. They don't want to be strapped down to a bed. They don't want to have continuous monitoring...”

Again, these women want to step outside of the role of the passive patient. In the biomedical model, there is an alarming lack of prenatal counseling, consent before procedures are done, an abundance of rushed visits and dismissive attitudes (Rosenthal 2006, Novick 2009). Women who choose to step outside of this model are longing to be treated with the respect they feel they deserve. More specifically, in this case they long for meaningful ways to directly feel purposeful and empowered during the childbirth experience.

One way that midwives give mothers this in a tangible way is through the multitude of positions laboring mothers can choose from. One midwife (interview 9) talks about the choice of positions as a distinguishing feature of the philosophy because it is so rare to find a physicians who allow women to deliver in different ways. The biomedical model has been attacked for this because the standard position of labor for a woman in a hospital setting (on her back) is seen as serving the physician rather than the mother. Because in this position a doctor can see much more clearly than any other way, it benefits him more than the laboring mother, because it is usually one of the more ineffective positions for delivery. Midwife Kathryn remarks that in the biomedical model there is a “standard...it has to be a certain way, when [doctors] don’t realize that it needs to be what she mom needs it to be.” For midwifery clients, the best way to deliver is the one that the mother feels most effective and comfortable in.

Another way midwifery clients are active and autonomous in labor and delivery is through processes offered to them by midwives for managing long labors or times in labor where little progress seems to be made. These are tricks or mechanisms midwives use to make mother feel like they are actively affecting the outcome of their labor. For example, mother of one, Rachel, mentions the “rotisserie” process she employed in labor: two contractions on your back, two contractions on your side, two on your belly, and two on your other side, etc. At this mother’s request for something she could do to feel control in the situation, the midwives gave her this tool. She told me:

"I have no idea if it actually works or if it...just gave me something to do to think that I was doing a process...looking back, I have no idea. But that is what I wanted. I wanted them to give me some way to feel like I was still in control, and they did...they gave me a process."

So, the different techniques employed in midwifery allow women to avoid the role of passive patient and fully satisfy their need for autonomy, independence, and achievement. These and other aspects of the midwifery philosophy including the space for mothers to be knowledgeable partners in their pregnancy and labor process, enable mothers in, as midwife Kathryn remarks: "finding a voice...more people are learning that they can question, that they can play an active role in the decision-making as to their health in general."

5.2.4 - SELF OWNERSHIP: Along these lines, the idea of self-ownership creates conditions under which women believe they should be accountable for decisions that affect health outcomes. Comments referring to such an idea emerged in many of the interviews with the midwives:

"For someone to choose a home birth, they have to have a level of autonomy. They have to be at a point where they understand the responsibility of having it at home because it is a huge responsibility because you are making a statement that, I am going to do this for myself. I'm not going to just lay over let someone do it for me." (Barbara)

"I mean, somebody who is going to do something this outside of the norm is typically going to be fairly motivated and have researched it...Most of these women truly want what is best for them and their baby and, in doing research...will...want low intervention..I want to be treated like an adult with a brain. I want to know what is going on and to have a say, to have a voice." (Kathryn)

"I feel like our clients have the...wherewithal to stand up and say this is what I want, so that is why they are doing [it]. And they have the desire to do it the way they want to do it, not the way they are told to do it." (Anna)

These midwives all commented on the idea of autonomy: conscious decision making, taking responsibility for birth outcomes, and demanding to be treated with respect by their healthcare providers. As in Zadoroznyj's research (1999), the women in this group are perceived by their midwives as having a more internal LOC, associated with better-educated, higher income individuals. This internal LOC is demonstrated in these mothers feeling a strong sense of their own part in determining the outcome to health care experiences.

This characteristic cannot be narrowed down to a specific personality trait, however, such as a type A or anti-establishment mother, as midwife Barbara explains:

"It goes back to owning their body and that self respect and self ownership...You see type A people because they want control of it, they want to out of the hospital and [then] other types of people...think control is in the hospital. Thousands of years have gone by with women doing this, and that is empowering..."

"You can't even narrow it down to someone who is...anti-hospital...I think that all [these] women recognize that birth and childbirth is not a sickness, so it does not need to be treated as a sickness, which is what you get when you to go the hospital...I'm not sick, I'm just having a baby."

The universal similarity in the women who choose to use a midwife seems to be this idea of owning your body and yourself, and empowering yourself by connecting to your innate strength and capabilities as a woman. Finally, Barbara emphasizes that these women are not afraid to ask the tough questions, and to question faith and trust in a conventional medical system that does not seem to serve them or empower them: "I think that women who...come to midwives are

women who want to be liberated from that blind faith, blind trust and want to be able to take their health into their own hands.”

5.3: Respect for the Mother

5.3.1. - RESPECTING MOTHERHOOD: The third theme that emerged from the interview data was an overwhelming respect for the mother. Specifically, many of the interviewees had an enormous amount of respect and reverence for motherhood itself. These two examples, the first a mother, Rachel, and the second a midwife, Barbara, reflect this:

“[A midwife is] someone who is going to see you at your absolute most intimate vulnerable time...someone who is going to guide me through a process...part of the labor process is that you lose all inhibition, so you want to know who you are going to have no inhibitions with.”

“It's precious to be a part of...the most intimate moment in their life where they are just laid bare and to...be the person that...potentially ...first touches someone when they come into the world. That's precious, it's absolutely precious.”

The remarkable thing about the midwifery philosophy is that it has such admiration for the process of childbirth and the miracle of life, and thus the women that it is serving. In the eyes many of the midwives I interviewed, they see themselves as lucky to be allowed to be a part of such a transformational time in a woman's life. Women who choose midwives as birth attendants seem to be looking for care from those who share their cultural values on motherhood, and in midwifery they find they support and respect they desire in this extremely intimate time. I also found it interesting that the mother above noted that birth is

a time when a woman loses all inhibition, and she wanted to specifically choose someone who she felt safe in that vulnerability with.

Leininger's Cultural Care Diversity and Universality Theory advocates for a new definition of medical care that takes into account cultural differences in patient expectations, and these responses from the data are a perfect example as to why there is a need for that (Leininger 2002). This helps explain why this subgroup of women has such different expectations and medical care practices than the norm and why midwifery as an institution fulfills what the conventional model is lacking for this community.

Midwifery also posits mothers as central actors in the childbirth experience, with all other social actors facilitating her, unlike in the biomedical model. This reflects this respect for motherhood once again. Midwife Jamie describes that respect as creating a social support system that empowers mothers and enables them to look back on their experience fondly:

"The midwifery model of care basically...should be about...coming together and supporting this woman in a process that is difficult but doable and one that...she is going to look back at with a lot more joy and far less depression than someone who feels like her voice has not been heard..."

These responses are all in line with Fraser and Hyde's research (2007), which found that the main reasons midwives went into the field were to empower women and because they believed it was a privilege to be a part of such a life-changing experience in a woman's life. Jamie also said:

"I think most midwives go into it because they love birth...They love the process. They are enamored. They have a great desire to help women at this

point in time. [For me it was] that I did see women weren't getting supported in their choices."

Midwives seem to be in love with and have the utmost respect for motherhood in general, and the care that they provide their clients reflect this. These women see themselves as co-creators and facilitators of positive experiences of pregnancy and childbirth, "being with the women to support, empower, and care for her, and to create the right environment for their positive images of birth to be fulfilled" (Fraser and Hyde 2007:314).

5.3.2 - CAPABILITIES AND CHOICES: Similarly, inherent in an immense respect for motherhood is the belief that women are fully capable and made for such a moment. Midwifery posits women as fully competent and able to successfully take on the experience of pregnancy and childbirth. The mothers, for the most part, call the shots on what they are capable of and where their limits lie:

"I view them as being intelligent women who have read and researched and studied and are capable of making intelligent decisions...In the hospital setting...these women are not told why something is going to happen, and they go and refuse something because they don't understand, whereas if you just treat them as though they are adults who are capable of understanding and explain the why behind it, then they are usually going to agree to it."
(Kathryn - midwife)

Midwives communicate and interact with mothers from a place of equality, from a place of respect, and this respect filters down into the decision making process. Where as in the conventional hospital setting, many women are not given thoughtful answers or explanations when they ask questions, midwives believe mothers are intelligent enough to deserve this. They also articulated

that when you treat mothers in this manner, the decisions then made by her are usually well thought out and responsible. She has her and her baby's best interests in mind.

The ability to treat women in this way is described by many midwives as giving mothers options, and allowing them to choose what works best for them and their birth experience. This appealed to midwife Mary in her decision to pursue such a career path: "I think what appealed to me in being a midwife was the giving women the opportunity to have options..." As Fraser and Hyde (1997) noted, a major reason that women who go into the field of midwifery do so is because they wish to empower women in their experience of motherhood. Overall, midwives trust in a mother's intuition and judgments about what she feels comfortable and capable of doing. Mother Rachel articulated this in her interview when she said:

"[My midwives had] respect for the birth process and then respect for the mother to do what she needed to do, and even if what I needed to do was go to a hospital and I told them that, they would respect that decision...they had no judgment at all."

Rachel felt that if she had decided she needed to transfer to a hospital to deliver for whatever reason, the midwives she had chosen would have trusted her decision without any judgment or hesitation. Along those lines, midwife

Barbara echoed similar sentiments:

"You have to be respectful of the woman's choice in every area because it is her choice and even if you have a set of standards or beliefs for your life...you can't bring any judgment...[its important] that there is a level of respect...anytime you are in a conversation, if you come to [it] with disrespect

or even body language that could be demeaning...[a] response is going to come..."

Midwives have to leave any judgments at the door and simply trust the mothers whom they are caring for to call the shots on what they are capable of. The decisions made during pregnancy and childbirth, especially during labor, are a reflection of this respect.

5.3.3 - STANDARDS OF CARE: A final way that the midwifery model of care shows respect for mothers is by its care standards, specifically in terms of prenatal care and office visits. Midwives spend significantly more time with the mothers in their care, developing deep relationships with them and getting to know their emotional needs and personalities. Midwife Mary described the standards of care as "one of the things that we do a little bit differently" than conventional medicine. At the beginning stages of pregnancy, a full hour is given to prenatal appointments, because at this stage mothers have a lot of questions and midwives want to make sure their needs are being met. Later on, visits drop back to 45 minutes. Mary remarked that it only takes about ten minutes to do the clinical parts of most office visits, and that the remaining time is allotted to getting to know the mothers personally, and "finding out what their likes and dislikes are, and we are finding out how they cope with stressors in their life. That help us to be able to help them in labor." Clearly, mothers are given the opportunity to work through any emotional issues or fears that are to be expected with such a life-changing event as having a child. This is very

empowering and facilitates them throughout the entire pregnancy and childbirth experience. These two responses, the first from midwife Jamie and the second from a mother, Rachel, both reiterate this standard of care:

“Home birth and midwifery care really does support the woman and listens to the woman...the fact that midwives provide so much time in prenatal is tremendous because you don’t get to birth without having some knowledge of the woman...by the time we get to birth we have a connection.”

“The negotiation to me, all of it goes back to trust. I trusted my decision to choose them. They built a trust because they did all of my prenatal care and walked me through so many scenarios and talked to me...”

The institution of midwifery really does get to know the mother herself, her needs, desires, and fears. It posits her as the central player in the birth process. The relationship between midwife and mother is built over the course of her prenatal care, and the foundation of that relationship is trust and understanding. That “connection” allows both parties to feel prepared and capable when the moment of labor arrives.

Another way that midwives indicate their respect for the mother is by the rhetoric that they use while they are providing care. As midwife Kathryn emphasized, permission is asked of the mother to do anything, such as checking the cervix during labor, prenatal tests, etc., rather than her being told. Within this dynamic, the mother always possesses the right to refuse. This posits her as capable and empowered. On the other hand, in the conventional care setting, midwife Mary saw doctors as overpowering and condescending:

“[Midwives] show a certain level of respect, that women have brains and can do the research and can decide what they want and that they are capable of

making those decisions...capable of understanding a very simple chart. But instead [with doctors], we have to elevate ourselves and make you feel stupid...so that you won't ask any questions because you are taking up my time."

From her perspective and experience with obstetricians, mothers often feel dismissed and unheard, basically disrespected. She sees midwifery as an institution that offers mothers the respect and the answers she did not feel like they could get from the conventional birth option. In midwifery, as mother and midwife Anna stressed: "I definitely was a person and not a number, someone who just showed up."

Additionally, it seems that some women come into conventional care birth settings with a birth plan that might veer slightly from normal; perhaps they want to deliver naturally, or perhaps they do not want their umbilical cord cut right away. According to two of the midwife respondents, any variation from the norm, or any deviation from the doctors' standard of care, is extremely hard to follow through with.

[In the conventional setting] "a lot of women who would be educated, they would be informed, they would have their birth plans...they would just go in they were just not respected...they did not have the tools to get through. They weren't given the support..." (Jamie)

"[In the hospital] I don't think you have that continuous support in labor there if you're relying on someone else to provide that...I think it would be very hard to stick to what you want to happen or what you hope to happen and to have your wishes respected when you are in a situation that has more rules or different expectations or different time lines ...I think it is really hard." (Anna)

In midwifery, alternative plans are the norm, and time is taken with each mother to establish a relationship that facilitates and supports her vision of birth:

“You develop a relationship with a client, and it is just that, it is a relationship...spending time together....you are walking with her and spending time and educating...” (Barbara)

Whereas in conventional obstetrics, the overbearing rules, lack of tools and support, and overall different type of expectations makes it much harder for a mother to have a unique childbirth experience.

5.4: Natural Birth as Social Movement

An unexpected theme emerged from the data concerning midwifery as a social movement. Since in recent years the institution has experienced a resurgence in popularity, it makes sense that respondents would speak about midwifery in these terms. Social movements theory, specifically deprivation theory, argues that that people who are deprived of things that they feel are valuable join social movements with the hope of obtaining them (Merton 1938). If the conventional model of care was increasingly not adequately addressing the needs of some mothers, it follows that the alternative institution of midwifery would grow and expand as a result. A desire for improved conditions based on what this group of women feel they deserve sparks an interest in and awareness of other options.

5.4.1. - THE SPARK: Many of the women I interviewed spoke about their particular journey into the midwifery movement. They often cited experiences

where there was a spark; a moment of clarity where they understood that there were other models of care to serve them and where they understood that they had the right to play an active role in their health care decisions. In these moments, they realized that midwifery model more adequately addressed their needs as women, and they sought it out as their prenatal and delivery care option because it served them better:

“It started with a germ of an idea idea and a class...It was the class that interrupted everything you had been told about...I realized there were options I had...but I did not even know that there were options until my senior year of college, and the rest of it was research that I did on my own.”

“I think that midwifery is growing and becoming more popular because women are realizing, some of them for the first time, that they have the right to ask questions and to be a part of the decision-making...”

As the first response from mother Rachel indicates, this experienced “interrupted” everything she knew about maternal care. These moments, or epiphanies, lit a fire in these women; they were empowered by this knowledge and then sought out more information on midwifery on their own. The second response, from midwife Kathryn, refers again to this metaphorical veil being pulled away from the eyes of women for the first time. It seem that the reason the movement is gaining speed is because women are realizing their own personal power. Perhaps more importantly, they are realizing their abilities to create experiences that empower them and give the respect they feel is lacking in conventional obstetrics; they are exercising their agency.

5.4.2 - ACCESS TO KNOWLEDGE: Along with that, it seems that more and more women are experiencing these “spark” like moments because the access to such information has increased tremendously over recent years: “I mean there is so much more accessibility now. The internet, television shows, everything...people are realizing...there are such options out there...[and] that normalizes it”. As this midwife Kathryn says, the internet and other media are largely responsible for this increased awareness and access to midwifery philosophy and the shortcomings of the biomedical or conventional birth model. Movies like “The Business of Being Born”, produced by Ricki Lake, and “Birth Story” are being seen by thousands and thousands of women as well. I myself was first truly exposed to the midwifery model of care when I watched “The Business of Being Born.”

There is also reference in the respondents to this idea that with increased exposure to these ideas and experiences, a process of normalizations occurs. The more common place using a midwife or an alternative birthing plan becomes, the more women will trust in it as a viable and safe option for maternal care:

“I think its probably growing because people are hearing more about it, hearing about birthing centers...like me, I did not realize there were any other options...So, I think as people hear about it...it will grow...it may at some point become more accepted because...it is far more cost-efficient than what we are doing now.” (7)

This respondent, midwife and mother Anna, feels that because more women are hearing about these alternative options, the institution of midwifery is growing. Again, after the moment of “spark” occurs, mothers realize there is

another option besides giving birth in the hospital that is safe and legitimate and satisfies their needs as capable and autonomous women. Here is a possible explanation for the recent rise of interest in midwifery-assisted childbirth.

5.4.3 - WOMEN SHARING EXPERIENCES: When women have successful and empowering childbirth experiences, they obviously want to share them with other women, like any other experience they are happy with and proud of.

Mother Rachel in particular talked about how she shared her experience with her friends and saw the “spark” happen right before her eyes: “Several of them were like, I did not even know you could do this. So, I saw the light bulb go off with them....It suggests to me that the biggest step is to know that there are options.”

As women communicated and share these transformational birth experiences within their social circles, it follows that more and more women will be motivated to look into the institution and explore all their options when they are expecting. Also, it seems that this further normalizes the institution and allows women who may have otherwise been hesitant to participate feel as though it is safe; a tried and true option, in other words. Social networks of women will do the job of a kind of campaign manager for the social movement of midwifery.

5.5: Midwifery’s Relationship with Conventional Medicine

Midwifery and conventional obstetrics continue to coexist in the state of South Carolina, with women utilizing midwifery to be the clear minority as previously stated. I believed at the start of this research that midwifery itself as a social institution posits itself against the overwhelmingly powerful biomedical

structure of our larger healthcare system. The ability that these women have to participate in an alternative model demonstrates a way that social actors are engaging their own agency in order to form identities as women who are in control of their bodies and their social selves. However, when asked about their relationship with obstetricians or their thoughts on conventional medicine, it was clear that the issue was not as black and white as previously thought.

5.5.1 - CONTENTION: When asked about the population of women that participates in midwifery care, mother Rachel had this to say: “Its people who don’t hate the system, still like the medical system, but do want another option that seems a bit more trusting in their own body.” So, it seems that while she can identify plenty of shortcomings and faults in the conventional medical system, this mother still sees its place and benefits in society. Midwife Kathryn responded in a very similar way when asked about her relationship with obstetricians in her area:

“I think [midwifery] is offering women another option. I don’t view the medical community as the enemy at all...I am blessed in this area tremendously with being able to consult with OB’s and the high risk OB’s here in town and being able to transport and know that our moms are going to be well cared for. I think that this is what we should have everywhere.”

For the most part, the responses seem to be congruent with this view of conventional medicine; a genuinely non-contentious relationship. Overall, the most common responses I heard were that obstetricians have a valuable skill in high-risk pregnancies and the most important thing is for women to have the full spectrum of options of care for their childbirth experience.

However, there were a few examples of contention that I came across in the data analysis. Anna, a midwife, describes how she thinks obstetricians view midwifery care: “I think they are threatened because we do have time to spend with our clients versus they don’t have time. They barely have time to walk in and catch a baby.” There is a clear “us versus them” tone to this comment. The accusation that obstetricians are threatened by midwifery casts the interactions between the two institutions in a hostile light. Also, there is the allegation that doctors have no time to give their patients the care they deserve and are dismissive to the mother’s needs, while midwives are able to satisfy this need and respect the mothers they are serving.

In another instance, midwife Mary remarked that there are some examples of strong oppositional or confrontational attitudes in certain midwives, noting: “I think every midwife comes into it in a different time and place, and I think that some people do have a very rebellious spirit.” It seems that while this type of midwife is not the norm, at least in this group of respondents, they do exist. The way in which a midwife posits herself in relation to conventional obstetrics can prove to be extremely important and influential in emergency situations, however.

5.5.2 - TRANSPORTS: Sometimes there are scenarios in home and birth center births using midwives where mothers need to be transported to hospitals for more specialized care. Perhaps their labors have gone on too long, the baby is in a strange position, or there is severe hemorrhaging post birth. When I asked

midwives to talk about such situations, the responses given frequently stressed the need to have good relationships with obstetricians:

"I don't fear taking women into the hospital. I feel pretty confident...For the most part...[OB's] are very warm and cordial to you...we are even allowed to stay and support [the mothers]..." (Mary)

"So you can bunk the system all you want, but when you need a physicians support, you better hope you've not pissed him off." (Barbara)

From their perspective, if midwives are able to form quality relationships with obstetricians in their area, it will serve them better in potential caregiving scenarios when they need to transport a mother to the hospital. A theme began to emerge in the data: for the most part these women, both the midwives and the mothers who used them, were not against conventional medicine and indeed recognized its merits in certain situations. They simply desired a system where options are given to pregnant women; options that empower mothers by respecting their knowledge, intelligence, and innate capabilities.

5.5.3 - THE FUTURE: There was a shared vision and hope that emerged in talking to these women; a hope that perhaps eventually a spectrum of prenatal services can be offered to women in our culture; not an either or scenario but rather an integrated system of care:

"I think we need to integrate the entire system...I like to know that my goal is that we will eventually affect the maternity care system and that women who want to birth in a hospital naturally will have that as a viable option and they will not be looking at them as though they have two heads..." (Mary - midwife)

“Do we feel that we can do a better job in normal birth? Yeah. Do they do a better job if there are complications? Yeah. We need to be partners.” (Jamie - midwife)

“I think that home birth midwives should be less shut out, they should be welcomed into the community...I feel like there is, in some ways, a lot of paranoia about the hospital system. I myself have felt it. Some of it is unjustified. Because there are some excellent doctors out there...[so] let's work out a middle place. And then they should be allowed to be in that middle space. The birth center...I am going to use the word nexus...they are a meeting of the two systems.” (Elizabeth - mother)

The need for partnership is emphasized more than anything else here. Though I was expecting to talk to women who viewed a relationship with conventional medicine as simply a necessary evil, that was not what I discovered at all. Surprisingly, these women want to work within the healthcare system and not against it. From their responses, it seems that they believe this is the fastest way to the full spectrum of prenatal and birth care available to all types of women. The birth center itself could stand at the center of this new model of care; offering the best of both worlds to laboring mothers.

A second theme that emerged in reference to the future of the midwifery care model is this strong need for legitimization. It was topic that was heavily focused on in the interview of one mother, Amy, who is particularly active in the midwifery community:

[At the midwifery council meetings] they are talking about how do they get people to see them as professional and how do they get OB's to see them as professional because that is [how] they have to work...with the biomedical system. I don't think that is ever going to change...”

She comments here that professionalization is a huge topic of interest within midwifery as an institution, at least in South Carolina. She comments that midwives realize they have to work within the biomedical model of care, and thus they need to work on building and fostering good relationships with obstetricians. Amy also commented that there is a subgroup of midwives who are less interested in conforming to conventional care standards:

“There are others who kind of opt out of the system and they don’t get licensed and they practice underground...you have those midwives too. I think its important to have both in some ways just so...all women can have options.”
(10)

In her eyes, it is important that these underground midwives maintain their practice, because there will always be the a minority of women who desire this type of care and are heavily anti-hospital. However, for the most part “[Midwives] want people to see them as professional and they want people to look at actual...evidence of safe medicine....look at...the outcomes that they have, and [that] they are good.”

Generally, the midwives I spoke with wanted to work within the system that exists in order to legitimize themselves. Midwives can provide evidence based, numbers driven data to backup the claims that they have better birth outcomes for low risk pregnancies. These care providers want to prove that they are a truly legitimate, safe, and empowering option for more and more mothers to be, especially with all the changes going on in the healthcare system of our country.

5.6: Masculinity and the Role of the Father

Finally, an unexpected and interesting theme regarding the experience of the father in childbirth emerged from the data and is worth exploring. There has only been a little research done on the topic of a father's place in the modern birth scenario, but what has been done indicates that there is an increasing trend towards birth being attended by fathers (Johnson 2007, Draper 1997).

5.6.1 - A FATHER'S PLACE IN CONVENTIONAL BIRTH: In the conventional birth setting, it seems as though the inclusion of the father is almost an afterthought, if he is thought of at all. The research of Johnson (2007) focused on the increasing desire for males to attend hospital births, but the resulting unclear roles or functions provided for the father to take on during labor and childbirth itself. Thus, it seems that fathers come out of the conventional experience not feeling clear if they were helpful or needed at all. In my data, I found similar feelings. Mother Elizabeth articulated how part of her decision to use a midwife was because the model of care provided a clear way for her husband to be involved:

"I do think it is a women's issues which I think really makes it a men's issue because when you have a heterosexual partnership, men are also abdicated...My husband, who is really involved...he said, I'm afraid to see you in pain...and so...[with] our birth classes...he got really excited about it, he wanted to catch the baby, he wanted to be involved, and sure enough, he got me all the way to transition...because he had confidence. He understood what was happening, and he told me later...I felt like I was seeing something that men don't see...My point is that it begins as a feminist women's issue but men are being shortchanged terribly by this system because they are either standing there wringing their hands, out in the hall, or they are expected to bring their PlayStation. I have heard that from so many women."

The conventional model of birth is not only lacking in addressing the needs of laboring mothers, it is also inadequately addressing the modern father's increasing desires to be more directly involved, both prenatally and during the birth itself. This particular father felt as though he was getting to experience something that most men are not able to. His experience reflects what Henwood (2003) calls the New Fatherhood Model; one that supports the increased role of the father in such life changing events as pregnancy and childbirth. Culturally, men want a deeper and more meaningful experience in becoming fathers, something they can really connect with their partner over and support her via. In the conventional model, as this mother stressed, men are severely limited in their options, even resorting to playing waiting games in the hallway.

5.6.2 - SPACE FOR MASCULINITY IN MIDWIFERY: On the other hand, the midwifery philosophy of care provides much clearer expectations and roles for fathers in the prenatal and childbirth experience. The research of Howell-White (1997) mentions that the mothers who chose to use midwives were much more likely to vocalize that they desired support from the baby's father. Along those same lines, these two mothers, Sam and Katie, comment on how their husbands were given space to support them in their birth scenario:

"It was just me and Eric...you know, that was the other thing that led us to home birth...that I felt like he was really what I needed...and I had confidence that we could do it, but we needed a professional also." (Sam)

"I felt very accomplished because I worked hard to have a baby and my husband worked hard, and he was just as much a part of me having her as I was. I mean, he was there with me, he was birthing and laboring with me, and his body was hurting...not in the same way, but because of all of the pressure and everything that I was going through...it was hurting him while we were going through it." (Katie)

The midwifery model of care provided avenues for these husbands to be purposefully involved in labor. Similarly, Draper (1997) found there to be more direct means for male participation in the midwifery model in her ethnography and review of the literature. There is a huge focus on the tangible ways that men can be involved and supportive in midwifery, from labor coaching, attending birth classes, catching the baby, etc. To go even further in support of the father, midwifery experts are now increasingly advocating for increased awareness in providing for men's needs at this transitional and extremely transformational time (Draper 1997).

CHAPTER 6

LIMITATIONS AND CONCLUSION

The ideas that were expressed by the interviewees and organized into the above six themes overlap with one another and tend to express similar impressions repeated in different ways or contexts. What is present in each of the themes is a perception among midwifery childbirth participants that the model of care and philosophy of midwifery addresses a mother's (and father's) needs in ways that the conventional system is lacking and in ways that honor and respect the intelligence, autonomy, and competency of the childbearing woman.

Approximately 1-2% of American women give birth at home, in hospitals, or in birthing centers using midwives. The goal of this research was to explore the reasons why this small minority of women chose to have a midwife-assisted birth and the ways in which these women and the midwives who serve them articulate their understanding of the needs of the mother in childbearing. Specifically, I set out to focus on themes of agency, control, and achievement in mothers' and midwives' narratives. Additionally, after conducting and analyzing the interviews, other interesting themes began to emerge: ideas about education and social movements, midwifery relationship with conventional medicine, and modern masculinity's impact on the role of a father in the childbirth process

The knowledge garnered from this research demonstrates that midwifery as an institution offers a viable alternative to conventional medicine that is worth studying from a sociological perspective. This research can be integrated into literature on midwifery care, childbirth and women's studies, medical sociology, and social movements.

My previous work in the healthcare field, specifically in an OB/GYN private practice, possibly contributed to biases in my research and is worth noting. As a researcher, we all unavoidably experience personal biases, and I tried to be aware of how my experience with conventional medicine was affecting my work at all times.

Motherhood is a transformative factor in shaping a woman's identity and social relationships. It can give a sense of purpose or meaning to a woman's life. Little is known about the maternal perspectives on the choice of birth attendant and what the expectations of proper and satisfying prenatal care are. This research seeks to offer a sociological perspective on the perceptions of childbirth among women who choose midwives. As this subculture continues to become more vocal in their opposition toward the conventional model of birth, it is important to examine it in greater detail sociologically, especially as the drawbacks of the conventional method become more and more apparent. It is vital that those in the medical field learn about and respect these alternative options in order to ensure that prenatal care is acceptable to all women's expectations.

The data has its limitations as well, suggesting several potential additional studies to take the findings further. A bigger respondent pool could have offered richer data, especially if I could have gained access to some of the more “off the radar” midwives and midwifery participants in the state. Additionally, use of qualitative data analysis software such as ATLAS.ti could have provided additional insight into questions of why these women choose to participate in this alternative model of care. Future studies should employ such software in order to get a full picture of any additional themes emerging from the data as well. Finally, analyzing these participants from a demographic standpoint, especially with a much larger database, may provide additional insight and connections into the institution of midwifery and its participants. Future studies may also look to compare midwifery participants in South Carolina versus another state. As midwifery continues to become an increasingly popular care option among childbearing women, a continued analysis of it offers opportunities for understanding women’s health issues, healthcare issues, gender and family roles, and social movements in our culture.

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APPENDIX A – QUESTIONS FOR MOTHERS

DEMOGRAPHICS:

Race:

Occupation:

Education:

Income:

Age:

Marital Status:

Number of Children:

Questions:

Why did you choose to use a midwife in your pregnancy?

Describe, in as much detail as you feel comfortable, your pregnancy and birthing experience.

Tell me about your expectations during your pregnancy. What does your ideal birth plan look like?

Was this your first pregnancy? First pregnancy using a midwife? If you've had a child before conventionally, what made you decide to use a midwife?

What does "control" mean to you in the context of pregnancy and birth? How much of this did you experience in your pregnancy and birth? Who possesses "control" and how is it negotiated?

Describe your support system during your pregnancy and birthing experience (the baby's father, friends family, the midwife, etc).

How do you feel now about the experience overall? Would you make this decision again?

Why do you think midwifery or a natural birth is important option for expecting mothers?

Describe the way you see the conventional birthing option.

Describe your level of concern regarding risks and complications during your pregnancy. Describe any issues you may have had. How did you resolve them?

APPENDIX B - INVITATION LETTER FOR MOTHERS

Dear _____,

My name is Jordan Keels. I am a graduate student in the Sociology Department at the University of South Carolina. I am conducting a research study as my thesis as part of the requirements of my master's degree, and I would like to invite you to participate.

I am studying the practice of midwifery, and I am contacting you specifically because of your involvement in this field. If you decide to participate, you will be asked to join me in an interview session, meeting with me to discuss your experiences. In particular, you will be asked questions about your experiences using a midwife during your pregnancy. The meeting will take place at a mutually agreed upon time and place, and should last about an hour on only one occasion. The session will be audio recorded so that I can accurately reflect what is discussed in my research. The tapes will only be reviewed by me when I transcribe and analyze them.

If any questions make you feel uncomfortable, you do not have to answer them. Although you probably won't benefit directly from participating in this study, I hope that others in the community and society in general will benefit from a more precise and enriching understanding about the practice of midwifery and about the very special experience of childbearing in a woman's life.

Participation is confidential. Study information will be kept in a secure location at the University of South Carolina. Your identity will remain anonymous. No one will know what your answers are.

Taking part in the study is your decision. You do not have to be in this study if you do not want to. You may also quit being in the study at any time or decide not to answer any question you are not comfortable answering.

I will be happy to answer any questions you have about the study. You may contact me at keels.jordan@gmail.com or (803) 261-1347 at any time. If you

have any questions about your rights as a research participant, you may contact the Office of Research Compliance at the University of South Carolina at (803) 777-7095.

Thank you for your consideration. If you would like to participate, please contact me to discuss. I will call you or email you, whichever you prefer, within the next week to follow up

With kind regards,

Jordan Keels
1421 Brentwood Drive
Columbia, SC 29206
(803) 261-1347
keels.jordan@gmail.com

APPENDIX C - QUESTIONS FOR MIDWIVES

DEMOGRAPHICS:

Race:

Education as a midwife (i.e. any licensing, degrees, etc):

Years of experience:

Income:

Age:

Marital Status:

Number of Children:

Questions:

Talk about your decision to become a midwife. Talk about the ideology of midwifery practice.

Talk about how you define “control” in the birthing process. Who possesses “control” and how is it negotiated?

Describe the midwifery standard prenatal care treatment of a mother. Describe the birthing experience.

How do you facilitate the mother’s expectations during pregnancy and childbearing?

How do you see your occupation in relation to conventional obstetrics?

Why do you think midwifery or a natural birth plan is an important option for expectant mothers?

What do you give the women you assist in terms of social support?

How do you evaluate the level of risk involved in a woman’s pregnancy?

APPENDIX D - INVITATION LETTER FOR MIDWIVES

Dear _____,

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