

The Moral Dimensions of Contemporary Childbirth

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Abstract

Although some childbirth experiences (e.g. caesarean section) appear to be understood in moral terms, there is a dearth of empirical work on how women situate birth experiences within a moral framework. The aim of the current doctoral research was therefore to explore how women morally position various childbirth related options, interventions, decisions, and experiences within their narratives of childbirth, and to explore how these narratives and moral valuations reflect broader ideologies of mothering and childbirth. Narrative interviews, in which women described their experiences with pregnancy, childbirth, and the transition to motherhood, were conducted with first-time mothers ($N=21$) who had given birth within the last 18 months. Interviews were analyzed using an inductive, thematic approach which explored both semantic and latent aspects of women's narratives. Findings illustrated that women negotiated with both natural and medicalized understandings of childbirth, although tenets of alternative childbirth ideology were especially prominent in women's narratives. Women frequently used a moral voice of justice and autonomy within their childbirth narratives, which brought the concepts of individual harm, rights, and justice to the fore and reflected a valuation of autonomy and choice. The salience of autonomy was further illustrated in how women's autonomy was supported, constrained, or transgressed during labour and delivery, and the significance this had for how women felt about their childbirth experience. Additionally, women invoked a moral casual ontology and a moral voice of care wherein they described particular birth choices (e.g. epidural and induction) as potentially harmful, and situated the primary responsibility for birth outcomes in themselves and their decisions. Finally, women negotiated with moral, biomedical, and ideological frameworks in ways which helped them re/negotiate a positive moral and maternal identity in the wake of undesirable birth outcomes and birth-related stigma. Findings make visible the ways in which the moral dimensions of childbirth may be understood and negotiated by women, and offer insights into how maternity care can incorporate such understandings and promote supportive, respectful care.

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Introduction

Dominant practices and discourses¹ surrounding pregnancy and childbirth have shifted throughout history, in response to an array of ideological, political, economic, scientific, and technological factors. There is a significant body of scholarly literature examining various aspects of childbirth in contemporary Western societies, including notions of “natural” and “medicalized” childbirth. Scholars have increasingly argued over the last few decades that current Western dominant practices and discourse surrounding childbirth position it as a highly risky event in need of medical management, and that this “medicalization” can be to the detriment of childbearing women (Callaghan, 1993; Davis-Floyd, 1994, 2003; Fox & Worts, 1999; Hausman, 2005; Kornelsen, 2005; Possamai-Inesedy, 2006). Conversely, an alternative set of practices and discourse (which tend to be associated with midwifery) operate in direct critique of medicalization and position childbirth as a “natural” event, which can and should unfold without medical intervention unless absolutely necessary (Beckett, 2005; MacDonald, 2006; Mansfield, 2008; Monto, 1997; Rooks, 1999). In the contemporary Western context, childbearing women engage with these discourses and practices through the maternity care they receive, the birth-related literature they read, and the conversations they have with others about pregnancy, childbirth, and motherhood.

Importantly, these discourses and practices are not value-neutral. Previous literature suggests that that particular birth-related practices and options are imbued with moral valuations, which may be informed not only by discourses on childbirth but also by cultural ideas about “good” vs. “bad” mothering. This can be seen, for example, in the ways in which home birth is morally positioned in relation to hospital birth (e.g. Viisainen, 2000; Craven, 2005), and in how caesarean sections are constructed as both a “failure” on the part of the naturally birthing mother and as a necessary management of risk for the responsible mother (e.g. Hausman, 2005; Bryant, Porter, Tracy, & Sullivan, 2007; Crossley, 2007; Kornelsen, 2005; Beckett, 2005). These moral dimensions of childbirth are visible in the literature but have largely been neglected as an explicit focus of analysis.

¹ Discourses are the linguistic frameworks used to construct objects and phenomena; Lupton (1992) defines a discourse as a group of ideas or patterned way of thinking that is situated in social structures and visible in communication.

Examining the moral dimensions of childbirth is important to illuminate “what is at stake” for child-bearing women, and to gain a better understanding of the meanings that inform their birth-related decisions and experiences. Moreover, this endeavor can contribute to making explicit the ways in which childbirth and motherhood discourses are negotiated with, understood, and employed in women’s experiences of childbirth in North America. The overall purpose of this research was therefore to understand how women morally position various childbirth related options, interventions, decisions, and experiences within their narratives of childbirth, and to explore how these narratives engage broader ideological discourses.

This dissertation begins with an introductory chapter which provides some background on contemporary childbirth-related practices and their development over the 20th century, followed by a discussion of dominant childbirth-related ideologies and how these may intersect with dominant mothering ideologies to inform women’s understandings of childbirth. This discussion leads into an introduction to the current doctoral research, which closes the chapter. Chapter 2 provides theoretical and epistemological grounding for the concepts and methodology employed in this research, with particular focus on the concept of morality, and details the research and analysis methods utilized to generate findings. The following four chapters delineate women’s descriptions of preparation for birth and how they drew upon moral and ideological frameworks (Ch. 3), women’s use of a moral voice of care and responsibility to position themselves as morally responsible for birth outcomes (Ch. 4), the salience of agency, autonomy, and self-determination in women’s birth narratives (Ch. 5), and the social negotiation of maternal and moral identity in relation to birth-related stigma (Ch. 6). Finally, the significance and implications of these findings are discussed in the concluding chapter. Altogether, this dissertation endeavors to make visible the moral dimensions of childbirth embedded in women’s understandings and narratives of birth, and consider their importance to the provision of maternity care.

CHAPTER 1

AN INTRODUCTION TO CHILDBIRTH IN NORTH AMERICA: IDEOLOGIES AND MODELS OF PRACTICE

1.1 Setting the Stage: Historical and Contemporary Childbirth in a Western/Canadian Context

Contemporary childbirth in a Western context, including a Canadian one¹, is dominated by technology and takes place in a highly medicalized setting. In the United States, the percentage of 21st century births which take place out of a hospital² is only around 1%, consistent with numbers from the latter two decades of the 1900s (MacDorman, Menacker, & Declercq, 2010; Curtin & Park, 1999). Although current data on the percentage of hospital vs. out of hospital births in Canada does not seem to be available, by the early 1980's less than 1 percent of the births in Canada, the United Kingdom, Finland, Norway, Sweden, Germany, and France took place at home (Declercq, DeVries, Viisainen, Salvesen, & Wrede, 2001). For those births which take place in the institutional setting of a hospital, women undergo very high rates of medical intervention in labour and birth processes. In a recent pan-Canadian survey of childbirth intervention rates, almost half the sample of women (44.8%) had their labour induced, 57.3% had epidural analgesia, and 90.8% of women were strapped to an electronic fetal monitor; for 62.9% of the women sampled, this monitoring was continuous (Chalmers, Kaczorowski, O'Brien, and Royle, 2012).

The prevalence of caesarean sections in Canada and other Westernized nations, and debate over their appropriate use, are a significant indicator of medicalized childbirth. Chalmers et al. (2012) reported a caesarean rate of 26.3%, which is congruent with estimates of provincial and overall rates in Canada between 2010 and 2013³ (Canadian Institute for Health Information).

¹ Since the current research is in a Canadian context, efforts are made to highlight childbirth practices in Canada (particularly the historical context of childbirth in the country). However, given the available research and because there are many similarities in contemporary discourses and practices between Canada and the United States, as well as other Western nations, "Western" discourses and practices will be referred to for the majority of this work.

² In the document referenced, out of hospital births include home births as well as those which take place in freestanding birth centers, doctor's offices, and elsewhere.

³ This is the most current year of data available from the Canadian Institute for Health Information.

In Saskatchewan, as elsewhere, the rate of caesarean sections varies between hospitals. In 2010-2011 the percentage of Caesarean births per hospital was as high as 38.84%, with the provincial average sitting at 22.18% (Canadian Institute for Health Information). In 2013, 23.5% of all babies in Saskatchewan were delivered by caesarean (Canadian Institute for Health Information). Caesarean rates are even higher in the United States, with the national average sitting at 32.9% of all births in 2009 (Martin, Hamilton, Ventura, Osterman, Kirmeyer, Mathews, & Wilson, 2011) and declining slightly to 32.7% in 2013 (Martin, Hamilton, & Osterman, 2013).

Concern over caesarean rates and debate as to when a caesarean section is appropriate was actually evident all throughout the 20th century (Mitchinson, 2002). However, the procedure has become increasingly common, and increasingly politicized as a symptom of what many argue to be costly and overly medicalized and interventionist systems of maternity care. The recent phenomenon of caesarean sections on demand (women electing to receive caesareans without medical rationale), has also sparked professional and public debate about best childbirth practices, public health costs, and the right of women to choose how they give birth (see, e.g., Plante, 2006a, 2006b; Högberg, Lynöe, & Wulff, 2008; Klein, 2004; O'Boyle, Davis, & Calhoun, 2002; Minkoff, Powderly, Chervenak, & McCullough, 2004). It has been argued that there is not sufficient empirical evidence demonstrating maternal request is a significant factor influencing caesarean section rates⁴ (Gamble, Creedy, McCourt, Weaver, & Beake, 2007; Mazzoni et al., 2011; McCourt, Weaver, Statham, Beake, Gamble, & Creedy, 2007), which suggests that high caesarean rates remain primarily a function of risk-based, interventionist medical systems. Regardless of the extent of their impact on rising caesarean rates, the existence of caesarean sections on demand as well as the high overall proportion of caesarean births illustrate the extent to which birth has become technologized and viewed as a medical event.

Although the medicalized model of maternity care is certainly dominant in North America, midwifery is emerging as a viable alternative. The legal and professional recognition of midwifery in Ontario in the early 1990's was a critical step for birth care in Canada and marked the entry of midwifery into the health care system (MacDonald, 2004). Midwives currently work as part of the health care system in most of the provinces and territories. Recent estimates

⁴ Although many publications on the topic of patient choice caesareans report that actual rates are unknown (and that there are problems in assessing the percentage of caesareans that are truly patient choice without medical indications, see McCourt et al. 2007), a review from 2004 suggests that 4%-18% of caesareans may be patient requested (Wax, Cartin, Pinette, & Blackstone).

suggest that less than 10% of all births in Canada are attended by midwives although the profession's size and influence are quickly growing (Malott, Davis, McDonald, & Hutton, 2009). However, access to regulated midwifery care in the Yukon, Prince Edward Island, Newfoundland and Labrador, and New Brunswick remains a problem due to lack of legislation or regulation and funding for the profession as part of the health care system (Canadian Association of Midwives, 2016). Canadian midwifery exists as a profession separate to nursing, which has blended aspects of nurse-midwifery and "lay" midwifery, and Canadian midwives have a fairly independent and broad scope of practice in that they attend births both in hospital and at home (Bourgeault & Fynes, 1997).

In contrast to Canada, midwifery as a profession in the United States is divided between nurse and non-nurse/direct entry or lay practitioners, each with their own primarily separate sphere of practice (hospital and home, respectively) (Bourgeault & Fynes, 1997). The consequences of this have been that nurse-midwives have been more accepted by the medical system and able to influence dominant hospital practices than non-nurse midwives; they are, however, more controlled by this system than their direct entry counterparts (Bourgeault & Fynes, 1997; Davis-Floyd, 1998). American nurse-midwives have even been critiqued as becoming "mini-obstetricians", due to their primarily hospital-based training and the need to use hospital guidelines over their own judgment regarding the use of technologies (Rothman, 1982). Certainly the consensus is that contemporary midwifery in North America is different than its historical forms, whether this is perceived in terms of loss or of gain (Daviss, 2001; Van Wagner, 2004; MacDonald, 2006).

In Canada and the United States, as in many other countries, maternity care and childbirth practices are in a continual state of flux. Not only is childbirth an important event in the lives of many women, but the ways in which women give birth are important from a cultural and social perspective and often politicized. DeVries, Benoit, Van Teijlingen, and Wrede (2001) provided several reasons for why maternity care, more than any other area of medicine, is a highly charged mix of medical science, cultural ideas, and structural forces: a) ideas about sexuality, women, and families are inextricably linked to childbirth and the care provided to women; b) rather than disease, the essential task in pregnancy and delivery is the supervision of normal and healthy processes; c) infant mortality rates and the quality of maternity care is often used as proxy for the

quality of an entire health care system; and d) ultimately what is at stake is the reproduction of society.

Because of these factors, stakes in how women give birth are high not only for individual women and their families, but also for broader professional groups, the institution of medicine, and the health care systems and self-reproduction of nations. Childbirth practices are highly influenced by the various groups who have a stake in how women give birth. Childbirth is therefore not just a product of our knowledge about childbirth, but rather is shaped by ideological, political, economic, scientific, and technological factors. This is well illustrated in the history of Western childbirth practices over the last century or so, and the often referred to “medicalization” of childbirth.

1.1.1 The Medicalization of Childbirth in North America: A Historical Context

Medicalization can be said to center upon a redefinition of a problem, behavior, or condition within a health and illness framework, using medical terms and language, understood within a medical framework, or “treated” with medical intervention (Conrad, 2007). Within the literature on childbirth, medicalized childbirth refers to a model of care which focuses on the classification and management of risk, and involves both a range of interventions in the birth process and control over birth by medical practitioners. Although it can easily be argued that the medicalization of birth began long before the 1900’s, as the scientific-rational view of the body and grounding of birth within a framework that contrasted “normal” with “deviant” was propagated (see Cody, 2005), the 20th century saw a number of changes which intensified this model. Three major changes (the shift from home to hospital birth, the development of discourses which situate childbirth in terms of risk, and the development and/or use of new medical procedures and technologies related to childbirth) will be discussed below to illustrate how the context in which childbirth took place became more medicalized over the course of the 20th century.

Crucial to the medicalization of childbirth was the movement of childbirth from home to large hospitals. Place of birth greatly shapes the birth experience, determining who is in control and what technologies are employed (Delclercq et al., 2001). The movement from home to hospital followed a similar pattern (although at slightly different times) in many industrialized countries. The United States was the earliest and most rapid shift; by 1954 only 6% of births took place out of hospital (Delclercq et al., 2001). Canada was not far behind, with 76% of births

occurring in hospitals by 1950 (Payeur, 1998; as cited in Mitchinson, 2002). This shift in birth setting took place in the context of a broader movement to provide health services out of the home, making feasible a large client base and increasing the efficiency of health care (Delclercq et al., 2001; Wertz & Wertz, 1989). The hospitalization of birth was therefore shaped by political and financing mechanisms, notably the drive to both monitor birth (given its crucial role in the reproduction of the nation⁵, and concerns over maternal and fetal mortality rates) and provide efficient and cost-effective care. The shift also served the interests of physicians and increased their control and power, which was particularly important given the low professional status of obstetrics at the time (Delclercq et al., 2001; Arms, 1994; Mitchinson, 2002). Although many individual physicians in Canada were not opposed to home birth⁶, the medical profession had both professional and financial interests in controlling childbirth and encouraged both physician care and use of the hospital (Mitchinson, 2002; Wertz & Wertz, 1989). Other factors influencing the move from home to hospital were the ideological redefinition of hospitals from dangerous to safe places (both in general and in relation to maternal mortality) that occurred in the prior half of the 20th century, the fact that hospitals were the only place women had access to the administration of anesthetics and new technologies, and the redefining of birth as illness in broader cultural discourse (Mitchinson, 2002; Wertz & Wertz, 1989; Declercq et al., 2001).

Cartwright and Thomas (2001) suggested that the crux of the medicalization of childbirth was the shift transforming danger (ie, a fatalistic perspective on maternal or fetal death) to risk, which implies an active stance in relation to birth accompanied by monitoring, medical technology, and often intervention (Hausman, 2005). Discourse was mixed as to whether pregnancy was a normal or pathological event even in the early 1900's— for many of those working within the medical field, emphasizing the pathological and dangerous nature of childbirth may have been a way to increase the importance of obstetrics (Mitchinson, 2002). Still, perceptions of birth as risky and potentially pathogenic flourished, aided by the efforts of influential advocates for routine interventions in normal birth such as Dr. DeLee in the United

⁵ National and political interest in reproduction is exemplified in policies such as Family Allowance (“baby bonuses”) implemented in Canada near the end of the Second World War, and China’s one child policy (recently reversed). Childbirth is significant in medical, social, and economic systems and as DeVries et al. (2001) noted, at stake in human reproduction is the continued growth and reproduction of society.

⁶ This is in contrast to the United States, where there was a concerted campaign against midwifery care and efforts to eliminate home birth entirely (Delclercq et al., 2001).

States (Wertz & Wertz, 1989). After the First World War, the image of birth as pathological greatly intensified. Even as discourses which defined childbirth as risky helped influence the shift towards hospitalization, because more births were taking place in hospital it was increasingly difficult to see birth as a natural, as opposed to a medical, event (Mitchinson, 2002). Moreover, in keeping with the importance placed on obstetrical science, physicians spent a significant amount of time keeping track of various aspects of the labour process of their patients. Observation led to standardization, whereby various aspects of the “average” woman were transformed into normal, and by extension parameters for the abnormal or at risk were delineated (Mitchinson, 2002). An increasingly developed culture of fear regarding childbirth, based in part on the high death rate caused by childbirth during periods of history where women lived physically limited and unhealthy lives that affected their ability to give birth, also informed the risk-based practices of medicalized childbirth (Arms, 1994; Reiger & Dempsey, 2006). Finally, advances in science and technology contributed to the discourse of risk which underlies the medicalization of childbirth. The accessibility of knowledge creates new types of risks, and the ways in which they are defined and managed (for example, through routine use of technological interventions such as electronic fetal monitors which exist to identify potential harm to the fetus during labour) reinforce an ideology of risk (Possamai-Inesedy, 2006; Hausman, 2005). As Cartright and Thomas (2001) argued, the social construction of birth risk involves the selection of a particular danger, which often becomes visible or measurable through the development of a new technology. This birth-related risk must then be diagnosed, controlled, and treated. In the current context of Western maternity care this tends to mean the use of additional technology and interventions, including the creation of protocols and hospital rituals designed to reduce risk even if there is no data to support their routine use (Cartwright & Thomas, 2001).

Intimately linked to both the shift in birth setting and the re/production of childbirth as a risky process is the increasing role medical technology and intervention had to play in childbirth. Tools to intervene in the birth process, such as forceps, were used long before the 20th century (Cody, 2005). However, many other procedures were either developed or refined (e.g. various new forms of analgesia, the caesarean section, electronic fetal monitors, an array of drugs to stop, start, or hasten labour) during this time. Statistics from hospitals and private practices in Canada suggest an increasing rate of birth interventions through the first half of the 20th century

(Mitchinson, 2002). Technology and intervention can be heralded as beneficial or problematic depending on context, use, outcome, and social or ideological position. Although the benefits of new birth technologies were often heralded during this time (Mitchinson, 2002), Pasveer and Akrich (2001) argued that the use of medical technologies changes the very ontology of the pregnancy and birth, shifting it much more outside the woman's body and distributing it over multiple actors and external points of reference (ultrasounds, fetal monitors, IVs, etc.). Moreover, the use of technological interventions operates to redefine the birth experience as a high-risk event, sending powerful cultural messages about the role of the woman, her body, science, and medical experts (Pasveer and Akrich, 2001; Davis-Floyd, 2003). The increasing use of medical technologies therefore served to reinforce the discourse of risk which underpinned the rationale for treating childbirth as a medical event.

Caesarean sections were no exception to the medicalization of childbirth in the 20th century; in fact, they were closely tied to other trends in maternity care given that certain interventions are associated with an increased likelihood of caesarean delivery (Thacker, Stroup, & Peterson, 1995; Alexander, McIntire, & Leveno, 2000; Cammu, Martens, Ruysinck, & Amy, 2002; Walker & O'Brien, 1999; Ngyyen, Rothman, Demissie, Jackson, Lang, & Ecker, 2010). Although there was some concern over the use of caesarean sections, particularly near the beginning of the 1900s, relative indicators (those requiring a judgement call on the part of the physician) for their use broadened as practitioners became more comfortable with the surgery and maternal and fetal mortality rates dropped (Mitchinson, 2002). Caesareans were desirable to avoid embryotomy⁷; this was influenced by religious prohibitions against taking life and in line with the strong pronatalist values of the time (Mitchinson, 2002). Moreover, caesareans glorified the "hero" physicians who performed them, and (along with other interventions) helped justify the rationale for physician attended labour (Mitchinson, 2002). Economic factors have also been implicated in the increasing rates of caesareans, particularly in the United States, where caesarean rates have been identified as higher among women who have private insurance and in private clinics compared to hospital clinics (Podulka, Stranges, & Steiner, 2011; de Regt, Minkoff, Feldman, & Schwarz, 1986; Stafford, 1990). Desire within a risk-based culture to avoid malpractice lawsuits is also related to caesarean delivery (Localio et al., 1993). Finally, the

⁷ Embryotomy refers to dismemberment of the fetus when vaginal birth was life-threatening for the mother, often by puncturing the brain of the fetus and removing its contents so the body could be delivered (Mitchinson, 2002).

development and use of technologies such as electronic fetal monitoring (e.g. Alfirevic, Devane, & Gyte, 2006; Thacker et al., 1995), epidural analgesia (Walker & O'Brien, 1999; Ngyyen et al., 2010), and pharmaceuticals to induce labour (Heffner, Elkin, & Fretts, 2003; Maslow & Sweeny, 2000) may be associated with increased rates of caesarean births.

One of the most prolific medical interventions in 20th century maternity care was the use of anesthesia & analgesia in labour; records from Kingston General Hospital in Ontario indicate that anesthesia was used in more than 90% of births by 1929, and in more than 97% of births by 1940 (Mitchinson, 2002). “Twilight sleep”, a pharmaceutical cocktail of morphine and scopolamine which induced a light sleep and produced amnesia (although the drug appeared to have a limited effect on pain, leading to women being restrained as they thrashed around, only to awaken with no memory of the birth), was widely used through the early-mid 20th century in many European countries and the United States (Wertz & Wertz, 1989). There was only limited use of “twilight sleep” in Canada, but certainly other drugs were used routinely for pain relief (Mitchinson, 2002). Although giving women drugs during labour made them easier to manage for physicians and obstetricians, women themselves were extremely influential in advocating (both individually and as part of a social movement) for painless birth, which increased the routine use of anesthesia (Mitchinson, 2002; Wertz & Wertz, 1989). This, in turn, fed into the hospitalization of birth since hospitals were where these medications were available, in addition to other technological care (Delclercq et al., 2001).

The role pharmaceuticals played in childbirth throughout the 20th century was not limited to pain relief. Arms (1994) argued that the predominant technology in North American childbirth from the beginning of the 1950's has been drugs: for pain reduction or relief; to stop excessive bleeding; to maintain pregnancy; to treat infections or disease; and to stop, start, or speed labour. Mid-century saw a significant increase in the use of pharmaceuticals, such as Pitocin, to intervene in the induction or speeding up of labour; a group of metropolitan teaching hospitals in the United States averaged a 9% rate of Pitocin use as early as 1955 (Hellman, Kohl, & Schechter, 1957). Moreover, induction often led to other forms of intervention (Mitchinson, 2002). Labour induction rates continued to increase in the United States, with a national rate that more than doubled from 9% in 1989 to 20.5% in 2001 (Martin, Hamilton, Ventura, Menacker, Park, & Sutton, 2002). This rate further increased to 23.2%, almost a quarter of all births, in 2009 (Martin et al., 2011). As previously mentioned, a recent survey of Canadian women

suggested that nearly half had their labour induced (Chalmers et al., 2012). Medical interventions in the timing and length of the labour process may occur out of convenience and considerations of cost, but they are also intimately linked to the underlying discourse of risk informing birth and the standardization of the labour process discussed earlier.

The historical context of the medicalization of childbirth through the 20th century in North America⁸ illustrates how childbirth became increasingly redefined and enacted as a medical event, as opposed to a natural one. Although some influential writers (e.g. Arms, 1994) positioned patriarchy and medical hegemony at the core of the medicalization of childbirth, it is important that attention to these themes does not eclipse the significance of economic, cultural, and technological factors in the changing meanings and practices of childbirth over time. Moreover, it is important to acknowledge the role of childbearing women in the medicalization of childbirth, and how the promises of medicine and technology exerted a significant influence on professional and public discourse and were often met with enthusiasm. New or improved medical technologies and procedures related to childbirth were heralded by the world of medicine as life-saving, particularly for babies, and were demanded and embraced by many women. Good (2010) used the concept of the “medical imaginary” to describe the cultural power of medicine, whereby new biotechnologies engender enthusiasm and hope for new possibilities in care and their uptake. For physicians and childbearing women in the 20th century, this meant the hope of life where hope previously did not exist (i.e., the replacement of embryotomy with caesarean section), and the imagining of new ways to experience childbirth (e.g. an extended stay in a sterile hospital where women were relieved of other household responsibilities, and the promise of pain-free childbirth). The medical imaginary, then, in addition to the redefining of childbirth in terms of risk, played an important role in linking technology to childbirth in discourse and practice.

In providing a historical context for childbirth in North America, it is also important to examine the role that midwifery, often constructed as the antithesis of medicalization, has played in childbirth over the 20th century. Moreover, related to midwifery care and in direct opposition to the medicalization of childbirth, a counter discourse and movement of “natural” or alternative childbirth developed over the latter half of the 1900s (MacDonald, 2006; Mansfield, 2008; Rothman, 1982). As a counterpoint to the history of medicalization described above, midwifery

⁸ This history is similar to that of many other Western societies (see, e.g., DeVries et al., 2001).

and the alternative birth movement provide crucial context to the history of childbirth in North America as it informs contemporary discourses and practices.

1.1.2 Midwifery and the Alternative Childbirth Movement in North America: A Historical Context

Despite the increasingly medicalized discourses and practices characterizing childbirth in North America, midwifery (often considered the antithesis to the medicalization of birth) also played a small part in 20th century maternity care in North America. As Mitchinson (2002) describes, midwifery in the earlier part of the century meant many different things. A midwife could be a person (usually a woman) who informally helped others in their community through labour, apprenticed with a midwife and regularly delivered babies, or took some type of formal training. However, the title midwife was most often conferred under specific circumstances by the Church, community, or Crown, and reserved for individuals who had acquired specialized skills either formally or through years of experience (Biggs, 2004).

Midwifery care through the first half of the 20th century varied greatly depending upon the particular midwife's training and skill set, as well as her or his cultural background and the cultural context of the community (Mitchinson, 2002). In fact, the ability of midwives to provide culturally appropriate and sensitive care to birthing women within their community was very important to their practice (Biggs, 2004). In general, midwives provided little to no prenatal care although they did provide a significant amount of postpartum care (Mitchinson, 2002). When the woman was ready to deliver, most midwives would come to her home although occasionally a midwife requested that the birthing woman come to her or his residence (McNaughton, 1989; as cited in Mitchinson, 2002). Although some historians have suggested that midwife intervention could actually be quite extreme (contrary to popular discourse regarding midwifery), Mitchinson argued that the equipment midwives used was in all time periods minimal compared to that used by physicians. Moreover, their interventions were less intense or invasive (e.g. herbal brews, stretching the vagina, turning the baby to a better presentation, inducing labour using castor oil) when compared to those used routinely by physicians (breaking waters, manually dilating the cervix, pharmaceuticals to induce and hurry labour, chloroform and other forms of anesthesia for pain relief, forceps episiotomies, and, of course, caesarean sections) (Mitchinson, 2002). Over time, however, Mitchinson pointed out that the practice of many midwives increasingly mirrored that of physicians.

In the United States, the ascendance of obstetrics & the medical paradigm of childbirth included a direct attack on the profession of midwifery (Delclercq et al., 2001). Birth was increasingly portrayed in the media and by physicians as dangerous to mother and baby, requiring a skilled professional versed in the science of birth. In conjunction with this medicalised discourse, hospitals were strongly promoted as the “proper” place for birth, where women could access proper medical care and new technologies (including Twilight Sleep); moreover, the rapid growth of medical insurance increased accessibility to a medicalized hospital birth (Delclercq et al., 2001). As stated by Rothman (1982), although the balance of power between midwifery and medicine varies across the Western world, in the United States the ascendance of medicine almost wiped out midwifery.

In Canada, as childbirth became increasingly part of the medical domain, midwifery was increasingly marginalized. The effect of this marginalization in many provinces was to make it “alegal”; not illegal but not part of the national health care system either (Plummer, 2000). Canadian midwives had been excluded from licensure in most provinces by the early decades of the 20th century (Comacchio 1993; as cited in Wrede, Benoit, & Sandall 2001), and during the first half of this century there were no formal training programs for midwives although lay or “granny”/neighbour midwives practiced in parts of the country. As a result, midwives were not numerous in 20th century Canada, but they worked in isolated areas, within immigrant populations, in maternity homes on the prairies, and among poor and First Nations populations (Mitchinson, 2002). Federal and provincial governments within Canada made limited use of midwives and nurses trained in midwifery skills in remote areas during particular periods over the century, to cover gaps in maternity care (Plummer, 2000).

There were a number of factors which influenced the decline of midwifery in both Canada and the United States, including those professional (the ascendance of public health, nursing, and obstetrics), economic (limited resources and the structure and competition of health systems), cultural (changing understandings of birth based on discourses of pathology and risk), and as mentioned previously, technological; hospitals were represented as clean, safe places where women could obtain anesthesia and modern high-tech care using technologies which were not available to midwives (Biggs, 2004; Mitchinson, 2002, Rothman, 1982; Plummer, 2000). Biggs (2004) suggested that these factors, in addition to race, class, imperial, and colonial

politics, converged in different ways in specific times and places in Canada so that there are really multiple histories of midwifery within the country⁹.

Mid twentieth-century saw the birth of the natural childbirth/alternative birth movement, which is a worldwide grassroots movement intimately connected to midwifery (Arms, 1994; Daviss, 2001). This movement drew upon three overlapping ideologies of birth: a traditionalist ideology emphasizing a woman's femininity and family role; a feminist ideology where the focus is on a woman's autonomy and personal fulfillment; and a more mainstream medical ideology emphasizing choice and incorporating aspects of consumer demand for a more humane and less interventionist style of birth (Rutherford & Gallo-Cruz, 2008). The main tenets of the alternative childbirth movement are that birth is a normal physiologic event, women should have a major role to play in decision-making and the information to make informed choices, and midwives are best qualified to empower women and facilitate normal birth (Daviss, 2001). The various individuals and organizations comprising the alternative birth movement worked to directly challenge the dominant ideology of childbirth as a medical procedure through contesting definitions and alternative mythologies of birth as a "natural" process (O'Reilly, 2001).

The roots of this movement lay in the writings of two male physicians (Dr. Grantly Dick-Read and Dr. Fernand Lamaze), and with the growing numbers of women in the United States and Canada who were voicing dissatisfaction with current obstetrical care and techniques, and beginning to make alternative choices like giving birth at home (Daviss, 2001; Arms, 1994; Rothman, 1982). Many childbirth reformers did not initially consider themselves part of a specific movement; in fact, the alternative birth movement was (and remains, to a lesser extent) a composite of many varied birth activists, community or religious groups, and organizations. However, this movement grew and gained focus within the context of the larger social movements of the 1960's and 1970's, spawning some very influential organizations composed of parents and consumers of maternity care, midwifery supporters, and midwives (Daviss, 2001). Daviss (2001) described a number of successes in childbirth reform during the 1970's and 80's which can be credited to the work of the alternative childbirth movement. These include the inclusion of partners and sometimes siblings in labour and delivery rooms, the end of the

⁹ In more cohesive or isolated groups, for example, such as many Aboriginal, immigrant, and religious communities (e.g. Hutterites in Saskatchewan), the use of community-based midwives persisted even as it declined elsewhere. Aboriginal midwifery flourished more broadly when white settlers were in a situation of dependency and needed their assistance, but their skills were increasingly denigrated and seen as inferior with the expansion of colonial power (Biggs, 2004).

“twilight sleep” era, the introduction of rooming-in and the use of a single room for labour, delivery, and recovery in many hospitals, alternative birthing centers in hospitals, the right to eat and drink in labour (in some hospitals), and steps towards making childbirth education universally available to women. The most significant achievement of the alternative birth movement, however, has been the renewal of midwifery in North America.

Through the latter half of the 1900’s nurse-midwifery developed and proliferated in the United States, as sort of a middle ground between traditional midwifery and medicine (Rothman, 1982). These midwives differ from obstetricians in their attitude towards birth (as normal and healthy) and the use of their hands (vs. obstetrical tools). However, as described previously, the way in which nurse-midwives are trained and practice (in hospital, and as an ancillary service to medicine rather than an independent profession) has led to critique that they have been to some extent coopted by the medical system (Rothman, 1982). Meanwhile, non-nurse or direct entry midwives have faced a significant amount of hostility and struggle with obtaining acceptance and legitimacy as maternity care providers. Direct entry midwifery remains illegal in many states, with licensure unavailable in others (Arms, 1994; Bourgeault & Fynes, 1997; Midwives Alliance of North America, 2011).

Daviss (2001) suggested that the branches of the alternative birth movement in Canada have been more successful than in the United States, partially because Canadian activism and feminism was more pro-state and socially acceptable than the American versions, and also because the movement in Canada focused more on mobilizing resources and political structures whereas the movement in America retained a lot of focus on individual transformation and the spiritual aspects of birth. In Canada, midwives and midwifery consumers and supporters were successful in retaining a fairly independent and broad scope of practice, which has blended aspects of nurse-midwifery and “lay” midwifery and includes births both in hospital and at home (Bourgeault & Fynes, 1997). There was government support for the integration of midwifery into the health care system for two main reasons: the argument that midwifery was a cost-effective form of maternity care, and the fact that the government could be viewed as being progressive in supporting women’s issues and women’s rights by supporting midwifery (Bourgeault, Declercq, & Sandall, 2001).

The existence of the alternative birth movement and midwifery in North America suggests that throughout the 20th century there have been some alternatives to medicalized birth,

despite its hegemony in maternity care. Regardless of the successes by the alternative birth movement, however, DeVries, Salvensen, Wiegers, and Williams (2001) argued that these were primarily small adjustments and that overall obstetrics “digested” the alternative birth movement, attesting to the cultural dominance of science. These two movements (towards medicalization and natural and alternative birth) provide a historical context to understanding how contemporary birth might be constructed. Bringing these two movements together to focus on the contemporary context of childbirth, the following section explores the ideologies and discourses amidst which North American women (and therefore the Canadian women who are the focus of the current research) prepare for, experience, and narrate childbirth.

1.1.3 Ideologies and the Contemporary Construction of Childbirth

After a century of medicalization and resistance to this medicalization from the alternative birth movement, including midwives and midwifery advocates, two strong and opposing conceptions and discourses of birth are posited by scholars to exist in contemporary North America. The first of these is the concept of the “medicalized” birth, referring to a series of practices, generally equated with medical obstetrics, which include hospital birth, control over birth by medical practitioners, and a range of technological interventions in the birth process. These practices are embedded within the technocratic and/or biomedical models that rest on the Cartesian duality between mind and body, where the body is viewed in mechanistic terms and technology and science are considered superior over imperfect and dangerous nature (see Davis-Floyd, 1994, 2003; Hunter, 2006). Central to “medicalized” birth is the discourse of risk during pregnancy and childbirth which underlies current maternity care within the medical model. As noted in the history of childbirth in North America, one of the crucial factors in the medicalization of birth was the redefining of birth in terms of risk, leading to close monitoring of the birth process and a lack of distinction between risk factors and actual pathology (Rooks, 1999; Cartwright and Thomas, 2001). Moreover, by emphasizing risk in childbirth the onus is on the medical provider as the person with the power to reduce or control the chance of risk, leading to interventions as prevention (Hunter, 2006; Rooks, 1999). Risk discourse dominates the medical model of childbirth, and is propagated by obstetrics and other medical officials (Davis-Floyd, 2004; Reiger & Dempsey, 2006; Craven, 2005), hospitals (Rutherford & Gallo-Cruz, 2008), the media (Reiger & Dempsey, 2006), and the general public, including many birthing women (DeJoy, 2010; Possamai-Inesedy, 2006).

The medicalization of childbirth in Western societies has been strongly criticized on a number of different levels. Fox and Worts (1999) summed up the scholarly critique of medicalized childbirth as follows: “Medical professionals, acting on a definition of childbirth as hazardous, intervene in what is essentially a natural process. Their management of birth decreases the control of the birthing woman, fails to improve the physical and emotional outcome of the birth, and even alienates the woman from a potentially empowering experience” (pp. 327-328). Another line of critique centers upon what is perceived as the massive overuse of interventions in the birth process, which are seen as often medically unnecessary, harmful to women and their babies, and as begetting further interventions (Beckett, 2005; Davis-Floyd, 2003; Hausman, 2005; Wolf, 2001).

The second dominant conception of birth as described in the literature is that of “natural birth”, emerging from the alternative birth movement and discontent with the medical model. This discourse constructs birth as a normal life event and women’s bodies as natural and strong, their bodies designed to carry a fetus and labour successfully without (in most cases) technological or medical intervention (Callaghan, 1993; MacDonald, 2006). Although “natural” childbirth seems to be conceptualized primarily as the absence of drugs and/or medical interventions (Brubaker & Dillaway, 2009; Davis-Floyd, 2003; Fox & Worts, 1999; Machin & Scamell, 1997; Mansfield, 2008), features of “natural” childbirth may also include women’s control over the birth process, self-empowerment, minimal mother-baby separation, and early and exclusive breastfeeding (Machin & Scamell, 1997; MacDonald, 2006; Young, 2009). “Natural” childbirth is often conceptually equated with a midwifery model of care and situated within a larger ideology of holism, where the woman’s strength and natural ability to labour is foregrounded, the body and mind are seen as linked, and care focuses on additional aspects of the childbirth experience other than just the physical (Mansfield, 2008; Rooks, 1999; for an in-depth discussion on holism, see Davis-Floyd, 2001). “Natural” birth often emphasizes the need to embrace the bodily processes of labour rather than try to control them (Gaskin, 2002), avoiding the intrusion of intervention and technology into what is viewed as a natural unfolding of events. Natural processes and ability are highlighted in a discourse often invoked in direct critique of medical control, which emphasizes the ability of women to give birth without technological intervention (Beckett, 2005, Rooks, 1999).

As with medicalization, the rhetoric of the “natural” as invoked through the alternative birth movement has also been criticized. Specifically, critics have argued that this discourse super-values the “natural”, setting up births which do not conform to this ideal as failures. Furthermore, the ideology in which the discourse of the “natural” is invoked essentializes women to their reproductive and mothering capabilities, denies the ability of women to use technology in ways which are empowering, and increases medical surveillance over pregnancy and childbirth through practices such as childbirth classes (Beckett, 2005; Brubaker & Dillaway, 2009). Lyerly (2006) argued that a “natural” birth (e.g. the absence of anesthesia) can decrease women’s agency, participation in, and satisfaction with the birth, while the use of technology such as anesthesia or forceps can engender an empowering and participatory birth experience, depending of course on the woman and context. To obscure that women’s choice of technology (be that anesthesia, ultrasound, forceps, etc.) can be an enactment of agency with positive and empowering outcomes, or suggest that a “natural” birth sans technology is the appropriate or ideal way to birth, does not do justice to the range of women’s desires, capabilities, and experiences.

Although “natural” and “medical” birth are constructed within the literature and in popular discourse as dichotomous and in constant ideological tension, they may not be quite as dichotomous in practice. Many hospitals engage significantly with the rhetoric of the alternative childbirth movement and natural childbirth, including acquiescing with the demand of women to make informed decisions regarding what their birth will involve (or not involve), and offering various types of natural childbirth classes, although their ability to successfully support many versions of “natural” birth within the institutional setting is questionable (Rutherford & Gallo-Cruz, 2008; Mardorossian, 2003). Many women seek a middle ground between the medical and the natural, such as by attempting to balance pain with a lower level of intervention (Fox & Worts, 1999). Interventions may also be part of “natural” birth within a midwifery model. Certified nurse midwives’ rate of use of certain interventions (electronic fetal monitoring, ultrasound, and induction and stimulation of labour) was as high or nearly as high as the rate of use by physicians through the latter part of the 20th century (Curtin & Park, 1999). Moreover, the use of interventions cannot necessarily be equated with a model focused on risk, nor are they incompatible with a model of women’s bodies as naturally strong and capable of birth. MacDonald (2006) argued that contemporary Canadian midwifery retains its focus on women’s

power and ability to birth *and* allows for some incorporation of the medical; neither midwives nor their clients saw interventions judged to be necessary as taking away the “naturalness” of a birth. Indeed, not only obstetricians but midwives as well may limit women’s control and choice over interventions based on medical factors and conceptions of risk (McKenzie & Oliphant, 2010; Westfall & Benoit, 2004; Crossley, 2007; Lazarus, 1994). As an example, Westfall and Benoit (2004) found that many of the Canadian women in their study who experienced prolonged pregnancy, including women under the care of midwives, reported feeling pressured by their maternity care providers to use labour induction methods.

The childbirth literature illustrates Rothman’s (1982) assertion that pieces of both the medical model and midwife/alternative childbirth model, with their respective ideologies, have become part of American culture, a statement that is also applicable to Canada. Women weave strands of both dominant discourses into descriptions of their childbirth expectations (Miller, 2007). Most contemporary birthing women do not expect either a “natural” or “medicalized” birth, but rather something in between; this suggests that these concepts should be seen as existing on a continuum rather than dichotomized (Brubaker & Dillaway, 2008; in Brubaker & Dillaway, 2009). Similarly, Rooks (1999) suggested that the midwifery and medical models operate in practice as more of a continuum, with most individual practices falling around the middle. It is within this context of strong, dichotomized discourses and a continuum of “natural” and “medical” practices in which contemporary women consider childbirth-related decisions and understand their childbirth experiences. Moreover, there may be considerable variation among women on what is a “natural” and “medical” practice. Meanings of “natural” and “medicalized” childbirth are being re/constructed over time, and contemporary meanings, particularly of “natural” birth, are unclear (Brubaker & Dillaway, 2009). Although primarily conceptualized as a birth with the absence of drugs or interventions, for some “natural” childbirth may refer to a birth without epidural anesthesia, or simply any vaginal birth (Rutherford & Gallo-Cruz, 2008). Moreover, the variation of meanings which underscore these concepts, and how these meanings are linked to and differentiated from broader cultural discourses, require more research.

Both conceptions of “natural” and “medical” birth connect with understandings of “prepared” childbirth. Rothman (1982) used this term to refer to the humanization of the medical model to make it more pleasant for women— including incorporating the partner as coach, aesthetically pleasing rooms, and childbirth classes. Prepared childbirth, in this sense, involves

efforts to better accommodate the demands of the alternative birth movement and the wishes of the women using their services. Rutherford and Gallo-Cruz (2008) illustrated how hospitals in the United States go to great efforts to advertise their maternity care using both “medical” and “natural” rhetoric. Marketing their services to childbearing women, these hospitals try to create the setting for an enchanting, fulfilling birth experience within their institutional protocols, rituals, and parameters of safety and risk. As argued by Rothman (1982), however, “prepared” childbirth is really just socialization into the medical model— efforts to prepare women for the types of birth which are realistic within the institutional setting. In line with this, Armstrong (2000) illustrated how hospital-provided prenatal education serves primarily to prepare women to expect and comply with hospital procedures. Similarly, birth plans (meant to empower women by allowing them to specify childbirth-related decisions regarding the care they want to receive) may be disregarded or presented to women as printed menu-like forms so that women have very little real choices available to them (Baker, Choi, Henshaw, & Tree, 2005; Rutherford & Gallo-Cruz, 2008; Whitford & Hillan, 1998).

Although Rothman (1982) focuses on the efforts of the medical world to prepare women for satisfaction with birth within this model of care, another aspect of prepared childbirth is the efforts and preparation that *women* undergo to achieve the birth that they want to experience. A key feature of contemporary childbirth is the ability of women to “shop around” for the providers, setting, and protocols which they want to shape their birth experience (Rutherford & Gallo-Cruz, 2008)¹⁰. In a sense, the experience of birth itself has become commodified. With the belief (based on neoliberalist and feminist ideologies) that women should be autonomous, self-governing subjects in their experiences of labour and delivery, comes belief in their entitlement to the consumption of birthing information and services in order to structure their desired or “ideal” birth (Rutherford & Gallo-Cruz, 2008; Bryant et al., 2007). The process of making decisions regarding one’s birthing experience requires a certain amount of active thought and preparation on the part of the pregnant woman, particularly if it is a birth which is less in line with the institutional guidelines of a medical model. In order to obtain information about childbirth and aid in making childbirth-related decisions, the majority of women attend some type of childbirth classes, which are strongly encouraged to women receiving prenatal care (Lu,

¹⁰ The extent to which individual women are actually able to shop around for care providers and birth setting or engage in forms of preparation such as childbirth classes is of course varied and sometimes limited, particularly by socio-economic and geographic factors.

Prentice, Yu, Inkelas, Lange, & Halfon, 2003). Women also obtain information from other sources, including childbirth advice books (Declercq, Sakala, & Corry, 2006; as cited in Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009). Childbirth advice books, in turn, stress the plethora of choices available to women and the importance of preparing for childbirth, both to achieve a desired birth experience and in order to live up to maternal responsibility by maximizing the chances of a healthy pregnancy and healthy baby (Mansfield, 2008; Marshall & Woollett, 2000). Books on childbirth and the other resources women use to prepare for childbirth reinforce aspects of natural and medicalized birth discourses (primarily the latter) and send powerful ideological messages about birth (Marshall & Woollett, 2000; Mansfield, 2008; Armstrong, 2000; Rothman, 1982).

Contemporary childbirth, then, arguably takes place in a context where women are expected to prepare for birth amidst competing ideologies of childbirth, each with a different set of discourses used to construct pregnancy and childbirth and different conceptions of how childbirth should be. It is in reference to dominant discourses of childbirth, ideologically opposed but less dichotomized in practice, that women must consider the options available to them, make childbirth-related decisions, and understand or make meaningful their own birthing experiences. These ideological discourses are not, of course, the only cultural messages which are brought to bear upon women's experiences of childbirth. Labour and birth are a woman's physical passage into motherhood, a role which is invested with strong sociocultural expectations. Dominant mothering ideology is therefore also important to understanding women's experiences of childbirth, and is relevant to the literature which speaks to the moral dimensions of childbirth.

1.2 Being a “Good” Mother and the Moral Nature of Childbirth-Related Options

1.2.1 Dominant Mothering Ideology

The way we perform mothering is culturally derived; each society has its own models of motherhood which include rituals, beliefs, expectations, norms, and symbols (Thurer, 2007). That there are culturally variable ways of mothering is well illustrated by research documenting cross-cultural differences in various aspects of parenting, including how mothers communicate with their children (e.g. Bornstein et al., 1996; Goldin-Meadow & Saltzman, 2000), parenting

practices and styles (e.g. Wu et al., 2002; Claes, Lacourse, Bouchard, & Perucchini, 2003), childrearing values (e.g. Tamis-LeMonda, Wang, Koutsouvanou, & Albright, 2002; Jose, Huntsinger, Huntsinger, & Liaw, 2000), and women's ideas about ideal child-rearing behaviours in relation to their own parenting and that of their partners (Bornstein et al., 1996). The extent to which mothers perform the work of child-care is culturally variable as well, with this work commonly the primary responsibility of others in many societies (see discussion in Rogoff, 2003). There is also cultural variability in rituals regarding the transition to motherhood, such as post-partum rituals and practices (see Bashiri & Spielvogel, 1999, for a brief discussion on this topic). Specific mothering practices, styles, beliefs, values, and rituals within any society form cultural models of motherhood, and are part of larger cultural ideologies and belief systems. As Hirao (2007) illustrates through a discussion of maternal roles in contemporary Japan, models of motherhood inform as well as are informed by the structural systems of societies, including economic systems and state policies concerning the family, work, and education— although at times these factors are also very incongruent with cultural mothering expectations.

Cultural models of motherhood are historically variable and continually being reinvented (Thurer, 2007; Hanson, 2007). Just as culture is perpetually changing, cultural models and ideologies (systems of ideas and beliefs) of motherhood also evolve throughout time. Since shortly before World War II, the dominant mothering ideology in contemporary North American culture has been what sociologist Sharon Hays outlined in her 1996 work as “intensive mothering.”¹¹ According to Hays, intensive mothering is a child centered, expert guided, emotionally absorbing, labour intensive, financially expensive ideology in which mothers are primarily responsible for the nurturing and development of the child, whose needs take precedence over the individual needs of the mother. Hays stated that within this ideology, the child is viewed as sacred and innocent, completely removed from the economic logic of the world outside the home. Maternal care and affection (the proper kind, as laid out by experts) are viewed as both natural and essential for the development of the child; this intensifies the need to be a “good mother” and raises the standards of what that entails. In fact, Douglas and Michaels

¹¹ Hays (1996) details the evolution of intensive mothering from a historical perspective, documenting dominant parenting trends and behaviours and some of the factors contributing to intensive mothering ideology. Interestingly, scientific research and theory on child development (e.g. Harlow, Piaget) contributed to this ideology, with its emphasis on mother-child attachment and the need for parents to shape child development. The valorization of science contributed to the promotion and adoption of these ideas, and responsibility lay with mothers who were responsible for the home/child-rearing despite increasing participation in the workforce.

(2007) argued that through intensive mothering a phenomenon called the “new momism” has emerged: a set of ideals, norms, and practices that seem to celebrate motherhood but really promote unattainable standards of perfection.

Hays’ (1996) description of intensive mothering as our current dominant mothering ideology has been supported by many other scholars (e.g. Douglas & Michaels, 2007; Garey, 1995; Johnston & Swanson, 2007; O’Reilly, 2007; Swanson & Johnston, 2003). For example, Garey (1995) found that night shift nurses used the night shift so they could construct themselves as full-time, stay-at-home mothers during the day. These mothers sacrificed their sleep to create an environment where they were always available to meet their children’s needs, and could preserve cultural norms about their role as mothers (Garey, 1995). This example highlights how individuals’ day-to-day mothering behaviours and experiences of motherhood, as well as their identities as mothers, are shaped by and interpreted within this dominant cultural construction of motherhood.

The degree to which individual mothers engage in intensive mothering is, of course, variable. Specific women may accept or reject specific aspects of intensive mothering ideology, and a variety of factors may encourage or constrain this style of mothering, including women’s degree of financial security, the parenting role adopted by the father, and women’s own confidence, feelings of life accomplishment, and beliefs regarding their ability to increase their baby’s well-being (Fox, 2009). Women therefore do not always embrace the tenets of the dominant mothering ideology, but these tenets are difficult to ignore and individuals construct motherhood in relation to this ideology (Johnston & Swanson, 2007). As Hays (1996) stated based on interviews with American mothers, mothers “recognize, interpret, sort through, and respond to the ideology of intensive mothering” (p. 72).

1.2.2 Moral Aspects of Childbirth: Being a “Good” Mother

Mothering models, including intensive mothering, are inherently moral. That is, they are culturally and socially shaped, reflecting personal and collective values and conceptions of “good” and “bad”. They also carry strong prescriptions about who should (and should not) be a mother, and how women who are mothers ought to (and ought not to) behave. As women’s biological entry into motherhood, childbirth may be an important site for the construction of

maternal and moral identity. The academic literature¹² on women's childbirth-related decisions and experiences suggests that some of women's childbirth options (in particular, choice of birth setting, care providers, and caesarean section) are morally valued, and that these moral valuations center upon their identities as mothers. The current section explores what links between childbirth and morality have been made or are evident in the available childbirth literature, and how this research provided the rationale for the current dissertation.

First, childbearing women's decisions appear to be imbued with one of the core tenets underlying intensive mothering ideology: that it is mothers who are ultimately responsible for their children. A "good" mother must focus on the needs of her child above her own, and is responsible for maximizing the outcome of the pregnancy (i.e., as close to a perfect baby as possible). This cultural logic is visible in women's own accounts of their decision making process regarding choice of birth setting and care provider, both for women who choose physician or obstetrician-assisted hospital birth and for women who choose midwife assisted home-birth; women describe wanting the best start for their babies (see, e.g., Lazarus, 1994; Viisainen, 2000). The following is an example from Lazarus (1994) of how this responsibility informed one woman's choice of a (highly) medicalized hospital birth:

I don't really care about the birth experience like a lot of patients do— into soft lights, soft music garbage. For me it was getting a good baby. I've seen too many times where patients are so concerned about it being a lovely experience for them that this has overridden their desires for having a good baby and then they put themselves and their birth experience in front of having a "good" baby come out and having the best care for that baby. (p. 35)

The above quotation is illustrative of how the birth setting may be morally valued in relation to mothering ideals, through reference to the "good" and prescriptions of what type of birth should be chosen. This woman's decisions regarding her birth position delineate, by extension, how other mothers might fail to live up to maternal responsibility.

Second, the literature illustrates how women face negative judgments regarding their childbirth decisions, particularly from health providers (Viisainen, 2000), and disapproval is often communicated through aspersions regarding their abilities and capabilities as mothers

¹² The academic literature related to childbirth is highly interdisciplinary, and represents contemporary research and theory on the topic rather than work that stems from a particular discipline or framework.

(Cheyney, 2008). Women whose decisions could be seen as prioritizing the maternal experience may be construed as selfish, jeopardizing the well-being of their baby. Even among individuals who have been given knowledge on the topic, midwifery is often positioned as a selfish option, where women are choosing a more positive birth experience for themselves over the option that is deemed by many to be safer for their babies (Dejoy, 2010). In this way, good mothering is linked to the choice of hospital-based obstetrical care. In the context of legislative debates in the United States regarding the legislation of direct entry midwifery, Craven (2005) illustrated how medical authorities targeted the mothering identities of women who choose home birth. Specifically, these women were discursively linked to other women deemed pathological (e.g. child abusers, negligent mothers, and drug users), and constructed as subpar mothers unwilling to properly consider the risks of home birth and put the needs of their unborn child first. Conversely, midwives and homebirth supporters defended the mothering identities of home birthers by arguing that they are very much good mothers prioritizing the health and safety of their babies, who are making a rational choice based on perceived risks of hospital birth and previous negative experiences with birthing in a hospital (Craven, 2005). These examples illustrate how decisions about birth setting entail moral judgment, and how these moral judgments are expressed in relation to “good” or “bad” mothering.

Third, the literature suggests that childbirth discourse on risk is intimately linked to ideas of “good” mothering and moral judgments of women’s decisions. The choice to have a caesarean section, for example, is often constructed in terms of risk and may be linked to the ideal of the selfless mother who is making the sensible and safe choice for the good of her baby (Bryant et al., 2007). There is an important moral dimension to risk; the choices women make are often organized in terms of safety/unsafety or life/death, which in turn carries moral meanings whereby women’s mothering identities are structured as good or bad depending upon how they choose to manage these risks (Bryant et al., 2007). In Bryant et al.’s (2007) research, obstetricians and women who experienced a caesarean positioned the procedure as particularly advantageous for babies’ health and safety (in fact, this was often expressed in terms of the risk of fetal death); not having a caesarean was therefore constructed as jeopardizing the baby’s safety and by extension, the woman’s commitment to being a good mother. In fact, the argument that elective caesarean sections should be available rests largely on the pervasive cultural logic of dominant mothering discourse: good mothers put the needs of their child above their own and

make sacrifices for their children, and women should make that sacrifice to save their children from the potential risks of vaginal birth (Beckett, 2005). After all, as Possamai-Inesedy states, “What expectant mother disregards the possible threats, hazards, and risks that are constantly highlighted as a threat not only to herself but her unborn child?” (p. 406, 2006).

Finally, the literature suggests that discourses of the natural have moral significance and that women feel a sense of guilt and moral and maternal failure when they are unable to live up to the ideals of alternative birth ideology. One of the critiques of “natural birth” discourse is that in the veneration of the natural, it is highly moralistic and leads to the perception of births that do not conform to the “natural” ideal, such as cesarean sections, as “unnatural” (Bryant et al., 2007). “Natural” childbirth rhetoric involves a representation of proper birth that portrays a caesarean section, for example, as a failed birth experience (Hausman, 2005). Bryant et al. (2007) found that midwives (and a minority of the women who had undergone caesarean-sections) positioned the caesarean delivery as damaging to the development of full and meaningful mothering identities, in that it undermines a feminine ‘sense of self’ gained through giving birth and interferes with the mother-baby connection. Women may view their birth negatively and experience a significant sense of failure when they are unable to live up to their ideals of “natural” birth, particularly when they undergo caesarean section (Crossley, 2007; Fenwick, Holloway, & Alexander, 2009; Kornelsen, 2005; O’Reilly, 2001; Hausman, 2005). Moreover, although women may describe their caesarean sections in terms of failure of their body or failure as a woman, this sense of failure is often situated in relation to ideals of “good” motherhood (Fenwick et al., 2009). This research on how caesarean sections are perceived and experienced by childbearing women again suggests that birth related options and events may take on moral overtones, in that they may be seen as a reflection of an individual’s worth and “goodness”.

1.3. The Moral Dimensions of Birth: Introduction to the Current Research

Taken together, what the literature on women’s childbirth-related experiences suggests is that at least some birth-related options (choice of birth setting, care providers, and caesarean section) may be positioned by childbearing women and others as moral decisions and experiences, which are informed by both mothering ideals and dominant birth ideology. The moral dimensions of childbirth, however, have largely been neglected as an explicit focus of analysis. Moreover, although there is some research to suggest that other childbirth options (e.g.

epidurals, induction of labour) may also be imbued with moral valuation (Heinze & Sleigh, 2003; Monto, 1997; Westfall & Benoit, 2004), very little empirical work focuses on these more commonly practiced and less publically scrutinized childbirth experiences. Additionally, how these options are moral and positioned as such by childbearing women has not been a focus of analysis.

This dearth in the literature informed the rationale for the current dissertation, whose focus is on delineating the ways in which women morally position various childbirth related options, interventions, decisions, and experiences within their narratives of childbirth, and exploring how these narratives engage broader ideological discourses. Specifically, the following two-part research question was posed: a) how/are childbirth related decisions and experiences morally positioned by mothers in their birth narratives; and b) how/do these narratives and moral valuations reflect broader ideologies of mothering and childbirth? The moral dimensions of childbirth are important to examine in order to understand what is “at stake” in women’s experiences of childbirth, and how women negotiate with moral and ideological frameworks in a climate of competing ideological truths about childbirth. How individual women negotiate with the moral power of cultural and ideological narratives may have a substantial impact on their birth-related decisions, experiences, and feelings, and as such is an important focus for empirical research.

CHAPTER 2

MORALITY AND METHODOLOGY: MAPPING THE MORAL DOMAINS OF CHILDBIRTH

2.1 Morality: A Theoretical Discussion

As a central aspect of the framework for the current dissertation, how morality is being conceptualized requires explanation and theoretical grounding. Although most traditionally a topic explored within the philosophical domain, throughout the 20th century a number of prominent scholars from within the social sciences (e.g. sociology, education, psychology, and anthropology) have applied their own disciplinary insights into the study of morality, moral goods or values, and moral development. Given the scope of the field and relevance to this dissertation, work that is from psychology, anthropology, and sociology will primarily frame my exploration of morality in relation to childbirth. The following discussion will briefly describe some common threads in how morality can be understood before outlining the theoretical framework guiding the current work.

Luckmann (2002, p. 19) defined morality as “a reasonably coherent set of notions of what is right and what is wrong, notions of the good life that guide human action beyond the immediate gratification of desires and the momentary demands of an individual.” Although he goes on to elaborate a particular understanding of morality as being embedded within communication, this definition taps into two key elements of morality which appear to span different perspectives. The first of these two elements is that morality involves an understanding of the “good” (and conversely, the “bad”). The “good” tends to be conceptualized in the literature in relation to norms, values, principles, and judgments (see, e.g., Bergmann, 1998; Gibbs, Basinger, Grime, & Snarey, 2007; Gilligan, 1977; Harris, 2011; Kleinman & Kleinman, 1997; Kohlberg, 1969; Lyons, 1983; Parker, 2007; Rozin, 1999; Shweder & Haidt, 1993). As human beings, particular things matter and are valued, which is at the core of moral experience (Kleinman & Kleinman, 1997; Parker, 2007). What these things are, and the degree to which they are considered universal, varies within the literature on morality. Kohlberg’s (1969) influential stage-based approach to moral development is predicated upon justice as a universal moral “good”; Gilligan (1977) argued in her critique of Kohlberg’s work that, for women, morality centers upon a valuation and language of responsibility and care. Harris (2011) took a

broader approach to argue that values and the good are all things that support human well-being (as a whole, not necessarily individual happiness). Within this perspective, morality and moral truths are shaped by environment and neurology, and can be understood scientifically. Science illustrating the harms of particular behaviours to human beings (e.g. harsh physical punishment) therefore provides evidence as to what should be considered moral vs. immoral behaviour. Others have argued that although humans may refer to fundamental moral principles such as justice or harm, the specifics of what is seen as “good” or “bad” (ie, morally laden) is heavily dictated by historical, social, and cultural contexts (e.g. Brandt, 1997; Luckmann, 2002; Rozin, 1999; Shweder & Haidt, 1993). Regardless of variation in perspectives, valuation and the “good” are at the heart of morality.

The other fundamental feature of morality expressed in Luckmann’s (2002) definition is that morality is prescriptive; it guides and shapes behaviour and self-presentation, and sends prescriptive messages about what is appropriate and inappropriate or good and bad. Parker (2007) suggested that in addition to being centered upon goodness and value, morality involves the question “what is it right to do?” (p. 45). Moral concepts help people to organize, interpret, and make meaning of ambiguous or conflicting information (Mechanic, 1997). Thus, it is in relation to principles, values, and local norms that individuals engage in moral reasoning, decision making, and everyday moral practices (e.g. Gilligan, 1977; Kohlberg, 1969; Shweder & Haidt, 1993, Duncan, Edwards, Reynolds, & Alldred, 2003). Moreover, moralizing, which consists of positive or negative evaluations of both one’s own behaviour and that of others, acts as a form of regulation to encourage conformity to particular norms (Luckmann, 2002; Brandt, 1997; Bergmann, 1998).

These two features of morality, its prescriptive nature and focus on the “good”, are a common pair of assumptions embedded within descriptions of morality across disciplinary perspectives and are also adopted within this dissertation. However, the current work is situated within a sociocultural¹ approach to morality (see, e.g., Tappan, 2006) which entails a particular approach to understanding these features and involves a number of additional assumptions about the nature of morality and how it is constructed and enacted. The following three elements can be considered central to a sociocultural perspective, and to the perspective adopted in this

¹ “Sociocultural perspective” is being used as a general category to describe a relatively diverse set of individual arguments/frameworks which share common elements. Although the term sociocultural was preferred, many of these elements have been classified as symbolic interactionist (see, e.g., Doucet, 2006).

dissertation: a) morality (and moral identity) is constructed within everyday social interactions; b) language plays a central role in the expression and enactment of morality; and c) morality is shaped within particular social, cultural, and historical contexts.

2.1.1 Morality and Moral Identity is Constructed Within Everyday Social Interactions

Kleinman (1999) stated that moral experience centers upon what is at stake for people in their local worlds², and is about the processes (collective, interpersonal, and subjective) which enact values during everyday life. Both Kleinman (1997; 1999) and Zigon (2009) highlighted the everyday nature of morality; as a function of growing up in a particular context with specific values and patterns of interaction, people are able to behave in ways that are normative or “good” often without conscious reflection. As Bergmann (1998) suggested, morality is such a common and intrinsic part of everyday social interaction that it is usually invisible to us; we behave morally, and speak in moral terms, without conscious reflection or consideration of ourselves as moral agents. Through participation in social interactions and dialogue with others, moral thinking is shaped (Tappan, 2006).

Although we refer to particular moral concepts or frameworks in order to guide behavior, it is through social processes and interactions that morality is actually enacted (Shweder & Haidt, 1993). Finch and Mason (1993) illustrated how moral processes are enacted through their large-scale qualitative study on family obligations. They argued that there is no clear consensus (i.e. fixed moral code) regarding one’s responsibility within a family. Instead, people understand familial actions in reference to a set of moral guidelines or concepts (reciprocity, generosity, in/dependence, responsibility of care), which are negotiated through social interaction. It is in people’s behavior within these social interactions, and how their behavior is responded to, that moral meaning is constructed.

The moral meanings communicated and enacted within social interactions are inextricably tied to personal identity. Through everyday interactions, people’s identities as moral beings are being constructed, reconstructed, and confirmed (Doucet, 2006; Finch & Mason, 1993; Tappan, 2006). This may be particularly salient in interactions where important goods are “at stake” or those which strongly invoke shared moral principles such as justice (Kohlberg, 1969; Gibbs et al., 2007) or the responsibility of care (Gilligan, 1977; Finch & Mason, 1993;

² “Local world” refers to the physical, social, relational, and cultural contexts of a person’s life.

Doucet, 2006). Doucet (2006) argued that caring for others is intricately connected to people's identity as moral persons; this is exemplified most strongly in the responsibility of care embedded in understandings of parenthood (see also Duncan et al., 2003). Women's moral identities as "good" or "bad" mothers (and similarly, men's identities as fathers) are enacted, negotiated, and judged within their social interactions and public presentations of parenting (Doucet, 2006). Although this moral negotiation of identity occurs in relation to ideas of "should" and "shouldn't", moral principles, and broader discourses and ideology, the interactions between people are central to the construction and expression of morality.

2.1.2 Language, Morality, and Moral Voices

Although moral communication does occur through nonverbal means and body language, for example a frown of disapproval (Luckmann, 2002), language is considered the central means of communicating moral meanings and is often the explicit focus of a sociocultural perspective on morality. Within such a perspective, language is used both to express moral meaning and create it; again, moral functioning exists in processes of social communication and relations (Tappan, 2001; 2006). The designation of something as moral or immoral requires the association of action with particular meanings, which are generated from shared assumptions and understandings and both constructed and expressed linguistically (Tappan, 2006). Moral development involves the internalization of these associations between actions and meanings as individuals participate in dialogical and narrative practices (Tappan, 2006).

Luckmann (2002) outlined two main forms of moral communication: thematization and moralizing. Thematization refers to explicit discussion of moral meanings, and includes descriptive statements about moral values, narratives about moral examples of behaviour, and more abstract references to ethical principles and criteria. Moralizing, on the other hand, involves the valuation or judgment of one's own behaviour and/or that of others through various levels of praise or condemnation. Morality is therefore not restricted to communication about moral dilemmas and abstract principles, but is enacted whenever respect/approval or disrespect/disapproval is expressed (Bergmann, 1998). Similarly, moral communication can be both explicit, such as an explanation of why something is right or wrong, or implicit, such as the indirect construction of particular behaviours as non/appropriate through subtle linguistic cues that occur within social interactions (Bergmann, 1998; Luckmann, 2002). As a topically relevant illustration of the latter, Heritage and Lindström (1998) investigated the discursive interactions

that occurred in standard health visits following the birth of a baby. Although the health care professionals in question rarely explicitly criticized mothers' baby care practices or challenged their capacities, the authors illustrated how moral imperatives around mothers' obligations to do the best thing for their child implicitly structured the advice, claims, and counterclaims in these health visits. Women continuously oriented to the evaluative dimensions of these interactions (they were essentially "on guard" against the threat of negative moral evaluation), and worked to express their capacities as competent and living up to their moral responsibility through the discursive claims they made regarding how they took care of their baby. Although social interactions can therefore involve direct expressions of moral rules, dilemmas, or evaluations, moral language can also be so subtle that it is not easily recognized as such.

Given that moral communication is structured to some extent by shared moral ideologies and abstract moral truths (Gibbs et al., 2007; Gilligan, 1977; Shweder & Haidt, 1993; Tappan, 2006), the ways in which morality appears in everyday communications and interactions often references shared understandings of what is "good" or "right". One of the most influential scholars to focus on moral language was Gilligan (1977), in her critique of Kohlberg's stage-based approach to moral development which prioritized principles of justice as moral truth. Gilligan (1977) argued that women's understandings of moral issues and the way they approach moral dilemmas are much more contextual and relational than men's, and that women are more strongly oriented to an ethic of care and responsibility. According to Gilligan, they have a feminine moral language which is distinct. Further research suggests that people adopt different moral voices (i.e., ways of understanding and constructing morality that are oriented towards particular moral principles, values, and ideologies), that these moral voices are to some extent gendered, and that they can be adopted (or not) separately or simultaneously in any particular context (Chang, 1996; Jaffee & Hyde, 2000; Lyons, 1983; Smetana, 1981). The way in which the self is conceptualized (as relatively connected with, or disconnected from others) is related to the extent to which individuals invoke a moral voice of justice or care, although most people speak in both of these moral voices (Lyons, 1983; Gardner, Gabriel, & Lee, 1999; Gilligan & Attanucci, 1988). As Gilligan and Attanucci described, for example, most people talked about moral dilemmas in reference to in/equality, respect, standards, and rights (a justice perspective) *and* issues of attachment, relationships, attention, and response to need (a care perspective)³.

³ For examples of these moral voices from Gilligan and Attanucci's data, please see Appendix A.

Cultural understandings and language themselves further structure moral voice; moral worldviews are embedded in ways of thinking and expression, so that speaking a different language can facilitate the adoption of a particular moral voice (Chang, 1996). The concept of moral voice focuses on the everyday construction of morality through language, as well as the degree to which shared moral principles and ideologies structure the understanding and expression of morality. As such, moral voice is one way to understand how morality is enacted through everyday communication within a sociocultural perspective.

2.1.3 Morality is Shaped Within Particular Social, Cultural, and Historical Contexts

Central to the sociocultural grounding of morality is the acknowledgment of how moral understanding and expression is shaped by social, cultural, political, and historical contexts. Shweder and Haidt (1993) argued that human beings have access to basic moral truths, which are abstract but fairly self-evident in their status as moral goods (e.g. reciprocity, freedom from harm). Indeed, cross-cultural work suggests that the endorsement of many abstract moral truths (contract, truth, affiliation, life, property, law, and legal justice) is reasonably universal (Gibbs et al., 2007). These abstract moral principles or truths provide what Shweder and Haidt (1993, p. 363) refer to as the “gross architecture” of morality, which provides a skeletal framework for, but does not constitute the moral understandings and practices of a society. Local and divergent moral practices are developed and implemented in relation to the cultural systems of meaning in which they occur, so that the same general moral principle is enacted in different ways across cultural contexts.

Local and situational enactments of morality are therefore influenced by collective constructions of morality, which are socially displayed and often enforced through direct and indirect means. It’s through social participation and dialogue with these collective constructions that individuals learn shared moral norms and practices (Tappan, 2006). Zigon (2009) described these collective constructions of morality as being both institutionalized and public. The public discourse of morality is all the commonly articulated moral beliefs, conceptions, and prescriptions within social discourse, accessible through the media, everyday articulated beliefs and expressions of ideologies, and familial teachings. These articulations may or may not be directly espoused or enforced by an institution, which play an important role in the construction of morality within a society. Institutions (formal and non-formal social organizations and groups which hold power over individuals) both prescribe and enact moral values (Zigon, 2009).

Although institutionalized morality may be less explicit in many contemporary (Western) societies, there is often a strong implicit moral discourse inherent in even “rational” models such as the biomedical context of healthcare (Bergmann, 1998).

Within any sociocultural setting, specific moral principles are more or less accessible and institutionalized (Shweder & Haidt, 1993). Shweder, Much, Mahapatra, and Park (1997) outlined three domains of moral discourse, which are constituted by clusters of moral principles. The first of these is an ethics of autonomy, which encompasses moral concepts such as harm, rights, and justice, and promotes will and choice. Secondly, moral discourse can involve an ethics of community, which invokes regulative concepts such as duty, hierarchy, interdependency, and souls or selves, and promotes the moral integrity of social roles within a society or community. Finally, individuals can draw upon an ethics of divinity, which involves concepts like sacred order, natural order, tradition, sanctity, sin, and pollution, and promotes the protection of the soul, the spirit, spiritual aspects of individuals, and nature. These discourses, which Shweder et al. (1997) defined as symbolic systems for describing aspects of experience, are essentially synonymous with the concept of moral voice described above.

Different cultural traditions foreground particular moral goods which predominate in the development of social practices and moral ideology, so the degree to which the three moral discourses are employed varies (Shweder et al., 1997). Shweder and colleagues (1997) argued that in Hindu society, it is the discourses of community and divinity that are foregrounded and institutionalized, whereas in the United States it is the discourse of autonomy. Other scholars have illustrated cultural differences in the extent to which a moral voice is adopted, and the propensity of individuals in Western societies to invoke an ethics of autonomy versus other sociocultural settings in which a different moral voice (particularly one of community) may be more prevalent (e.g. Haidt, Koller, & Dias, 1993; Miller & Bersoff, 1992; Snarey & Keljo, 1991; Vasquez, Keltner, Ebenbach, & Banaszynski, 2001). Even when the general moral voice is the same across different societies, however, specific moral concepts and practices (such as the concept of karma) are often culturally grounded and distinct (Shweder et al., 1997; Tappan, 2006).

Just as culture is an ever-evolving process rather than something static, moral practices and understandings change through time. Historically, moral codes in Western societies used to be strongly institutionalized through religion, particularly a Judeo-Christian ethic framed in the

language of sin and the redemption of sin (Katz, 1997; Luckman, 2002). Now the moral norms and codes enacted through moral communication and everyday interactions are more heterogeneous (Luckmann, 2002). Similarly, as socio-historical conditions change, particular behaviours become moralized; objects and activities that were previously considered preferences take on values and moral significance both in individual lives and at a shared, sociocultural level (Rozin, 1997; Rozin, 1999). This process of moralization has been widely illustrated within Western societies in the field of health. Increasing knowledge about the variables contributing to disease and health has been accompanied by a moral focus on individual risk, choice, responsibility, and deviance and the moralization of things like smoking, eating particular foods, and exercise (see, e.g., Brandt, 1997; Conrad, 1994; Leichter, 1997; Katz, 1997; Rosenberg, 1997; Rozin, 1997; Rozin, 1999; Rozin & Singh, 1999). Conversely, amoralization (the diminishment or loss of moral significance) further alters the moral landscape of a society (Rozin, 1997). A sociocultural perspective on morality therefore accommodates change and variation in expressions of morality and what constitutes moral (and immoral) behaviour.

2.2 Theoretical and Epistemological Assumptions Guiding the Current Work

Based on the above description of a sociocultural perspective on morality and commonalities in how morality is conceptualized across disciplines, several theoretical principles or assumptions about morality guided the current work. Firstly, morality was understood as being both prescriptive and about the “good”, so that expressions or judgments of value, disrespect and respect, responsibility, and what one ought or ought not to do were considered key markers of the moral domain. Secondly, morality was considered to be shaped within particular socio-cultural-historical contexts. This entailed the assumption that the specific ways in which Canadian women negotiated morality in their narratives of pregnancy, childbirth, and the transition to motherhood were done in relation to culturally based values, beliefs, and practices. It also informed the attempt to understand how moral understandings were intertwined with and informed by culturally dominant ideologies of risk and mothering in these women’s contemporary childbirth-related experiences. Thirdly, morality was understood as being enacted and expressed within everyday social interactions. This assumption is consistent with the methods employed within the current research, which avoided the deliberate invocation of moral reasoning and instead sought to understand morality within women’s descriptions of and

reflections on their experiences with the topic at hand. Lastly, morality was conceptualized as being expressed and constructed primarily through language. This privileges or draws particular attention to discourse and moral voice, and logically positions narratives as ideal for understanding the moral aspects of childbirth.

As Reiger and Dempsey (2006) stated, “Birth can be seen primarily in terms of various levels of activity— from broad cultural discourses to local practices and embodied, psychological realities, all of which intersect and over-determine each other in complex ways.” (p. 367). It is the narrative space between women’s embodied and psychological experiences of birth and cultural discourses which is the focus of the current study. Narratives can be many things, including a short answer to a question, an exchange between multiple people, and an extended monologue. For the present research, narratives are conceptualized as communications where an individual connects events into a sequence that is consequential both for later parts of the story and for the overall meanings being communicated by the speaker (Riessman, 2008).

As expressions of experience (Bruner, 1986), narratives refer to past experiences but also construct and create them (Mattingly, 1998; Riessman, 2008). Therefore, although narratives are connected to the childbirth-related events which women live on a bodily level they are also thoughts and reflections upon these events, organized into a sequence or story to be told in a particular context (Riessman, 2008). As Pollock (1999) noted, birth stories are similar to a re-performance of the initial experiences on which they are based. In the birth stories Pollock heard, most followed a linear, progressive structure (from planning to conception to pregnancy to a whole and healthy birth, much as it is described in prenatal classes). Many also followed an “almost-but” structure, where the labour itself involves danger, hardship, or conflict but resolves in the good ending of a healthy baby— delivering “order from disorder and pleasure from abandon, transgression, and pain” (p. 4). Although the narratives highlighted in Pollock’s work were ones that she felt challenged conventional birth storytelling in different ways, the fact that a conventional structure exists speaks not only to more statistically common embodied experiences but also shared understandings of what childbirth is supposed to entail.

A number of scholars (Billig, 1997; Bristor and Fischer, 1993; Gergen, 1985; Harre, 1995; Sherrard, 1997; Weedon, 1997) have pointed out that narratives allow us to see how individuals negotiate with ideology and discourse to construct meaning and identity, and make sense of their experiences (Swanson & Johnston, 2003). As moral orientations or ideologies are

expressed through words, language, and forms of discourse (Tappan, 2006), the ways in which women narrate their birth-related experiences allows for an examination of how moral language, voice, and discourses are and are not employed in relation to women's childbirth related experiences. Moreover, as identities are also constructed through narrative (Riessman, 2008), when women narrate their experiences of childbirth they are constructing particular identities as mothers and moral individuals. The use of narratives to understand the moral aspects of childbirth can also, therefore, lend itself to the exploration of how they are connected to women's identities as mothers.

Consistent with this conception of narratives as constructions of experience rather than solely reflections of experience, and the grounding of morality within language and social interaction, the research questions guiding this project were framed within the epistemological perspective of social constructionism. Social constructionism is anti-essentialist and anti-realist in orientation; there is no real, objective 'essence' residing in phenomena and our knowledge is not a direct perception of reality or an objective truth (Burr, 1995). According to the social constructionist perspective informing this project, and in line with Crotty (2003), phenomena such as childbirth are not solely objective realities, but rather constructed phenomena which are meaningful because of the interpretations and understandings of human beings. That is not to say that birth is not a highly embodied experience; however, the way in which it is experienced and the meanings invested in it rely on language and sociocultural understandings. One could argue that the body is consistently enacting social and cultural meanings (see, e.g., Butler, 1988), so that the bodily experience of birth is shaped by and reflects cultural understandings. However, it is the meanings which are communicated by women as they narrate their experiences which are the focus of the current work. Childbirth is grounded in meanings that are culturally, socially, and individually negotiated on a daily basis, and trying to understand this process is important because these meanings inform lived experiences and identity. The adoption of a social constructionist framework privileges the investigation of shared, socially grounded understandings and discourses, and how these are employed in the construction of phenomena and identities. Through this framework, the ways in which women understood and created meaning from their childbirth-related experiences were explored.

2.3 Reflections on My Position in This Research

In addition to the theoretical and epistemological frameworks detailed above, as a researcher, mother, and human being I brought my own assumptions, values, interests, and experiences to this work. As Finlay (2002) argued, most contemporary qualitative researchers accept it as a given that research and meanings are co-constructed, so that the researcher is an active participant in determining what data is generated and how it is analyzed and presented. Some reflection on my own position as a researcher is therefore warranted, in order to try and make explicit some of the intersubjective elements that informed the generation of data, analysis, and writing associated with this research.

The first of these intersubjective elements is my own social location as a mother. This social identity afforded me status as an “insider” in the sense that, like my participants, I too have undergone experiences of pregnancy, childbirth, and mothering, and therefore have embodied and personal knowledge of these experiences as well as immersion in the discourses which inform them. As noted by Acker (2000), being an “insider” may elicit somewhat different narrative accounts from participants, and even put the researcher in a better position to generate trust, sharing, and the expression of emotions during interviews. During the process of data generation, I spontaneously drew upon this social identity as a means of making a personal connection with participants whom I had not previously met. I deliberately continued to bring this aspect of myself to the forefront as I realized the extent to which it fostered interpersonal connection, put participants at ease, and increased their comfort with sharing both technical and intimate details of their childbirth and mothering experiences. It should be noted, however, that the actual values and experiences that participants recounted were variable and diverse, so that I was more or less of an insider and outsider at different points in our conversations. As Chavez (2008) described, personal identification or closeness between the researcher and participant shifts from moment to moment as not all aspects of experience and social identity will be shared.

Although having a common social identity and sharing many similar experiences with my participants facilitated and enriched the methods of data generation described below, it also entailed an extra level of reflection when doing analysis and writing work (particularly the latter). Specifically, I was conscious of which common aspects of my participants’ stories I connected with the most on a personal level, and did not want my analytic and writing choices to be dictated by or auto-ethnographically include my own experiences (see Finlay, 2002 for a

description of analytic processes which do involve this type of reflexivity). I also was not necessarily interested in “bracketing”, whose various definitions involve the identification (and often the “setting aside of”) one’s own assumptions, biases theories, previous experiences, etc. (see Tufford & Newman, 2010). Essentially, I approached this research with the understanding that I was a co-constructor of data and meaning, but did not consider the research to be about me. I therefore recognize that my own experiences contributed to the conversations that unfolded with participants, my reactions and re-reactions upon reading their transcripts, and some of the choices that I made in writing (for example, in trying to “balance” dominant themes with less dominant examples in order to construct an analysis which included multiple voices and perspectives). However, I also attempted throughout to present an analysis where my analytic claims were thoroughly grounded in the data/participants’ own words. In addition to the importance of this type of grounding for the trustworthiness of qualitative work (Morrow, 2005), I considered the inclusion of many (and some long) excerpts from participants’ narratives important in order to maximize the extent to which their voices and experiences were represented in the final document.

Finally, I was aware that my own personal beliefs about childbirth (which are much more situated in alternative childbirth ideology than medicalized discourse) might encourage particular interpretations of the data. This was compounded by my personal identification as a proponent of midwifery, a view that has been greatly strengthened by my academic work and increased exposure to the many positive outcomes of midwifery care that are documented in the literature (see, e.g., De Koninck, Blais, Joubert, & Gagnon, 2001; Harvey, Rach, Stainton, Jarrell, & Brant, 2002; Oakley et al., 1996; Sandall, Soltani, Gates, Shennan, & Devane, 2013). Again, I engaged in some reflection on this as I wrote my analysis, and attempted to present an analysis which fairly explored the main themes in women’s narratives while also honoring the diversity among stories. Ultimately, I recognize that I approached this research with my own values, beliefs, and experiences, but strove to construct an analysis that is not focused on them and is both truthful to the stories that women shared and well-grounded in their voices.

2.4 Methods

2.4.1 Participants

In order to investigate how women understand and morally position their childbirth-related decisions and experiences, and how these moral valuations are connected to broader discourses of mothering and childbirth, interviews were conducted with twenty-one women who had given birth to their first child within the past eighteen months. Although the vividness of the childbirth experience and the tendency of women to spend a lot of time thinking and talking about their birth may lead to generally consistent description of the details even many years later, some details may be forgotten or their meaning and significance may change with time (Simkin, 1992; Waldenström, 2004). This is not a methodological limitation per se as the epistemological grounding employed does not assume or require that a narrative is completely factually accurate; narratives are a way of making sense of and expressing experience and tend to change to some degree with each retelling (Bruner, 1986; Riessman, 2008). However, in order to try and maximize the level of detail and richness of the narratives, twelve months after birth was viewed as a reasonable cut-off point for participant inclusion. During participant recruitment, this was extended in order to accommodate potential participants who were interested in participating but whose children were older than one year. This resulted in a sample where the age of participants' child ranged from 2 weeks to 19 months old. Participants whose babies were older at the time of interview tended to narrate extremely detailed, vivid descriptions of their childbirth experiences with few instances where they indicated not being able to remember a detail they wanted to share, suggesting that the ability to construct a detailed and vivid narrative was not impeded by a longer passage of time since the birth. Moreover, these participants had much more to say about their transition to motherhood, given that they had a broader spectrum of motherhood experiences to draw upon than those whose babies were very young.

Participants were recruited through a variety of methods aimed at capturing a relatively diverse sample. The primary method of recruitment was pamphlets (see Appendix B) advertising the study. The midwives who work in Saskatoon aided me with participant recruitment by including a number of pamphlets on their information table in the Women's Health Centre at City Hospital. These pamphlets were also given to women at their postpartum follow-up visits by Healthy and Home nurses, who provide postpartum support and follow up to families in

Saskatoon and surrounding areas⁴. Although this method appeared the most effective, it was also costly. To limit the burden on Healthy and Home nurses, pamphlets were put into the information packets given to all postpartum women at follow-up (which was approximately thirteen per day) regardless of whether their newborn was their first child. I considered the inclusion criteria of the birth being the woman's first to be important, as I thought that women likely spend the most time explicitly reflecting upon their childbirth related options and experiences with their first birth. Similarly, I thought that with their first birth women may also be the most likely to experience a disconnect between cultural discourses of childbirth and motherhood and their experiences. I therefore expected that narratives about a first birth (as opposed to a subsequent birth) would likely contain more explicit reflection, emotion, and negotiation of meanings which would lend itself well to my exploration of the research questions posed. This meant, however, that by far the greatest proportion of pamphlets was given out to women who did not meet the inclusion criteria for the study. Given the costly nature of this method of recruitment, I limited it to two rounds of pamphlets (which still meant that several hundred were given out). Other formal methods of recruitment included posters (see Appendix C), which were placed at civic centers around the city, and an ad on Kijiji (see Appendix D). Finally, several participants were recruited through word of mouth or snowball sampling, whereby either someone I knew or a previous participant mentioned the study to other women who met the inclusion criteria.

The final sample of 21 women who were interviewed were all Caucasian except one woman who identified as Métis, but were otherwise more diverse. Most women (14) reported no religious affiliation, with others identifying as Catholic (3), Buddhist (1), Jehovah's witness (1), Protestant-Evangelical (1), and one as belonging to the Church of Jesus Christ of Latter-Day Saints. The majority of participants (11) reported having completed an undergraduate degree, with three indicating high school as their highest level of education completed, three reporting having completed trade school, and four indicating that they completed some form of graduate education. Overall this group of women were quite highly educated, and presumably of moderate to high socioeconomic status (SES). All women reported being part of the workforce (although many women were on maternity leave at the time of the interview and one woman had just made

⁴ A description of this program can be found here:
https://www.saskatoonhealthregion.ca/locations_services/Services/Healthy-Home

the decision that she was not going to return to her career), and held a variety of jobs (e.g. dental assistant, grouter, editor, youth care worker, student, interior decorator, nurse, journalist). Of particular note was that two of the women reported doula as their primary or part time occupation; these women's narratives both employed more technical understandings of the birth process and were more highly reflective of an alternative birth ideology.

Participants ranged in age at the time of interview from 23 to 36 years ($M = 29.48$), with none really falling outside of what is generally considered common or appropriate child-bearing age in Western societies. This likely had implications for the ways in which women made sense of and narrated their experiences, as research suggests not only that teenaged mothers are often stigmatized and constructed as problematic (Breheny & Stephens, 2007; Hadfield, Rudoe, & Sanderson-Mann, 2007), but that older mothers may be viewed negatively and portrayed as selfish or irresponsible as well (Hadfield et al., 2007; Shaw & Giles, 2009). It should be noted, however, that with demographic shifts in Canada towards a later child-bearing age⁵ comes changing cultural conceptions and discourses regarding when it is normal and appropriate to have children (Whitley & Kirmayer, 2008). In fact, Whitley and Kirmayer found that their Anglophone Euro-Canadian participants who were in their early twenties (under 25) did feel stigmatized as a result of their "early" childbearing. In the current research, however, only two participants were younger than 25 at the time of interview and age-related stigma did not emerge as a salient feature in any of the narratives. Also consistent with culturally normalized ideas about childbearing, 18 of the 21 women interviewed were married or in a partnership that had lasted longer than two years. Two women left their partners while pregnant and another woman separated from her husband several months after the birth of her child.

2.4.2 Data Generation

Data for the current research were generated through narrative interviews with participants. Narrative or open-ended interviews are useful in exploring how participants construct meaning, as they are designed to elicit participants' interpretations and descriptions in extended narrative fashion (Rothe, 2000; Riessman, 1993). Although extended stories can even be elicited through questions which can be answered with a yes or a no, questions which open up

⁵ In 2011, over half (52.2%) of all babies in Canada were born to women aged 30 or over, compared to 23.6% in 1981, and the average age of first-time mothers in 2011 was 28.5, which has been shifting steadily upwards for the past half-century (Statistics Canada, 2013).

topics are more likely to encourage rich and detailed narratives (Riessman, 1993). In order to maximize participants' control in shaping their interview narratives, I developed an interview guide which (in line with Riessman's recommendation) had only seven broad, open ended questions designed to elicit women's stories about their experiences with pregnancy, birth, and the transition to motherhood (see Appendix E). For each question, I had a list of several prompts prepared that I could refer to, in case the participant had trouble getting started talking and to encourage elaboration (Riessman, 1993). For example, one of the primary questions on the interview guide was: *"I'm interested in hearing about your labour and the birth of your baby, both the events that happened and other details that you feel are an important part of the story. Starting wherever it makes sense to you to start, tell me the story of your labour and birth!"* Prompts for this question included *"What are the things that you remember most about your labour?"*, *"How did you feel about that"*, *"At what point did that happen"*, *"How was that decision made?"*, and *"How were the other people in the room involved in your labour?"* I found that women tended to launch easily into detailed and lengthy narratives, particularly regarding their labour and birth, and so I adopted a relatively passive interviewer approach during most of the interviews and instead tried to engage in active and supportive listening, using verbal (e.g. *"Yeah"*) and non-verbal (e.g. nodding) affirmations and other expressions which illustrated I was engaged and understanding (and empathetic to) what participants were communicating (Flick, 2009; Wengraf, 2001).

Participants were interviewed at a place of their choosing; most women preferred that I come to their home but several interviews were conducted in an interview room at the University of Saskatchewan. Upon meeting each participant I would introduce myself and chat a little bit with them, introduce the study itself and explain what their participation would entail, and provide them with a brief questionnaire (see Appendix F) comprised of basic demographic questions such as age and age of child, marital status, and level of completed education. Interviews themselves took approximately an hour to complete, with the average interview time being 65 minutes. Women who participated were compensated with \$15 for their time and willingness to share their experiences, although two women declined this compensation stating that they just wanted to help and share their stories. The research was conducted in accordance to the ethical standards delineated in the Canadian Tri-Council and University of Saskatchewan policy statements about research involving human subjects. Ethical approval was also obtained

from the Saskatoon Health Region, who assisted me with participant recruitment as described above.

As interviews were completed, I transcribed them in reference to several of the basic conventions suggested by Flick (2009). The transcription conventions I used were as follows:

I: Interviewer

P: Participant

Word: Underlining indicates stress or emphasis

Wor— : Hyphen indicates that a word, sound, or sentence was broken off or shifted abruptly

WORD: Drastic increase in volume is indicated by capital letters

Word...: Ellipses indicated a word or sentence which trailed off, either resumed or not

(()): Used to indicate paralinguistic utterances— for example, ((laughs)) and significant pauses

(): Used to indicate the title of names within the transcript— for example, (Partner)

Keeping some basic features of *how* things were said on the transcripts aided in the process of understanding how women made sense of their childbirth related experiences in their narratives.

As I transcribed each narrative I wrote up initial analytic notes, which illustrated and organized features of the narrative which I found particularly interesting or relevant to my research question (see example in Appendix G). These initial notes helped me to gain a deeper understanding of the transcripts, a critical first step in many forms of qualitative analysis (Wertz, Charmaz, McMullen, Josselson, Anderson, & McSpadden, 2011). Thus, by the time I began the more formal analysis described below, I was already cognizant of some of the features and patterns within the data that were relevant to the research questions being explored.

2.4.3 Interviews

The interviewing and transcription process resulted in 21 transcripts (almost all between 20 and 30 pages) documenting women's birth narratives as constructed in the interview, as well as their communicated experiences with pregnancy and the transition to motherhood⁶.

Interestingly, most women did not describe their pregnancy at length or with a lot of detail, unlike their descriptions of labour and delivery which tended to be very detailed in terms of the

⁶ Given the specific focus of this dissertation, some of this material was not required to answer my research questions; however, I coded *all* data as described in this subsection. Analysis of this additional data, consisting mainly of the transition to/experiences of motherhood, will be communicated in other forms (e.g. presentation, manuscript) as its inclusion would have diminished the coherency of this dissertation.

events women recounted and how they felt during these experiences. For the most part, women told very vivid stories with few questions or prompting on my part, and I had the sense that they had previously told versions of their birth story to others or had spent a lot of time thinking about it and recounting it to themselves. As Simkin (1992) stated, women tend to recount their first birth experiences “vividly and with deep emotion” (p. 64).

Pollock (1999) noted that most birth stories follow a linear, progressive structure, and one that is “almost-but” (p. 4); where the labour itself involves conflict or danger, but resolves in a happy or good ending of a healthy baby. The women in the current research were not an exception to this observation. Their childbirth narratives tended to begin or solidify⁷ with a description of early labour. This phase of labour was characterized primarily for most women by uncertainty (generally accompanied by excitement) as they tried to interpret the physical sensations they were experiencing in relation to their understanding of labour norms⁸. For the most part, women’s stories of early labour detailed their preparations (e.g. phoning care providers or family) and actions (e.g. walking around to encourage contractions). Narratives then followed different forms of the conflict/danger plot noted by Pollock (1999), as women’s labours deviated from normative expectations. The form that this took varied between women but generally involved situations like fetal distress, intense pain, stalled labour, home-to-hospital transfers, conflict with primary maternity care providers, and/or unexpected twists in delivery timing, place, and assistance⁹. These segments of narrative were characterized by much more emotional language as women recounted experiences that were variably intense, challenging, exciting, frustrating, and frightening. Indeed, during interviews women often became extremely animated during these re/tellings of labour leading up to the delivery of their baby. Descriptions

⁷ In the interview schedule, questions about pregnancy and planning were followed by asking women to tell me about their labour/the story of their child’s birth. Participants occasionally described aspects of labour which connected to experiences of pregnancy (this was often in relation to maternity care provision or childbirth-related options), so that their birth-related narrative was not wholly linear. However, the beginning of labour tended to be the start of a progressive and chronological story even when women had described some aspects of their labour previously or “foreshadowed” particular events. Although where a birth story might “begin” would be open to interpretation (one could consider stories of conception and pregnancy part of a birth narrative), there was a solidification of a progressive, linear story which generally began just prior to/with the onset of labour.

⁸ Pollock (1999) noted that women use “normal” temporal labour plots in order to emplot their own labour and understand their experiences; this was evident for many of the women interviewed as they described their uncertainty about whether they were in labour, how far along they were in the process, and what they should do.

⁹ These deviations sometimes, but not always, implied risk of a negative labour outcome; in other cases they centered on the intensity and challenge of labour and delivery or related challenges that the woman had to overcome, which were often related to maternity care providers.

of the delivery were also emotional for many of the women interviewed (several women were visibly emotional re/telling the event), and constituted the resolution of chaos, conflict, or danger and the “good ending”; delivering “order from disorder and pleasure from abandon, transgression, and pain” (Pollock, 1999, p. 4). After this point there was significantly more divergence in narrative structure as women continued to describe their experiences, since women differed in their focus (i.e. what was salient to them to recount after describing the birth of their child) and described a wide range of emotions and reflections related to their labour, the delivery, and their transition into motherhood.

2.4.4 Methods of Analysis

After completing my initial analysis notes during transcription, I engaged in two main phases of analysis with the transcripts described above. The first phase was a general thematic analysis, intended to identify patterns within how women narrated their childbirth-related experiences. As noted by Braun and Clarke (2006), thematic analysis is a flexible method which can be compatible with a range of theoretical and epistemological perspectives. Thus, I could utilize it in a way that was congruent with the theoretical perspectives described earlier, which entailed particular assumptions about the importance of language in constructing meaning. The primary purpose of this first phase of analysis was semantic: to describe and interpret based on the explicit meanings observed within the data. Following Braun and Clarke (2006), data was coded in order to identify interesting and relevant features of the data. This coding was inductive, so that codes were developed based on what I saw within the data rather than being pre-determined according to theoretical concepts. As a useful organization tool, NVivo was used for coding. After completing the coding, codes were sorted into initial themes, and their coherence, relationship to each other, and relevance to the research questions posed were considered. After this stage of analysis, I had a set of general themes which illustrated how women made sense of their childbirth-related decisions and experiences in their narratives.

At this point, I used NVivo to recode all the narratives again, this time using values coding (Saldana, 2013), to explore in more detail how particular ideologies and discourses were constructed through women’s narratives. This second phase of analysis entailed the identification of values (the importance attributed to a person, thing, or idea), which illustrated what women considered important or at stake in their childbirth-related experiences and decisions. In addition to coding for values, I also coded for beliefs, which Saldana describes as “part of a system that

includes our values and attitudes, plus our personal knowledge, experiences, opinions, prejudices, morals, and other interpretive perceptions of the social world” (2013, p. 111). Once codes were generated, I examined which (and how) particular values and beliefs were reflected in the themes I had generated previously, and also considered how they coalesced together as part of broader ideologies and moral frameworks which were invoked within participants’ narratives. This phase of analysis was to some extent a form of latent thematic analysis, as I sought to explore the underlying ideas, assumptions, and ideologies (including the moral) which appeared to inform how women made sense of their experiences (Braun & Clarke, 2006).

Following these two phases I explored my analysis more broadly, considering how particular themes fit together within and across narratives and extending my interpretations in relation to the theoretical work on morality. Weaving together the findings generated through these two phases of analysis, the following four chapters describe important aspects of how women understand and position their childbirth-related decisions and experiences in relation to moral and ideological frameworks. Chapter 3 explores the ways in which women described their preparation for birth and the different birth-related options available to them, including how these descriptions drew upon moral and ideological frameworks. Chapter 4 extends on many of these themes in order to delineate how women adopted and negotiated with a moral voice of care and responsibility that positioned them as morally responsible for birth outcomes. As another central theme in how women understood their birth-related experiences, Chapter 5 explores the related concepts of agency, autonomy, and self-determination, and the salience of these concepts to women’s narratives and how they made sense of their experiences. Finally, the focus of Chapter 6 is on the ways that women described morality as being socially negotiated in the form of birth-related stigma, and the strategies that women used in order to maintain a positive moral and maternal identity in the face of moralizing judgments from others. Together, these chapters represent major themes within women’s childbirth narratives related to the moral dimensions of childbirth and the frameworks that women drew upon to create meaning from their birth experiences. The analyses in chapters 3-6 are primarily descriptive in relation to theory, with a relatively neutral analytical voice and minimal consideration of the broader implications for practice or policy. In the final chapter of this dissertation I pull together the analytic findings to make some general conclusions, and consider their implications for the provision of maternity care.

CHAPTER 3

“YOU GOTTA KNOW WHAT YOUR OPTIONS ARE”:

BIRTH PREPARATION AND THE VALUATION OF BIRTH-RELATED OPTIONS

The focus of the current chapter is to explore the different ways in which the women in this study narrated their impending birth and different birth-related options. As such, the scope of this chapter primarily entails the sections of women’s narratives in which they either described the period leading up to the impending birth, or spoke about birth-related options in a general fashion. Of particular interest is how women drew upon ideological discourses of birth (medicalized or natural) and the extent to which they positioned different birth-related options within a moral framework, or adopted a moral voice in their narratives. This analysis is separated into two main sections, based on this overarching purpose and the themes which were constructed during analysis. Firstly, the ways in which women emphasized the importance of preparing for childbirth are explored, and how these reflected particular understandings of birth and maternity care (Section 3.1). Secondly, the ways women described birth related options are delineated, and how these descriptions drew upon moral and ideological frameworks (Section 3.2). In exploring how women positioned birth options within their narratives, I first describe the ways women talked about their choice of care provider, and the values and beliefs which informed how they understood their decision. Secondly, the ways in which women positioned birth related options within their narrative are described, particularly the strong influence of alternative childbirth ideology on how women talked about particular options and decisions. Finally, the ways in which women drew upon a moral framework or spoke in a moral voice (or not) in their descriptions of birth related options is explored. Taken together, the findings explicated in this chapter illustrate in-depth how this group of contemporary Canadian women made sense of, described, and de/valued the options that were available to them, and how these meanings were associated with dominant ideological constructions of birth itself.

3.1 The Prepared Birth

Women’s narratives reflected a significant degree of deliberation, decision making, and preparation regarding their impending birth, constructing childbirth as something which requires

active education and engagement to successfully achieve. The majority of women described participation in standard hospital-provided prenatal classes, although a few women took hypnobirthing classes, prenatal yoga, or other alternative, labour-focused courses (either in addition or in lieu of hospital-based courses) to help them manage labour. Women also sought information from multiple different sources, including the Internet, health care providers or others perceived as knowledgeable about birth, childbirth books, and documentaries and videos. They engaged in both mental (e.g., visualization) and physical (e.g. prenatal yoga) preparation for birth. Finally, they engaged in preparation through the decisions that they made in order to set up a particular type of birth by choosing particular care providers and birth settings. From the initial choice of prenatal care provider to physical and mental preparation for the labour itself, all the women interviewed engaged in some degree of knowledge seeking and preparation for the birth of their child.

References to researching different birth options featured prominently within women's narratives. As Lana explained:

I'm the type that, like, I wanted to know everything, like I wanted to know my options, that's why I read a lot. But I was pretty ok with however way it went, but I wanted to know what are my options, you know? I'm that t—I want to know I could do this, this or this, and then if we end up doing any of them, I know what to expect kind of.

For Lana, preparing for birth through researching different birth-related options was framed predominantly as personally helpful or anxiety relieving, a way to understand and cope with an unfamiliar landscape. Researching different options was a way to assert control over an experience that was to some extent unpredictable; if things did not go according to plan Lana wanted to at least have an understanding of what could happen and what different options might be like. She went on to state “*I think it was important for me, just with my personality type was like I said, I wanted to know as much as I could, which helped me relax I think about things.*”

Lana and several other women constructed birth as unpredictable and the particulars as being best approached with an open mind. While these women still engaged in knowledge seeking and preparation, they emphasized the importance of being flexible and the understanding that even the best laid birth plans may go awry. As Christina stated,

We definitely departed from the birth plan, um, I've since heard people um say that birth plans are pointless because they never go as planned, but um, the book I read was really

good— The Doula's Guide to Birth. Because they said, you know, have a plan, have a birth plan, but know that that might not be exactly how it goes. And your birth plan can include those exceptions, right? So that was really intuitive, because I was already thinking that way. And in my birth plan it said like, if we end up at the hospital, like this happens, if this happens, so you've got like, this is plan A, and then of course there's like, B C and D kind of thing.

Christina's comments express several women's beliefs, that birth is unpredictable and, to an extent, unknowable in advance of the experience. Framed within this context, birth preparation can therefore be understood as self-education and knowledge in order to best deal with whatever that experience involves. With the underlying belief that labour was inherently capricious and could not be expected to conform to a particular path, some degree of knowledge and preparation was understood as beneficial or even necessary in order to successfully manage whatever events occurred.

Although Lana and Christina's narratives reflected both the importance of preparation and the belief that birth is unpredictable, Valerie was one of the few women who put very little emphasis on knowledge or preparation. Although she did make a reference to having "*read the books and stuff*", within Valerie's narrative birth was depicted as an event to be experienced rather than something which required her preparation or expertise:

Again, I wasn't— I didn't make any firm decisions on like how I wanted the labour and delivery to go, because every time I've heard of birthing plans and stuff, they just get thrown out the window, or people are too disappointed if it doesn't go according to plan. So I kind of left it open, just going to the hospital, seeing what I can get through myself, if I need the epidural then, then I'll get it, but just see what I can get through. And then yeah, just see how the— how the whole ordeal goes... so I was pretty open minded about it. And my doctor's pretty good too, so I put all my trust in her, and— and I knew she wouldn't be giving me anything if I didn't need it too, so. So, yeah, my decisions were pretty much just go to the hospital and keep my mind open ((laughs)).

For Valerie, birth was depicted as an ordeal and something which could best be managed by not setting a firm plan in place, and by placing decisions in the hands of her trusted care provider. In relation to this understanding of birth and her role in it, preparation and knowledge were not particularly necessary or valued, as she had a trusted expert who already possessed the necessary

knowledge to make good decisions about her care. Cherise described a similar understanding of birth; she avoided talking much about what birth would be like and regretted following through with a girlfriend's suggestion that she watch some childbirth videos on YouTube. Cherise's preparation for birth was a minimal part of her narrative and focused on her efforts to ensure she had a good care provider. She described receiving advice from her mother and doing her own research into particular care providers:

“So she had that done, so she was like you know, go to this guy. And I looked up the reviews online, and everything was really great, so I was like, ok! And like, and I went to a further hospital, cause I wanted this doctor, specifically, um, or— or one of the doctors that works in that hospital, cause I knew that they were all really, really good.”

For Cherise and Valerie, rather than research into childbirth itself and the different options available or any other forms of physical or mental preparation, the importance of feeling comfortable with a care provider who was able to assume an expert role and whom they could trust to act on their behalf during the labour was given primacy. Although this still reflected the importance of preparation, it focused preparatory efforts on the ability to feel safe and comfortable with the birth while minimizing one's own responsibility for knowledge, decision making, and control.

In contrast to Cherise and Valerie, most of the other women interviewed situated research as an important factor in being able to shape and control their birth experiences. Beyond the ability to feel comfortable dealing with new and unfamiliar experiences of labour and delivery as they arose, women described preparing for the birth through research as a way to ensure, as much as possible, that they were able to have a birth experience with which they were happy. For some women, this meant research and self-education throughout the course of their pregnancy in order to make a number of specific decisions about what they wanted. As Karen stated:

So we were really lucky that we got into the midwifery program. And then from there, um, you know, I'd been doing research and reading a lot of stuff before that, but once I started meeting with the midwife our visits were long and they'll answer any question that you have right, and I started doing a lot more research and then having a lot more discussions with them about the kinds of things that uh, you know, the kin— the way that we wanted our birth to be. And, um, you know that just sort of fueled more discussion and fueled more thought.

Having access to information about birth and the different options available allowed women to feel that they were making informed decisions about their labour and delivery. The effort which women put into discussing, reading, and thinking about different childbirth options was described as an important part of figuring out what they wanted their birth to be and how to make decisions which would ensure it was enacted according to their wishes.

Although generally invoked in relation to initial decision making about options prior to birth, several women also positioned preparation as important for making informed decisions during the labour and delivery. For example, women discussed preparation in relation to feeling pressured to accept some level of intervention or protocol by health care providers. Mackinzie described a scene during her labour where she was being attended by a resident whom she did not know or trust to make an informed decision on her behalf:

Um... so he... not that he didn't— sounded quite like he didn't know what he was doing, but he sounded like he didn't quite know what he was doing ((chuckles)). So he told us what the doctor— they'd called the doctor on call, and she'd said to induce us. And we'd— well I guess this is part of the pregnancy thing, we did read a little bit about that and why we didn't necessarily want to do that, because it sounded a bit risky in terms of changing the baby's heartbeat, and kind of stress on the fetus and stuff like that, compared with a lesser risk of infection once the water had broken. Um, and the nurses on the ward sort of confirmed that, because we told them and said we're not too sure what to do, and they were really nice actually, because they said you know, we can advocate for you if you don't want to get this.

Mackinzie positioned the research that she and her partner had done during pregnancy as allowing her to understand the potential ramifications of the intervention being suggested by the resident, and make a decision accordingly (although as discussed in Chapter 5, it was only with the help of an advocate that she felt able to enact that authority). Similarly, Kiana described her lack of research as negatively impacting her ability to make informed decisions and to assert agency in a setting wherein she perceived a significant power imbalance between herself and the health care providers. Kiana had done some preparation for the birth of her baby; she and her partner attended prenatal classes through the health region, and she had watched several birth-related documentaries and videos. She firmly characterized her approach as one of avoidance, however, and felt that she had done little active preparation and particularly decision making

regarding the impending birth. Within this context of understanding, Kiana repeatedly emphasized the importance of preparation in being able to make decisions about her care and assert a degree of control over the birth process:

But I think that yeah, I would definitely force myself to prepare more. And get myself sort of mentally ready and also just... really prepare myself, ahh, to be able to talk to those doctors and tell them what I want. And know what I want first of all, I think I just still was kind of wavery and I didn't know what I wanted, I didn't know what was good to have or what was necessary, like do I need this epi?

Kiana described the birth of her baby as traumatic, framing it as a painful, chaotic, and powerless experience. She framed her lack of knowledge and preparation for the birth as one of the factors which contributed to what she characterized as a position of passivity and lack of power to shape a more positive experience. Having gone into labour without a lot of research and forethought into birth and the different options available, she found her ability to make informed decisions or assert her wishes hampered.

Women who were pursuing more alternative births tended to explain their preparation for birth in ways which placed a high degree of value on research (both medical and models of birth) and the ability to enact informed choice, as they strove to enact birth in a way that fell outside of the dominant model of maternity care in Canada. These women also described mental preparation as necessary as important for achieving their desired birth, as Carmon explained:

I spent a lot of time during the pregnancy like, mindfully uh, working towards the kind of birth that I wanted. I know that you don't get that really wonderful birth if you don't trust it. And if you have a lot of fear or reservation you need to work on it, and so I did, um, every day. I probably spent hours on a daily basis picturing what I wanted, what I felt comfortable with. If I was afraid of something particular I wrote about it and I talked about it, and yeah, it was, it was good, I had a great time. I really wanted to be pregnant and really wanted to put the effort in.

The degree to which Carmon reflected preparation as a crucial part of her birth experiences is clear in the above quotation; hours of daily thought and preparation constituted a greater emphasis on preparation than most of the other participants. Carmon's words also, however, illustrate the high value she placed on the birth itself and on the ability to achieve a particular experience. Carmon did not want just any birth, she wanted a "really wonderful birth" (which

for her, was an unassisted birth at home), and this involved not only preparation in order to make specific birth-related choices, but also to think about and experience birth in a particular way.

Women who described this mental preparation drew heavily on alternative birth discourse which actively rejected medicalized understandings of birth grounded in risk and fear. Annabel explained the importance of mental preparation to reframe her understanding of birth:

So women especially in Western civilization are given a very fear factor around their pregnancy and labour and it's not normal, it's not an emergency and you don't need a doctor to intervene. Women are made to feel like they can't do this, and that you need some more outside support to be able to do this. Your body is not enough. So I read a lot of books that were kind of reinforcing— trying to get rid of those old negative ideas and just having positive affirmations. And also to train myself to not view the sensations associated with labour as pain, but just as sensations...so I did a lot of like, positive reinforcement, and a lot of prep to know that this was going to be one of the most intense experiences of my life, but that I can do it and your body knows how to do this.

Annabel's description of mental preparation invoked alternative birth discourse which positioned the woman as strong, emphasized the capability of her body to give birth, and rejected medical intrusions on the process. In addition to self-affirming preparation, part of preparing for a non-traditional birth involved the active rejection of medicalized constructions of birth which emphasized fear, pain, and medical intervention, which might jeopardize one's ability to achieve one's desired birth experience. For several of the women planning non-hospitalized birth experiences, this involved the explicit rejection not only of a general ideology pertaining to birth as a medical or risky event but also of how others in their lives invoked medicalized discourse when discussing birth. Mental preparation therefore involved both embracing an understanding of birth as positive, natural, and safe, as well as rejecting an understanding of birth as negative, in need of medical management, and risky.

Overall, preparation for birth was a salient theme within women's narratives, in line with previous scholars who have suggested that Western birth entails women's consumption of birth-related information and services in order to pursue their desired birth (Rutherford & Gallo-Cruz, 2008; Bryant et al., 2007). Women described preparation through education as being an important part of informed choice, which was expressed both explicitly and implicitly as a value within their narratives. The ability to make informed choices and have some degree of control

over shaping how the birth experience unfolds, which can be understood as part of an ethics of autonomy (Shweder et al., 1997), has been well-illustrated as an primary factor impacting women's birth satisfaction (see, e.g., Green, Coupland, & Kitzinger, 1990; Hodnett, 2002; Howarth, Swain, & Treharne, 2011; Knapp, 1996; Lazarus, 1994). In their analysis of how women understood the concept of control as related to childbirth, Namey and Lysterly (2010) identified knowledge (access to information, understanding, intuition, and a sense of familiarity with the childbirth process) as an important part of feeling in control during birth. Other researchers have suggested that participation in childbirth education classes enhances childbearing women's feelings of control and increases birth satisfaction, regardless of factors such as pain relief (Hart and Foster, 1997). The ways in which women described their preparation for birth are congruent with these findings in that preparation was framed primarily in relation to informed choice and control rather than physiological or obstetrical impacts. Women understood preparation primarily as a means to engage in informed decision making prior to labour, equip them with the knowledge and power necessary to enact choice during the labour and delivery process (or, for a small minority of women, feel confident in the power of their care provider to do so), and cope with the unfamiliar or unpredictability of labour.

Importantly, preparation was not understood uniformly across participants. Different women placed more or less importance on preparation within their narratives, evidenced by how often they invoked this concept, the degree of preparation they described engaging in, and the ways in which they situated it as important for their experiences. Thus, women understood or described the concept of preparation in various ways, which appeared to correspond, at least partially, with different beliefs and valuations about birth itself. Women who expressed a more negative view of birth (as risky, a painful ordeal, and a means to an end) that aligned with the medical model tended to de-emphasize the importance of preparation, whereas those who expressed a more positive understanding of birth (as safe, a positive experience, and a valued journey in itself) that aligned with the alternative model described their birth preparation in more detail, emphasized its importance, and/or linked it more explicitly to informed choice and control. These findings align with previous research looking at the preparation of first time mothers in Australia, in which women who had a home birth described investing significantly more time and effort into preparing for birth than those who gave birth in hospital (Dahlen, Barclay, & Homer, 2008).

To some extent, an emphasis on preparation can be understood as part of alternative birth ideology. Previous research has suggested that emphasis on birth preparation, particularly as understood in relation to agency and informed decision making, is described quite differently in mainstream childbirth advice literature versus that which reflects alternative birth ideology. In mainstream childbirth advice literature, agency and control over the birth process tend to be situated primarily in medicine and the hands of physicians, as the end product (a healthy baby) is given primacy (Kennedy et al., 2009). For those women who did not place a high value upon the experience of birth itself and trusted an expert health care provider to assume the primary decision making role (so those women who expressed a more medicalized view of childbirth), preparation was not as strongly emphasized and elaborated in relation to informed choice and control. Conversely, in alternative birth literature, preparation (in the form of knowledge acquisition, emotional and physical preparation, and decision making) tends to be emphasized and framed as essential to enhancing the agency of women during birth (Kennedy et al., 2009; Mansfield, 2008). The emphasis on preparation in many women's narratives, particularly in relation to informed choice and control, may reflect a broader commitment to or influence of alternative birth ideology which emphasises informed choice, personal fulfillment, and autonomy during the birth process (Daviss, 2001; Rutherford & Gallo-Cruz, 2008). The act of engaging in preparation through information seeking and making decisions prior to labour likely also shaped women's birth expectations and solidified their decisions (see Dahlen et al., 2008), as was suggested in the narratives of several women who made specific choices (such as a home birth) only after researching and discussing their options with others.

In summary, the emphasis on preparation and the degree of time and effort invested in getting ready for the birth, which was for some women extremely significant, suggests that the women in this study understood birth as an important and unique experience, one which should involve at least some degree of active work pre-event on the part of the mother. Particular women did, however, invoke and describe preparation differently as a reflection of particular childbirth beliefs and ideologies. The exploration of how women's childbirth narratives are shaped in relation to underlying beliefs and dominant childbirth ideologies is furthered in the next section of this chapter, which is focused on women's childbirth choices and the frameworks they employed to talk about particular childbirth-related options.

3.2 The Valuation and Framing of Birth-Related Options

As described in the above section, preparation for birth was a significant theme in women's narratives. As part of this preparation, and in relation to the labour and delivery itself, women described different birth-related options and decisions in ways which illustrated systems of beliefs about birth, risk, and responsibility. The following analysis explores the ideological and moral frameworks women employed to describe different birth-related options. Firstly, the ways in which women described their choice of care provider as a central and influential decision is detailed. Following this, the prevalence of alternative birth ideology in how women described their options is illustrated, as well as the ways in which this ideology was countered by discourses of risk underpinning the medical model. Finally, the degree to which women described particular options as part of a moral framework is explored.

3.2.1 Feeling Supported: Women's Choice of Care Provider

One of the most basic choices, which many women explicitly positioned as crucial to shaping their birth experience, was the decision of a particular care provider or care providers. Nine of the women in the current study ended up having a midwife for their antenatal care (a couple of participants wanted a midwife but were not able to have one due to the current demand and low numbers of midwives in Saskatchewan¹. Three women ended up having an unassisted birth, where a doula or birth attendant² was in the residence but no health care provider who is legally mandated to perform deliveries. The rest of the participants had either a general practitioner (GP), obstetrician (OBGYN), or a combination of health care providers (e.g. midwife and OBGYN, GP and OBGYN). Additionally, eight participants sought care from a doula, who often took a primary role in prenatal preparation, labour support and decision making.

Regardless of what type of birth they wanted, women overwhelmingly described the importance of woman focused maternity care where they felt supported and their individual desires for their birth were taken into account, both prior to and during the birth. Women whose

¹ As of April 20th, 2015, the Saskatchewan College of Midwives lists 13 full practising, licensed midwives in the province (Saskatchewan College of Midwives, 2015) and although this number is increasing, demand for midwifery services continues to exceed capacity.

² A birth attendant is an experienced individual who practices intrapartum care but is not formally licensed as a midwife or nurse (they may or may not be a doula). A doula is a labour supporter who is not trained or licensed in clinical midwifery practice, but who is experienced with childbirth and has most likely received formal training in labour support techniques (Downe, Simpson, & Trafford, 2007).

primary care providers were midwives spoke at length about their appreciation for this woman focused care, often in relation to what they perceived as very non-woman centered care from doctors and OBGYNs. Christina had a GP until quite late in her pregnancy, having been on the waiting list for a midwife. She described switching to a midwife as opening up a range of decisions and affording her greater freedom in feeling supported to make her own decisions about care:

It's just, I would say, like when you have a doctor it's like ok this is how we're going to do things, and there's a lot of like, I was asking about certain things, like can we use this... I don't know, for example, can we um, use different positions, like for pushing. You know, on your hands and knees. And it's like yeah, we don't really do that, so— you're kind of like ok, well you're just going to kind of follow in, and I found my birth plan was like really defensive. Um...because of all the interactions I'd had, my birth plan was like I do not want this, I do not want this, like no episiotomy, no forceps, you know, all of that sort of thing. And I didn't really realise it until I got a midwife at 32 weeks, and then I started going through it and crossing off all the things that were irrelevant, that I didn't feel I needed to be defensive about anymore. So that was— the interesting that was that it had sort of made me feel like, even just getting a midwife, and not even really working with them, it was just all of a sudden now I feel a little bit in more control, and now my birth plan... is more about what I do want, rather than what I don't want.

Christina's description was quite typical of the women who had midwives as primary care providers during their pregnancy; they clearly valued being able to enact choice from a range of birth options and play a primary role in shaping their birth experiences. Again, the importance of choice and the ability to have some control or act in an agentic fashion to shape the birth experience were values expressed in most women's narratives as they talked about their care providers. Women who had midwives tended to emphasize the importance of the choice of care provider both in terms of shaping the range of other options available to them and for their birth experience in general. As Melinda explained,

Um... I think probably the most important decision was to have a midwife. And-although we were lucky that we even had that choice, because midwifery services are so scarce and there are so many women who want to choose that who choose it can't access it. So, um, but that was— I think that was the best decision that I made that made the most

difference throughout my whole experience, because I would have felt um, very helpless and even more defensive if I had been with an OBGYN.

Melinda felt that she had to fight for what she wanted for her birth even with a midwife, as she had desperately wanted to give birth at home but ended up having a hospital birth due to a non-pregnancy related medical condition that worsened during the pregnancy. However, at multiple points in her narrative she emphasized the choice of a midwife as crucial to having a positive birth experience and giving her a wide range of birth options and the support to make informed decisions about her care.

Inherent in both the above quotations is a mistrust or wariness of the care provided by doctors and OBGYNs, which was related to a belief that doctors and OBGYNs push interventions during the birth process. This belief was expressed within the narratives of approximately half of the women participating in this study, and was constructed as a threat to their ability to make informed decisions as well as to achieve their desired birth. For some women, this formed part of the rationale for choosing a midwife in the first place. As Betty described:

So... that got me really scared, and I had a fear of having a doctor. I really didn't want a doctor. Um, just because I just felt that uh, I wouldn't be given enough time, I'd be forced into an induction, or I had all these kind of— heard stories from friends and stuff, that I just really, really, really, really wanted a midwife.

Betty specifically referred to personal knowledge (friends' experiences) as informing her belief that a doctor attended birth meant unwanted intervention which would compromise the type of birth that she wanted. Other women, particularly those who chose more alternative births, drew heavily on alternative birth discourse to describe “*the typical hospital birth*” as one where women go in to the hospital and are immediately subject to interventions which, as Brenda described, “*interfere with the natural process*”. Kiana referred to the typical medicalized birth as that which is depicted in the film *the Business of Being Born* (2008), which is a highly influential documentary critiquing medicalized childbirth in the United States that many women in this study referred to in their narratives.

Although this belief tended to be expressed more often by women who chose alternative births, some women who chose hospital births with a doctor or OBGYN also described having to

be wary of interventions pushed on them by doctors. In reflecting on what she would want to do differently if she could redo her birth experience, Jackie stated:

But if I were to do that one all over again, I would stay at home. Until things got quite intense. I think that would have saved me one from getting the epidural too soon, it might have saved me from using Oxytocin, it might have saved me from lying on the bed. It might have saved me from a whole lot of things. Because you go into the hospital and we as nurses and doctors like to poke and prod. Yeah. You're here for a reason, so we're going to— we're going to interfere, yeah.

Jackie was happy with her family doctor, describing her as “very, very good, and she was present for the birth” (other women were not so lucky and described the lack of continuity in health care provider very negatively). However, she perceived the medical institution as a whole as being very interventionist, which shaped how she understood her birth experience. Other women, such as Caitlyn, made the choice of a doctor or OBGYN as their primary care provider while doing other things to maximize their ability to enact informed choice and resist what they saw as an interventionist model of care. Many women did this by hiring a doula, who women perceived as enhancing their ability to make informed choices prior to labour and also supporting their ability to enact these choices and assert agency during the labour and delivery itself. Caitlyn, who was very set on a hospital birth and had a GP as her primary care provider, spoke positively of her doula's role in her long and difficult labour:

So I really relied on her to like, k here's the pros and cons of each of these things, like not coming from a doctor, cause obviously the doctor thinks you need those things, he's going to convince you to use it, whereas she was very, weighed every option through the whole process, you know? So, yeah. Yeah, she was awesome. I'm so glad I had her.

As a knowledgeable expert, doulas were understood as an option for a secondary care provider who, for women like Caitlyn, enhanced informed choice and supported woman-centered maternity care. Felicia, who also had a hospital birth with a physician, also emphasized the importance of feeling supported and able to assert choice in both birth and postpartum decisions. She relied on information and support from a close friend who had multiple children of her own rather than her doctor:

Yeah. And it was really good, cause she's [Dr.], like, she's a very confident woman, so it makes you feel better about what's happening. So... ((chuckles)). I liked it. She—I didn't

tell her that I wasn't getting the e— I didn't tell her any of my birth plan, really. I just— me and my friend figured it out, so... yeah.

Felicia described her friend as endorsing natural birth and a more alternative birth ideology (and therefore openly sharing her belief system about birth), but perceived her as non-pushy, supportive, and therefore as enhancing Felicia's own ability to choose and enact the type of birth she wanted. Although Felicia's friend was not a professional, she considered her an authority on pregnancy and birth and valued both her knowledge and experience, as well as her support for what Felicia decided she wanted for her birth.

Importantly, although woman-centered care was described primarily in relation to midwives and doulas (whereas doctors and OBGYNs were often constructed as a threat to women's ability to choose and shape their birth), a few women also described their doctor or OBGYN very positively, and as supporting their choices or wishes for birth. Although Felicia did not engage with her doctor in order to figure out what she wanted for her birth or how to achieve it, she liked her doctor and appreciated that she did not try and assert control over her decisions or judge her negatively for them, as she did experience this from others:

Actually, my doctor was the least opinionated at it— like she's— like I had to ask her, you know what I mean? Like I asked her with the sports, like cause I was actually— and she, she very much felt that it was my decision. So she's like well you could, you know, you could continue if you want, or you could— you know, you just have to continue in these ways. So she was really good. And you know she asked me if I was breastfeeding at the two week visit and I said no, and she was like ok, that's good. I really like— that's what I really liked. She didn't have like, strong opinions.

Again, Felicia valued being the one who was in control and able to make her own decisions about her care, without what some women perceived as overbearing, threatening, or judgmental input from others. That was not to say that women necessarily *devalued* the professional opinions or advice of their health care providers, whoever they were— they just valued the ability to make informed choices and feel that those choices were supported.

In summary, many women positioned the choice of maternity care provider as an important and influential decision, particularly those who chose a midwife. Certainly, previous research does suggest that women's choice of care provider influences their birth experience; midwifery care tends to be associated with much lower rates of birth interventions (Bodner-

Adler, Bodner, Kimberger, Lozanov, Husslein, & Mayerhofer, 2004; Janssen, Ryan, Etches, Klein, & Reime, 2007; Janssen et al. 2009; Sandall, Soltani, Gates, Shennan, & Devane, 2013; Soltani & Sandell, 2012) and greater participation in and control over birth and maternity-care related decisions (Callister, 1995; Soltani & Sandell, 2012) when compared to physician and OBGYN care. Interestingly, a few of the women who chose doctors or OBGYNs did not spend a lot of time describing this decision in the abstract or rhapsodizing about the significance of this choice (which was in contrast to those women who chose midwives as their primary care provider). This may have been partially due to the fact that a couple of these women were not able to have their chosen care provider during labour, which had a negative impact on their ability to form a supportive relationship with the individual who delivered their baby. It may primarily suggest, however, that for this smaller subset of women, the choice of care provider was not understood as a significant decision or one with many options. Dahlen et al. (2008) described a similar pattern in regards to the decision to have a home or hospital birth, concluding that it was difficult to follow the rationale of women who chose to birth in hospital, because often they did not consider any other option. For a few of the women who chose to have a GP or OBGYN, little thought may have gone into the decision of care provider, because their choice was congruent with the dominant and expected model of maternity care and they took the option which logically presented itself (e.g., they had a family doctor who delivered babies). It should be stressed, however, that the majority of women (regardless of who they chose) did position the choice of care provider as very important.

When examining the ways in which women described their choice of care provider/s, women overwhelmingly used a discursive framework which emphasized an ethics of autonomy (a domain of moral discourse referring to concepts such as harm, rights, and justice, and promoting the values of individual will and choice; Shweder et al., 1997). That is, their descriptions were oriented within a framework of understanding which promotes will and choice as important values in and of themselves, to be supported and respected. The ways in which women talked about their care provider/s reflected the valuation of informed choice and having their choices supported, so that the care provided took into account their perceived needs and desires for birth and was woman-centered. As with preparation for birth, language emphasizing the value of informed choice in regards to the choice of care provider was most prevalent for women who wanted more alternative births or had a midwife for their care. However, the

importance of being able to make decisions about their care and feel supported in their choice of particular birth options was also reflected in the narratives of women who chose physicians or OBGYNs as their primary care providers. This is in line with recent research suggesting that maternity centered care (whereby women are informed and involved in decision making) is an important factor in birth satisfaction (Jenkins, Ford, Morris, & Roberts, 2014).

To some extent an ethics of autonomy is congruent with alternative birth ideology, in that it reflects the belief that women should have a major role to play in decision making and the importance of informed choice (Daviss, 2001; Rutherford & Gallo-Cruz, 2008). As care providers who arguably operate within this ideology, midwives explicitly endorse their model of care as promoting the ability of women to make informed choices (see, e.g., Canadian Association of Midwives, 2015). Indeed, the degree to which women in the current study who had midwives described issues of choice and control within their narratives suggested that these values strongly informed both their choice of care provider and how they were perceived. Another major aspect of the alternative birth movement has been the overt rejection of the medicalization of birth, which includes a critique that contemporary Western birth involves an unnecessary overuse of interventions in the birth process (Beckett, 2005; Davis-Floyd, 2003; Hausman, 2005; Wolf, 2001). The influence of this discourse was evident in women's narratives, as approximately half of the sample (more so women who chose midwifery care, but women who chose GPs and/or OBGYNs as well) explicitly expressed a general belief that doctors and obstetricians encourage or overuse interventions, which they often described feeling though they had to protect or defend themselves against. For many women, these descriptions both reflected a desire to exert autonomy within their birth and worry that their autonomy would be impeded within a medical model of care. The prevalence of both the value of informed choice and a wariness about the perceived authoritarian and interventionist care of GPs and OBGYNs also suggest that many of the childbearing women in the current study drew heavily on alternative childbirth discourses in their understanding of maternity care providers, although endorsement of the medical model may have been reflected primarily through the *absence* of description. The ways in which women drew upon dominant childbirth discourses in their narratives was further reflected in their descriptions of other birth-related options and decisions, which is the focus of the section below.

3.2.2 Childbirth Options and the Influence of Alternative Birth Ideology

As women narrated their childbirth-related experiences, it was clear that overall they made sense of their birth-related options in ways which drew upon both medicalized understandings of birth (primarily discourses of risk) as well as alternative birth ideology. For these participants as a whole, however, the influence of alternative birth ideology was quite striking. Eleven women sought some kind of alternative to a hospital birth with a physician or OBGYN, although this was not always the experience that unfolded for them. Moreover, six women hired a doula as an additional support and care provider, who facilitated a less medicalized experience. In terms of more specific birth-related options which women described as wanting or not wanting for their birth, there was a significant degree of variation. In addition to place of birth (which shaped the ways in which different options were both understood and available), individual women valued particular options (e.g. natural birth, labouring at home, delayed cord clamping) and eschewed others (e.g. induction or augmentation of labour, epidural). The ways in which birth-related options were de/valued tended to coalesce around four broader beliefs about birth and risk which reflected aspects of dominant childbirth ideologies: 1) medical interventions should be avoided; 2) birth should be a natural process; 3) labour and delivery is a meaningful experience in its own right; 4) and childbirth can be risky. Overall, the ways in which the women in this study spoke about their birth and birth-related options illustrate the degree to which alternative birth ideology influenced the way they constructed meaning from their childbirth-related experiences, and suggest the impact of this ideology on contemporary Western understandings of birth.

Most of the women in this study expressed the view that medical interventions should be avoided as much as possible, which informed how they understood different birth-related options and made decisions. For several women, this was positioned as a culturally given assumption, which played into the decision to enter birth without a pre-specified plan— if medical interventions were only going to be used if they were absolutely necessary, why bother to outline all the interventions that they did not want? This logic was evidenced in Mackenzie's statement:

I think, you know, nobody wants ((laughing)) maximum interventions to get the baby out, so what's the point really in handing them a sheet, cause, ((laughing)) you're not going to say we want all the things, we want vacuum and forceps and everything you've got! So you know, we just hoped, I guess, that it would go smoothly.

Not only did Mackinzie clearly state her assumption that no one would want numerous interventions in their birth, her laughter suggests that actually wanting numerous medical interventions in the birth would be ridiculous. Indeed, no one in the current study described a pre-specified desire for an extremely medicalized birth (elective caesarean or elective induction, maximum pharmaceutical pain relief, episiotomy, and so on). For some women, however, their attitude towards interventions did shift during birth itself in relation to the amount of pain they were experiencing or perceived risk, which will be discussed in further chapters.

Although in Mackinzie's quotation above the desire to avoid medical interventions was presented as a widely shared belief and therefore one which did not need to be explicitly addressed in birth preparation, many participants described their desire to avoid medical intervention as something which needed to be both researched and expressly communicated. Some medical interventions were presented by women as simply unnecessary, maternity care rituals (see Davis-Floyd, 2003) performed on a routine basis without improving care. Elizabeth, who had chosen a midwife-attended birth but also considered an unassisted birth, was firmly committed to a non-medicated home birth. She also communicated very specific preferences which touched on several issues of routine maternity care:

Um, like I said I didn't want my membranes touched, at all. I requested only one cervical check, and I think I had three while I was here... as for labour, I had... I didn't want to know the time, I didn't want to be told to get in the pool, or if I was content to push the baby out where I was I didn't want to get in. But it turned out I really wanted to get it ((chuckles)). And um... I didn't want anybody eating around me, but I wanted to be able to eat and drink freely myself, which I did, which I think is why I was able to go for so long. And um, when the baby was born, I wanted delayed cord clamping. I didn't want any erythromycin.... Yeah, lots of things like that. Oh, I didn't want— they do a shot of Pitocin in the hip, just so you don't hemorrhage, and I didn't want it unless I was showing signs of hemorrhage. And they usually do it just as a precaution, and I said no to that.

Women described a variety of interventions as unnecessary within their narratives, although these descriptions tended to be brief and their rationale was often not narratively elaborated. In general, interventions which were seen as unnecessary tended to be those which could be understood more broadly as medicalized aspects of care (e.g. ultrasounds, prenatal diagnostic

screening, electronic fetal monitoring, multiple cervical checks, early cord clamping), although interventions such as the induction of labour or caesarean section were also understood by some women as potentially unnecessary. After explaining why she felt that prenatal cervical checks were unnecessary and she decided against having them, Janice went on to state:

But like, I guess that was the biggest thing. W— we weren't just going to do it because that's the way it was done. Because honestly I feel like it's flawed. Like our system right now is flawed. And like, even the number of caesareans, it's like really high compared to what it used to be.

Here and explicitly later in the interview, Janice questioned the degree to which caesarean sections were necessary and lifesaving, versus an over-performed procedure that was not always necessary (including as a result of prior medical interventions). For many women in the current study, particular interventions were seen as part of a medicalized system of maternity care rather than necessary aspects of care, and were therefore viewed with a certain extent of suspicion. This suspicion was related to the previously noted tendency to position doctors and OBGYNs as overly interventionist, although a couple of participants described even midwifery care as entailing some unnecessary medicalized protocols.

Medical interventions were not only expressed at points within women's narratives as being unnecessary, but also as potentially harmful. Approximately two thirds of the women in this study depicted medical interventions as causing problems for the labour, mother, and/or baby. Annabel drew heavily on this understanding of medical interventions to describe the "awful" birth experiences of many of her friends:

They have typical— and when I say awful, they have the typical hospital experience, it is very common for women to go in, they're a little bit overdue or for some reason they want to induce you. So they get induced, and then the induction medication causes the pain to be unbearable, so they get the epidural. The epidural slows down the labour so they get induced again. And then the contractions are so strong on the baby that the baby's in duress and they go, 'We need to give you a c-section.' Then they go 'Oh my goodness, thank goodness the doctor's there to give you a c-section!' So the women go 'Oh, I had a c-section, thank goodness the doctors were there.' But they didn't realise those initial interventions set the ball rolling.

The most common narrative of the harm caused by medical interventions focused on labour induction or augmentation and epidurals. Participants suggested that induction of labour (and similarly pharmaceutical labour augmentation) led to more intense and difficult labour that could be risky for the baby, caused more pain and physical difficulty for the mother by rushing a process that her body was not ready for, and precipitated further intervention (specifically, epidural). Epidural was constructed very similarly by many women, who described their beliefs that it interfered with the progression of labour, increased the likelihood of caesarean section, caused physical problems (e.g. headaches, feeling dizzy or sick, slowed recovery from birth), and had negative effects on the baby after birth, making them potentially lethargic. Overall, there was a strong discourse of anti-medicalization in women's narratives when they talked about birth options, in which medical interventions were seen as used unnecessarily, potentially harmful, and best avoided as much as possible (although the degree to which particular women endorsed this view and how it related to specific birth options varied).

Closely related to the tendency of women to position medical interventions negatively and talk about their desire for a non-medicalized birth experience was the valuation of the "natural", which was a concept invoked within the narratives of approximately half of the interviewed participants. Women's descriptions of natural birth varied quite significantly. Some, like Andy, focused exclusively on the lack of epidural for pain relief as a natural birth: "*I was like I'd like to try natural, without any medication,*" whereas others expanded the concept to encompass vaginal birth, home birth, and birth without any intervention. Brenda described her understanding of the natural:

My perception of a natural birth is not messing with it. So like, as little intervention as possible. So not being induced, not trying to get your labour going by any, like unnatural causes, so sex or walking sure, if that's how you want to induce your labour, but anything else like stripping the membrane, already I consider that as like you're messing with the process. And my opinion was, once you start— it's like a natural, you know, divine process that's been like perfected over thousands of years, so once you start fiddling with it and doing interventions, it messes with it, and then it can't continue the way it should. So, my— I mean, I guess I would still consider a natural birth any vaginal birth, but, no to me I feel like a natural birth is as little intervention as possible, like not having to use a vacuum and— and stuff like that. Just letting things progress. That's kind of how I see it.

As illustrated in Brenda's words, for some women the concept of the "natural" was heavily informed by multiple aspects of alternative childbirth ideology and care which aligned with this discourse, such as home birth, the belief that women's bodies are designed for labour and interventions interfere with that process, and positive views of labour and delivery as natural and safe. Within this framework then, maternity care options which were perceived to entail the least interference with or control over the woman and her body during labour and delivery were valued, such as midwifery care, non-hospital birth, and the avoidance of different interventions such as induction or epidural. Women who espoused a more narrow definition of natural as the lack of epidural, on the other hand, did not necessarily draw broadly upon alternative childbirth discourse in their narratives or make decisions that were aligned with an alternative model of care.

The ways in which women described different birth related options were also informed by the extent to which they valued birth as an experience in its own right, which was expressed primarily in relation to epidural, home and/or unassisted birth, and the mode of delivery (vaginal versus caesarean). Many women described the epidural as altering, or taking away part of the experience of labour, which was part of women's rationale for wanting to avoid it during labour. As Marianne explained,

Um, I wanted to experience it all! I— I wanted, I was grateful that I could become pregnant, um I was worried for whatever reason that it might not happen for us, and so I was excited to be pregnant and I wanted to experience all of it. And I was confident that my body could do it. And that it would be more rewarding for me to do it without it than it would be to have that help [the epidural] I guess. I just wanted to... I wanted to experience it all.

Although there were several beliefs underlying Marianne's rationale for being determined to avoid an epidural in labour, she saw it as important to being able to have a full and authentic experience. As these first time mothers had never experienced labour and delivery, the experience was both unknown and valued in its own right, which was reflected in how many women described epidurals. Similarly, a few women described their belief that un-medicated birth created a positive birth experience, or hormonal high, as Brenda explained in relation to an acquaintance's vocal pro-epidural stance:

And to me it's like ok, I see your point, but... it's such a transformational experience that why wouldn't you want to experience it? And what I was afraid of was that if you introduce drugs, it would like, stunt that high that we would have after.

Brenda's valuation of birth as a transformative experience, and belief that un-medicated birth produces a positive experience and physical high, show the extent to which she placed importance on the childbirth experience itself.

Although the importance of the birth experience tended to be expressed in relation to the desire or choice to not use an epidural or pain relief, it was also reflected in how women talked about the decision to utilize this birth option. Almost all the women interviewed wanted to avoid the epidural prior to labour (and no one stated that they intended to have one), but several of these women did choose to get one during labour due to the amount of pain they were experiencing. At this point, most women described the pain relief that they experienced as enhancing their experience of labour by not only minimizing their distress, but also clearing their mind of pain which allowed them to be more cognitively present during the labour and delivery. Felicia, who did labour and deliver without an epidural, explained her rationale for wanting to have one if she gave birth again in the future:

So... but at the same time, I see a point for an epidural, because I was not of right mind for a lot of things. Like, my doctor... before I was in labour, I thought it would be a cool idea to pull my own baby out. I didn't tell my doctor this, but she offered it like before I started pushing, she said do you want to pull your baby out? And— like I remember recognizing in my mind I did want to do this, but because of so much pain, I was like— I didn't feel safe with myself to do it. Cause I didn't feel like I could control my body, with the amount of pain I was in, so I said no. And then when he was coming out, my doctor's like here, grab him! ((laughs)) And I was like no I c— cause I don't know if I was flailing, but I felt like I was, I felt like I was kicking my legs and stuff like that, and that I wouldn't be able to hold him, you know what I mean? So I see the point for an epidural, cause if you're able to be of sound mind, and participate, it'd be a lot cooler, cause then I'd be like hey hold up the mirror, so I could see what's happening, and be more present for it. But it also was kind of cool to see how much it actually did hurt.

A common theme among women who had epidurals (which will be described further in Chapter 5) was that the anesthesia restored a sense of control and the ability to think, which many women

felt was lost during the intensity of labour. This restoration, in turn, was framed as heightening one's ability to experience and enjoy the experience of labour. Both the desire to experience all the sensations of labour and to create a positive labour experience were therefore reflected in how women talked about epidurals, and illustrated the valuation of birth as an experience in its own right.

The valuation of the birth experience was often expressed by women who wanted to avoid a medicalized experience and made the decision to birth at home with a midwife, birth attendant, or unassisted. For these women, the context of the birth was very important and illustrated both the valuation of birth as well as the desire to achieve a particular type of positive birth experience. Carmon, for example, explained when asked about her decisions prior to birth:

You know, ((exhales)) before we got pregnant and I think after the loss³, he [Partner] was a lot more like no, we'll have a midwife, you can have this home birth it'll be great, but he wanted somebody there. But through the pregnancy and very early on he was just like no, it's your thing. And what you feel comfortable with is more important to me. And even by the end I told him you know, when I picture this, my perfect birth, you're not there. No one is there. I do it by myself. And that just feels right.

Carmon had put a great deal of thought into her birth experience and what type of experience (not just outcome) she desired, illustrating the importance of this event to her life. Context and care provider were often described in relation to the desire to have a positive birth experience, and reflected discourse which invests childbirth with value in and of itself.

Although aspects of alternative childbirth ideology were prominent in women's narratives, some women also described particular childbirth options through reference to childbirth as risky or risk to the fetus. Home birth, in particular, was not considered a desirable option by about a third of the women in the study, which was either stated as "the obvious" or explicitly linked to the risk of childbirth. Mackinzie, for example, despite feeling disappointed in how her hospital birth unfolded, described her intentions for a future birth:

Uh, I think we would still have a hospital— like I wouldn't be interested in having a home birth or anything, I don't think there's any particular point in that. I'm quite happy to be where all the useful things are, if anything goes wrong— that's good for me.

³ Carmon suffered a previous miscarriage before the pregnancy which resulted in the birth of her son.

For these women, the hospital represented safety and insurance that if something happened during birth they would be safe. Women also referred to the necessity of having a trained medical professional there to deliver the baby. Other women utilized risk discourse to describe their consent to medical interventions during the pregnancy (ultrasounds or induction of labour) or labour (e.g. labour augmentation, caesarean section). The conversational exchange below is a typical example of how risk discourse was invoked in relation to birth-related decisions:

Valerie: I was more worried about the induction than anything. All of my horror stories were about women getting induced.

Mel: Oh what did you hear about the induction?

Valerie: Just like, having super painful deliveries, where babies didn't want to come out, and all of those horror stories so I was scared for that. But um, she ended up having a really good labour, so— or, birth.

Mel: And was it— was it up to you whether to induce then or was it pretty much...

Valerie: Um, they pretty much just booked me in, yeah. Like I wouldn't, I would've wanted to wait until the bitter end kind of thing, but um, the risks were just too high. And I didn't want anything to happen to her so I just kind of did what the doctors told me to at that point ((chuckles)).

Valerie's depiction of her induction was fairly typical of how women referred to risk in their narratives in that the medical intervention was initially positioned as unwanted and potentially harmful, but the risk of harm to the fetus was paramount in making the decision to intervene. As was often the case, risk was invoked as a generalized concept as opposed to specific risks, and as a potential rather than in any probabilistic terms. Valerie also clearly invested authority and decision-making power to the medical professionals who were providing her with prenatal care, which was not always the case (women who drew more heavily on alternative childbirth ideology in their narratives often constructed themselves as the agent who made the decision regarding intervention).

The degree to which women drew upon risk discourse to describe birth related options was influenced to some extent by the context of their pregnancies. Valerie had cholestasis, a liver condition whereby the flow of bile in the gallbladder is disrupted by high levels of pregnancy hormones. As she had been informed that this condition can cause stillbirth, she understood the stakes involved in this decision as being life or death. Moreover, her pregnancy was medicalized

in general as she was being carefully monitored and had seen multiple specialists. This medicalized context of pregnancy was similarly influential in how Nadia understood birth related options and made decisions. Nadia had suffered three unexplained miscarriages prior to the birth of her daughter, and described the context of her pregnancy as entailing more interventions that she would otherwise have had (prenatal testing, many ultrasounds) which she expressed as motivated by fear for her fetus. These experiences influenced how she positioned birth options as well:

And I was trying to go into it with an open mind. Because I didn't— I didn't want to be one way or the other, knowing that you had no control in the environment, but yet I did—I read as many books as I could on natural methods, I took a prenatal yoga class to sort of, you know, try to learn breathing techniques to try and do it was natural as possible. I had my mind open that I would— could do an epidural if worst came to worst, but I was convinced I probably could do it fine without. And, so yeah, I did think a lot about that. I thought about, you know, I never once wanted to have her at home, just based on my past experience. I felt safer in the hospital.

For some women, the particular context of their pregnancy may therefore have shaped invocations of risk more so than shared exposure to a dominant cultural understanding of childbirth.

As was clear within Nadia's narrative, even women who described more medicalized or risk-based understandings of childbirth in relation to birth options also referenced aspects of alternative childbirth ideology such as valuation of the natural and mistrust of medicalized childbirth or particular interventions. Cherise was the only participant in the current study who described her birth-related experiences almost entirely in relation to a technocratic model of birth (Davis-Floyd, 2003). Her pregnancy was described in relation to risk, birth was construed as an ordeal and not described as something valued in its own right, preparation was focused around the investment of authority in a trusted health care provider, and birth interventions were described matter-of-factly as par for the course. Framing childbirth and childbirth options in relation to notions of risk was relatively limited in women's descriptions of birth-related options and decisions prior to birth, although as will be delineated in more detail in later chapters, it was invoked by many women in relation to their birth experiences and decisions made during labour.

Overall, the women interviewed for this research described birth options in ways which aligned significantly with alternative birth ideology. They did so through reference to childbirth as a natural and safe process, the valuation of natural birth and of birth as an experience in itself, and suspicion of and resistance to medicalized interventions or routine aspects of maternity care, all of which can be understood as intertwined and part of an alternative set of practices and discourses around birth (see, e.g., Beckett, 2005; Charles, 2013; MacDonald, 2006; Mansfield, 2008; Monto, 2007; Rooks, 1999). Conversely, women also drew upon discourses of risk in their understandings of particular birth options, which is aligned with a technocratic or medicalized framework of understanding (Davis-Floyd, 1994, 2003; Hunter, 2006, Rooks, 1999). Interestingly, the degree to which women reflected understandings of childbirth itself as risky in their discussion of birth choices was limited in relation to the degree to which they drew upon tenets of alternative discourse. Although women are inundated with risk discourse related to reproduction (Possamai-Inesedy, 2006), the women in this study did not draw heavily upon it when describing their desires for childbirth. Rather, the ideal birth, and what most women appeared to strive for, was heavily influenced by rhetoric of the natural and anti-medicalization discourse.

Indeed, one of the significant narratives which women employed when describing birth-related options situated risk not in childbirth itself, but in a medicalized model of care: interventions were positioned by many women in the current study as being employed when the situation does not warrant them, and as having the potential to cause problems with the labour and/or health of mother and baby. Interestingly, although previous research has suggested that this perspective aligns with the choice of home birth and/or midwifery care (see, e.g., Dahlen et al., 2008; Kornelsen, 2005; Viisainen, 2000), this was only partially the case in the current sample. Several women who birthed in hospital, including those who had a GP or OBGYN as a primary care provider, drew upon anti-intervention discourse as well when talking about birth-related options. Moreover, as stated previously, no one described the desire for a heavily medicalized experience—interventions tended to be positioned extremely negatively, with caution, or with the attitude that they were acceptable if necessary. A very similar understanding of interventions was reported by Malacrida and Boulton in their recent (2014) research with women in Alberta, suggesting that this contemporary perspective is not limited to the (mainly) Saskatchewan context of this study or this particular sample of women.

Given that women described a significant amount of preparation in the form of research about different birth-related options, their mistrust or apprehension regarding different birth interventions may stem partially from being informed about their potential negative effects. Women alternated in their narratives between invoking the concept of risk as a general or vague concept and referring to particular risks, which have been noted in previous literature and are often invoked by proponents of the alternative birth movement. Research has illustrated, for example, that epidural analgesia may slow second-stage labour⁴ and is associated with higher rates of labour augmentation (Anim-Somuah, Smyth, & Howell, 2005; Cambic & Wong, 2010; Cheng, Shaffer, Nicholson, & Caughey, 2014). Labour induction is also associated with further interventions and disruption of the childbirth process, including increased rates of epidural (Alexander, McIntire, & Leveno, 2000; Cammu, Martens, Ruyssinck, & Amy, 2002); as noted by Simpson & Atterbury (2003) the process entails a more medicalized experience overall with an intravenous (IV) line, continuous fetal monitoring, and so forth. Research has also suggested that epidural analgesia and labour induction or augmentation may increase the likelihood of instrumental vaginal delivery (Anim-Somuah et al., 2005; Cambic & Wong, 2010; Maslow & Sweeny, 2000; Tracy, Sullivan, Wang, Black, & Tracy, 2007) or caesarean section (Alexander et al., 2000; Cammu et al., 2002; Maslow & Sweeny, 2000; Tracy et al., 2007). Although this evidence is by no means conclusive, particularly the proposed association between epidural and caesarean section (see, e.g., Anim-Somuah et al., 2005; Cambic & Wong, 2010; Sanchez-Ramos, Olivier, Delke, & Kaunitz, 2003; Zhang, Yancey, Klebanoff, Schwarz, & Schweitzer, 2001), it does suggest that particular interventions may not be without undesired effects on the labour process. This may be especially true for nulliparous women who are having their first baby (Maslow & Sweeny, 2000; Tracy et al., 2007).

In addition to their own research, women may have received information about the potential negative effects or side effects of interventions such as epidural in prenatal classes, as Betty described. Alternatively, women's tendency to position interventions as negative or harmful may also illustrate an increasing exposure to alternative birth ideology in shaping how contemporary Canadian women think about birth and the options available to them, as midwifery becomes increasingly incorporated into the Canadian health system (Canadian Association of

⁴ The second stage of labour refers to the period after the woman's cervix is fully dilated to 10cm until the baby is delivered.

Midwives, 2014) and hospitals engage more and more with rhetoric of informed choice and natural childbirth (Rutherford & Gallo-Cruz, 2008). Although the current findings are certainly consistent with Miller's (2007) research suggesting that women draw upon both medicalized and alternative discourses in descriptions of their childbirth expectations, alternative childbirth ideology was quite dominant in the narratives of this group of childbearing women.

Much of the contemporary literature exploring women's attitudes towards particular birth options, or the prevalence of their use, has focused on particular options: caesarean section (including women's decisions regarding vaginal birth after caesarean), care provider, epidural, and place of birth (see, for example, Boucher, Bennett, McFarlin, & Freeze, 2009; Chadwick & Foster, 2014; Fenwick, Gamble, & Hauck, 2007; Heinze & Sleigh, 2003; Klein et al., 2011a; Malacrida & Boulton, 2012; Miller & Shriver, 2012). The findings explicated above add additional insight to this literature by exploring the beliefs underlying a diverse group of Canadian women's descriptions of birth related options (as opposed to the views of one specific group, or views of one specific birth option), and how these are informed by dominant childbirth discourses. The section which follows explores women's understandings of birth options further to look at when, and how, birth-related options are framed morally.

3.2.3 Birth Options and Moral Frameworks

Previous researchers have made the distinction between moral reasoning and personal reasoning (e.g. Smetana, 1981), and between personal preferences and values which illustrate moral significance (e.g. Rozin, 1997; Rozin, 1999). The purpose of the current analysis is to examine how women positioned particular birth options which were available to them in ways which demonstrated a personal (i.e., a preference) or moral (i.e., through expressions or judgments of value, responsibility, rights and autonomy, and prescription) framework. One such moral framework, the ethic of autonomy, was already described above in relation to maternity care providers, and the value that women placed on informed choice. The current section extends this discussion to examine how women drew upon personal and moral frameworks in relation to the birth options available to them as they prepared for labour. The following three themes illustrate dominant patterns in how women talked about birth options which reflect moral understandings: personal decision making, choice in general as a right of childbearing women, and choice as maternal responsibility.

When women talked about particular birth options that they wanted prior to birth they primarily did so in a way that either did not explicate any moral reasoning, or by framing these options as personal preferences. Kella, for example, explained:

So she um...we had— she had a list, like a checklist that we went through and just uh, to start the discussion, but really the only thing I decided was that I did want to do an un-medicated birth, and... you know, I did want to delay cord clamping, I did not want to save the placenta unless she wanted it, but I wasn't planning on making pills. I couldn't get over that, ((ugh)) I just couldn't. I understand the medical benefits, I just couldn't get over it. Annnd ((long pause)) skin dir— you know, right away skin to skin contact. And... we did talk about stuff like um, I think they put— I can't remember now, like drops in their eyes, and ((pause)) something else, poke their toes. There's some— some med— some standard medical procedures they do on the baby after, that I was fine with. She just explained what— bilirubin or something. So we just discussed, some people don't want it and some people do.

Kella did not evidence any moral reasoning in her description of the birth options described above— she did not refer to them in terms of rights or responsibility, prescriptions that should or should not be followed, and so on. Rather, she explicitly framed them as an individual preference. While personal preference does suggest a general orientation towards a moral framework of autonomy, with its emphasis on individual will and choice, Kella did not emphasize its importance or situate any particular options morally.

As a birth-related option that eighteen of the twenty-one women in the current study explicitly described not wanting prior to their birth, epidural was frequently discussed and the reasoning behind the decision was often well-explicated by women in their narratives. Although many women also presented this choice through reference to a moral framework, some women positioned it as a personal preference. About a quarter of the women who were interviewed described not wanting to have an epidural because they were afraid of the process itself; as Mackenzie stated, “Um.... we talked about not having an epidural. Mostly because the idea of the epidural freaked me out more than the idea of having the baby ((chuckles)). The needle in the spine thing.” Many women described getting opinions from other people on whether or not they should get an epidural, and presented their choice as a personal one in relation to the attitudes of others. Felicia, for example, explained:

But, like I chose before not to get an epidural because I didn't like the i— I didn't like needles, I didn't like the idea of it being near my spine. Um, not— like I don't, it wasn't anything to do with like chemicals or anything like that, like that kind of...

As with Mackenzie, Felicia framed the epidural as an option which she decided she did not want because of a personal attribute (afraid of needles), as opposed to moral considerations or framing it in a way that was prescriptive or spoke to a shared moral value.

A few women also referred to their general dislike of pain relief medications and other drugs in their reasoning as to why they did not want an epidural or other medical forms of pain relief for their birth. Caitlyn, who wanted to have a “*natural birth as much as possible, like no drugs or anything*”, described her reasoning for this decision:

So yeah, even though— like I didn't want morphine, I'm really— and I don't take prescription drugs, I don't take over the counter— like I— I won't, I'll very rarely even take Tylenol, right? So I mean for me to accept morphine, I was very like, I don't want it right? I don't drink, I don't— like I don't do anything that really, I don't know, impedes my judgment or alters me in any way, right? Like I just— I'm very— I just don't. And so it was like, even the morphine I was very like, ohh I really don't want to do this, right?

As with fear of the process, women who referenced a general dislike of medications or mind altering substances when describing birth options framed their decision as a personal one, where there were no moral prescriptions informing how the option was presented. Although women did not generally moralize the epidural as a choice for others and tended to present it as a personal choice when talking about their preparation for birth and the decisions which they made, epidurals were otherwise rarely discussed absent of moral considerations (as will be discussed at length in Chapter 4).

Underlying women's positioning of epidural as a personal preference was an assumption that they had the ability to enact choice; this was also the case in relation to other birth-related options. Beyond the valuation and assumption of choice, several women drew explicitly on justice-based discourse to describe the choice of birth options they desired. Annabel, for example, drew upon this discourse to describe the importance of choice and informed decision making:

I just, I feel very um, grateful that I had a support system that allowed me to be educated to your options. That's the thing that I honestly think every woman should have, is they

should learn um their rights, as a pregnant woman, the type of care they want, how to write a birth plan, and how to choose what they want.” Because I think a lot of times women are just pressured into feeling very helpless and very um, not an active role in, you know, making their options. And for me based on after being educated, I chose the plan that I did.

For Annabel, as well as several other women, choice was narratively situated using a moral voice of justice, reflecting an ethics of autonomy (Shweder et al., 1997)⁵, wherein options and choice were seen as a basic right which should be afforded, and not denied, to women in their reproductive experiences. Conversely, this language (often implicitly, but not always) suggested a certain responsibility on the part of pregnant women, to prepare for and work towards a particular birth. This rights-based language was most prevalent or explicit in the narratives of Annabel, Carmon, and Elizabeth, all of whom drew heavily upon different aspects of alternative birth discourse throughout their narratives and pursued births which were distinctly non-medicalized and alternative⁶. Within this narrative framework, individual rights and agency were highly valued, and informed choice was crucial to being able to shape one’s desired birth experience. In general, it was the women who pursued more alternative births who drew more heavily on language which emphasized autonomy and politicized the issue through reference to rights (and restrictions, both of the medical system and of midwifery as currently incorporated into the health system).

This discourse of rights and the ability of women to choose their birth options was prevalent throughout the narratives of women in this sample, so that the converse discourse, women’s right to choose a particular birth option should be limited, was uncommon. Even when women made references to the safety of the hospital (as opposed to home birth), they did not usually use prescriptive language that positioned it as a negative option for others. Really the only communication of disapproval regarding a birth option in general was aimed towards home

⁵ My use of the terms “moral voice of justice” and “ethics of autonomy” is a reflection of a theoretical grounding in morality that is based on multiple scholars. As described by Gilligan and Attanucci (1988), a moral voice of justice centers upon the concepts of in/equity, respect, standards, and rights. I consider a moral voice of justice part of an ethics of autonomy as described by Shweder et al. (1997), which is a broader orientation towards the moral concepts of harm, rights, and justice, and the valuation of will and choice.

⁶ Carmon pursued and achieved an unassisted home birth, Annabel gave birth at home with a birth attendant (someone who is not formally certified but has experience helping women give birth), and Elizabeth pursued a midwife-assisted home birth after deliberating an unassisted home birth, although she ended up having to transfer to hospital.

birth with no licensed professional maternity care provider in attendance, and this was only expressed by a couple of women. Felicia, for example, stated:

Um, what's important to me is that, like... no one should feel really pressured by different, like how they want to do things. Of course there's unreasonable things like... you shouldn't just give birth at home if there's a doula right, you need a midwife, you need to do things like, safely.

Although Felicia stressed the right of women to be able to freely choose their reproductive-related options throughout her narrative, she did place prescriptive limits on these rights by placing doula-assisted birth outside of what is acceptable and safe. Carmon, who had an unassisted home birth, obviously did not express disapproval of this option in general but placed individualized limits on it:

I think it's important that we give women the ability to choose, and I do not feel that we have that in our um, current health care system. They're limiting women's ability to choose where and how they birth their babies on a daily basis, and really tightening the reins around the midwives so they can't even provide the quality of care that they did before it was legislated. And I think that that's all a travesty, and that we're going to see, probably, a rash of unassisted births by women who may not be the best candidates, especially now that they're not allowing home birth after caesareans anymore.

Although Carmon did suggest some women should not birth unassisted, it is clear that her disapproval was mainly aimed towards the structure of maternity care as it limited the rights of women to choose their birth options. Rather than other pregnant women violating a moral code, Carmon therefore constructed the health care system as violating women's reproductive rights.

The right of women to choose therefore tended to be given primacy over individuals' beliefs about particular birth options, so that women avoided expressing disapproval over the choices of others. Although they sometimes described their own choices in ways which could be interpreted as holding up an implicit moral standard, they did not explicitly communicate disapproval of these alternative choices. Annabel, for example, explained:

Regardless of the type of birth people want, I'm not— like I am very pro-home birth but I'm not by any means anti-home— uh hospital birth. Because some people— the bottom line for pregnancy is— what my belief is— is you need to feel safe. And supported. And for some women honestly, if you just can't shake that feeling that you don't feel safe, you

need to be in the hospital. Because it will like, appease a part of you that you'll know you're in a safe supportive environment.

Annabel, who talked at length about the rationale behind her doula-assisted home birth, explicitly negated any higher moral standing inherent in her choice by positioning it as the right choice for her, but not for everyone. Again, she drew upon a discourse of autonomy whereby individual choice to ensure personal wellbeing was the most important consideration regarding birth-related options.

Although women did not tend to describe birth-related options in a way that was morally prescriptive, they did describe some options in a way that illustrated there was something at stake in the decisions that were made. This was evident in how they described many birth interventions as having subsequent negative consequences, as noted in Section 3.2.2 above and explicated further in Chapter 4. Jackie explained her understanding of the potential negative consequences that could arise from epidural analgesia:

Yeah, well because partly— epidural, because— yes, because it— it wasn't that I was so opposed to pain relief exactly, but I mean I had done the research, and I st— still believe it even after working on labour and birth, that for the majority of women, the epidural slows down birth. You— you're— you start this intervention, which starts a cascade. And it— it's absolutely true. You can't deny it. That you start to slow down— manipulate those contractions, from an epidural, then you have to manipulate them with Oxytocin. Um, and such. So— and then the Oxytocin can put baby in distress, meconium, who knows what, you know, just— just it can start a cascade. I think it's more complicated than I realized it was, cause I thought it was black and white, just don't have the epidural. But I— I understand now it's more complicated than that. But for the majority I think it does— it can start a cascade, yeah, yeah.

As illustrated in Jackie's explanation, there are perceived negative consequences of epidural that stem from women's decision to have one during labour. By expressing an understanding of particular birth-related options (most commonly epidural and labour induction or augmentation) as having negative consequences if chosen, women imbued their choices with a significant degree of moral responsibility for how their labour progressed, which meant that their ability to both protect themselves and their babies from harm *and* achieve their desired birth was dependent to some degree on the choices that they made.

For several women, this responsibility was linked very explicitly to their mothering identity, in that the choices women made were positioned as reflecting their responsibility towards their soon-to-be-born baby. Carmon described this as the general rule in which she felt all women followed when making decisions about their birth:

You know, people, I— I fully believe that people, especially women during pregnancy and birth are wholly making the choices that they feel are best for their babies and themselves. No one's making a choice thinking ohh, my— well my experience is better than the health of my baby, or um, whatever else...

This quotation not only reflects women's responsibility towards their babies, but suggests that women are morally obligated (in line with intensive mothering ideology) to place their baby's health first and foremost ahead of their own needs. To do otherwise would be to fail to fulfill one's responsibility to their baby, which Carmon suggests mothers simply do not do.

Similarly, Melinda, who approached her birth with a set of beliefs strongly grounded in alternative birth ideology (although these beliefs shifted as a result of her subsequent birth experience) described how she felt like her mothering identity and responsibility as a mother was what was at stake in the birth-related decisions that she made:

Perfect. Amazing. That it was going to be amazing, and that how it went would um— would determine um what kind of mother I would be. That even, that— the choices that I made were, um, part of the kind of mother that I was. Were a key part of what kind of mother I was, right from the very beginning. Right from the beginning of the pregnancy even.

As evident in the above quotation, Melinda explicitly understood her birth experience and decisions as a reflection of her mothering identity. Moreover, it was clear in her description that there were different kinds of mothers, who made different kinds of decisions— and to be the mother she wanted to be, she had to make particular types of decisions. Women's options, therefore, were not necessarily value-neutral or personal preferences, although they were often positioned as such when women described what they wanted prior to birth. Rather, as will be illustrated further in Chapter 4, they reflected women's moral understanding of maternal responsibility towards their child.

In line with intensive mothering ideology and the notion of specifically *maternal* responsibility, birth options and decisions were usually discussed using language that suggested

that they were ultimately the responsibility of the pregnant woman. As illustrated in the above quotations the use of “I”, as opposed to “we” (e.g. in reference to the pregnant woman and her partner), was pervasive in women’s narratives when they spoke about birth-related decisions. Indeed, a few women barely mentioned or even alluded to their partner (i.e. by using “we”) when talking about preparation and birth options and decisions. Moreover, as is also illustrated in the quotations above, when participants reflected on the value of choice using rights-based discourse choice was described primarily as a *women’s* right or something that women needed. This gendered element to choice and decision-making was clear in rights-based discourse about birth, but also in some women’s narration of their experiences. Indeed, a couple of women explicitly stated that as women who were doing the physical work of labour and delivery, birth-related decisions were ultimately theirs. As Carmon explained,

I put a lot of effort into it, and um, I got him to read a lot of birth stories. I gave him all the stuff if he wanted to, but I think he trusted me and also knew that regardless of what he wanted I was the one that was going to do it, so it really was my choice.

The perspective that decision-making authority was ultimately the pregnant woman’s was often reflected more implicitly; for example, women often positioned their partner’s role as being primarily to support them in the decisions that they made, rather than adopting equal decision-making authority. Marianne, for example, stated in relation to her partner that “...*he didn’t have any strong opinions on things so it was mostly just my call, but he was definitely supportive*”. Similarly, Brenda described herself as actively seeking information and making the decisions about what she wanted, while being very appreciative of her partner’s interest and support:

And— and from then on we talked about things, like when I would learn things from my doula or whatever I would always talk to him about it, and he was really receptive, and... basically whatever I wanted to do but he thought that doing a water birth at home would be awesome.

Some women did describe their partner as having more of a shared role in birth-related decision making and preparation. Betty, for example, used both “I” and “we” when talking about birth-related options, and described how hypnobirthing classes fostered dialogue between her and her partner about the upcoming birth:

I think it— it was really good because my husband was really, really busy in school, and— and we didn’t have a lot of time to spend together to talk about what was about to

happen. And so it was good because it was five kind of weekly meetings, and we kind of talked about the birth, and about what we wanted, and about different things so it was a good opportunity to— not really learn hypnobirthing, but just to hang out with my husband.

Other women used “we” to suggest that particular decisions were made jointly. There was therefore variation in the extent to which individual women presented decisions as their, or (in general) women’s, right or domain. Overall, however, gender and embodied experience were highly salient to how women talked about choice and decision-making regarding birth. As mothers and individuals who were experiencing the biological processes of labour and delivery, it was specifically *women’s* choices that appeared to be valued and seen as a right, and therefore (as discussed in chapter 4) women who assumed the primary responsibility for decisions and their outcomes.

The above analysis illustrates that in their childbirth narratives, women drew on several distinct voices (both moral and not) when describing their childbirth-related options. When talking about what they wanted for their birth experience women generally situated these decisions as personal preferences or choices. That is, they stated their preference or decision without rationale that presented it in relation to moral claims or using moral language. Indeed, in line with the value placed on choice more generally and research suggesting the importance many women place on choice during childbirth (e.g. Hodnett, 2002; Howarth, Swain, & Treharne, 2011), women often presented particular options as something which may be “right” for one person but not necessarily a better option in general. Within this framework, particular options tended to be described in ways which framed them as individual preferences, rather than prescriptive values (as Rozin, 1997; 1999 would argue indicates moralization). Indeed, women sometimes explicitly refrained from placing a moral value on particular birth-related options, by stressing the personal nature of the choice and avoiding explicit valuation (and therefore devaluation of the converse decision) of options or decisions.

As scholars have previously argued, however, any individual person draws upon multiple voices and frameworks in order to interpret and communicate their beliefs, decisions, and experiences (Chang, 1996; Lyons, 1983; Gardner, Gabriel, & Lee, 1999; Shweder et al., 1997). Although particular options were therefore often presented as value-neutral or personal preference, there were two predominant ways in which women drew upon moral discourse when

talking about birth-related options. Firstly, some of the women who were interviewed described choice itself (rather than particular options) through reference to a moral framework. Rutherford and Gallo-Cruz suggested that beyond being an expectation, there is a belief that women are *entitled* to pursue the information and services required to shape their birth experience. This belief was reflected quite explicitly in the narratives of several women, notably those who were pursuing more alternative births, through a moral voice of justice that reflected the values of rights and choice, and therefore reflected an ethics of autonomy (Shweder et al., 1997). This discourse prioritized the rights of pregnant women to access safe, comfortable, and desired maternity care, and the freedom to enact particular options that they desired. Conversely, restrictions on these rights were presented as being harmful to the woman and violating her rights as an autonomous human being and seeker of care. Choice was therefore presented, at least by some women, as a fundamental exercise of freedom and autonomy in the effort to pursue their goals and preserve their dignity, comfort, and safety. Within this framework, which prioritized justice and the avoidance of harm, a moral responsibility was constructed on the part of the care provider (to support choice and avoid harm). Conversely, however, (and more or less explicitly in different women's narratives) this discourse suggested that women themselves were responsible for doing the things necessary to inform themselves of the options which were available and shape a positive birth.

The concept of moral responsibility was also invoked in the ways many of the women in the current study presented the choice of particular birth-related options (especially induction or augmentation and epidural) as causing harm (to the progression of labour, themselves, and/or the baby). The implicit assumption in this discourse, described further in the subsequent chapter, is that by accepting or choosing these options for birth women were liable for any resultant harms or negative outcomes. Part of the moral responsibility expressed focused specifically on women's responsibility towards their child and to protect them from harm, which can be considered part of an ethics of care (Gilligan, 1977). This was described explicitly as part of one's role as a mother by a few women, when choices regarding birth were positioned as baby-centric (i.e., the best thing for the baby) or constituting one as a particular type of mother. As Weiss (2013) has argued, however, the type of moral responsibility a pregnant woman has towards a fetus is distinct from the type of moral responsibility she has towards a child when it has been born. Before the birth of a baby, mothering responsibility is part of a woman's

responsibility for her own body, as care for that fetus can only be provided indirectly. As such, moral reasoning about birth-related options does not necessarily have to be explicitly child-centered to reflect an ethics of care. To some extent, responsibility for potential harms accrued within the labour and delivery itself can also be understood as part of an ethics of care whereby moral responsibility is understood in terms of relationships with others, as the other is (to some extent) part of the self.

3.3 Conclusions

Overall, the findings described in this chapter illustrate the commonalities and variation in how this group of Canadian women described their preparation for the birth of their baby and the birth-related options that were available to them. Two primary overall conclusions can be drawn from the findings delineated above. Firstly, although women clearly negotiated to various degrees with both natural and medicalized understandings of birth, the influence of alternative birth ideology (conceptions of the natural, the valuation of woman-centered care and informed choice, anti-intervention discourse) was quite striking and was present even in the narratives of most women who did not choose an “alternative” form of birth such as home or unassisted birth, or birth with a midwife. These findings suggest that this discourse is salient to how women make sense of the options available to them, and illustrate how it resonates with the ethics of autonomy that is predominant in Westernized societies.

Secondly, women employed both personal and moral reasoning when talking about their impending birth. Women tended to avoid direct moralization of particular choices when talking about their preparation for childbirth, and were more likely to frame specific options as personal preferences or choices. A moral ethic of autonomy was reflected in the ways women talked about individual will and choice as important values that should be supported and respected. As will be discussed further in the concluding chapter of this dissertation, the degree to which autonomy, choice, and individual will and self-determination were valued has important implications for how women engage with maternity care providers and the models of care which they work within. Although some women drew upon an autonomy and justice-oriented moral voice to describe women’s right to informed choice and reproductive autonomy, when this moral voice was invoked it also reflected an ethics of care, whereby (from the initial preparation for birth) women assumed responsibility for shaping and enacting a positive and desired birth and

protecting both themselves and their fetus from harms. Moreover, moral responsibility was invoked in many women's perception of the negative consequences stemming from particular options or interventions (mainly epidural and labour induction or augmentation). It is this moral responsibility, and how it reflects an ethics of care, which was illustrated in women's narratives as they described their labour and delivery experiences and is the focus of the following chapter.

CHAPTER 4

“I’VE NEVER FELT SO AWFUL, I SAID ‘OH IT’S ALL MY FAULT THIS HAPPENED’”:

MORAL VOICE AND FRAMEWORKS OF UNDERSTANDING BIRTH EXPERIENCES

As described in Chapter 3, women assumed responsibility in their narratives for shaping a positive and desired birth through preparation for the birth and decisions about particular birth-related options. Consistent with how women talked about their impending birth, they primarily described their labour and delivery in ways that situated responsibility for how their birth went in themselves and the choices that they made. In doing so, women often drew on a moral language of care and responsibility whereby moral good is understood in relation to what pleases, helps, or protects others, and the moral person is one who helps or meets one’s obligations and responsibilities to others (ideally without sacrificing or hurting oneself) (Gilligan, 1977). This chapter explores a) the ways in which women described their childbirth experiences using a moral voice of care and responsibility; and b) how women negotiated and re-defined moral responsibility in childbirth when they were not able to achieve their desired birth and their positive moral and maternal identity was threatened.

4.1 Guilt, Joy, and Moral Responsibility for Birth Outcomes

For women who achieved either their ideal birth or a reasonably close approximation of it, situating responsibility for the birth in themselves and their decisions engendered a sense of accomplishment, mastery, and joy. This was especially evident in the narratives of women who invested a great deal of significance in the processes of birth themselves. Annabel, who was very committed to a home birth with a birth attendant, described the birth of her son as the most magical experience of her life:

And it was wonderful and magical and because I didn’t have any drugs, you have that natural rush of oxytocin afterwards. And nothing’s more amazing than bringing a child into the world. Like honestly it was like a religious experience. It was just the most amazing experience... And I think all the prep, you know, all the prep made it good. Yeah, so it was great. And it was great because we were at home. So you know after a home birth, like I was actually— he was born on the hottest day, the hottest day of the year. It was plus thirty-nine the day he was born in my house. So afterwards they like

helped me get out of the pool, and we laid like plastic sheets down and towels and stuff and we laid down in bed with him, and we didn't cut his cord til about 45 minutes after so all the blood had completely drained. And then uh, my birth attendant took down the pool and me and ((Partner)) just hung out, and we basically all just hung around naked cause it was so hot. And he was just great, like he didn't get jaundiced or anything cause we didn't cut the cord early, and he just— he had beautiful— he always had beautiful colouring, like beautiful complexion, like it just was so wonderful. And I think because I had gone to the chiropractor, everything was in line, so it was just like everything went so smooth, like it was honestly the perfect experience...

Annabel clearly felt a significant sense of joy and achievement at what she experienced as a wonderful birth. In the above quotation, it is also clear that she narratively situated the responsibility for her birth in herself, with particular decisions (not having any kind of analgesia, preparation, birthing at home, delayed cord clamping, chiropractic care) having causal force and contributing to her successful birth and healthy baby.

By causally linking outcomes to her actions, Annabel presented a moral account of herself where she fulfilled her responsibility to both herself and her baby, making what she saw as the correct decisions to achieve a positive labour, delivery, and transition into motherhood. Carmon, who chose to birth unassisted, similarly assumed responsibility for her own care, decisions, and birth outcomes throughout her narrative and described her positive birth as both an achievement for herself and an act of care towards her baby:

So it took a few hours but then it was just— I could not believe that he was ours and that I uh, had given him this like gentle, gentle birth, minus me trying to force him back in¹, and uh that he was being so gentle with us, and yeah it was great. He was eight three [8lbs, 3oz.] when he was born, and um twenty-one and a half inches long, with a bigger than normal head ((chuckles)). So there's a reason things happened the way they did. And yeah had— when they got there he had perfect Apgar scores everything was great. It was perfect, it was pretty much the exact birth I wanted from the get go.

¹ Refers to the following part of Carmon's narrative, left in her own words: "With the next contraction (Baby) crowned, and it was the most horrific pain I could have imagined, and I pushed his head as far up as I possibly could back inside me. Because I was just AHHH I'm gonna rip like four ways from Sunday it's going to be terrible! ((chuckles))"

In describing what she considered to be her perfect birth, Carmon used a moral voice which illustrates the relational embeddedness of how she understood a good birth. That is, she presented an understanding of the birth of her son that reflected her particular idea of a “good birth”, and emphasised how she met her responsibility towards her baby and provided *him* a good birth, avoiding potential harms to both parties. As argued by Gilligan (1977), attention to moral principles of protection from harm, preservation of relationships and fulfillment of relational responsibilities, and balance of one’s own needs with those of others are principal components of a moral voice of care and responsibility. As such, Carmon presented a version of a positive birth that was framed morally and presented as an act of good mothering.

Although the positioning of oneself as responsible for one’s birth and birth outcomes was therefore described in terms of joy, accomplishment, and moral good for those who achieved a birth that was desired and valued, the converse was true for many of the women whose birth did not go as planned or was described as a negative experience. These women described feelings of disappointment, guilt, and failure, and often assumed responsibility for outcomes they considered negative by linking them to choices they had made in labour. Nadia, for example, described experiencing significant guilt after the delivery of her daughter by forceps:

I actually had a hard time with the birth in particular for the first— I think first few months after, cause I felt really guilty that I should have been able to do it better, or that I should have got up and walked around when I had my epidural, that if I had been able to do that, maybe she wouldn’t have turned... I just feel guilty that I could’ve done more to avoid having had an epidural to begin with. Like I could have been tougher, I could have managed the pain better, I could’ve you know, I could’ve hung in there longer. Um, cause I— you know, in my mind I was thinking that’s what caused her to flip, and all of these things. But we’ll never know. So yeah, that’s what I felt guilty about. Now, I don’t feel that way as much.

Although Nadia had an experience quite different from, for example, Annabel, she similarly used a moral voice of care when talking about the birth of her daughter, wherein moral good depended on the avoidance of harm within a relational context. As she situated birth outcomes as stemming from her decisions and maternal responsibility, this left her feeling morally culpable when harms were not able to be avoided. Although the harms in this case were arguably minor (an assisted vaginal delivery and a small mark on the baby’s forehead from the forceps which disappeared

after several days), they were extremely significant to Nadia. In understanding her choice of epidural as a potentially causative factor in the baby not being properly aligned in the birth canal, this decision became morally significant and threatened her sense of moral and maternal identity.

Although women generally invoked a moral voice of care in relation to responsibility for their baby, occasionally this sense of responsibility was broadened to involve additional relationships. This tended to be the case when women perceived one or more people around them as being invested in a particular type of birth (although not all of these women described a sense of moral responsibility in this way). Janice, whose labour ended in a delivery by caesarean section, explained:

I felt like a failure. I felt like I'd let her down, like I'd let me down, and (Partner) down. I— like I— everyone who I'd taken a class from, you know, and the doulas even, like that was a really hard— even the doulas, that was hard. Feeling like I'd let them down by not going drug free. They never said anything, or anything like that, but it's just like— yeah. Yeah, like I'd failed. Like I'd... yeah. Not, not run the course that I'd expected, and it was my fault for putting us on that course, when I said yes to that epidural. 'Cause that's how I felt. I felt like had I not had the epidural, then I wouldn't have needed a c-section, and it wouldn't have got infected, and that wouldn't have made me take the antibiotics, which wouldn't have made me get the other infection, which wouldn't have caused the pain [with breastfeeding], which wouldn't have— like you know, it goes on and on and on, right?

Although the harms that Janice described were arguably to herself, she clearly understood them within a relational context that involved a moral responsibility to others to manage her labour and achieve a particular type of birth. Importantly, although Janice described not receiving explicit negative feedback from others about her birth-related decisions, she felt an internalized sense of guilt, failure, and disappointment at having been unable to manage her labour in a way that avoided harm and fulfilled what she perceived as responsibilities to others.

As described in Chapter 3, most women suggested that medical interventions, particularly epidurals and induction or augmentation of labour, could cause problems for the progression of labour, mother, and baby (and were therefore to be avoided). These beliefs were reflected in how women felt about their childbirth experiences and were at the core of many of the causal links that women made between labour outcomes and their own decisions or actions. The decision

whether or not to get an epidural was particularly moralized, both in relation to its potential negative effects and a valuation of female or maternal strength and the work of labour symbolized by non-medicated birth². This was explained at length by Jackie, who stated:

It's kind of the idea that you know, back when they first kind of came out with pain relief during pregnancy, they had— it was— it was kind of about equality of women, right, to take away the pain would make them equal to men, in a sense. Because they didn't have to be this victim of the pain in labour and birth. But then it's changed now to where we fear that pain, when really it can represent us going through that, and facing that, it can represent our endurance and strength as mothers, and women. Um, and I think a lot of people— it's not important to a lot of people and that's fine, but a lot of women even— especially in sort of vulnerable cultures where it's very hard for them to feel like they can accomplish anything, that is one thing that they can accomplish. Um, and for me, I needed to know that I could do that, even though it didn't work out for me. That's part of the story, but, um, I really, really wanted— I really wanted that. Because sometime then when you're faced with difficult things in the future, you can look back and say I did this. It's a st— you know it's a strength, and um, a sense of accomplishment that you are strong enough to deal with what life brings you, because... yeah.

The above quotation suggests that for Jackie, and several other women who similarly spoke of the value of strength and the work of labour, relying on epidural analgesia during birth threatened their identity as strong women and mothers. This lack of “authentic” labour experience, tied to mothering and feminine identity, was a significant part of some women's disappointment at undesirable labour outcomes, particularly for women who had to have a caesarean section. Jackie also narratively situated the epidural as causing her labour to slow and potentially contributing to poor positioning of the baby (which led to vacuum delivery), which was similar to causal chains described by other women.

Women were therefore mistrustful of epidural analgesia and saw it as a causal factor in subsequent problems with the labour and delivery, as well as with their health (e.g. Cherise

² This association between non-medicated birth and strength was not accepted by all the women interviewed (and was explicitly questioned by Andy) but in general the “work” of labour tended to be valued by women.

thought that it may be the cause of severe headaches she experienced in the postpartum)³. Most of the women who received an epidural were also, however, profoundly grateful for the pain relief it offered. They described the epidural as contributing to decreased pain, the ability to rest, and the capacity to think more clearly during labour. As Melinda explained:

I'm induced, and then— so again, things get stronger but I don't feel them, cause I have this wonderful epidural, which is amazing. It was just, when I got that epidural, it was like um, some— it was like I came out of like, being deep inside of me. And it was like I opened my eyes for the first time in— in twelve— not in twelve hours, but in, in many hours. And I realized I hadn't— I'd been inside myself and I remember I got it and it kicked in and I was like oh, (Partner), hi! Oh, (Midwife), hello! You know? And then I was aware of what was going on around me.

The epidural was therefore valued for the relief from pain and return to control and cognitive clarity that it offered. For women who felt strongly about its harms, however, the decision to have an epidural was contentious, as they attempted to balance harms to themselves (from labour pain) and potential harms that they feared the epidural would cause. Later in her narrative, Melinda, whose baby was delivered by caesarean, described how she felt about how her labour and delivery had gone:

So I'm disappointed that it didn't go how I— I wanted it to, because I didn't get to push. I feel like I didn't get to complete, you know, the whole thing. Um, a lot of doubt, and especially in the first few weeks and months postpartum. I felt really disappointed in myself, and... um, wondered if I made wrong choices, if I'd made different choices if it would've um.... if it would've— things would have been different. Choices to get the epidural and the Pitocin. Or if there was more I could've done, um, maybe if I'd been induced earlier he wouldn't have been so big, I don't know. Or— or you know, maybe I should've done the squats (chuckles) and the pelvic exercises, I don't know. But mostly if I should've made different choices, um, during the labour.

While Melinda made a decision to get the epidural during her labour and expressed gratitude for its positive effects, she (along with many other women) framed it as a potential causal factor which led to an undesirable labour outcome. As such, the use of epidural was described in terms

³ As noted in Chapter 3 (see section 3.2.2) this mistrust may reflect the critique of birth interventions and medicalized birth that is part of alternative birth discourse; it may also reflect women's own research into particular interventions or information that they received during prenatal education.

of a moral dilemma, where different harms (to self, to baby, to others who were perceived to have a stake in the decision) had to be balanced and resolved in light of women's moral responsibility to reduce or prevent harm to themselves and others, especially the baby. Epidural was therefore a particularly complex birth decision, as it was understood by most women within a moral context.

By narrating their experiences of childbirth in ways which highlighted a responsibility to protect their self, baby, and invested others from harm, most of the women interviewed invoked a moral voice of care. That is, their moral understandings were heavily relational and centered upon the avoidance of harm to self and others, and their related moral responsibility within these relationships (Gilligan, 1977). Gilligan (1977) suggested that the central moral problem women face is the conflict between self and other, which poses a dilemma that they need to resolve in ways which demonstrates responsibility and care towards themselves and others. In the case of responsibility to the fetus, the responsibility of protecting either self or baby from harm can be particularly complex as care for the baby is mediated through the mother's body (Weiss, 2013). In their descriptions of labour and delivery, women's moral dilemma between self and other (Gilligan, 1977) was represented most prominently in relation to the use of epidural analgesia. This birth option represented, on one hand, the promise of cessation of pain, but on the other hand, a moral lack of strength and fortitude and a variety of potential harms to labour, self, and baby. The contentious nature of epidural use described above is consistent with previous research illustrating that women feel the desire for pain relief in labour is both expected and discouraged, and that they are caught between a medicalized narrative where pain relief is necessary and a desire to be "strong" (Maier, 2010). This provides context for the quantitative findings that 88% of women who chose an epidural after electing to have a natural childbirth believed that their epidural made their childbirth experience less satisfying, despite reporting far less pain during the latter stages of labour than women who did not receive an epidural (Kannan, Jamison, & Datta, 2001). Indeed, two-thirds of the women who chose to have an epidural in Kannan et al.'s study reported the belief that natural childbirth was better for the baby. Understood within a moral framework based on care and responsibility where both the avoidance and use of the epidural may cause harm, it is understandable that women's descriptions of utilizing this birth option were emotional and multi-faceted.

By drawing causal links between birth-related decisions and a variety of positive and negative outcomes, women situated the responsibility for care in themselves and evaluated the morality of their decisions according to both their beliefs (i.e. about particular interventions, or birth more generally) and how these decisions worked out. As Lyons (1983) argued, when understanding and reasoning from within a morality of care, individuals evaluate the resolution of a moral dilemma or decision through considerations of response: what happened, how things worked out, and whether relationships were maintained or restored⁴. This type of moral evaluation was evident in how women presented their experiences; their sense of responsibility for positive or negative labour outcomes informed how they understood and evaluated the goodness of the decisions they made during labour. The extent to which the causal links drawn by women in their narratives would be considered valid from a medical perspective is unclear. As described in Chapter 3 (Section 3.2.2), interventions such as epidural analgesia and labour induction have been associated with further medicalization of labour and an increased likelihood of additional technological intervention, although some of these associations are not found consistently (see, e.g., Alexander et al., 2000; Anim-Somuah et al., 2005; Cambic & Wong, 2010; Cheng et al., 2014; Cammu et al., 2002; Tracy et al., 2007; Sanchez-Ramos et al., 2003; Zhang et al., 2001). However, from within the theoretical perspective being employed, there is no assumption that women's narratives do or do not represent objective or factual truths (Riessman, 2008). Rather, the focus is on how the women who were interviewed constructed knowledge and interpretations about their experiences through their narratives of childbirth.

In understanding and communicating experiences of childbirth within a moral framework of care and in relation to maternal responsibility, it is clear that women have a great deal at stake in childbirth. Previous researchers have documented women's disappointment when they do not achieve their desired birth (particularly when delivery occurs by caesarean section), and have illustrated the role of pre-birth expectations, the degree of control women retain, beliefs about birth as a rite of passage into motherhood, and natural birth discourse in how women perceive these experiences (see, e.g., Bryant et al., 2007; Charles, 2013; Crossley, 2007; Fenwick et al., 2009; Hauck, Fenwick, Downie, & Butt, 2007; Kornelsen, 2005; Malacrida & Boulton, 2012; Malacrida & Boulton, 2014; O'Reilly, 2001). Additionally, similar to the women in the current

⁴ Alternatively, within a morality of justice framework, individuals evaluate the resolution of a moral dilemma through considerations of rights: how the issue was decided, thought about, or justified; and whether values, standards, and/or principles were maintained (Lyons, 1983).

research, Malacrida and Boulton (2014) reported that the Canadian mothers in their study held themselves (and not medical professionals) responsible for undesirable birth outcomes. As such, they ascribed to a sense of individualized responsibility, whereby individuals are increasingly held responsible for their lifestyle behaviours, decisions, and positive or negative health status (Lupton, 1999; Malacrida & Boulton, 2014; Rosenberg, 1997). This concept of individualized responsibility could also be used to interpret the experiences of women in this study, although it fails to capture the moral valence of women's descriptions. The current analysis, which illustrates how women communicate their childbirth experiences through a moral voice of care and responsibility, offers additional insight into the ways that women understand their birth-related experiences and outcomes, be they positive or negative. Within this framework of understanding, women's assumption of responsibility and their emotions regarding childbirth (guilt, mastery, disappointment, euphoria) are communicated using a moral voice and reflective of a deeply held ethic of care.

4.2 Causal Frameworks and the Re-Negotiation of Moral Identity

As individuals interact with others, their identities as moral persons are being re/constructed through the moral meanings communicated through their actions and words (Doucet, 2006; Finch & Mason, 1993; Tappan, 2006). Indeed, the construction of identity is one of the primary functions of narrative (Riessman, 2008), and through narrative one's moral status is negotiated (Gergen, 2005). As women recounted their experiences with childbirth, it was evident that their maternal and moral identity was at stake in their communication of responsibility and causal links to birth outcomes. Women who achieved their desired birth were able to present a positive and desired moral identity, whereby they upheld ideals of personal and maternal strength and successfully fulfilled responsibilities to self and others. However, women who were not able to achieve their desired birth, and drew causal links towards their decisions and negative birth outcomes, communicated a self whereby their positive moral and maternal identity was in jeopardy. As they narrated their birth experiences, these women worked to re-negotiate and maintain a positive moral identity in the face of self-doubt and possible moral recrimination.

In reframing negative birth experiences that threatened their moral identity, women drew upon a biomedical frame of medical understanding which positioned medical intervention as

necessary. One example is getting an epidural, which women often described in terms of need and highlighted the context of their labour as being unique— particularly painful, long, or unexpected. Janice, for example, stated:

And I wanted to, like I— I really, I do long distance running, I really believe in mind over matter. And I wanted to use my mind to get past what was going on. But, (Baby) had a different plan, and um it just became obvious that it wasn't going to happen that way, that we— I was going to need something else to get us through. It just went so fast, like I had always like, first thing you thought it was so slow, that things moved so slow. And I thought I'd have time to like you know, eat, and get my strength and my game face on, and all that, you know.

By placing their decision in the specific context of their bodily experience, as opposed to a general sense of what was right or good, an option such as epidural or induction was able to be reframed as necessary (if still not desirable). This was one context during which women often emphasized the corporeal experience of labour, as they described the pain they were experiencing.

Other women, like Karen, described the decision to use labour augmentation and epidural within a biomedical framework based on risk:

And I mean, she [Midwife] laid out the facts for us, like we'd been in labour for a number of hours already, we'd been labouring first naturally at home and then naturally at the hospital, and you know, in her mind it's like a— not a game, it's a question of risk, right? So now that it had been x number of hours that the baby had been presumably in meconium, the risk was this, and here's what we need to do, and so— you know, again, it wasn't that she was coming in and pushing her views on us, and same with our doula. Like, she was just there to support us and help us talk through the options, and obviously she wasn't— she's not a huge fan of epidural and oxytocin either, but you know, given the situation at that point in time, that was the midwife's recommendation. And it wasn't really a recommendation, and we weren't really going to question it, because she's been— she's delivered a thousand babies. And um, we want ours to be born safe and healthy, and she thinks that's the best way to do it, and we trust her.

By invoking notions of heightened risk to the baby if an intervention was not accepted, Karen positioned the decision to intervene as being necessary due to the circumstances of her labour.

Moreover, she emphasized the expert role of her care providers in being best suited to manage that risk, as well as the trust that she placed in their recommendations. Several women stressed that their trust was heightened specifically because their care providers were midwives (and sometimes doulas). Karen went on to state:

Like, because we had built a relationship with our midwife, um... like we'd watched the Business of Being Born and stuff like that and knew if you got Oxytocin you got epidural. If you got epidural then your chances of c-section are higher. Like we kind of knew that this progression could take place. But you know, because we worked with our midwife and talked with her throughout, and she'd already been with us for like, I don't know, a number of hours at that point. It wasn't like she was a doctor, checking in and checking out and saying like, I got places to be, get this shit going.

Because midwives and doulas were seen as being anti-interventionist and supporting natural birth, and had spent a lot of time with women both prenatally and during the labour itself, their recommendations for intervention were described as being more legitimate and necessary than if they had come from a doctor or obstetrician.

In addition to re-framing the initial interventions as necessary in their particular situation, women who took responsibility for negative birth outcomes also worked to re-frame the final outcome as inevitable despite of the earlier decisions that they made. Melinda, in describing her disappointment over her caesarean delivery, explained:

It was one of the most disappointing times— uh, moments of my life. Um, and at that point I didn't have a choice, I— I feel. Like, what else could I do. And I know now, you know, that there was no other option, that he wasn't coming out. And so, I guess— uh, he was in a bad position. Um, his head was down but he was uh, face up? I don't know, whatever. He was in, not... he was turned— yeah. It doesn't matter. So he was in a position that is very difficult to birth, let's put it that way. And, so he was in a bad position, his heart rate was dropping, which maybe is my fault for accepting the Pitocin, I don't know. Um, he was um, so he was covered in meconium. Which is like a sign of distress right, so babies will empty their bowels if they're in distress in utero.

By invoking a biomedical narrative of causality, Melinda and a couple of other women described medical intervention as necessary due to factors which were beyond their control. In framing negative birth outcomes in relation to medical or biological factors, women re-negotiated

responsibility for these outcomes by describing them as inevitable and part of the biological progression of their labour. Medical markers of risk (e.g. meconium) were presented as facts which supported this biomedical framework of understanding, and offered reassurance that things had happened in a way that was necessary and beyond women's control. Notably, in the above quotation, Melinda still placed her decision to receive Pitocin within a moral framework wherein she may be partially at fault, illustrating how these two frameworks of understanding were often invoked simultaneously as women worked to re/negotiate moral responsibility.

Through reframing negative birth outcomes in ways that preserved a positive moral and maternal identity, women shifted the focus within their narratives from the potential harms of their birth-related decisions and the negative outcomes to a focus on what was described as the *ultimate* outcome— a healthy baby. In doing so, women worked to absolve themselves of any guilt or negative feelings accrued as their labour and delivery deviated from what they considered the ideal. Melinda, for example, stated:

Yeah, so really just disappointment, cause it didn't go how I wanted I guess I felt some guilt, that I hadn't done the right thing, um, and of course this was all relieved by (Baby) being a completely healthy baby, right?

Similarly, Nadia explained:

I actually had a hard time with the birth in particular for the first— I think first few months after, cause I felt really guilty that I should have been able to do it better, or that I should have got up and walked around when I had my epidural, that if I had been able to do that, maybe she wouldn't have turned. Or, you know, I sort of blamed myself for a long time... you know, without just sitting back and saying she came out fine. She was healthy. What's the big deal.

By focusing on the fact that, overall, their babies were healthy and did fine after delivery, women were able to reframe their birth experiences (both for themselves and in how they were narratively presented to others). In doing so, they were able to better preserve a positive moral and maternal identity in relation to their experiences of birth. Karen re-framed her caesarean in order to downplay her feelings of disappointment and highlight her decisions as a personal sacrifice for the health of her baby, explaining: “*But I felt, you know... like... now that I see her, how, you know, how could anybody look and be like no, I'm going to make you keep breathing in poop while Mom powers through. Come on!*” A short while later, she concluded, “*So anyways,*

things happen for a reason, and she is here and healthy, and so you know you can't really be too sad about not getting to have your home birth in a pool." By presenting the health of the baby as the ultimate standard for judging birth experiences, women who had negative experiences were therefore able to re-frame them in ways which either minimized the impact of their decisions in contributing to negative outcomes, or situated their decisions as having avoided other, potentially worse outcomes. In doing so, they worked to preserve a positive moral and maternal identity through the adoption of different frameworks of interpretation.

A couple of women spoke about supportive others who helped them in the process of reframing their labour so that they could emplot their experiences in ways that did not threaten their moral or maternal identity. On the day that she returned from the hospital, Karen's neighbour told her that her own son would not suffer from serious health problems if she had been able to access a caesarean section when delivering him. Karen described this knowledge as helpful in her efforts to shift her focus to the ultimate health of her baby, lessening her negative feelings about the birth of her daughter. She did not, however, feel comforted by the efforts of her health care professionals to ease her disappointment regarding the caesarean:

One of the things that the nurses and our doula and things kept saying was that, you know, 'You've worked really hard, and it's ok to have a c-section, and you know, don't—you've done the best you could,' and stuff like that. And...I don't know. Because I was prepared mentally for like, labour and delivery, at home, I was sort of like saving my reserves as we went along. Like I was—I was prepared to have it be a long process, and to have to use a lot of um, like breathing techniques, and mental exercise, and things like that, to get through it. But because um, because we went to the hospital and had the epidural, you know, I felt like I never really had to tap into those reserves. So when people were saying like, you worked really hard, and don't—don't beat yourself up, you worked really hard, I was like, I really haven't.

Although she accepted a medical framework of understanding in which her experiences and decisions may have saved her baby from lasting harms (which also supports a positive moral and maternal identity), Karen was not able to adopt the maternal strength script provided by her health care providers. Although she recognized their efforts as being good-hearted and potentially beneficial for others, she did not feel that narrative resonated with her experiences and was therefore not able to use it to frame her caesarean more positively. She still presented a

version of failed experience, having been unable to follow through with the work of labour and rite of passage described by Jackie above. Conversely, Melinda stated:

I felt, um, I did get reassurance um from my midwife that— that each step of the way I made the— really, the only choice that was possible, and so, I felt like— you know that— so in a sense that it was out of my control made me feel better.

Melinda's midwife reinforced an explanation of causality wherein Melinda had done the only thing she could given the medical circumstances, which she was able to at least partially adopt to describe her experiences. In doing so, Melinda was better able to absolve herself of any understanding of having failed in her responsibilities, which lessened her negative feelings about the birth and supported her in constructing a more positive moral and maternal identity. These examples illustrate how women reframed the ways they understood birth through their interactions with others, although the thoughts and narratives which others offered could also be rejected.

Shweder et al. (1997) argued that human beings are driven to create meaning from suffering and misfortune by understanding the causal meanings of experiences, and how these relate to other people, in order to gain control over events and attribute responsibility or fault. In making sense of negative experiences, people can draw upon causal ontologies (either one or elements of several) to locate suffering within a framework of understanding. Shweder et al. (1997) described one of these as a moral causal ontology, which is focused on transgressions of obligation: "omissions of duty, trespass of mandatory boundaries, and more generally any type of ethical failure at decision making or self-control. It is associated with the idea that suffering is the result of one's own actions or intentions, that a loss of moral fiber is a prelude to misfortune, that outcomes— good and bad— are proportionate to actions" (p. 122-123). This concept of moral ontology can be thought of in the same terms as moral voice. Whereas moral voice is often invoked in the literature to distinguish between different moral frameworks (e.g. justice vs. care) in how people interpret and communicate about decisions or experiences, a moral ontology refers more generally to whether individuals draw upon a moral framework in creating causal meaning from their experiences. As illustrated in (Section 4.1), women did tend to situate their birth experiences, both positive and negative, within a moral ontology (specifically, using a moral voice of care) that was focused on their responsibilities to self and others and linked birth outcomes to their decisions regarding labour and delivery.

For women whose birth experiences were negative, however, understanding their experiences within this framework was emotionally detrimental and threatened a positive moral and maternal identity. As such, women re-negotiated how they understood and communicated their experiences by drawing on an alternate, biomedical causal ontology. Within a biomedical ontology, the locus of suffering or negative outcomes is genetics, hormones, physiological impairments, and other biomedical factors (Shweder et al., 1997). In this framework of understanding, rather than human agents being primarily responsible for their own misfortune, outcomes are situated as being outside of human action, responsibility, or control. These elements were evident in the causal links constructed in the narratives of women whose births did not go as desired, through biomedical indicators such as uncontrollable pain, unusually long labour, small pelvis, and malpresentation of the fetus, the narrative displacement of responsibility and control so that it was external to the woman, and renewed emphasis on the medical expertise of care providers.

Gilligan (1977) suggested that when alternatives in moral decisions both involve hurting someone, neither can be considered morally positive and women may avoid or deflect responsibility for the choice. Although this is presented as inferior moral reasoning within Gilligan's framework, the above analysis illustrates that women may draw upon multiple frameworks of meaning to understand and communicate their birth experiences, and that invoking a moral causal ontology can cause women significant distress if things do not go as planned. Understanding technological intervention as necessary from a biomedical perspective helped women to shift the meaning of this decision away from a moral frame of personal culpability. As Kornelsen (2005) noted for women birthing at home who transferred to hospital, believing in the necessity of intervention eased disappointment and negative feelings about the birth. Through re-signifying their labour and delivery experiences primarily within a biomedical causal ontology, rather than a moral one, women worked to shift the responsibility for undesirable outcomes away from themselves. In doing so, negative outcomes were no longer as threatening to a positive moral or maternal identity, and indeed could be presented positively in relation to ideas of maternal responsibility and sacrifice. Although situating birth within a medicalized framework is often criticized for contributing to a negative cultural understanding of birth and increasing rates of intervention (see Hunter, 2006; Fox & Worts, 1999; Rooks, 1999), women's ability to frame their experiences within a biomedical causal ontology may support

their ability to present a positive maternal and moral identity in the wake of a birth that did not go as desired.

As with all narratives, those of birth are not static; they are told in particular contexts, for particular people, and are amenable to a significant degree of flux as individuals re-negotiate meanings and work to achieve particular purposes (Bruner, 1986; Riessman, 2008). Although I was privy to only one specific narrative constructed at a specific point in time for the purposes of this study, it was evident in the descriptions of women who were disappointed with their birth that the ways in which they understood it did shift over time. As women grapple with and retell their experiences to others, they no doubt continue to negotiate birth-related meanings and may engage with multiple frameworks of understanding in doing so.

4.3 Conclusions

The findings delineated above illustrate the salience of a moral ethic of care and responsibility to how the childbearing women in this study understood their birth experiences and communicated the events of their labour and delivery. Women's understanding and communication of their birth experiences using a moral framework where they were responsible for birth outcomes could have the effect of bolstering women's moral and maternal identity, and engendering a sense of pride and accomplishment. These findings also speak to the importance of having a positive birth experience for women; it was clear that women took tremendous pride in achieving a "good" birth and that this importance was linked to their perceptions about their role in achieving a positive outcome. For women whose birth did not go as desired, however, this responsibility left women morally culpable for the decisions that they made. It may be partially this moral responsibility which contributed to the strong desire for a positive birth experience expressed by most of the women interviewed⁵. Success or disappointment within this context appeared for many women to mean more than the inability to achieve (or not achieve) a desired outcome; it could be perceived as a success or failure of moral and maternal responsibility. For women who did not have their desired birth experience, efforts to reframe the way they understood the events of their labour and delivery meant shifting from a moral framework of

⁵ This is a feature of contemporary alternative birth discourse as well, which represents a cultural shift from understandings of birth as an ordeal that just has to be endured until labour and delivery are completed.

understanding to one which emphasized the biomedical and placed outcomes beyond their personal control.

These findings highlight the salience of moral and maternal responsibility to how women understand their experience of childbirth, and illustrate the degree to which this affects their feelings about these experiences. It was clear from women's narratives that maternal identity is more or less (varying among women) entwined with understandings of childbirth and ideals regarding positive birth experiences. Childbirth is clearly, for many women, more than a physical event heralding their baby's exit from the uterus and into the world as a separate being. Rather, it seems to be understood as an aspect of mothering, and therefore subject to the same prescriptions and ideals that scholars have argued characterize contemporary mothering ideology. Given the unattainable ideals (see Douglas & Michaels, 2007) and enormous pressure on mothers within this ideology, women's desire for positive birth experiences and need to present a positive maternal identity is not surprising.

Finally, the focus on moral responsibility in women's narratives suggests that many women are drawn to accounts of childbirth in which they are the primary moral actors (with the moral responsibility that this involves). The following chapter picks up this idea to explore another primary theme that was strongly related to how women made sense of and felt about the birth of their child: agency, self-determination, and autonomy in childbirth.

CHAPTER 5

“ANOTHER PREGNANT WOMAN WHO’S SCREAMING AND YELLING FOR WHAT SHE WANTS”:

AGENCY, AUTONOMY, AND SELF-DETERMINATION IN CHILDBIRTH

As illustrated in Chapter 4, women situated birth-related outcomes within particular causal frameworks which had bearing upon how they felt about their birth and self. It is not just outcomes, however, but how women understand the process of labour and delivery itself that was reflected in their feelings about their birth experiences. Three related concepts in particular captured essential aspects of how women understood and communicated their birth experiences. The first of these concepts is *agency*, or the degree to which women valued and expressed themselves as able to exert influence on their functioning and circumstances during birth (Bandura, 2006). Agency is inextricably intertwined with moral responsibility, as moral agents reflect on the moral implications of choices and accept at least some responsibility for their actions. Even more fundamentally, assuming responsibility for actions is predicated on seeing oneself as an agentic being. Agency, therefore, centers upon one’s sense of being able to act and influence one’s self and circumstances. The second, and highly related concept, is that of *self-determination*: the ability of individuals to make decisions and live their lives in ways that are guided and shaped by their own choices and values (Powers & Faden, 2006). An important aspect of self-determination is *autonomy*, which can be understood as an individual’s need for volition and control in relation to their behaviour, and the sense that they are acting willingly and endorsing those actions and their associated values (even if those actions are requested by others) (Chirkov, Ryan, Kim, & Kaplan, 2003; Ryan & Deci, 2002; Ryan & Deci, 2006). In order to act in a self-determined way, an individual’s basic need for autonomy must be supported (Ryan & Deci, 2002). Although these concepts are defined in various ways by different scholars (and there is a significant degree of overlap between the concepts in many of these conceptions), the definitions described above guided the current analysis. Autonomy and the right to self-determination form an important part of contemporary medical ethics through processes like informed consent, and are part of the institutional context in which contemporary childbirth often takes place (O’Boyle, 2006). They are also, as described earlier, part of an ethics of autonomy (Shweder et al., 1997) with its emphasis on individual will, rights, and choice. This chapter

explores the ways that agency and self-determination were reflected and valued in women's narratives of childbirth, and delineates how women described their agency and autonomy during childbirth as being fostered and/or constrained.

5.1 Birth Experiences and Valuations of Agency, Autonomy, and Self-Determination

Almost all of the women who were interviewed talked about their experiences in ways which expressed agency and self-determination as valued, and as informing how they felt about the birth of their child. As introduced in Chapter 3, the importance of choice was repeatedly emphasized as an important part of giving birth in a way that was agentic and in line with one's values and beliefs. Melinda, for example, explained:

I had a midwife, who was very, um, supportive of us making choices um, according to our values and giving us options. For everything, all the prenatal care, our plans, um, for—for the birth, um, she... so some of the standard things that are done, that are applied to just, just about every woman, um, we—we were allowed to make choices about that, whether we wanted them or not, just—they weren't just expected.

Melinda stressed the importance of agency and choice at multiple points in her narrative, although interestingly she noted at one point that she came to feel that there was too much choice and information, which made it difficult to make a decision. Ryan and Deci (2006) noted that providing people many options may lead to feelings of being overwhelmed and resentful at the effort that decision-making requires; someone can therefore have numerous options but not feel a sense of autonomy. While choice is not synonymous with autonomy it can certainly enhance an individual's experience of volition and facilitate self-determination, as choice tends to make it easier for someone to find an option that they genuinely endorse and is consistent with their values (Ryan and Deci, 2006). Both before and during labour, women described choice as being important in being able to give birth in a way that was aligned with their values. Choice is not synonymous with autonomy, since someone may have only one option but endorse that option and act.

The extent to which women emphasized agency (in the sense of being a primary actor in their birth experience) varied between women, and this was related to the degree to which their ability to enact agency and self-determination during their labour and delivery affected how they felt about their birth. Women who highly valued agency (that is, they repeatedly invoked the

importance of choice, control, and active participation in the process) generally felt extremely positive and capable regarding their birth when they felt that they were able to act autonomously and in ways which reflected their values and choices, but felt very negatively about their birth if they perceived themselves as being constrained from doing so. To illustrate the valuation of agency, autonomy, and self-determination in relation to the ways women made sense of their birth experiences, excerpts from the narratives of three women (Carmon, Elizabeth, and Cherise) are explored below.

5.1.1 Carmon: “He’s here and I did it, the way I wanted, I did it.”

From the beginning of her narrative, Carmon adopted an agentic voice wherein she described a clear choice to become pregnant and immediately took charge of the direction that her pregnancy and birth would take, having decided many years prior that if she ever had a child she wanted an unassisted home birth. Carmon described her pregnancy and preparation for birth in ways which were highly agentic, stressing the very active role that she played in her own pregnancy care and in her extensive preparation for the birth. She located herself as the primary agent shaping her experiences:

Um... during the pregnancy, uh, the decision to ((pause)) trust myself from the beginning and provide myself with some level of prenatal care. Not like, midwifery style care or anything like that, but that every day I was going to palpate my own belly, no matter how small the baby was, so I could figure out where he was. That I listen with the fetal scope every day just to reassure myself and then you know, I... you gotta know what your options are.

By emphasizing her own ability to influence her experience through prenatal preparation and care, Carmon situated herself as a primary agent in shaping her birth experience. Although she had professional experience as a doula which allowed her to assert more direct control over her prenatal care, other women also emphasized the importance of agency through their efforts to prepare for the birth, especially research and decisions about birth options (as described in Chapter 3). Similar to several other women, Carmon described herself as the ultimate authority over birth-related decisions, even over her partner (whereas some women described decisions as being made primarily in partnership), stating that he supported her in her choice of an unassisted home birth:

But through the pregnancy and very early on he was just like no, it's your thing. And what you feel comfortable with is more important to me. And even by the end I told him you know, when I picture this, my perfect birth, you're not there. No one is there. I do it by myself. And that just feels right. And uh, yeah he was fine with it...

Carmon drew upon a discourse of autonomy (Shweder et al., 1997) that emphasized her right to choose the context of her birth and the importance of being able to act in a self-determined fashion to give birth in a way that reflected her desires, values, and beliefs. In doing so she reflected a valuation of personal agency, in which she positioned herself as the appropriate primary agent in her birth experience. Her sense of agency and capability in enacting it was evident in her description of labour and delivery, as she guided herself through the process and made decisions (e.g. where and how to labour, who was in her space, delivery position) throughout that reflected both her immediate needs and broader desires and values.

Carmon described the joy she felt at her son's delivery in relation to her ability to act autonomously and enact her desired birth:

And uh, then I turned, and he [Partner] handed me the baby, and he got undressed and got in the tub and then we spent the next at least half an hour in complete silence the three of us, just hanging out and getting to meet our baby, outside! And uh, he didn't cry, he didn't— he just looked, and... it was crazy. I did not have that moment where I looked at him and I fell in love. I was so high on the experience that I kept going I did it. I did it. He's here and I did it, the way I wanted, I did it. And I could have like, jumped up and down I was so excited I did it. And uh, he just was so relaxed and calm.

More so even than the arrival of her son, Carmon understood her initial feelings of empowerment and joy as stemming from her ability to birth in a way that was agentic and self-determined. As she placed a high value on personal agency throughout her narrative, this informed how she understood her labour and delivery and affected her feelings about the experience overall. She went on to reflect:

Um, something that I did from the beginning was I didn't hand over my health care to somebody else. I don't do that in regular life either, I— I have a fantastic relationship with my GP, and she's lovely, but I don't go to her and expect her to fix my problems or fix my body. If I wanna change something it's totally up to me to do it, and I accept that responsibility. And I accepted all the responsibility of my pregnancy, and my birth, and

the postpartum. And no one was going to do any of that but me and I know it, and I can't be saved from it if I've having a tough time. I have to either accept the tough time or do something about it. And too many women decide that they're just going to hand it all over. To their midwife, to their doctor, to their doula. And it's not, that's not helpful. And it's not going to help you get to the place you want to go. It gives you someone to blame when things don't go the way you want, but if things wouldn't have went this way, and I would've had to go to the hospital, or have a c-section or whatever else, I don't think I would've felt negatively about the birth. Because I still would have been empowered by my own ability to choose, and I still would have... would have put the time and effort into it.

The importance of agency and autonomy is evident in how Carmon presented herself, both in relation to birth and more broadly. Moreover, in the above excerpt Carmon made it clear that her sense of responsibility stemmed from a sense of personal agency. Indeed, the attribution of responsibility depends on the assumption of individuals as conscious agents who have the appropriate status and capacity to take responsibility (Harré, 1995; Shweder et al., 1997). Agency is intertwined with moral responsibility, as moral agents both reflect on the moral implications of their choices and accept responsibility for their actions and the consequences that they might have for others (Bandura, 2006). Women who highly valued agency and presented themselves accordingly therefore had a higher stake in negotiating moral responsibility for undesirable outcomes, as they understood themselves as primary causal contributors to their birth experience and outcomes.

5.1.2 Elizabeth: “Next time it’ll be all me.”

Like Carmon, Elizabeth presented herself very much as an agent in her narrative through her descriptions of preparing for the birth and trying to achieve an experience that was reflective of her beliefs, values and desires. Although she knew what type of intrapartum care she desired prior to conception, she took control in negotiating her care when it was not available:

As soon as I found out, I phoned for a midwife. And heard back in a couple of weeks that all the spots were taken. And so I started planning for an unassisted home birth, and began interviewing doulas who would put their names on the line for that. And... was cruising along with that plan, switched from my GP to an OB, and... just so I had good prenatal care, so that I knew if there was anything going on ahead of time. And then in

June, the midwifery office called and the new midwife had space available. And so I got a midwife, which resulted in a few weeks of... debating whether I should take it or not. Because we'd already planned so much, and, although I didn't want to be unassisted right off the shot, I.... had fallen in love with the plan.

Elizabeth's sense of agency was clear even in the face of structural constraints that threatened her desired birth, as she described immediately acting to shape a birth experience that was still reflective of her desires (she did end up taking a spot with the midwives when it became available). Her valuation of agency and self-determination was also evident in her construction of a detailed birth plan, which entailed a number of specific requests limiting intervention (e.g. cervical checks, Pitocin, erythromycin drops) and protecting her autonomy (e.g. being able to choose whether or not to eat and drink during labour, delivering in whatever position she desired at the time).

After labouring at home for over 24 hours, Elizabeth's labour failed to progress past 7 centimeters dilation and she ended up transferring to hospital. As she described her labour at home, the value she placed on having her agency and autonomy supported was clear in how she talked about the care that she received from her midwives. She primarily described these interactions and her labour at home as positive, but explained:

Um... I had said no drugs, and I was actually upset that the nitrous got brought in here. I saw it and I wanted it, cause I was... if it hadn't been there, I wouldn't even have thought of it— hey, can you go get me a tank of nitrous? And... which in the end it didn't matter, but the fact that it was there kind of violated what I wanted.

Although put in the broader context of her labour Elizabeth did not position the presence of nitrous oxide as having particularly detrimental consequences, she perceived it as a violation of her desires and birth plan and therefore as a threat to her ability to enact the birth that she wanted. Conversely, she went on to describe the efforts of her midwives to support her agency and autonomy in the face of a labour that did not go as desired:

And... so it was a group effort the whole time. Most of my requests were honoured, I can't really think of anything else that ticked me off. The hospital transfer I had specifically said that my midwives would tell my doula, my doula would tell my husband, and he would tell me that, and that happened.... And I think— the midwives actually pushed it further than they should have, cause around the 24 hour mark, they're

supposed to, supposed to get OB consult. And... so they, they worked harder than they had to, to try and give me more time, it was good. Yeah.

Despite not being able to achieve her goal of a home birth, Elizabeth emphasized the value she placed on the efforts of her midwives to preserve her autonomy by honouring the terms of her birth plan and supporting her efforts to birth according to her values and desires. This support increased Elizabeth's sense of agency in the process, as the "group effort" allowed her to exert influence over what was happening during the course of her labour. Even when the outcome was undesired, she felt positively about the extent to which her midwives had supported her attempts to birth in a self-determined fashion.

After Elizabeth was transferred to hospital, however, she indicated that her sense of autonomy was severely constrained, in that she did not endorse the actions that were taken or the values behind them as her labour unfolded. This constrained autonomy and associated diminishment of agency (as other people exerted a high level of control over her labour) were reflected in her descriptions of labour as an extremely negative and violating experience. As someone who placed a high degree of value on agency and autonomy, as well as having wanted a very non-medicalized birth, Elizabeth perceived the hospital protocols and her interactions with hospital staff negatively and with suspicion. The crux of these negative experiences were interactions where Elizabeth described her autonomy as being denied; this eroded her sense of agency and made it impossible to continue labouring in a way that reflected her desires:

While on Pitocin, of course they have to put an internal fetal monitor in, and the resident put it in, left, whatever, came back and did another cervical check, she was very rough, very— she was cocky and arrogant and I hated her. I actually said no, and everyone told me I had to... Um... and I felt like that resident... wanted, wanted me to have a c-section. So like I said, about thirty-eight hours, they started prepping me for surgery, and went down. And... everyone in the OR was great except for her. She didn't speak to me, she didn't look at me, um... while they were prepping me, of course nobody on—I'll say my team— was in there, and she told them that when I arrived— sorry— ((gets emotional, needs to pause)) that I refused the epidural ((teary)). She was lying about me. And... ((said through tears)) talking smack, like I wasn't even there. Like saying that I refused the epidural and was on Pitocin, without an epidural, and that I couldn't handle the contractions. Which was so offensive, because I had to... to be there in the first place

was so, so crushing. And then swallowed my pride, took the epidural, because I knew the Pitocin would be too strong, and was already done. And then to say that I couldn't handle it, because I made a bad decision not to get an epidural, when I did... It was horrible.

Elizabeth described a series of interactions in which her requests were denied and her wishes were ignored or contradicted. This diminished the sense of agency that she had felt earlier and left her feeling unable to assert autonomy within her birth experience. She felt extremely negatively about her birth experience in the postpartum, and explained that next time she would go with an unassisted birth plan, where she hired a doula to help with the birth:

And so, a super experienced doula, would be able to see— see if something is throwing up any red flags. She wouldn't be able to provide the same care, but I don't feel like what the midwives and obstetricians did really saved my life at all. We weren't really in any danger til I got to the hospital. My blood pressure was high and that was it. Which, why wouldn't it be ((chuckles)). And... so I don't—I don't feel like it's a medical event ((chuckles)). And I ended up not listening to myself so much, and listening to what other people had to say. So next time it'll be all me.

In reflecting on her birth and what she would do in the future, Elizabeth focused on the valuation of autonomy as a key aspect of a positive birth experience and understood her lack of perceived autonomy and sense of agency as having significantly impacted how she felt about the birth of her daughter. This, in turn, prompted her desire to plan a future birth that would be outside of the structures of formal Canadian maternity care, in order to guarantee that she would be the primary agent in her birth experience and that her autonomy would be protected.

5.1.3 Cherise: “My doctor decided to induce me, so, he did.”

In contrast to Carmon and Elizabeth, Cherise placed less emphasis on the importance of agency, autonomy, and self-determination in how she narratively presented herself and her experiences. She described less preparation and effort to dictate the terms of her birth than most of the other women did, although she did try to enact particular aspects of what she wanted: having a particular doctor, an epidural-free birth, and having a private room. Overall, however, she situated herself fairly passively when describing her approach to the birth. When asked what types of things she thought about when she was trying to decide what she wanted her birth to be like, Cherise responded:

I don't know, ((laughing)) I guess like the, you know, the ideal situation, you know, that it would just happen, you know, you'd be fine, and it would be really fast, and you know, everything would be good ((laughs)).

In comparison to most of the other women interviewed Cherise therefore described a fairly passive and hands-off attitude regarding her impending labour and delivery, wherein she didn't strongly situate herself as a primary causal force in how the labour would go. The main decision that she presented as being really important to her was to have a particular doctor who would be good and manage the birth for her:

Um but then like, I was induced, cause she was a week late. And he [Doctor] was— he was gone on vacation. So I was supposed to be induced on Thursday, but there was no room in the hospital to induce me, so they put it off 'til Friday. And then I uh, um, and then he went on vacation, and I didn't have her yet, so. And, like, and I went to a further hospital, cause I wanted this doctor, specifically, um, or— or one of the doctors that works in that hospital, cause I knew that they were all really, really good. So I was like yeah whatever, just, you know, if it comes down to it I'll just take whatever doctor in this hospital, that will have me. And then when he went on vacation, the doctor that like was the on-call doctor for that weekend, was a doctor from the hospital closer to my house. Not even a doctor from that hospital.

Cherise's description of trying to secure a trusted maternity care provider was one of the only points in her narrative where there is a suggestion of agency, autonomy, or self-determination as being important to her in her birth experience (in pursuing a particular doctor who she could trust to shape a positive experience, which is a form of agency and suggests a degree of self-determination). For the most part, and as illustrated in the above quotation, she presented herself passively in relation to her care providers and the events of her daughter's birth. She described her induction, for example, as a decision which was made by others and done to her, which she reiterated further in her narrative: "*So I was like a week overdue, so my doctor decided to induce me, so, he did. Like I just had like whatever, like the— some sort of gel, I don't know really what it is, they just put in some sort of gel.*" This decision was described clearly and matter-of-factly by Cherise as being her doctor's and within his realm (not hers) of knowledge, and she situated herself as the passive recipient of his decision.

As she narrated the events of her labour and delivery, Cherise continued to describe herself as being relatively passive through her experiences and did not evidence a strong valuation of autonomy or agency in relation to birth. She made the decision to have an epidural, which she presented as her own decision (reflecting self-determination and autonomy) and as relatively uncomplicated (she described the decision in terms of the labour pain and did not evoke a moral framework). Otherwise, her description of events suggested that she saw others as the primary agentic forces in her labour and delivery:

I had a nap, and yeah the nurses kept coming in to check me, and then they're like— I think it was midnight, they're like ok you're ten centimeters. So I had to start pushing, I was just like ok! So then I did that. My epidural was awesome, so I was like ok. So then I pushed for like two hours, and she wasn't really coming down, and they gave me um, like Oxytocin to strengthen the contractions, and she still wasn't coming down. So maybe at like three in the morning they decided I should have a c-section.

As with her induction, Cherise described herself as relatively passive in the experience in relation to others, who were the primary decision-makers and directors of events. When asked directly about the decisions that she made, Cherise explained that she was given the choice of either an assisted or caesarean delivery, and did specifically decide to have the caesarean:

And then um, like with the c-section, like they gave me the option of continuing pushing, or going— or having like the vacuum, but I had to go up to the OR, and then have that anyway. And then if that didn't work, then I had to have the c-section. And I don't like that vacuum thing, it freaks me out. Cause they like, suck on their head. Yeah. And my mom had a— my mom had all c-sections. So I was like, you know what— this is probably gonna happen anyways, so... just give 'er... I think we talked about the c-section for like a second. I was like we might as well just do it, cause you know, this might result in that anyways, and sh— I've been pushing forever.

Even as Cherise described her decision making process she suggested that a caesarean was likely inevitable and out of her control, so she accepted the doctor's recommendation without much hope of a more positive outcome or internal locus of control regarding how the labour had progressed. Although she described her caesarean as being scary and physically uncomfortable, she did not frame her birth experience as being particularly negative. In line with not situating herself as the primary agent in her experience, Cherise did not invoke a moral framework of care

whereby she was responsible for the outcomes of her labour and delivery. Rather, she accepted both the decisions of others and the outcomes of her labour as acceptable and, if not beyond, at the margins of her control.

The narratives of Carmon, Elizabeth, and Cherise constitute three examples of how agency, autonomy, and self-determination were valued to different extents and informed how women felt about their birth experiences. These three narratives illustrated the clear links between the degree to which agency and its related constructs were valued and how women described their birth experience. Carmon, who highly valued agency and autonomy and was able to labour and deliver in a very self-determined fashion, felt extremely positively about her experiences and described a sense of accomplishment. Elizabeth similarly valued agency and autonomy, but was not able to enact a birth that reflected her childbirth-related values and beliefs. More crucially, she described experiences in the latter half of her labour wherein she clearly felt that her autonomy was being denied and she felt a diminished sense of agency. This diminishment of autonomy and agency caused her significant distress, and evoked resentment and a sense of distress which bothered her long after the birth of her baby. Conversely, Cherise evidenced very little valuation of agency and autonomy in her narrative of childbirth, with very little emphasis on decision making and the situating of most birth events as outside of her personal control. Although she did not narrate a birth experience in which she was a primary actor or one that was congruent with most of the other women's constructions of a "good birth" (e.g. her labour ended in a caesarean delivery), Cherise did not describe her childbirth experiences with strong negative emotions, regret, guilt, or frustration.

These three narratives represent the broader pattern observed within women's narratives in which women who highly valued agency tended to have a great deal at stake in their birth experiences, and therefore felt strong positive or negative emotions associated with their labour and delivery. Conversely, if women did not evidence a high valuation of agency they tended to describe their experiences more neutrally and did not invest the events of their labour and delivery with a great deal of significance. The narratives of Carmon, Elizabeth, and Cherise were strong exemplars of this pattern; for some women agency, autonomy, and self-determination were clearly valued but did not feature as prominently throughout their narratives. Many narratives instead featured particular contexts, situations, or moments when women's agency and autonomy were either supported or violated, constraining their ability to birth in a self-

determined way and illustrating their importance and impact on women's feelings about their birth experience. The following section continues the exploration of agency, autonomy, and self-determination in childbirth by detailing its constraints and facilitators as described by women in their birth narratives.

5.2 Constraints and Facilitators of Agency, Autonomy, and Self-Determination: Protocols, Pain, and Power

5.2.1 Protocols

Women described a number of features of the current maternity care system as either potential or experienced constraints to autonomy, agency, and self-determination or their ability to shape and enact the birth that they desired. Difficulty accessing a preferred maternity care provider (either personally or as an issue with maternity care in general) was described by approximately half of the women who were interviewed. For some women, like Janice, this difficulty meant the inability to access the type of maternity care they desired (specifically, midwifery):

We uh, they made a— like when you, when you apply, I guess for one, they ask you a few questions, and then the midwives get together and they select who they're going to— because they've only got four or something in the Health Region. Um, and so like not everyone can get one... So we didn't... so that was one of the choices we made, but it impacted our delivery in that we couldn't— right from the hop, we weren't going to be able to do what we wanted.

Being unable to access her preferred model of care limited Janice's ability to enact the birth that she wanted (i.e. to birth in a self-determined way); she could no longer pursue options like home birth. Kella similarly indicated that she and her partner had discussed home birth, but abandoned this option when they were not able to access midwifery services. Inability to access a desired model of care and maternity care provider also, however, affected the degree to which Janice was able to assert autonomy and feel a sense of agency during her labour and delivery. She disliked the resident who ended up being on call during her labour (the obstetrician she had seen for prenatal care was not available) and did not experience a collaborative relationship with the obstetrician who performed her caesarean section:

Anyway eventually they let (Partner) come in, but I never saw the face and I didn't even know the name of the doctor who delivered our baby until later. Cause we had the resident, (Resident) but then the doctor, (Doctor), never introduced himself, like we never met—I have no idea, yeah. I could see him on the street and wouldn't know. And I did not want that ((chuckles)), at all.

The absence of any relationship with her obstetrician precluded a situation whereby shared decision making based on trust could occur. Thus, the structure of maternity care services was described by women as a potential constraint to self-determination, autonomy, and agency. The inability to access a preferred model of care or care provider sometimes left women unable to pursue options that were in line with their desires and values, and limited the extent to which they felt able to assert autonomy or feel a sense of agency in their birth. Women who had not previously met the maternity care provider who ended up delivering their baby were left particularly vulnerable in this regard, as they had not had time to develop a collaborative patient/provider relationship prior to labour.

During labour itself, women described situations in which maternity care protocols and environment hampered their sense of agency, autonomy, and ability to labour and deliver in a way that was self-determined. For many of the women who delivered in hospital, electronic fetal monitoring was described as a negative aspect of their experience which limited their ability to move around during labour and greatly increased their stress level and anxiety (almost every woman who had an EFM reported problems with it not working properly or giving false alarms). Elizabeth explained:

Oh yeah, my external fetal monitor too, the one that they strap around your middle? It kept like, falling—falling losing her heart rate. And so there were all these red flags about that too, and there were no nurses because I had two midwives, and they ended up calling a nurse in because it kept falling off. And so they told me I had to stay in one spot. And so that was just terrible. And I said, get me a new machine, and the nurse laughed at me. And I was like no, this machine is broken, it's making it look like I have a dead baby ((laughs)), go get me a fucking machine! And then, that was probably four hours later, they did bring a new machine because it was, like, the alarm was going off that there was no heart rate.

Elizabeth continued on to describe the contrast between her labour at home, where she was able to move autonomously and direct her body to do what felt good, and her labour in hospital, where her ability to move around was constrained by the fetal monitor:

And when you have this magical walking epidural, that's so ahead of the times, and— ok, I can't use it, we have to be perfectly still so we can hear the baby's heart rate. And I've just done 29 hours of moving, and rocking, and dancing through my contractions, and then to be told to sit still, lay there and take it.

The electronic fetal monitor was a protocol that, depending on the course of women's labour, was explained to them as advantageous or even necessary by the health care professionals with whom they were working. As evident in Elizabeth's narrative, the fetal monitor could be experienced as a very constraining protocol which decreased women's sense of being able to act autonomously and labour the way that they wanted. Rather, it involved directives to lie still which women often felt strongly against but complied with. The stress engendered when it did not function properly could also diminish women's sense of agency, as it left them unsure whether there was risk to their baby and therefore more likely to feel like events were out of their control. This lack of confidence and loss of control also at times left women more likely to capitulate to interventions. Kiana, for example, stated:

So I was just having these horrible contractions, and so I was just like... ((sighs)) whatever. Do whatever you need to do, like just get the baby out, cause also they were—they were always having trouble finding— keeping the monitor, heart monitor on the baby. So that was like really worrisome, cause they couldn't tell if it was like the machine, or if it was actually the baby's heart beat that was going out.

Constrained autonomy, agency, and self-determination were also described in relation to delivery position. Several women stated their desire to deliver in positions other than the lithotomy position, be that on hands and knees, sitting up, or squatting. That did not appear to be an option that was easily supported within a hospital environment, as Jackie recalled:

I had asked her [Physician] about positions for pushing, and she said the— the bed makes into a chair. Like the bottom goes up and the bed makes into a chair. And I thought, like, a chair, sitting up, perfect! I didn't ask any more questions. But it's not a chair sitting up, it's a chair laying down basically. And I was extremely disappointed at the time when it came time to push. I really felt a little bit, um... uh I guess— I mean it

sounds really strong to say this, I felt a little bit like a victim, like this was happening to me, like or— and I know that, yeah, I just— I wasn't prepared for that because I had misunderstood, is all... Because I literally felt like I was pushing my baby up. That's just how it felt. Sure, that's not what I was doing, but when I was laid down kind of— that's how it felt. Um, and I wish I had either spoken up for myself, or— I just was kind of so taken aback that I didn't even know how to respond.

Although Jackie overall had a very positive, collaborative relationship with her doctor, during the labour itself she felt helpless and unable to assert her agency (in order to control her position of delivery) within an environment that did not support her desires. Other women stated that they wished there were more delivery options (e.g. birthing stool or squatting bar); Mackenzie described how they had been told in prenatal class that she would have the option to deliver in different positions but that during her actual labour it was “No, no— it was just you get on your back to deliver the baby.” Although not an official protocol, there appeared to be little support (either in the physical hospital environment or among care providers) for women's autonomy in choice of delivery position. Kella described her efforts to birth in a non-lithotomy position:

But I really wanted to get on my hands and knees. It just—for some rea—I like to move around, I never get still, I—I just wanted to move my hips so bad. It just felt wrong to be in that position on my back. And, it just felt wrong at that point. But they wouldn't—they all looked up, I said can I get on my hands and knees and they all looked up and they said no, because it's easier for us. And I couldn't believe that! I thought, it's easier for you? I'm kind of in a tough position here. So that one we didn't win. They just wouldn't allow it. And maybe if I had enough um ((pause)) guts though I would have just hopped up and did it. They weren't holding me down, right? And...the other thing, other than that, I did nego—the only thing I was able to negotiate they moved the bed all the way up pretty much into a, almost a ninety-degree angle for me cause that was all I was able to get out of them. I couldn't believe that. They just looked up and said no, it's easier for me. Easier for us.

Delivery position was therefore another common context in which women felt that their agency, autonomy, and self-determination were constrained. As evidenced in Kella's quotation above, women could try to reassert autonomy by arguing or trying to negotiate with maternity care

providers, but their narrated experiences suggest that they were often unsuccessful. Their sense of control over delivery and agency was therefore diminished.

Although less commonly invoked, women described a number of other constraints to autonomy, agency, and self-determination during labour that were related to protocol and environment. These included the inability to access pain medication when it was desired (either because there was no anesthesiologist available or because delivery was full), perceptions that they would lose options (epidural or caesarean) if they waited to make a decision or discussed it at length, and the need to abide by whatever protocols were demanded by the type of maternity care being accessed. This latter point was stressed by Carmon, Elizabeth, and Annabel in relation to midwifery care and the choice of an unattended birth: these three participants felt that midwifery care itself is constrained (in terms of the protocols that they are required to follow and their accountability as part of provincial maternity care) and subsequently constrains the degree to which women are able to enact their desired birth. Carmon, for example, stated:

I think it's important that we give women the ability to choose, and I do not feel that we have that in our um, current health care system. They're limiting women's ability to choose where and how they birth their babies on a daily basis, and really tightening the reins around the midwives so they can't even provide the quality of care that they did before it was legislated.

For women who believed that the protocols characterizing formal maternity care were too restrictive and constrained their autonomy and self-determination, unassisted birth or birth with a birth attendant was seen as preferable. In relation to what she perceived as a highly disappointing birth outcome, Elizabeth explained:

And I ended up not listening to myself so much, and listening to what other people had to say. So next time it'll be all me... I think this time I knew what I wanted and I had lots of information, but... I just, I did what other people thought was good. Like taking the midwife, and listening to all of their protocol. Because their protocol isn't to try and get women to have c-sections, it's to protect women. But it wasn't, it didn't protect me.

Although many of the constraints to autonomy, agency, and self-determination that women described were related to a hospital environment and medicalized model of maternity care, some women therefore also perceived constraints within a midwifery model of care.

Besides stepping outside of formal Canadian maternity care, women described other things that appeared to facilitate their sense of agency, autonomy and ability to labour and deliver in a self-determined fashion. Certainly the choice of midwives as primary care providers enhanced the degree to which women felt they were making informed decisions about their labour and delivery (see Chapter 3), which related to their ability to birth in a self-determined way as well as their sense of agency and autonomy. Knowledge and preparation were also described as important to the ability to birth in a self-determined way even within an environment and protocols which women felt constrained the options that were available to them. Felicia stated:

But like, but yeah, if I hadn't decided anything beforehand, like they don't come up to you and say here's your options, we have morphine or Fentanyl or this, like they don't say that, they're just like— you have to ask. And then the only question they asked me, was do you want an epidural. And then— and I said no, I want the gas. And they're like what, you have gas? And I was like no, I want the laughing gas. Whatever it's called. So— in that way, you don't really... like you need to know what you want before you go, cause they don't ask you what you want, or anything. It just happens.

Felicia described a protocol (offering epidural as pain relief) that constrained the ability to choose from a variety of options, and clearly positioned her own preparation and research as being the factor that facilitated her ability to choose a method of pain relief during labour. Knowledge and preparation allowed her to assert her autonomy and act in a self-determined fashion that reflected her desires and beliefs, rather than passively accepting what was provided or given without endorsing it.

Mackenzie similarly suggested the importance of knowledge to being able to effectively question protocols and assert agency in an environment in which she felt it was diminished:

Like I feel that— as if it was... ((sighs)) taken out of our hands. And you know why— like they must deliver thousands and thousands and thousands of babies, but ((sighs)) calling it a cookie cutter birth may be overstating it, but it sort of felt a bit like we were put on the conveyer belt of how the doctor wanted to it to play out. And um, we were in a pretty vulnerable position, especially with the first one right, I mean we had no idea what we're doing, or what was— what to expect, or you know, we can read and read and read about it, but... ((laughs)) in the end when you're there, it's not going to uh, do that much. So I

did kind of feel like it was maybe a bit medicalized when it didn't need to have been, but I don't think I had enough information to sort of insist that having my water broken and not going into labour was ok for longer than 24 hours, that sort of 24-hour window that they gave us. Um, so since then I guess I've thought a bit about you know, if we'd had a midwife I wonder if that would have been another p— another voice to say actually it's ok to do that, or it's not ok to do that, or, um... you know, I feel like the doctor was sort of the overriding uh, force in the whole delivery process, rather than anything else.

In the situation described above, Mackinzie described a protocol (labour induction after 24 hours after water has broken) that she was uncomfortable with and did not believe was necessary, but felt unable to effectively argue against. Perceiving oneself as knowledgeable was an important component of being able to assert autonomy and challenge protocols which women perceived as unnecessary and/or went against their birth-related values and desires, ultimately facilitating a sense of agency in the birthing process. Carmon described the importance of knowledge to being able to ensure her autonomy and wishes would be respected if she had to call her midwife for backup during her unassisted birth:

Our midwife again was super cool the whole time. And I had worked with her many times and we had a good rapport, but she also knew that I could come with a ton of research and say look, you know as well as I do that x y and z is actually safer and whatever else.

Knowledge was therefore a form of power, which provided women with the confidence and sense of authority to question protocols and aspects of the environment that they did not agree with. Conversely, not feeling knowledgeable could diminish women's sense of autonomy and agency, shift the balance of power entirely to the health care provider, and decrease their ability to negotiate aspects of their labour environment and experiences.

Finally, having a knowledgeable advocate was described by some women as a facilitator of agency, autonomy, and self-determination in relation to potentially constraining protocols and aspects of their environment. In the situation described by Mackinzie above, for example, the nurses who were caring for her during labour stepped in to advocate for deviating from protocols regarding labour induction. Kella, who wanted but was unable to deliver her baby in a non-lithotomy position, described her doula's efforts to support her ability to birth how she wanted to:

Well... at first I didn't argue with them, and then when (Doula), my doula got there, then she was able to kind of um, advo— advocate for me. But um... we weren't in there very long, so we had the discussion after, she said you know if we were there for a longer time it would be easier to try and negotiate some things. But because we were in there for such a short time, by the time you actually settle the argument, it's not helping you. So we were just— she was just trying to manage um, just trying to make sure that they weren't doing anything I didn't want.

Although Kella perceived her doula as an advocate who could protect her from protocols that she did not want, she was unable to assert her autonomy regarding delivery position and was forced to deliver her baby how the doctor wanted her to. Women were not always able to assert their autonomy, feel a sense of agency, and birth in way that reflected self-determination in the face of restrictive protocols and aspects of their environment.

5.2.2 Pain

As women narrated the experiences of their labour and delivery, many described the pain and intensity of their labour in some detail (especially, as noted previously, in relation to the decisions they made during labour). Women's perceptions of pain and the physical sensations they were experiencing were important to their understanding of the labour process and where they were situated along this process. Women frequently described judging their contractions and pain in order to determine whether or not they were in "real" labour, assess how far along in labour they might be, and make decisions such as whether or not they should go to the hospital. Andy, for example, spent a lot of time labouring at home prior to going to the hospital, trying to decide based on her physical symptoms whether or not she was actually in labour:

So I was kind of in and out of the bath all night, going like ok I'm pretty sure I'm in labour. But they said to me don't come in until you're in so much pain that you can't talk. And I just thought that was really scary, cause like ((mmm, whimpery)) I'm already in a lot of pain, how do I— like there's more pain, what is the ah, what— I don't know when... you know, cause I was already when I was calling between contractions I felt like I'm already in a lot of pain. But their response was really like don't come in, and you're not in real labour yet kind of a thing.

Many of women's descriptions involved this kind of uncertainty, when their bodily experience was incongruent with either *their* preconceived notions of what labour should be like (e.g.

sudden painful, fast contractions rather than a slow progression) or did not match the perceptions or conclusions of others. Lana similarly described her uncertainty when her perceptions of the pain she was experiencing were not consistent with the progress of her labour as communicated by her midwife:

Anyway, so she showed up, and by this point they were regular, with the 5-1-1 kind of thing, and so she wanted to check how dilated I was. So I went on the bed, and she checked, and she said she— that I was only about— well when she first checked, she said two to three centimeters. So I was like “Are you serious!” cause by then it was like, really hurting. And she was like “Well let me check while you’re contracting”. I didn’t know that it really changed when you’re having a contraction. So she checked how far I was when I was having a contraction, and she said I was about five centimeters. So apparently that’s a— I don’t know, again I didn’t know it changed so much. Anyway, so uh, she said about five, and I was still thinking like, man, this feels a lot more intense. So, uh— but then again, they just started to come really fast then, and then, like, closer and closer together, and super intense. So that by the time (Midwife) was there, I was in a lot of pain. It was ((chuckles)) really hurting kind of thing. And I was like “I think we have to go”. Um, and then eventually she started to see how fast they were coming, and said, “Oh yeah, we should go to the hospital”. So we decided to pack up, and my mom and (Partner) were scrambling to get everything in the car, and I was trying to just manage, sort of ((laughs)), but they were really painful. Yeah, and... and then at one point I was like, “I don’t think I can go in the car, and I don’t think I can make it there.” But whatever, so I— I made it in the car, and (Partner) drove, and it was like out of a movie. ((chuckles)) Like I was screaming, like “Oh my god, this hurts!” ((chuckles)) and he’s driving.

Both Lana and Andy’s quotations illustrate how women tried to assign meaning to their pain and bodily experiences (that was generally related to an expected progression of labour), and the uncertainty that could be involved in these constructions of meaning. They also illustrate the degree to which women tended to describe the pain of labour as intense and frequently overwhelming. Caitlyn explained how her embodied pain and discomfort was augmented by the sheer length of her labour:

Like not sleep- like on a regular basis, try not sleeping and not eating for two days. Without anything else, right, like by the end you're exhausted, and you're grumpy, and you're a totally different person right? Now throw in a contraction every two minutes for those 48 hours and it's like uh, I could kill somebody right now right?

These descriptions of pain, discomfort, and intensity were important to how women understood their experiences of labour and the birth-related decisions that they made.

Approximately two thirds of the women interviewed described how the pain of their labour affected their cognitive capacity to focus on their environment, think or reason clearly, and communicate effectively with the people around them, all of which affected their decision-making ability and sense of agency. Phrases such as “*My head wasn't there at all*”, “*My mind wouldn't go with me*”, “*I didn't feel I could control my body with the amount of pain I was in*”, and “*I'd been inside myself*” illustrated the degree to which women felt their state of mind shifted during labour. For some women, like Brenda, this was accompanied by a heightened awareness and focus on the capacity of their body to get them through labour and delivery:

I couldn't talk, because I was having another contraction, and then two contractions later at the end of it I was grunting I guess, and it was so like, everything was so primal about it, that like I wasn't doing it, like my body was doing it.

Brenda described this shift of mind as actually facilitating her decision-making ability, as she just prioritized and followed her body's cues during labour with the guidance of her doula.

Annabel described a similar experience, whereby she let go of the information on labour management that she had learned during her pregnancy and instead focused on what her bodily experience was telling her. The bodily experience of labour could therefore contribute to women's sense of agency, when they were able to shift their experience of agency from mental capacity to physical capacity¹.

Other women felt that the pain and diminished capacity to focus beyond their bodily experience hampered their ability to exercise self-determination and make autonomous decisions. Christina described her struggle to think clearly in order to make a decision that was in line with her birth plan:

¹ It should be noted that many women were giving birth in an environment that did not necessarily support their freedom to follow all their bodily cues (e.g. they were hooked up to a fetal monitor in a hospital room and were therefore unable to move around) or events during the course of their labour necessitated a higher degree of cognitive reflection, reasoning, and decision making.

I think prior to that, they had asked me if I wanted my water broken, and I remember looking at (Doula) and being like, you know... I don't know! Like, I don't remember! I just—I could not think at all. I—I knew I had a birth plan, and I knew in that birth plan I had mentioned something about my water being broken, but I had no idea whether I wanted it, or I didn't want it—like I was so foggy, it was weird. And I'm never like that right, I'm very decisive and ((chuckles)) so I completely departed from—um, and so I couldn't really remember, and she didn't want to offend the midwife, so she was kind of saying, you know, we talked about getting your water broken unofficially, and what it can do. And I'm going, yeah you need to tell me what—like what I decided, because I don't remember.

At several points in her narrative Christina emphasized her inability to think clearly as an impediment to being able to communicate her desires and influence the course of her labour the way she would have liked to.

For women who anticipated or experienced a diminished ability to make autonomous decisions that reflected their birth-related values, supportive allies who could communicate their wishes for them and support their autonomy were important resources. As Christina explained,

I need to make someone responsible for saying like, um this is what she wants, this is what you wanted, and so she can remind me of what I said. Because I'm just a person that completely loses my decision making skills when in labour. I don't know if any—everyone's like that, but I am.

Women relied on different support people to be their voice and/or advocate, from friends to birth professionals. As described previously in Chapter 3, several women hired a doula to facilitate informed decision making, and their ability to act autonomously and in line with their values during labour. Other women, like Valerie, enlisted their partner to play this role:

So when it came to me, what I said that I wanted, like I remember having to sit down with him and saying like we need to talk about this, in case I'm not being—I'm not able to make these decisions, like these are the things that I want.

In addition to the utilization of support people as proxy decision-makers and reminders, women described these individuals as important resources for the physical and emotional support that they needed in order to carry through decisions that they made. Specifically, for women who did not want an epidural (which was almost all of the women in the current sample), the support that

others provided during labour could be very important to their sense of agency and ability to birth in a self-determined way. Jackie described her lack of support in the face of pain as a constraint to her ability to follow through with the birth that she desired:

And by the time we went into the room, I started kind of going blind with the contractions. Like they were just so intense I couldn't even see. Um, and then a had a nurse that was saying, you know, and nobody to kind of tell me that I could do this. And you just— all your doubts and everything just kind of come forward. So, I did get— I did get the epidural at that point... Cause you're just— you're weak, you're in pain, and they ask you, and you say yes, alright, I can't do this. Because nobody tells you you can... And I would have liked to have gotten... found a support person, either a professional or someone who would tell me that I could do this. And I might not have made it without an epidural. But I would've liked to have had the opportunity to really try.

With the threat that pain posed to her desire to enact the birth that she wanted, Jackie considered a supportive advocate an important facilitator to overcome these pain-imposed constraints. For women who changed their mind mid-birth and desperately wanted an epidural, the support from others in the face of this altered plan facilitated their sense of autonomy and agency.

Several women described how having an epidural (despite the internal moral conflict many women experienced around this decision) restored their ability to think more clearly during labour. Janice, for example, explained:

Anyway, as soon as they gave that to me, it was like night and day. I could open my eyes, I could think! Like that's the biggest, thing, I couldn't— you know how I said I believe in mind over matter? I couldn't get my mind over that matter. Like my m— like, I couldn't do it! My mind wouldn't go with me. So I was, yeah, I could think. That's the biggest thing, I could think. And open my eyes and see (Partner), and see where I was, and like, you know, everything just was so much better.

It was evident that for many women, the pain relief that they experienced from the epidural was accompanied by a strong sense of regaining control. Women described a renewed sense of agency in their ability to think and engage with their environment; they no longer felt helpless in the face of pain but felt capable of directing their behaviour, communication, and labour. In sum, although pain could be a constraint to agency and autonomy, women generally tried to deal with

this constraint by either having an advocate who could enact their decisions by proxy, or through the use of pain relief.

5.2.3 Power

Power was implicated in many of the constraints and facilitators of agency, autonomy, and self-determination that were described by women in their childbirth narratives. Although there are different ways to conceptualize power, I am following Lawrence (2008) in thinking about power as a relational phenomenon, vested in social and cultural systems but enacted in the social interactions between people in particular contexts. Lawrence stated that power is “a property of relationships such that the beliefs or behaviours of an actor are affected by another actor or system” (2008, p. 174). Health care providers, in their interactions with women, could enact power in ways that functioned to constrain their autonomy, agency, and self-determination during labour and delivery. Several women described either specific situations or a general sense of powerlessness which permeated their labour and delivery experiences, wherein they felt that the health care provider was the expert and they did not have the authority to assert themselves against that power. Kiana repeatedly emphasized these power differentials between health care providers and patient, which she felt were amplified by the medicalized environment of the hospital:

And I think also that from watching some of those videos and documentaries like, and just— I just thought that it would be, and expected to have a pretty smooth, not so heavily medical sort of experience, is kind of how I envisioned it. But, yeah. But I think I really underestimated the power of when you get into... a hospital, that power differential between even the nurses and doctors and you and immediately just kind of deferring to whatever they say and doing whatever they say.

Again, power was intertwined with knowledge, as health care providers were the experts and not all women felt that they were confident and knowledgeable enough to assert their autonomy during what was a new and unfamiliar experience. French and Raven (1959) referred to this form of social power as expert power; the expert status (and therefore credibility) of an individual encourages others to accept information and conform to their wishes. Women recognized the expertise of their health care providers as to their labour and delivery, and for some women this contributed to a reluctance to assert themselves or question information or directives that diminished their sense of agency.

Non-collaborative communications between health care providers and patients, where health care professionals gave orders or performed actions without involving the wishes or consent of the women, reinforced feelings of powerlessness. Melinda described the interactions that she had with the OBGYN who performed her caesarean:

The gynecologist who came in, the OBGYN came in twice during my labour. Um, first, uh, to... and— there was no choice at all in her mind, it was just this is what you need to do, if you don't do this you're making the wrong decision. And the first time I think was about the antibiotics, and the second time was about having the c-section, that she believed it was time... well again, she was very condescending, the OBGYN. She said, either you— either you induce, or I cut this baby out. So those are your options.

In contrast with her relationship with her midwives, who she described as supporting informed maternal choice, Melinda was frustrated with the extent to which these non-collaborative communications minimised her ability to be an active participant in informed decision making during her labour. In a similar vein, Jackie explained:

And I— I'm very aware that nurses, for some reason, find it difficult to actually explain to the patients the options. Rather than just sort of presenting them as the b— that this is the best solution, this is what you should do. But they don't explain ok if we don't do this, what could happen if we do this, what could happen, you know this is your decision, not ours, you know.

When women were told what to do rather than engaged in a collaborate discussion regarding their options, their ability to make informed decisions was hampered and they often described a diminished sense of agency. This model of interaction reinforced health care professionals' power and did not support women to assert their own power in labour and birth.

Several women described how health care providers did not always explain what was happening or ask for their permission to perform procedures, which further constrained their ability to birth autonomously and in a self-determined way. Nadia, for example, described how happy she was with the nurses (which was a common theme) but not her doctors, who she did not feel involved her in a collaborative way:

I had really good care, the nurses were fantastic, the doctors not so much, but the nurses that were there the whole time were just wonderful. They were so attentive. The doctors I found were just— were pretty, you know, like how doctors are. They're rushed and

they're busy and they don't take the time to explain what's happening. So, maybe I would have asked more questions, the next time, and been a little bit more forceful... There was no questions. Even the water breaking, they just did it. And I— I suppose there was a— I should have, you know there was an opportunity I could have said don't break it. But at that point I felt like, this is good, I want this to be on its way so I was fine with that. But a lot of the stuff yeah, didn't ask for consent much on things.

When health care providers reinforced their expertise at the cost of women (by taking charge of the woman's labour without her participation), it constrained or even eliminated women's ability to act autonomously and feel as though they were asserting influence over the course of their labour and delivery. Both Nadia and Kiana described being given episiotomies without being told what was happening or providing consent or input into this decision, as Kiana explained:

And then, yeah when the baby was almost there, it was just like the push, bear down and all that stuff, then uh, the doctor snipped. Like I felt like a snip, and she cut. I obviously couldn't see, but I could tell from my husband's face and my mom and (Partner)'s face that it was like— and I felt it, like I felt like, a cut.

Kiana described her delivery experience as being extremely surreal, with multiple people in the room yet not knowing what to do or what was going on. The lack of collaborate communication with health care providers reinforced the power imbalance that she already strongly perceived and left her feeling unable to assert her autonomy. Kiana described her birth experience as traumatic and emphasized the lack of agency that she experienced:

...going through the process the way that they kind of forced it to go versus having sort of any real say or agency and making it the experience that I wanted. Yeah. I just kind of wasn't involved at all. It was just kind of happening to me is generally how that felt.

One aspect of non-collaborative communications that was frequently described by women was health care professionals' denial of women's own perceptions and body knowledge regarding what was happening in their labour. Marianne, for example, described being frustrated at being sent home from hospital during labour (as she was not yet very dilated) only to return quickly as she felt that she was ready to deliver and felt the urge to push:

So we go back to the hospital, we don't even check in, we just go straight up. And um, and I tell them, I was like I need to push. And of course they'd seen me about half an hour before. And so the nurse was like oh, the baby just probably dropped, it's no big deal. So

they're like, you know, slowly getting me into the (sighs) assessment room, and hooking up all this stuff, and— and meanwhile I'm having these really deep contractions. And the student nurse... probably saved our life. Because she's the only one who was taking us seriously. And um, she checked me again, and was ok you're fully dilated! Like, I'm going to get a second opinion, cause no one probably would have believed her if she didn't. And so they got a nurse who was above her to come and she checked me and she was like yeah, you're going to have a baby!

This experience of having their bodily knowledge denied was described by women, like Marianne, whose labour did not follow a general norm or pattern. Health care professionals relied on their expert knowledge based on extensive experience with birth, communicating this expertise to women through their interactions but at times de-validating women's own perceptual knowledge in doing so. In the face of this expertise women were left with the difficult choice of either being persistent in communicating their concerns or bodily knowledge, or denying their own intuition and perceptions and acquiescing to the expert opinion being presented. The power dynamic within these interactions often made it difficult for women to feel as though they could disagree and assert their autonomy, leaving them frustrated and with a diminished sense of agency in the labour and delivery process. Valerie described a similar experience:

I was by myself. Yeah. So, and I mean— because of my past history, like I have dealt with like a lot of things by myself in the hospital so it wasn't that big of a deal, but at that point I was just like ok I need to— like, I felt like the nurses weren't really cooperating with me very well. Cause they're like you're only seven centimeters, and I was like well, something's going on, like it's not just the baby's head, like the pressure, like something's going on! And then, so my husband finally found me cause they had moved me to the birthing room, and uh, he found me in there and it was like seven forty I think when he found me in there, and I was just about to get the epidural, cause I was asking for it at that point, thinking that it could be drawn out for another day or something, you know? And then he was there with me for my epidural, and then he went to the washroom I remember, my doctor went and gowned up, and I was like I'm pushing, ((laughs)) I have to do this kind of thing, and everyone's like trying to tell me not to. Finally my doctor was like, let's just take a look, and by the time she looked the baby's head was like

right there. And then I only actively pushed for like two minutes, and then she came out ((laughed)). It was very fast.

Although Valerie tried to assert her knowledge and intuition in this situation, she described doing so as difficult and did not feel as though her voice was not being heard or taken seriously by the health care providers working with her. Later in the interview she described her frustration at this diminishment of agency and the way that she was treated overall during her labour and delivery.

Women whose health care providers were midwives tended to describe more collaborative communications during labour and delivery, and fewer instances of health care professionals' denials of their bodily knowledge and intuition (and in turn, fewer situations where women's autonomy and agency were diminished). This was not universal; Betty described a situation characterized by her midwife's denial of her bodily knowledge and intuition based on expert knowledge:

I would want to stay in water. In the bath. For sure. And I think she may have come out quicker. Because at one point, I was in the tub, and I felt a very big urge to push. And I said I NEED TO PUSH! And the midwife told me, uh, I don't think you're— just wait, I don't think you're ready yet. And— and she said you don't want to push before you're ten centimeters, cause I'm— that can cause issues. And— and so I think that— that kind of like, threw me off guard. Because— or kind of— I think it wrecked my— my sense of um.... it— it... I— I kind of lost my bearings I guess. And so then m— maybe I didn't know what the urge to push was anymore, because I was like if that's not it, I don't know what it is! So then I was maybe k— I was lost, in terms of when to push, and... but, so I kind of wish that hadn't happened. That she hadn't said anything. You know? And if that I was yelling I need to push, that she would have been in there and said push! You know? And just kind of went with what I was saying. So that's the only thing that sticks with me that was like, you know, I think that might have slowed things down. You know, and just... should have gone with the gut ((chuckles)).

In an otherwise positive birth experience, Betty identified this particular situation as being something that she would have changed about her labour and delivery. Although her midwife was acting on expertise and experience, this denial of Betty's bodily knowledge and intuition left her feeling confused and unsure, diminishing her sense of agency and influence over labour.

In addition to other features of healthcare provider-patient interactions which constrained agency and autonomy, maternity care providers' use of risk discourse limited women's ability to disagree with a recommended option. Since women predominantly took moral responsibility for their birth outcomes, an emphasis on risk highlighted their role as responsible protector of their baby which hampered their capacity to assert their autonomy during labour and delivery. When women had a good relationship and level of trust with their care provider, however, risk discourse constrained women's ability to make particular decisions but did not erode their sense of autonomy in the process. This was evident in Karen's description of her labour:

And I mean, she laid out the facts for us, like we'd been in labour for a number of hours already, we'd been labouring first naturally at home and then naturally at the hospital, and you know, in her mind it's like a— not a game, it's a question of risk, right? So now that it had been x number of hours that the baby had been presumably in meconium, the risk was this, and here's what we need to do, and so— you know, again, it wasn't that she was coming in and pushing her views on us, and same with our doula. Like, she was just there to support us and help us talk through the options, and obviously she wasn't— she's not a huge fan of epidural and oxytocin either, but you know, given the situation at that point in time, that was the midwife's recommendation. And it wasn't really a recommendation, and we weren't really going to question it, because she's been— she's delivered a thousand babies. And um, we want ours to be born safe and healthy, and she thinks that's the best way to do it, and we trust her.

It is clear in the above quotation that risk discourse minimized Karen's ability to choose the progression of labour that was consistent with her desires (i.e., to birth in a fully self-determined way). However, Karen perceived her overall birth-related values and beliefs to be compatible with those of her midwife, and as such she did not experience a problematic sense of loss of autonomy in this interaction. Although she agreed to a different course of labour than anticipated or desired, she could still endorse the unwanted interventions even though they were requested by others.

Conversely, other women described interactions with their health care provider/s that illustrated a reduced sense of autonomy, in that they felt pressure to make decisions based on risk that were not congruent with their values and desires and that they did not endorse. Mackenzie, for example, explained:

I remember after the— after we'd been listening to the heart rate all night and they said they were going to get the doctor in to see how I was progressing, I remember saying to my husband, if she says we need a caesarean let's just have it. Which I really was not keen on the idea of at all, but at that point I sort of felt like, we'd been worn down, like, you know, the induction, and then we have to do this, and it's time that you do this, and we could... give your baby an infection and it sort of felt like you know, you're putting your baby at risk if you don't... it's what it was at, so by that point, I just kind of said if they say we have to have a caesarean, let's do it. Um... which.... I don't know, I think I was in quite a different frame of mind then, and been made to feel like we were kind of putting him at risk. Another sort of hindsight thing that I'm not particularly comfortable with or happy about, you know?

At several points in her narrative of labour and delivery, Mackinzie described how the attending doctor's use of risk discourse compromised her ability to assert her autonomy and decline unwanted interventions. The suggestion that she may be jeopardizing the baby's safety (and therefore failing in her maternal responsibility) constrained her ability to make autonomous decisions which did not fall in line with the doctor's recommendations. Unlike Karen, Mackinzie experienced this as a diminishment of agency (the ability to exert influence over her labour and delivery as a primary actor) and autonomy (the ability to act in desired ways and endorse those actions). Rather, she felt worn down and essentially gave up trying to assert her autonomy in the face of perceived risk to her baby.

Risk discourse, as observed in the current research, was an enactment of legitimate power. As described by French and Raven (1959), this is a form of power through which influence (and subsequent compliance) is achieved by referring to socially or culturally prescribed norms that appeal to an individual's internalized standards and beliefs. As such, legitimate power is strongly tied to morality. Raven (2008) described three forms of legitimate power: *legitimate power of reciprocity*, which is based on norms of reciprocity (reflecting a morality of justice); *legitimate power of equity*, which appeals to norms of equity and a "compensatory norm" that also involves righting a wrong (also reflecting a morality of justice); and *legitimate power of responsibility*, which appeals to ideas of social responsibility (reflecting a morality of care and responsibility). Risk discourse as discussed within women's birth

narratives was an enactment of legitimate power in that it encouraged women's compliance through appeals to maternal and moral responsibility.

Some women were very aware and wary of the power that risk discourse had to reduce autonomous decision making, and experienced its use by health care providers as inappropriate or coercive. This enactment of power was understood as coercive in that it strongly implied punishment and negative consequences if women failed to conform (see French & Raven, 1959). Melinda's primary maternity care provider was a midwife, but she had to consult with an obstetrician as part of her prenatal care due to a health condition which had the potential to impact the pregnancy. Melinda described the risk discourse used by her obstetrician in this consult as inappropriate and highly dismissive of her own personal agency and autonomy:

The OBGYN I found very disrespectful. Um, absolutely um.... patronizing and paternalistic, and saw no—I had no choice. Um, I had no choice in the matter. It was—she told us what we should do and our opinion didn't matter. When we asked questions and asked for evidence and gave our concerns, um, she disregarded them and told us that um, we needed to think of our baby. Used scare tactics, gave us information that actually is incorrect...

At several points in her narrative Melinda emphasized the lack of agency and autonomy that she experienced during her interactions with her obstetrician prenatally and during labour, and described her disappointment in this disempowering care— particularly since she had very positive and supportive interactions with this health care provider in a previous context. Risk discourse, then, was experienced differently by different women in the specific interactional context, but tended to function as a constraint to personal autonomy and agency. In the context of discourse emphasizing potential harm to their baby, women often felt unable to enact their desired decisions and/or retain a sense of agency throughout their labour and delivery.

Just as power relations enacted within interactions with maternity care providers could diminish women's agency, autonomy, and self-determination, they could be facilitated by interactions which supported informed maternal choice and collaborative communication and decision making. Melinda described the value of these interactions during her prenatal care with the midwives:

Almost at every visit you know, there's— they use a standard prenatal record, and, um, which at— you know at each week or each visit there's some standard things that they do

screening for. And— so I can't remember all of them. But, I just know— and some we chose and some we didn't, um, to follow through. But there was— everything was explained to us. And it was shown as optional. And she told us her understanding of the— what the standards are, what the evidence is behind it, and then allowed us to choose.

Both the value of autonomy and the sense of agency which accompanied Melinda's description of collaborative interactions which supported maternal choice are evident in her words above and through her narrative in general. Providing women the opportunity to have discussions and voice their wishes during labour was important, as Caitlyn described:

Cause they would come in and like, for every decision, like the Pitocin, and the water breaking, like, they would come in and say okay, like this is where you are, you know you're stuck here or you're whatever, this is what's happening, you know, here's our choices, they'll— let us know kind of thing. And they'd give us fifteen minutes and come back. So yeah, even though— like I didn't want morphine, I'm really— and I don't take prescription drugs, I don't take over the counter— like I— I won't, I'll very rarely even take Tylenol, right? So I mean for me to accept morphine, I was very like, I don't want it right? I don't drink, I don't— like I don't do anything that really, I don't know, impedes my judgment or alters me in any way, right? Like I just— I'm very— I just don't. And so it was like, even the morphine I was very like, ohh I really don't want to do this, right? But like, we talked about it a lot, like probably a good hour before we decided to do it, but like I could go home, I could maybe get some sleep, like things weren't moving fast, it wasn't like I was just going to go bam and she was going to come out right, like I needed to do something, right? So like every decision we definitely discussed at length. She [Doula] was really, really helpful with those things, yeah... We did what we had to do. Every decision we definitely discussed at length, which was good.

Caitlyn described her very lengthy labour as an ordeal in general, but she was happy with the interactions that she had with her health care providers. Many of these positive comments centered upon her perceived autonomy to make decisions that she endorsed and felt were best for her, through the provision of information and collaborate discussions. When information and recommendations were laid out in a matter-of-fact way (without heavy-handed use of risk discourse), and when women felt that their values and choices were respected, autonomy and

agency were fostered. Similarly, health care providers who listened and took into account women's intuition and bodily knowledge supported their autonomy and agency.

As with protocols and pain, having an advocate during labour and delivery was important to facilitate agency, autonomy, and self-determination in relation to issues of power. An advocate (whether this was a friend, partner, or secondary care provider such as doula or nurse) could enhance women's ability to talk through different options and feel that they were asserting agency in their labour and delivery. Having an advocate could also enhance women's ability to manage the power differentials that they perceived between themselves and their primary health care provider, as they could draw upon the advocate's authority and expertise as well as their own to enact autonomy, agency, and birth according to their values and desires. Mackenzie, for example, explained in relation to her physician's directive to break her water:

Um, and the nurses on the ward sort of confirmed that, because we told them and said we're not too sure what to do, and they were really nice actually, because they said you know, we can advocate for you if you don't want to get this... Yeah, it was very— that was really helpful. Because you know, when you're presented with a doctor saying here's what you should do, then... they're a doctor, right? And it's hard to say well I kind of... I don't know, I know my body, or I sort of know how I want this to go and that's not quite what I want right now. Because the doctor's saying... so the nurses said, uh, that they would help us out if we didn't want to do that, and they would talk to the doctor, and they said you know, we have people who go into labour really prematurely, or their water breaks really prematurely, and we don't induce them, because it's too early to have the baby. So you can have your water break and not get an infection, you don't ((chuckling)) have to get the baby out instantly! So that was really reassuring. All of the nurses in the hospital were just like, amazing, the whole time.

Advocates could provide validation for women's own intuition and knowledge. If they had expert knowledge regarding knowledge and birth, as in the example above, they could also increase women's power within the health care context by utilizing their expert status to advocate directly on women's behalf for specific courses of action during labour and delivery. As described previously, women also described their own knowledge as a form of power that helped them to communicate and negotiate with health care providers and make informed

decisions, which enhanced their sense of autonomy, agency, and ability to birth in a self-determination fashion.

5.3 Discussion

Using three illustrative narratives, the first section of this chapter detailed some of the ways in which women valued (or not) agency, autonomy, and self-determination and how this informed their feelings about their birth experience. As a general pattern, most women evidenced a strong valuation of agency, autonomy, and self-determination during labour and delivery, and the degree to which these constructs were experienced and enacted during labour and delivery influenced how they understood and framed their birth experience as positive or negative. This is congruent with previous research identifying self-determination, agency, choice and decision making, and personal authority and control as key domains of what constitutes a good birth (Fair & Morrison, 2012; Goodman, Mackey, & Tavakoli, 2004; Hart & Foster, 1997; Namey & Lyerly, 2010). Moreover, it highlights the salience of an ethics of autonomy (Shweder et al., 1997), with its focus on freedom, rights, justice, individual will, and choice, to how women make sense of and communicate their birth experiences. The degree to which women valued and framed their experiences in relation to a discourse of autonomy did differ between individuals. Previous research has illustrated that particular aspects of agency and autonomy during labour and delivery, such as active participation in decision making and control, are more salient and important to some women than others (e.g. Fox & Worts, 1999; Kjaegaard, Foldgast, & Dykes, 2007; Kornelsen, 2005). Generally, however, childbearing women are more confident, comfortable, and appreciative when they are able to assert autonomy through collaborative decision making (VandeVusse, 1999). Collaborative decision-making, where the patient and clinician (and perhaps others) go through the decision-making process together, has garnered increasing interest as a middle ground between paternalism and informed medical models of decision making that has the potential to positively impact patient satisfaction, particularly in longer or ongoing patient-provider interactions (Joosten, DeFuentes-Merillas, de Weert, Sensky, van der Staak, & de Jong, 2008). Although shared decision making is similar to informed decision making in that both models stress the importance of information provision, shared decision making emphasizes that patients should be encouraged to be as active as they would like in decision making without necessarily taking on sole responsibility (Joosten et al., 2008; Stiggelbout et al., 2012). While women in the current research varied in the extent to which they

valued and enacted control over decision making, the absence of opportunity to participate in active decision making was perceived as highly problematic.

Agency, autonomy, and self-determination were particularly salient in women's narratives when they perceived them as being constrained, by protocols, pain, and the power relations enacted through interactions with health care providers. Clearly, there is a limit to individual women's ability to assert control over or make decisions about all aspects of their maternity care. Under the current system of maternity care, women may or may not be able to access a preferred care provider or model of care (especially midwifery), which impacts their ability to give birth in a self-determined way. Moreover, midwifery care itself (in relation to obstetrical or physician based care) both promotes and is associated with increased maternal agency, control, and active involvement in decision-making (Bylund, 2005; Charles, 2013; De Koninck, Blais, Joubert, Gagnon, & L'équipe d'évaluation des projets-pilotes sages-femmes, 2010; Fair & Morrison 2012; Thachuk, 2007). From an American perspective, Miller and Shriver pointed out that economic and geographic factors (the latter applicable in Canada as well) may determine the care provider options available to women.

The findings from the above analysis highlight the key role of maternity care providers in constraining as well as facilitating agency, autonomy, and self-determination. In order for women to feel a sense of autonomy, they had to feel as though they were willingly able to make meaningful decisions that they endorsed (and ideally were congruent with their interests, values, and desires). When maternity care providers supported women's ability to make meaningful decisions through collaborative discussions and support for maternal choice, autonomy was fostered. On the other hand, features of patient/maternity care provider interactions such as lack of collaborative communication, the de-validation of women's intuition or bodily knowledge, and heavy-handed risk-focused discourse constrained women's ability to make meaningful choices and endorse the way that their labour unfolded. When this occurred, rather than autonomy women were left with a problematic sense of heteronomy, where they perceived their actions as being controlled by others rather than themselves (Chirkov et al., 2003). In turn, this diminished their ability to labour and deliver in a way that was self-determined (i.e. guided by their own desires and values) and decreased their sense of agency throughout the process. Even women who appeared to invest less significance in autonomy and agency spoke negatively about situations where they perceived maternity care providers as unnecessarily controlling aspects of

their birth experience and constraining their autonomy. The quality of women's interactions with maternity care providers significantly impacts how they experience and understand their childbirth experiences (Baker, et al., 2005). As Baker and colleagues (2005) illustrated, poor communication and denial of women's knowledge, concerns, and ability to choose contributes to a sense of lack of control characterized by feelings of disappointment, anger, and a sense of being bullied.

One of the ways by which women's autonomy, agency, and self-determination could be constrained by health care professionals was through the use of risk discourse. Risk discourse in health care contexts can take many forms, from implicit talk to very explicit discussions of risk, and particular individuals and groups of health care providers may be more or less likely to routinely invoke risk as a concept (Linell, Adelsward, Sachs, Bredmar, & Lindstedt, 2002). In the current research, the invocation of risk could function to constrain women's sense of autonomy and agency in that they felt they had less meaningful choice and control over interventions and the course of their labour. Moreover, some women perceived explicit and moralized risk discourse as coercive and a deliberate threat to their autonomy. As Linell et al. (2002) noted, health care providers may see risk talk as important not only for patients to make informed choices but also to motivate them to engage in particular behaviours. The utilization of risk discourse may be influenced not only by the health care provider's personal and clinical framework of understanding but also the clinical pattern of practice within their associated institution. Institutional power is often enacted in the form of agenda control, in which a situation is presented to an individual in ways that deny him or her alternatives which the person/s in charge and presenting the situation do not want them to adopt (Moe, 2005). By invoking risk discourse, health care providers could limit or engineer the options that women felt were available to them according to personal, clinical, and institutional conceptions of risk.

Interestingly, recent research suggested that at least some maternity care providers consciously utilize risk discourse in order to maximize their professional integrity, control, and power in interactions with patients, whether or not there is actually a significant risk (Hall, Tomkinson, & Klein, 2012). As one maternity care provider within their research stated, *"I've heard that. 'Well, you don't want your baby to die, do you?' We call it pulling the dead-baby card. We really want you to do this thing..."* (Hall et al., 2012, p. 583). This strongly moralized discourse does not support collaborate decision making or informed choice, as it highlights

women's moral responsibility and constrains their ability to disagree with the recommended option. Some practices are invested with so much moral significance that it discourages people from considering them a choice at all (Shwartz, 2000); risk discourse could be employed in such a way in the context of labour and delivery. As Edwards and Murphy-Lawless (2006) stated, rejecting or arguing with the scientific judgment of risk can be seen as immoral. The use of such discourse as described by women in the current research was an enactment of legitimate and at times coercive power (French & Raven, 1959), which may have induced compliance but diminished women's sense of agency in the process.

At the same time, however, health care providers themselves have a responsibility for the health of the woman and baby, and have their own professional, personal, and moral considerations of risk and beliefs as to how they can best minimize it (Hall et al., 2012). These considerations may be at least partially informed by fear of legal responsibility and blame for negative outcomes, which may be reflected in maternity care protocols and health care providers' behaviours including the communication of risk (Hall et al., 2012). Both clinical indications and protocols may constrain how health care providers understand and communicate risk, and the use of this discourse may be appropriate and necessary. Moreover, risk discourse as evidenced in the current research did not necessarily diminish women's sense of autonomy and agency. When it was utilized within a relationship where power was shared between provider and patient and women felt as though they were making an informed decision (based on knowledge, discussion, and trust in their care provider), it did not leave women with a sense of heteronomy. This is consistent with Baker and colleagues' (2005) assertion that it is not necessarily interventions themselves that are experienced by women as problematic; it is factors such as inadequate information provision, poor or coercive communication, and not feeling able to participate meaningfully in decision-making.

In navigating potential constraints to agency, the importance of supportive others was repeatedly highlighted by women. Bandura (2006) distinguishes between personal agency (the ability of individuals to exercise influence on their own functioning and environment) and agency through proxy, which is important when people do not have direct control over conditions. Agency through proxy is a form of socially mediated agency, whereby individuals enact agency through others who are able to act on their behalf to help them achieve desired outcomes (Bandura, 2006). Agency by proxy was clearly evident in women's descriptions of

friends, partners, doulas, and health care providers who were their “voice” when they did not feel they had one, either because of pain or because they perceived themselves to have little power due to lack of knowledge or medical expertise and what was described as the authoritative power of hospitals and doctors. Secondary care providers who were seen as knowledgeable or experts in childbirth were described as particularly effective in helping women enact agency by proxy, as they were able to help communicate knowledge to women as well as exhibit a higher level authority in communications with primary care providers. The presence of continuous doula support during labour has been previously identified as beneficial, both for psychological health and labour satisfaction and for physical health (shorter labours and lower rates of interventions such as analgesia, oxytocin, assisted delivery, or caesarean) (Hodnett, Gates, Hofney, Sakala, & Weston, 2011; McGrath & Kennell, 2008; Scott, Berkowitz, & Klaus, 1999). The present analysis illustrates the benefit that doulas and other supportive people can offer in facilitating women’s sense of agency and autonomy, and helping them to birth in a self-determined way. Important to this benefit is women’s perception that doulas are there to “follow the woman’s wishes” (Lundgren, 2010, p. 176); that is, a large part of their role is specifically to provide woman-centered support that respects her needs and supports her choices. Across contexts, then, others (and especially those who had expertise in childbirth) were important facilitators of agency.

The support of women’s agency and autonomy in childbirth is important even if the labour process and outcomes do not ultimately align with women’s desires and plans. Indeed, Deci and Ryan (2000) argued that it is not just the degree to which people are able to achieve their valued or desired outcomes that is important for both short and long term well-being, but the degree to which people are able to satisfy their basic psychological need for autonomy as they try to enact these outcomes. The current findings support this assertion in that the degree to which women felt a sense of autonomy, versus heteronomy, was generally very important to how they felt about their birth experience and the maternity care providers who attended them. The basic needs sub-theory of self-determination theory (SDT) suggests that in addition to autonomy, two other needs underlie well-being and self-determination: competence and relatedness (Ryan & Deci, 2002, Deci & Ryan, 2000). Competence refers to an individual’s sense of efficacy and capability in their interactions with the social environment, whereas relatedness refers to an individual’s feelings of connectedness with others and a sense of caring and being cared for

(Ryan & Deci, 2002). Beyond autonomy, the analysis delineated above illustrates how competency and relatedness supported women's ability to birth in a self-determined fashion. When women felt knowledgeable about their birth options and had the opportunity to engage in informed decision making, this enhanced their sense of autonomy and ability to birth in a way that was self-determined. Supportive others who could be proxy decision makers and/or offer physical and emotional support helped to fulfill women's need for relatedness and contributed to their capacity for autonomy and self-determined behaviour. Maternity care providers were crucial to the construction of a social context which supported women's sense of competence (e.g. by encouraging informed and/or shared decision making), relatedness (e.g. by building a relationship of trust with women), and autonomy (e.g. by avoiding coercive discourse and supporting choice). The provision of such a social context satisfies these basic psychological needs and facilitates women's autonomous motivation and self-determined behaviour, whereas a constraining social context promotes controlled motivation or a lack of agency (Deci & Ryan, 2002)². The current data therefore illustrates the degree to which autonomy, relatedness, and competence were entwined in women's birth narratives, and their importance to women's well-being and their feelings about their birth experience.

5.4 Conclusions

The findings described in this chapter highlight the ways that individual women valued and experienced agency, autonomy, and self-determination during childbirth, and how this affected their feelings about their childbirth experiences. Overall, the findings suggest that agency, autonomy, and self-determination are important aspects of a positive childbirth experience for most women. When agency and autonomy are facilitated, women are more likely to be able to birth in a self-determined fashion and feel positive about their capabilities, participation in decisions, and relationships with their maternity care providers. Conversely, direct constraints to agency and autonomy may threaten relationships with care providers and can engender a sense of passivity, frustration, and powerlessness. As a basic psychological need along with competence and relatedness, the degree to which autonomy is supported impacts

² The impact of this type of context was evident in Kiana's narrative, wherein none of these three needs were adequately met and she experienced a strong lack of agency and birth experience which she described as traumatic.

women's achievement of self-determined behaviour and has a significant influence on their wellbeing and feelings about their childbirth experience.

Some of the constraints to agency, autonomy, and self-determination described above may be relatively unavoidable given broader structural factors (e.g. limited accessibility to midwifery care or inability to have a preferred care provider during labour and delivery) as well as individual factors (e.g. medical factors during pregnancy or labour which reduce women's ability to feel they can exert influence in the birth process or birth in a way that is consistent with their values and desires). Other constraints are very amenable to change, however, particularly as many of them are related to the communication between women and maternity care providers. While events of labour do not always proceed as one might wish and women may not always be able to achieve their desired birth, it appears that women are able to feel a sense of influence over their self and context and have the ability to act in ways that they endorse, even when these actions do not reflect their birth-related desires. This is highly dependent upon women's interactions with their maternity care providers, and the ways in which options and risk are communicated. It is a sense of heteronomy (feeling as though one's actions are being controlled by others) and the perceived restriction of action that may be most problematic for childbearing women and detrimental for their well-being. These findings illustrate the salience of an ethics of autonomy to how women make sense of childbirth, and highlight the importance of others to these experiences. The following chapter continues this thread to explore how women negotiate others' perceptions of their birth-related choices and experiences; specifically, birth-related stigma.

CHAPTER 6

*“YOU JUST HAVE TO GO TO THE HOSPITAL, AND IT’S SO DANGEROUS, AND YOU’RE
RISKING THE BABY’S LIFE”:*

NEGOTIATING BIRTH-RELATED STIGMA AND MORAL IDENTITY

The previous three chapters delineate the different ways in which first-time mothers understand their birth-related options and experiences, with a particular focus on how these are situated and negotiated by women in relation to dominant moral and ideological frameworks. In doing so, I have argued that women may have a great deal at stake in childbirth and that these negotiations center upon the preservation and presentation of a positive moral and maternal identity. Importantly, morality is constructed not just in individuals’ self-narratives but communicated and situated in the context of social interactions (Bergman, 1998; Luckmann, 2002; Finch & Mason, 1993; Shweder & Haidt, 1993; Tappan, 2006). Women described many circumstances and events in their childbirth narratives that demonstrated how particular options or decisions and ultimately a positive moral identity were threatened or delegitimized by others. Through direct and indirect moralizing (Luckmann, 2002), other people participated in the negotiation of moral meanings surrounding childbirth and were important to how women negotiated a moral identity. The current chapter explores birth-related stigma and how many of the women who chose more alternative birth options engaged in stigma management techniques to maintain a positive moral and maternal identity in the face of actual or perceived negative, moralizing judgments from others.

6.1 The Negotiation of Birth-Related Stigma and Moral Identity

In his influential work on stigma and the management of identity, Goffman (1963) described stigma as “an attribute that is deeply discrediting” (p. 3), which through processes of social interactions marks an individual as being both different and seen less favorably than others. Although a lot of stigma research has focused on “tribal stigmas” (of race, nation, and religion) or stigmatized conditions which are of the body (e.g. HIV/AIDS or other chronic illnesses, various types of disability), Goffman (1963) noted that stigmas of individual character, which are rooted more in individuals’ behaviours than appearance, are also prevalent. These

stigmas suggest the failing of an individual to live up to the values, norms, and standards upheld by a community, and are therefore deeply cultural and inherently moral. Indeed, Yang et al. (2007) described processes of stigma as moral judgments and sanctions made about individuals who violate core, culturally held values. Moreover, they argued that stigma should be seen fundamentally as a moral issue, in that processes of stigmatization threaten what matters most to people (their moral experience).

Real or perceived norm violation also threatens the ability of individuals to present a positive identity, and stigmatized individuals often engage in various information management techniques in order to preserve or foster a positive and moral self (Ashforth & Kreiner, 1999; Clair, Beatty, & Maclean, 2005; Friese, Becker, & Nachtigall, 2008; Goffman, 1963; Hylton, 2006; Ingram & Hutchinson, 1999; Miller, 2012; Sykes & Matza, 1957; Woods, 1993; Zerubavel, 1982). Goffman (1963) suggested that for the “discreditable”, individuals whose stigmas are not immediately visible or known to others, social interactions involve the management of identity-threatening information about the self: “to display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when, and where” (p. 42). Individuals who perceive negative moral judgments may choose to pass (concealing, fabricating false details, or not disclosing information about their stigma), or cover (revealing some discrediting information but in ways which minimize its significance or focus and may obscure the real stigma or its most significant aspects) (Goffman, 1963; Hylton, 2006; Ingram & Hutchinson, 1999; Miller, 2012; Park, 2002; Peters & Jackson, 2009; Woods, 1993; Zerubavel, 1982). Alternatively, individuals may disclose— that is, communicate information about him or herself that is otherwise not directly observable or known (Herek, 1996). When stigmatized individuals do choose to disclose, they may engage in a significant amount of work to manage the impression that others have of them and present a positive self in the face of doubt or negative moral judgment from others. Researchers have described a number of strategies which characterize the positive identity work¹ done by individuals with a stigma, including normalizing their difference, reframing the meaning attached to a stigmatized activity or identity, minimizing the visibility of their stigma, and justifying or neutralizing behaviour that is considered deviant or stigmatized through consideration of contextual factors and the attributes

¹ Identity work can be defined as the activities individuals engage in to construct, present, and maintain personal identities (Snow & Anderson, 1987).

of those casting judgment (Ashforth & Kreiner, 1999; Clair et al., 2005; Davis & Hagen, 1996; Friese et al., 2008; Park, 2002; Sykes & Matza, 1957; Woods, 1993).

Experiences of stigma and stigma management strategies were described in the narratives of the first-time mothers interviewed for this study, specifically those who deviated from the medical model of birth. Nine of the women interviewed described how others made negative judgments about their alternative birth choices (working with doulas or midwives, and/or having a home or unassisted birth), and most of these women described explicit, perceived, or feared judgments in ways which indicated that their moral identity as a responsible or good mother was threatened. Brenda, who described herself as mistrustful of the medical model of birth and medical system more generally, saw a physician throughout her prenatal period but relied heavily on her doula for prenatal care and advice. Although she had planned to deliver in-hospital given that she was unable to have a midwife as a primary caregiver², she made a last-minute decision during her labour to remain at home and deliver her baby with the assistance of her doula. Brenda described how this decision was seen as deviant, irresponsible, and engendered judgments about her maternal fitness:

So many people that I had talked to along the way or even now if they hear about our birth story are like, that is so dangerous. Or, you know, “How irresponsible of you to do that, like I would never do that” and stuff... And uh, but yeah, people who are genuinely like “That’s neglectful almost, like you should— it’s scary that you would do that.”

Unassisted and/or home birth appeared to elicit the most explicit and negative judgments from others, including family, friends, and health care professionals who worked within the medical model. Most of the women who chose home or unassisted birth in this study felt positively and even passionately about their choice but indicated their decision was viewed negatively by at least some of the people with whom they interacted. As a stigma of “individual character” (Goffman, 1963), the choice of these birth-related options deviated from the dominant model of birth (hospital birth with a physician or obstetrician), and therefore marked the individual as deviant and engendered concern and moral judgment.

Stigmatizing judgments (both experienced and feared) were framed as particularly problematic when they came from health care providers or from people within women’s close

² Brenda had applied for a midwife as her primary care provider but remained on the waiting list and was unable to secure a spot with their program.

social network such as parents, who were invested in women's care and were in a position of power. Women were very unappreciative of unsupportive health care providers or those who disparaged midwives or home birth, even women who did not make those choices themselves. Elizabeth felt extremely stigmatized for her choice of midwife-assisted home birth when she had to endure a hospital transfer upon failure to progress:

I felt as though my home birth transfer made me almost a leper to them. They— she was not impressed. My midwives got treated like shit. Yeah, it was bad. And my doulas. They were asked to leave, and they didn't, because I said no.

Later in her narrative, Elizabeth described her perception that both her and her midwives were treated as though they were incapable and irresponsible by the OBGYN and other medical staff in hospital, which she attributed to negative views of home birth. Although certainly not all maternity health care providers who practiced within hospital were described as being anti-alternative birth practices, when women did encounter these judgments it had a negative impact on their relationship with the care provider.

Although unassisted and/or home birth appeared to be the alternative birth options which elicited the most explicit and negative judgements, several women described negative judgements and stereotypes which arose from their choice of a midwife as primary care provider or their inclusion of a doula as a secondary care provider. Although Kella planned a hospital birth she still felt defensive in the face of reactions from others about aspects of her birth which were more alternative, stating that “*Lots of people don't know what a doula is either. So then they thought I was doing something uh, way out there. Birth in the woods or something, yeah.*” Although Kella saw a physician for prenatal care followed by an obstetrician (for the latter part of pregnancy and labour and delivery) her inclusion of a doula in her labour invoked stereotypes and judgment from others, marking her as deviant. Christina experienced similar judgments over her choice of midwives as primary caregivers and a doula as a secondary caregiver:

Yeah, I was definitely cautious about, um, who to... tell that we were working with midwives, and that we were thinking about a home birth, because, um... everybody seems to have their opinions about those sorts of things, and for me it causes me a lot of stress to hear like, somebody start questioning that and they're unhappy with the decision I'm making, and I'm going well it's my own birth and my own body type of thing. And we did actually have quite a bit of confrontation with (Partner's) mom over that, um, she found

out we hired a doula and like... completely lost it ((chuckles)). Yeah, she was like highly against me consulting anyone other than a doctor, about the birth—the birthing process.

Christina's description of both feared and experienced negative reactions to her choices of birth option illustrate how even working with midwives and/or a doula may elicit negative judgments from others. Moreover, women described others as often quite vocal in communicating their disapproval.

The processes of stigma which women described in relation to alternative birth choices were rooted in their deviance; they failed to make decisions which aligned with the dominant model of birth. Stigmatization primarily resulted from the evaluation of the deviation as being potentially risky and irresponsible, which threatened women's moral status and their "good mother" identity. As dominant mothering ideology dictates, good mothers are primarily responsible for the nurturing and development of their child, should follow expert instruction on how to do so, and always prioritize the child's needs above their own (Hays, 1996; O'Reilly, 2007). By stepping outside of the medical model of birth in their choices of care provider and context, women opened themselves to criticisms of their mothering behaviour and identity. As such, the processes of stigma associated with alternative birth choices threatened women's positive moral and maternal identity and necessitated identity work in their interactions with others.

In women's narratives, engagement with various stigma management techniques was evident as they described explicit, perceived, and feared judgments from others about stigmatized birth-related decisions. Although women's pregnancy was highly visible, their actual choice of alternative birth was not and therefore their stigma was invisible and they had maximum control in most contexts over how they managed discreditable information. As such, they had the option to pass (Goffman, 1963), by not disclosing stigmatized details of their intended or actual birth experience. Five women did describe passing in particular contexts or with specific people, in order to avoid negative and moralizing judgments. Karen explained how she and her husband negotiated the non-disclosure of her planned home birth with others in the face of experienced stigmatization:

I definitely wasn't a home birth type person and we had to keep that, you know, keep that decision from different people because uh, it worries people... I shouldn't say we kept it from people, the only people we were purposefully trying to keep it from were my

husband's parents, because we didn't want them to panic and say that we were risking the baby's life and um, to forbid us from having a home birth or anything like that. So they were the only people that we didn't actually tell. Other people that we would chat with, uh, we would say you know, we're thinking about having the baby at home, and a look of terror would cross their face, and they would say "Oh my God you cannot do that, oh my God, you can't do that, you have to go to the hospital." And we would say "Well, why", and they'd be like "Well you just have to go to the hospital, and it's so dangerous, and you're risking the baby's life", and I'd be like "So what do you know about it, like have you done any research on home birth?" "Well no, but my friend's a nurse. And she says you've just gotta go to the hospital." And I'm like well ok, alright. So we just sort of selectively learned to stop talking with people about it.

Karen and her partner proactively agreed that her husband's parents would react so negatively to her planned home birth that they didn't disclose their actual plans, and therefore passed as "normal" expectant parents who would birth in hospital. As with the other women who described passing, they chose to do so selectively according to both audience and social cues. When individuals were perceived as particularly disapproving and judgemental regarding alternative birth choices, women would use discretion (i.e., not bring it up) or lie in order to conceal the details of their birth experience. Alternatively, women described disclosing to others who they perceived as more supportive or less judgemental. As noted in Karen's excerpt above, and as she elaborated upon later in her narrative, passing could entail a learning curve whereby the frequency of this strategy increased after disclosure was met with negative judgments. Indeed, Karen indicated that towards the end of her pregnancy she stopped disclosing her birth plans altogether.

As a middle ground between passing and disclosure, covering (Goffman, 1963) allowed women to reveal some potentially discrediting information but in ways which minimized its significance or most stigmatizing aspects. Christina described framing her birth plans as being very tentative, or an option that they had not ruled out, in order to forestall moralizing judgments from others:

But most other people, like I was really cautious about being like, yeah, we're thinking about maybe doing a home birth, I don't know. And you know, I wasn't very—I was pretty nonchalant about it, because I didn't want any, any confrontation.

Through presenting her plan to birth at home with a midwife as an option rather than a decision that she had made, Christina was able to minimize association with a stigmatized identity (a home birther). Framing plans as tentative allowed women to be more honest about their impending birth while minimizing its significance and impact on a moral identity. As with other women, Christina used different strategies of information control depending on the audience and context. She spoke more freely with people who supported her choices, but used covering or passing when social cues were negative or unclear.

Annabel also covered by framing her birth plans as tentative in order to manage discrediting information. Additionally, because her birth experience (a home birth with a birth attendant rather than a maternity care provider licensed to deliver babies) was considered particularly deviant³, she ended up concealing the most stigmatizing detail of her birth from most people:

So mostly only the people who knew our situation were close friends and family, and afterwards the majority of the time (Partner) and I would just tell people that it was just us two, to protect our birth attendant's anonymity and to also, so that way, it's not coming down on her for anything if people are like what, it was just you and your husband, it was kind of like, the grief is only coming on to us. So— but in a way too, weirdly enough, people almost take that more positively by being like wow, like you guys are brave, what a good couple, you guys must be really close! And so it's almost a little more given in a good light than even saying well we had a birth attendant. They're like, a birth attendant, ((disapproving voice)) what's that? So just learning kind of the ways to be discreet enough but only give enough information that you kind of solidify that it was a very safe positive environment.

Since Annabel perceived fewer negative judgments about giving birth at home per se than she did about saying that she had an unregistered birth attendant, she only revealed what she felt were less stigmatized aspects of her son's birth. Covering allowed her to edit out information to minimize moralizing judgments from others, without having to fabricate her birth experience

³ Although skilled birth attendants/lay midwives delivered many babies prior to the legalization and regulation of midwifery in 2008, all individuals working as midwives in Saskatchewan must now be registered with the Saskatchewan College of Midwives (The Midwifery Act). Annabel's concerns therefore included the protection of her birth attendant.

entirely. As such, she accepted the stigma related to a home birther identity but still managed information that she felt would engender further moralizing judgment.

All of the women who described the management of discrediting information about their birth plans or birth experiences through covering or passing also disclosed to some people, or in particular contexts. If the audience was not already receptive to or supportive of their birth choices when women did disclose, they worked to manage stigma and a positive identity by reframing their choices and experiences as positive, safe, and normal. Women sometimes took an educative role, as Brenda described:

And we tried to explain that like, it was— she's [Doula] there emotionally, and um, you know, for some physical relief, you know, whether it's hip compressions or whatever it was, she was there to help with that. She wouldn't be like, doing any of the fetal heart monitoring or anything like that, so um, yeah. That was definitely— I had to explain to a lot of people what a doula was, and what a midwife did, and that they could deliver babies without a doctor there. As long as there were no complications.

By educating people about their birth choices, women sought to change others' negative opinions and counter moralizing judgments that called their responsibility into question. As most of the stigma attached to deviant birthing behaviours related to perceptions of risk and safety, this often meant trying to reframe alternative birth options as equally safe or even more safe than adherence to a medical model of birth. In response to moralizing comments related to the safety of midwifery-attended home birth, Elizabeth stated: *"I would just spout off some statistics about home birth and how it's safe, and the infant mortality rate is the same either way, and birth outcomes are better at home anyway."* Education was therefore one way that women tried to reframe birth-related options positively, in order to change negative moralized meanings communicated during stigmatizing interactions. This education did not always need to be fact based. Indeed, Annabel managed stigma by reassuring people more broadly that she was calm, competent, and prepared for her home birth, and that it was a safe, positive experience:

Well at first we really had to get over trying to educate people. Because I'm a very like, ((chuckles)) I'm a kind of stubborn person sometimes and I'm always, I wanna like— sometimes you have to see through when people are kind of antagonistic towards you, sometimes they don't really want to hear an explanation, they just want to hear like you know what, I appreciate how concerned you are, you're like— you're a good friend, I can

assure you that I've done tons of research and we're prepared, and we— this was a very safe thing. And sometimes even that's better than trying to explain statistics and this and that, and why a hospital birth statistically is more dangerous than a home birth, and this and that. So I had to get over that, so by the time I had had the baby I had already gotten used to being very discreet and private about it. But just saying enough to be like, it was a positive wonderful experience. The person there was a very qualified— she's done tons of birth, we were medically safe, um I was not high risk in any way, so just reassuring people.

By reframing her birth choices as safe and positive in a way that highlighted her own competency to achieve the birth that she wanted, Annabel presented a positive moral identity that challenged negative perceptions while maintaining relational harmony. Moreover, she was able to reframe home birth positively by describing her own wonderful experience, providing a positive example to counter people's concerns and moralizing judgments. By making it clear that no harm was done and their experiences were positive, women were attempted to neutralize the negative value of the stigma (Ashforth & Kreiner, 1999; Sykes & Matza, 1957).

Reframing alternative birth choices as positive and safe were important aspects of the work women did to normalize their decisions. Women also reframed the meanings of birth choices by drawing on shared understandings of good mothering, emphasizing that they prioritised the safety and health of their baby just like other mothers. Annabel went on to state:

They just want to be reassured that yeah absolutely I was concerned about emergency. I care about— as a parent, I did lots of research, I'm not high risk, you know, we had— we're very close to a hospital, kind of tell them the things that they want to hear. Because then people are like oh yeah, you're good. You know?

By aligning herself with other parents and the cultural understanding that the health of the baby is paramount, Annabel presented herself as a responsible mother and normalized her birth-related decisions. Similarly, Brenda made it clear that the health and safety of her baby was her priority, and maximised through her decision to birth at home:

....so I don't even really take it personally, like that they think it's irresponsible. It's like nnnno, it's not actually. It's the best thing we could have done for our baby. Cause I mean, she was healthy, it was a totally normal good birth, I was only in labour for ten hours, and that's fast.

By explicitly invoking their maternal status and drawing upon shared understandings of mothering wherein the baby's needs are prioritized, women constructed their decisions as normal and rational despite deviating from the norm. In doing so, they worked to present a positive maternal identity that countered the threats of irresponsibility that were communicated in stigmatizing interactions.

All of the techniques of stigma management described above were utilized in social interactions with perceived or feared moral condemners, in order to either hide discrediting information or reframe its meaning to present it as positive. Also prominent in women's narratives was "condemnation of the condemners" (Sykes & Matza, 1957), reflected in women criticizing more broadly (in this case, within the context of their interviews) the character, knowledge, and authority of outsiders to judge their birth-related decisions. Elizabeth, who planned a midwife-attended home birth that ended in a hospital transfer, defended her desired birth by both focusing on the positives of her experience and criticizing the people who had suggested it was unsafe and inappropriate:

I don't know, I had fun. My labour at home was lots of fun. Like it was painful and long, whatever, but it was everything I wanted it to be. And I've had a few people say things like, don't you wish you would have just scheduled a c-section. Like people are so stupid and insensitive. And it's like well no, because I got to labour and actually I got to experience that, my cervix got to get to seven or eight centimeters, and at least it knows how to do that. And my milk came in so well, because of all the natural hormone rushes, I just didn't get the end part, right?

By criticising the character of people who had expressed negative judgments about her birth choices, Elizabeth reaffirmed her own authority and capacity to make good maternal decisions. Her ability to do so was further bolstered by attending a caesarean section support group, who she described as receptive and supportive of how she felt about her labour and delivery.

Since many of the individuals involved in stigmatizing interactions were women's friends and family, they most often condemned the condemners specifically in relation to their lack of knowledge about birth (as opposed to broader aspersions on their character). Brenda, for example, stated:

Most of the negative reactions we get are from people who, um, either are expecting a baby of their own or are kind of around that age who are going to do it, like and

basically just think that it's totally old school and crazy. And that it's not safe. And have— like if something went wrong, that's what everyone says. Like it's mostly friends of ours, people sort of around the same age as us. And what if something went wrong, I would never do it at home if something went wrong. It's like yeah but, we had somebody there. And usually there's like a warning sign before things start getting wrong, you know? So, that never even bothered me because, um, whatever. But I mean when they say that stuff I just say no, you have to educate yourself. Because I know you don't know ((laughs)). You need to learn more, like I've studied the whole birth thing, I was crazy about it, I just wanted to know more and more I couldn't know enough. And it's like ignorance, they just don't know...

By situating others' negative moral judgments as a function of their lack of knowledge regarding birth, women were better able to dismiss these judgments as valid threats to their moral and maternal identity. Moreover, as evidenced in Brenda's words above, women were able to juxtapose the ignorance of others against their own birth-related research, planning, and knowledge to present themselves as experts in the context of their birth-related decisions. This type of social weighting was another means of supporting a positive identity despite behaviour that was considered deviant by others.

The above analysis illustrates that most of the women who chose birth-related options that deviated from the norm (which in this context remains a doctor-attended birth in hospital) described some form of negative moralizing judgments from others. Within this sample, unassisted birth, home birth, and for some participants even the use of a midwife or doula were often “discrediting” (Goffman, 1963) decisions that marked them as different and engendered moralizing judgments. The most negative judgments were described by women who gave birth with the help of a birth attendant and/or at home. The majority of these negative judgments stemmed from the dominance of the medical model of birth (so that alternative decisions were markers of alterity) and centered upon perceptions of risk and safety. Previous research in a North American context has suggested at least some alternative birth options (specifically, home birth and midwifery care) are predominantly perceived as risky or communicated as such to pregnant women (e.g. Cheyney, 2008; Craven, 2005; Dejoy, 2010; DiFilippo, 2015). These perceptions may be further reinforced by medical health care professionals; for example, recent research illustrated that although 71% of surveyed obstetricians supported regulated midwifery,

89% were against home birth (Klein et al., 2009). In a national sample of younger (aged less than 40) Canadian obstetricians, the proportion who reported being opposed to home birth was over 97% (Klein et al., 2011b), illustrating the degree to which this birth option is devalued by the dominant maternity health care providers in Canada. The current analysis extends this work to delineate women's experiences of being perceived negatively for their alternative birth choices, which emerged within their narratives of childbirth. I argue that these experiences reflect processes of stigma, in that birth choices which diverged from the dominant model marked the individual as deviant and elicited moralizing judgments that threatened a positive identity.

Yang et al. (2007) have argued that processes of stigma "threatens the loss or diminution of what is most at stake, or actually diminishes or destroys that lived value" (p. 1530). In the current study, what was most at stake for women and threatened by birth-related stigma was their identity as capable, responsible mothers. Motherhood is an important social category, and is associated with a strong ideological demarcation of bad/good and in/appropriate boundaries of maternal behaviours and identity. Previous research has illustrated the ways in which positive maternal identities must be managed in the face of stigma by mothers in many different social locations, such as teenaged/young and older mothers, HIV-positive mothers, poor or welfare-using mothers, and drug-using mothers (Davis & Hagen, 1996; Friese, Becker, & Nachtigall, 2008; Ingram & Hutchinson, 1999; McDermott & Graham, 2005; & Radcliffe, 2009). In the only identified research applying stigma theory to childbirth, Miller (2012) described processes of stigma and stigma management in a group of women who birthed at home unassisted. For mothers in all of these stigmatized social categories, it is their moral identity as appropriate and good mothers that is threatened. These same threats to maternal identity were observed in women's descriptions of the moralizing judgments they received from others about their birth choices, as their maternal fitness in regards to prioritizing their baby, keeping their baby safe, and making responsible decisions was implicitly and explicitly questioned.

In order to preserve and present a positive maternal identity in the face of moralizing judgments and interactions, women utilized a number of information management strategies regarding their birth-related decisions and experiences: passing (Goffman, 1963), covering (Goffman, 1963), reframing (Ashforth & Kreiner, 1999), and social weighting via "condemning the condemners" (Sykes & Matza, 1957). As concealment strategies, passing and covering often entailed women withholding some or all of the true details of their birth from others.

Concealment strategies can range from being very passive (e.g. the avoidance of discussions on the details of their birth or birth plans) to very active (e.g. the fabrication of details or outright lying) (Goffman, 1963; Woods, 1993; Zerubavel, 1982). Although passing and covering have been described as potentially very stressful, involving dishonesty and the suppression of authentic identity (Clair et al., 2005; Woods, 1993), high levels of stress and negative personal cost did not characterize the current sample. This could be due to multiple factors about the nature and context of birth-related stigma. With discreditable information about childbirth, as with discreditable information about sexual identity, passing may be facilitated by the general assumption that one belongs to the “normals” (Goffman, 1963). Since it is presumably generally assumed that individuals in Canada are going to have a birth that falls within the medical model, participants may have simply allowed others to make that assumption regarding their own birth experiences. As the details of childbirth are not a common topic of conversation in many circles, it may also have been relatively easy for women to avoid conversations that would reveal discrediting information. Moreover, discrediting birth-related information is only salient during a relatively short period of time, limiting the extent to which these strategies could be perceived as necessary and by extension the stress experienced by women.

Conversely, much of the personal stress or confrontation that women described resulted from disclosure of their birth plans or experiences, which often resulted in future passing or covering, rejection of negative judgments through “condemning the condemners”, and/or the use of additional information management techniques to present a positive identity. These forms of information management centered upon reframing (Ashforth & Kreiner, 1999), wherein women tried to transform the meanings of stigmatized birth choices in order to cast them (and themselves) positively. Women did so through two complementary forms of reframing: *infusing* (Ashforth & Kreiner, 1999), whereby they imbued their birth choices with positive value by emphasizing and educating others on the value and benefits of their choice; and *neutralizing* (Ashforth & Kreiner, 1999), whereby they denied injury by emphasizing the safety of their actions and their positive birth outcomes. Both these forms of reframing supported women’s efforts to normalize their birth-related decisions, which they bolstered by explicitly aligning themselves with other, “good” mothers. To do so, women drew upon situational cues and dominant mothering ideology in order to present an identity that was congruent with shared mothering values. In this context, this shared meaning centered upon the role of the mother as

protector and the importance of prioritizing the child's needs. Research in other contexts has also illustrated how women work to figure out and protect what is at stake in preserving a positive identity. For example, in her research with voluntarily childless individuals, Park (2002) illustrated how they worked to interpret the meaning or value of parenting held by the questioner/condemner, and then responded in a way that showed how their own behaviour encapsulated that value (e.g. the value of nurturing was highlighted by emphasizing their work with people). Both Park's participants and the women in the current study appealed to shared values in order to normalize their decisions, reject assumptions that they were abnormal or rejected these dominant values, and preserve a positive identity.

Although disclosure of alternative birth related experiences and decisions appeared to elicit negative social consequences for many of the participants in this study, necessitating positive identity work, this work is important. On an individual level it fosters the preservation and presentation of a positive maternal identity, but it may also contribute over time to change the dominant meanings of stigmatized birth-related options. Women who choose alternative birth options speak of birth in ways that challenge dominant biomedical constructions, and as such have significant potential to contribute to changing social meanings around childbirth (Chadwick & Foster, 2014). By reframing stigmatized birth options as positive, normal, and safe, women who disclose contribute positive meanings about alternative childbirth options to the public conversation.

It is important to emphasize that stigma is socially constructed, and as such is understood and negotiated differently across particular social relationships and settings (Hylton, 2006; Major & O'Brien, 2005). In relation to this, two features of the current findings are important to highlight. Firstly, the extent to which women described processes of stigma related to alternative birth choices varied depending on their overall social circle. Melinda, for example, described her membership in a peer group and subculture in which alternative birth and parenting are the norm. Strong cultures often coalesce within stigmatized groups, because the stigmatized identity both becomes more salient and solidifies a defined group (Ashforth & Kreiner, 1999). Within the context of an alternative subculture, birth-related stigma may be more likely to be elicited by the pursuit or experience of medicalized birth options, and women may have greater discursive and social resources to combat perceived stigma from those outside of the group and preserve a positive identity. Although some previous research has suggested that women in alternative birth

subcultures are stigmatized for choices which deviate from this ideology (e.g. Westfall & Benoit, 2004), a similar pattern was not observed in the current research.

Secondly, the stigma management strategies women drew upon were highly situational and depended on audience and social cues. Similar conclusions about the importance of context and audience to stigma management strategies have been stated by others (e.g. Hylton, 2006; Miller, 2012), so that Miller (2012) stated that these techniques could be considered “situationally bound” (p. 422). When managing discrediting information women relied on both immediate and past social cues, which tended to result in a pattern of decreasing disclosure after receiving negative judgments. A similar finding was noted by Miller (2012), in her research on how women in the United States who chose to birth unassisted managed stigma. Although these women adopted four main strategies (choosing silence, failure to correct or passing, selective disclosure or disclosure etiquette, and evangelism), the most open and proactive of these strategies (evangelism) was rarely used and women often shifted into silence upon negative reactions from others.

Goffman (1963) noted that the stigmatization of people on moral grounds can operate as a means of social control. Inherent to processes of stigma are moralized, negative evaluations, which morality theorists have emphasized function as a form of regulation in order to encourage conformity to particular norms (Luckmann, 2002; Brandt, 1997; Bergmann, 1998). From this viewpoint, the processes of stigma described by women who chose alternative birth options can be understood as social forces which encourage the maintenance of dominant childbirth ideology and medicalized maternity practice. Despite the role of stigma in reinforcing the status quo, however, women who desired a more alternative birth worked to actualize it regardless of the judgments they anticipated or experienced from others. Moreover, those who actively worked to reframe alternative birth options contributed to positive constructions that challenged dominant medical hegemony. Ashforth and Kreiner (1999) noted that both stigmatized and positive constructions of an activity are defensible, and may each be preferred by some segment of society. Although the birth-related stigma experienced by women who chose more alternative birth options suggests that these options are still stigmatized by many, positive constructions of these options counter negative moralizing judgments which reinforce the status quo.

6.2 Conclusions

Women's stories of childbirth suggest that despite the proposed salience of alternative childbirth ideology to contemporary Western childbirth, women who choose alternative childbirth options may still face moralizing judgments from others. I have suggested that these moralizing judgments can be considered birth-related stigma, in that alternative birth choices marked individuals as deviant and led to negative appraisals of their moral and maternal responsibility. Moreover, this stigma threatened their status as "good mothers" and constituted a threat to their positive maternal identity. While many tenets of alternative birth ideology may be increasingly salient to childbearing women's understandings about birth (at least as illustrated within this particular sample of women from within Canada), medical hegemony over birth and conceptions of childbirth as risky and best performed within a medicalized context appear to be prevalent and inform moralized constructions of unassisted birth, home birth, and the use of midwifery or doula care.

These findings highlight the degree to which moral meanings are co-constructed and negotiated through social interactions, as women engaged in numerous stigma-management techniques in order to combat this threat and present themselves as responsible, child-focused mothers. Some of these strategies functioned to preserve a positive identity by hiding stigmatized birth-related decisions from individuals who were, or might be, judgmental. Other strategies involved reframing stigmatized birth-related options in positive ways, which could involve appeals to dominant mothering ideology (aligning these options with ideals of the good mother) and the rejection of a medicalized birth ideology that emphasizes the risks of childbirth and the necessity of physician or obstetrical care, a medical setting, and technology (reframing options from deviant to normal, and risky to safe). In conjunction with the conclusions from other chapters, women's identity work in the face of stigma illuminates how a positive moral and maternal identity is at stake in women's childbirth-related decisions and experiences.

CHAPTER 7

“AT THE END OF THE DAY SHE WAS PERFECT AND HEALTHY”:

MAKING SENSE OF WOMEN’S BIRTH STORIES AND THEIR IMPLICATIONS FOR MATERNITY CARE PROVIDERS

In the previous chapters, I explored major themes within women’s birth stories that related to the primary purpose of this research: to understand how women morally position various childbirth-related options, interventions, decisions, and experiences within their narratives of childbirth, and to explore how these narratives engage broader discourses. In doing so, I illustrated how women described birth preparation and birth-related options, how they talked about their birth experiences (and in particular drew upon moral frameworks to do so), the importance of agency, autonomy, and self-determination to how they understood these experiences, and the efforts that many women went to in order to negotiate a positive moral identity in the face of birth-related stigma. The purpose of this concluding chapter is twofold. First, I aim to pull together these analytic themes in order to discuss the role of ideological and moral frameworks in women’s narratives of childbirth, and how these are related to moral identity or what is at stake for childbearing women. Second, my goal is to explore what pragmatic insights can be drawn from these findings, and their implications for current practices of maternity care.

7.1 Taking Stock: Ideological and Moral Frameworks in Women’s Narratives of Birth

7.1.1 Ideological Frameworks in Women’s Birth Stories

In the background to this dissertation, I described the contemporary construction of childbirth as consisting of several ideologically distinct concepts: “natural birth”; “medicalized birth”; and, less commonly invoked, “prepared birth” (see Bryant et al., 2007; Callaghan, 1993; Davis-Floyd, 1994, 2003; Fox & Worts, 1999; Hunter, 2006; MacDonald, 2006; Machin & Scamell, 1997; Mansfield, 2008; Rothman, 1982; Rutherford & Gallo-Cruz, 2008). Consistent with research by other scholars (e.g. Brubaker & Dillaway, 2008; in Brubaker & Dillaway, 2009; Rothman, 1982; Miller, 2007), most of the women in the current study clearly drew upon both medicalized and natural understandings of birth to situate the birth-related options that were available to them and their experiences of labour and delivery. However, it was

clear that the understandings of birth communicated by this group of women were strongly informed by alternative birth ideology and its corresponding valorization of natural birth. Valuation of natural birth and of birth as an experience in itself, of woman-centered care and informed choice, and anti-intervention discourse were pervasive in their narratives of childbirth. Moreover, these values were expressed in the decisions that women made about care provider/s and birth setting; approximately half of the women interviewed chose to deliver their baby under the care of a midwife or unassisted at home.

These findings suggest that the alternative birth movement has been very successful in contributing to public discourses around birth, and shaping the understandings of childbearing women as to what birth does and should entail. As this was a small-scale qualitative study, the ability to draw generalizations about how this particular group of women represent or do not represent Canadian childbearing women as a whole is limited. Moreover, this was a self-selected sample of participants, and it is not only possible but likely that women who were inherently interested in the topic of birth (and therefore more likely to be knowledgeable about and value the process in itself) were overrepresented in those who volunteered to be interviewed. There is certainly evidence to suggest that although women may draw upon multiple ideological tenets in constructing personal meanings of childbirth and related options, there are also distinctions between groups of women (e.g. women who birth at home versus hospital, or women who birth with a midwife versus an obstetrician) as to how they make sense of birth-related options and experiences (see, e.g., Dahlen et al., 2008; Klein et al., 2011a; Kornelsen, 2005). This was also evident in the current research; elements of alternative birth ideology were particularly salient and cohesive in the narratives of women who chose more alternative births. However, the prevalence of many of these elements (especially a mistrust of labour interventions and valorization of natural birth) in the narratives of women who chose a more medicalized birth in-hospital with a physician or OBGYN does suggest an overall exposure to and acceptance of many of the tenets of alternative birth ideology. This was a discourse which was readily available to childbearing women, and informed how they understood and communicated their options, decisions, and experiences.

Although this argument suggests that alternative birth ideology may be becoming more pervasive in cultural and personal understandings of birth in Canada, it is not entirely synonymous with disinclination towards medicalized understandings and practices of birth. In

the current study, although they generally eschewed medical interventions in labour and delivery, many women did communicate medicalized understandings of birth centered upon the concept of risk in relation to their childbirth-related options and decisions. A couple of women positioned childbirth itself as risky, some perceived particular childbirth-related decisions as risky (e.g. home birth), and others invoked potential or perceived risks to the fetus as the justification for decisions and interventions. As Hausman (2005) pointed out, risk is the defining concept of medical childbirth, and drives many of the current practices that comprise the medical management of pregnancy and women's acceptance of technocratic birth practices. The meanings that childbearing women and their care providers construct regarding risk, and their communications related to this topic, are central to how childbirth unfolds and is experienced (Hall et al., 2012; Surtees, 2010).

Attending to the interactional nature of how risk is constructed and communicated, it is important to highlight how women understood and described risk as it was communicated by others. Discussions of risk with their maternity care providers were frequently recounted when women narrated their labour and delivery experiences, and it was clear in relation to some of these interactions that women perceived the concept of risk as being inappropriately or coercively employed. Women were therefore cognizant of the manipulative potential of risk discourse that has been acknowledged by maternity care providers (Hall et al., 2012). While presumed risks could be accepted as matter-of-fact, a common aspect of childbirth, or as a believable reality specific to the woman's situation, they could also be sites of suspicion or contention. In the latter cases, women questioned or rejected conceptualizations of risk that they felt arose although standardized or medicalized maternity practices. In doing so, they challenged dominant childbirth discourses which highlight risk and the necessity of deferring to experts, even if (as was sometimes the case) in the actual interactions they described, they did capitulate to expert requests that they did not agree with or feel were necessary.

Similar resistance to risk discourse was evident in women's descriptions of the moral judgments that others made about their alternative birth-related decisions, particularly home birth and the utilization of a midwife as a primary maternity care provider. Indeed, DiFilippo (2015) identified discourse positioning childbirth as risky as the most fundamental misconception that women who choose home birth negotiate with and challenge. Although women's experiences of birth-related stigma suggest a pervasiveness of medicalized childbirth ideology among the

Canadian public, these women often resisted the adoption of this viewpoint and engaged in various information management strategies to preserve a positive identity in spite of the deviant label attached to their birth-related decisions and experiences. Although women therefore frequently engaged with the concept of risk during their childbirth-related experiences, the degree to which they individually espoused a medicalized childbirth ideology was fairly infrequent in comparison to stories of resistance. In sum, although aspects of both medicalized and alternative childbirth ideologies were represented in how women made sense of childbirth and narrated their experiences, tenets of alternative childbirth ideology were especially reflected in the values, beliefs, decisions, and interactions that were communicated in these narratives.

7.1.2 Moral Frameworks in Women's Birth Stories

At the crux of this dissertation were efforts to delineate the moral dimensions of birth, marked by expressions or judgments of value, disrespect/respect, responsibility, and what one ought or ought not to do (see, e.g., Luckmann, 2002; Kleinman & Kleinman, 1997; Parker, 2007; Gilligan, 1977), as they were communicated by women in their stories of childbirth. Previous research has identified women's ethical responsibility to and for their infant (e.g. Weiss, 2013), and pointed out ethical difficulties around how to best balance informed consent and maternal autonomy and the provision of health care during the perinatal period (e.g. Torres & De Vries, 2009). The childbirth literature is also populated with research findings which speak to the moral dimensions of birth, in that particular options and outcomes (especially home birth and caesarean sections) are frequently positioned negatively in relation to risk discourse and ideals of motherhood (e.g. Bryant et al., 2007; Craven, 2005; DeJoy, 2010; Fenwick et al., 2009; Malacrida & Boulton, 2012). Extending this work, the purpose of this dissertation was to thoroughly explore how childbearing women drew upon moral frameworks and positioned different options and experiences morally in their understandings of birth and their own childbirth experiences.

As the first of two dominant moral frameworks that they employed to narrate their childbirth-related experiences, women frequently used a moral voice of justice and autonomy within their childbirth narratives, which brought the moral concepts of individual harm, rights, and justice to the fore and reflected the valuation of autonomy and choice (see Gardner et al., 1999; Gilligan & Attanucci, 1988; Lyons, 1983; Shweder et al., 1997). These findings are consistent with the notion that discourses of autonomy are predominantly invoked in Western

societies (Haidt et al., 1993; Miller & Bersoff, 1992; Shweder et al., 1997; Snarey & Keljo, 1991; Vasquez et al., 2001). Women repeatedly emphasized the importance of research and preparation in order to make informed choices about their impending birth, whatever these choices may be, and having their decisions and autonomy supported during labour and delivery. In line with research suggesting that women perceive their birth experiences positively when they felt that they were able to exercise self-determination, agency, choice, and personal authority/control (Baker et al., 2005; Fair & Morrison, 2012; Goodman et al., 2004; Green et al., 1990; Hart & Foster, 1997; Hodnett, 2002; Howarth et al., 2011; Knapp, 1996; Nancy & Lysterly, 2010; VandeVusse, 1999), almost all of the women in this study valued agency and autonomy during childbirth and judged their experiences according to how well it was fostered or denied. Instances where women's choices were not supported, and their autonomy was denied, were generally perceived as unjust and a violation of their rights to access safe, comfortable, and desired maternity care that reflected their values.

Emphasizing the moral dimensions of how women understand these interactions offers additional perspective to previous work illustrating the importance of choice, control, and autonomy to women's childbirth experiences. If women perceive the exercise of choice and autonomy as a personal right and as moral goods, then maternity care which validates and supports these moral goods is highly valued (as the current findings reflect). When choice is denied and autonomy is constrained, however, this is seen as a wrong and women may perceive health care professionals as moral transgressors who have denied them their rights to choice and autonomy. This interpretation places particular birth-related options as enactments of moral values, so that it is the enactment of these moral values themselves (choice, autonomy, self-determination, and justice) which informs how women understand their birth-related experiences.

In addition to a moral voice of justice and autonomy, women drew heavily upon a moral voice of care and responsibility in which moral good is predicated upon helping, pleasing, protecting, and fulfilling obligations and responsibilities to others, while balancing responsibilities and care for one's self (Gilligan, 1977). This moral voice aligns most closely with Shweder et al.'s (1997) description of moral discourse focused around an ethics of community, which centers upon concepts of duty, hierarchy, and interdependency and promotes the moral integrity of social roles. Women's biological and social roles as mothers, and the

associated responsibilities and duties towards their infants, underpinned the ways women described their birth experiences.

Central to women's birth narratives was the concept of moral responsibility, and their efforts to balance and fulfill responsibilities to themselves, others involved in the birth, and especially to their baby. Lupton (2011) has illustrated the centrality of maternal and moral responsibility in women's narratives of both pregnancy and infant care, and their efforts to live up to these responsibilities. Similarly, Carter (2010) described how women echoed cultural ideals of self-control over the body and individual responsibility for their pregnancy and infant. Women situated responsibility in themselves for the health of the baby rather than in their body, their baby, their baby's body, the baby's father or his body, or in any of the social circumstances which provided the context for their experiences. In the current research, moral responsibility was expressed through the ways women described some birth-related options (particularly epidurals and induction of labour) as having potential negative consequences, so that their ability to protect themselves and their babies from harm and achieve the birth they wanted was predicated upon the choices that they made. As they narrated their experiences of labour and delivery women drew heavily upon moral understandings that were relational and centered upon the avoidance of harm to self and others (Gilligan, 1977), and emphasized their responsibility for the avoidance of these harms. Situating responsibility for labour outcomes in their decisions resulted in extremely positive valuations of the birth and feelings of joy, achievement and pride when birth outcomes were desirable, but significant feelings of guilt, failure, and sorrow when they were not. Malacrida and Boulton (2014) similarly described women's feelings of disappointment, guilt, and inadequacy when their expectations were not met, which were rooted in the assumption that they could have made different choices. As Lupton (2011) noted, "*guilt is an emotion intimately linked to morality: having 'done wrong' in some way...*" (p.648); situating their decisions and labour outcomes within a moral framework of care and responsibility left women vulnerable to self-blame when things did not work out as planned.

The ways in which women structured their narratives of childbirth within moral frameworks also, therefore, illustrates some problematic aspects of moral discourses which privilege autonomy and care and responsibility in relation to childbirth. Both of these discourses highlight the responsibility of childbearing women for making birth-related decisions, and place a significant amount of pressure on women to be able to make the *right* decisions in order to

fulfill their responsibilities to self and other. Malacrida and Boulton (2014) described how the notion of individualized responsibility holds women individually responsible for understanding the risks attached to different choices and making decisions, and leaves them culpable for any negative outcomes resulting from these decisions. This individualized responsibility is reflected in moral discourses of autonomy and care and responsibility, and the potential emotional impact this can have is illustrated in the stories of women whose births did not go as desired.

Indeed, although women strongly valued autonomy and informed choice, and situated many of their choices as moral decisions which led to particular birth outcomes, previous scholars have noted the complexities of “choice” in maternity care. Women may face economic, geographical, or situational barriers to choice (Miller & Shriver, 2012), the birthing environment may be so inflexible as to prohibit any real choice (Lothian, 2006), and accepting one labour intervention may restrict further choice (Malacrida & Boulton, 2014). Furthermore, even when supposedly given a choice, the authoritative knowledge of maternity care providers and their judgments of risk and how it should be responsibly managed may preclude any real choice on the part of the woman (Campo, 2010; Crossley, 2007; Edwards & Murphy-Lawless, 2006; Jomeen, 2012). Many constraints to choice and autonomy were illustrated in the current findings, including maternity care protocols, labour pain, and poor communication and uneven power dynamics between women and their care providers. Jomeen (2012) argued that the problem of choice as an idealized norm in maternity care is that it offers the promise of an experience that may not or cannot be met, puts pressure on women to make the “right” choice, and leaves the woman open to blame if decisions are perceived as “wrong”. Understanding choice as a valued aspect of autonomy, and particular decisions in relation to moral responsibility, puts a lot of pressure on childbearing women in a context where “real” choice may be difficult to achieve. Indeed, women for whom birth did not go as desired ameliorated their guilt and self-blame by working to re-construct their understanding of their birth experiences within a biomedical framework, which absolved them of the moral responsibility for outcomes that they initially located in their birth-related decisions. The moral concepts which women used to give meaning to their experiences could, therefore, be threatening in that they held up ideals that women may not have been able to fulfill.

7.2 Moral Identity and What is at Stake

Johnson (2008) noted that pregnancy and childbirth are sites for the construction of identity; natural childbirth, exclusive breastfeeding, caesarean sections, and so on are “markers of one’s place in society” in that they locate the self along the continuums represented in broader discourses of childbirth and motherhood. The findings from this analysis of 21 women’s birth narratives supports this contention, and suggest that it is specifically women’s moral and maternal identity which is constructed, contested, and ultimately at stake in their childbirth-related experiences. Although moral identity is constructed through narrative and social interaction (Tappan, 2006), individuals do conceive of moral identity as an individual definition of oneself as a worthy and acceptable individual based on the standards which govern these interactions and relationships (Gergen, 2005). That is, although we enact morality socially, we have an introspective sense of ourselves as moral which is both based on how we enact morality and informed by our actions.

Women clearly situated their childbirth experiences in relation to moral concepts of autonomy, justice, and responsibility (see Gilligan, 1977; Shweder et al., 1997), and their narratives illustrated their efforts to enact a positive moral and maternal identity. Regardless of where their choices fell in relation to ideologies of birth, women’s pursuit of the good (most often represented in maternal choice, autonomy, and/or the avoidance or minimization of harm to self or others) was clear. Women’s descriptions of birth-related options emphasized, for example, their moral responsibility to protect their child and self from harm, and the importance of choice to their experiences. As they narrated their labour and delivery, they drew upon a moral framework of care and responsibility which positioned their decisions as moral dilemmas and themselves as morally responsible for birth outcomes, either positive or negative. Highlighting the socially enacted nature of moral meanings and identity (Doucet, 2006; Finch & Mason, 1993; Shweder & Haidt, 1993; Tappan, 2006), women’s narratives illustrated the degree to which their moral and maternal identities were enacted, threatened, and negotiated during their childbirth-related experiences.

In situations where a positive identity was in jeopardy, women worked to reaffirm their moral good. When utilizing a moral framework to make sense of their birth experiences caused women emotional distress and pain, they explored other ways of constructing meaning in order to redefine the situation so that they were not left morally culpable. Specifically, drawing upon a

biomedical framework (Shweder et al., 1997), women were able to redefine their negative birth outcomes as inevitable or outside of their ability to alter, and a result of physiological factors or an abnormal situation. When a positive identity was threatened by birth related stigma arising from others' perceptions of their birth-related decisions as deviant, women worked to redefine their presentation of self by engaging in various information strategies designed to preserve or foster a positive moral self. Through passing, covering, reframing, and social weighting (see, e.g., Ashforth & Kreiner, 1999; Goffman, 1963; Sykes & Matza, 1957), women strategically presented versions of the self which countered aspersions of irresponsibility, selfishness, and so forth. This work to redefine both self and situation illustrates the extent to which moral identity was at stake for women in their experiences of childbirth, and how they worked to protect it.

At many points throughout this dissertation, I have referred to “moral and maternal identities”. This choice of wording reflects the obvious notion that a maternal identity is not the only possible moral identity, yet highlights the degree to which a positive moral identity was intertwined with a positive maternal identity in the current research. Certainly the emphasis on care, responsibility, and relationships that is paramount in a moral framework of care and responsibility (Gilligan, 1977) overlaps with the social role of mother, where women are positioned as ultimately responsible for the needs, nurturing, and development of the child (Hays, 1996). Discourses of maternal responsibility and protection are paramount in mothers' narratives of both pregnancy and motherhood, and viewing oneself and being recognized by others as a good mother is central to the mothering decisions that women make (Lupton, 2011). Moreover, mothering itself is moral; dominant mothering ideology is culturally and socially shaped and reflects personal and collective values, which are reflected in strong prescriptions about who should (and who should not) be a mother, and how women who are mothers ought to (and ought not to) behave.

In women's narratives of their childbirth experiences, the moral identity that was at stake was specifically one's identity as a “good mother”. Previous research has illustrated links between childbirth and good mothering; decisions which embody selflessness, sacrifice, and pain during labour are often constructed as “good mothering” (Bryant, 2007; Dejoy, 2010; Malacrida & Boulton, 2012), whereas decisions perceived to be for the mother (i.e. selfish) or those which are considered risky (Craven, 2005; Dejoy, 2010; Fenwick, 2009; Malacrida & Boulton, 2012) are constructed as “bad mothering”. Women's descriptions of both birth-related stigma and the

use of risk discourse by health care providers illustrated similar findings, whereby the positive maternal identity of women who chose alternative birth options or were resistant to health care providers' advice was often implicitly or directly called into question. In terms of women's own perceptions of birth-related decisions, epidural use and labour induction were frequently situated as morally contentious. These options were the most likely to be viewed by women as potentially causing harm, and epidural was seen by some women as diminishing the authenticity of the maternal experience of labour and delivery.

The current research, with its focus on morality, illustrated that in adopting a moral framework of care and responsibility to make sense of childbirth experiences, the ways in which women's identity as a good mother was maintained or threatened depended greatly on how the labour and delivery unfolded. As pointed out by Lyons (1983), central to a moral framework of care and responsibility is the consideration of a moral situation in terms of its outcome— what happened, or how things worked out. When women's labour did not go as desired, understanding events within a moral framework of care and responsibility meant that they were morally culpable for the decisions that they made, and a positive maternal identity was threatened. When women's labour went well, understanding events within a moral framework meant that they had “succeeded” as mothers due to the effort they had put in and decisions they made in order to secure the desired outcome. When women did not strongly situate their birth experiences within a moral framework, they were able to separate ideals of “good mothering” from the birth-related decisions they made. Similarly, when women worked to re-negotiate the meanings of how their labour and delivery unfolded according to biological rather than moral criteria, they were able to either separate “good mothering” from these outcomes or to utilize biological narratives of causality in order to illustrate how they were good and responsible mothers after all (see Bryant et al., 2007, for similar findings reflecting the latter).

The findings of this research suggest that positive moral/maternal identities are at stake for childbearing women, particularly women who are drawing heavily on a moral framework of care and responsibility to make sense of childbirth. They also highlight how moral meanings of specific child-birth related decisions are not fixed, but rather constructed in particular situations and interactions. A caesarean section, for example, could be understood as the result of a bad maternal decision (epidural), then redefined as a responsible maternal decision in an inevitable situation. A woman who chose a home birth could be criticized as putting her baby at risk, and

then work to either redefine herself (e.g. by choosing not to disclose to others) or redefine the situation (through reframing) in order to present herself as a caring, responsible mother. From preparation for birth to postpartum, women engaged in the negotiation, presentation, and preservation of positive moral and maternal identities.

7.3 Implications for Current Practices of Maternity Care

The prevalence of moral discourse in women's childbirth narratives, and their use of moral frameworks to understand their decisions and experiences, suggests several important implications for the provision of maternity care. First and foremost, it highlights the importance of acknowledging the moral dimensions of birth, and that often women's choices are not just choices; they are reflections of deeply held values and beliefs and are enactments of moral and maternal identity. As such, decisions which health care providers may see as relatively inconsequential or as being an obvious choice may be, for childbearing women, moral dilemmas which engender a careful balancing of potential harms to self and others (Gilligan, 1977). Kleinman and Benson (2006) argued that the most basic and crucial aspect of providing health care is understanding the moral meanings that inform how the patient/individual understands their situation, and understanding what is at stake for them. The authors suggest that even the busiest health care providers should be able to routinely ask patients what matters most to them in their experience of illness and treatment, and use this information to guide their interactions, decision-making, and negotiating with patients. The value of this type of patient-centered care is that it allows individuals to make explicit their values and beliefs, so that these can be considered in subsequent communications and the care that is provided.

In maternity care, birth plans have risen in popularity as a means of making explicit some of these values and beliefs in the form of written preferences for particular options and aspects of care. These plans, however, may be disregarded by maternity care providers during labour and delivery, or may follow a standardized format that allows very little actual choice (Baker, et al., 2005; Campo, 2010; Rutherford & Gallo-Cruz, 2008; Whitford & Hillan, 1998). Research is mixed as to the effectiveness of birth plans in promoting patient-centered care and communication with maternity care providers, maternal autonomy, and satisfaction with care/birth experiences during labour and delivery (see, e.g., Brown & Lumley, 1998; Kuo et al., 2010; Lundgren, Berg, & Lindmark, 2003; Whitford & Hillan, 1998). Health care providers and

birth attendants specifically identify gaining a better understanding of women's values and beliefs as a benefit of birth plans (Aragon, Chhoa, Dayan, Klufinger, Lohn, & Buhler, 2013), suggesting their potential as an initial conversation tool and reference for maternity care providers. However, the provision of maternity care which is patient centered and aims to understand the moral dimensions of care as perceived by women may be better facilitated by an approach similar to Kleinman and Benson's (2006) model, in which providers explicitly engage in conversations with childbearing women about how they understand particular birth-related options, and what matters most/is at stake in their experiences of birth.

The current research illustrates the crucial role that maternity care providers play in how women make sense of their birth-related experiences. One potential aspect of exploration for future research and the provision of maternity care is how maternity care providers contribute to women's narratives of childbirth, and how they bolster or negate moral frameworks of understanding. For women whose birth did not go as desired and utilized a moral framework of understanding to emplot the events of their labour, a gradual reframing of events within an alternative (biomedical) explanation appeared to be beneficial to helping them move past feelings of guilt and distress. As Kjaegaard et al. (2007) stated, reconciliation of negative birth outcomes is a positive endpoint for mental health; while this may happen gradually over time, there may be potential for maternity care providers to facilitate this process. It was evident in some women's narratives that their maternity care providers did help them to co-construct a biomedical narrative of causality, and that this diminished their sense of moral culpability for how their labour and delivery unfolded. In a similar idea to narrative therapy (see, e.g., Carr, 1998; Etchison & Kleist, 2000), the ways which individuals understand and relate their experiences have an enormous impact on the constitution of identity and relationships. Although obviously the work of narrative therapists is beyond the purview of maternity care providers, simply the provision or reinforcement of alternative casual frameworks which do not enhance women's self-blame¹ could positively shift the meanings women create from their birth experiences. In a similar vein, there may be utility in examining empirically how the meanings of birth-related options are constructed in interactions between women and their care providers, both prenatally and during labour. There was a clear tendency of women to ascribe to an anti-

¹ In the current research, understanding technological intervention as necessary from a biomedical perspective and perceiving outcomes as beyond maternal control appeared to be important facets of a biomedical casual ontology.

intervention ideology, and see the use of epidural analgesia and labour induction in particular as pivotal decisions which could cause a cascade of interventions. The degree to which health care providers contribute to particular constructions of birth-related options through their interactions with women, and the manner in which they address the potential consequences of interventions or position them morally, is unclear and an avenue for future research.

Perhaps more crucially, findings illustrate how different aspects of the interactions women had with maternity care providers facilitated and constrained maternal autonomy, self-determination, and agency, which informed how women understood and felt about their birth experiences (see also Fair & Morrison, 2012; Goodman et al., 2004; Hart & Foster, 1997; Nancy & Lyerly, 2010; VandeVusse, 1999). In recent research in Australia, childbearing women identified woman-focused care (particularly being informed and involved in decision-making) and having competent but also caring and empathetic care providers as the most important aspects of maternity care (Jenkins et al., 2014). Given the salience of autonomy, self-determination, and agency to how most of the women in this study made sense of their childbirth experiences, and their associations with birth satisfaction, this suggests that optimal maternity care should support these moral principles in practice. This is also consistent with the conceptualization of autonomy (being the perceived origin or source of one's behaviour, and having the ability to act in ways which one endorses) as a basic psychological need, which affects self-determination and both short and long-term wellbeing (Deci & Ryan, 2000; Ryan & Deci, 2006).

Shared decision-making and the opportunity for women to make informed choices have been called for as integral aspects of maternity care which need to be supported (e.g. Carter et al., 2010). Despite such calls and the importance of autonomy as a basic principle of health care ethics, the women in the current research described many constraints to autonomy and agency that were rooted in maternity care protocols and their interactions with health care providers. As noted previously, many factors may constrain the childbirth-related choices available to women. For many other aspects of maternity care, however, maternal autonomy could be better fostered; one example is by supporting women's choice of delivery position (an issue for several women in the current study). Given the numerous benefits² of delivering in an upright or lateral position

² These benefits include reduced pain and duration of the second stage of labour, a reduction in the likelihood of episiotomies or assisted deliveries, fewer abnormal fetal heart rate patterns, and possibly less perineal trauma.

as opposed to supine or lithotomy positions (De Jonge, Teunissen, & Lagro-Janssen, 2004; Gupta, Hofmeyr, & Smyth, 2004; de Jong, Johanson, Baxen, Adrians, van der Westhuisen, & Jones, 1997; Terry, Westcott, O'Shea, & Kelly, 2006), restricting women's choice of delivery position does not reflect best practice and may unnecessarily restrict her autonomy, agency, and self-determination. Initial qualitative investigation suggests that being able to adopt birthing positions freely (according to women's preferences in conjunction with professional suggestions) appears to contribute to a sense of agency and a better overall delivery experience (De Jonge & Lagro-Janssen, 2004). For this and any other options which do not significantly increase risk or negative consequences, there are no evidence-based or moral justifications for restricting women's autonomy in childbirth. Moreover, the absence of specific informed consent or informing the woman what was being done to her body (observed, for example, in women's stories of suddenly realising that they were being given episiotomies during labour) does not reflect respectful care that supports women's autonomy and agency and is easily avoidable by health care providers.

As noted earlier in this chapter, although an ethics of autonomy may inform how women perceive childbirth and their satisfaction with experiences, "real" choice may not always be possible or realistic and heavy reliance on this discourse may set up a moral standard in itself with "right" and "wrong" choices (Campo, 2010; Crossley, 2007; Edwards & Murphy-Lawless, 2006; Jomeen, 2012; Lothian, 2006; Malacrida & Boulton, 2014; Miller & Shriver, 2012). Moreover, it was evident in women's narratives that there were factors which facilitated informed choice, autonomy, and agency. Research and preparation prior to labour helped women feel more knowledgeable about their options and allowed them a more authoritative voice in negotiating their care with maternity care providers. Having a positive, collaborate relationship with their health care provider facilitated communication, and communication about options which focused on information and did not rely on coercive moralized discourse positively fostered women's autonomy and agency.

Although the choices that many women made may not have been fully "free" in the sense of having multiple positive options that could be selected free from other influences, what appeared to be most important was the absence of heteronomy— feeling as though one's actions were controlled or dictated by others (Chirkov et al., 2003). Controlling conditions, like demanding language (including coercive risk discourse) and minimization of choice, promotes

controlled regulation and heteronomy and minimizes autonomy (Ryan & Deci, 2006). By keeping women informed and discussing different options, communicating to the best of one's ability without coercive discourse, and supporting maternal or shared decision-making as much as possible, health care providers can better support women's autonomy and agency in birth without negating their professional responsibility to mothers and their babies. As discussed by Quill and Brody (1996), enhancing maternal autonomy does not mean adopting an "independent choice" model of decision making wherein care providers recite statistics and provide objective facts but avoid the provision of any guidance or opinion; the authors argued that this model is as problematic as medical paternalism. Nor does it necessarily mean giving women many options or choices, since what is important for autonomy is facilitating the *experience* of "choicefulness" or volition (although this is often enhanced when multiple options are provided) (Ryan & Deci, 2006). Rather, the enhancement of autonomy requires a relationship-centered model in which care providers engage in open dialogue, inform patients about genuine possibilities for action (and their potential consequences), explore the patient's values and their own, and offer recommendations that consider both sets of values and experiences (Quill & Brody, 1996).

In the current research, women who chose midwives as their primary care providers spoke very positively about their care and the facilitation of autonomy, agency, and self-determination that it provided. Specifically, women frequently described continuity of care, a positive relationship and high level of trust, provision of information about many birth-related options, clear support for maternal choice, and shared decision making as being important features of the care they received. This supports assertions that the midwifery model promotes woman-centered care and enhances both maternal autonomy and satisfaction with care (e.g. Bylund, 2005; Charles, 2013; De Koninck et al., 2001; Fair & Morrison 2012; Thachuk, 2007). In conjunction with research illustrating comparable or favorable obstetrical outcomes³ of midwifery care compared to obstetricians or family physician-based care (e.g. Janssen et al., 2007; Johnson & Daviss, 2005; Oakley et al., 1996; Tracy et al., 2013; Turnbull et al., 1996), these findings provide additional support for the continued integration of midwifery into the Canadian health care system as a beneficial model of care for pregnant women. Doula care and the presence of supportive others was also described very positively by women as a facilitator of

³ These favourable outcomes include lower rates of birth interventions, fewer birth complications, maternal lacerations, and infant abrasions, and comparable neonatal outcomes and mortality rates.

autonomy, agency, and self-determination, allowing women to enact agency by proxy (Bandura, 2006) and providing woman-centered support (see also Lundgren, 2010). In light of these findings and those which suggest positive psychological and obstetrical outcomes from continuous doula support (e.g. Hodnett et al., 2011; McGrath & Kennell, 2008; Scott et al., 1999), the presence of such support should be encouraged.

Although the value of midwifery and doula care to supporting autonomy, agency, and self-determination was clear in the present research, it should be emphasized that care which supports these principles is achievable by any maternity care provider. Although women in the current research described many negative in-hospital experiences with medical staff/physicians and obstetricians, they also described positive experiences in which they felt their values were respected and valued, and their autonomy and agency were fostered. Similarly, it needs to be noted that there is a wide degree of intra-profession variation in attitudes towards birth and maternity care practice. Recent work by Klein et al. (2009), for example, illustrated how despite an overall tendency of obstetricians to report more favorable attitudes towards technological approaches and interventions in birth, at least 15% of surveyed obstetricians held attitudes that were similar to the majority of midwives. The conclusions drawn from this research should, therefore, be considered applicable to all groups of maternity care providers. Through providers' reflection on current practice and what is at stake for women in childbirth, and efforts to understand what matters most for individual women and support their values, maternity care provision can be strengthened.

7.4 Concluding Statements

The goal of the proposed research was to explore the moral dimensions of childbirth; how women engage with moral and ideological frameworks to make sense of childbirth-related options, decisions, and experiences. The current research illustrated how women negotiated childbirth-related meanings within a context of competing truths rooted in dominant childbirth ideologies. It also highlighted the salience of moral frameworks of autonomy and moral frameworks of care and responsibility to how women made sense of their birth experiences, as well as the moral regulation that manifested in the form of birth-related stigma. Ultimately, findings spoke to the salience of childbirth as an important site for the construction and negotiation of moral and maternal identity.

There were several limitations to the current research. First, as women self-selected to participate, it is unclear as to how representative the current sample was of the general population. Although generalizability per se was not the goal of this qualitative work, the hope was to gain a diverse sample of mothers in order to explore patterns of meaning relevant to the research questions at hand. Although relatively diverse in some aspects, the women who participated in the research were overall fairly highly educated and may have chosen to participate because they were more likely to invest significance in the process of birth itself or had particularly impactful birth experiences. A related note regarding the context of this particular group of women is that most of them (18 of 21) were living in Saskatchewan at the time of their child's birth. As midwifery has only been regulated and part of publically funded maternity care in the province since 2008 (Government of Saskatchewan), midwifery care and associated birth practices (such as home birth) may not be as familiar to a larger proportion of the population as compared to, for example, Ontario. The presence of birth stigma described by many of the women who had alternative birth experiences may not be prevalent in a different cultural milieu in which more of the population is exposed to alternative birth practices. The findings and conclusions of the current work must therefore be considered in light of this specific sample of women.

Second, the exclusive focus on mothers meant that the voices and experiences of fathers or non-paternal partners were absent in considerations of the moral dimensions of birth. This absence is characteristic of research in the area but leaves a significant gap in terms of understanding childbirth experiences, and specifically (to this research) how moral and ideological frameworks are employed to do so. The extent to which women spontaneously described paternal or partner involvement and opinions regarding the birth varied significantly across narratives. For example, some women clearly presented decision-making as a joint process, whereas in other narratives the father or partner was generally absent. Aspects of how fathers and non-paternal partners construct or co-construct moral meanings with women are another important dimension to this work that remains to be explored.

Despite these limitations, the findings of the current research add to the literature by empirically exploring the moral dimensions of birth in women's narratives of childbirth, and how women construct their experiences in relation to moral and ideological frameworks. Exploring the patterns and variation in how childbearing women make sense of their experiences, and

making explicit these moral dimensions, adds another layer of understanding to research on childbirth. Making visible the ways in which childbirth is negotiated as a moral enterprise helps to illuminate what may be at stake for women; beyond the health of mother and infant, the current research suggests that maternal and moral identity are at stake in women's experiences of childbirth. Moreover, the current findings offer insights into the crucial role of maternity care providers in women's birth experiences and suggest avenues through which maternity care can facilitate maternal agency and autonomy. In exploring the moral dimensions of childbirth the hope is that the ways women engage with childbirth can be better understood and considered in relation to healthcare provision, in order to promote supportive and respectful maternity care for women birthing their babies.

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Appendix A: Examples of Care and Justice Moral Voices

<i>Justice</i>	<i>Care</i>
1) [If people were taking drugs and I was the only one who wasn't I would feel it was stupid, I know for me what is right is right and what's wrong is wrong... it's like a set of standards I have.] (<i>High School Student</i>)	1) [If there was one person it would be a lot easier to say no, I could talk to her, because there wouldn't be seven others to think about. I do think about them, you know, and wonder what they will say about me and what it will mean... I made the right decision not to because my real friends accepted my decision.] (<i>High School Student</i>)
3) [I have moral dilemmas all the time, but I have no problem solving them usually. I usually resolve them according to my internal morality . . . the more important publicly your office is, to me the more important it is that you play by the rules because society hangs together by these rules and in my view, if you cheat on them, even for a laudatory purpose, eventually you break the rules down, because it is impossible to draw any fine lines.] (<i>Lawyer</i>)	3) [I have to preside over these decisions and try to make them as nondisastrous as possible for the people who are most vulnerable. The fewer games you play the better, because you are really dealing with issues that are the very basis to people's day-to-day well being, and it is people's feelings, people's potential for growth, and you should do everything in your power to smooth it.] (<i>Lawyer</i>)

Examples from Gilligan & Attanucci (1988, p. 226)

Appendix B: Recruitment Pamphlet

Front cover



Birth Stories Study



Inside
pages

**This research study is for
women who have given
birth in the past year and
are interested in sharing
their stories about
pregnancy, childbirth,
and motherhood**

- Participation in this study involves participating in an approximately one hour interview about your experiences with pregnancy, childbirth, and the transition to motherhood. Compensation (\$15) will be provided as a thank-you for your time
- You will also be invited to participate, if interested, in a 90 min focus group (refreshments provided) to share your thoughts about birth-related decisions, options, and values



**For more information
or to participate,
please contact the
researcher using the
contact info provided
below!**

**Melanie Bayly, Ph.D. student
Department of Psychology
University of Saskatchewan**

**melanie.bayly@usask.ca
(306) 966-6159**



Appendix C: Recruitment Poster



Have you given birth to your first child in the past year?

Are you interested in sharing your stories about pregnancy, childbirth, and motherhood?

Consider participating in a research study conducted through the University of Saskatchewan



- Participation in this study involves participating in an approximately one hour interview about your experiences with pregnancy, childbirth, and the transition to motherhood. Compensation (\$15) will be provided as a thank-you for your time
- You will also be invited to participate, if interested, in a 90 min focus group (refreshments provided) to share your thoughts about birth-related decisions, options, and values

For more information or to participate, please contact the researcher, Ph.D. student Melanie Bayly: melanie.bayly@usask.ca or (306) 966-6159

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Appendix D: Recruitment Post on Kijiji

Title: Birth Stories Study

Description:

This research study is for women who have given birth in the past year and are interested in sharing their stories about pregnancy, childbirth, and motherhood

- Participation in this study involves participating in an approximately one hour interview about your experiences with pregnancy, childbirth, and the transition to motherhood. Compensation (\$15) will be provided as a thank-you for your time
- You will also be invited to participate, if interested, in a 90 min focus group (refreshments provided) to share your thoughts about birth-related decisions, options, and values

For more information or to participate, please contact the researcher, Melanie Bayly (Ph.D student at the University of Saskatchewan) at (306) 966-6159 or reply to this ad.

Appendix E: Interview Guide

1) I'm interested in how you experienced your pregnancy, and what aspects of pregnancy stood out the most for you. Start wherever it makes sense to you and tell me about your pregnancy.

-What do you remember most about it?

-At what point did you notice that?

-How did it change over time?

-How did you feel about that?

-Who did you talk to about that?

2) What decisions that you made during pregnancy do you think were the most important?

-Why do you think that particular decision was so important to you?

-Where did you seek information about that option?

-How did your opinion change throughout your pregnancy?

-Who did you talk to about that decision?

-What kinds of feedback did you receive from other people about any of the decisions that you made?

3) Backup in case they do not mention labour-related decisions:

I'm also interested in what kinds of plans about your labour and birth you may have made when you were pregnant, tell me about any plans you had

-Tell me a little more about why you made that decision

--Where did you seek information about that option?

-How did your opinion change throughout your pregnancy?

-Who did you talk to about that decision?

-What kinds of feedback did you receive from other people about any of the decisions that you made?

4) "I'm interested in hearing about your labour and the birth of your baby, both the events that happened and other details that you feel are an important part of the story. Starting wherever it makes sense to you to start, tell me the story of your labour and birth!"

-What are the things that you remember most about your labour?

-How did you feel about that?

-At what point did that happen?

-How were the other people (partner, doctor, midwife, family, friends) in the room involved in your labour?

-How was that decision made?

5) Looking back, how do you feel about the way that your labour and birth went?

-Why do you think you feel that way?

-How was your labour different from how you expected it would go?

-How do you feel about the decisions that were made during your labour?

-How did your opinion on that change from when you were pregnant?

-How do you think your partner feels about it?

-How would you do things differently if you were to have another baby? Why?

6) I'd also like to hear about what happened after the birth- tell me about the first few days after your baby was born.

-What stands out the most for you about your first few days of motherhood?

-What was the most difficult part of the first few days after the birth?

-Who did you talk to about that?

-How did you feel about that?

-Why do you think that happened/you felt that way?

-How did that compare to what you expected?

-How did that change over time?

7) I'm interested in what has happened since then. Tell me about what motherhood has been like for you

-Tell me about a time when you experienced that/felt that

-How did you feel about that?

-How did you deal with that?

-Has that matched your expectations?

-Why do you think that is?

-How have your feelings about motherhood changed over time?

Appendix F: Participant questionnaire

Participant #: _____ Age: _____ Occupation: _____

Highest level of formal education completed:

- ☐ Primary School
- ☐ High School
- ☐ High school equivalency
- ☐ Undergraduate
- ☐ Trade school
- ☐ Graduate
- ☐ Post-Doctoral
- ☐ Other: Specify _____

Primary country of residence

(where you've lived most of your life): _____

Ethnicity: _____

Religious affiliation: _____

Relationship Status:

- ☐ Partnership >2 years
- ☐ Partnership < 2 years
- ☐ Married
- ☐ Single
- ☐ Separated/Divorced

Sexual Orientation:

- ☐ Straight
- ☐ Gay/Lesbian
- ☐ Bisexual
- ☐ Other: Specify _____

Current age of child: _____

Place of child's birth

(city and location: hospital/home/other): _____

Appendix G: Example of Transcription Notes

Initial notes/thoughts- Participant #17

Context: “Textbook” pregnancy, very pro-midwife and had a midwife and a doula for care. Very self-educating within preg and into motherhood. Planned a home birth but had a hospital transfer; seems to pin some blame on the decision to break her water. However, she had a vaginal hospital birth with the midwives and was very positive about her birth experience. Transition was positive other than breastfeeding, which made for a very difficult and emotional couple weeks. She actually did stop breastfeeding (now uses donated breast milk) which was itself difficult to deal with but also a relief and she describes as being a very positive decision. Quite agentic throughout (in fact, her issues with labour centered around not being able to enact the same level of agency) both in terms of what she wanted , what was done, and dealing with negative feedback/pressures from other people. Overall themes: Hard to say. Definitely the importance of self-education and effort that went into all stages of her experiences as presented in her stories really stood out for me.

Pregnancy: Describes as really easy- no morning sickness, no complications, “textbook pregnancy” (7-13, 22-24, 152). Interesting reflection that pregnancy made her nicer, which was against the stereotype (150). Does mention later being really uncomfortable during the last few weeks of pregnancy (363-370). Interesting note that she feels like you forget all about the preg after the birth (363).

Birth plans: Was very excited to get a midwife- this shifted the plans for the birth (13-21). Partner was pro-home birth (18). Felt like she made more decisions/had more control once she had a midwife, they listened and supported her wishes for the birth- contrasts it with dr. care where you follow the rules and have to fight to NOT have things done that you don’t want (32-45, 93-104). Valued the time doula spent talking about birth with them (& this was a source of info) (57, 87). Got information from her, midwives, books and online- as with many other Ps, definitely prepared and thought about the birth- birth plan and read a lot (53- 16-18, 88-93, 373-380). Birth plan- frames as tentative, trying to be open to other possibilities. Wanted to do it as natural (no drugs) as possible, wanted to do it at home or at home for as long as possible, wanted

the freedom to move around and eat. *positions lots of what she wanted as restricted in the hospital. Wanted water to break naturally- belief that body will do what it's ready for , no induction (67-84). Treated birth plan as the preference and had alternate plans built in (373-380).

Epidural: Was actually the reason why she was ok with doing a hospital transfer- she was very excited to get the drugs for pain relief! (248-258, 274-282). Describes being comfortable with epidural (279), but had some issues with being too frozen to push (290-303). Midwives told her epidural causes kind of a crash three days post birth- she questioned whether this was true but did experience it (491-496).

Labour: When she was in very early labour the midwife asked her if she wanted a “stretch and sweep”- she said yes (breaking birth plan) but tells it as not really understanding what she was asking. Led to stronger contractions (178-187). Describes early labour as being relaxed, hanging out, bouncing on ball and watching TV, “working through” contractions (187-197). When she switched to what she called active labour *note about where they draw that line! She describes as uncomfortable, went in the birthing pool, and on a long walk. Like a lot of the women describes being very out of her head during labour (209-225, 252, 265-272, 388-390, 428-436). Talks a lot about the decision to break water or not (205-228). Water breaking led to increased contractions and the use of laughing gas for relief from pain she now describes as intense (227-235). Like a lot of women who pointed to an intervention (usually epi) as causing subsequent labour problems, this P points to breaking her water as the key element (see above, also 390-395). When baby was OP and not a lot of progress was being made/she was getting tired, the midwife suggested a hospital transfer- initial reaction was a strong no, not in the plan and felt like they had done so much work to do a home birth- thought of pain relief was what changed her mind. (247-259, 282-290). When it was time to push, some interesting stuff on position- she seemed to really want to use an alternative position but didn't find them comfortable, and frames it as sort of disappointing that she pushed baby out on her back. Links her birth position to possibly why she tore (302-320). Really describes her birth experience as being quite positive (322-332, 373-381, 412-437), which is mainly consistent with how she talks about it through her narrative – had a lot of support as well. Describes that moment of holding him right away as great and emotional (332-346). She did wish that the pushing stage had been prolonged or better

prepared her to birth without tearing- again notes that she didn't feel capable of voicing any hesitation or thinking through decisions (381-390). Although she describes having a doula as optimal, she positions the doula as not always being enough of an advocate- pushing and water (383-395, 428-436, 969-980). Very positive about her hospital transfer- felt like staying at home long saved her from hospital interventions (412-421). Talks positively about partner's support during labour (235-237, 449-459, also going for walks and some "we language", see immediately after birth as well)

Breastfeeding: Initial attempt at nursing was fine (346). Some really interesting language around nursing- body changed to vessel/machine (523-529). Frames nursing efforts as emotionally detrimental- anxiety, guilt, and a sense of personal failure *actually notes that the only time she felt like she might have PPD was with nursing (536, 556-575, 595-611, 623-625, 712-719, 934). Some interesting stuff on the pushing of breast is best discourse and how it made her feel bad (558, 597-611, 921-942). *interesting note that she felt like if formula didn't exist she'd have not been able to help her baby live (563). Expectation (dashed for her) that nursing is supposed to be a bonding experience (537- 541, 929). Like other women, tried a lot of different things/put a lot of effort into trying to make it work- SNS, creams, seeing different consultants (441-446, 569-573, 577-591, 929-938). Like most women, talked about how everyone had different advice and pinned difficulties on things that she (as the mom) was doing wrong (577-591). Interesting that they went to donated breast milk- helped them deal with sense of guilt or failure upon quitting (587-611). Despite the negative feelings/guilt frames her decision to stop breastfeeding as very positive, as being the right thing for them, and as having some advantages for parenting (ie more equal distribution/sharing) (546-551, 755-772).

Transition: Followed midwife's recommendation to stay overnight since baby was born in the evening- like most women, actually found it ok in the hospital (links to the reassurance) (347-356). Interesting that she actually replayed how the birth went in the couple weeks after, to help** her deal with the emotional period she experienced after birth(396-401, 491-496, 490-)** is this because she had doubts about decisions she made, or to make her feel better about breastfeeding struggles? Had to play hostess to family after the birth, which was not planned or ideal *funny story here (463-490). Does describe having a lot of support though in the form of

her mom, a mommy group, and especially the midwives - this support really positively influenced her transition (488, 502-509, 612-623 698-733). Interesting bit about “mommy instincts” - story about phantom cries (501-511). Breastfeeding didn’t match her expectations and contributed to transition difficulties (see above). Otherwise describes motherhood as awesome- seemed to actually have some negative expectations (isolation, loneliness, boredom) which did not live out at all. Put effort into and found a lot of reward in connecting with other new parents (614-627). Actually states that things she thought would be hard aren’t (629). Frames sleeping as the biggest challenge- 2 things that pop out here, one is the perceived need for scheduling/control and the other is the effortful work that goes into achieving it (629-641, 755-759, 781). And- this is framed as one of the most rewarding things about her motherhood experiences, the achievement of sleep (737-745). The other challenge that she describes with motherhood was her initial worry about her partner not bonding with baby/jumping into fatherhood, which she frames as changing because of baby is more playful as he ages (also framed as normal for dads) *now partner is described as very involved (641- 666). Some really interesting stuff on sex, which was primarily absent from women’s narratives- seems to frame it as helping partner with that transition into parenting, and definitely saw it as solidifying their partnership despite addition of baby (666-691). Interesting also that it was framed as satisfying partner’s need, which then lessened her own emotional burden of feeling guilty/not there for him. Interesting story about baby being sick and the joy when he was better and happy- nod to IM “You kind of live to make your child happy, so that’s pretty cool (p. 745-751).

Feedback from others: As with some other Ps she didn’t fully disclose all the details of her birth plan with some of the people who she knew and received some neg. feedback, e.g. from mother in law (109-140). Interesting that she actually had a lot of support from own mother, even in labour, who she found out later was very nervous about a home birth (109). Took an educative role in trying to tell people about midwives and doulas (121). An interesting story about people treating her differently when pregnant- making a comment about her being hormonal (145-153) which she places within a larger context of people reinforcing pregnancy stereotypes. Received negative judgments from others about the donated breast milk- the safety as well as the perceived grossness of using someone else’s milk- definitely some “you’re harming your baby” stuff. Dealt with this by being firm and pushing back. (789-867).