A QUALITATIVE STUDY OF WOMEN WHO USE MIDWIVES FOR CHILDBIRTH

Presented to the Graduate Council of
Texas State University–San Marcos
in Partial Fulfillment
of the Requirements

for the Degree

Master of ARTS

by

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San Marcos, Texas
December 2007

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I would like to dedicate my thesis to my God and to my family,

without whom I could not have achieved this goal.

ACKNOWLEDGEMENTS

Many people deserve credit for this project. I would like to thank my husband, most of all, for your patience, support, and encouragement. There were many times you reminded me to persevere. Thank you for all you have done to make sure I could achieve this goal. Mom and Dad, I want to thank you for always supporting me in every aspect of life. I would also like to say a special thank you to my mother-in-law, Kay Osterkamp, who gave up a couple of weeks of her summer vacation to watch my son so that I could work on this project. To my son Caleb, thank you for the endless smiles and giggles that make any stresses in life seem less significant.

I would like to thank my thesis committee for their participation in this endeavor. In particular, I would like to express my gratitude to Dr. Patti Giuffre. You have been an amazing mentor for this project. I really appreciate all you have done to make this a success. To my thesis committee and all my professors in the sociology department at Texas State University-San Marcos, thank you for your contribution to my educational experience.

This manuscript was submitted on October 15, 2007.

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ABSTRACT

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Childbirth in America is a highly medicalized experience. Women who choose to go outside of this norm are viewed as deviant by others in society because women who use midwives reject the cultural expectation of medicalized birth. Utilizing in-depth interviews with fifteen women, this study provides an understanding of how and why some women choose to go against the norm of medicalized birth. These women rejected the idea of the necessity of intervention in childbirth. They sought out alternative views, engaged in meaning making, and formed their own perspectives on childbirth. Each woman encountered some negative reactions to their decision to use a midwife; however, the women in this study had social support that enabled them to oppose the cultural

norms. Some of the women overcame the stigma associated with deviating from the norm of medicalized birth through becoming activists in favor of midwifery, and others simply avoided people who embraced the medical approach and criticized their decision.

CHAPTER I

INTRODUCTION

The norm for childbirth in the United States is for prenatal care and birth to be a highly medicalized experience. The majority of American women have medicalized births, with many of these women electing to use pain medication. Women who choose to go outside of this norm are viewed as deviant by others in society because women who use midwives reject the cultural expectation of medicalized birth. It is important for sociologists to understand more about women who choose to use a midwife for prenatal care and delivery.

Currently, there is little research about the experiences of these women in choosing a midwife and their experiences with the birth itself. In this study I conducted qualitative interviews with women who have used a midwife for childbirth in the last two and a half years. I chose in-depth interviews, rather than quantitative data analysis, in order to gain greater insight into the experiences of these women. By conducting this research, I will contribute to the body of knowledge about women who choose to go outside of the typical norms surrounding childbirth. This study provides an understanding of how and why some women choose to reject the norm of medicalized birth. In addition, my desire is to empower women to make informed choices that suit their own desires rather than simply conforming to the norm. For the women in my

study, midwifery was the right choice for them. Through this research I am able to give them a platform to express their views and opinions surrounding their decision.

My research questions were the following: What is the experience of women who choose to go outside the medical model of childbirth? Why do women choose to have a midwife? What was the experience of the women during prenatal care and childbirth with a midwife? How did others (family/friends) respond to their decision to use a midwife? Using a symbolic interactionist approach, I analyze the data and present my conclusions.

CHAPTER II

LITERATURE REVIEW

Conrad defines medicalization as "the process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (1992:209). It is a "sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession" (Conrad 1992:211). Events in women's normal cycles of life, such as childbirth, lend themselves to medical intervention, according to researchers. Even though pregnancy and childbirth are normal, healthy stages in a woman's life, they are treated as illnesses or conditions.

Conrad explains that there are three levels at which medicalization occurs. On one level, which he terms the conceptual level, medical terminology is used to define the issue, but no intervention is imposed. At the institutional level, "organizations may adopt a medical approach to treating a particular problem in which the organization specializes" (Conrad 1992:211). The most involved is the interactional level, in which "a physician defines a problem as medical (i.e. gives a medical diagnosis)" and prescribes treatment according to the diagnosis (Conrad 1992:211). In Western and developed countries, particularly in the United States, pregnancy is considered a medical condition, and it is

expected that women seek treatment throughout the pregnancy. In fact, women are considered bad mothers if they neglect supervision by doctors (Smith 2004).

Most American women are socialized to believe medical intervention in childbirth is appropriate, and even necessary. As a consequence, many women are unaware of the possibility for a safe and natural childbirth experience. McCracken (2000) asserts that American culture persuades women to participate in the medical framework for childbirth. Women who do not adhere to the norm of hospital birth are viewed as deviant by the rest of society. In spite of the evidence of safe outcomes, women who choose to give birth outside of the hospital "are greeted with alarm" (Smith 2004:7). However, Conrad (1992) notes that in recent years the consumer movement and feminist politics have begun to curb the notion that medical involvement in childbirth is always necessary.

Conrad (1992) suggests that medicalization has been greatly affected by secularization. Although he points out that trust in science and medicine has in many ways replaced trust in God, he acknowledges that the relationship between religious faith and medicine is a complex, multidimensional issue. In addition, the status of medicine in American culture has evolved. Conrad states, "Professional dominance and monopolization have certainly had a significant role in giving medicine the jurisdiction over virtually anything to which the label 'health' or 'illness' could be attached" (1992:214). Midwives are considered by many in the medical community to be inferior to doctors. There is an implication "that the woman is somehow catering to her own selfish wishes for a quality experience and subjecting her child (and herself) to unacceptable risks" (Smith 2004:7). In addition, Smith asserts that doctors assumed the responsibility for childbirth because of its relative safety. She explains, "In contrast to

other conditions and diseases of the time, childbirth outcomes were generally good, leading to increased respect for the emerging medical profession" (Smith 2004:6).

Conrad also explores the idea of medicalization as a form of social control, or a method society uses to regulate behavior (Johnson 2000). He notes that Durkheim indicated that restitutive controls are characteristic of complex societies. In addition, Conrad points out that Parsons pioneered the idea of social control through medicine. Parsons "depicted illness as deviance and medicine and the 'sick role' as the appropriate mechanism of social control" (Conrad 1992:215). Other sociologists, such as Zola (1972), believe that medicine is a major source of social control, and it is quickly replacing the role of religion and the state. Unlike the apparent nature of political power, the power of doctors is an "often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by making medicine and the labels 'healthy' and 'ill' *relevant* to an ever increasing part of human existence" (Zola 1972:487).

Perhaps the greatest strength of medicalization is the power of doctors to define people in terms of conditions. Conrad and Schneider state, "The greatest social control power comes from having the authority to define certain behavior, personas and things" (1980:8). Conrad (1992) asserts that while social control may or may not be initiated by the medical profession, it is quickly followed by medicalization. Even though evidence suggests that "outcomes are best for women giving birth with midwives rather than physicians, and whose births take place outside of the hospital, in a freestanding birth center or at home," doctors successfully reify the necessity for hospital birth (Smith 2004:6).

Zola contends, “If anything can be shown in some way to affect the workings of the body and to a lesser extent the mind, then it can be labeled an ‘illness’ itself or jurisdictionally ‘a medial problem’” (1972:495). Although pregnancy and childbirth were once considered a normal healthy part of life, they are now considered a medical problem. It has only been in the last century that doctors have been involved with pregnancy and childbirth. Childbirth was formerly in the sole domain of women and only attended by midwives and/or female relatives and friends, but the medical profession assumed the role in the early twentieth century (Wertz and Wertz 1977; Ettinger 2006).

Women were receptive to the medicalization of childbirth for various reasons. Many women died in childbirth from complications and/or infections. Medical involvement seemingly provided protection from such feared outcomes (Ettinger 2006). In addition, the fashion of the day for middle and upper class women included corsets, which deformed the female body and caused more pain for childbirth. These women sought after medication to ease and/or eliminate pain in childbirth (Wertz and Wertz 1977).

Wealthier women of the time chose to give birth in hospitals, where there was access to drugs and the appearance of safety (Declercq et al. 2001). Today, the medical model is the dominant approach to childbirth, but the trend seems to be that some wealthier, more educated women are seeking “natural” options for childbirth, including choosing doulas and/or midwives over doctors and birth centers over hospitals (Nelson 1983). However, while women in the middle and upper class have knowledge of and

access to alternatives to the medical model of childbirth, women in the lower classes do not have the same opportunities.

Lazarus (1994) found notable differences between middle class and poor women regarding the primary concerns during maternity care. She explains, "Many poor women have no health insurance, leading to fewer choices for perinatal care. Thus many resort to clinics for low-income patients where they often have difficulty communicating with doctors" (Lazarus 1994:26). The poor women in the study were less concerned about control and more concerned about receiving adequate and continuous care. Interestingly, the middle class women expressed a wide range of desires including a great deal of technological involvement, as well as "natural" childbirth with very limited technology.

Many women today accept the medical model of pregnancy and childbirth, and the medical profession has provided a new range of specialties to meet the demand (Zola 1972). As doctors laid claim to the domain of childbirth, they also asserted authority over "prenatal, postnatal, and pediatric care; not only to conception but to infertility; not only to the process of reproduction but to the process and problems of sexual activity itself; not only when life begins (in the issue of abortion) but whether it should be allowed to begin at all (e.g. in genetic counseling)" (Zola 1972:496).

Researchers have documented that physicians asserted control over childbirth through providing pain relief, touting official training, and discrediting midwives (Wertz and Wertz 1977; Ettinger 2006). However, not all physicians supported the concept of birth shifting from home to the hospital. In fact, Ettinger (2006) explains that many obstetricians in the early twentieth century believed that hospitals posed additional risks to birthing women, and they accused others in their profession of overuse of medical

procedures in childbirth. Despite those who spoke out against the medicalization of birth, many factors contributed to increased medicalization of childbirth (Wertz and Wertz 1977; Declercq et al. 2001; Ettinger 2006).

Conrad notes that "gender is an important factor in understanding medicalization" (1992:222). Women have been historically regarded as inferior, and medicalization reinforces this concept (Davis-Floyd 1987; Davis-Floyd 1992). The message provided by the medicalization of childbirth is that women are not capable to deliver babies without the assistance of science and men, due to the dominance of men in the profession. In some ways, women's health can be seen as more susceptible to medicalization for a number of reasons. Childbirth is an aspect of women's health that requires a woman to seek help, whether from a midwife or a doctor. Another reason women are more susceptible to medicalization may be the socialization of women. Girls are taught that it is okay to cry, to be hurt, and to get help, while boys are taught to be tough. Socialization plays a major role in the willingness of women to participate in medicalization.

Although childbirth is still medicalized in the United States, "in the last 15 years, the childbirth, feminist, and consumer movements have challenged medicine's monopoly of birthing" (Conrad 1992:225). Many hospitals now have "natural" birthing options such as birthing suites, nurse-midwives, and allowing the family to be more involved. All of the concessions are tempered by continued control of the childbirth process (Devries et al. 2001). The medical profession established regulations to govern the midwife field. In fact, the idea of a nurse-midwife is a method to maintain medical control of childbirth. A nurse-midwife is a person who is certified as a nurse and also has

training specific to childbirth. In this way, the medical profession can maintain control of midwifery, through the regulation of nursing certification (Ettinger 2006).

Some women have strong convictions about natural childbirth. Many of these women have experienced medicalized childbirth, as well as natural childbirth. McCracken (2000) believes that once women have experienced childbirth without slowed labor from monitoring, increased pain from Pitocin, and lack of control from epidural, women will realize that they were a product of socialization. McCracken writes about her own personal experience and explains that her previous birth experiences in the hospital "[were not] female birth – it was electrode birth, clinical birth, irrational birth, cruel birth" (McCracken 2000). According to some feminists, the medicalization of childbirth strips women of dignity and independence. For McCracken, breaking free from medicalization is an empowering experience. She believes that her experience with natural childbirth helped her to overcome feelings of inadequacy she felt during medically assisted childbirth. McCracken believes that the idea of the necessity and superiority of medicalized childbirth is a deception, and that women who experience natural childbirth will have a passionate belief in the beauty of natural childbirth.

One of the primary criticisms of the medicalization of childbirth is the message it sends to women about their bodies. Smith (2004) explains that the American society cultivates fear and shame about the feminine body. The message is that women's bodies are flawed and are in need of assistance from doctors to reproduce, according to critics of medicalization. Although there are now many women doctors, the field of medicine has been a male-dominated field since its inception. Women are made to feel that they have inferior bodies by the implication that their bodies are inadequate for childbirth (Davis-

Floyd 1987; Davis-Floyd 1992; Smith 2004). Smith finds it quite troubling that society accepts the idea that the mother and child are "at odds with each other, as if the wellbeing of one [was] in conflict with the wellbeing of the other" (Smith 2004:7). Her desire is that women be empowered to make the right decision for themselves and their babies.

Davis-Floyd (1987) passionately describes the medical approach as a negative message to women. She explains that labor is made to conform to the technological model, and the underlying theme is that the female body is defective. When the labor does not conform to the standard, it provides justification for further intervention.

Although a great deal of literature provides the basis for a critical approach to the medicalization of childbirth, some literature provides a slightly different perspective. Fox and Worts (1999) explain that social support greatly affects the extent to which women choose medical intervention. For some women without adequate support, the choice to use medical intervention is a positive decision. These women used technology to help them through the childbirth process, in the absence of strong social support. Women in the study who had a strong social network found relief from pain and their concerns during labor from their network and did not feel the same need for medical involvement.

Sacks and Donnenfeld (1984) studied the differences among couples using a hospital, birth center, or home birth and found that all three groups of couples valued control as the highest priority in choosing the birth environment. Knapp (1996) also found that women have a desire for control during childbirth. She studied women who gave birth in a hospital and found a significant correlation between the perception of control and satisfaction with the childbirth process.

Critics of medicalization tend to emphasize that women experience lack of control in a hospital setting. It seems that regardless of the birth environment chosen, many women desire control in their birth process. Contrary to the criticisms of medicalization, some women find the control they are looking for within medicalization. Sargent and Stark (1989) found that some women interpreted control as the absence of pain. Such women would likely prefer the medical model of childbirth so that they have access to drugs that control pain.

There are a number of studies about midwifery. Simmons (2002) explains that midwifery provides a complete alternative to the medical model. She emphasizes the difference in the concept of time and the response of midwifery versus the medical approach. It is her opinion that midwifery returns power to the woman. Davis-Floyd (1987) also views the medical model as limiting the power of women; however, she explains that not everyone buys into the medical ideology. Her study found that twelve percent of women had homebirths and twenty-five percent had "natural" births in hospitals while actively controlling the amount of intervention.

Some women choose midwifery in reaction to bad experiences with the medical approach. Davis-Floyd (1992) found that some women experienced a great deal of medical involvement in previous births, which prompted them to seek less medical involvement in the hospital or homebirth for subsequent births. Viisainen (2001) conducted a study of women in Finland who had homebirths. She found that many of the women were looking for a natural experience, and they felt like they were not listened to adequately with traditional health providers. They also wanted more control over the birth process.

Other researchers have found that women are looking for more time with their provider to talk over concerns and to build rapport with them (Sullivan and Beeman 1982; Gabe and Calnan 1989). Sullivan and Beeman (1982) found a strong association between time spent in discussion with providers and the level of satisfaction with the provider. Communication was crucial, and control was important as well. When patient's preferences were not honored, satisfaction declined significantly.

My study will provide a greater depth of knowledge of the individual experiences of women who choose to use midwives. Although we have understanding of the medicalization of childbirth, less is understood about the reasons why some women choose to go against the common method of birth in the United States. My study will also provide understanding of the social repercussions of choosing an alternative method of birth.

CHAPTER III

METHODOLOGY

For this research I conducted a qualitative study involving in-depth interviews. Interviews were the best way for me to gain information about personal experiences of women who chose midwifery. Esterberg (2002) explains that in-depth interviews provide a way for the respondent to convey their own feelings, experiences, and ideas without forcing them into the researcher's preconceived categories. In this way, the respondents were able to shape the discussion of their experiences. Esterberg also states that in-depth interviews are beneficial when the researcher wants to explore a particular topic in detail. My desire in this study was to give voice to experiences of these women. I interviewed fifteen women who have used a midwife for prenatal care and delivery in the last two and a half years. People tend to subconsciously reconstruct their memories over time to fit present feelings and situations; therefore, I limited the time between childbirth and delivery to two and a half years (Thelen 1989).

Finding a sample of women who have used a midwife in the last two and a half years is difficult, so I have chosen snowball sampling. With snowball sampling, the first person interviewed provides referrals of other possible interviewees. I have a friend who used a midwife within the last two years, and she agreed to do the interview, as well as

provide referrals of other women who fit the research parameters. In addition, I contacted a midwife in the area who assisted me in finding interested parties, and I also posted information about my study on an internet message board. Each woman interviewed was given informational letters to pass on to other interested parties.

For the purpose of anonymity, I have used pseudonyms for all of my interview participants. All of the women I interviewed were white, a limitation of this study. The age range of the women was between 25 and 39. Five of my interview participants had only one child, five had other children, but this was the first child using a midwife, and five had used a midwife for more than one of their children. Each woman in the study indicated some degree of higher education, ranging from some college to graduate level degree(s).

The interviews were conducted at their home, a local restaurant, or coffee shop, and the interviews lasted approximately forty-five minutes. The interviews were audiotape recorded and later transcribed. I constructed an interview guide (see Appendix A) that reflected my research questions. I focused my inquiries on the women's experiences with choosing a midwife and their experiences during prenatal care and childbirth. In addition, I inquired about their experiences with others regarding their decision to use a midwife. The questions were open-ended to allow the participants to direct the conversation.

After conducting my interviews and completing my transcripts, I identified themes through coding techniques described by Esterberg (2002). Themes were noted with open coding, and I consolidated and organized the themes using focused coding. All

of the transcripts were read repetitively and thoroughly to ensure that important themes were captured.

CHAPTER IV

FINDINGS

All of the women in my study were unique in their experiences; however, three themes consistently emerged. Many of the women were looking for a particular birth experience. In addition, the decision to use a midwife had multiple dimensions, and finally, the women experienced various reactions to their decision to use a midwife. I will argue that although each woman was unique, many of them shared similar thoughts and desires regarding birth. The women resisted the dominant medical logic regarding birth in favor of their own view of birth.

Birth Experience

A common theme indicated by the women in my study was a desire for a particular birth experience. For many of the women, this desire stemmed from a previous experience with hospital birth. These women expressed dissatisfaction with the doctor and/or hospital they used for a previous birth. One of the first time mothers indicated that she was uncomfortable with hospitals, which was one of the reasons she sought out a midwife. Several other woman indicated disagreement with the typical medical approach to childbirth.

As Sacks and Donnenfeld (1984) found, control is one aspect of the childbirth experience that many of the women in this study valued. Most of the women indicated

that using a midwife afforded them more control over their childbirth experience. Some of the women who had previous birth experiences in hospitals compared the two experiences, highlighting the disempowerment they felt in the hospital setting. Kelly stated, "I felt vulnerable…I ended up having a episiotomy, which really, really, really pissses me off." Fiona felt like her labor was put on her doctor's time schedule. She said, "He didn't feel like I was progressing fast enough, so he put me on Pitocin, which I really didn't want to do, and I explained to him I didn't want to do it, I didn't want to do it, but he finally convincingly got me to have Pitocin."

The women emphasized that with the midwife, their wishes were honored, and they were in charge. Joanna explained, "[The midwives] were just in the background, kind of against the wall, there to help if they needed, but not really pushy, you know. They let me labor, how I wanted to labor." Brenda stated, "I felt like I was in control of the process, and that is not what they let you have in a hospital," and Ellen said, "I think there's more, um, avenues, they don't just, they don't have the fear of malpractice, they're not trying to hurry." The midwives affirmed the women's belief that they knew what was best for their own birth experience.

Some of the women believed that the element of control was tied to respect. They voiced a desire to be respected throughout the process. One woman, Amy, stated it in this way. "[The midwife] kind of let me run our appointment. She made us [her and her husband] feel really comfortable." Another woman, Brenda, said "[Nurses/doctors are] taught to, kind of, take over…but with a midwife you really get to be in control…[the midwife] feels that the birth process is really mine and my body's and the baby's and my

partner's." The respect shown for the women by the midwives confirmed their shared belief that the birth process belonged to the mother.

While most of the women expressed a desire for control in their childbirth experience, a few of them mentioned feeling as if they had too much control with their midwife. Donna said, "Sometimes it's hard for me to articulate exactly what I want." Reflecting on her birth experience she said, "What [the midwife] probably did, was just, took for granted that I knew everything I wanted, and I knew how I wanted to go." Donna explained that she would have preferred her midwife to be more hands on. Isabel was also uncomfortable with the level of control given to her at her birth. She said, "A midwife comes much more down to your level and kinda put you in control, as the patient, um, as far as how you want to do things, and sometimes that's kind of unsettling to me." There was a limit to the amount of autonomy the women desired in their birth process.

The women in my study consistently highlighted the importance of having a relationship with their provider. Some of the indicators of having a good relationship were the amount of time available to spend with the provider and having their questions adequately answered by the provider. Cathy said, "There was no one who had appointments anywhere near us, and we would just sit and talk with her for so long, I feel like, I feel like she's my friend, you know, I feel like we could talk to her about anything. Um, she would certainly never be in a hurry." Amy stated, "I felt like she had all the time in the world with me," and Brenda stated, "She had so much information that I felt comfortable asking her anything, and taking my time and not feeling rushed." The midwives made the women feel valued through the amount of time spent with them.

Just as the amount of time the midwife made available to the women contributed to having a relationship, personal attention was key as well. Isabel stressed the importance of the midwife "tuning in" to her and her needs, "not just going down a checklist that needed to be checked." Monica explained the difference between her experience with a doctor and with her midwife. She said, "You always feel rushed, and you felt like a number, and oh I'm just another woman having a baby, here it was, it's all about me." Nicole found the personal touch to be very important. She put it this way, "[The midwife] was also, just, very concerned personally also, always very kind…comforting." Personal involvement with their midwife made the women feel more secure.

Most of the women stressed the importance of having a good relationship, but that meant different things to the women. Many of them mentioned having a friendship with their midwife. Ellen explained that she felt like her midwife became like a friend to her. Monica said that she felt like she "had a friend, that's gonna be with [her] through it." Hannah wanted more of a friendship relationship, but felt as though the midwife's personality did not mesh with her own. She said, "If I was looking for a midwife and I know then what I know now, I probably would have looked for somebody I could relate to more on a personal level…because I think I would have enjoyed the experience more." This is consistent with findings in other studies of doctor-patient relationship (Sullivan and Beeman 1982; Gabe and Calnan 1989). These studies demonstrate that patients prefer to create rapport with their health care providers through conversation.

While several women had, or wanted, a friendship relationship with their midwife, Kelly did not want a friendship relationship. She wanted a positive relationship

with the midwife so that the midwife would know and respect who she was and what she wanted, but Kelly specifically stated, “I didn’t necessarily need to have, you know, a girlfriend, you know, from them, because, I, I’ve got girlfriends.” Even though they wanted ample time and attention, not all of the women wanted a friend.

One of the main concerns of some of the women was that their husbands be welcomed in the birth process, and they believed using a midwife provided the best environment for him to be included. Amy explained that her husband was welcomed at all of the prenatal visits, and that he was included as much as she was throughout the process. Brenda explained that she and her husband worked together during the labor process and that the midwives gave them privacy. In addition to wanting her husband actively involved in her birth, Ellen wanted her daughter to be welcomed. She explained that this was one of the primary reasons she had influencing her decision to choose a midwife. She said, “I had a four year old daughter, who I wanted to come, to be a part of it, and you can’t have a sibling in the hospital room.” Using a midwife allowed the women greater freedom in choosing their support system.

For a few of the women, their experience with midwifery care at the birth of their child was not what they were anticipating. Two of the women mentioned that their midwife was not there for the majority of their labor. Both women explained that the midwife arrived moments before the actual birth of their child. This bothered Isabel, who said, “I’m uncomfortable with the fact with this last birth, that she came so late.” However, Nicole felt like there was nothing the midwife could have done differently. She said, “She couldn’t have been there sooner. It was, I called her as soon as my water broke, I was just, it was all very fast….she left as soon as I told her.” Despite the

problem of arriving late, both women were still satisfied with their decision to use a midwife.

Ellen found that her midwife was not as nurturing as she had hoped. She went to a birth center with multiple midwives. She said, "I didn't particularly care for the one I got, you know, it's like, you know, um, a luck of the draw." Ellen explained that in the future, she would like a home birth with a single midwife, versus the birth center with many midwives on call at different times.

A few of the women mentioned that they really enjoyed having more than one midwife attend their birth because of the way the different personalities played off of each other. Monica said, "Their personalities completely complement each other." She explained that one of the midwives was younger and more medically inclined, while the other midwife was "more like the old fashion kind of hippie." Monica said that this dynamic "actually made for the most incredible combination of complementary service…there was nothing that was lacking." In fact, Lilly chose her midwife specifically because she worked with a partner. She said, "I think two heads think better than one, so, in a critical situation, you know, I felt comfortable having two midwives." The women found it reassuring that their care was covered by more than one person.

Many aspects of the birth experience these women desired, such as rapport and control, stemmed from the women's interpretation of birth. Even though these women were exposed to the predominant ideology about birth, they chose to reject medicalized notions of childbirth and substitute their own meaning regarding the birth experience. Midwives did not compete with this ideology, but rather affirmed it.

Decision to Use a Midwife

Some of the women viewed the decision to use a midwife as their decision, while others saw it as a decision between themselves and their husbands. Fiona said, "It was something that we both, um, wanted to do." Gabby explained that it was her idea, but after discussing it, her husband agreed. Interestingly, Amy's husband was the one who suggested the idea, but she noted that it was a decision they made together. Isabel stated that it was a decision between her and her husband, and that he "just thought it would be the coolest to have, a, a, home birth." Making the decision together seemed to be very important to some of the women.

Nicole told me that it was a decision between her and her husband, but it sounded as though it was her decision. She explained that if he had been opposed to the idea, she would have taken his feelings into consideration. She said, "He was ambivalent, but he wasn't opposed, and he knew that was something I really wanted to do, and so we, so we went ahead, but if, if it was something that he had really strong feelings against, I would, I would've at least seen the OB/GYN more, and considered a hospital birth." She was fairly set in her decision, but she wanted to show respect for her husband's concerns.

Other women identified the decision as their own. Olivia felt that the decision was hers, but she appreciated the support of her spouse. Monica explained that although it was her decision, she "would not discount [her] husband's feeling or thought in it." She said, "If he'd said no, we would have discussed it further." Lilly initially gave in to her husband's concerns and went to an obstetrician, but the obstetrician dropped her as a patient without warning. At that point, Lilly went with her original choice to use a midwife. Kelly went with her desires from the beginning, but spent the majority of her

pregnancy trying to convince her husband to support her decision. She said, "I don't know, how, much he actually bought into it, but he bought into eventually just, you know, shutting up and supporting me." Regardless of who made the decision, all of the women desired to be supported in their decision.

Finances played a role in the decision making process for several of the women. However, each of the women indicated that finances were not the deciding factor. Olivia said, "I would have used a midwife even if I had insurance with the chance to use the hospital…um, I don't know what I would've done if I'd thought that a midwife wasn't right for me and I still didn't have insurance…I guess I just got lucky that way." Monica explained that finances were a motivation in exploring the option; however, "in the back of my mind, it always was a first choice to be a home birth." Even though finances played a role in the decision process, the women expressed a desire for a midwife birth apart from the financial incentives to do so.

Even though finances were a factor, some women chose to use a midwife in spite of insurance coverage available using obstetricians. Kelly said, "Initially when I was first looking insurance was a factor, you know, who my insurance covered, but I ended up choosing someone who was not on my insurance, just because they, things were more in line with what, with what I wanted." Her desire for a midwife birth persisted even though insurance would have covered a birth in the hospital.

Many of the women in my study valued the experience of the midwife in making their decision, although the women valued different types of experience. Amy explained that her midwife shared personal experiences with her own children, and that she found that to be very useful. Brenda valued the personal experience of her midwife, as well.

She stated, “These women were not just versed on birth because they had been educated on it through the midwifery program. They had experienced it multiple times, you know, themselves.” Cathy said, “[The midwife] had 4 children and the assistant had 6 children, so between the two of them, they had so much experience, plus being around birth all the time.”

Several of the women valued professional experience. Isabel said, “[Her midwife] has done midwifery for, I mean, it’s got to be like forty or fifty years. She’s been around forever.” She went on to explain that the midwife’s professional experience was one of the primary factors in the decision to choose her. Joanna explained that her midwife’s experience was a big factor. She told me that her midwife has “delivered over a thousand babies,” and that “[the midwife is] very safe, and very experienced.”

The majority of the women in my study used recommendations of others in deciding which midwife to use. Several mentioned talking with friends to find recommendations for a midwife. Nicole explained that most of her decision was based on the recommendation of a friend. She said, “My friend liked her and I thought that’s good enough for me.” The recommendation that Olivia relied upon came from her gynecologist. Since her midwife had a good reputation in the medical community, Olivia felt a great deal of confidence in choosing her.

Another aspect of the decision process was active research of their options. Cathy interviewed several midwives before making her decision. Brenda expressed, “If I’m going to do something, I’m going to research every aspect of it.” One of the things that Amy liked about her midwife was that she gave them information and also encouraged her and her husband to do further research. Olivia said, “I researched the

heck out of it before I even got pregnant, so that I would, I would kind of know what I was getting into." Isabel researched midwives to learn "how much knowledge and experience, and training these midwives actually do have," but she also felt as if she could have been better informed about various aspects of pregnancy. She said, "If I could change anything, I would change my willingness to be, to be more educated about, um, pregnancy, childbirth, um, procedures, tests, the things that I have a choice in using a midwife." Isabel felt that more research would give her more confidence in making pregnancy and childbirth related decisions.

Confidence in their bodies was expressed by many of the women. Brenda expressed, "[Childbirth] is a natural process, and I don't think that intervention is necessary." Cathy stated, "Childbirth is super, super natural, you know, I mean, it's like what our bodies were made for." Amy explained, "My mom had raised me to believe that I could deliver without any drugs or assistance, and so that was in the back of my mind, that I could do this." However, a few of the women indicated their confidence came from past experiences of easy pregnancies without complications. Nicole said, "I have really textbook labor, they're, they're really, I mean not painless, but they're, they're aren't, haven't been any complications." The confidence expressed by the women indicated that they rejected common notions that women need assistance to birth children.

Even some of the women who indicated confidence in their birthing ability and their decision to use a midwife, also indicated that they experienced some hesitancy in the beginning. Cathy saw two midwifes for a short period of time, due to nervousness over her decision. Olivia said, "I was hesitant at first, too, because I was, I had the same

attitude as most people in our culture, which is, um, wow, that sounds really scary." The evolution of thought was not an easy transition.

Some of the women struggled between societal pressure and/or socialization and their own desires and ideas. Mead described it as the tension between the "I" and the "me;" the "I" represents individual desires and the "me" represents constraining factors from society. He explained that individuals balance competing ideas to make choices based on understood social expectations (Described by Ritzer 2004). The women in my study wrestled with competing ideas of childbirth, but ultimately they chose their own concept of birth, rather than yielding to their understanding of societal expectations.

Most of the women indicated a belief that most of society is against natural childbirth. Amy said, "I found that our society, in general, does not think we can deliver naturally," and Brenda stated, "We're indoctrinated to think that we can't possibly do it, that we have to have this medical setting and these medical people." Olivia felt like people were very condescending toward her choice. She said, "I knew it was the right decision for me, but I felt a lot of social pressure, um, I, I felt like people were saying, you know, that's irresponsible, that's really dangerous, I could never take that risk with my own baby, stuff like that." Cathy explains, "To choose to have a birth with a midwife, you really have to reject all of that."

Each woman in this study chose to reject what they perceived to be the dominant logic regarding childbirth and created their own meaning about the experience. The women explained the resistance of society to natural childbirth as a product of fear and/or ignorance. According to Merton, deviant behavior is a result of people choosing to reject the concept of success or accepting the concept of success but lacking the means to

achieve it (Described by Ritzer 2004). Similar to Merton's concept of deviance, these women have rejected the norm of medicalized childbirth and substituted their own meaning regarding childbirth.

Reactions to Decision

Friends and relatives of the women had mixed reactions to their decision to use a midwife for childbirth. Several women had very supportive family members, while other women had very unsupportive family members. Overall, the women experienced a variety of reactions, but in spite of any criticism or concern, each woman expressed confidence in her decision.

Nearly all of the women had supportive spouses, and most of the respondents had supportive mothers, even if they were concerned. Most of the unsupportive reactions came from male family members. One possibility for this is the socialization of men to view women's bodies as inferior and in need of assistance. Some of the reasons the women were not affected by negative reactions were that they had created meaning about the birth process, they had already decided to reject the norms related to childbirth, and the women had other social support.

While most of the spouses were supportive, a few of them were very excited about the idea of using a midwife. Amy explained that using a midwife was her husband's idea. She said, "He really pushed for it…he thought it would be better for us, and he was definitely right." Hannah said, "I was really surprised, my husband was really gung-ho about it." These spouses did not buy into the dominant logic regarding birth and encouraged their spouses in making a different choice.

Some women had very strong negative reactions from family members. Kelly's father did not approve of her decision. She said, "After dinner one day, he brought up the topic, and, really let me know that he was not happy with it, because he was asking questions in a very belligerent manner [laughing], and then he'd get really quiet after the questions, you know, kind of in a sulking sort of way." Brenda's brother would not even acknowledge her decision. She expressed, "The strongest reaction I got was my brother's non-reaction, like, just not acknowledging it at all." His reaction did not change her decision in any way, but she stated, "It put a little wedge in our relationship, because I was really disappointed in that reaction." Donna's father and brother disapproved of her decision. She felt that her father was concerned, but that her brother was judgmental, rather than concerned. She attributed her father's concern to fear, rooted in ignorance. She did not falter in her decision, however, but she explained, "I wished that, in retrospect, I had more communication and more dialog, and not been insecure in my confrontation with him." Donna thought that she should have been more assertive in sharing her point of view.

Even though the women said they did not allow the negative reactions to affect how they felt, some of them avoided telling certain people about their decision. Amy, Kelly, and Olivia each stated that they purposively did not tell certain family members about their decision in order to avoid the conflict. Olivia chose to not engage in conversation about her decision to protect herself from negativity. She said, "I specifically did not engage people in, like you know, a discussion about whether or not it [was] statistically safe, or, try to convince them in any way, you know, I just tried to

ignore them." The women made efforts to surround themselves with support for their decision and avoid confrontation.

The women engaged in stigma management behaviors similar to those documented with other marginalized groups (Roschelle and Kaufman 2004). Some of the women managed the stigma of using midwifery by passionately explaining the safety and superiority of homebirth. They would like to see the midwifery approach replace the dominant logic regarding birth. Other women simply explained the decision as the right one for them. One method they used to manage the stigma surrounding midwifery was to surround themselves with people who were like-minded in order to avoid feelings of doubt or insecurity about going against the norm of medicalized birth. These methods of stigma management are important to understanding women's health. It is possible that these methods are common in other areas of women's health that are also medicalized.

Some of the women did not experience any negative reactions. Isabel said, "Nobody really gave me a hard time about it…the only negative, um, things that people had to say were, oh, I could never do that." Ellen explained, "My neighbor across the street, good friend of ours, she was not negative, she was just a little cautious," which she believes stems from the neighbor's career as a pediatric nurse. A couple of the women explained that the positive reactions are partly due to the fact that they had like-minded friends. Nicole said, "Everyone was accepting, and I, but I expected that, I would've been very surprised if anyone I'd known had a really a negative reaction." The preexisting social network of these women was supportive of the midwifery approach to childbirth.

Although most women experienced some negative reactions, each of the women had a network of support through friends, family, and/or midwifery literature. Any negative reactions did not change the way the women felt about their decision. Their interpretation of midwifery was based on their own research and interaction with others who viewed midwifery in a positive light. Each woman chose to reject ideas of childbirth that did not coincide with their interpretation. The meaning the women associated with childbirth and midwifery was constructed and validated within a subculture of acceptance.

CHAPTER V

CONCLUSION

Medicalization provides many benefits to individuals and groups. Medicalization allows some people to be accepted in society, even when their behavior would ordinarily cause them to be stigmatized. War veterans pushed for the diagnosis of post-traumatic stress disorder to medicalize the problems they were having after experiencing war (Conrad 1992). Once it was medicalized the veterans' experiences and symptoms were validated, and they could received treatment.

The norm for childbirth in American society is for birth to be highly medicalized. However, many sociologists are critical of the power that medicalization gives to doctors, hospitals, and other medical authorities. Scholars such as Conrad and Schneider (1980) maintain that although medicalization may have some positive effects, when something is medicalized it becomes the sole domain of "experts." Interviews with women who have used midwives allow us to understand how and why individuals resist medicalization.

There is a growing number of women who choose to deviate from the norm of medicalized birth and seek natural childbirth options. The women in my study were seeking a specific birth experience, which included a natural approach, an element of control, and a good relationship with their provider. The decision to use a midwife was multidimensional. Some of the women considered the decision their own, while others

felt it was a decision between them and their spouses. For some, finances were a part of the decision making process, but most women made their decision apart from financial concerns. Most of the women valued the experience of the midwife, as well as recommendations from other women, in making their decision. These women rejected the idea of the necessity of intervention in childbirth. They sought out alternative views, engaged in meaning making, and formed their own perspectives on childbirth. Each woman encountered some negative reactions to their decision to use a midwife, as discussed by Smith (2004). However, as the study by Fox and Worts (1999) found, the women in this study had social support through their husbands, most of their mothers and friends, which enabled them to resist the cultural norms. Some of the women resisted the stigma associated with deviating from the norm of medicalized birth through becoming activists in favor of midwifery, and others simply avoided people that embraced the medical approach and criticized their decision.

This study provides insight into the experiences of women who use midwives for childbirth. While quantitative data can provide generalizable conclusions, the true experiences of women who choose midwives would be left unknown. Because this study is qualitative, I was able to uncover real experiences of women who use midwives. The information found in these interviews gives the sociological community greater depth of insight into understanding the reasons some women choose midwives, factors affecting their decision, and the meaning making process surrounding the use of midwives. No other study has shown the experience women have in resisting the dominant logic regarding childbirth.

This research provides a platform to explore other areas of women's health that are medicalized and movements to demedicalize them. Examples include medicinal treatment for PMS and menopause and prophylactic mastectomy for breast cancer risk. Just as women sought out medicalization for birth and now some are seeking to reverse it, other aspects of women's health have experienced similar patterns. Women with other health concerns may have similarities with these women in their experience with society regarding their decision. This study gives researchers a place to start for future study.

Because this research was conducted with a small sample of women, all of whom were white and educated beyond high school, the findings cannot be used to generalize to the entire population of women who use midwives. Women who use midwives that live in other areas of the United States may have different experiences in choosing midwifery. In addition, women of color may have other factors influencing their decision. In the future, it would be valuable to conduct further research about women who use midwives and include women of color, women in different areas of the country, as well as women with different levels of education.

APPENDIX A: INTERVIEW GUIDE

I. Experiences with choosing a midwife
   a. How did you come to the decision to use a midwife? If you have other children, did you use a midwife for their births as well?
   b. How did you choose the midwife that you used?
   c. Did you have any hesitancy with your decision prior to the birth of your child?

II. Experiences during prenatal care and childbirth with a midwife
   a. Describe your experience of prenatal care with your midwife. Did you meet with her/him regularly? Did you feel prepared for childbirth?
   b. Describe your experience of childbirth with your midwife. Was the care your received what you expected?

III. Experiences with others regarding your decision to use a midwife
   a. Describe any experiences you had with others regarding your decision to use a midwife. How did your spouse/partner and/or family react to your decision? Was it a family decision or yours?
   b. How did others' reactions make you feel about your decision?

IV. Concluding questions(s)
   a. If you could change your decision to use a midwife, what, if anything, would you change?
   b. What advice would you give to someone contemplating the use of a midwife for childbirth?

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