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Keeping it Together, Falling Apart and Everything in Between: A Phenomenology of Women's Experience of Childbirth

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An abstract of

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Abstract

Keeping it Together, Falling Apart and Everything in Between: A Phenomenology of Women's Experience of Childbirth

By Priscilla Joy Hall

The childbirth experience is a meaningful life event that affects a woman's sense of herself as a human being and a mother. The positive or negative quality of birth has a profound effect on women's emotions following labor, with both short- and long-term effects on women's wellbeing and relationship to the newborn. There is little research on childbirth as a holistic, complex experience of mind-body in relationship to the environment, time and space. The purpose of this study was to examine childbirth in this complexity, with all of the nuances of emotion, thought, and sensation that create the experience using descriptive phenomenology, a method to study human experience. Eight essentially healthy women of different ethnicities and socioeconomic status with spontaneous term vaginal births were interviewed 3-12 weeks after the birth, with a second interview conducted 6-12 weeks later. The phenomenon of childbirth was an experience of being a body and a self, the physical and non-physical elements of the human being with dynamic changes in emotions, physical sensations and human relationships moment to moment across the process. Women experienced contrasting states of being with co-existing positive and negative emotions. There were four pivotal elements that changed the quality of the experience. These were confidence in the capacity of the body and the self, physical and emotional comfort, positive or negative human connections and agency, the ability to act on your own behalf to achieve well-being. These elements did not act singularly but rather influenced each other in a complex web of interactions. This study has demonstrated the importance of developing maternity care services and education directed at supporting confidence, comfort, and agency in order to promote wellness in the childbirth experience and support the optimal function of the normal, physiological childbirth process.

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Dedication

I would like to dedicate this work to all of the mentors and teachers who have invested in my development as a midwife and a scholar

Carolee Dunivan CNM, Betsy Greulich CNM,

Martha Kayne CNM, Louanne Watson CNM

To my friend, Dr. Cathy Smith, who believed in the idea of a PhD for me when it was the tiniest of sparks,

To the women who offered me their stories so that we can understand better how to care for other women during birth,

To my family, for their regular deposits of support, humor and sanity in all the falling apart and triumphant moments of the PhD process,

And finally, to the person who taught me to love complex words and human stories when she taught me how to read,

my mother,

Joy Anne Sloan Hall

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Chapter One: Introduction and Specific Aims

Childbirth is a pivotal life event of great meaning to women (Larkin, Begley, & Devane, 2009; Parratt, 2002; Rilby, Jansen, Lindblom, & Mårtensson, 2012; Simkin, 1991, 1992). It is an experience of paradox, both exhilarating and stressful at the same time. Women experience intense emotions: anticipation, hope, joy, fear, anxiety, and helplessness (Crowther, Smythe, & Spence, 2014a; Leap, Sandall, Buckland, & Huber, 2010; Leeds & Hargreaves, 2008). The physical sensations of labor are intense, including pain and pelvic pressure (Chajut, Caspi, Chen, Hod, & Ariely, 2014; Lowe, 2002), nausea (Anderson et al., 1959), and fatigue (Tzeng, Chao, Kuo, & Teng, 2008; Tzeng, Kuo, & Tsai, 2013). The labor process is unpredictable. The exact beginning of labor and duration of labor are unknown (LeRay & Anselm, 2011; Neal et al., 2010; Zhang et al., 2010) so that the period of waiting for labor to start while trusting that it will progress is an exercise in patience, managing anxiety and working with late third trimester discomforts. Childbirth requires enormous effort (Hall et al., 2009), and women require great emotional and physical support (Hodnett, Gates, Hofmeyr, & Sakala, 2013). Although improvements in maternity care have decreased maternal and neonatal mortality considerably in the 21st century (World Health Organization, 2012), some women still fear for their well-being and that of their baby (Melender, 2002a, 2002b; Nilsson & Lundgren, 2009; O'Donovan et al., 2014; Saisto & Halmesmaki, 2003). Finally, childbirth marks the life transition to parenting a newborn, which brings additional stress because of the disruption of life routines and changes in important relationships (Emmanuel, Creedy, St John, Gambel, & Brown, 2008).

The quality of the labor experience affects women's well-being. Women remember birth experiences in vivid detail years later, as demonstrated in Simkin's classic work on women's memories of birth (Simkin, 1991, 1992). The process of birth potentially shapes a woman's perception of herself (Parratt, 2002; Parratt & Fahy, 2003) so that a positive birth experience contributes to feelings of satisfaction, pride in the accomplishment, confidence in the body's capacity and in the self (Hardin & Buckner, 2004; Leap et al., 2010; Lundgren & Dahlberg, 1998; Parratt & Fahy, 2003). Negative birth experiences increase maternal distress (Sorenson & Tschetter, 2010; Thomson & Downe, 2008, 2010, 2013; Waldenstrom, Hildingsson, Rubertsson, & Radestad, 2004) and the risk for post-partum mood disorders (Ayers, Joseph, McKenzie-McHarg, Slade, &Wijma, 2008; Elmir, Schmied, Wilkes, & Jackson, 2010; Vossbeck-Elsebusch, Freisfeld, & Ehring, 2014). Women with negative birth experiences have an increased risk for post-traumatic stress disorder (Elmir, et al., 2010). PTSD is an anxiety disorder that follows an experience of actual or perceived threat that caused intense feelings of helplessness and/or fear and is characterized by ruminant thinking about the traumatic event (re-experiencing), avoiding reminders of trauma, and a general increase in anxiety (American Psychological Association, 2014). There is no standardized definition for a negative birth experience, but generally, it is a birth in which significant aspects of the birth were stressful, or there was a preponderance of negative emotion that caused a woman to rate it as overall negative.

There are approximately 4 million births in the United States each year and although the exact number of women who start labor is unknown, more than 2/3 of these

women will experience labor[1] (Martin, Hamilton, Osterman, Curtin, & Mathews, 2013). The prevalence of a negative birth experience is variable, but rates from 7% (Waldenstrom, Hildingsson, Rubertson, & Radestad, 2004) to up to 30% have been identified (Creedy, Shochet, & Horsfall, 2000; Soet, Brack, & Dilorio, 2003). Although the rate of PTSD after childbirth is relatively low, between 2-6% (Alcorn, O'Donovan, Patrick, Creedy, & Devilly, 2010; Slade, 2006; Soderquist, Wijma, Thorbert, & Wijma, 2009), rates as high as 20% have been reported in some settings (Modarres, Afrasiabi, Rahnama , & Montazeri, 2012). Furthermore, 19-30% of women have partial post-traumatic stress symptoms (Ayers & Pickering, 2001; Czarnocka & Slade, 2000; Leeds & Hargreaves, 2008; Maggioni, Margola, & Filippi, 2006; Soderquist, Wijma, & Wijma, 2006; Soet, Brack, & Dilorio, 2003).

In addition to PTSD, there are other effects of a negative birth experience. Women with negative birth experiences have increased risk of post-partum depression (Righetti-Veltema, Conne-Perréard , Bousquet, & Manzano, 1998; Rubertsson, Wickberg, Gustavsson, & Radestad, 2005), as well as antepartum depression and anxiety in a subsequent pregnancy (Furber, Garrod, Maloney, Lowell, & McGowan, 2009; Nilsson, Bondas, & Lundgren, 2010; Nilsson et al., 2011; Rouhe, Salmela-Aro, Halmesmäki, & Saisto, 2009). Women with negative birth experiences are more likely to experience severe fear of birth (Nilsson, et al., 2011) and may request an elective cesarean delivery (Hildingsson, Thomas, Karlstrom, Olofsson, & Nystedt, 2010) despite the increased in adverse health effects associated with this mode of delivery for women

[1] The vaginal delivery rate in the United States is currently 77.2%, so at least that many women experience labor. Many cesareans are done during labor, which means a portion of the 32.8% of women who have cesareans also experience labor for a period of time, even if they have a cesarean birth.

as well as their newborns (Althabe & Belizan, 2006; Lee & D'Alton, 2008; O'Neill et al., 2013; Wylie & Mirza, 2009).

Negative emotion and distress are important risk factors for developing PTSD following labor (Anderson, Melvaer, Videbech, Lamont, & Joergensen, 2012; Olde, et al., 2006), although not all negative emotion is associated with PTSD (Ayers & Pickering, 2001; Dixon, Skinner, & Foureur, 2014). Women with traumatic births report intense feelings of helplessness, defeat, discouragement (Ayers, 2007) fear, worry (Leeds & Hargreaves, 2008; Nicholls & Ayers, 2007), anger (Mozingo, Davis, Thomas, & Droppleman, 2002; Thomson & Downe, 2008, 2011), and shame (O'Donovan et al., 2014). Intense helplessness is one of the characteristic elements of PTSD (American Psychological Association, 2014).

Women in labor experience a contradictory state of emotion where positive and negative emotions occur almost simultaneously, or co-exist (Leap et al., 2010; Tinti, Schmidt, & Businaro, 2011). The research on women's emotions in labor tends to focus on the specific emotions in relationship to one element, such as pain (Lundgren & Dahlberg, 1998; Tinti et al., 2011), fear (Nilsson et al., 2010), anger (Mozingo et al., 2002) or joy (Crowther, Smythe, & Spence, 2014a). Additionally, there is a focus on women's own internal experience of emotion, with less attention to the woman-environment relationship and how this influences the quality of the birth. The childbirth experience is a universe of sensation, emotion, relationships, space, and meaning. The environment of birth, the people who are present, their beliefs and attitudes, and the events of the labor process are all likely to shape the experience of birth. The complex interactions of these factors have not fully been explored.

One of the elements that influences the presence of positive or negative emotion is the experience of powerlessness. Powerlessness and helplessness are significant factors in maternal distress during labor and also are a key element in the development of PTSD after childbirth (Andersen et al., 2012; Ford & Ayers, 2011, O'Donovan et al., 2014; Thomson & Downe, 2008). The converse is also true. Feeling powerful or effective in the birth is associated with a positive or satisfying experience (Aune, Dahlberg, & Ingebritsen, 2012; Christiaens & Bracke, 2007; Goodman, Mackey, & Tavakoli, 2004; Leap et al., 2010; Nilsson, Thorsell, Hertfelt Wahn, & Ekstrom, 2013) and it increases women's ability to cope with labor pain (Christiaens & Bracke, 2007; Carlsson, Ziegert, Sahlberg-Blom, & Nissen, 2012; Leap et al., 2010; Tinti et al., 2011). For women who have experienced a previous traumatic birth, the experience of reclaiming power is an essential element of their psychological healing (Beck & Watson, 2010; Thomson & Downe, 2010, 2013).

Agency is an element of empowerment, an individual's ability to define those goals that affect wellbeing and enact these in the world in a context in which this capacity has historically been constrained (Kabeer, 2001). The concept of agency is useful to childbirth research because it depends on the woman's own definition of her well-being, something that is highly unique to each individual. A woman who wants to be actively involved in all of the decisions during her birth and a woman who chooses to delegate most or all of the decision making to a provider are both exercising agency. Despite the recognition of the importance of women's agency during birth, this element has been historically constrained (Davis-Floyd & Sargent, 1997; Katz-Rothman, 1991). The authority of the provider is supported through a process that involves medical hegemony,

patriarchy, cultural constructions of women's bodies as pathological, fear of birth, and the role of technology (Keating & Fleming, 2007; Worman-Ross & Mix, 2013). Although this power dynamic has been changing because of the development of the concept of patient-centered care, the structures of maternity care continue to be hierarchical and resistant to change (Kennedy, Nardini, McLeod-Waldo, & Ennis, 2009; Simonds, Katz-Rothman, & Norman, 2007).

The concept of agency emphasizes what the woman herself brings to the birth and her own unique definition of a good birth, an experience that is highly individualized. This concept aligns with the principles of patient-centered care, which is a holistic approach to care that respects individual wishes and empowers persons to be involved in decisions that affect their health (Morgan & Yoder, 2012). Patient centered care is one of the fundamental aims for the improvement of health care quality recommended by the Institute of Medicine (Institute of Medicine, 2001). Although this study did not focus on any one specific concept relevant to childbearing, because agency is an important element of the childbirth experience, it was highlighted as a topic of concern.

The purpose of this study was to examine childbirth as a complex whole, with all of the nuances of emotion, thought, and sensation that create the experience using descriptive phenomenology, a method to study human experience (van Manen, 1990). Phenomenology, a philosophy as well as a research method, explores the essence of human experience outside of or apart from any theoretical framework to explain it (van Manen, 2014). A second objective of this research was to increase understanding of the mind-body-environment interactions during labor and identify short- and long-term implications of this process for women and their families. The interchange between mind

and body in labor is not well understood, but there is evidence that stressful emotions decrease the effectiveness of the labor process and also increase the perception of pain (Reck, Zimmer, Dubber, Zipser, Schlehe, & Gawlik, 2013).

The intention was to build evidence that will support maternal wellbeing in labor, promote positive birth experiences, and by reducing negative emotions, support the normal physiology of labor so that it can work optimally.

Specific Aims

The Specific Aims of this research were as follows:

Aim I: To explore the lived experience of childbirth in the context of the internal (the elements of the self) and external landscape (other humans, the setting/space and time) of the birth.

Q1: What are emotional reactions, cognitions, and physical sensations associated with childbirth?

Q2: What is the women's lived experience of the birth setting, human interactions, and time in childbirth?

Q3: How do these elements interact to form the whole experience?

Aim II: To explore the meaning of being a physical and non-physical self as an inseparable whole person in labor.

Q1: How do women experience labor as a physical self?

Q2: How do women experience labor as a non-physical self?

Q3: How do the physical and non-physical selves interact during labor?

Theoretical Frameworks: Stress, Coping, and Agency in Childbirth

During the initial development phase of this study, I had an interest in the well-known framework of stress and coping by Lazarus and Folkman (1984), as a meaningful way of explaining how women navigate and manage emotion in labor. As the work developed, the phenomenon of childbirth was much more complex and nuanced than I previously identified and it became clear that using a specific framework to explain this experience was not going to capture the complexity. The method of phenomenology specifically omits using a theoretical framework, so that the phenomenon can be explored away from the constraints of any explanation that may have been imposed on it (van Manen, 1990). One of the purposes of phenomenology is to separate the phenomenon from any pre-conceived notions or explanations, so that it can be understood and described in its fundamental essence (van Manen, 1990). While it is not possible to completely separate the research from one's assumptions and pre-conceptions, it is one of the goals of phenomenology to make an attempt by acknowledging and owning one's pre-understandings of a phenomenon.

Nevertheless, the stress and coping theoretical framework is included here to demonstrate the development of the research and the early shape of the study. Stress is a transaction between a person and their environment that is taxing to the individual's well-being (Lazarus & Folkman, 1984). The stressor can be a challenge, a threat, or loss, and the individual responds in a way that restores well-being, either by changing the situation that caused the stress or by changing their emotional response to the situation. Modifying the emotional response is important because this reaction can be stressful in and of itself, and interfere with other forms of coping (Folkman & Moskowitz, 2004).

Coping strategies also modify the meaning of an experience. When a stressor is interpreted to change the meaning, for example, seeing something as a challenge rather than a threat, the stress response is diminished (Pearlin & Schooler, 1978). In labor, a women may interpret the pain sensation as something that brings the baby, rather than an indication of harm or injury to the body (Lundgren & Dahlberg, 1998). This changes the nature of the experience from negative to positive, and decreases negative emotions women might have about the intense sensation of labor pain.

The concepts of coping and agency are very similar. To cope, a person activates resources to change a stressful situation or change the emotional response to stressors in ways that support wellbeing. Agency is the ability to determine goals that will support one's wellbeing and enact these goals in the world (Kabeer, 2001). Although both concepts include the human capacity to act on one's own behalf to achieve some good that is valuable, they are not synonymous. While the coping concept focuses on the response to stressors, the agency concept focuses on the capacity to act.

The experience of agency requires two things. First, authentic choices must be available and accessible. Individuals must have some knowledge of what the choices and options are (Kabeer, 1999). Second, individuals must feel that they are entitled to make a choice and that it is their right to do so (Nussbaum, 2000; G. Sen, 1993)--what has been called "the power within" (Kabeer, 1999, p. 3). Women's agency in labor is constrained by both of these mechanisms. When women encounter authoritarian provider-patient relationships or rigid institutional routines, their choices are constrained (Davis-Floyd & Sargent, 1997; Katz-Rothman, 1991). When these institutional routines are very nearly

ubiquitous (as suggested by Cook, 2012), women's belief that they have a choice is also diminished (Cheyney, 2011; Fahy, 2008).

This human ability to act on one's own behalf in the face of a stressor is a considered a coping resource (Skinner & Zimmer-Gembeck, 2011). When human efforts to manage a stressor are productive, there is a decrease in the physical and psychological stress response (Steptoe, 2007) as well as improved physical and mental well-being (Skinner, 1995). This process is dynamic and amplifies across the individual's life span, as their responses to stress become more effective over time and their confidence in their ability to manage stress increases. Loss of control and helplessness have a similar effect in the opposite direction. Individuals who do not feel effective or competent have greater negative emotional reactions to stress, and greater physiologic responses (Skinner & Zimmer-Gembeck, 2011). In the case of childbirth, feelings of helplessness or powerlessness are well documented risk factors for distress and childbirth-related post-traumatic stress (Elmir et al., 2010).

Summary

Childbirth is a pivotal, meaningful life event for women and their families. It has the potential to enhance personal growth or increase women's vulnerability to psychopathology and increase women's suffering. In this research, the meaning of the childbirth experience was explored within the context of the woman's life-world, the inseparable mind-body-environment of the labor process and all that it contains. In the following chapter, the literature of women's subjective birth experiences will be explored as it relates to the research questions.

Chapter Two: Background, Significance and Literature Review

The Literature Review From a Phenomenological Stance

The focus of phenomenology is on the experience itself, attempting to describe the essence and meaning of experience before the experience has been interpreted, reflected on, or explained, in the human mind (van Manen, 1990). The purpose of a literature review in a phenomenological study is not to lay out what is known about a topic, presenting a "string of facts" (Smythe & Spence, 2012, p. 21) to create an argument about what knowledge is missing to support the purpose of the study. Rather, the purpose of the literature review is to engage in a conversation with the work of others because it suggests ways of looking at a phenomenon or reveals facets of meaning, previously not considered (van Manen, 1990). The key purpose of the literature is invite the reader to think about the phenomenon, "...standing back to see the big picture, grasp the flavor, discern the meaning between the lines." (Smythe & Spence, 2012, p. 21).

The Labor Experience: Holistic And Paradoxical

The holistic experience of labor has been described as having paradoxical elements, positive and negative elements that co-exist (Lundgren, 2005). Labor pain is intense and difficult but bittersweet, because it brings the baby. Managing the intensity of pain is empowering, and this strength translates into other life domains, especially mothering (Callister, Vehvilainen-Julkunen, & Lauri, 2001). The empowerment makes the experience positive (Nilsson et al., 2013).

There are other paradoxes in the childbirth experience. Labor demands having control over one's-self while also loosing control by surrendering to the process and going with the flow (Lundgren, 2005; Namey & Lyerly, 2010). Labor is an encounter

between a woman and her body but it is also a transcendent experience that goes beyond the physical (Callister et al., 2001). The intense pain is a normal part of the experience, and it means that labor is working, not that they body is injured or diseased (Lundgren, 2004; Nilsson, Thorsell, Hertfelt Wahn, & Ekström, 2013).

What is Known About Important Elements of Birth

Research about childbirth tends to focus on single elements, and how women respond to that singular component. The experience of pain (Hodnett, 2002; Lundgren & Dahlberg, 1998), emotion (Curzik & Jokic-Begic, 2011; Ford & Ayers, 2008), human interaction and support (Hodnett et al., 2013), patient-provider interactions (Lundgren & Dahlberg, 2002), empowerment (Carlsson et al., 2012; Hermansson & Martensson, 2011), comfort (Schuiling, Sampselle, & Kolkaba, 2010) medical interventions (Baker, Choi, Henshaw, & Tree, 2005; Crossley, 2007; Nilsson et al., 2013), and the physical setting of birth (Fahy, 2008) have been explored.

The experience of pain. The pain of labor is probably the most feared element of the birth experience (Rilby et al., 2012). Labor pain is rated as being higher in intensity than most of other types of pain experiences (Lowe, 2002). For example, it is rated higher than non-terminal cancer pain, back pain or herpetic neuralgia in the classic work by Melzack, Taenzer, Feldman, & Kinch (1981). The experience of pain has physical and affective components (Lowe, 2002). Generally, labor pain is mild at the onset of labor and increases as labor advances when the contractions become longer and closer together (Lowe, 2002).

Popular perceptions and portrayals of labor pain present this element as a universally negative experience, nearly unbearable without medical interventions (Morris

& McInerney, 2010; Kennedy et al., 2009) but there is evidence that labor pain is a complex experience, containing both positive and negative elements. The pain of birth is contradictory, hard to describe (Lundgren and Dahlberg, 1998), demanding, difficult, overwhelming (Karlsdottir, Halldorsdottir & Lundgren, 2014), but also challenging, hard work (Halldorsdottir & Karlsdottir, 1996). Women perceive pain as suffering when there is little or no progress in labor but having a sense of personal power increases coping with pain (Carlsson et al., 2012) .

There is a contrast in how different women frame the pain of labor in relationship to having control. For some women, being able to work with pain is empowering, because they emerge from the experience with a sense of strength and accomplishment (Carlsson et al., 2012; Leap et al., 2010). A perception of control decreases the perceived intensity of pain (Tinti et al., 2011). For others, the intensity of the pain contributes to feeling out of control, and receiving an epidural is what brings calm and control back to a frightening situation (Nilsson et al, 2013). Severe, unrelieved pain and not having control over pain management modalities are risk factors for PTSD after childbirth ((Nicholls & Ayers, 2007; O'Donovan et al., 2014; Olde et al, 2006; Stramrood et al, 2011; Waldenstrom et al, 2004) although there is another paradox in terms of the use of pain medications. Women who receive an epidural or pain relieving medications do not always feel positive or satisfied with the birth experience (Callister, Khalaf, Semenic, & Vehvilainen-Julkunen, 2003; Green, Baston, Easton, & McCormick, 2003; Hodnett, 2002).

Another paradox in the childbirth pain experience is that women report pain sensations as being very intense while at the same time they feel calm and capable of

coping (Leap et al., 2010). Schuiling (2003) identified that pain and comfort are not opposite but can co-exist. Women who view the pain as a purposeful, normal part of childbirth and relax into the pain are able to maintain a positive relationship with the pain sensation (Whitburn, Jones, Davey, & Small, 2013).

Emotion influences the perception of labor pain. Women who catastrophize the pain (Whitburn et al., 2013) or have increased anxiety and fear of birth report increased pain (Beebe, Lee, Carrieri-Kohlman, & Humphries, 2007; Curzik & Jokic-Begic, 2011; Lang, Sorell, Rodgers & Lebeck, 2006; Saisto, Kaaja, Ylikorkala, & Halmesmäki, 2001). They also require epidural anesthesia more frequently (Adams, Eberhard-Gran, & Eskild, 2012). Human connections and support modify the experience of pain. Leap and colleagues described women's confidence in their ability to work with pain increased when they knew and were known by their care providers (Leap et al., 2010).

A woman's connection or sense of her own body and its ability influences the pain experience. Trusting the body to work with the pain is mentioned by Lundgren and Dahlberg (1998) as well as Nilsson and colleagues (2013). The body guides a woman through the pain (Karlsdottir et al., 2014). Being able to turn inward, focusing on the body sensations helps with pain, and this resonates with the concept of mindfulness, a concept borrowed from Buddhism concerned with keeping the mind focused on the present moment. Mindfulness based therapies have been used for the treatment of mood disorders and chronic illness (Hempel et al., 2014). Mindfulness based therapies have also been explored as potentially useful modalities for women in childbirth, although there are no studies about this topic currently (Hughes et al., 2009).

The experience of positive and negative emotion. The presence of negative emotion in childbirth is well-documented. A search in Pub Med using the terms "emotion" and "childbirth" revealed 296 journal articles published between 1996-2014. Of these, 293 addressed negative emotions in childbirth and only three mentioned positive emotions. There were no studies specifically addressing the presence of positive emotion in childbirth, rather, the topic was addressed indirectly. This is consistent with the findings of Crowther and colleagues, who searched for literature about the experience of joy during birth, and found the concept neglected, hidden or only addressed indirectly (Crowther, Smythe, & Spence, 2014a).

Positive emotions are described indirectly in connection to other aspects of the childbirth experience. For example, Leap and colleagues (2010), mentioned in the previous section on pain, studied the experience of continuity of care and focused on the effects of the midwife-patient relationship that developed over time. Women identified positive emotions as a result of this ongoing, trusting relationship with the care provider. They felt calm, brave, and confident as a result of the connection with a midwife who knew them, and this contributed to feeling proud, accomplished and joyful after the birth (Leap et al., 2010). Similarly, Crowther, Smythe and Spence (2014b) identified hope, optimism, joy and calm that came from the positive relationship to the health care provider. Confidence and a "feeling of power" that results from trusting in the body's strength and capacity were mentioned by Carlsson and colleagues (2012, p. 88). There are positive emotions at the moment of birth. Callister, Holt and Kuhre (2010) reported awe and happiness right after delivery, as did Nilsson and colleagues (2013).

The literature about negative emotion in labor is abundant. Severe fear of childbirth is a significant problem for many pregnant women, complicating 5-20% of pregnancies (Adams et al., 2012). Fear of birth is a risk factor for the development of PTSD following labor (Soderquist et al., 2009; Slade, 2006; Than, Christensson, & Ryding, 2007). It is associated with increased length of labor (Adams et al., 2012) and increased perception of pain (Saisto et al., 2001).

The increased perception of pain contributes to an increase in the use of epidural anesthesia, a technology that has been very beneficial to women but with adverse effects on the labor process for some (Anim-Somuah, Smyth, & Jones, 2011; Lieberman & O'Donoghue, 2002). Epidural anesthesia is associated with maternal hypotension, fever, urinary retention requiring catherization, increased risk of prolonged second stage, operative vaginal delivery, and increased risk of cesarean delivery for abnormal fetal heart rate patterns (Amin-Somuah et al., 2011). The use of anesthesia requires other care modalities to address these adverse effects, such as continuous fetal monitoring, IV fluids, the use of oxytocin and restrictions of oral intake. Epidural anesthesia restricts women's mobility.

The use of epidural anesthesia is associated with an increased need for oxytocin to increase the strength of contractions (Anim-Somuah et al., 2011) although oxytocin has been identified as having an increased risk for harm (Clark, Simpson, Knox, & Garite, 2009; Institute for Safe Medication Practices, 2012; Simpson & Knox, 2009). Excessive doses of oxytocin are associated with uterine tachysytole, fetal hypoxemia and acidemia, increased labor pain, placental abruption, uterine rupture, cesarean delivery, and postpartum hemorrhage (ACOG, 1999; Crane, Young, Butt, Bennett, & Hutchens, 2001).

Approximately half of all obstetric litigation claims involve misuse of oxytocin (Clark, Belfort, Dildy, & Meyers, 2008).

Women with severe fear of labor are more likely to request a cesarean delivery, even without medical indications (Saisto & Halmesmaki, 2003). While cesarean births are beneficial to women with pregnancy and birth complications (Althabe & Belizan, 2006; Betran et al., 2007; Dumont, de Bernis, Bouvier-Colle, & Breart, 2001), an increased rate of cesareans beyond 10-15% have been associated with short and long-term adverse health effects for women as well as their infants (Belizan, Althabe & Cafferata, 2007; Gibbons et al., 2010; Lee & D'Alton, 2008; Steer & Modi, 2009; Wylie & Mirza, 2008). Women with cesareans have an increased risk for postpartum hemorrhage, endometritis, readmission to the hospital after discharge, abnormal placentation in a subsequent pregnancy (Lee & D'Alton, 2008), and the increased risk for uterine rupture in a subsequent pregnancy. Cesareans are more expensive than vaginal deliveries (Gibbons et al., 2010). For infants, there is a risk of injury during surgery, increased risk of iatrogenic prematurity, increased risk for respiratory distress, and admission to neonatal intensive care (Steer & Modi, 2009).

Cesarean births are also more costly (Podulka, Stranges, & Steiner, 2008). The cesarean rate in the United States is currently 32.8% (Martin et al., 2011) although the WHO recommendation is for the cesarean rate to be 10-15% for optimal birth outcomes (World Health Organization, 1996). If the recommended 15% cesarean rate were achieved in the United States, there would be an estimated savings of $1.63 billion for third party payers (Neal & Lowe, 2012).

The experience of human others. Very few human societies idealize unassisted birth and women have sought the help of others in labor for most of human history (Davis-Floyd & Cheyney, 2009). For most of history, women have labored with the help of female friends and family, but when birth moved to the hospital in the early 20th century, women had medical and nursing care for the delivery but labored essentially alone (Wertz & Wertz, 1989). The importance of support was identified in the early 1980s by Klaus and Kennel (Sosa, Kennell, Klaus, Robertson, & Urrutia, 1980) and this research opened the door for more relaxed hospital policies that allowed women to bring a spouse, partner, or family member to offer support and comfort.

Currently, in the United States, most hospitals allow one or more companions to stay with women in labor. Women may also choose to engage a doula, a companion who is trained in labor support techniques, to provide support in labor (DONA International, 2005). Health care providers may be supportive but they are also responsible for medical evaluation, decision making, and medical procedures; they are also responsible for the care of multiple women in labor simultaneously.

Human support is essential to a positive birth experience, more important to the quality of the birth than other factors, such as childbirth preparation, the physical birth environment, pain, medical interventions or continuity of care (Hodnett, 2002). Poor support in labor is associated with having a negative birth experience (Waldenstrom et al., 2004), whereas positive support enhances coping (Leap et al., 2010; Lundgren, 2005), increases feeling empowered (Hermansson & Martensson, 2011), increases maternal confidence (Gibbins & Thomson, 2001), and decreases a negative memory of birth (Lundgren, 2005; Waldenstrom et al., 2004).

Support in labor confers physiologic benefits as well. Women with continuous support have shorter labor and are less likely to require medications for pain and they have more spontaneous vaginal births (Hodnett et al., 2013). Women who receive support in labor are less likely to have an infant with a low five minute Apgar[2] scores (Hodnett et al., 2013).

Support in labor sometimes includes the help of a labor doula. A labor doula is a companion without medical education who is trained to provide physical and emotional support (Simkin, 2012). Doula care has long been recognized as an valuable resource for childbirth (Scott, Klaus, & Klaus, 1999), associated with increased satisfaction with birth, shorter labors, decreased use of pharmacological analgesia, and operative delivery (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2003). Doula care offers postpartum benefits as well, including decreased postpartum depression, increased self-esteem, improved breastfeeding, and increased maternal sensitivity to the infant's behavior cues (Scott et al, 1999). Despite the multiple benefits of doula care, only 6% of women use this service in the United States (Declerq, Sakala, Corry, Applebaum, & Herrlich, 2014). The reasons for diminished use of doulas are complex, but cost is one of the barriers. The doula fee is $600-$800 in Atlanta, and up to several thousand dollars in some parts of the United States (see http://expectingthebestbirth.com/doula-cost and http://www.parents.com/pregnancy/giving-birth/doula/how-much-do-doulas-cost/). Doula care is not covered by medical insurance.

Most women labor accompanied by family members, but there are very few studies on the effect of labor support from family members. In a systematic review,

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[2] An Apgar score is a screening scale used to quickly evaluate a newborn's successful transition to life outside the uterus. The newborn is rated on 5 items: breathing, color, muscle tone, responsiveness, and pulse, at one and five minutes of life. The score ranges from 0 to 10, with 10 being a good score.

Rosen (2004) identified only one study (out of five total) to evaluate the effect of supportive care from female relatives. Research about fathers' experiences of birth identified that men are highly motivated to be involved in the birth process but feel vulnerable and inadequate, especially in regards to women's childbirth pain (Johansson, Fenwick, & Premberg, 2015). Although there has been an increase in the literature on father's experiences of birth in recent years (Abushaika & Massah, 2012; Bedwell, Houghton, Richens, & Lavender, 2011; Bradley, Slade, & Levinston, 2008), a literature search for research on the effect of labor support by fathers did not identify any articles on this topic. Spouses or partners of the woman in labor as well as other family members have the benefit of an intimate acquaintance with the woman in labor and this may increase their sensitivity to women's needs. Conversely, family members also bring their own anxieties and stresses to the situation which may amplify the woman's experience of negative emotion.

A particular kind of human other: professional caregivers. In the United States, women encounter perinatal nurses, responsible for the moment to moment care, and physicians, responsible for medical evaluation, decision making and for the birth. They may encounter midwives, whose role encompasses some of aspects of the nurse role and some aspects of the physician role. The therapeutic presence of the nurse or midwife is essential to the role, a fundamental element of the midwifery model and the American College of Nurse Midwives' philosophy of care (Hunter, 2009; Rooks, 1997). Midwifery research about women's experiences of labor highlights this relationship, which includes affective components such as sensitivity, personal attention, nurturing, support, and guidance, in addition to the knowledge, professional expertise, and advice. (Hermansson

& Martensson, 2011; Hunter, 2009; Kennedy, Shannon, Chuahorm, & Kravetz, 2004; Lundgren & Berg, 2007). Walsh has called this relationship, "the professional as a friend" (Walsh, 1999, p. 169) because of the element of human warmth and affective aspects.

The friendly qualities of warmth, caring, and empathy are also described by the American College of Obstetrics and Gynecology (ACOG) in their professional documents about provider-patient relationships. They recommend shared decision making and giving the patient equal time to speak in the health care encounter, a sign of respect (ACOG, 2014c). Although ACOG documents highlight the value of these affective elements of provider-patient relationships, physicians are not writing about them, at least to the extent that midwives and nurses write about this. Although the nursing and midwifery literature about the affective elements of the provider patient relationship is abundant, a search in the medical literature for this topic only identified 2 articles (Lipkin, 1996; Pedersen, 2009).

The experience of feeling powerful. The right to have a say in shaping one's own life circumstances, to determine choices that affect one's well being is a human need as well as a human right (Doyal & Gough, 1991; United Nations, 1997). This ability influences how a person copes with stress by reducing the stress response (Skinner & Zimmer-Gembeck, 2011). In childbirth, women associate feeling empowered with positive birth experiences (Nilsson et al., 2013), and identify its absence in negative birth experiences (Baker et al., 2005; Nicholls & Ayers, 2007; Thomson & Downe, 2008).

How to conceptualize feeling powerful in birth has been problematic. There has been some inconsistency in the concepts that have been used: empowered (Hermansson

& Martensson, 2011), in control (Namey & Lyerly, 2010), agency (Walsh & Devane, 2012), mastery (Humenick & Bugen, 1981), self-efficacy (Lowe, 1991) have all been used. Although there is a robust discourse about the importance of these elements to women in childbirth, there is little research about what they actually are, or how women experience them. The concept of control has been used more commonly (Green & Baston, 2003) but it places the provider and woman in a position of potential conflict, if both parties feel they need to control the birth. Furthermore, it is difficult to have control, in other words, to exert dominance, when in a vulnerable state, such as labor. The concept of control has so many different meanings that Namey & Lyerly (2010) have recommended that it be de-emphasized in midwifery research for this reason.

There are two elements that relate to the experience of feeling powerful that are important. The first pertains to a woman's ability to have a say in what happened, to influence the events according to her own internal definition of a good and satisfying birth. This is agency (Kabeer, 2001). The second element is the sense of power or capacity of her body, to effectively do the work of labor, manage the sensations and bring the baby out. In childbirth literature, there has been greater attention on the former type (woman's agency) but they may be related. For example, Carlsson and colleagues (2012) place them together in the same category of "maintaining power" (p. 88).

Women have identified elements of feeling powerful or powerless. Women wanted to be active participants in the birth, rather that just having the birth happen to them (Nilsson et al., 2010). Being able to push the baby out and accomplish the birth helps women feel powerful (Leap et al., 2010), in the sense of being capable of accomplishing an important task that requires great stamina and effort. Being able to cope

with pain contributes to a sense of power for a similar reason, it represents the ability to achieve something extraordinarily difficult (Carlsson et al, 2012; Leap et al., 2010). Feeling powerless involves not having authentic choices (Ayers, 2007; Nicholls & Ayers, 2007; Leeds & Hargreaves, 2008; Thomson & Downe, 2008; Rijnders et al., 2008), not being included in important discussions or given information (Baker et al., 2005; Beck, 2004; Nicholls & Ayers, 2007; Thomson & Downe, 2008), not being included in decisions (Allen, 1998; Waldenstrom et al., 2004), having your body movement restricted (Cook, 2013) and having your own body knowledge discounted (Thomson & Downe, 2008). The authoritarian quality of some patient-provider relationships, being ignored, and not being able to control who came in the room are factors that contribute to PTSD (Elmir et al., 2010).

Feeling powerful or powerless affects women's emotions in labor. Women who feel powerful experience less fear (Lindgren & Erlandsson, 2010), and report positive emotions such as joy and delight or even bliss (Leap et al., 2010; Thomson & Downe, 2010). Women associate empowerment with an increased ability to cope (Gibbins & Thomson, 2001; Hardin & Buckner, 2004; Lavender, Walkinshaw, & Walton, 1999; Leap et al., 2010), as well as an increased ability to work with pain (Carlsson et al., 2012; Christiaens & Bracke, 2007; Lindgren & Erlandsson, 2010; Tinti et al., 2011). They feel a sense of accomplishment at the end of labor (Gibbins & Thomson, 2001; Leap et al., 2010) and they experience greater confidence in their mothering and other life domains (Cheyney, 2008; Parratt & Fahy, 2003). The opposite of feeling powerless, feeling effective or powerful, is a fundamental element of positive birth experiences. This quality is associated with a satisfying birth (Aune et al., 2012; Christiaens & Bracke,

2007; Goodman, Mackey, & Tavakoli, 2004; Leap et al., 2010; Nilsson et al., 2013). For women with previous birth trauma, the experience of reclaiming power is an essential element of psychological healing (Beck & Watson, 2010; Cheyney, 2008; Thomson & Downe, 2013).

Feeling powerless is associated with negative emotion, such as anger, anxiety, and grief which may persist long term (Mozingo et al., 2002; Nilsson et al., 2010). Thomson and Downe (2008) identified similarities between the birth stories of women who felt powerless in labor victims of crime. Women described feeling violated, assaulted, and brutalized (Mozingo et al., 2002; Thomson & Downe, 2008), or even analogous to having been in jail (Baker et al., 2005).

The experience of feeling comfort. Comfort is a holistic phenomenon and basic human need of seeking sensations of ease and/or relief (Schuiling & Sampselle, 1999). Promoting comfort is an essential component of the nurse's role (Richeson & Huch, 1988; Morse, 1992). The human response to comfort involves the whole person although there can be different contexts for the experience. Kolkaba (1996) has divided comfort into physical, psychospiritual, and social contexts but comfort provided to one aspect of the person has an effect over other aspects. Comfort enhances a human's ability to function, and when provided to women in labor, may have a strengthening effect (Schuiling, 2003). Simkin recommends that comfort measures be provided to women in labor to decrease the need for pain medications, or to delay their use (Simkin & O'Hara, 2002).

Even though there is a general agreement that comfort is important in labor, there is little research on this topic. Schuiling (2003, 2010) explored the presence of comfort in

labor by comparing pain and comfort in early and advanced labor in a sample of healthy women in spontaneous labor. She described comfort as a complex element of the labor experience, related to pain but not strictly its opposite. For example, she identified that while pain scores increased as labor progressed, comfort scores were similar at both of these time points. There was a paradoxical relationship between pain and comfort, for example, women who experienced freedom of movement, one-to-one support, and massage had higher comfort scores, even when pain scores were also high (Schuiling, 2010). Pain relief was not synonymous with comfort. For example, the comfort scores of women with pain medications and without pain medications were not significantly different. Women who used epidural anesthesia had pain scores that were very low, but also comfort scores that were low (Schuiling, 2010).

The experience of medical interventions. Medicalization is the process by which normal biological processes become defined and treated as medical problems (Conrad, Mackie, & Mehrotra, 2010). Although pregnancy is not the only life process that can be medicalized, (menopause and death are two additional examples), Zadoroznyj suggests that pregnancy exemplifies the extent of the medicalization of women's reproductive health (1999). The biomedical model emphasizes the risk and potential for harm inherent in the processes of pregnancy and childbirth (MacKenzie & van Teijlingen, 2010), and privileges medical knowledge as authoritative (Trevathan, 1996) to correct the deficiencies of women's bodies. Maternity care in the medical model favors provider control over the birth process to improve safety, focuses on the importance of medical interventions to treat potential problems, and emphasizes the outcome of a healthy infant is more important than the quality of the woman's experience

(McKenzie & van Teijlingen, 2010).

The medicalization of normal, healthy childbirth is common in the United States, and medical interventions, such as IV fluids, a policy of no oral intake, continuous electronic fetal monitoring and limitations to women's mobility are used almost routinely. In a national survey, Declerq and colleagues identified 55% of women received IV fluids in labor, 67% used epidural anesthesia, and 50% of women received oxytocin to induce or augment labor contractions (Declerq et al., 2014). More than 50% of women were confined to bed for the duration of labor, and 59% were restricted from eating or drinking. For women with longer labors in the hospital, this period of fasting can be lengthy and uncomfortable.

Part of the difficulty with initiating medical interventions for normal labor is the use of one intervention may requires another to correct the adverse effects, in what has been called the cascade of interventions (Jansen, Gibson, Bowles, & Leach, 2014). For example, epidural anesthesia is associated with increased need for oxytocin augmentation and prolonged second stage of labor requiring forceps or vacuum assisted delivery (Jansen et al, 2014). Furthermore, epidural anesthesia increases the risk of maternal fever, requiring antibiotics and a fever evaluation of the newborn, including blood cultures and sometimes, a spinal tap (Lieberman & O'Donoghue, 2002). This cascade of medical interventions increases health care costs. Tracy and Tracy (2003) identified a 50% increase in health care costs for primiparous women and up to 36% increase for multiparous women as labor interventions accumulated.

Medical interventions reduce women's agency by reducing women's mobility and choice. Continuous electronic fetal monitoring (EFM) is an intervention applied to almost

all women during birth in the United States, and rates of continuous monitoring are as high as 94% (Declerq et al., 2006) even though safe alternatives exist for low risk women in physiologic labor (Hersh, Megregian, & Emeis, 2014). Cook (2012) identified four separate ways in which EFM threatens women's autonomy and agency: it prioritizes seemingly objective information that must be interpreted by an expert over the embodied knowledge and lived experience of the mother, it delegitimizes her values, leads to a greater likelihood of a false positive indication of fetal distress and increases her chance of a cesarean delivery. It limits her mobility in labor and control over her bodily position, and thereby removes a potential method she has for affecting the course of labor as well as her comfort. It prioritizes fetal oxygenation over maternal needs and suggests that labor is inherently risky for the fetus.

This routine application of medical interventions normalizes their use, so that women come to see them as normal or necessary to the birth process (Cook, 2012; Hall, Tomkinson, & Klein, 2012). To access another set of options, women need to know they are safe, and have the determination to negotiate for this alternative set of options or be able to select a birth setting where other options are available. Campo (2010) suggests that women's acceptance of birth care based in the biomedical model has two elements: their belief in the hegemonic biomedical model of birth and their lack of confidence in their own ability to birth without medical expertise. This confidence is subtly eroded in the medical encounter and through cultural fears surrounding birth.

Women themselves have both positive and negative perspectives on the use of medical interventions. "Medical things" can feel like a psychological security blanket (Campo, 2010, p. 6; Hall, Tomkinson, & Klein, 2012) because they are perceived to

make birth safer for the fetus. Women feel a moral obligation as mothers to protect the baby's wellbeing (Horton-Salway & Locke, 2010; Hall et al., 2012), and accept medical interventions because of the belief that they decrease the risks of birth. However, interventions decrease women's comfort and may also increase the perception of weakness or illness during birth, since medical interventions (such as IV fluids and intensive monitoring with technology) are care modalities used in hospitals for people who are ill. These care modalities privilege objective data over a woman's own bodily experience, which alienates a woman from her body and her own birth process (Young, 2005). Baker and colleagues identified that the negative reaction to interventions was not because women did categorically rejected all interventions, but because they are applied routinely and without informed consent (Baker et al., 2005).

The experience of the birth setting. The environment of health care settings is more than just "inert space" (Hammond, Foureur, Homer, & Davis, 2014). The design and aesthetics of the physical space has been recognized as having an effect on health and wellbeing particularly with regard to decreasing stressful emotions and increasing patient control (Bilchik, 2002; Schweitzer, Gilpin, & Frampton, 2004; Ulrich & Barach, 2006). As mentioned previously, decreasing stressful emotions is important because these emotions have the ability to disrupt the labor process (Foureur, 2008).

The design of birth space has been evaluated in terms of how it affects both patients (Foureur, Leap, Davis, Forbes, & Homer, 2010; Hodnett, Stremler, Weston, & McKeever, 2009) as well as health care providers (Hammond et al., 2014). Of particular importance to midwife researchers is how the design of the birth space promotes or hinders physiologic birth (Hodnett et al., 2009) and the midwife's role in supporting

physiologic birth (Hammond et al., 2014). Since the 1970's, many hospitals responded to women's desire for an improved birth space by making birth rooms less clinical and more home-like although these changes did not necessarily result in changes in policy and practice, just prettier rooms (Hodnett et al., 2009).

Women's own experiences of the physical space of birth have not been well studied. In a national survey of women's attitudes about birth rooms in the United Kingdom (National Childbirth Trust, 2003), nine out of ten women indicated that the physical space of birth affected their birth experience. Their priorities for birth space design included privacy, control, and physical comfort as well as beauty, nature, and ambience. More specifically, women wanted control over the temperature and lights, a pleasant place to walk, pillows, beanbags and floor mats instead of the hospital bed, a non-clinical environment, the ability to make noise without disturbing anyone else, and access to food and snacks. Only 50% of women indicated they had access to these items. Additionally, women wanted access to a bathtub or warm pool for pain relief and a private bathroom with a shower and/or tub. One third of the women surveyed did not have access to these items.

The hospital birth setting generally uses space in a manner reflective of the prevailing obstetrical/biomedical paradigm (Davis & Walker, 2010). The bed occupies a central position in the room, suggesting to women that that she will be recumbent and passive through the process. The bed may be the only object in the room she can use or rest on. Most of the other objects are medical equipment and their use is controlled by medical personnel (Davis & Walker, 2010).

The arrangement of furniture and objects in labor rooms facilitates the work flow

of the provider, and this workflow is focused on the use of medical interventions (Lepori, Foureur & Hastie, 2008) rather than to optimize physiologic birth. The visible presence of medical technology communicates to women that they are at risk, increasing stressful emotions such as fear and anxiety, waiting for "something to go awry." (Davis & Walker, 2010, p. 386). Midwives generally agree that it is harder to keep birth normal in the hospital (Davis-Floyd, 2001; Davis & Walker, 2010; Earl & Hunter, 2006; Everly, 2012; O'Connell & Downe, 2009) and this seems to be true when you compare rates of spontaneous vaginal deliveries according to the birth setting. A recent evaluation of birth outcomes and place of birth for low risk women showed a 44% vaginal birth rate for hospital births, 69.2% for freestanding birth center births and 90% for home births (Homer et al, 2014).

The place of birth affects women's experience of power and agency, in relationship to her experience of her body's capacity but also in terms of her ability to exert her will towards what she wants or needs. The preference for bedrest, with the woman in a recumbent position highlights expectations of a passive, submissive role. Fahy argues that this submissiveness weakens women, "physically, intellectually and emotionally, which detracts from her feeling strong and confident about birth." (Fahy, 2008, p. 3)

The home birth setting has been idealized as a place of greater autonomy and agency for a number of reasons (Cheyney, 2008; 2011). The woman herself has ownership over the space and the objects that are contained there. There is no medical equipment to interfere with movement and women are free to birth in the manner and place of their choice. The woman herself controls the boundaries of the space and who is

present. However, this idealization of home as the location of greater agency has been criticized by Fannin (2003), who points out that a teen who delivers at home alone or a rural woman who cannot travel to the hospital are not necessarily empowered by the home birth experience. Home does not signify a greater agency for all women, for example, women with intimate partner violence have less safety and less agency in their own homes (Jasinski, 2004).

What Is Not Known About The Birth Experience.

Childbirth is an experience of many elements that interact dynamically to create the whole. Although the single elements of labor have been explored, less is known about the labor experience as an unpredictable, complex whole, particularly as it moves and changes across the process. This research explored the dynamic, complex whole of labor taking into account all the interactions of the mind and body, person and helpers, emotions and agency as they form the whole.

Labor is a lived, human experience, not just of the physical body but of the whole person that is shaped by a socio-cultural, political and historical context. Phenomenology is a research approach concerned with the human being inside their life world-the world of space, objects, other humans, culture, time, history that forms all human experiences. The following chapter explores the method of phenomenology and the rationale for the choice of this method for the study.

Chapter Three: Research Design and Method.

Purpose and Design

In chapters 1 and 2, it was established that childbirth is a complex human experience with layers of sensation, emotion, and meaning in the life-history of a family, a physical and psycho-spiritual event (Hall, 2008) that requires great physical strength, confidence, and endurance. It is also an experience of interaction with health care systems and patient-provider relationships that influence a woman's experience of having power. A qualitative approach is an appropriate choice to describe and understand a complex, dynamic human experience. Phenomenology has been used extensively in childbirth research, to study women's experiences of birth trauma (Beck, 2004), women's experiences of pre-eclampsia (Cowan, Smythe, & Hunter, 2011), women and midwives' experiences of labor pain (Lundgren & Dahlberg, 1998; 2002), and midwives experience of "being with women" during birth (Hunter, 2011).

Phenomenology: Philosophy And Method

In chapter 1, phenomenology was introduced as a philosophy as well as a research method, as it explores the human experience as it is perceived by the human consciousness (Husserl, 1970). Phenomenology is the study of "the things themselves" (Husserl, 1985, p. 35), before they have been measured, catalogued, reflected on, categorized or otherwise evaluated (van Manen, 1990). An additional purpose of this method is to describe the universal essence of an experience, the fundamental elements that all such experiences share in common (van Manen, 1990). The end result is a composite account that includes what women experience during childbirth, how they experienced it and what the experience meant (van Manen, 1990).

There are two major approaches to phenomenology, descriptive and interpretive. The purpose of descriptive phenomenology is to reveal the essential meaning structures of a phenomenon (Findlay, 2009), that which makes an experience exactly what it is and what makes everything else not-the-experience (van Manen, 1990). Descriptive phenomenology seeks to edit or bracket all preconceived notions and theoretical frameworks that explain an experience so that the description is purely how they person perceived it and experienced it.

Interpretive phenomenology, an approach developed by Heidegger (1962) focuses on interpretation of human experience rather than description, because the lived experience is an interpretive process (Racher & Robinson, 2003) and human experiences are interpreted as they occur and given meaning. Heidegger believed that the primary phenomenon that concerned phenomenology was the meaning of being in the world, which gave interpretive phenomenology an ontological (rather than epistemological) focus (Cohen & Omery, 1994). Heidegger also felt it was impossible to bracket or set aside all of the researchers presuppositions and ideas about the phenomenon, and he recommends rather, that these be acknowledged and understood as integral to shaping the work (Dowling, 2007).

Important concepts in phenomenology: the life-world. The lifeworld of phenomenology is the immediate, pre-reflective consciousness of life, an every-day, common place way of perceiving things (Moustakas, 1994). All human experiences of being occur inside of a horizon of elements, the context that influences the experience in innumerable ways (Husserl, 1972; Smythe, 2011). For example, in childbirth, the physical events of cervical dilatation, movement of the baby and uterine contractions are

not separable from all of the other elements: the person's beliefs and evaluations, the state of the body with its perceptions and sensations, interactions with other humans, the physical space and the passing of time. The lifeworld is a background of on which all things appear and are given meaning according to judgments that are socially, culturally, and historically constituted.

Important concepts in phenomenology: intentionality. Intentionality is the principle that every mental act is related to some object, and that all perceptions have meaning (Moran, 2000). When human beings think, they think about something (van Manen, 1990). Intentionality is the fundamental concept for understanding and classifying conscious acts and mental practices (Moustakas, 1994). In order to understand human experience requires the study of the ways in which objects, thoughts, and events appear or present themselves to the human mind (Dowling, 2007).

Important concepts in phenomenology: reduction. Descriptive phenomenology seeks to separate out the fundamental essence of the experience from all of the rest by a process called phenomenological reduction. Reduction is the bracketing or setting aside of any preconceptions, theories, or judgments about an experience so that the researcher can describe the fundamental essence, that which makes something exactly what it is (van Manen, 2014). The life-world is full of elements that are taken for granted, not acknowledged or recognized in the day to day dealings with life experiences. In order to understand experience, this every day perception must be identified and set aside. This will allow the phenomena to be seen as free as possible from the background of the life-world (Dowling, 2007).

Important concepts in phenomenology: the four existentials. There are four themes or elements important to phenomenology that constitute the life world of human beings, regardless of their historical, cultural, or social situatedness: the experience of the lived body, the experience of time, of space and of human relationships (van Manen, 1990). These four elements or concepts provide useful guides in the reflection of human experience.

Corporeality. Corporeality is the experience of the lived body. The concept of the lived experience in the body is central to phenomenology, because all human phenomena are lived with and through the physical body. Childbirth is a physical experience, being in a body and being a body. The body is the starting point for apprehension of the world but also its construction (Merleau-Ponty, 1962). A human being is never separate from his or her body, but is the body (Ricoeur, 1992). The body is not just a physical, biological organism, but is the means by which we encounter, perceive and interact with the world (Merleau-Ponty, 1995/1945). Any object or experience is felt, noted and interpreted by the body and it is through the body that the world becomes meaningful (Dahlberg, 2011). Although the health and illness of human beings can be understood objectively, in vital signs, lab values and during labor, in the timing of contractions and dilatation of the cervix, this understanding is only partial, because the experience of health, illness or labor are inseparable from the individual's subjective experience of their own body (Dahlberg, 2008).

Temporality. Temporality refers to the experience of time, and is the experience of subjective time rather than measured/objective time (van Manen, 1990). The physical body does not inhabit time, rather it combines with time and belongs to time (Merleau-

Ponty, 1995). Human experience is inseparable from time, which is a successive flow of "now moments" (Heidegger, 1998, p. 474) which are themselves influenced by a person's previous experience and expectations about the future (van Manen, 1990). Merleau-Ponty considers the now to be a juncture between the past and the future and it is by drawing on the experience of the past and anticipation of the future that meaning is created in the present (Dahlberg, 2008).

Relationality. Relationality is the lived experience of relationships in the shared interpersonal space/time/body with others (van Manen, 1990). To be in the world means sharing the space with others and being with them. Humans see themselves reflected in the experience of others (van den Berg, 1955). Although one human being can never completely enter into or understand the experience of another person directly, humans understand the experiences of others by having empathy, when past experience of one's own self provides an analogue for understanding others and their experiences (Dahlberg, 2008).

Spatiality. Spatiality refers to the lived, felt space of human experience. The body is never detached from the space it inhabits, but is always using, interpreting, and giving meaning to the space (Dahlberg, 2008). Human beings are affected by the physical quality of the space, for example, it can space can feel crowded, small or expansive. Being in a labor room in childbirth can feel safe, or restricting. Space is associated with specific functions that human beings interpret socially or historically, and this shapes the meaning and the experience of the space (van Manen, 1990). van Manen places a particular interest on the space of a person's home: a place that is generally

protected, “that secure inner sanctity” where a person can be what they truly are (van Manen, 1990, p. 102).

The research approach: descriptive or interpretive. This research primarily used a descriptive approach. Generally, most phenomenological researchers follow one approach or the other although Findlay proposes they are on a continuum where a specific work may be more or less descriptive or interpretive (2009). Langdridge suggests that to create a hard boundary between description and interpretation would diminish individuality and creativity, something that the phenomenological tradition values (2008). This research is primarily descriptive, but followed the analysis recommendations of van Manen (1990). van Manen emphasizes the pre-reflective study of the world but also asserts that this process involves interpretation (Dowling, 2007) and his work is considered to be a hybrid of the two approaches (Dowling, 2007; van Manen, 1990). He recommends against bracketing because it is not possible to truly set aside what a person knows, believes or thinks about a human experience, but that this knowledge tends to slip back in to the analysis (Dowling, 2007). Dahlberg offers the term bridling, rather than bracketing, because it indicates that pre-suppositions and assumptions are recognized and acknowledged, rather than eliminated (Dahlberg, 2008).

This research also referred to the work of Merleau-Ponty, generally considered to be an interpretive phenomenologist, but whose work was focused on the human experience of the body, which is what a person uses to interact with the world and which is the medium for all perceptions of human experience (Dowling, 2007). The body is not merely an object that can be moved but is a “subjective object” (Dahlberg, 2011, p. 23) that a person can never turn away from. Merleau-Ponty points out that a human being

does not have a body but rather is a body (Merleau-Ponty, 1995/1945). Because childbirth is an experience of being a body, the work of Merleau-Ponty is a relevant reference point.

Phenomenology is an appropriate method to study a complex human experience such as childbirth, an experience of meaning to women and their families. Childbirth is an experience of a person/being and their body, two elements that are not separate, but form the whole human being. In the following section, the method for the research will be described.

Population and Sample

The criteria for sample selection in phenomenology is that participants have had the experience in question and are willing and able to articulate their experience (van Manen, 1990). Phenomenology seeks in-depth insight rather than patterns or commonalities of experience (van Manen, 1990). The presence of rich variation in the narratives is essential to phenomenology, and for this reason, purposive sampling of different ages, demographic characteristics and childbirth experiences is useful (Dahlberg, 2008). The purpose of the variation in the sample is not to make comparisons among the different categories, but to "spark thinking" on the part of the researcher about the phenomenon (Smythe, 2011). For this study, women were sought from different ethnicities, both primagravidas and multiparas. The sample included hospital and home births. Seeking a sample that included a variety of perspectives created a fuller description of women's experience of childbirth.

Variation in the sample also allowed the researcher to elicit perspectives from a variety of important, yet different, standpoints. Feminist standpoint theory proposes that

human knowledge arises from and is shaped by the social location, conditions, opportunities, and understandings unique to each individual (Haraway, 1988). Systems of oppression have influenced the circumstances of individuals, including their living circumstances, opportunities, and treatment in social situations. The difference in situations gives rise to different ways of looking at evidence (Inteman, 2010). Haraway suggests that the classification of knowledge boundaries (in other words, what counts as knowledge and what does not) is determined primarily by power and not by truth. Groups with less power have an advantage in their evaluation or creation of knowledge because they are not trying to maintain power (Haraway, 1988; Wylie, 2003). Members of marginalized groups have a unique position with regards to knowledge because they understand the worldview assumptions of the dominant group to effectively navigate the world, but have knowledge of personal experience that conflicts with dominant views and generates an alternative perspective (Hill-Collins, 1991; Wylie, 2003).

The recruitment plan involved recruiting 12-16 women of different ages, parities, ethnicities and socioeconomic status. The original recruitment plan is listed in Table 1. Recruitment of women from Hispanic or African-American backgrounds proved challenging, and the final sample contained 8 women. There was a modest amount of variation in the sample, even though not to the degree originally planned.

Recruitment

Ethical approval for the study was granted by the Institutional Review Board at Emory University and the Research Oversight Committee of Grady Memorial Hospital. Women were recruited from childbirth education classes, two local midwifery practices, and several mother and baby related websites. Additionally, announcements were placed

on several bulletin boards at Emory University, where the study took place. The inclusion criteria for this study were as follows: a) essentially healthy women between the ages of 18-45; b) English or Spanish speaking; d) who had a vaginal delivery at term; e) delivered at home or in the hospital; and f) had a healthy infant. Exclusion criteria included: a) major medical or psychiatric illness, b) complications of pregnancy or birth, c) operative delivery, and d) infants who were premature or required critical care in the neonatal intensive care unit. Spanish speaking women were included in the study because the investigator and one of the committee members are fluent in both English and Spanish, and the inclusion of Hispanic women added variation to the sample.

The women in the sample were aged 25-39, 3 primagravidas and 5 multiparas[3]. There was one home birth and all others were hospital births. All of the participants except two were college educated, and three were educated above the master's level. One additional participant was in a master's program at the time of her birth (she was a nurse-midwifery student). There were three nurses in the sample, and one public health professional. The two Hispanic participants had a third and tenth grade education, respectively. All of the participants except the two Hispanics had private insurance coverage. Both the Hispanic participants had emergency Medicaid coverage for delivery and received prenatal care in a local public health clinic. The participant characteristics are listed in Table 2.

Six of eight participants started labor spontaneously and did not require any medical interventions. Two participants had labor induced, one for pre-labor ruptured membranes and the other an elective induction at 40 weeks. These two participants used

[3] A primagravida is a woman during her first pregnancy. A multipara is a woman who has had one or more births, in other words, not her first pregnancy.

epidural analgesia; all other births were unmedicated. Most of the participants with unmedicated labors did specifically plan this, however, there was one participant who arrived at the hospital minutes before her delivery and was unable to use medication because she delivered within minutes of her arrival. The total length of labor for this participant was about 2 hours. She did indicate in the interview that she might have wanted medications for pain if she had not arrived at the hospital so late.

Five of eight participants had midwifery care in labor, and three had physician providers. Of the four midwife patients, two specifically sought a midwife for care, and the other two had midwifery care because it was the standard at the facility where they delivered. These two participants delivered at the county hospital, where most of the vaginal deliveries are conducted by midwives. One additional participant wanted midwifery care, but there were no midwife providers listed on her insurance preferred provider list and paying for midwifery care out of pocket was not feasible for her.

There was a range in terms of the length of labor. The longest labor, one of the inductions, was approximately 60 hours, and the shortest labor, mentioned above, lasted 2 hours. One of the participants had an average length of labor (about 20 hours for a primagravida), but the length of second stage was very prolonged, lasting four hours. The average length of second stage for primagravidas has historically been 45 minutes to up to 2 hours (Friedman, 1967) although more recent work has demonstrated that a longer second stage is not associated with an increase in adverse outcomes, and lengths of up to close to 3 hours can be considered normal (Zhang et al., 2010). The birth details are given in Tables 3 and 4. Details of the birth experience are the from the participant's own recollection. The medical record was not extracted for this study.

Data Collection

Informed consent was obtained prior to conducting the data collection for each participant. The informed consent process for both Hispanic women was conducted in Spanish by the principal investigator, who is fluent in Spanish. The written informed consent was translated into Spanish, verified for correctness by a translation service and approved by the IRB at Emory University. A copy of the consent form, English and Spanish, are presented in Appendix A and B.

The phenomenological interview. The aim of an interview in phenomenology is to create a medium for developing a conversational relationship with the participant about the meaning of a human experience and to gather narrative material to develop an understanding of this phenomenon (van Manen, 1990). van Manen recommends staying close to the experience by asking for descriptions of the experience as it was lived without making generalizations or interpretations, attending to how the body felt, how things smelled, and how they sounded (van Manen, 1990).

The data for this study were generated from in-depth, semi-structured interviews with each woman after her delivery. Each participant completed two interviews. The goal was to conduct the first interview as close to the delivery experience as possible, around 2-3 weeks postpartum with a second interview about a month later. This proved to be challenging, especially for the five multiparas, who had other children. The interviews were conducted during the postpartum period when the participant had a window of time, and this proved to be a fairly wide window, between 2-12 weeks for the initial interviews and 6-10 weeks for the second. There were delays in scheduling

interviews because of illness in other children, women returning to work, and bad weather.

There is little theoretical literature on the optimal window to interview women about their birth experiences, but in prior research, investigators have interviewed women between 3 days and 6 months (Waldenstrom, Rudman & Hildingsson, 2006; Waldenstrom & Schytt, 2009). There is reasonable evidence that the birth story is to some extent stable over time (Simkin 1991, 1992) although Waldenstrom identified a tendency for women who experienced the birth as negative to have an increased memory of labor pain (Waldenström & Schytt 2009). For the population in this study, the window in which women were free to be interviewed was highly variable. The second interview was also challenging, because most women had returned to their professional obligations and finding a convenient time was more difficult.

During the initial interview, the goal was to capture the most immediate recollections of the birth experience. The goal of the follow-up interview was to clarify meanings and obtain greater detail on important themes and anecdotes in the first interview. At the beginning of the analysis, important themes were identified because they occurred multiple times in the interview, or because they had a more intense emotional or meaningful content. The English and Spanish Interview guides are presented in Appendix C.

In this group of participants, the first and second interviews yielded very similar information. Issues that were important in the first interview were re-visited in the second interview. Each participant had certain specific key points in the narrative. These key elements of the narrative tended to be focused on a negative aspect of the labor

process, for example, such as an epidural that didn't work, or the negative emotions that emerged when labor was prolonged. These elements were described again and again. Although these participants were not assessed for the presence or absence of post-traumatic stress symptoms, the negative rumination resembles the re-experiencing characteristic of post-traumatic stress (Ayers, 2008) or a negative attention bias, which is the psychological tendency to devote more attention to negative information (Smith et al., 2006).

Bridling. Bridling is the process of recognizing the researcher's pre-understandings and lifeworld in order to acknowledge their effect on the research, including both data collection and analysis (Dahlberg, 2008; 2011; Gadamer, 1982/1960). Bridling involves restraining the researcher's beliefs, theories and assumptions so that they do not mislead one's understanding of meaning, although it is impossible to eliminate their influence altogether (Dahlberg, 2008).

In phenomenology, as with all qualitative research, the investigator is the instrument of data collection, and all aspects of the research process are influenced by the researchers assumptions and beliefs about the topic and the world (Smythe, 2011). The researcher has a life-world of his or her own, an interpretive link to the physical, social, and cultural world (Husserl, 1964). The practice of phenomenology is letting "the things themselves" speak (Dahlberg, 2008, p. 121) while making a genuine attempt to understand and acknowledge the researchers internal landscape, the way that the research question, data collection, related literature, and interpretations all proceed from the researcher's person and experience in the world. Because it is not possible to fully detach the researcher's pre-understandings of the research, they cannot truly be set aside or

bracketed (van Manen, 1990). Nevertheless, they can be acknowledged and their effect on the research can be understood.

In the process of this research, I began to examine my beliefs about the childbirth experience and the systems of care where women give birth. I have been a midwife and a nurse for 30 years, and have been concerned about the impact of care systems on women's birth experiences. As a newly graduated nurse, I worked for a large, public health care facility. Care was extremely dehumanizing partly because of the patient volume (in my first year there as a labor nurse, the hospital did 18,000 deliveries), but also because this was the culture of the setting. The dehumanizing could be mild or egregious, but there was an assumption that this was the only way to do things. Therapeutic relationships between providers and patients were rare. In many instances, the woman and the provider did not know each other's names, and no effort was made to correct this. The use of medical technology was excessive and invasive, applied routinely to women who truly needed it as well as those who did not. There was one way to do things, and women did not have any choices about their care. The was very little concern for the person or their human experience. I encountered an African woman in labor who managed her pain by singing hymns from her church service as a way of helping herself with the pain. As the contraction increased in intensity, the singing got more and more loud. The resident yelled at her for making so much noise. I found this dehumanizing system disturbing, especially because it was viewed as normal by most of my colleagues, and no one questioned its impact on women's wellbeing. The effect of this dehumanizing care on the provider was ignored as well.

I transferred from the high risk labor unit to the midwife-led birth center in the same facility after two years. The patients were the same, and the volume of deliveries was still high, but the midwives were concerned with the patients as women and mothers. They offered women choices about their care. Women were mobile in labor, if they wanted to be and there was a greater respect for the normal physiological process. The midwives waited much longer before using interventions, and specific criteria were applied in making the decision to use interventions. We were concerned about the quality of the experience and the creation of a patient-provider partnership that invited women to be participants in their own care.

As a result of my exposure to these two systems, I developed an internal list of priorities as a clinician, and now I find the same list is shaping my approach to research. I have a lifelong concern with women's experiences of trauma and recovery, partly because of the iatrogenic trauma I witnessed as a labor nurse at the county hospital, but also because so many women shared stories of their previous trauma. The patients at the county hospital were Hispanic immigrants, and they told stories of sexual violence in their own countries as well as violence they experienced when they made the treacherous journey into the United States across the desert from Mexico and Central America. When these patients received trustworthy care, they found the experience healing. When care was dehumanizing, women were re-traumatized.

The problem of disrespect and abuse in obstetrics is not unique or unusual and has been identified in South Africa (Jewkes, Abrahams & Mvo, 1998), Brazil (d'Oliveira, Diniz, & Schraiber, 2002), the Caribbean (Miller et al, 2003), Ecuador (Gonzalez, 2007), and Nordic Countries (Swhanberg et al., 2007). The issue has been called the "blind

spot" of maternity care, because of its wide prevalence in many countries and the lack of visibility of the problem to governing authorities (Freedman & Kruk, 2014). Wagner describes the phenomenon as, "fish can't see water" (2001, p. 1). Contributing factors have been identified, including poor working conditions, lack of provider autonomy or support, and compassion fatigue (Bowser & Hill, 2010) but interventions to ameliorate the problem have not been entirely successful. A recent landmark report on the quality of global maternity services calls for a clearer definition of the problem of disrespect and abuse in order to address it on a policy, structural and individual level (Freedman & Kruk, 2014).

The term "obstetrical violence" has emerged from the discussion of this problem in Latin America, defined as"…the appropriation of the body and reproductive processes of women by health personnel. . . expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women."(D'Gregorio, 2010, p. 201; see also www.fiscalia.gov.ve/leyes/10-leyderechomujer.pdf). Obstetric violence includes untimely or ineffective emergency medical attention, forcing the woman to birth in a supine position, impeding the early attachment of the infant, altering the natural process of low risk delivery by acceleration techniques without obtaining voluntary, informed consent, and performing delivery via cesarean section when natural childbirth is possible (D'Gregorio, 2010). Obstetrical violence is classified as a form of violence against women, which increases the visibility of the problem, and facilitates addressing the issue from a policy perspective (D'Gregorio, 2010).

My interests and concerns-with women's empowerment, with the quality of the birth experience, with the patient provider relationship-have shaped all aspects of this research. Throughout the research process, I have kept written memos of my understandings as well bringing them to discuss with the research committee. This personal reflection served to identify the frame of reference that shaped the formation of the research questions as well as the analysis. This was done to acknowledge my own pre-understandings before and during the research process so their effect on the research process could be understood (van Manen, 1990). Additionally, the dissertation committee provided valuable feedback on aspects of the analysis where my long-experience of being a clinician prevented me from seeing the data in a new light.

Participants were asked if they wanted to read the report of the findings, and all indicated they wished to do so. A summary of the findings was made available to six out of the eight participants. I was unable to reach the two Hispanic participants to share the results with them because their contact information had changed.

Data Management

The audio recordings were transcribed verbatim by a professional transcriptionist. The principal investigator compared the accuracy of the transcriptions with audio recordings to ensure the integrity of the narratives. There were very few errors or omissions, and most of the changes made to the transcripts were changes in grammar and punctuation. Spanish language interviews were translated into English by myself, so that the committee could have access to them. The accuracy of the translation was confirmed by a bilingual administrative assistant and native Spanish speaker at the Nell Hodgson Woodruff School of Nursing at Emory University. Field notes, observations during the

interviews, and memos were typed and filed with the interview data. Pseudonyms were developed to identify the participants to protect their confidentiality, and any names (physicians, nurses, family members) in the transcripts were modified. Demographic data and personal information as well as the original audio recordings were kept in a password protected file at the School of Nursing. MAXQDA software (http://www.maxqda.com) was used to organize and manage the data and provided the template for which to conduct the analysis.

Data Analysis

Phenomenology began as a philosophy and evolved into a research approach or method. In phenomenology, data collection is not separate from analysis, but rather one informs the other so that they occur more or less concurrently (Smythe, 2011). As each interview text is analyzed, it offers new avenues of asking/listening/thinking to pursue during the next interview (Smythe, 2011). Analysis of the text involves moving back and forth from the text as a whole to the smaller ideas that make up the narratives. These themes point to or focus on the meaning of the phenomenon (van Manen, 1990). The themes were not identified during the actual interview, but were noted in the reading and re-reading of the text, as ideas that came up repeatedly or were more vivid and central to the narrative.

The process of data analysis for phenomenology is not linear, but strategies are carried out simultaneously and/or in an iterative manner across the research process (van Manen, 1990). The texts were read and re-read multiple times, noting important ideas, parts of the narrative that had strong emotion or were colorful. The purpose of the reading/re-reading is to obtain an overall understanding of the experience and clarify any

unclear or missing elements, and develop new lines of inquiry (van Manen, 1990). For example, in the initial reading of these data, it was clear that there was a richness of emotion that had a changing, dynamic quality. Additionally, who was there and what they did were important as women told stories of feeling connected or disconnected, and so I focused some of my questions in subsequent interviews on human interactions and women's emotions.

Data analysis generally followed the procedures described by van Manen(1990),as well as Dahlberg (2008) and Smythe (2011), both midwife phenomenologists who have done work with women's childbirth experiences. The initial process of analysis involved multiple readings of the text to identify issues, ideas, themes that might direct the process of analysis towards an understanding of the meaning of the childbirth experience. Potential analytic lines were identified looking at any vignette or portion of the narrative that contained more powerful emotions, or was something that the participant returned to again and again in their birth story. Two examples from these data are reported in the findings in chapter 4, Talisa's experience of her mother's love and support when she rubbed her feet, and Anita's descriptions of the desperate quality of the pain experience when the midwife ruptured her membranes.

Codes were used to label these important ideas. The development of codes was both inductive and deductive. As discussed earlier, interpretive phenomenology identifies four elements that are fundamental characteristics of the life world: the experience of the body, of time, of human relationships, and of lived space (van Manen, 1990). These elements became the basis for codes used to label the data. Because of my interest in women's agency, which is the ability to act on one's goals, I used several

codes, such as “something that I wanted” and “something that I didn’t want” to identify women’s expressions of their wishes and goals in labor. Additionally, I labeled verbs that expressed an action and examples of mobility or restricted mobility as indicators of women’s agency.

Women’s emotions were identified early in the analysis as being a fundamental to the story of meaning, because of their intensity as well as the complexity of emotions and their changeability. Because emotion was clearly important to the meaning of being in labor, I labeled emotions in the text, such as feeling hopeful, feeling desperate, feeling tired. In this process, I attempted to stay close to the text, labeling an emotion when the participant specifically indicated they felt said emotion, such as “I felt frustrated” or I felt angry.” The coding schema is given in Appendix D. An example of the emotions in labor for one of the participants, Anita, is given in Appendix E.

van Manen(1990) recommends that the process of isolating thematic idea statements be done in three steps that are iterative, and I followed this process. The text was read through in its entirety to identify phrases or theme categories that capture a sense of the whole experience. A selective reading was done to identify statements or phrases that are essential to the phenomenon or are particularly revealing, that highlight some aspect of the experience. Then the text is read sentence by sentence to identify what each sentence is saying about the phenomenon (van Manen, 1990).

Reflecting on the categories and/or structures of the experience was the next step in the analysis. This was done in written form and in discussion with committee members. I created a summary of each narrative, with salient elements and components. Each narrative was discussed with committee members to explore salient elements and

meanings. This was to identify what meanings and elements were characteristic of the whole, composite experience of labor rather than each individual participant's experience of labor.

At this phase in the research, the relationships between medical interventions, the element of time, women's beliefs in the capacity of their bodies, human interactions, and the element of changing, shifting emotions were the analytic lines that I prioritized. I returned to the data and began to specifically re-examine these elements, comparing how the different participants described them at the various phases of labor. This exploration was done with phenomenological writing, an essential component of the analysis and not just a means of reporting the results (van Manen, 1990, 2006) and in further discussions with the dissertation committee. I also developed several matrices of statements by participants about their experiences related to a specific element, such as pain, emotion, agency, comfort, or interactions with specific persons-nurse, doctor, doula, family, etc. An example of one of these matrices is given in Appendix F, a comparison of the emotions of the moment of birth. An additional example of comparisons of the pain experience is given in Appendix G.

Texts were compared and contrasted to identify and describe common meanings. Identifying common meanings was challenging, because while each story had vibrant, salient elements, these did not necessarily resemble each other. In other words, what each participant identified as important or notable was unique while the goal of the analysis was to identify what elements of meaning they all shared. The experience was similar to the proverbial blind men describing the elephant. There was a sense that all the elements had an underlying commonality, just not necessarily apparent. There were

elements they all shared, such as both awe and feeling dazed at the moment of birth, for example. There were elements that some participants experienced in a positive aspect, while others experienced the same element in a negative aspect. For example, some participants were confident about the body's ability to birth, others lacked this confidence, and for some, the confidence waxed and waned.

This iterative process continued until all transcripts were analyzed and interpreted. Through the analysis process, I kept a research journal to document the developing process as well as meeting notes and photographs of diagrams that illustrated the analysis. This was to document reflexivity (Mays & Pope, 2000; Rodgers & Cowles, 1993).

The final step of any research endeavor is the writing of the report, to communicate the findings to a larger audience. As mentioned previously, for a phenomenologist, the writing is an integral element of the research, not merely to report the findings but to engage fully with the phenomenon in an effort to describe what is indescribable, a human experience. The research is inseparable from the writing (van Manen, 2014). In this analysis, summaries of each individual experience were developed and shared with the research committee for their comments and insight. These were then incorporated into an abstract whole, that while moving away from the particulars, still maintained the fundamental elements of the phenomenon. The structure of the writing generally followed the four essentials of corporeality, relationality, spatiality, and temporality, as identified by van Manen (2014).

Trustworthiness

The use of peer review is recommended to provide an external check of the research process (Lincoln & Guba, 1985; Miles & Huberman, 1994). This research project was conducted with input from a dissertation committee, whose members collectively have extensive experience in qualitative and feminist research. I kept a written record of all meetings. The credibility of the findings depends on researcher self-awareness and reflexivity as an instrument of data collection and analysis (Rodgers & Cowles, 1993). I kept a research journal to clarify my biases and assumptions as well as ideas about the research, as recommended by Koch (1994).

The process of member checking can be problematic. Sandelowski (1996) posits that the researcher and participant both have investments in the research that may shape the process of member checking. Social norms about politeness and social desirability may influence what participants communicate. Participants may not recognize their story in the abstract, scientific summary of the findings. The researcher has the challenge of deciding what synthesis of the data should be presented. For these reasons, I did not ask participants for feedback on the analysis, although they have indicated an interest in reading the results and a summary of the findings was made available to them at the completion of the study.

Maxwell (2013) identifies two broad threats to validity in a qualitative study: researcher bias, and reactivity. Bias is the researcher's theories, beliefs, and perceptual lenses that influences what data are collected, how they are collected and how they are analyzed. While it is impossible to detach the researcher's bias from the study, it is possible to own and acknowledge it. My work with women in labor and women who

have experienced violence have made me more sensitive to how these elements influence women's lives, their embodied experiences and their births. I care deeply about the ethics of the provider-patient relationship when the patient is in a vulnerable state. I am interested in supporting the normal physiology of birth because I have seen the iatrogenic effects of the over-medicalization of healthy pregnancies. I became aware of how these beliefs shaped my data collection, and in working with the dissertation committee, was able to identify how they were shaping the analysis.

For example, in the initial readings of the data, the issue of medicalization was very prominent for me, and it seemed that everything related to women's choices in labor was constrained by the use of medical equipment or by routine institutional practices that involve medical technology or interventions. This medicalization of normal, healthy pregnancy is a concern of the discipline of midwifery. Both the American College of Nurse Midwives and the International Confederation of Midwives have position statements on the appropriate use of technology for normal, healthy childbirth (ACNM, 2014a; ICM, 2005). My focus on this issue is a reflection of my education and the discourse of my profession. However, there was one committee member (not a midwife) who stressed that it was important to look past this issue to see the complexity of all of the issues that influence women's choices, and not just those imposed by the hospital system. In the end, I still think that medical routines and medical technology have a detrimental and unnecessary influence on women's choices in labor, but I came to understand that medical culture is not monolithic, and women's choices are shaped by many other factors.

The second broad threat to validity is reactivity, the influence that the researcher has over the data collection (Maxwell, 2013). As noted previously, in a qualitative study it is not possible to eliminate the researchers influence over the study. In the development of the interview guide, I attempted to ask questions that would not lead the participant in a specific direction. I became skilled at allowing silence in the interviews to allow the participant to continue their story. This was initially uncomfortable socially, but I quickly realized it yielded better data and I became more comfortable. I made an effort to identify what parts of the interview made me smile or laugh, because this could be perceived as approving of some aspect of the narrative and prompt the person to offer a socially desirable answer.

Summary

The purpose of phenomenology is to describe the universal essence and meaning of a lived experience (van Manen, 1990). Childbirth is a complex experience influenced by cultural beliefs, attitudes, physiology, psychology, family structure, gender norms, provider-patient relationships, and institutional practices-to name a few aspects. It has meaning in the life history of a family. Phenomenology, with the focus on the meaning of lived experiences is an appropriate method for this study. The following chapter will review the findings from the analysis.

Chapter 4: Results

Keeping it together, falling apart of the Body-Self in Space, Time, and With Others

In this exploration of the lived experience of being in labor, we sought to understand more clearly what the internal landscape of the experience was, how women move through the labor process, and are affected by all the interacting elements that form the whole. In this chapter, these elements of the labor experience, including the inseparableness of the body-self in space and time, pain, comfort, confidence in one's capacity, emotion, agency, and human connections will be described. Although these elements are described separately, they actually do not exist in isolation from one another, but rather interact in a myriad of ways to create the whole experience.

The birth narratives were as varied as the participants. Most of the births were physiologic, unmedicated births, either because the women specifically planned it this way or because there were circumstances in the birth that precluded the use of pain medications or anesthesia. Five participants specifically wanted unmedicated births. Of these participants, three made specific plans to support this choice, by selecting the provider, the birth setting or both. One participant might have wanted an epidural but arrived at the hospital less than 5 minutes before her delivery. There was no time to give her pain medications.

There was one home birth in the sample. She did not use pain medication in labor because the use of narcotics is not very common at a home birth. Most women who give birth at home use relaxation techniques and intense emotional and physical support to work with the pain experience.

Two participants had inductions, one for pre-labor ruptured membranes, and the other was an elective induction of labor at term that the participant herself requested. Both of these two participants received epidural anesthesia. Additional details of the births are found in Table 3.

This chapter explores what it means to women to be a changing physical and non-physical self. First by exploring how women experience their bodies--believing or doubting the body's capacity for the childbirth process, working with the sensations of pain and effort, the body as it experiences support and comfort, the body in motion or restricted, and the body's experience of time and the physical space. Secondly, how women experience emotion, particularly how the physical experience affects the experience of emotion. This chapter will also explore the experience of agency, the ability to act in ways that affect the body or the person to increase wellbeing. Finally, in this chapter I will explore women's experiences of others and how these human interactions shape the birth experience.

The Phenomenon: Keeping it Together, Falling Apart, Everything in Between

The phenomenon of being in labor was being a changing, moving human being in an inseparable experience of physical body and non-physical self woven together. Women experienced contrasting states of being: feeling capable, feeling unsure of their capacity; feeling joyful anticipation, feeling like labor will never end; feeling connected to others, feeling alienated by an insensitive remark; feeling the powerful attachment and love when the baby is finally out, and feeling too exhausted to muster up any emotion. The state of being waxed and waned between positive and negative but there were always small amounts of positive emotion even in the worse moments, and the positive moments

were tempered by small negative elements. Women were exquisitely sensitive to what was in the environment--human beings, physical objects, the passing of time and perceptions about the passing of time.

Women experience labor as a body-self, a being that has physical and non-physical elements that are inseparably woven together. What happens or is perceived by the body affects the person/self, and what emotions or experience are perceived in the mind affect the body. For example, in labor, the body experiences the sensation of pain but the mind frames the experience to determine if the pain feels like work or if it feels like torture. This finding is consistent with the framework of phenomenology, where the body is not an object, separate from the mind, but is a self, the fusion of mind and body from which the world is perceived, lived, and interpreted (De Beauvoir, 1949/1989).

The physical body changes internally as the contractions open the cervix and the baby moves down in the birth canal. The physical self moves in space, looking for ways to be more comfortable, work with contractions, and access what is needed to help manage. Women walk, get into the shower or the bath, move from their homes to the car to the hospital, and are wheeled to the labor room in a wheelchair. The body moves.

The non-physical self moves. Emotions change and shift with the labor process. Women in labor experience excitement, joy, fear, worry, anger, anticipation, comfort. The emotional landscape of labor shifts from keeping it together, falling apart, and everything in between, moment to moment, as women respond to the sensations of labor, the presence of supportive or unsupportive others, the birth setting, their beliefs and attitudes, their knowledge, and previous experience. Emotions move from positive to negative and back again almost simultaneously. Women are confident they are capable of

the incredible effort of birth and at the same time wonder if they might not be. They feel concerned that something might go wrong and they will need a medical intervention to save them from injury or harm.

The experience of agency also shifts and moves. Women in labor choose to move, choose a provider, find something to eat or drink, refuse to lie in bed, ask someone to rub their back and count out loud so they can tell when the contraction is starting to go away. They ask for medical interventions, such as an induction or an epidural. They put plans in place so that they can decline medical interventions when they do not need them. The ability to ask for what they want can be diminished by the intensity of the labor process and its sensations, or the need to be polite. There are moments in labor when women know what they want and need, and moments when they have no idea what might help. The intensity of the process alters a woman's ability to explain what she wants or know what that is. Sometimes, the intensity of labor pushes a woman to give up all social norms and do something drastic to rectify what is not working, like removing their own monitors or turning off the IV pump. Agency is a link across the mind and the body, as women, moment to moment in the birth process act in ways that help themselves, physically or psychologically to achieve the birth. The end result is a birth that affirms the capacity of the person, their ability to achieve something they value and believe to be important.

Keeping it Together, Falling Apart From Pain

"I did not want to know anything about anything because of the pain" (Julia)

The experience of pain in labor is an intense, all consuming experience that changed with the moving of labor. One moment of pain was manageable, while another

moment felt like torture. Pain in the context of a moving body was different than pain when movement was restricted. Pain was contradictory, according to Margaret, who said, "it was the worst" but also "not as bad as I expected." While the pain sensation was powerful and difficult to work with, she did not need someone to take it away or modify with medications or anesthesia.

Pain was not just a physical sensation isolated from the rest of the experience, but was shaped by a context of time, space, and relationality, the cornerstones of phenomenological description (van Manen, 1990). This complex, contextualized experience of pain is consistent with what is known about pain in general, that it a multidimensional experience with both sensory and affective components (Lowe, 2002). Descriptions of the pain experience among these women fell into two general categories, working with pain and falling apart from pain. Participants moved back and forth in these two states.

Working with pain. There were moments in labor where pain was part of the experience, but not overwhelming, something a person could work with. Techniques for coping with pain worked, and there was a successful feeling of doing something about the pain that was effective. Working with pain was dependent on agency, comfort and connection. When women could move freely, receive encouraging support, feel comforted, they could work with pain. When labor progressed as expected, this gave them confidence in their bodies and the pain sensation felt like work.

Freedom of movement. All participants had intense pain, but the participant with the greatest freedom of movement had the fewest comments about pain. Catherine, who gave birth at home barely mentioned pain at all, even though it is clear in the narrative

she had pain. She mentions the word pain in passing, when she is talking about her childbirth class. Conversely, the participants who had the greatest restriction of movement requested epidural anesthesia. Freedom of movement was related to comfort. It was important to be able to get comfortable, and to do this, participants needed to be free to chose their own position. The pain sensation receded to the background when women could move about freely or choose their own position, and it was much more difficult when movement was restricted.

Knowledge and pain. There were different kinds of knowledge that enhanced women's ability to work with pain. Childbirth education was one important resource to help women work with pain, and all participants had attended childbirth education at some point, primagravidas more recently. Multigravidas had childbirth education from a previous pregnancy or had attended a childbirth class more recently as a refresher. The two Hispanic participants, new to this country, attended childbirth classes for the first time, even though they had previous births. They both commented on the lack of childbirth education in their own country, Guatemala and were amazed that there was a way to work with labor by relaxing and breathing.

Breathing and relaxation are a cornerstone of childbirth education (see http://www.lamaze.org/10LaborTips, and also http://www.nct.org.uk/birth/managing-pain-during-home-birth), and important techniques for working with pain, either because they actually do help and/or because the woman has a positive response to the pain sensation that helps to frame it as work rather than torture. Catherine comments,

> I would try to relax my body. That does help. It's hard to do. . . because first instinct is to just tense up, for me at least, when I feel the pain coming. But just relaxing helps and just letting it happen.

> . .Doing those helped while I was resting. . . until I hit transition, then not much helped.

Her observation that it worked until she was in transition[4] was true for other participants, when the ability to work with pain diminished because of the intensity and frequency of contractions.

Previous experience was also a source of information about how to work with pain, but this could be helpful or unhelpful, depending on whether previous experience with pain was positive or negative. Multigravidas described knowing how to do labor, because they had done it before. But if the previous birth experience was very negative, the memory created fear, rather than confidence.

Falling apart from pain. Falling apart from pain happened when a collection of factors brought about an I-cannot-do-this moment. All participants but one experienced falling apart moments in labor, and these moments coalesced around the issues of slow progress, contractions that were too fast and furious, feeling alienated from providers or moving to the hospital from home in advanced labor.

Slow progress. When progress in labor was slow, women had more anxiety which colored the pain experience. Anxiety was about something-being-wrong in the body, and concerns about not being able to achieve the birth effectively and safely. The anxiety had a temporal element, a worry about how much longer will this last and how much longer will I be able to work with this? It is not clear if the difficulty of slow labor was related to participants having less ability to work with pain when labor was longer or if the anxiety about something-being-wrong decreased the ability to work with pain, or both.

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[4] Transition is the phase of labor in between the first and second stages right before the cervix is completely dilated and the phase of pushing begins. In general, contractions are very intense and close together.

This anxiety could be powerful. When Talisa was less than one centimeter after four hours of painful contractions, she felt panic, like, " I got hit by a brick!" For Anita, it was that this labor was longer than the last. She expected to be completely dilated two hours after her membranes ruptured. She could manage intense contractions as long as she was close to the end. Two hours after her membranes ruptured, with very intense and fast contractions, she was only dilated five centimeters. For both of these participants, the slower than expected progress and intense contractions precipitated a request for anesthesia.

Too fast and furious. As labor advances, contractions do commonly become stronger and closer together, and this is a well described phenomenon as women get close to the second stage of labor (Winter, 2009). Downe and colleagues have recommended that this recognizable phase of normal, physiologic labor be studied as a reliable indicator of labor progress and possibly, a herald of the second stage of labor. This would offer providers a way of assessing progress in labor without having to use a vaginal exam, which is an invasive procedure (Downe, Gyte, Dahlen, & Singata, 2013; see also Winter & Duff, 2009). Out of the six participants who had unmedicated labors, five had this classic, falling apart experience close to second stage of labor.

For Anita, this falling apart came much earlier in labor, and she attributes this to the Pitocin infusion she requested to induce her labor. For her, the pain was too fast to breathe, relax, or find a comfortable position so that the sensation felt manageable. It was so powerful and overwhelming that she could not feel any support. The pain felt, not like work, but like torture. It was as if the whole universe was about unbearable pain, and the

only solution she could think of was to turn the Pitocin off or ask for anesthesia. She asked for anesthesia.

No-one-is-listening: provider untrustworthiness. There were circumstances in labor where caregivers were unresponsive to participant's wishes, and the upset precipitated by this experience exacerbated the pain sensation and decreased working with pain. Nydia narrates this experience. When she had been on the monitor in bed for the fifteen minutes required by hospital protocol, she called the nurse to take her off so that she could walk and she needed to go to the bathroom. She was in the later phase of labor when her contractions were close together and very intense. When no one responded, after several calls, she felt abandoned, uncomfortable, and in a lot of pain. She began crying hysterically, but it was not just from pain but from all of the factors working together to diminish her coping.

Changing location at the end of labor. For Sharon, labor pain was manageable when she was at home on her hands and knees in the bathtub. She was in her own space, and she was free to choose whatever movement or position worked with her labor. This changed when she had to stand up and move to the car to get to the hospital. This was in part, because she was in advanced labor, but also because she was very close to the birth and genuinely afraid she might have the baby in the car on the way to the hospital. These converging elements caused a lapse in feeling comfortable and confident about managing the pain.

> I couldn't control the pain as well. . . I fell apart a little bit. I started to worry. I wasn't able to keep myself calm and keep myself composed. . . I also had to leave my little zone of privacy. I had to come out, I had to walk downstairs, I had to go out of the house. . . I wanted to be more together than I was when I was coming out of there[the house].

Keeping it Together, Falling Apart Around Comfort and Discomfort

Comfort and discomfort were central to the keeping-it-together-falling-apart experience. Like other elements of the birth experience, this comfort-discomfort experience waxed and waned with events and interactions during the process. The relationship between pain and comfort was complex, where emotional and physical comfort were intertwined. Comfort helped to frame the pain experience as something to work with. Conversely, the relief of pain was not synonymous with feeling comfort. For participants with epidural anesthesia, it was still possible to feel uncomfortable both physically and emotionally, even in the absence of pain. It was possible to feel comforted and comfortable in the middle of having great pain.

Physical and emotional comfort influenced each other. Helping the body to feel better shifted emotion to a positive direction, and helping the emotions to shift in a positive direction helped the body, by reducing physical tension. Participants do not make a distinction between comfort for the body and comfort for the self. Family members also tended to collapse physical and emotional comfort into the same space and time. For example, when Talisa's mother rubbed her feet and spoke to her in soothing comments, there is no distinction between the experience of emotional comfort in her mother's loving presence and the physical comfort of having her feet rubbed.

Being comfortable. The experience of comfort was associated with relaxation, relief, calm, and quiet. Comfort started in the body, and when the body felt better, women felt calmer, emotions were more positive, and the ability to work with labor pain increased. There are many examples of comfort in these narratives. When the nurse brings water, juice, and a warm blanket for your legs, the empathic concern from another

person brought a sense of wellbeing, calm, safety, and being cared for. This was important, because being able to relax and stay calm were key strategies in working with labor pain.

Talisa describes the effect of her mother's comforting actions when her epidural did not work, and she was looking for ways to work with the pain that she had not expected to have. Her mother's comforting gestures changed her relationship to the sensation of pain, and her body's response to the pain.

You could feel my shoulders relax. I was in the bed and in that moment I just wanted to think about how good it felt when she rubbed my feet and just feel the relief, literally came over me. And in those moments. . my mom was talking to me during that process . . .not talking about the pain, but just talking. . .it helped take my mind off the pain. In those moments I just felt like I was taken away from the pain.

Being uncomfortable. The inability to relax and relieve tension was uncomfortable. Because relaxation was such an important strategy in terms of working with labor pain, the inability to relax brought distress and fear that labor would stop or get stuck. When Anita identified that she could not relax because of pain, she was afraid that the tension would prevent her cervix from dilating and effectively giving birth. This was part of her rationale for the request for anesthesia, so that she might relax and let the baby come out. Effective pain relief, however, did not mean she was comfortable. The immobility, the worry about progress in labor and stresses with her caregivers were still issues that caused emotional discomfort.

I-do-not-know discomfort: what exactly is it? For some participants, the experience of pain and discomfort were collapsed into an uncomfortable amalgam of

experience where the participant was not sure what she was feeling. Talisa explains how she experienced being uncomfortable with pain.

> Pain isn't even the right word for what I was feeling. . . It was more like extreme discomfort. It was just like I couldn't relax and couldn't get comfortable. . .I'm saying pain, but it wasn't. . .I couldn't lay and relax and that was frustrating.

For her, it was not just one element or another, but all of the experiences collapsed into one, emotion and physical sensations together.

Restricted movement and discomfort. Being unable to move was uncomfortable for two reasons. It was easier to work with labor when women could find a position that felt just right to the body, usually upright and out of bed. Lying down made labor worse, generally. There was also comfort in having a choice of how to position the body, where women's own embodied knowledge and agency came together to increase comfort, which helped to work with labor. Gabriela explained this when she talked about going home in the middle of labor. She wanted to be in a place where she was comfortable, and where she could position herself in "any way I wanted [because that] would help the baby come faster." Increased comfort is associated with helping the baby to come.

There are many other examples of restricted movement in these narratives. When Sharon arrived in the labor room minutes before her birth, she went on to the bed in the only position she could move into, onto her hands and knees. When the nurses asked Sharon to turn over so they could apply the fetal monitor, she was so uncomfortable that she was not sure she could push the baby out like that, even though her urge to push was overwhelming.

Body shame and discomfort. Participants experienced discomfort when their bodies acted in ways that felt unreliable and/or publicly unacceptable. These experiences

caused shame and emotional discomfort. For example, Gabriela thought it was shameful to be leaking fluid after her water broke so she refrained from getting up and out of bed to walk, even though she would have preferred to be up and mobile. It was not proper to walk around with the body leaking fluid. Her husband reinforced these opinions when he said, "You can't go around walking like that!" The body in labor is not able to keep internal fluids inside where they belong.

In labor, bodily functions that are normally private become public. Women felt shame for having a bowel movement, even though this is a normal part of labor. Anita discussed how she felt about the nurse being present to the smell of her bowel movement, in addition to having to clean the soiled body part and change the linen. Participants felt shame for making noise, making a strange face, urinating on the floor, and leaking amniotic fluid, The female body in labor becomes, as Shildrick and Price identified, "unpredictable, leaky and disruptive" (1999, p.2).

The physical space and discomfort. Spatiality is the experience of lived space, not just the mathematical dimensions of space (length, height, and depth) but how the body-person feels and moves in a given space (van Manen, 1990). Recent work in the effect of space on human experience has highlighted the potential of birth spaces to support women's confidence or increase their fear of the risks of childbirth (Foureur, 2008). Additionally, the effect of the place of birth on women's agency has been an important consideration in midwifery research (Fahy, 2008).

The birth space of hospitals is comfortable in that it offers the safety of personnel and equipment in case something goes wrong (Kitzinger et al., 2006) but uncomfortable because women did not have ownership or control over what happened in the space. The

objects and furniture were for use by providers, not the women. When I asked Talisa to talk about the space of birth, she said, "it was as comfortable as it is possible in a hospital" for two reasons: the hospital is a place for people who are ill (and she was not) and because she was "at the mercy of others." She understood why women would have a homebirth, because being in her own space at home, wearing her own clothes, going outside to take some air would have made the birth more comfortable. Ownership over the space, the ability to act in anyway that she chose, and the ability to control privacy were important to her. This lack of ownership could explain why Anita found it so uncomfortable to have a bowel movement at the end of her labor. It is not socially acceptable to have a bowel movement in front of strangers at someone else's house.

Participants in the hospital did not have control over who entered into the space. Five out of the seven participants who labored in the hospital mentioned an influx of personnel for the delivery. The presence of strangers was problematic because the birth was an intimate experience and the body was exposed. Women wanted to be in the presence of humans who knew them intimately to share in the intimate nature of the birth experience. Participants also wanted to exercise choice over who was present. Anita wondered, "Who are all these Looky-Lous and why are they here?" when being close to delivery brought an influx of personnel that she had not invited. This occurred when she was pushing, a point in labor when she was maximally exposed.

Catherine, who birthed at home, compared her current experience of comfort and ownership with her previous hospital births.

> In the hospital, there's a bit of you're encroaching on somebody else's space. . . I may feel I need to get permission to eat something, whereas at home, I do not have that issue. Or the nurses don't want me out walking the halls, well,

> then I guess I'll stay in whereas at home, I could be wherever I wanted. So just a greater comfort and a greater ability to just be myself, I guess.

Keeping It Together, Falling Apart And Confidence: Will My Body Work?

The body's capacity for labor was a fundamental concern for participants, but their confidence in the body was tenuous and vulnerable, more powerful when labor was progressing but easily lost if the provider suggested the baby might be a little bit big. Participants were certain one moment the body was healthy and could do the work or labor, but at other moments, were certain it would all fall apart in an emergency cesarean.

This body-confidence affected emotion. When they had confidence in the capacity of the body, the experience was manageable. They felt OK, and emotions shifted in a positive direction. They could work with pain. Participants assumed they were healthy, their body would probably work, and the baby would probably come out safely, but there was a slight uncertainty about whether that was true for my labor, my body, and my baby at this point in time.

When labor was prolonged, women understandably had more fear and concern that the body was not working, but even for those participants whose labor was uncomplicated this concern was present in some form. For example, Sharon had a short, 2-hour long, uncomplicated, natural birth. At the end, she was pleasantly surprised that her body had achieved the birth without external assistance. The pleasant surprise suggests a modicum of worry about her capacity all along.

Time and the perception that the body is capable. This concern about the body's capacity is itself framed within the concept of time. Time was a measure of how well the body performed. When labor moved forward according to women's (and their

health care providers') expectations, women had more confidence in their bodies and their strength. When labor was longer than expected, even if the length of labor was what could be considered normal, they feared a catastrophe.

Women had specific expectations of the beginning and the length of labor, even though the exact moment when labor starts or the length of labor are, like other physiological functions, imprecise. When assumptions about the length of labor were not met, women felt anxious about their body's capacity to labor. When health care providers were also worried, this anxiety was exacerbated.

Laboring with the calendar: will the body start labor on the right day? The due date was the first of several time points that became a focus of concern and anxiety, as if the body doesn't exactly know when to start labor and might start labor at the wrong time. It might start too early, before 39 weeks. It might start too late. Participants who were just one or two days past the due date talked about being "overdue" even though a pregnancy is not defined as post dates until 41 or even 42 weeks (ACOG, 2014b).

The perinatal mortality increases slightly at 41-42 weeks but is still relatively rare, about 1-6 perinatal deaths out of 1,000 (Divon et al, 2004; MacDorman et al, 2012; Smith, 2001). The current management guideline is to recommend an induction at 41 weeks, although the induction process carries a certain level of iatrogenic risk (Goer & Romano, 2012). The due date is an estimate, with wide variation in the onset of normal labor (Jucik, Baird, Weinberg, McConnaughey, & Wilcox, 2013) and the moment at which mortality and morbidity begin to increase for the individual is unknown. The due date represents the 40 week mark, generally considered to be the normal length of

pregnancy although less than 5% of women go into labor on the due date, and some research suggests the normal length of pregnancy may actually be longer than 40 weeks (Jucik et al., 2013; Nguyen et al, 1999; Mittendorf et al, 1990; Bergsjø et al, 1990; Smith, 2001).

In this study, at the end of pregnancy, all but two of the participants mentioned the due date as a concern, either going into labor too soon or too late. Going in to labor before 39 weeks was a problem for two participants, who mentioned the March of Dimes campaign about the benefits of waiting for 39 weeks (March of Dimes, 2014). Although the true purpose of the March of Dimes campaign is to discourage providers from offering elective labor inductions before 39 weeks by educating women, for these participants, the 39 week mark became a test they had to meet successfully. For example, when Catherine delivered at 38 weeks and 6 days she was dismayed that she did not get to 39 weeks, even though her labor was spontaneous and resulted in a healthy birth. There was something a little wrong with her body because she went into labor early by one day, the wrong time according to the calendar. Her infant was a very healthy seven pounds at birth, so for him, 38 weeks and 6 days was actually the perfect time for labor.

Women were anxious about starting labor after the due date. Gabriela was close to 42 weeks at the time she started her labor, and she was very worried that the baby would run out of water and oxygen in the uterus, and that "he might drown." Although the risk of intrauterine fetal death increases at the end of pregnancy, the actual rate of mortality is still low, 1-3 per 1000 at 41 weeks (Gulmezoglu, Crowther & Middleton, 2006), slightly more at 42 weeks (Divon et al, 2004; MacDorman et al, 2009; Smith,

2001). For Gabriela, the possibility of fetal mortality was a very real concern, as if her baby might die at any moment, even though she received prenatal care and had access to interventions that would, for the most part, prevent a fetal death. For her, labor was also at the wrong time according to the calendar.

Uncertainty in early labor: The body will not keep a schedule. Not only does labor not know when to start, it does not have a clear, specific, discrete beginning. Contractions can be irregular and start/stop for hours or days. For participants, certainty was important. For Margaret, the joy of having ruptured membranes was that it was an unmistakable sign of the beginning of labor and she did not have to make several trips to the hospital only to be sent home because she was not in 'real labor.'

This irregular labor pattern can be very uncomfortable and disruptive, especially at the end of pregnancy when the body is very uncomfortable. Helpful friends and family ask why the baby is not born yet. Not all of the participants experienced this phase, but for those who did, they had difficulty accepting the irregularity and uncertainty of it. For primagravidas, there was the additional burden of recognizing the beginning of a process they had not experienced before. Nydia spent the early part of labor online, looking for herbal remedies she could take to help her labor be more definite and move along. She describes this experience.

> I felt like I was most anxious at the very beginning when I couldn't really tell if it was real labor or like what was going on. Because all day Sunday I had contractions, but they weren't very strong, and they were very sporadic. I was overdue at that point. So I was like, okay, what is that? Is that a cramp? Is that gas? Is that a contraction, is my water going to break? What's going on? So that just made me kind of really anxious because I hadn't been through it before and everybody's birth experience is different. So the more people you talk to, the more confused you end up getting.

One of the stresses of waiting for labor was that participants were accustomed to a highly structured concept of time. They had scheduled lives and responsibilities to fulfill. The participants who had small children needed to know if they were in labor so that they could obtain childcare for other children. This was especially true for Catherine, who labored at home, and for Sharon, whose labor was very short. Talisa needed to know when to tell her mother to make the six hour drive from Alabama to be present for the birth.

This need to schedule events was the reason Anita chose an elective induction. She was in school, and if her baby was not out by a certain date, this would affect her ability to register for classes the next semester. This obligation coupled with later third trimester discomforts and the irregular contractions precipitated the decision to request an induction.

The case of starting labor at the perfect time: luck or a self fulfilling prophecy?

Margaret's assessment of the beginning of her labor was that it was at "the perfect time." She did not have the discomfort or anxiety about the beginning of labor that other participants did. She also had the most confidence in her body's ability to labor, stating that labor is "what we are intended to do. Our bodies are made to do that [labor]." Margaret's labor confirmed this belief, by starting at the perfect time, making the correct amount of progress, and concluding without her needing any interventions, all of which were important to her.

She experienced ruptured membranes at 4 AM with a large gush of water-an unmistakable sign. There was enough time for her husband to find a substitute for work and for her to take a shower so she could look "cute" when she got to the hospital. She

had time to eat. The onset of her labor met her expectations and needs, making it fit comfortably into her normal life rhythm. When her labor started at the right time and made the normal amount of progress, this supported her view that her body was working as it should and she could trust the birth process.

Margaret relates her decision to not use an epidural when she was 7 centimeters to the fact that she was making progress.

> I knew I could make it because I knew where I was... I feel like if I had been in 4 cm, like, all day... that would be really discouraging. If you were just experiencing it over and over again but there's no progress, but every time there was more progress.

The challenge for her started when she failed to push the baby out in 5-20 minutes, "like on television." She was very uncomfortable. This part of labor was, "like trying to poop out a cement block." Part of this expectation was shaped by television media, where women push for 5 minutes and then are shown holding the baby nicely wrapped up and clean. Even though Margaret had childbirth classes and knew that pushing could take two hours, the visual picture of a short second stage is what stayed in her mind and shaped her expectation.

Contrasts in time and the birth space: hospital versus home. Time has different meaning in the hospital space than it does in the home space. In the hospital, the measurement of progress over time is highlighted or emphasized. At home, time is relaxed. Labor can take as long as it does. Participants who labored at the hospital felt time pressure, especially as it relates to needing interventions to improve labor progress. At home, the absence of this focus on time offers relief and anxiety at the same time.

Hospital time: the clock is front and center. The measurement of labor progress against time parameters is a fundamental element of labor care in hospitals. Expectations

about labor progress are generally based on Friedman's curve (Friedman, 1967), a graph of what is considered normal labor progress developed in the 1950s. There has been controversy over the use of Friedman's curve to establish norms for physiologic labor because they were based on the labor progress of a small sample of hospital births which included twins, babies in breech presentation, oxytocin augmentation heavier doses of sedation than are used currently, factors which are known to affect the length of labor (Albers, Schiff, & Gorwoda, 1996). Additionally, Friedman defined the outer limits of normal labor statistically, rather than by increases in adverse outcomes (Dykes & Downe, 2009). Recent research has demonstrated that the length of normal, physiologic labor may actually be much longer than previously thought ((Neal, Lowe, Patrick, Cabbage, & Corwin, 2010; Zhang et al., 2010) and that the active phase of labor, where the rate of dilatation is faster, does not start until later in the labor process (ACOG, 2014b). This newer evidence, while beneficial for women in labor, may not have filtered into clinical practice at this point in time.

The measurement of time in labor was a cause of stress and negative emotion. The clock placed directly in in front of the bed was not a friend, reminding women that they were not as far along in the process as expected, a reminder of the body's inadequacy. They worried about how much longer would labor last, and if they were making normal progress. If contractions became slow, rather than perceive this as a time to rest and regroup, they worried that something was wrong with the labor process. If labor was slow, providers suggested Pitocin, or hinted that there might be something wrong with the baby's size.

Perceptions of time were distorted in labor. Gabriela observed that the passing of time slowed down as her labor became more intense. Each minute that she had a contraction was endless, but there was no movement forward, in her body or in the clock. This was her description.

> "The clock was right in front of me. And each minute it was not going forward.... I wanted time to pass and for the contractions to be a little easier, but it was actually the opposite. The contractions were more intense and time was not moving forward at all!"

When the body made progress, women felt reassured because their confidence in the body's ability was affirmed and these moments of greater confidence helped to work with labor pain. When labor progress was slow, or perceived to be slow, they felt more anxious, helpless, and the pain was harder to work with. What if labor never ends? What if I need a cesarean? What if something happens to the baby?

When there was a discrepancy between the anticipated length and the actual process of labor, women felt much more anxiety and doubt, even when the length of labor overall was still normal. Nydia assumed that her baby would be born by dinnertime. When dinnertime passed and there was no birth, she thought the birth would happen by midnight. Then she thought the birth would happen by 1 AM. Then by 2 AM. The clock directly in front of the bed was a constant reminder that she had been in labor longer than she expected, and each hour that passed increased her fatigue and diminished her confidence in her body's work.

As each time point passed and there was still no baby, she had stronger feelings of self-doubt. Her emotions fluctuated between the confidence that came from knowing her body was healthy, and the worry over the labor being prolonged. She thought constantly about all the possible bad outcomes: a cesarean, an infection, or something being wrong

with the baby. She thought about "there's a certain window of time that most people want the baby out before things start to get a little dicey." The term "dicey" does not have an exact medical definition; it just isn't good. It conveys a sense of doom.

When Anita's progress in labor was very slow, she became intensely anxious about having a cesarean. Her labor lasted (by her own report) close to 60 hours, she had meconium stained fluid[5] and she had developed a fever. The actual possibility of a cesarean may have been real. In addition to the worry about a cesarean, she also worried that something was wrong with the baby, and that she might develop hypertension or diabetes. If something is wrong with the body in labor, than there may be other things wrong with the body as well, unrelated to labor.

The second stage of labor is generally longer for primagravidas (El-Sayed, 2012; Zhang et al., 2010), and with the slower progress, they needed more reassurance that the body was working as it should be. When the birth was finally near, the negative dynamic changed. The women had renewed hope and energy. When the baby's head was finally visible, it was possible to push harder than before. Nydia, who had been pushing for close to four hours at this point, describes finding, "…some store of energy that I did not really know I had." When Margaret's birth was close, and her doctor came in to the labor room, she announced, "I'll push all day long. Like, I'll push forever!" Being close to the end helped to replenish the energy and the happiness that the baby will soon be born helps you "table the pain," according to Talisa, perhaps because of the realization that the effort and suffering of the second stage were not endless, but time-limited. Seeing the baby was a confirmation that the body is working as it should, doing its job, and that the

[5] Meconium stained amniotic fluid means the baby has had a bowel movement inside the uterus. Meconium is a thick, viscous substance and can cause respiratory difficulty for the baby if it is inhaled.

pushing efforts were effective. This confirmation helped women push just a little bit harder to get the baby born.

Homebirth time: different space, different perspective on time. The home birth narrative offers a set of interesting contrasts to those births in the hospital. Catherine was particularly articulate about time at home in comparison to time in the hospital. At the hospital in previous births, her cervix was checked at regular intervals, with specific expectations about how fast she should be progressing. She observed, "You never progress as quickly as you should, as they expect you to." There was always something a little bit wrong with the contractions, a little bit wrong with the changes of the cervix. If she were not dilated enough, she needed Pitocin. If her Pitocin was already at the correct dosage, and she still was not dilated enough, she would need a cesarean.

At home, time and numbers did not matter. There was no monitor to tell her that the contractions were five minutes apart. This caused a different worry than her previous births. How would she know what phase of labor she was in? When she expressed worry that she was not timing the contractions correctly, the doula suggested she stop timing them. When her contractions slowed down to every nine minutes, the midwife suggested she have a bite to eat, or take Tylenol PM to see if it would make her drowsy so she could rest. She was surprised that no one suggested she needed Pitocin. When the midwife arrived at her house, she did not even do a cervical exam. The midwife sat and asked her how she was doing.

After four hospital births, Catherine was still very focused on the expectation of moving through labor on a time line. Her midwife asked if she wanted the exam when her labor suddenly changed in intensity after twelve hours of labor. She agreed to the

exam, and discovered she was five centimeters, about halfway dilated. She assumed she would be in labor another twelve hours. She fell apart. She could not do it anymore. Contractions were very intense. She could not get comfortable. She needed an epidural. Her delivery was actually, only 40 minutes later.

"The cervix is not a crystal ball" was her conclusion. Sometimes a cervical exam does not mean what you think it should. In previous births, the condition of the cervix, how dilated it was and how fast it was changing were fundamental elements in estimating the length of the journey through labor, used to predict the timeline, and the timeline in the hospital was extremely important. But for this baby, born at home, having a five centimeter cervix after twelve hours of labor was not a predictor of anything. The cervix can change very quickly, and the birth could be unexpectedly close, even though you are only 5 centimeters dilated.

Working outside of time was frightening and exhilarating. Catherine obsessed about timing the contractions correctly. How could she identify when she needed to call the midwife if she did not have a monitor tell her how far apart the contractions were? She did not want to call the midwife away from her own life and inconvenience her is she wasn't in true labor. She was afraid she might not recognize the labor signs correctly and have an unattended home birth. There was no definition for the right time to do these things at home.

But having enough time for the body to do labor at its own pace gave her confidence as a mother. Away from the monitors and cervical exams, she realized her body could successfully do the work of labor, and this experience of her body's capacity gave her confidence to be a mother and take care of her baby. When she compares this

home birth to the other births in the hospital, she talks about what it means to always feel your body is not quite right, and cannot fully be trusted to accomplish the work or labor. Her final remark, at the end of the interview, was, "You need confidence to be a mother. You should not come through labor with a belief that your body is broken and needs to be fixed."

Keeping it Together, Falling Apart with Emotion: the Highs and Lows of Labor

Emotion in childbirth was a fluid state, where negative and positive emotion fluctuated, shifted, and changed moment by moment as the labor process unfolded. Participants experienced the depth and breadth of emotion in the human experience. They felt hope, joy, and anticipation. They experienced fear, anxiety, and worry. They felt comforted. They felt vulnerable, but in the middle of the vulnerability, they felt strong and felt confidence in their bodies. At moments, they felt powerful and at other moments, they felt dependent on others. They felt tired. The intensity of the process left them speechless. When the baby was finally out, they were exhausted, elated, and in love.

Emotional states in labor were not strictly positive or negative, but shifted from more OK to less OK, from elated and confident to discouraged and scared, including all the nuances of feeling in between. There were positive emotions in the negative parts of labor and negative emotions in the positive aspects of labor. The state of emotion was be contradictory, with a moment of absolute despair that dissolves into confidence when labor progresses or as the result of a supportive word or gesture. Women were overwhelmed with stressful emotions yet have some small measure of confidence persistent deep down.

As described earlier, the emotional shifts of labor depended in large part on time and labor progression. When women felt that labor was progressing as it should, they were more confident. Anxiety and worry moved to the background. When the length of labor exceeded their expectations, or the expectations of health care givers, anxiety moved to the forefront. This anxiety was focused on the perceived lack of progress, but also included anxieties about the baby's well being and their ability to cope with the process if it was going to last longer than anticipated.

The input and attitudes of caregivers and family had a strong influence on women's emotions. It was very important to hear that their bodies were capable and could do the work of labor; this was a message they needed to hear almost continually. When family members or providers were positive and encouraging, women felt less negative emotion. When the provider looked worried, they felt more worry.

The passing of time and emotion in labor. There was a specific trajectory of emotion that occurred with time and progressing through labor. Emotion had a more positive quality in early labor that became more negative as labor increased in intensity. There were many small moments of OK-ness in between negative emotions and small moments of falling apart even when they were doing OK.

Tired of pregnancy, longing to meet the baby: anticipating labor. There were two elements that defined looking forward to labor: being tired of being pregnant and the joyful expectation of meeting the baby. For many women, the third trimester is generally associated with increased discomfort, including stronger and more uncomfortable

Braxton-Hicks contractions[6], low back pain, fatigue, sleep disruption, and general malaise (Davis, 1996). These symptoms were disruptive and the beginning of labor would end this phase of pregnancy. According to Nydia, "I was just uncomfortable and totally done with being pregnant."

Being in labor was the event that brought the baby, and women anticipated this with joy and hope. For Julia, it was something "that made her smile." For Anita, "It was . . . like Christmas. You're about to open the presents and you're wondering what's in the package. . . [you] know you're oh-so-close, [it] is the excitement, the fun of it that it's about to happen."

Not all participants looked forward to labor with this joyful expectation. For some, the expectation was one of anxiety. For Gabriela, because she felt uncertain that her body would successfully initiate labor and bring the baby out safely, the anticipation of labor was one of worry. She also felt worried about the experience of labor pain. This was her third baby and she remembered the pain from the other two births with fear. For her, looking forward to labor involved trepidation along with the joy of the baby's arrival.

Hope, confidence and worry: the beginning of labor. Early labor could involve hours of irregular contractions that started and stopped. This presented several challenges: it could be very uncomfortable even while progress was very slow, or for primagravidas, there was the problem of identifying if it truly was labor. The uncertainty of this beginning was stressful for women accustomed to having important life events scheduled.

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[6] Braxton-Hicks contractions are irregular episodes of tightening of the uterine muscle that become more frequent at the end of pregnancy. They may be painless or painful and they increase women's discomfort at the end of pregnancy

The stress was focused around knowing that you really were in labor and deciding to move to the hospital or bring the midwife to your house, for homebirth. Primagravidas had greater difficulty with this phase, because they had more uncertainty about identifying the point in time where they needed to be in the hospital. This could lead to being admitted to the hospital before it was necessary, for fear of not recognizing the labor symptoms and having a birth in the car on the way.

Even for participants with more experience, this early labor period could still be uncomfortable, uncertain, and full of anxiety. Catherine had four previous vaginal births in the hospital and for her first home birth, she found it difficult to be responsible for recognizing the signs of true labor without a monitor and a nurse to conduct a cervical exam. Trusting in her own body sensations was a new experience for her.

I think I can do this. . .maybe I cannot: Moving into the middle of labor. In early labor, the sensations were powerful but not severe, and coping strategies worked, but as labor became more intense, emotions were more negative with fear and anxiety being prominent. Feeling confident about the process was present but more vulnerable. They were no longer so sure they could do labor physically or manage the emotions and sensations. Fatigue exacerbated this phenomenon. Women wonder, "what if I can't do this?" and "how much longer?"

For the participants who were committed to a natural births, this was a period of questioning whether they could achieve this goal. Margaret and Nydia thought about getting an epidural. A large part of the worry was that the sensation might become unmanageable or that they might lose control and start screaming, an experience that felt frightening in and of itself.

I know I am strong but this is really hard: being in second stage. The second stage of labor felt good and right to participants because they could finally "do something" to help the birth, but it was terrible because the sensations of labor and the effort of pushing were so intense. The second stage of labor was "the hardest, most challenging thing I ever did" according to Talisa. When the second stage was short, women were surprised by the intensity. When it was more prolonged, they experienced frustration and self-doubt because it was slow.

Emotions in this phase of labor followed patterns of emotion in earlier phases of labor, although the intensity of the effort and sensations increased the intensity of emotions. There were moments of confidence and moments of doubt. For primagravidas, the second stage of labor was longer and required more effort. For other participants with prolonged labor, the second stage was an experience of disbelief and fear that it might not work. Anita mentions this in relationship to having an epidural. Since she could not feel the baby moving through the pelvis, she was convinced that she was pushing wrong or that everyone was lying to her. She wanted to feel the ring of fire- that stinging sensation that accompanies the crowning of the baby's head. This sensation right before the baby is out is for most women unpleasant and undesirable, but for Anita, it represented her graduation to being a mother, and she felt cheated when she did not get to experience this.

Triumph and exhaustion: The moment of birth. There were two separate responses to the moment of birth. Participants felt elated, excited, with a great relief and release when the pain stopped, noise stopped, time stopped, and they experienced the initial moments with the baby. There was the moment of holding a wet, squishy, warm,

soft baby. For Talisa, "just feeling whole, having her on my chest and she was so warm. . . when they put her on me and so soft." When she realized her baby was healthy, Gabriela described, "feeling as if her soul had been cleansed. . .all the worry went away" and she was "at peace with God." Her worry stopped and her pain stopped.

The second response to the birth was one of sheer exhaustion, so much that it was not possible to respond to the infant in that moment, or have any emotion, positive or negative. Margaret summarizes this experience as, "I just need some space here." Although they expected a flood of positive emotion at meeting the baby, they also needed a moment to regroup. They felt a need for continued nurture and support for themselves in those first moments after the birth. When all the attention turned suddenly to the baby, they felt a little abandoned. Nydia explained what it was like to suddenly lose everyone's attention.

> I did feel a little bit like I kind of lost. . .my support. . .because he [her husband] was glued to her and here I was. . .bleeding everywhere. He was just off with her, which is what I wanted him to be doing, but at the same time. . .shouldn't you be showing me a little bit more[attention]? I just produced this child.

Keeping it Together, Falling Apart and Agency: Knowledge, Vulnerability, Determination.

As introduced in Chapter 1, agency is the experience of identifying what might affect one's wellbeing and causing it to happen in the world (Kabeer, 1999). It is more than simply participating in decisions but involves bargaining, negotiation, and resistance (Kabeer, 1999). In labor, women's experience of agency involved participating in decisions but also being active in defining the decisions being made, being able to identify what each person's notion of what a good birth was, and bringing that about.

The shifting, changing quality of the labor experience affected women's experience of agency. There were moments in labor of feeling powerful and clear about what they wanted, and moments when they felt vulnerable and dependent on caregivers. These moments waxed and waned in relationship to the intensity of the labor process, the support of others, what different knowledges they brought to the labor experience and for some, the decisions that were made before labor that would support their plans during labor.

Knowing what the body-self wanted. Knowledge is an agency resource (Kabeer, 2005) that can expand a woman's ability to evaluate and make choices for herself. Participants in this study had different kinds of knowing that informed their wants and hopes for the labor process. Some participants were more certain about what they knew and wanted, and advocated with greater determination to achieve their birth plans. Other participants were less certain about what they wanted, and when they encountered hospital routines, they went along with what was being offered.

In general, participants did know what they wanted for labor. Five participants indicated they did not want medical interventions that they did not truly need. The only participants that did not bring up this issue were the two Hispanic participants, probably because opting out of medical treatment might not have occurred to them. One other participant, Anita, chose medical interventions when she opted to have an induction.

Participants were clear in describing what issues affected their well-being. They wanted freedom of movement; providers who would treat them with kindness and respect; privacy, the ability to request, accept or decline medical interventions; protection of their dignity and sensitive caregivers who could read their behavior and provide help

when the labor process compromised their ability to make requests. They also wanted help during labor that was consistent with their goals and values. For example, Nydia, who was very determined about having a natural birth, did not want the midwife to suggest Pitocin and an epidural when her labor became prolonged, even though this could be considered a prudent choice after pushing for three hours with very slow progress. It was not what she wanted.

What does the body self know? Women operated with different knowledges—internal, bodily intuition, previous experience about the body's capacity, or externally gathered knowledge from childbirth classes, family birth stories, information that came from friends, or public media (television and internet). Information gathering started before the birth and for some, before pregnancy.

Childbirth classes were one source of knowledge about birth. There are different types of classes and women tended to select the class depending on their own ideas about birth, or previous experience with birth, in the case of multiparas. Participants also selected classes because they were affordable or because they had did not have access to an array of different classes and chose what was available. Women developed perceptions about birth from watching television, talking to friends, hearing their families' experience of birth, reading books, life experiences with the body, and health information from professional caregivers.

Outside knowledge: childbirth education. Attendance at childbirth education is a common phenomenon in the United States (Declerq et al, 2013). Six of the eight participants discussed childbirth classes. The two participants who do not mention childbirth education were Anita, a multipara who was a midwifery student and thought

she did not need them, and Sharon, who was a multipara, and likely had childbirth education with her first baby. Most participants attended hospital based childbirth education, which has been criticized for being an orientation to hospital labor care, rather than a genuine discussion of options and information about the birth process (Armstrong, 2000; Hotelling, 2013). Participants who specifically wanted a natural birth sought out additional information about coping with pain. For example, Catherine attended Hypnobabies, a class that uses hypnosis techniques to help mothers relax during contractions (see https://www.hypnobabies.com/start-here).

For the two Hispanic participants in the study, the choice of childbirth classes was limited to those they could afford and classes offered in their language. For participants of lower socioeconomic status, options are limited to classes that are low-cost or free. Both Hispanic participants attended free childbirth classes offered by a local Catholic charity. According to the two participants, the content of the class was focused on relaxation and breathing as techniques for coping with labor pain.

For some participants, the information from childbirth education did not meaningfully inform their decision making in labor or shape what they wanted. Both Talisa and Margaret identified that the information in hospital based childbirth classes was not entirely meaningful or helpful. Talisa identified that she could not remember the childbirth class when she was in labor. Childbirth classes are usually offered early in the third trimester, which can be as early as 8-10 weeks before the birth (Mayo Clinic, 2014). Additionally, she noted that many of the options the class offered as helpful during labor were not possible in the hospital. When her labor pain became intense, she didn't know

what to do. This made her much more dependent on medical providers for information about birth, and specifically about pain management.

Finding the right knowledge: you have to know where to look. Two of the participants who wanted natural births sought other sources of information in addition to the hospital childbirth classes. Margaret attended the same hospital based childbirth classes as Talisa, but when she noted that the content was not especially helpful she she sought information on alternative forms of care, strategies for coping with pain without relying on medications. She brought a doula to her labor in case she needed support to implement these strategies. She sought out prenatal groups where natural birth was being discussed as a viable option. When her pain became intense, she walked, got in the shower, counted, breathed, and had someone rub her back. She brought helpers to labor that would support her in using these strategies and selected a doctor who would support this plan. Because these forms of care are more alternative—in the hospital, birth is medicalized (Cook, 2012; Declerq et al, 2013)—Margaret had know there were alternatives, and have the resources to find classes that would teach her about these alternatives.

To arrive at the decision to have a natural birth, participants needed to know that it was possible, that it required opting out of the standard hospital routine and that it would not compromise the baby. This exposure, to natural births and some of the shortcomings of the hospital as a site for birth, started before pregnancy. For Margaret, a recently graduated registered nurse, exposure to the concept of natural birth occurred when she was in college, during her educational process. Her maternity instructors were midwives and the coursework explored the differences between natural and medicated

births. In her hospital maternity experience, as a nursing student, she had seen medicalized birth and did not have a positive view of it. She identified that the hospital does not facilitate physiologic birth or women's choice. If she wanted this option, she needed to make decisions about it before labor and outside of the power structure of the hospital. She arrived at the hospital with a plan, and resources that would keep her plan in place throughout labor.

Inside knowledge: life experience. Participants relied on previous life experience to tell them what they were capable of physically and emotionally. This was an area where the body-self acted in concert. Labor required great physical strength and effort, but also non-physical strength: determination, confidence, the ability to manage, endure, or cope with the physical sensations. When participants had previous experiences of strength and endurance, they were more confident about managing labor. Previous knowledge of their physical capability increased their confidence. If I can do something physically difficult, I can do labor also.

Three participants specifically related their experience of labor to a previous experience of physical effort. These participants compared labor to exercising hard and working out. For Nydia, her knowledge that she could perform a challenging yoga pose for 60 or 90 seconds reassured her that she could work with a contraction that lasted that same amount of time. For Talisa, getting to the end of the pushing phase was just like running: you know you can push harder and longer because you knew you were almost at the end of the journey. Margaret compares labor to climbing out of the Grand Canyon with a broken foot and a 20-pound backpack on her back in the heat of the day, an experience she had before she was pregnant..

Inside knowledge: knowledge of the body. Women's relied on intuitive, embodied knowledge to tell them about labor, a knowledge embedded in their own physical, human experience. Sharon talks about knowing she was in labor, even though she had mild contractions every ten minutes. Some of this knowledge came from previous experiences of birth. They recognized labor and knew how to manage it because they had done this before. Sharon described this element when she was at home in early labor, "I was trying to talk myself through the contractions and breathe real slowly. I knew that I could do that part because I had done that part before."

However, this embodied knowledge felt uncertain, as if it was not entirely reliable. For primagravidas, this was related to the lack of previous experience. They did not know what body sensations meant. Even when the pain sensation was very intense, there was a doubt that it was really labor. Talisa describes feeling an "an immense pain all over" with contractions, but the sensation was not like anything she had read about, discussed with friends or expected. She was not sure that the immense pain was actually a contraction, and depended on her husband to read the fetal monitor to tell her.

When participants encountered medical knowledge, their own embodied knowledge felt more uncertain by comparison. This may be one reason why the monitor readout was more important to Talisa and her husband than her own pain sensations. Participants did not trust their own body-sense, especially if there were medical instruments to read the body's signs. For her home birth, in the early part of labor, Catherine was pre-occupied with identifying the labor process without a monitor, because she was not confident about her own knowledge. In her previous births, the knowledge

from the monitor was always more important than her own knowledge of sensations and her body.

Conversely, Sharon knew at the onset of labor that she was going to delivery quickly. She does not elaborate on how she knew, she just did. When she noted regular contractions every ten minutes, she informed her doctor's office to ask for their advice.

> I'm actually in labor. What should I do? . . .They said, "Well, when your contractions are three to five minutes apart, come into the office, and we'll check you and decide if you need to go down to labor and delivery." I thought, "Well, that's kind of risky." But I'm good at following directions, so I paid attention, and I filled up the time.

Thirty minutes later, she could hardly get out of the bathtub and get dressed to get in the car. Her husband had to flag down an ambulance to escort them to the hospital and she gave birth three minutes after her arrival.

An interesting element of this vignette is the location of the agent in her interaction with the nurse. Ownership of the evaluation of her labor, the decision about what was happening with labor and the decision about where she needed to be were located with the professional and her authority, not with Sharon. When the nurse said, "we will check you" and "we will decide" the locus of control remained with the professional who is claiming the authority of this decision. There is an absence of a partnership with Sharon, where both kinds of knowledge (professional and embodied) are fully involved in decisions about her care and where she needed to be.

Vulnerability and agency. Vulnerability is an experience of corporeality, a condition of the body, and relationality, the self in relationship to others (van Manen, 1990). The body-self is vulnerable because of the intensity of the labor experience and the emotional response to the intensity. This diminished participant's ability to speak up

about what they wanted, and increased their dependence on caregivers. If caregivers were attentive and sensitive to women's behavioral cues, participants were able to get their needs met. For example, when Catherine's doula rubbed her back the wrong way, she was unable to speak and ask her to stop or to tell her how to rub the right way. It was all she could do to push the doula's hand away to make her stop. The doula noticed this behavior and stopped the rubbing. If caregivers were busy, inattentive, or unconcerned about the participants wishes, her ability to exercise agency was diminished.

Being vulnerable in labor had a time dependent element, because women's vulnerability increased when labor sensations and effort intensified as they progressed. In early labor, women were able in early labor to ask for what they wanted, but less able as the labor progressed and increased in intensity. Several participants described being in a alternative state where reality felt "surreal." According to Margaret, this was an experience of being in ". . .this alternate place. . .you are there but you are not really there. . .you can hear people talking but you are not responding. . .you can't talk." This was especially true for participants who had very long labors and encountered a degree of sleep deprivation. Anita described being "in and out", waking up to ask questions but then drifting back off to sleep before the response really registered. Being in a surreal state impaired participants' ability to ask for what they wanted.

This dazed state could add a layer of anxiety because being dazed felt unfamiliar, an experience of not being one's normal self. For Nydia, the dazed state was associated with feeling like she did not have any control and "being out of it." She was not a person who liked being out of control. She explained that during her four hours of pushing:

> I would get into this funky daze where I would fall in and out of sleep and. . . I've never felt like that before. It was really weird. And I

> could feel myself doing it like nodding off and getting really hazy, and then I'd have to bring myself back. And I thought, okay, well apparently my brain is just shutting off. *So I don't know if we're going to make it through this or not (emphasis mine).*

It is notable that a healthy woman with medical insurance in the hospital in physiologic labor actually had that thought, that she and the baby might not make it.

Because women in labor were very nearly speechless, one important aspect of doula care was being able to read the body language of women in labor, because even if they can not verbalized that something is not working, they can and do demonstrate this with their bodies. When Catherine's husband was pushing on her back and it was not working for her, she abruptly moved his hands away because she could not verbalize that she did not like the pressure on her back. Catherine describes this further.

It's really hard in labor to express what I'm needing or wanting, and sometimes I don't even know. So it really helps to have people who are quietly watching. That's one thing I really loved about having my doula. . .they were good at watching. I remember something my doula said to my husband, she said, "Try things, and then she'll let you know if it's not working.

Determination: having a voice and a plan. The use of one's voice is an experience of corporeality, but to have an effect on the world, there must be a trustworthy human being who is listening, so it is also an experience of relationality. There were occasions when women asked for what they wanted in labor and moments when they did not. A substantial number of wants or wishes were not expressed at all. In the narratives, these wishes were identified by their absence, when women described the emotions experienced because an important or necessary item was not part of the birth experience.

Using one's voice: asking or not asking. Julia wanted to stand up in labor. Sharon wanted to stay on her hands and knees. Anita wanted the people coming and going in her labor room to stop and introduce themselves. Talisa wanted to walk outside and get some air, and to wear her own clothes. All of the participants wanted to labor out of bed. These are things women wanted but did not ask for. Being vulnerable impaired women's ability to ask for things they wanted, but also there was a concern about being impolite, asking for too much. Other barriers to asking were related to hospital routines. On arrival to the hospital, the monitors were applied, the IV line inserted and once these items were in place, mobility was constrained. For the Hispanic participants, the language barrier added an additional obstacle to asking.

The experience of not-asking is an example of latent power, when the mechanism for expression of power (in this example, the power to prevent a decision by preventing the discussion of the issue altogether) is covert or hidden (Komter, 1989). Women may self-silent anticipating a negative reaction from the caregivers, and avoid expressing their wishes altogether.

In this study, when I asked participants, "would you have wanted to stand up?" and "what position would you have wanted to give birth in?" the conversation stopped completely. This possibility was not part of the narrative. Sharon, after giving it some thought, wondered if she might not have needed an epidural with her first baby if they had let her stay on her hands and knees.

Gabriela did not ask to get out of bed because she was too embarrassed by all of her vaginal secretions to get up and walk. She wanted to ask for underwear and pads

(she knew they existed) but was too embarrassed to ask for them. She explains that she did not want to be rude,

> I said [to myself], why don't I ask for one of those so I can go walking but. . .it was like I lost my courage . . .the embarassment that I had to ask. . .uncomfortable. . .it must be that I am not acustomed to always be asking, if they would offer, I would say, "Oh, yes!" But ask for it? No.

On the ocasions when participants did speak up, some requests were granted but not others. Anita and Talisa requested epidural anesthesia and they received it. But when Gabriela requested care from a midwife that did not perform painful vaginal exams, the labor nurse told her there was no one else available to perform the exams. While it was possible to ask for something that the hospital offered, such as an epidural, if a participant wanted something that was not on the hospital menu, this request was less likely to be granted. Obtaining an epidural is a simple, straightforward process but asking to get out of bed met with more barriers.

Making a plan: a form of asking. A birth plan is a set of decisions made before labor, that may be laid out in a formal document or may simply be general ideas about what a person wants in labor. Although a birth plan can be a valuable tool for communication between patients and caregivers, they have been criticized for creating unrealistic expectations about control during labor and increasing the risk for patient-provider conflict (Lepsch, 2005).

Having a birth plan is one way that women may circumvent the latent power at play in the hospital (Komter, 1989), because the plan is developed before labor, and away from the power dynamics of the institution. A birth plan gives women the opportunity to

make choices that will support their preferences, like hiring a doula or finding a provider who will support the plan.

However, even with a birth plan, women encountered resistance to expressions of their agency. Nydia's birth plan included intermittent monitoring (listening to the baby every fifteen or twenty minutes with a hand held ultrasound device), but the nurse required Nydia lie in bed fifteen minutes out of every hour for continuous monitoring. The option of a telemetry monitor[7] was not offered to Nydia or the option of standing next to the monitor, although this would have been an acceptable choice and met the requirement for the 15 minutes of monitoring. She was told this monitoring practice was hospital policy, although intermittent monitoring is an acceptable, safe form of fetal monitoring (ACNM, 2010) and there is no evidence that fifteen minutes of continuous monitoring is necessary for healthy women in spontaneous labor (Devane, Lalor, Daly, McGuire & Smith, 2012). Telemetry monitors were available at all of the hospitals where these participants gave birth, but not offered to the women. None of the participants knew it might be possible to request them.

Three participants-Margaret, Catherine, and Nydia-wanted natural births and created birth plans to support this wish. They sought a provider who would be comfortable with natural birth. Margaret chose a doctor who was known in the community to be supportive of natural births, because midwifery care was not an option in her insurance plan[8]. She was confident about this physician's ability to support her

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[7] A telemetry monitor is a wireless device, and therefore, not connected to the machine. This leaves the person free to walk, as long as they remain in the range of the wireless signal. The person is still not free to go anywhere they would like.

[8] This is an example of one of the barriers to accessing midwifery and natural birth care. Aetna is the primary insurer for all employees of Emory University and Emory Hospital—approximately 42,000 persons. They do not list any midwife providers on their preferred provider list. If an employee wants midwifery care, they require personal knowledge of which local physician providers also employ midwives.

plan because he "doesn't care what they say.... he's going to do what he wants to do at the end of the day... he'll chew them out if he needs to." For Margaret, it was not so important that he have a pleasant personality, but that he be able to support her birth plan.

Nydia and Catherine chose midwifery care. Catherine opted out of the hospital altogether and chose a homebirth. Although the out of hospital birth plan felt more risky, she had autonomy and authority at home. The knowledge about the birth was located with her, not with the caregivers or the technology. Having her own knowledge was gratifying. She was very excited when she identified on her own that her labor was progressing. She comments on the differences between the home and the hospital, where she had her first four children.

> I think, no matter where the setting . . . it's showing concern and. . .respect for the mother's autonomy, I think. It can be very hard in a hospital. . .for the mother to feel like a patient, as in giving up choices. [You] do what they tell you to do. . . I think that's a big issue with the maternity system . . .we need more informed consent, we need more working together. I think that was a big difference for me.

Some participants had birth plans but did not create a formal document. Sharon had two items on her birth plan: not to receive interventions she did not really need, and not to be tethered to the bed (by the monitor and IV). Because of her late arrival, she did achieve her wishes for the most part, although she had to change into an uncomfortable position for the nurse to apply the fetal monitor.

Talisa hoped she would not need interventions, but did not make a birth plan because she did not want to be disappointed if the birth did not go as she hoped. She did not want to grieve about the birth experience that she did not get to have. Anita's birth plan involved a mix of medical interventions and natural birth. She requested an

induction, but wanted to have a waterbirth "where everyone was singing Kumbaya." Gabriela and Julia (both Spanish speaking immigrants) did not mention birth plans, possibly because they did not know that requesting specific kinds of care was possible.

When induction is the plan, what happens to agency? There are points in the labor process where one decision or set of decisions influences what options become available at a later phase. Talisa hoped for a birth with no interventions, and when she had ruptured membranes, she hoped that she could wait to see if her labor might start on its own. After four hours of waiting, her providers recommended that she have an induction of labor, and she concluded that because "the cervix did not dilate anymore at all. . . they had to, at that point, intervene."

The management of prelabor rupture of membranes at term is controversial and has changed in recent years. In 2007, the American College of Obstetrics and Gynecology recommended an induction at the time of presentation (ACOG, 2007), although a Cochrane Review in 2010 did not find sufficient evidence to recommend induction and concluded that women should make an informed choice regarding induction (Buchanan, Crowther, Levett, Middleton, & Morris, 2010). The primary risk associated with prolonged ruptured membranes at term is the increased chance of an intrauterine infection that would affect both the mother and the baby (ACOG, 2007), but the induction process is not risk-free, either (Goer & Romano, 2012). In 2013, ACOG amended their recommendation to be more consistent with the Cochrane Review (ACOG, 2013) although this evidence may not have started to fully inform hospital practice at this time. About 79% of women with ruptured membranes will start spontaneous labor within

12 hours and 95% will be in labor within 24 hours (Dare, Middleton, Crowther, Flenady, & Varatharaju, 2006).

Talisa may have chosen an induction had it been presented to her as a choice, but in this situation, her perception is that induction was the only option. There was no discussion of the possibility of waiting for labor to start or the limitations to her freedom that an induction would bring. When she agreed to having the induction, she became committed to continuous electronic fetal monitoring (EFM), IV fluids and bedrest, which made it less likely that she would be able to achieve her goal of remaining mobile. It also made it more likely that she would require an early epidural for pain management (Moore, Shan, & Hatzakorzian, 2013). This was the case, as she requested an epidural after four hours of labor when her cervix was still closed.

Anita also had an induction, which she specifically chose and negotiated for. Her provider, a midwife, was against it because her Bishop's[9] score was low, and the likelihood of a successful induction is less with a low Bishop's score. Anita was a nurse and a midwifery student, so she was well versed in the process of induction and what it involved. Anita emphatically negotiated for the induction, even after she had been in labor for 24 hours with very little progress. Anita pressured the midwife to rupture her membranes, because this would commit her to moving towards delivery and also increase the chance that the induction would work more effectively (Cunningham, Leveno, Bloom, Hauth, Rouse, & Spoong, 2010a).

[9] Some time before labor starts, the cervix begins to demonstrate the body's readiness for the labor process, by becoming shorter, softer and slightly dilated. The Bishop's score is a scoring system that rates these changes and has been used to predict the success of an induction. When the Bishop's score is low, there is an increased risk that the induction will result in a cesarean delivery.

Although this plan of care was Anita's expressed wish, she lost control over other items of the birth that were important to her. In all clinical protocols, an induction requires continuous EFM and IV fluids. The rupture of her membranes and the Pitocin infusion caused severe pain and the pain prompted her to request an epidural. The use of the epidural committed her to bed rest.

The pain relief was necessary but she did not like being immobile. She had not envisioned this loss of control over her experience. Although the induction was her choice, and something she had to insist and renegotiate at various points in her labor, the effect of the medical procedure was to reduce her freedom and prevent her from accessing some of the choices that were important to her. She describes this conflict and how it affected her,

> You're strapped to a bed, especially once you have the epidural. You can't get up and move around. Before that, I wanted to get in the shower and they're like you can't really get in the shower because you have this and that going on. I. . .[said] I want to go walk around and do this. They [said], well, we need to check you. So when you have people telling you opposite of things that you want to do, it just got so frustrating, like you just lost control of the whole situation. So she[the doula] would just reassure me. . . you know that you can't have it.*[all of the other options she could not have, like getting into the birth pool for pain relief]*. . .I'm like I know. But it's kind of frustrating when people tell me no. . . For someone else to control it and I could not . . . that was very hard. . . It wasn't supposed to go that way. We were all supposed to be singing Kumbaya in the pool and all of that.

Asking for an epidural: the unexpected effects of pain relief. Two participants used epidural anesthesia in labor, Talisa, who requested an epidural after 4 hours of labor, and Anita, who requested an epidural after 24 hours of labor. The benefit of pain relief

notwithstanding, the use of pain medications and anesthesia increased women's vulnerability by limiting mobility and for Anita, fatigue having an additional effect as well.[10] The immobility with an epidural can be variable, but most women with anesthesia in labor need help changing position in bed and need to be catheterized to avoid bladder distention (Mayberry, Clemens & Anindya, 2002). The limitations of mobility and dependency on others places women in labor into a position usually only occupied by infants or adults who are extremely ill.

With an epidural, Anita found the loss of control over her own body distressing and difficult. She could not feel anyone touching her legs, and she could not change her own position, so the nurses had to turn her from side to side. She had to have a catheter for her bladder, and when she had a bowel movement in the second stage of labor, the nurse changed the linen and cleaned her. She did not like the fact that she could not feel other people touch her body. The anesthesia relieved the pain, which was a blessing, but the loss of control over her own body was difficult in and of itself, even without the labor pain.

Agency and feeling desperate: taking matters into your own hands. Feeling desperate was an experience of relationality that had become untrustworthy or unreliable, of encountering human beings who were unconcerned about one's well-being. When requests for help or care were met with resistance or were ignored, women felt anger, frustration, and helplessness. The lack of concern and compassion, for example, when Nydia's nurse would not take her off the monitor to go to the bathroom, or when Gabriela's midwife did painful vaginal exams, contributed to feeling desperate, and the alientation reduced women's drive to be nice and polite. Gabriela described her

[10] Talisa's induction lasted 23 hours, and Anita's induction lasted 60 hours by their own reports.

experience, “She would stick her whole hand in, she didn’t care if it hurt or not.” Not only did the midwife cause pain, Gabriela perceived that she did not care that her exams were causing pain, so the care was all the more calloused and insensitive.

There were different responses to feeling desperate. Gabriela wanted to go home in active labor, and she seriously considered it. A number of conditions prevented her from actually going home. Getting out of bed to try and find another hospital and another provider was impossible in active labor. Furthermore, she was an immigrant with Medicaid insurance, and her choice of hospital and provider were restricted to those places that accepted her insurance. Alternatively, she could have an unnattended home birth, an option that was not viable from her perspective of safety. Finally, she and her husband did not believe she would be allowed to leave the hospital. This illustrates an important point; that if women in labor are unsatisfied with the care they are receiving, they are not in a position to find a setting or provider that might be more satisfying.

However, there were participants who felt desperate enough, and when the situation felt dire and unacceptable they reached a place where they were willing to be rude, to break the rules and take action that would resolve the dilemma. When Anita wanted her Pitocin dose turned down, with no results after several conversations with the nurse, Anita decided to take control of the dosage herself. She wanted to be in control of the level of pain, so that she could work with it.

> I felt like the Pitocin was doing all of the pain. . .I couldn’t get control of it and I couldn’t like prepare for it. So I just [said]. . . if you’re not going to turn it off, I will turn it off. Because no one is listening to me so I’m just going to do it. I think in between the screaming and me hitting the buttons, they kind of got the idea of what I was trying to say.

Nydia experienced this alienation and desperation when she needed to go to the bathroom, and the nurse left her on the monitor longer than the required 15 minutes. Her labor process was very intense at that point. She called the nurse several times. Finally, her husband suggested she could take the monitor off herself and she did.

> It was very upsetting to me and my husband kept going to get the nurse, my mom went to get the nurse, I hadn't seen the midwife in a while because she was dealing with another birth. And I don't know, I just felt like everybody is ignoring us, I'm in pain, I have this stupid monitor on me, and I can't go anywhere and I can't do anything.

Both participants were apologetic about their behavior, and not being able to be a 'good patient.' Nydia commented that she felt kind of silly over ". . .just a monitor and a strap" although she characterizes the incident as "the worst part [of labor]." There are two interesting issues in these narratives. Nydia seems to be operating with a need to be offered permission to take the monitor off. In this case, it was her husband, rather than the nurse, but it is interesting that she was waiting and the decision to go against medical advice was not something she could achieve unilaterally at that point. This demonstrates the vulnerability that women feel in labor.

The second interesting issue is Anita's understatement, ". . .Between hitting the buttons and me screaming they kind of got the idea." There is an interesting contrast between the intensity of her communication (hitting the buttons and screaming) and the blunted response (they kind of got the idea). There was a wide gap between what she needed, was asking for, and what caregivers were offering and her language underlines how alienated she felt.

Agency and spatiality: who owns the birth space? In general, women choose hospital birth because of perceptions of increased safety in the hospital, to access medical pain management, and be close to emergency care (Regan & McElroy, 2013). However, entering the hospital places women in a space where they do not have ownership. The furniture of the labor room consists in large part of equipment: for monitoring, for administering medications (such as IV pumps), or for performing medical procedures. These objects are for the use of hospital personnel and their placement is selected to facilitate the workflow of the hospital (Lepori, Foureur, & Hastie, 2008).

The bed is placed in the center of the room, and there may not be any other furniture where a woman can stand or lean on comfortably. The bed has side rails which are raised in labor, creating a kind of crib. If a woman in labor wants to get out of bed, someone standing by the bed has to put the side rails down, because the latch is placed on the outside of the rail. To go to the bathroom, be mobile or have some food or drink, a woman has to ask permission or ask someone to bring her the items. Because of the long standing practice of restricting food and drink for women in labor (ACNM, 2008), the nurse may be uncomfortable making food and drink available. Many hospitals still have restrictive policies around eating and drinking (Declerq et al., 2009).

Ownership of the space includes ownership of the body. Women in hospitals wear hospital gowns, even though there is no medical reason to do so. The gown is open in the back and has snaps over the shoulders to facilitate the placement of monitors and IV tubing. Talisa asked if she could wear her own gown in labor and she was told that it might get soiled. She wondered why the hospital should be concerned if the soiled gown was hers and the birth process and body fluids were also hers.

The placement of IV lines, application of the fetal monitor and vaginal exams are obstetrical routines that are nearly ubiquitous in the United States (Cook, 2012; Declerq et al., 2013) and specific consent is not usually sought for these items (I have observed it very rarely in 30 years as an maternity provider), although theoretically consent for these items is included in the general consent to medical treatment all patients sign on admission. Bergstrom and colleagues also identified that providers assumed consent from women prior to vaginal exams but did not specifically ask their permission (Bergstrom, Roberts, Skillman, & Seidel, 1992). In this study, the only example of a provider asking permission to perform an exam was in Catherine's home birth.

Ownership over the space includes how the space is used and what kind of interactions happen in the space. The morning of Anita's delivery, the nurses began an argument in her presence about their own work during change of shift. This was done without acknowledging Anita's presence or the effect an argument might have on her emotions. This staff argument defined the space as their work space, a place where it is appropriate to have a conversation about work. For Anita, this was dehumanizing, because it ignored her presence, but it was also one more reminder that others had decision-making power over the use of the private space of her birth.

Keeping it Together, Falling Apart Around Others: Relationality in labor

Relationality is the fourth of the four existential themes in phenomenology (van Manen, 1990). The human experience occurs in the context of a community of others that share, interact and shape what happens, how it happens, and how it is perceived. This experience of human connection (or disconnection) shapes and moves the dynamic, changing quality of the labor. When participants felt known and connected, when people

around them responded to their needs or read their behavior, emotions had a more positive quality and moved in the direction of keeping it together. When caregivers were neglectful or even unconcerned the woman's experience, women's emotions moved in the direction of falling apart.

There are three distinct clusters of humans women interact with in labor. Professional caregivers include registered nurses, midwives, and physicians who are responsible for the physical care of the woman's body in labor, for evaluating the labor process and in hospital settings, for choosing and implementing medical interventions. The second cluster is family, who are involved and invested in the emotional care of the woman in labor. By offering comfort and soothing negative emotions, they affect the physical self as well. Doulas bridge the gap between these two clusters, offering information and emotional support as well as emotional and physical comfort. The doula's also acts as advocate on behalf of a woman's wishes, helping her to know and choose the options she wants.

The body-self in relation to family. In the 1970's maternity care institutions began to allow the presence of family members in the labor room (Wertz & Wertz, 1977), and currently, it is an expectation that family will be available to provide support and comfort. All of the participants in this study labored with the support of husbands or other family members. Anita was accompanied by a doula and her 20 year old son.

Family members cared for both the body and the person, interacting with women in labor not as one or the other, but as a whole person. They offered physical comfort for the body: ice chips for dry mouth, a cool cloth for the forehead, a back rub. They offered emotional comfort, encouragement and affirmation, reminding the laboring women they

were OK, the baby is really moving down, you can do this. Talisa's mother kept a running commentary of soothing maternal remarks, "you are OK, this is normal, everything is fine now." Women needed to hear this message almost continually during labor in to feel more OK about the process.

Family members could offer mix of helpful and unhelpful behaviors. For example, Gabriela's mother thought she should have a cesarean so that her pain would stop, even though Gabriela emphatically did not want a cesarean. Additionally, Gabriela's mother made an unhelpful comparison when she said, "you look like a destroyed chicken" during vaginal exams.

Agency and family: they will do whatever you want for as long as you want. An area where women could and did exert their agency more freely was with their families. In general, with regard to family, the women in labor decided who could be present, who should leave, what kind of support they needed. When Nydia's mother made an unhelpful comment about how contractions looked on the monitor, Nydia responded decisively and swiftly by asking her mother to leave. Conversely, she was far less decisive about taking her own monitor off when she needed to go to the bathroom. Talisa described how her sister rubbing her scalp, and commented, "my sister gave me like a head massage. . . and [she] will do it as long as you need it." Families were less constrained by time and would provide whatever help was needed endlessly.

At first glance, the dynamics of family interaction appear to support women's agency but this was not strictly the case for all participants. Family members sometimes encouraged women to accept the hospital expectations. For example, when Julia arrived at the hospital in advanced labor, she refused to lie down. She was adamant about it. Her

husband had to convince her that she needed to behave according to the hospital's expectations. She explains,

> He was attentive and said, 'Please, lie down.' I said, 'No, because then they will have me lying down there and I do not want to. He said, 'No, those are the rules here that one has to. . . that all of you have to lie down.'

For Julia, the importance of this moment was not that her husband kindly helped her achieve her wish to stay out of bed, but that he kindly helped her to see and accept the hospital's rules.

Participants felt obliged by politeness and the need to be appropriate with family members, which could actually constrain their agency. Talisa admitted her mother-in-law into the labor room, even though she did not really want her present. She felt that she needed to give in to avoid strain in the family later on. She explains,

> I felt kind of pushed or bullied into the situation because. . . I don't like there to be [a] rift. . . I'm doing this to avoid her acting like that. I almost felt like it's feeding into the bully or feeding into the nuttiness that is what would come. Like, [the mother-in-law would later say] oh, her mom was in there but I wasn't and it's our grandchild.

Women felt a need to edit their behavior in front of family, feeling constrained to be polite and to keep quiet, even when the labor process was intense and women might have wanted to use their voices. Gabriela wanted to yell at her birth when the contractions were intense, but restrained herself because it would upset her family, and its not proper for a Hispanic woman to "make a scandal"[11].

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[11] Making a scandal is a phrase used in Spanish related generally to being loud in situations where softer speech is required. It could be translated as "don't make so much noise" but could also be translated as "stop complaining." Don't make a scandal is a phrase Hispanic mothers might say to small rambunctious children.

The body-self in relation to the doula. Three participants had doulas. Catherine and Margaret engaged doulas because they expected their husbands to need help during labor. Additionally, Margaret wanted to make sure she did not need support from the nurse at the hospital, because she assumed she would not receive much support from the hospital staff. Because she wanted a natural birth, it was important to have someone there who could support natural birth and knew how to help women navigate the labor process without using medications. Anita did not have a partner, and her son (who accompanied her) was only 20 years old. She was also hoping (at the beginning) to have a water birth, and may have engaged the doula to support this option.

One of the benefits of having a doula is that although a spouse might be very anxious about the labor process, the doula was not. Anita mentions that during the long night when she worried she would need a cesarean, her 20 year old son was calm because the doula was calm. This was especially helpful when the midwife ruptured her membranes and she "flipped out" from the pain.

The doula provided a respite from the focus on the medical aspects of the birth or the preoccupation with what might go wrong, which brought relief from the anxiety and concern about whether the body was working or not. Anita's doula would "make her laugh, talk about something else, or talk about life" when everyone else was coming in and focusing on "why haven't you gotten the baby out yet." This helped her to "keep [my]. . .mind off of why isn't the baby coming out."

Doulas offered instructions to the family about how to help the woman in labor. In a previous birth, Catherine had encountered a doula that took over all the labor support and left her husband feeling on the outside. She was anxious to have a doula that would

support her husband in a way that felt inclusive. Before her labor, she discussed this with the doula and selected a doula that would help her husband take an active role in Catherine's support.

The body-self and professional caregivers. There are three types of health care providers in these birth narratives: obstetricians, midwives, and registered nurses. Participants expected, or hoped that providers would know them as people, that they felt some form of personal connection and that they could conduct the job competently. Most participants kept the call schedule at home and had it memorized, trying to go into labor on a day when a specific physician or midwife they liked was on call.

There were exceptions to this finding. The two Hispanic participants did not mention knowing the provider or keeping the provider's call schedule, presumably because they did not expect to know the midwife in labor. In a public health system, knowing the provider is less likely and they may not have expected this option. The second exception was Margaret, who had a provider who was a solo practitioner.

It was important for women to hear caregivers express that they had faith in the body's capacity to labor, because this supported their confidence, which was important in determining how women felt during labor. For Margaret, this was a topic she brought it up repeatedly during her prenatal visits. She needed to hear her physician say, "I want you to do what your body's designed to do." During the last night of Anita's labor, when she was so afraid that she would have a cesarean, she asked the midwife to sit down and tell her what she (the midwife) was thinking about her labor. When the midwife said, ". . .I think you can have this baby" Anita stopped worrying. Anita needed her provider to

have confidence in her body. When the midwife expressed this out loud, it was a pivotal moment that changed the experience.

The range of caregiver interactions: connected, disconnected, alienated. Relationships with professional caregivers covered the spectrum of behavior from caring and sensitive to detached and dehumanizing. There were examples of caring and uncaring behaviors in all three professional groups. Time was not always an important element in the quality of the patient-provider relationship. There were examples of providers who had a very short relationship with patients and still created connection and warmth. The converse was also true-providers who had a longer relationship with women could feel very detached.

Feeling connected. The birth felt like an intimate, personal event and it was important that those present feel connected and intimate. Participants wanted a provider who cared about them as a individual, not just part of the job. Six of the eight participants wanted a provider that knew them and was a person they liked. The connection was fostered with verbal and non-verbal behavior. When Sharon arrived on the labor unit in a crazy panicked state, with "stuff pouring out of my body" the doctor looked at her eyes to speak with her, and Sharon felt "she was with me." This connection created a pivotal moment in labor. In the middle of all the craziness, embarrassment, and feeling out of control, there was one element that offered her an anchor, the human connection created when a person looked into her eyes.

There are other examples of verbal behavior that felt connecting. For example, when Gabriela's nurse kept up a soothing conversation during the part of her labor that felt so difficult.

> The nurse was very positive, she would say, look, your baby is coming, it's a little boy. What are you going to buy for him? Are you ready? Do you have all of his little baby things? Do you have a crib, his things? She would ask me so that I would not feel so bad.

The content of the conversation was not so important as the nurse's engagement with her as a person, a human being.

The connection could be just a feeling about the caregiver, an undefined quality that was reflected in their verbal and non-verbal behavior. Julia explained that her connection with the nurses in labor was like family, and that she felt loved. I asked if she meant the nurse was nice or that she liked her. She emphasized that what she and the nurse felt for each other was love, "like in a family." Julia explains this further,

> "I don't know English. I understand a little, and I felt they were speaking to me with great love. . .It was how they came close to talk to me and how they expressed themselves. I felt that one of them was my sister. They would say, 'let me support you, give me your hand so I can help you.' That is what I felt... a great love. "

The body-self disconnected. There were provider interactions that felt disconnected, for example, when participants felt the health care provider was busy with the care of other patients. Half of the participants mention that the caregiver's was busy. Talisa only saw her doctor twice in her twenty hour labor, on admission and at the delivery.

Although registered nurses were more present in the room than physicians, there were many more descriptions of the registered nurses absence. Participants perceived the registered nurses as very busy. Sometimes the registered nurse made specific references to being busy with another delivery. Only two participants describe the almost continuous

presence of the registered nurse in the labor room, Gabriela and Julia, who delivered at the public county hospital.

There were more descriptions of disconnected care than caring, connected care. Disconnected care involved being more concerned with the tasks involved in managing medical interventions, than the person and their human experience. Disconnected care occurred when providers were more concerned with policies, or the routine way of doing things at the expense of the woman's comfort or emotional well-being.

Disconnected care included not noticing the woman's behavior and understanding what it meant in the labor process, the opposite of what doulas did for women in labor. The experience of not noticing the laboring woman's behavior occurred when Gabriela and Julia informed providers they needed to push. On both occasions, providers instructed them not to push because it wasn't time yet. When they both started pushing spontaneously, caregivers were astonished, and had to scramble to get ready.

At times hospital caregivers talked around, above or at women and this contributed to feeling disengaged, even while the caregiver was performing some care on the body. Right before her birth, Talisa's nurse poured oil on her perineum to act as a lubricant for the delivery. This is an intimate act involving a private body part, and while the nurse explained to the doctor what she was doing, she did not explain it to Talisa. Talisa felt they were working on her body, doing a job but not caring for her as a whole person.

Talisa mentions that "they talk around you" and they talk to each other (about you) in your presence "more than they talk to you." In general, her overall experience of the nurse was positive and nurturing, but at moments when she wanted to have a

conversation about her care, she had a perception that the nurse was busy and that her request might be keeping the nurse from doing something more important.

Talisa wanted the professionals to include her husband into the conversations about her care. For her, his involvement was essential. As labor intensified, she felt more and more dependent on his support and information about decisions. She felt groggy and not fully present, and having her husband hear explanations became critical as her labor progressed. She had great difficulty getting her medical providers to include him in the discussion. In conversations, they would turn their backs. When he spoke up and indicated he was involved in the conversation, they would ignore him. She repeatedly had to ask him to come around to the other side of the bed and pretend he was in the conversation.

*The body-self, alienated***.** There were instances of care that was so detached from the person to be dehumanizing, when the woman in labor felt like a non-person, not someone deserving respect but just a body waiting for the baby to come out. These were examples of care when women felt completely excluded from having meaningful input into their own care. Nydia's experience of not being able to get to the bathroom because she was on the monitor, Gabriela's experience of painful cervical exams and the midwife's lack of concern about the pain she was causing, and Margaret's experience of being coerced into a vaginal exam in triage (even though her doctor had said she should avoid them) so that she could be allowed to go to the bathroom are examples.

For Anita, care felt dehumanizing when her caregivers began to have whispered conversations in her presence, conversations about her care and her situation that specifically excluded her from having any input. She felt like,

> When you're a school kid and there's the popular kids on the other side of the room and they're whispering and looking at you. You're feeling like oh, I'm not included or I must not be as popular. That's what it felt like, like I was that school kid not in the popular crowd at that point. . . But that's what it felt like, like I should be included in this. This is about me. But yet, they're not telling me. So once again, I was frustrated. . . I was angry like that little school kid, just had no way of dealing with it.

When she summarizes her feelings about her experience of labor care, she says it was "good care" because her vital signs were checked and the nurses came rushing in if there was anything abnormal with the baby's heartbeat. Her physical care was excellent, but the care of her person was not.

Summary

The experience of labor is a dynamic, complex, nuanced, multi-layered universe in which women, their families, doulas, and caregivers interact to bring about the birth. Women experience labor as a physical and non-physical self, not one or the other, but as a whole. The experience of labor takes place within the woman's body, but affects and is affected by her emotions and her agency. The relationships in labor belong, not just to the physical self or the non-physical self, but to the whole person.

The experience of labor is also a dynamic movement between positive and negative states, from keeping it together to falling apart and all the nuances in between. The body moves, the emotions shift and change from positive to negative and all the nuances in between. Women use their agency to cause the world around them to move, but the experience of agency itself also moves, stronger at times, vulnerable at others. These shifts in agency and emotion depend heavily on the dynamics of relationships with others and the experience of the physical space. Women labor moving in between states, between navigating and drowning, falling apart and pulling it together, vulnerability and

strength, feeling capable, and fearing that she or her body might not be capable. When the motion finally stops, they start the new adventure of welcoming a new actor, a wet, loud, warm, squishy newborn into their whole self-the body, the emotion and the agency of a parent.

Chapter 5: Discussion

The experience of the body, emotion, agency, interaction with family and health care providers, and of the space of birth have been described. This chapter will explore the meaning of these findings, and discuss the significance of having a contextual, holistic understanding of birth within the health care environment.

The Phenomenon: Moving Between Keeping it Together and Falling Apart

This findings from this study have demonstrated the complexity and dynamic nature of childbirth. Labor is a journey where the weather can change in an instant. Women move from back and forth from keeping it together to falling apart a few moments later. There are peaks and valleys of emotion, of agency, and of confidence in the body that shift as labor progresses and the body-self moves through space and time, interacting with other humans along the way.

A woman in labor is a person in a changing, moving state: from one body to two bodies, from woman to mother, from falling apart to confident, from hope to despair and back again to hope, from anguish to triumph. The configuration of her family is changing. The location of the birth may change, from home to hospital. Understanding the dynamic quality of the childbirth experience and the woman-environment feedback loop that creates the movement offers an opportunity to develop maternal care systems that address each unique individual in the context of her life, and strengthen a woman's sense of herself through the childbirth experience. This will promote birth experiences that enhance wellness and are salutogenic (Downe & McCourt, 2008), rather than traumatic.

This dynamic quality of the labor experience, fluctuating between being OK and falling apart was an unexpected finding, particularly in mixture of positive and negative responses. The description of the complexity of women's responses to labor was unique. Although other researchers have described the contradictory, oppositional quality of women's emotions, the mixture of positive and negative elements and the moment to moment shift in emotional states have not been described previously. In this study, there were positive emotions in the negative moments, and negative emotions in the positive moments. The effect is not a fluctuation between polar opposites, but rather one of co-existing states of being that shift and change moment to moment.

Keeping it Together, Falling Apart of Mind and Body

In this study, the keeping-it-together-falling-apart experience was deeply embedded in the sensations of the body, the beliefs about what the body could do, and the loving presence of others who touched the body in ways that were comforting and supportive. The experience of comfort involved being known, feeling love and intimacy, feeling human touch, and having calmer emotions. Keeping it together depended on ideas and thoughts women interpreted their labor experience with, but also on their ability to move in space and make the body more comfortable. When women experienced confidence in the physical being, their sense of self as a person was enhanced. If the body was restricted, hurt or injured, their sense of self diminished. The converse was also true. When the emotional self in labor was more negative, the body was more uncomfortable as well. Not a body or a self, but a body-self as a single entity responding to the labor process.

Women in labor wanted to be treated as a whole person. When they encountered health services that prioritized the care of the physical body, they felt diminished and experienced discord. In this research, there was a tendency in the hospital to prioritize the care of the body over the care of the whole person. This separation of body and self experienced by women in this study has been described by midwife writers, such as Fahy (2008) and Foureur (2008) as a characteristic of Western medicine, which developed within the Cartesian paradigm of mind-body separation. This paradigm is changing, and the interactions between mind and body are being recognized recently in the field of psychoneuroimmunology (Hyland, 2011).

This dynamic quality of the experience of body and self/mind/person is an unexpected finding. Although there is literature about emotion in labor and the experience of the mind (Crowther et al., 2014b; Dixon et al., 2014), and about the physicality of labor (Walsh, 2010), there is less focus on how these two elements act in concert with each other in relationship to the environment.

Keeping it Together Working With Pain: Comfort, Connection, Agency, Confidence

The experience of labor pain was not just an intense, unpleasant sensation but was contextualized by emotion, space, time, and others. Emotions ameliorated or exacerbated the experience of pain. Comfort, the freedom to exercise agency, confidence in the body's capacity, the progress of labor and interactions with other humans formed the framework that held pain. Women moved back and forth, from falling apart from pain to keeping it together in spite of pain, from *I-have-really-lost-it,* to *I-can-work-with-this*.

This finding is consistent with pain research showing the brain actively and selectively suppresses or enhances pain information turning the perception of pain up or

down (Linden, 2015). Negative emotion enhances the perception of pain (Linden, 2015), positive emotion decreases pain perception. One of the mechanisms by which this is likely is by the release of oxytocin. Oxytocin is one of the hormones that orchestrates the labor process by producing contractions, but it is also released in the brain in the presence of warm, positive human relationships and skin-to-skin touch (Uvnas-Moberg, Handlin, & Petersson, 2015). Oxytocin reduces activity in the HPA axis and ameliorates the stress response (Uvnas-Moberg & Petersson, 2013) but also works by decreasing pain sensitivity (Rash, Aguirre-Camacho, & Campbell, 2014).

The internal framework of working with pain—those thoughts, ideas and beliefs that women use to manage the sensation of pain have been described previously. Whitburn and colleagues (Whitburn et al., 2014) describe two opposite states of pain, having an acceptance of labor pain, holding the sensation without judging it as good or bad, versus being distraught with pain, which includes catastrophizing. These two states are consistent with the keeping it together versus falling apart in this study.

While the content of the Whitburn and colleagues study is similar to this present study, the emphasis is different. Whitburn and colleagues emphasize the woman's internal state, how her mind frames the pain experience to transform it, but in this present study, the external context that surrounds the pain experience is equally present, and the interaction between internal and external elements is dynamic. The passing of time, the presence of supportive (or hurtful) human others, comfort and the ability to choose what felt right to the body as well as each person's individual mindset all formed the platform on which women worked with or fell apart from pain. In this study, the internal elements and external elements worked together. For example, to manage pain, women needed to

feel confident about their capacity (an internal assessment), but the remarks of others and the presence of others influenced this belief (an external element).

Leap and colleagues (Leap et al., 2010) emphasize the role of confidence in working with pain in labor, and the relationship with the midwife as a space where this confidence develops. When women knew they would have a known provider in labor that they trusted, they felt supported, safe and cared for, and this gave them the confidence to manage labor pain. In this study, this element of knowing and being known were present but not as prominent, probably because these participants did not experience the same level of continuity of care with their health care providers. The knowing and being known aspect is more visible when participants described the effects of the presence of their families.

The element of time in women's working with pain has been described by Karlsdottir, Halldorsdottir, and Lundgren (2014) where pain in early labor is different than pain later in labor. In early labor, pain is more manageable because contractions are milder and there is the joyful anticipation of starting on the journey to birth. As contractions become more powerful later in the labor process, the process is more difficult to cope with. The focus of the Karlsdottir research is on the change in contractions over time with the advancing of the labor process. In this present study, the passing of time was less important than the perception of where the process of labor was in relationship to time. Participants worried about making the correct amount of progress, and perceptions of where they were in relationship to some expectation were also important.

The Karlsdottir and colleagues' (2014) study acknowledges the complexity of pain but is focused on the internal landscape of the woman's pain experience, her descriptions of pain and what she did without accounting for the environment, the actions of others, the quality of the experience of health care services, and other elements that were important in this study. The authors recommend that more research be done about the external landscape of women's experience of labor pain.

Understanding the contextual nature of labor pain creates an opportunity to develop a new paradigm for addressing this important issue with women. Current strategies for pain management focus on doing something about the unpleasant sensation. A better solution may be helping women to create a frame around the pain that will contextualize it in a positive light, understanding that this framing changes during labor. The knowledge of the other elements of the framing—comfort, confidence, the perception of progress, reassurance, and affirmation, the ability to choose how and where one wants to be—can guide providers as they work with women in each moment to create the frame.

Comfort and Discomfort in the Keeping-it-Together-Falling-Apart Continuum.

In this study, the experience of physical and emotional comfort were integral to working with pain and managing emotion. Comfort in labor was a moving target, and women fluctuated between comfort and discomfort moment to moment. Comfort of the person was related to calm emotions, and relaxation in the body. Comfort to the body induced the same.

Comfort and pain were not polar opposites, but rather waxed and waned in relationship to one another. At times, the experiences of pain and comfort were

paradoxical—participants in great pain experienced profound comfort, and participants with no pain were still very uncomfortable, just not in pain. This finding was surprising, given the current focus on the treatment of pain in labor (Roberts, Gulliver, Fisher, & Cloyes, 2010) although it has been identified by Schuiling (2003). While comfort influenced the state of emotions and the experience of labor pain, the converse was also true. The experience of pain and emotion affected the comfort-discomfort continuum.

The ability to influence one's own comfort by choosing position, movement, space, and the presence of others was important in this study. There is little research on what it means to women to choose their own comfort, to have ownership and control over comfort. In this study, participants equated being comfortable with helping the birth progress, so for them comfort was not just a nicety, but something essential to helping the body work. More research is needed about this relationship, between agency and comfort.

The association between agency and comfort has importance because of the ability to identify and act on what makes each individual more comfortable is idiosyncratic and unique, known only to the woman in labor, and perhaps those close to her. For this reason, women in labor need to keep their ability to choose their own comfort intact. When women's choices are restricted they lose an important source of information about how the body is doing and what might help labor move forward, an important tool to help them navigate labor.

Confidence in Motion: Between Trusting the Body and Feeling Uncertainty

Through the labor process, there was a dynamic motion between feelings of capacity and feelings of doubt. Participants thought their bodies might work or hoped they would work, but this belief was always a little uncertain. Much of the negative

emotion identified in this study was related to an uncertainty about the capableness of the body/self. Women were concerned that they could not physically accomplish the task, and they would not be able to manage the pain and emotion they experienced in some way that felt successful or acceptable to them.

This finding was surprising in an essentially healthy population. While there is always some uncertainty about the outcome of labor, a healthy woman with a normal size infant in spontaneous labor has an excellent chance at a spontaneous delivery. The cesarean delivery rate for healthy women with uncomplicated labor is 7-11% (Glantz, 2010).

These participants had more reasons to be confident about labor than they described. The need for efficiency in health care institutions and the biomedical approach to pregnancy, with the emphasis on the risk coalesce to diminish women's confidence. What would it be like if maternity care focused on developing women's confidence, much in the same way that women prepare for marathons? The preparation for labor could be much more focused on a step-wise strategy for building women's confidence in birth, with less focus on warning women about all the pathology that might develop. Although both of these paradigms of labor are true—that women's body's are capable of birth and birth occasionally develops pathology, where the emphasis is placed is important in affecting how women feel about the experience and the capability of their bodies.

When participants felt more confident about their own capacity, they exercised agency more easily. Feeling confident about one's body supported women having a

more independent relationship to medicalization. They could choose it if they wanted, but unless there was clear evidence to the contrary, they did not need it.

The association between confidence in the body and women's agency has been described previously as one of the motivators for choosing an out of hospital birth (Catling-Pauling, Dahlen, & Homer, 2011; Cheyney, 2008). Catling-Pauling and colleagues (2011) identified that feeling confident in the body contributed to wanting to retain control over the birth experience. In this study, confidence in the body was not related to control over the experience, but rather, being able to choose or decline medical technology and the associated restrictions.

There are no studies currently that explore women's own experiences of confidence, or what it means to them in labor to feel trust in their own capacity as they face the fluctuation of emotion and sensation that form the labor process. Much more research is needed in this area from the perspective of women themselves, how confidence develops, what is the meaning for women of the waxing and waning of confidence in labor and how they are influenced by the environment of birth to feel capable.

Time and the capacity of the body. Time—the actual passage of real time, human relationships with time and the perception of time--were influences on women's confidence. Time was a central element in how women assessed how labor was going and whether or not the body could manage the process. Will labor start at the right date? Will I be able to identify when contractions are five minutes apart? Will labor progress or will I need interventions to make it progress? How long will labor last? Will I be able to deal with labor at a later time point, even though I am doing OK now? Will I get to the

hospital on time? There are many moments of time where the body's capacity might be deficient that become a focus for feeling anxiety.

Time has been an element of modern life since the development of mechanical clocks in the 18th century, and particularly since the industrial revolution. With the development of precise tools to measure time, human behavior has become more regulated (Thompson, 1967). Post-modern human beings are accustomed to having important life events scheduled in discrete moments of time, to know when an important event is coming, and how long it will last.

Childbirth does not fit this concept of scheduled, discrete time. It is a physiologic process, and like other bodily processes, behaves with the regular irregularity that bodies normally behave. Labor rarely starts on the due date, and the contractions can start and stop, or build slowly over several days. The beginning of labor and the optimal time to move from home to the hospital can be challenging to identify. The dilatation of the cervix does not follow a linear pattern but rather accelerates as labor advances (Neal et al, 2010; Neal & Lowe, 2012). This temporal uncertainty of the labor process created an uncomfortable space for women where anxiety and worry collected.

This discomfort about the uncertainty of physiologic time is part of the culture of health care for providers and for the institution as well. Women's own discomfort with waiting for labor to start or to progress coalesces with provider and institution discomfort. This is one of the dynamics that creates a system where the medicalization of childbirth(designed to improve childbirth's efficiency) might be perceived as normal or even optimal.

This industrialization of hospital culture has been identified by McCourt and Dykes (2009; see also Simonds, 2002). The purpose of the hospital model is to care for many women as efficiently as possible. Women need to move in and out of the labor room in discrete quantities of time which creates an assembly-line quality of the care (Walsh, 2006). The efficiency standards meet the needs of the institution but not the normal rhythm of women's bodies.

Women are in the impossible bind of having to keep up, and lose confidence in their bodies because of the unrealistic expectation that labor will progress and be completed in a tightly bounded amount of time. In order to keep up, women require medical interventions, not because these optimize the outcome, but because the institution requires a speedy delivery (Walsh, 2006). These dynamics related to time in the hospital affect providers, who are educated in this system and may never witness a normal, physiologic birth (Simonds et al., 2007). This facilitates the perception that labor requires strict time parameters. Once these expectations about time become part of the culture of maternity care, they tend to self-perpetuate and it is hard for anyone—providers or women—to imagine something else.

Birth in no-time: Out of the hospital. Catherine identified a natural time rhythm in her home birth as one of the benefits, something that gave her space to experience her body's capacity because her home birth labor was not bound by the clock. She did not have to keep up with external expectations about how fast she should dilate. This quality of time characteristic of out-of-hospital birth has been called process time (Davies, 1990), where time follows a natural rhythm, operates in cycles and the completion of a process involves taking "as long as it takes" (Walsh, 2009, p. 131). The desire to avoid rigid time

parameters during labor is one of the reasons women choose home birth (Boucher, Bennett, McFarlin, & Freeze, 2009).

There is little written about the concept of time in out of hospital birth, but it is recognized as different, specifically because it "subverts the assembly-line" (Walsh, 2006, p. 1330) mentioned earlier. Walsh observed that freestanding birth centers have an absence of time-defined routines that free the staff to create a model of care based on "being with" rather than "doing to" (Walsh, 2009, p. 137). This model of care prioritizes comfort, calm and relaxation rather than efficiency and is more consistent with the midwifery model of care (ACNM, 2004; International Confederation of Midwives, 2005). "Being with" focuses on the nurture and agency of the mother rather than the requirements of the system for maximum efficiency.

The science of quality improvement values streamlining the process of work and reducing variability, in other words, creating an assembly-line of the same sets of structures or routines for all cases. The health care assembly-line model of care has both been praised for saving health care from waste and low productivity (Kaplan, 2014) but criticized for making providers and women "substrate for the Factory" (Graham, 2014, p. 247). The industrial model of care does not serve the needs of women in childbirth well. Childbirth is a unique life event requiring great confidence and strength that has the potential to affect a woman's sense of herself. The requirement that labor keep to certain time parameters reduces women's confidence and the application of the same routines or structures for all cases does not offer space for individual variation in the process.

Emotion in the Keeping it Together Falling Apart Experience

In this study, women experienced changing emotions moment to moment, with positive emotions in difficult moments as well as negative emotions in the good moments. This finding was unexpected. The literature about childbirth emotion tends to focus on one emotion at a time, rather than the changing quality or the mix of positive and negative emotions together. This paradoxical presence of positive emotions in negative moments has been identified by Lazarus and Folkman (Folkman, 2008) in their seminal work on stress and coping. They theorized that these positive moments provided a respite, a moment of diminished stress in an otherwise intolerable situation. They identified these small positive moments as a sign of healthy coping.

The presence of positive emotion in the midst of childbirth could be a very important finding in terms of helping women create a frame around the pain experience or moments of stress. There is very little literature about this phenomenon. There is a much larger focus on the negative emotions in labor (Haines, Rubertsson, Pallant, & Hildingsson, 2012; Jokić-Begić, Zigić, & Nakić Radoš, 2014; O'Donovan et al., 2014; Toohill , Fenwick, Toohill, Creedy, Smith, & Gamble, 2014; Räisänen, Lehto, Nielsen, Gissler, Kramer, & Heinonen, 2014). There is less focus on positive emotion or on the dynamic nature of women's emotions. The changing nature of women's emotion in labor has been mentioned by John (2009), who identified that women in labor have "wide swings of positive and negative emotion" (p. 637) but framed her analysis on women's fears of labor, a negative emotion, rather than the interplay of positive and negative. The findings from this study—that positive emotions are present in birth and that the experience of emotion is dynamic—are unique.

Dixon, Skinner and Foureur (2014) identified a trajectory of emotion over time that was similar to the emotions in this study. In early labor, feelings of anticipation and excitement color the experience more positively, and there is a shift to more negative emotion when labor becomes intense that returns to positive emotion at the birth. Women had more positive emotion and felt they could manage in early labor, were more afraid and less confident in the middle of labor, and had a flood of positive emotion at the birth. For primagravidas, the greater fatigue contributed to feeling exhausted and unwell at the birth, which dampened the immediate experience of positive emotion. Primagravidas experienced a delay in the flood of positive emotion after they had recovered. Dixon also identified the dazed or altered mental state that was present in this study, what she called "being in the zone"(p. 373).

In the Dixon and colleagues (2014) study, emotions were internal states of the woman in response to the labor process and the researchers did not explore the emotions of women in response to the environment. In this present study, women's emotion, the keeping-it-together-falling-apart experience was both an internal state and frequently a response to some thing in the environment, such as the interaction with another human present, the experience of physical space, or the culture of practice embedded in a specific space, such as the hospital. The example of time, mentioned earlier demonstrates this. Women did not only respond to the passing of time in minutes and seconds, but also to how providers and others perceive the meaning of the passing of time in relationship to the labor process.

The Ups and Downs of Agency: Trying to Get What You Want in Labor

Like other aspects of the birth experience, the experience of agency was complex, nuanced, contextual, and dynamic. It fluctuated during labor, depending on how determined a woman was, what she had put in place before labor to support her choices, and the experience of vulnerability that developed as labor progressed. There were participants who exerted agency before labor started, in choosing a certain type of childbirth class, creating a birth plan, and bringing an advocate. These plans were made outside of the power dynamics of the hospital system. There were participants who hoped they would have certain options, but left it up to chance. Some participants did not know that it was possible to make choices around childbirth practices.

Information and agency. Having the right kind of information was a support to women's agency, but participants who exerted more agency in labor (by creating birth plans, for example) also knew they needed certain types of information and knew where to look. Margaret knew that hospitals do not generally support patients with birth plans, and she was going to need help and support if she planned to have one. She brought the help and support with her.

How do women identify what they need to know in order to have the birth they hope to have? The sources of knowledge fell into two categories: embodied knowledge and externally gathered knowledge. The external sources of knowledge were stories from family and friends, childbirth education, written materials and audiovisual media. These sources of information have been identified in other studies (Carlsson et al., 2012; Regan, McElroy, & Moore, 2013).

Participants who wanted natural births had an unusual amount of exposure to the concept. They had midwife friends. They had seen natural births. Their own mothers had natural births. The availability of this information was related in part, to class privilege, for example, access to higher education and the health literacy that comes with it, access to the internet, and the ability to identify different sources of information and evaluate them according to how well they fit. Participants with less education (and fewer financial resources) accepted what they had access to.

Women's embodied knowledge came from previous experiences of pregnancy and from previous experiences of their own physical competence. Having the experience of being physically capable, to climb out of the Grand Canyon, to run a marathon, to hold a plank pose in yoga, informed their belief in their capacity during labor. Believing in the body's capacity supported the determination to achieve the birth on their own terms.

Carlsson and colleagues (2012) identified an association between knowledge, both embodied and externally gathered as a source of strength and power to women that supported their trust in the body. In this present study, the participants' confidence and determination was much more vulnerable and responsive to their feelings during labor and the environment of the birth.

The reasons for this difference are likely to be related to the differences in birth practices between the United States and Sweden, where the Carlsson and colleagues study was conducted. In Sweden, the cesarean section rate is 17%, and care during labor is provided primarily by midwives (Berg, Asta Olafsdottir, & Lundgren, 2012). In the United States, the cesarean rate is 32.8% (Martin, et al., 201, and oxytocin for induction or augmentation of labor is used for 50-60% of all births (Declerq et al., 2013). The use

of medical interventions during birth is much greater in the US than in Sweden, so that women are exposed to medical interventions more frequently and this exposure alters women's perceptions of the body's capacity for birth. In Sweden, women's faith in the body's capacity may be better supported by the midwifery model of care, which is the predominant model in that setting.

Determination, confidence, and agency: creating a birth plan. There was a convergence of confidence and knowledge that supported the determination to carry out a birth plan. Participants who selected natural births did have greater confidence in their bodies and their own knowledge of the body. It is not clear if having confidence in the body contributed to being more pro-active about seeking information and being active in the birth or the other way around, although perhaps this association is bi-directional.

Ethnicity, social class, and education played a role in what information women sought about birth, and their beliefs about having options. The Hispanic participants encountered language and economic barriers to having more choice, but also, by being immigrants with a lower education level, they likely had a more limited perception of having a choice. The perception of having a choice is as fundamental to the exercise of agency as the actual availability of choices (Kabeer, 1999).

Asking for what you want and feminine norms. Participant's ability to ask for what they wanted was circumscribed by the need to be proper and polite. This was an expected finding, something Martin has described as "the tyranny of being nice and kind (2003, p. 61). These behaviors are feminine norms--actions and behaviors that women are held accountable to in order to be feminine (Charlebois, 2012). These norms emphasize the subordinate position of women, the importance of being compliant with the wishes of

others, being physically vulnerable and being socially pleasant (Charlebois, 2012). Being overly confident or assertive are not supported (Shippers, 2007).

The extent to which participants felt they needed to self-censure was unexpected, for example, when participants classified their own emotional responses as "silly." This is all the more interesting when women describe a silly response to some form of egregious provider behavior. Komter (1989) has identified this self-censure as an example of invisible power when women adjust their behavior or expectations in accordance with the desires of a more powerful person. The exercise of power is invisible—the woman herself adjusts in order to avoid conflict or alienation. Being confrontive or even moving away from the untrustworthy person are not options in labor, so women censure their own normal, emotional response.

For women, maintaining expectations of feminine behavior can be a way of engaging provider support or helpfulness. When women do not act in accordance with expectations of feminine behavior, they risk being sanctioned (Shippers, 2007) and entering into a conflict with providers, something they cannot do in labor. For the hospitals and the providers, being able to avoid conflict is also important, because it maintains their own authority. It is easier to care for women who are compliant than women who question the health care providers recommendations.

Agency and intersectionality. There are social structures that create oppression apart from gender, such as social class, race, age, place of origin, and other categories of the self (Dillaway & Brubaker, 2006). There are several mechanisms by which intersecting social locations potentially influence women's choices in labor, including having the perception of self as an agent, having the material resources to access different

sources of information, the ability to choose a provider and birth setting consistent with one's wishes, and the social distance between the woman and her caregivers.

For immigrants, gender, lower socio-economic status, lower educational attainment, and the immigrant status all potentially contribute to a life-long passive relationship to life situations, including childbirth. In this study, the Hispanic participants had the least education and the greatest social distance from medical providers. Additionally, for Hispanics, norms of femininity coalesce with the norms of politeness towards medical providers.

Hispanics value warm relationships with medical providers with a strong preference for politeness, pleasantness, warmth, and respect (Flores, 2000). There is an expectation of passivity in relationship to the authority of the provider which diminishes the active participation in decisions (Levinson, Kao, Kuby, & Thisted, 2005; Xu, Borders, & Arif, 2004). Hispanics may not seek information outside of the patient-provider encounter (Levinson, Kao, Kuby, & Thisted, 2005), or ask questions because this would appear disrespectful (Flores, 2000) and the disrespect would jeopardize the quality of warmth in the personal relationship (Flores, 2000).

Women with material resources have greater access to multiple sources of information, including the internet, television, and the different types of childbirth classes. Not only does the individual woman have access to these resources, but so do her friends and family members so that her exposure to birth options is increased via her social network. The access to different types of information gives women experience in thinking critically about what they read and forming an opinion about how well it fits

with their own personal values and way of being in the world. This facilitates making a choice about childbirth practices that fit with what they want.

One of the ways that women ensure they might have options to different choices during labor care is to select a provider, and three of the eight participants did this. Having a choice of providers generally requires health insurance or the financial resources to pay for care out of pocket. These are options available to middle class women. The case of women who want midwifery care is an exception. It can be difficult to find a midwife practice. For example, the insurance provider for Emory University and Emory Healthcare is AETNA, and they do not list any midwife providers in their network. Out of hospital birth is rarely covered by medical insurance and most home births are paid for out of pocket(Andrews, 2014; Rosenthal, 2013).

Agency and Vulnerability: speaking up when you are lying down. The ability to ask for things in labor and express your wishes was compromised by the vulnerable state of being in labor. The wearing of clothing that leaves women exposed, the position of the body when it is lying down, the exposure and/or invasion of intimate, sensitive body parts, the state of fatigue and feeling dazed, and the fear of damage or injury to one's self or infant diminish women's agency. There is very little literature on the vulnerability of women in labor although there is a general acknowledgement of its importance (Goldberg, 2008, Dinc & Gastmans, 2011; Noseworthy, Phibbs, & Benn, 2012).

Agency and Medicalization. There is considerable literature on how the medicalization of childbirth has affected women's choices (Campo, 2010; Crossley, 2007; Davis-Floyd & Cheyney, 2009; Katz-Rothman, 1991; Walsh, 2009). This critique

has polarized into natural versus medical as being each the best expressions of women's authentic choice but Zadoroznyj (1999) points out that the reality of choice is much more complex and nuanced, from rejecting all technology, embracing all of it or selecting specific medical interventions because of a perceived need for them. This was the case in this study, where some participants went to great lengths to have natural births while another negotiated hard and long for an elective induction with an epidural. One of the participants, who was determined to eschew all interventions, accepted IV fluids because she was dehydrated and this exacerbated her fatigue.

There are two aspects of the experience of medical interventions for birth that are important to add to this discussion. While it could be said that some women will prefer natural births and some will choose medicalized births, in reality, birth care in the United States is very medicalized (Declerq et al, 2014), and interventions are nearly ubiquitous (Cook, 2012). This makes it harder for women to imagine birth without them, to believe in the capacity of their bodies, and to identify accurate information about safe alternatives. The medicalization of birth diminishes women's confidence in their bodies, and prioritizes biomedical (objective) information over embodied (subjective) information. This makes each person's embodied knowledge uncertain and facilitates the acceptance of medical authority in the birth process. The near-ubiquity of interventions is a barrier to opting out or even to perceive that opting out might be a safe option. For women who choose medical interventions, does this represent an authentic choice, or is it that in the hospital, it is hard to achieve a birth without them?

The interventions themselves reduce mobility, and this had a cascading effect on women's comfort, vulnerability, and perception of self as an active participant in the birth

process. The need to maintain mobility was one aspect of the birth process all participants universally agreed on. By decreasing confidence and increasing discomfort, the restrictions reinforce the belief that labor cannot be managed without interventions.

There are many places where women might learn what is expected of them in labor. The portrayal of passivity in visual media as well as literature on pregnancy in childbirth (Sears & Godderis, 2011; Morris & McInerney, 2010; Kennedy et al., 2009) has been discussed previously. Prenatal education could be a valuable resource for information gathering, but it has been criticized for providing a venue in "which to persuade women to adopt the values, expectations and orientation of the hospital."(Armstrong, 2000, p. 587; see also Hotelling, 2013). The Lamaze method has, at least in its earlier versions, emphasized women's control over their response to pain, creating a patient who was quiet, a "good patient...noncomplaining, obedient, cooperative (Katz-Rothman, 1991, p. 93).

Obstetrical medicine has dominated maternity care in the United States since the late 19th and early 20th centuries (Erhenrich & English, 2010). Medical practice in the US occupies a unique position of authority with the doctor as the gatekeeper to many health services including diagnostic testing, hospitalization, and pharmacological treatment (Starr, 1982). When birth moved from home to the hospital in the early part of the 20th century, obstetricians consolidated their control by preventing other providers (including midwives) from having practice privileges or being able to receive insurance reimbursement (Rooks, 1997; Erhenrich & English, 2010).

The presence of midwifery, with a commitment to women's autonomy and right to choice (ACNM, 2004; ICM, 2005) has had a smaller effect on the health care system

and its development, partly because, for most of the last century in the United States, the midwifery workforce has been small compared to the number of obstetricians (Rooks, 1997). There are fewer midwives and fewer midwife-led births (Martin, et al., 2013) and the midwifery paradigm has less of a presence.

In order to fully access normal, physiologic birth it is almost necessary for women to opt out of hospital birth altogether, as Catherine did. The homebirth rate in the United States is currently 1% (Martin et al, 2011), either because the demand for home birth is that low, or because there are barriers to accessing out-of-hospital birth care. There is not no research currently in the US about what is the consumer demand for home birth. In an recent Australian study of the public response to maternity quality improvement identified that 24% of the responses mentioned birth centers and 60% of the responses mentioned home birth, demonstrating that, at least in Australia, there is a demand for out-of-hospital birth were it to be more available (Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011).

Keeping It Together and Falling Apart Around Others

For most of history, women have labored in the company of other humans, because they need help and support with the process (Davis-Floyd & Cheney, 2009; Kitzinger, 2012). Human connection increases oxytocin, which decreases the stress response and also decreases sensitivity to pain (Uvnas-Moberg et al., 2015; Uvnas-Moberg & Petersson, 2005; Rash et al., 2014). Support from a companion in labor one of the most effective measures to improve both psychological and physiological outcomes of birth (Hodnett et al., 2013).

However, human interactions in labor are complex, layered, dynamic and

paradoxical. Family members and health care providers could be helpful and unhelpful almost at the same time. Family included humans that women in labor wanted present, and those they did not. Family members had their own anxiety about the process. They made supportive and unsupportive remarks. Health care providers included humans who were available and present or busy and absent. Providers were kind, affectionate and cared for the comfort of the person and the body. Providers ignored the person and focused their care on the body. Providers could feel like family. Providers acted in ways that were calloused, neglectful and hurtful. The paradox of the human being, imperfectly present contributed to the shifting, changing state of being, moving women back and forth from keeping it together and falling apart across the labor process.

There was no special magic or complicated formula to the qualities of human connection and presence that fostered a sense of keeping it together for women. Eye contact, "she was really there", kindness, comfort of the whole body/person, making room for women's agency and choice were all elements that fostered keeping it together. When these were present, women relaxed into the process. When these were missing, women fell apart more.

Keeping it together, falling apart with family. The support women received from family was, like all family relationships, imperfect-exactly what was needed in some moments and detrimental in others. Family members could be fierce advocates of women's agency, or they could encourage the birthing woman to keep the rules. Kabeer suggests that families can reproduce dominant ideas about gender and power which can constrain women's agency, as Julia's husband did, when he recommended she stay in bed, "because you have to keep the rules." Non-family relationships might provide a

better resource for challenging gender norms (Kabeer, 2011).

Family members could have their own anxiety and difficulty with the birth process, including the fear/worry that labor might not work, concern about the woman's experience of pain or that a cesarean might be necessary. Family anxiety in labor can be contagious (Bäckström & Hertfelt Wahn, 2009), which resonates with Catherine's arrangement for no eye contact with her husband during labor, because she could see his fear and she did not want to 'catch' his anxiety.

The focus of professional labor care is on the woman in labor, not her husband or family but the family, and husbands in particular, are also giving birth. This is an intense emotional experience, they have a great deal invested in the process, and are becoming a parents or grandparents. A husband may have difficulty navigating intense emotion, being a witness to the pain and effort, and dealing with the strong smells and bodily fluids of birth. In my own experience of conversations in maternity care units, there is an ongoing joke about giving the epidural to the husband, who perhaps needs it more that the woman in labor.

Research about male partners and birth has identified they needed support, but most of the support goes to the woman in labor. This can result in men feeling ignored (Singh & Newburn, 2000), helpless, or detached (Bäckström & Hertfelt, 2009). Men are in a strange land of "not-patient and not-visitor" (Steen et al., 2011, p. 422). Because they are not patients, they may not be included in the flow of information or in decisions, even though the birth, like parenting, is a shared, marital experience. This is consistent with the findings in this study. Participants identified that spouses didn't know what to do, felt anxious, and felt excluded from important conversations.

Husbands at birth may have difficulty managing intense emotions because gender norms of masculinity do not facilitate the expression of emotion, particularly vulnerable emotions (Premberg, Carlsson, Hellström, & Berg, 2010). Hegemonic masculinity consists of the qualities and behaviors that establish a hierarchical and complementary relationship to femininity and maintain the dominant position of men (Schippers, 2007). The expectation of behaviors that maintain dominance prevents men from feeling or acting in ways that reflect sensitive emotions. The need to maintain masculine norms when they are feeling vulnerable creates an additional burden for men.

Women's relationships with other family members in this study were mixed, with moments when they felt support and moments when another person's presence felt unbearable. This mixture of the good and bad qualities of family support is an unexpected finding, unique to this research. Khresheh & Barclay (2010) studied labor support by female relatives in Jordan and identified outcomes similar to other studies of support, with decreased use of pain medications and more women reporting a positive birth experience. Khresheh and Barclay (2010) did ask women in what ways had family members been unhelpful in labor, but if there were any negative or mixed responses, they did not report on them.

The effect of doula care. Three participants in this study had doulas. Doula care is associated with improved obstetrical outcomes of almost all measures: labor progress, use of interventions, postpartum wellbeing, breastfeeding, neonatal well being (Hodnett et al., 2013), decreased preterm birth, and decreased health care costs (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O'Brien, 2013). The WHO recommends that companion support (including doula care) be made available to all

women in labor (1996) as a standard of care.

The literature about doula care tends to focus on the outcomes of doula care, and less on the subjective experience of the woman receiving doula care. In this study, one of the important roles of the doula was in emotional regulation, helping women shift emotion from negative to positive, such as when Anita's doula made her laugh and talk about something else besides her frustrating birth. This use of humor is not mentioned in the literature about doula care, although the emotional regulation is described by Gilliland (2011).

Relationships with health care providers. The quality of the human connection between women and providers was important to women. They wanted to be known, to feel that they were more than just a job to their caregivers. In the United States, this somewhat idealized professional relationship is not entirely achievable in modern obstetrics. The group practice model is common in the United States, where approximately 70% of obstetricians work in a group and share on-call time (Rayburn, 2011). Women do not control which provider will be on call for their labor and may not have met the provider or had much contact with them prior to labor.

The hospitalist model of obstetrical care has developed recently in the United States, where a group practice will have separate groups of providers for antepartum and intrapartum care (Bailit, 2013). Providers are scheduled for a 12-24 hour period on the labor unit, and care for any woman admitted during that time. This model offers a number of benefits for providers, in that it facilitates scheduling, minimizes sleep disruption and may be associated with a lower cesarean section rate (Bailit, 2013), but it would offer no opportunities for women to develop an ongoing relationship with

providers who will care for them in labor.

The effect of an established, trusting patient-provider relationship on the labor process has not been studied, although women identify patient provider-trust as integral to a positive birth experience and feeling confident about their bodies and ability to cope (Leap et al., 2010). Research about patient-provider trust in obstetrics is hampered, in part, by a lack of tools to measure the concept (Soliday & Tremblay, 2013). Patient-provider trust seems to be an element in respect for women's agency. Hall, Tompkinson, and Klein (2012) identified that patient-provider trust increased providers willingness to share power and decision making with women and it increased women's ability to speak up about what they wanted.

The provider-patient relationship and time pressure. Participants perceived that providers were busy. They worried that they might be keeping the provider from doing something more important. They experienced providers as absent for long periods of time because providers were caring for other women. All three provider types were perceived to be busy.

There is little literature on the role of staffing patterns and provider busyness on the patient-provider relationship but busyness and time pressure are factors that contribute to work stress, burn out, compassion fatigue, depression and anxiety for nurses (McGillis & Kiesners, 2005; Greenglass & Burke, 2001). Severe, overwhelming time pressure is also a factor that contributes to the problem of disrespect and abuse in maternity care (Bowser & Hill, 2010). Sleep disruption exacerbates these difficulties for providers who work at night or take call for 24 hours or more (Bailit, 2011; Dorrian et al., 2011).

Time pressure contributes to medicalization. Continuous labor support is impossible if a provider has more than one patient in labor at a time. Midwives associate the inability to offer continuous support with higher epidural use (Aune, Amundsen, & Skaget, 2014; Aune et al., 2012; Van Kelst, Spitz, Sermeus, & Thomson, 2013). Intermittent fetal monitoring, which has the benefit of protecting a woman's mobility in labor in addition to other benefits requires the almost continuous presence of the nurse or midwife (Hodnett et al., 2013). Although the WHO (1996) recommends that intermittent monitoring be the standard of care for healthy women in spontaneous labor, many hospitals do not staff the labor unit so that intermittent monitoring is feasible. Only 13% of women in the US received this mode of care (Declerq et al., 2006).

Continuous monitoring allows a nurse to do her work remotely, and she is able to care for more than one patient in labor at a time, so it creates an easier workload. This diminished presence of the nurse (who is now doing her work from the nurses station, rather than the woman's room) facilitates caring for the body but not the person. A high patient to nurse ratio has been identified as a barrier to intermittent monitoring (Walker, Shunkwiler, Supanich, Williamsen, & Yensch, 2001; Priddy, 2004; Wood, 2003).

Am I not a person? Falling apart and untrustworthy relationships in labor. The disrespectful, neglectful or hurtful experiences with providers were unexpected findings, and at the same time, nor surprising. With the focus on patient centered care, patient's rights (Robinson, Callister, Berry, & Dearing, 2008) and humanized maternity care (Behruzi, Hatem, Goulet, Fraser, & Misago, 2014), one would expect to find untrustworthy provider behavior to be rare. On the other hand, it has been called the "blind spot of maternity care" (Freedman & Kruk, 2014, p. 1) precisely because it has

been normalized. For participants in this study, the response to this untrustworthy behavior was to normalize it, for example, when Nydia characterized her own distress (a normal response under the circumstances) at being confined to bed as "silly. There were also examples where participants objected vigorously. When Gabriela was describing her painful vaginal exams, she asked me, "Didn't she realize there was a human being in the bed?"

This problem has been amply described in maternity care and it ranges from insensitivity to the human being and their needs to coercion and physical or emotional abuse (Bower and Hill, 2010). It is a problem in both rich and poor countries (Freedman & Kruk, 2014). The root causes of disrespect and abuse are complex, but overwhelming work stress, high patient to provider ratio and compassion fatigue are factors (Bowser & Hill, 2010). The separation of the body-self in maternity care is another factor. When providers are focused on the function of the body but not the experience of the person, it facilitates treating the body while excluding the quality of the human experience or the woman's feelings.

Being in an industrialized birth setting, such as a hospital, the patient and the provider do not know each other, a factor that has been identified as reducing patient's agency (Hall et al., 2012). The time pressure on the provider contributes to anonymity and a lack of empathy and concern for the patient (compassion fatigue), and this can facilitate disrespectful or dehumanizing behavior (Bowser & Hill, 2010).

Keeping it Together and Falling apart: the Phenomenon of Chaos

The phenomenon of labor is a dynamic, constantly changing motion, back and forth between positive and negative, with the experience of positive and negative co-

occurring and embedded in each other. This complex system that moves constantly resembles chaos, and midwife researchers have suggested that this metaphor be used as a framework to study and explain the labor process. Many of the paradigms in maternity care are linear, such as the conventional saying that labor consists of the powers, the passage and the passenger (Cunningham et al., 2010b). Downe and McCourt (2008) have suggested that this paradigm is too simplistic and linear. This research has demonstrated the complex nature of the childbirth experience consistent with Downe & McCourt's observation.

The usual conceptualization of chaos is that it is a disorderly system that goes nowhere but in chaos/complexity theory, it is actually an "eco-system that has co-evolving elements" that interact in unpredictable ways, with reiterative feedback loops in networks of interaction (Kernick, 2006, p. 386). These complex interactions are unpredictable, not in the sense of being dysfunctional or unstable, but rather that there are many possible outcomes or pathways in the process and the likelihood of any one of them changes as the process unfolds (Downe & McCourt, 2008). The unpredictability of the system is actually a benefit, because it is in the unpredictability that adaptation occurs (Merry, 1995). A small change in one element of the system can create a large effect on the whole (Lorenz, 1993).

The chaos metaphor for labor is the opposite of the body-as-machine paradigm, which has been criticized for being too simplistic and contributing to medicalization (Davis-Floyd, 1992; Martin, 2001). The chaos metaphor fits with the findings from this study: labor is a mix of keeping it together, falling apart in multiple areas: time, space, relationships, emotion, body sensations and effort.

This is why the perspective of labor as a linear process of the body is so insufficient, and why the industrialization of labor care fails to meet women's needs in labor. If labor is an idiosyncratic experience, unique to each woman, her baby, her body, her family, and her providers, then a one-size-fits-all approach is woefully inadequate. The linear perspective separates a woman from the rest of herself and her world, failing to take into account the uniqueness of each woman, each family in their own life context.

Recommendations

In labor, the body and the self fluctuate, from positive emotion to negative emotion, from sitting to standing to lying, from connecting with others to pulling into the self. Women are exquisitely sensitive to changes in the environment, changes in their bodies, changes in the human beings present. To effectively care for women in labor, health care systems and personnel must respond to the body-person's fluctuating state with sensitivity that matches these normal fluctuations. Care in labor should be directed at the whole human being without prioritizing the care of the body, recognizing the changes in emotional state and vulnerability that occur over time and with the process of labor.

There were four elements identified in this research that help women frame the experience of pain: confidence in the body's capacity, agency, human connection and comfort. Labor care and communication during labor should be directed at supporting these elements, so that women can activate their own ability to work with pain. Freedom of movement is particularly important. Although the benefits of movement in labor are well known, almost all of the participants in this study encountered restrictions to movement, which increased negative emotion and discomfort.

Childbirth education should explore, with women, how to support confidence and comfort. A person's previous experience with physically strenuous achievements are an important element in knowing what the body is capable of and women can be encouraged to tap into this knowledge of their own strength as a resource. This highlights the importance of physical activity for young girls long before pregnancy, because it increases their own body-confidence, an important experience across a life-time and not just during childbirth.

Women and providers need to have a greater understanding of the fluctuating state of the labor process and the importance of human connection, confidence, agency and comfort in moving the fluctuating state in a positive direction, helping women to move through negative moments. The ability to anticipate the highs and lows of labor will decrease anxiety and diminish the tendency towards catastrophic thinking when labor becomes challenging. Providers should be educated to understand the influence they hold in moving women towards a negative state by communication that diminishes women's confidence or restrictions that diminish women's agency and comfort.

This research is the beginning of defining some important concepts that affect women in labor, but much more research is needed to more fully understand the relationships between comfort, agency, and confidence, and how these change with time, the physical space of birth and the progress of labor. Very little is known the ways in which the vulnerability of women in labor affects the dynamics of the patient-provider relationship. There is little recent work on the concepts of confidence and comfort, and there is a need for greater clarity in their definition.

An important area of needed research is the agency of women who have

pregnancy complications and women who disagree with provider recommendations for care. This is an area that generates considerable discomfort for providers (Finnerty & Chisholm, 2003), and this negative emotional response, which includes the concern over liability risk, can decrease flexibility and the commitment to meeting the patient as a unique individual. Developing a better understanding of these interactions is essential to authentic patient centered care and to patient-provider trust.

The environment of birth is focused on identification and treatment of the pathology that occurs during some pregnancies. IV fluids are in case women need medication. Blood pressure measurements every hour are because some women develop hypertension. Continuous fetal monitoring is in case the labor process adversely affects the oxygenation of the fetus. The combined effect of all these "just in case" elements is to reduce agency, comfort, and confidence. The environment of birth needs to serve the needs of healthy women as well as women with complications, individualizing care to maximize the strengths of each individual and what she brings to the birth process. There are two perceptions of time in the hospital, the institution's need to use space and time for the number of cases, and the need to respect each woman's unique variation in the labor process. Providers should be educated to perceive these as separate issues so that the needs of the institution do not take precedence over the needs of women in labor.

Midwifery care already incorporates many of these strategies into birth care, including the philosophy of pregnancy and birth as a normal, life event, selective use of medical technology and interventions for situations where there is a clear benefit, continuity of care from a known and trusted provider with a focus on the whole person (Sandall, Soltani, Gates, Shennan, & Devane, 2013). A recent Cochrane review of

midwife-led care demonstrated a decrease in preterm birth and still birth before 24 weeks, decreased epidural use, decreased instrumental vaginal births and decreased episiotomy when compared to obstetrician led care (Sandall et al., 2013). In a randomized trial of healthy low risk women in labor, midwife led care was associated with decreased use of oxytocin for augmentation, decreased epidural use and increased use of acupuncture (Bernitz et al., 2011; see also Monk, Tracy, Foureur, Grigg, & Tracy, 2014). The use of a midwifery hospitalist service (24 hour midwifery coverage for all singleton, term deliveries) was associated with significant reductions in the cesarean rate and increased successful vaginal birth after cesareans (Rosenstein, Nijagal, Nakagawa, Gregorich, & Kupperman, 2015).

Limitations

The recruitment for this study proved challenging. I recruited from childbirth education classes and via several internet mother's web pages. My sampling plan included women with private and public insurance, Hispanic, Caucasian and African American. I did achieve these goals, but the sample had slightly more than half who were highly educated, employed women with private insurance, most of whom had natural births.

The recruitment of Hispanic and African American women and women of lower socioeconomic resources proved challenging. For future studies, I will likely plan to develop recruitment strategies that would specifically seek this population. Women who attend childbirth classes tend to be Caucasian and more educated. When working with immigrants, the lack of trust was a barrier that contributed to attrition and in the future, I will need to develop strategies that will help with this as well.

The participants in this study happened to have a preference for natural births. This is partly because I sought women with uncomplicated, vaginal births and this was a group that also tended to want natural births. There are women who specifically desire and plan to have a medicalized birth. In this present study, the experiences of women who planned to use epidural anesthesia are not represented. In the future, I may specifically plan to recruit women who want medicalization to represent their perspective.

The challenges of enrollment resulted in birth narratives that were fairly widespread in relationship to the birth event, from 4 weeks to 12 weeks. There is evidence that the birth narrative is somewhat stable over time (Simkin, 1991, 1992), but the focus or emphasis may change as the story is told and retold to friends and relatives. The original intent of the study was to interview all participants in the initial 3-6 week window after birth, but in the end, I had to obtain the birth stories when I could, and when it was convenient for women to schedule them. In a future study, I may consider recruiting from the hospital post-partum unit in order to conduct the interviews in that very early postpartum period although this is a period when women are recovering from the birth and still very vulnerable.

Childbirth is an intimate experience in a person's life. Recalling experiences of intense emotion or especially negative emotion was distressing for some participants, and this required skill and sensitivity on my part to address this during an interview. There is a desire to probe deeper, because the intense emotion marks an important element of the story but the person being interviewed must be met with compassion and be invited to decide how much they wish to sit with their distress. There was one such person in this

sample who cried in the retelling of her birth experience. I stopped the interview briefly until she indicated she was ready to continue. I reminded her that the interview was voluntary and that she was not obligated to continue if she did not want to. I expressed empathy and concern for her distress and offered a referral for counseling, which she declined.

Some participants were reluctant to describe certain negative aspects of the experience. For example, one participant described how there was a problem with her baby's heart beat at one point, but she very quickly added, "but they came in and moved the bed and it was fine." In the narrative she emphasized how quickly they responded, as an illustration of the high quality of her care and the level of responsiveness of the nursing staff. Later she indicated it might be because they gave her too much Pitocin. She was very eager to explain that she wasn't anxious about the problem. I was not certain if that is how she genuinely felt, or if she was reluctant to experience the unpleasant emotions that would come with the admission that there had been a problem with the baby possibly caused by a medication error.

The primary data collection mechanism was through in depth interviews, and this requires a considerable skill level to establish rapport, keep the participant on target, and use probes to obtain important details of the story (Hennink, Hutter & Bailey, 2011). One of the difficulties of being a novice researcher is that interviewing is an experience of keeping the participant on target while at the same time, encouraging them to tell their story, not the story you are hoping to hear. Smiling, laughing, and body language all communicate agreement, and can prevent the participant from telling the real story. There is a fine line between being socially agreeable and helping a participant engage

with their own authentic narrative without influencing the shape of it. Initial interviews in this research were shorter and less detailed but working with the committee was helpful in identifying how to help participants tell their story in richer detail. Later interviews were much richer in their descriptions of the birth experience.

Summary and Conclusions

The phenomenon of childbirth is of movement, from keeping it together to falling apart as women respond to the labor process, the environment, and the presence of others. Women's confidence in their own capacity to labor was a critical element in how they felt during labor, and this confidence was vulnerable when the labor process became prolonged or challenging. Women's agency is vulnerable because the intensity of the labor process makes it difficult for women to ask for what they want or need. In order to protect the choices during birth, women had to make plans before birth. There are limitations to women's choices and freedom because of the medicalization of the birth process.

To support a more positive birth experience, labor care practices need to be directed at the whole person and not just the physical self. Also needed is a sensitivity of the keeping-it-together-falling-apart experience in the environment. Childbirth education and provider-patient interactions need to support women's confidence in their ability to birth. Care in labor should also be attentive to women's need for comfort and support. Finally, more research is needed into how to structure health care systems that are holistic and care for the person as a physical-psychospiritual being, and their families during birth.

Table 1. Recruitment Plan

Ethnicity	African-American		Caucasian		Hispanic	
Insurance	Private	Medicaid	Private	Medicaid	Private	Medicaid
Primagravida	1	1	1	1	1	1
Multipara	1	1	1	1	1	1

Total=12

Table 2. Participant Characteristics

Name	Age	Parity	Insurance	Education§	Ethnicity	Interview 1*	Interview 2 *
Margaret	27	G1P1	Private	16	Caucasian	12	22
Nydia	27	G1P1	Private	16	Caucasian	6	15
Sharon	32	G2P2	Private	20	Caucasian	3	13
Catherine	30	G5P5	Private	15	Caucasian	2	11
Talisa	27	G2P1	Private	20	African-American	6	14
Anita	39	G2P2	Private	18	African-American	5	10
Julia	28	G3P3	Medicaid	3	Hispanic	6	12
Gabriela	25	G3P3	Medicaid	10	Hispanic	7	12

Note. All names are pseudonyms.
§ Education in years completed
* Interview in weeks from delivery date

Table 3. Details of the birth experience I

Participant	Interventions	Pain Management	Oral Intake	Doula	Provider Type
Margaret	None	Hydrotherapy (Shower)	Fluids	Yes	MD
Nydia	IV fluids, EFM* 15 minutes per hour	Support,	Food fluids	No	CNM
Talisa	IV fluids, continuous EFM	Epidural	NPO§	No	MD
Catherin	None	Hydrotherapy (shower)	Food Fluids	Yes	CNM
Gabriela	Continuous EFM, IV fluids	None	Fluids	No	CNM
Julia	Continuous EFM, IV fluids	None	NPO	No	CNM
Sharon	None	None	NPO	No	MD
Anita	Continuous EFM, IV fluids	Epidural	Fluids	Yes	CNM

*EFM (Continuous electronic fetal monitoring)
§ NPO (no intake of food o fluids for the entire labor, some facilities offer ice chips

Table 4. Details of the Birth Experience II

Participant	Labor Length[1]	Childbirth Education	Labor Onset	Birth Location
Margaret	12 h	Yes	Spontaneous	Hospital
Nydia	20 h	Yes	Spontaneous	Hospital
Talisa	22 h	Yes	Induction: Cervidil & Oxytocin	Hospital
Catherine	12 h	Yes	Spontaneous	Home
Gabriela	6-8 h	Yes	Spontaneous	Hospital
Julia	4 h	Yes	Spontaneous	Hospital
Sharon	2 h	No	Spontaneous	Hospital
Anita	60h	No	Induction: Oxytocin	Hospital

[1]The length of labor was determined by self-report.

Appendix A. English Informed Consent

Emory University

Consent to be a Research Subject

Title:

An Interpretive Phenomenological Exploration of Women's Lived Experience Of Coping and Agency During Labor

Principal Investigator:

Priscilla J. Hall RN CNM MS, Nell Hogdson Woodruff School of Nursing, Emory University

Funding Source: American College of Nurse Midwives W. Newton Long Award, Nurses Educational Foundation Award

Introduction

You are being asked to be in a research study. This form is designed to tell you everything you need to think about before you decide to consent (agree) to be in the study or not to be in the study. **It is entirely your choice. If you decide to take part, you can change your mind later on and withdraw from the research study. You can skip any questions that you do not wish to answer.**

Before making your decision:

- Please carefully read this form or have it read to you
- Please ask questions about anything that is not clear

You can take a copy of this consent form, to keep. Feel free to take your time thinking about whether you would like to participate. By signing this form you will not give up any legal rights.

Study Overview

The purpose of this study is to understand women's experiences of coping and having agency (feeling empowered) during the childbirth process

Procedures

You will be asked to contact the investigator after your delivery and together you will set up a time that is convenient for you to be interviewed. The interview will take place at a location convenient for you, or at a private office at Emory University School of Nursing. The interview will take about 1 to 1 ½ hours, and will be about the experience of your

birth, and how you were able to cope with feelings of stress during labor. The interview will also ask about your experience of feeling empowered during labor. About 4-8 weeks after the first interview, the investigator will ask to schedule a second interview to review your responses to the first interview and ask follow up questions. A third interview may be possible about 2-4 weeks after the second interview. After the final interview, if you wish, the investigator may ask you to review a copy of the interview transcript so that you can make comments or add to your information if you feel a need to do so. After the final interview, you will receive a $25.00 gift card to thank you for your time and information. This study will not require you to give any blood or tissue samples, or subject you to any medical procedures.

Risks and Discomforts

This study is about a very sensitive topic, and women have a lot of strong emotions (positive or negative) about the subject of childbirth. There are aspects of your birth experience that may feel very private and you may not want to discuss them. There are aspects of your birth experience that feel upsetting or traumatic, and being interviewed about them may cause distress.

New Information

It is possible that the researchers will learn something new during the study about the risks of being in it. If this happens, they will tell you about it. Then you can decide if you want to continue to be in this study or not. You may be asked to sign a new consent form that includes the new information if you decide to stay in the study.

Benefits

This study is not designed to benefit you directly. This study is designed to learn more about women's experiences of childbirth, especially as it relates to feelings of stress and coping as well as experiences of feeling empowered. The study results may be used to help others in the future.

Compensation

You will receive a $25.00 gift card at the conclusion of the study to thank you for your time and information.

Other Options Outside this Study

If you decide not to enter this study, it will not affect your ability to receive care at Emory University Hospital or Grady Memorial Hospital. You do not have to be in this study to be treated for any condition or to obtain medical services.

Confidentiality

Certain offices and people other than the researchers may look at study records. Government agencies and Emory employees overseeing proper study conduct may look at your study records. These offices include the Office for Human Research Protections, the Emory Institutional Review Board, the Emory Office of Research Compliance and the Office for Clinical Research. Emory will keep any research records we create private to the extent we are required to do so by law. A study number rather than your name will be used on study records wherever possible. Your name and other facts that might point to you will not appear when we present this study or publish its results.

Study records can be opened by court order. They may also be produced in response to a subpoena or a request for production of documents.

Voluntary Participation and Withdrawal from the Study

You have the right to leave a study at any time without penalty. You may refuse to answer any questions that you do not wish to answer. If you decide to leave the study, you will need to contact the researcher (contact information below) and you will be asked to sign a revocation letter indicating that you wish to withdraw from the study. When you leave the study, you have a choice of allowing the researcher to use the information that has already been collected or not, and you will indicate your choice on the revocation letter.

The researchers and funder also have the right to stop your participation in this study without your consent if:

- They believe it is in your best interest;
- You were to object to any future changes that may be made in the study plan;
- The interview process is clearly upsetting to you and terminating the interview is necessary to allow you to recover.

Contact Information

Contact Priscilla J. Hall at 224-805-8673

- if you have any questions about this study or your part in it,
- if you feel you have had a research-related injury, or
- if you have questions, concerns or complaints about the research

Contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu:

- if you have questions about your rights as a research participant.
- if you have questions, concerns or complaints about the research.
- You may also let the IRB know about your experience as a research participant through our Research Participant Survey at http://www.surveymonkey.com/s/6ZDMW75.

Consent

Please, print your name and sign below if you agree to be in this study. By signing this consent form, you will not give up any of your legal rights. We will give you a copy of the signed consent, to keep.

_____

Name of Subject

_____ _____

Signature of Subject Date

Time

_____ _____

Signature of Person Conducting Informed Consent Discussion

Appendix B. Spanish Informed Consent

Emory University

Consentimiento para ser participante en una investigación científica

Titulo:

Una Exploración Usando Fenomenología Interpretativa Acerca de la Experiencia Vivida de Afrontamiento al Parto, y la Experiencia de Agencia Durante el Parto.

Investigadora Principal:

Priscilla J. Hall Enfermera Registrada, Enfermera-Partera Certificada MS,
Escuela de Enfermería Nell Hogdson Woodruff, Universidad de Emory

Fuente de Fondos: El Colegio Americano de Enfermeras Parteras, Fondo Educacional de Enfermeras

Introducción:

A usted se le ha pedido participar en una investigación científica. Esta hoja esta diseñada para decirle todo lo que necesita pensar antes de decidir que desea dar su permiso para participar en el estudio o no participar en el estudio. Esta decisión es completamente suya. Si decide tomar parte en el estudio, puede mas tarde cambiar su mente y retirarse del estudio. Puede pasar por alto cualquier pregunta que no desea contestar. Antes de tomar su decisión:

- Lea con cuidado esta hoja, o haga que alguien se la lea
- Haga preguntas acerca de cualquier parte que no le parece claro o que no entiende

Puede tomar una copia de esta hoja para guardar. Debe tomar la cantidad de tiempo que usted quiere para considerar si desea dar su permiso para participar en el estudio. Cuando usted firma esta hoja, usted no pierde ningún derecho legal.

Resumen del Estudio:

El propósito de este estudio es entender que son las experiencias de sentir afrontamiento y tener agencia (sentir empoderada) durante el parto.

Procedimientos:

A usted se le pedirá hacer contacto con la investigadora principal después de su parto y juntas, harán una cita para una entrevista. La hora y el lugar de la entrevista deben de ser convenientes para usted. La entrevista puede ocurrir en una oficina privada que esta

localizada en la Escuela de Enfermería de la Universidad de Emory. La entrevista tomara aproximadamente una hora o una hora y media, y el tema de la entrevista es la experiencia de su parto, y como usted se afronto a la experiencia de sentir estrés. La entrevista también le preguntara acerca de su experiencia de sentir agencia o empoderamiento en el parto. Aproximadamente 4 semanas después de la primera entrevista, la investigadora hará una cita para una segunda entrevista para repasar con usted el material de la primera entrevista y hacer algunas otras preguntas adicionales. Posiblemente, se hará una cita para una tercera entrevista.

Después de la entrevista final, si usted desea, la investigadora le mostrara una transcripción de sus entrevistas para que pueda añadir algún comentario. Después de la entrevista final, usted recibirá una tarjeta de $25 dólares para agradecerle su contribución al estudio.

Este estudio no requiere que usted done sangre ni ningún tejido humano, ni requiere que usted este sujeta a ningún procedimiento medico.

Riesgos e Incomodidades:

El tema de este estudio es muy sensitivo y privado. Muchas mujeres pueden sentir emociones muy intensas (positivas o negativas) a la experiencia del parto. Es posible que usted sienta que ciertos aspectos de su parto son privados y que usted no desea compartir esos aspectos de la experiencia y que no desea discutir ciertos temas. Pueden haber aspectos del parto que fueron muy negativos, traumáticos, o trastornantes, y puede ser que la entrevista le cause sentir estrés.

Informacion Nueva

Es posible que la investigadora aprenda algo Nuevo acerca de los riesgos de participar en el estudio. Si este es el caso, la investigadora le informara y usted puede decidir si desea continuar en el estudio. En este caso, es posible que usted firme un consentimiento adicional que incluye la informacion nueva.

Beneficios

Este estudio no tiene un beneficio directo para usted. Este estudio esta diseñado para aprender acerca de las emociones como el estrés durante el parto y como las mujeres se afrontan al estrés y también como la mujer tiene la experiencia de estar empoderada en el

parto. Este estudio puede ser útil para ayudar a mujeres en el futuro que están enfrentándose al parto.

Compensación

Usted recibirá una tarjeta de $25 como un agradecimiento por donar su tiempo y su informacion.

Opciones Afuera del Estudio

Si usted decide no entrar en este estudio, su habilidad para recibir cuidados de salud de el hospital de Emory University ir Grady Memorial Hospital. No es necesario que usted participe en este estudio para recibir tratamiento medico para cualquier condición.

Confidencialidad

Su derecho a privacidad y confidencialidad serán protegidos. Ciertas oficinas y personal de la Universidad de Emory además de los investigadores pueden mirar los registros y documentos del estudio. Agencias del gobierno y empleados de la Universidad que supervisan el conducto propio de la investigación científica pueden también mirar los documentos del estudio. Estas oficinas incluyen la Oficina de Protección de Sujetos Humanos de Investigaciones Acientíficas, la Junta de Revisión Institucional, la Oficina de Cumplimiento de Investigación Científica y la Oficina de Investigación Científica Clínica. Los documentos pertinentes a toda investigación por una de estas oficinas serán privados en la medida que lo requiere la ley. En los documentos pertinentes de la investigación se substituirá un numero en cualquier lugar que se encuentre su nombre. Su nombre y otros datos que puede ayudar a identificarle no aparecerán cuando presentamos los resultados o publicamos algún manuscrito presentando el análisis.
La corte legal puede producir una orden para pedir que se abran los documentos de una investigación científica, como también una citación o pedido para la producción de documentos.

Participación Voluntaria y derecho a retirarse del estudio

Usted tiene el derecho de retirarse o dejar el estudio en cualquier momento. Tiene también el derecho de no contestar cualquier pregunta que no desea contestar.
Los investigadores y las instituciones que regalaron fondos para este estudio tienen el derecho de parar su participación en el estudio sin su permiso si:

- Ellos creen que esta en su mayor interés

- Si usted no desea aceptar cambios que se podrán hacer al plan del estudio en el futuro
- El proceso de las entrevistas esta causando trastorno o estrés y es necesario terminar la entrevista para permitir que usted se recupere.

Informacion de Contacto Puede comunicarse con la investigadora principal, Priscilla J. Hall at 224-805-8673

- Si tiene preguntas acerca de este estudio o su parte en el estudio
- Si usted piensa que su participación en el estudio ha causado alguna injuria
- Si tiene preguntas, preocupaciones o quejas acerca del estudio

Puede comunicarse con la Junta de Revisión Institucional al 404-712-0720 o 877-503-9797 o irb@emory.edu:

- Si tiene preguntas acerca de sus derechos como participante
- Si tiene preguntas, preocupaciones o quejas acerca del estudio
- Puede también avisarle a la Junta de Revisión Institucional como fue su experiencia como participante en un estudio científico a través de nuestra encuesta para participantes de investigaciones científicas al http://www.surveymonkey.com/s/6ZDMW75 (en el internet).

Consentimiento

Por favor, escriba su nombre y firma si usted esta en acuerdo para participar en esta investigación. Cuando usted firma esta hoja, sus derechos humanos serán respetados. Le daremos una copia de esta hoja para guardar.

_____

Nombre del Participante

_____ _____

Firma del Participante Fecha y Hora

_____ _____

Firma de la persona que dirigió la discusión para el consentimiento y Hora Fecha

_____ _____

Appendix C. English and Spanish Interview Guides

1. Tell me the story about how your birth was.
2. Pay attention to the emotions, the thoughts and the physical sensations that you had in labor.
3. Tell me what other people were doing during the birth (husband, nurse, doctor, midwife, family). What were they like? How did you feel about them?
4. Tell me what the physical space was like and how it affected you?
5. Tell me about the passing of time. How did you experience the passing of time?
6. Tell me about an instance when you were able to obtain or achieve something you wanted during the birth.
7. Tell me an instance in the birth that was more difficult, or when you felt that you could not manage.
8. Tell me about a moment in the birth that stands out in your mind.
9. Was there a moment in the birth where you felt more confident or capable? Tell me about this moment
10. Was there a moment in the birth where you felt very discouraged or that you felt very negative?
11. Think about the moment when the baby was out, and you had that first contact with the baby? What was that moment like? What did you feel in your body? What thoughts did you have? What emotions did you have?

Spanish Interview Guide

1. Dígame la historia de su parto. Trate de recordar todos los aspectos y detalles que usted puede.
2. Cuales eran sus emociones, sus pensamientos y las sensaciones físicas que usted sintió.
3. Dígame que estaban haciendo las otras personas presentes. Piense en su esposo, otros familiares, la partera, el doctor, la enfermera. Como eran ellos? Como se sintió usted con estas personas?
4. Como era el espacio físico del cuarto? Como se afectó usted con el cuarto y el ambiente?
5. Cuénteme como era su experiencia de la pasada del tiempo.
6. Dígame acerca de un momento que usted consiguió algo que queria, que sintio que necesitaba. Dígame acerca de un momento que usted participo en alguna decisión.
7. Dígame acerca de un momento en el parto que fue mas difícil, o que usted sintió que no iba a poder.
8. Dígame un momento en el parto que se destaca en su mente, un momento que recuerda con mas detalle, con mas emoción.
9. Hubo algún momento en su parto que usted se sintió con confianza or con mas capacidad? Digame acerca de este momento.
10. Hubo algún momento en el parto que fue muy negativo, mas difícil o que usted se sintió descorazonada?

11. Piense en el momento que nació el bebe y usted tuvo el primer contacto. Como fue ese momento para usted? Como se sintió en su cuerpo? Que pensamientos tuvo? Que emociones tuvo?

Appendix D. Code Book

Code Name	Definition
A lot of emotion!	Instances where participants indicated strong feelings but did not specify what emotion they had
Accomplished	A sense of pride in the self because of your ability to achieve something
Anger	A strong negative emotion that is a reaction to disrespect or energetic displeasure
Annoyed	A milder negative reaction that denotes displeasure
Anticipation	An experience of looking forward with expectation
Anticipating something bad	Looking forward with the expectation of something negative
Awe	A positive emotion that expresses wonder and amazement
Is the baby OK?	An expression of concern about fetal wellbeing
Baby's heartbeat	Any mention of the baby's heartbeat, checking the heartbeat or the meaning of a recording of the fetal heartbeat
Being active	The ability to chose whatever position the woman in labor wanted or found helpful. Any mention of physical movement.
Being a good patient	Actions or speech that participants engaged in to cooperate with what medical providers requested
Being at the mercy of others	An expression of vulnerability to the wishes/demands of others, being subject to someone's authority while in labor
Being flexible	Being open to different ways the experience could turn out or go; Being open to having a natural birth or a birth with medical interventions, depending on the circumstances of labor.
Being healthy	The ability to affect one's own wellbeing or that of the baby

Being in a daze	An experience of disconnect from events, a diminished ability to hear, react to or respond to the environment because of fatigue or the intensity of the labor experience
Being polite and considerate	An expression of wanting to show respect or consideration; deferring to the wishes of others
Being present in the moment	An experience of being mindful, fully present to what is happening right now, both the body and the person.
Belief about labor	Ideas held to be true about the labor process, the person, or her body
Believing in my body	Ideas related to feeling that the body can accomplish the birth process
Birth plan	A list of items that the participant wanted (or didn't want) to have or experience during labor, could be a formal, written plan or just imagined
Body knows what to do	Any mention of the internal, intuitive experience of knowing what they body or the labor needs
Breathing	Mention of the act of breathing
Busyness	Any mention of an event or instance of being crowded with activity, especially as it relates to feeling neglected in labor because a caregiver had other things to do.
Calm	A restful acceptance of the moments or events in labor, feeling peaceful, relaxed
Not calm	An negative emotional response to not feeling like you can accept what is happening. Similar to anxiety or fear
Cesarean	Any mention of surgical birth
Clock	Any mention of the measurement of time with a clock
Comfortable	A state of physical or emotional ease
Uncomfortable	A state of not being at ease

Comforting	An element of labor that increased physical or emotional comfort, an action taken by someone present that resulted in feeling calm, soothed, relieved
Confidence	A feeling of being capable, feeling sure or certain that you can rely on your strength or your capabilities
Confused	Not understanding, feeling uncertain about information that you have
Contractions	Any mention of the rhythmic work of the uterus in labor
Control	Any mention of the word control, being able to exert power toward something that you want, or having someone else exert power that restricts you or directs your actions
Crying	The act of having tears
Crying wolf	Feeling like you are giving a false alarm about what is happening in your body.
Decision	The event of choosing to take an action
Desperate	An extreme emotion of despair and hopelessness, inability to manage
Disbelief	Refusing to see something as true (that is true)
Discouraged	Having lost confidence or enthusiasm
Disheartened	to have diminished energy or hope
Disappointment	Displeased that some expectation was not fulfilled; Feeling dissatisfied or discontent
Feeling dissatisfied	The feeling that happens when something didn't turn out as you hoped
Doctor said or did	Action or communication by the physician
Doula said or did	Action or communication by the doula
Due date	Any mention of the due date

Elated	Extreme happiness
Embarrassment	Feeling ashamed or having your private person exposed
Empowerment	Any mention of the word empowerment, the experience of being able to accomplish a goal or achieve something wanted
Encouragement	Giving someone hope and/or support
Epidural	Any mention of epidural anesthesia for pain relief
Excited	A feeling of being enthusiastic and eager
Expressions about ordinary life	An element that was part of the labor experience that is small, mundane and of no special significance
Family	Actions taken by human beings related to the woman in labor: sister, mother, husband, in-laws, brother
Edgy	Tense or nervous
Fear	Unease because of a real or perceived threat
Anxiety	Unpleasant feeling of dread
Antsy	Being restless because of nervousness
Feeling acknowledged and respected	Having your wishes and person recognized as important
Appreciation	Experience of gratitude or thankfulness
Feeling caged	Feeling trapped, restrained from accomplishing what you want
Feeling capable	Believing that you can accomplish what you want
Centered	A state of being calm and connected to oneself
Confined	Being restricted from movement
Connected	An expression of human connection or intimacy

Defeated	The emotional response to not achieving what you wanted, to loss when someone else has authority or power over you
Feeling detached from the doctor	Feeling like the doctor doesn't know you as a human being, they are just there to do a job.
Excluded	The experience of being ignored, not being part of information sharing or important conversations about the birth process or birth care
Hope	Feeling or having the expectation of a positive outcome
Ignored	Feeling like others are refusing to hear, see or acknowledge you
Feeling in my body	An expression of emotion or description of sensation that was specifically attached to the physical person, the body
Unable to feel my body	Not being able to perceive sensations in the body
Feeling like someone knows you	A feeling of connection with a person you have a history with, or with a health care provider that spends time getting to know you as a person
Feeling like they can do anything they want	A feeling of being vulnerable and powerless in the face of health care provider decision making
Love	Feeling affection or affiliation towards someone
Miserable	A negative, intolerable emotion or physical sensation
Feeling powerful	Having a sense of your own capacity, strength or ability to accomplish what you want
Feeling pressure	Sensation in the second stage of labor
Proud of myself	An experience of confidence or achievement, of being able to rely on the self to accomplish something
Feeling safe	An experience of trust in caregivers, the expectation of respect and protection from harm
Feeling strength	Feeling able/capable to accomplish the labor process

Tense	The state of physical or emotional tightness associated with negative emotion
Feeling weird	An emotional reaction to something strange, unexpected
Fetal Monitor	Any mention of the machinery used to monitor the fetal heart rate
Finding energy I didn't know I had	The experience of an unexpected burst of energy in the middle of being tired.
Focus	Being able to concentrate your attention
Frustration	An emotion of anger or discomfort caused by being unable to achieve something
Happy	Expressions of feeling pleasure, contentment, satisfaction with how things are going
Hated!	Intense hostility and aversion
Hospital has rules	Any mention of hospital practices or routines that are implemented whether you want them or not/need them or not
Hungry	The sensation of needing food
Husband said or did	Actions or statements by husband or partner
I can do this.	An experience of feeling capable in your self and your skill or strength
I can't do this!	An expression of doubt in your ability or strength
I did this	An expression of accomplishment about the birth
I didn't know what to do.	Feeling uncertain about how to manage or proceed
Important comment Intense	Salient, meaningful quote that does not fit any other code an extreme degree of emotion, physical sensation or experience
Irritated	An emotion of displeasure

Joy	A feeling of great happiness and/or delight
Knowledge	Having information, understanding or skill; Information about birth that is not a belief, received from family, friends, reading, childbirth education.
Labor progress	Any discussion about the changing labor process in terms of advancing forward-the dilatation of the cervix or descent of the fetal head. May be referred to as fast, slow and also non-progression of labor.
Labor was like...	Metaphors that describe labor
Laughing/smiling	Any mention of the act of smiling or laughing
Listening/not listening	Having a feeling that your expressed wishes, concerns and communication in labor are being taken in, responded to by caregivers.
In bed	Any mention of the experience of being confined to bed
Medical interventions	Any mention of the use of medical interventions-continuous EFM, IV fluids, vacuum assisted or forceps assisted delivery
Meeting the baby	Descriptions of the moment of birth and the first encounter with the baby
Midwife said or did	Actions or statements by the midwife
Misbehavior	Instance of participant's behavior that is not consistent with gender norms of being nice, polite and following along with what someone else wants
Mother said or did	Actions or statements by the participant's mother
Moving in labor	Any mention of being out of bed doing something during labor, such as walking, being in the shower or being able to moving/changing positions at will.

Natural birth	Any reference to unmedicated birth without medical interventions
Needing reassurance	Needing some communication that will allay fears or doubts.
Nervous	A feeling of unease or anxiety, uncertain that the choice/event/decision is going to turn out well in the end.
Nice	Mention of an element of the labor process or events of labor that was pleasant, helpful, comforting or supportive
Nurse said or did	Any action or statements made by the nurse
Overwhelmed	A strong emotion that takes over.
Pain	Any mention of the labor discomfort associated with contractions
Panic	Extreme, uncontrolled fear
Pitocin	Any mention of the use of the artificial hormone Pitocin
Prayer	Mention of religious prayer or thoughts, asking for God's help
Privacy	A desire to protect the self from exposure, emotional or physical
Pushing	The conscious effort of second stage to bring the baby out.
Relaxing in labor	Description of the release of muscle tension in the body
Relief	The cessation of discomfort, stress or tension
Relinquishing	Giving up an important goal or wish
Resentment	anger or displeasure about not getting your wish
Rest	The state of quiet repose that is restorative, the release of effort
Risk	Any mention or discussion of the concept of risk in pregnancy and birth

ROM	Any mention of the event of rupturing membranes, spontaneous or artificial
Sadness	An emotion of grief or unhappiness
Silly	When participants described some aspect of labor, some wish they wanted or some emotion that was unimportant, not serious, foolish
Something I didn't want	An expression of something the participant wanted to avoid in labor
Something I wanted	An expression of a wish, a goal, an expectation, something hoped for in and through the labor process.
Something might go wrong	A reference to potential harm or risk of the labor process
Something that I did to make things better	An action taken by the participant to improve the situation, create ease, relaxation, or achieve something they wanted
Support	An instance of an action or an act of helping a person; an instance of spiritual help; encouragement, emotional help, mental comfort
Surreal	A sense of unreality, dreamlike
Sweet moment	A moment in labor that felt pleasant, joyful or delightful
Taking matters into my own hands	Taking actions that are not approved by health care staff because it was important or because some aspect of care was intolerable and trying to negotiate with health care staff did not achieve a satisfactory result
Terror	Extreme fear or panic
Things that felt helpful	Behaviors the participant engaged in or support she received that helped her to be OK with the labor process; Using a behavior to help manage the contractions

Thinking about God	A reference to thinking about, feeling or wanted to experience a divine presence
Thinking about the baby	A reference to thinking about the baby
Time	Mention of the passage of time, how long something took, what time it was in the day, concerns about how long something was taking
Tired	Emotional or physical fatigue
Trust	Belief that someone or something is reliable, good, honest, effective, etc.
Using your voice	Instances where women spoke up to request something or decline something unwanted.
Vaginal exam	Any mention of digital exam to assess the dilatation of the cervix.
Vulnerable	" Its my body that is wide open for the world"; capable of being physically or emotionally wounded; open to attack or damage
What the hospital wants is not what you want	Any reference to the difference or conflict between hospital expectations/policies and what you might want in labor
Worry/No worry	To think about problems or fears : to feel fear and concern because you think that something bad has happened or could happen
Yelling/screaming	Making loud vocalizations or wanting to make loud vocalizations

Appendix E. Summary of Examples of Emotion for Anita

(G2P2, labor induction at 40 weeks)

Emotion	Exemplar
Annoyed	Because of slow progress (people kept calling: haven't you had the baby yet?) When people told her to breathe (why do I need to be reminded to breathe?)
Anticipation	When she was 10 cm
Anxiety	When the induction was started. After the second day with no progress When she had to ask CNM what the plan of care was About the pain intensity
Calm	When the midwife told her she believed the baby would be born vaginally
Comfort	-
Comfortable	-
Concerned	When she couldn't feel her legs, she wondered if she would be able to push correctly
Confidence	-
Disbelief	That the baby was coming out-she couldn't feel it
Discouraged	-
Disappointed	When the nurses got into an argument in front of her
Embarrassement	When she had a bowel movement in the presence of everyone, even though she knew this was normal
Exited	When she started the induction (It was like December 24 and you get to open the present. That she had a girl
Fear	-
Feeling capable	-
Feeling excluded	When they were whispering

Feeling powerful	-
Feeling pride	-
Feeling robbed	Because she wanted a water birth and it did not go that way.
Flipped out	After water broke, because the pain was so intense
Frustration	When the nurse and the CNM were whispering behind the curtain. Because of her slow progress. Because the birth was going in a different direction than planned. Because she did not have any control over the situation Because of not getting answers from anyone for a long time. When providers would whisper behind the curtain but not include her in the conversation. When she needed reassurance and did not receive it.
Gratitude	Because the baby was healthy
Gross/disgusted	When she had a bowel movement delivery because it smelled and someone else had to clean it.
Happy	Because she could get her labor started. To be laboring in a place where she had friends To feel supported in labor When it was all over, that she had done it.
Hated	Being told to breathe; CNM and nurse whispering behind the curtain
Hope	When she was 10 cm; When she was in a lot of pain, just to know that the anesthesiologist was coming.
Impatience	When she got to her due date and was not in labor yet.

Irritation	Because everyone expected her to hold her legs up to push and she was unable to. When she did not feel acknowledged. Because everyone acted like her birth was just one more delivery with meconium and not a special life event.
Joy	Enjoyment-that people were there to help her
Longing	For the water birth she didn't get
Managing	-
Not disappointed	-
Not stressed	When doula helped her talk about or think about other things besides labor
Overwhelmed	With worry about not making progress
Release	-
Relief	When the midwife told her she believed the baby would come out vaginally
Sad	That the birth wasn't what she expected; When she realized other women were delivering and she was still there.
Stressful	That the baby wasn't out yet
Support	-
Terror	-
Unbearable	-
Uncomfortable	That there were so many people at the delivery

Unprepared	About the loss of her ideal birth
Worry	That she might need a crash cesarean.
	That the baby might have to go to neonatal ICU.
	Because she was an older mother and had a risk for diabetes and hypertension.
	When she was completely dilated, the baby's station was still high and that could mean that she might not be able to push her out.
Vulnerable	When others had to be present when she was having a bowel movement.
	Being open for everyone to see her most intimate part- when there were so many people at her delivery that she did not know and did not introduce themselves

Appendix F. Descriptions of the Moment of Birth

Anita	Margaret	Nydia	Sharon	Catherine	Talisa	Julia	Gabriela
Being here, being healthy							
She's screaming, oh good.	-	I was ecstatic that she was healthy.	He was there. he was healthy, Nice to know he was healthy right away.	-	She has 10 fingers and 10 toes.	-	I was happy because my little guy was born, how beautiful.
Emotions							
I was relieved.	It was the biggest relief ever.	I was in awe of the whole thing	Such a release.	Once he was out they gave him to me.	Whew, pushing is done.	I was very proud	I felt a relief. I was at peace with everything.
I was exited.	I panted and then [I thought] what now?	I was so exhausted and drained and shaky and completely out of it.	Oh my God, he is here.	I don't remember much about how it felt.	Finally out, you could breathe. My body got hot and I just was like a wave of emotion	My husband was very emotional because he cut the cord	Relief for me and for him because my suffering was over
I was exited about it being a girl	I cried right after she came out	My husband was crying, the look on his face was gratifying.	A flood of emotion, it was so moving.	I was having a bit of shock.	Overwhelming welcoming. Elation, so much joy and pain simultaneously.	I felt very emotional.	I was happy because my little guy was born, how beautiful.
I wanted birth control right then I can't believe I put myself through all that drama.	Me and my husband were both crying. I was, "Why are we crying?"	I couldn't produce any emotions but it was nice to see it on his face.			I just felt stripped of everything else. You are so vulnerable and putting your trust in people.	It was a dream. My husband was very emotional because he cut the cord	I was very emotional because I missed him, I wanted him.
I can't believe this just happened.	It is a release of all that.	I was in a daze.			I hear her I look at my husband and he is in tears.		The worry went away.
	Somebody look at me.	My husband was smitten with her.			I felt so relieved and happy.		I felt a cleansing in my soul.

Anita	Margaret	Nydia	Sharon	Catherine	Talisa	Julia	Gabriela
	The baby is more important, I get it.	I just didn't have the energy for any kind of reaction			It is surreal because there is so much happening at once.		
	It was such an intense experience physically, mentally, emotionally all in one.	Shouldn't you be giving me some attention? I just produced this child!			It felt like the most natural thing in the world that was a great feeling.		
	It was a minute or two but it felt like forever.				I depended on people to have me		
<u>Welcome</u>							
It was good to see her face	We were just laying there cuddling.	How did you come out of me?	I looked down and his eyes were opened, he was looking back at me.	I tried to nurse him he was not very interested.	Felt so good to hold her. You can feel her and touch her.	They gave me the baby and I breastfed him	
I can't believe she Is actually here.	My contractions stopped.	I didn't register anything at this point, it was surreal.	They took him to the warmer and I kept trying to see him.	I was really tied up in getting him to nurse he wasn't nursing.	We are both here (together).	I had him for a while so he could feel my warmth, and hear my heartbeat.	
She went to the warmer because of the meconium.		I knew we had a baby	We had him, there was no waiting to see if he was ok.		Not noticing what's going on.	He was looking around.	
But I felt like you don't have to do everything over there right now.		I am a mom now? Her just existing	they let me hold him and nurse him right away		I wanted her skin to skin as soon as she came.		

Anita	Margaret	Nydia	Sharon	Catherine	Talisa	Julia	Gabriela
Just do the vital stuff and then give her to me so I can see her.		Being able to do it naturally.	Finally getting to see him, finally getting to hold him.		I wasn't thinking about anything else.		
I just kept saying I haven't seen her yet.			He was saying that's our baby, he confirmed the name we chose.		I couldn't believe there is this baby on my chest and she is warm and squishy		
I can't get up and go look and see what they are doing.			To have him and show him off and cuddle him.		We made a baby and now we are bringing her into the world		
I wanted to have her for skin to skin, look at her body, check her out.			You are here, you are part of our family now, I am your mom.		You are holding her and she is ok in that moment.		
I wanted to see her, her whole body			You hold him against me and feel his squirminess.		You work so hard and done so much and there are so many unknowns and everything changed in an instant. This is an entirely new journey.		

Appendix G. Comparisons of the Experience of Pain

Working with pain	Falling apart with pain
Talisa G1P1 Induction of labor	
But I just felt like I spent every moment trying not to be in pain, so when my mom could relieve some of that, even just like massage my feet or my sister massing my back or any of that, it was so refreshing.	The epidural didn't take and that took over the day, the entire day was about managing pain.
Its painful, its pain, it doesn't mean it was bad, it was just painful in the sense of like the pressure and the pushing and the exhaustion of working her out. But its really painful but its also very sweet.	We spent every hour like I am still in pain and what are things we can do to manage it?
And those moments I was just like that's all I needed[to have her mother rub her shoulders], just to feel relaxed because it was like the pain would come and then it would be worse and I would tense up when the pain was coming.	And I didn't expect it to not be painful. But I don't think I was prepared for the ebb and flow and I found that frustrating. For me, right when I got some relief, I went ah, oh, it was feeling better, and then not so. It was like a constant – it was constant work, and I don't know if I expected constant work.
To hear it because my mom – she told me that my grandmother, epidurals didn't work great on your grandmother either. I was okay, so other people have been through this, this happens. And maybe they don't just take and you're fine.	The pain would come and then it would be worse and I would tense up when the pain was coming. So then I was just tight all over.
I didn't know a foot massage would make me feel better. There's no pain in my feet, but it helped, it relaxed me and so – having my mom there helped with the pain management.	I got frustrated every time my pain came back, only because my hope was that the epidural was taking and my expectation was once you get the epidural, you don't feel anything. So I was frustrated that it wasn't working.
In those moments, I wasn't thinking about [my] back and my mom was talking to me, not talking about the pain, but just talking. And I found that it helped take my mind off the pain. In those moments I just felt like I was taken away from the pain.	When I felt the contractions, li was like an immense pain all over and I didn't feel like something's contracting and releasing. It didn't feel like that. And so I was so confused. I was like is this pain a contraction? I don't know.

Working with Pain	Falling Apart from Pain
Like I'm saying pain, but it wasn't. It was like I remember I couldn't lay and relax and that was frustrating. When mother was massaging my feet, it was like you were right on time. That's what I was thinking about, just feeling that relaxation start. It starts for me in my shoulders, it was feeling it there, just relief.	Pain isn't even the right word for what I was feeling in those moments. It was more like extreme discomfort. It was just like I couldn't relax and couldn't get comfortable. And I think that was what it was.
The pain was hitting, I was just like it's just pain, it's fine. I did a lot of self-talk because, I was trying not to be anxious about the next step. Even just trying to be just present, it's just pain and it doesn't feel good, are you really uncomfortable, and I kept saying out loud how I was feeling.	I'm saying pain, but it wasn't. It was like I remember I couldn't lay and relax and that was frustrating. The pain was just so intense and I couldn't get relief and I couldn't get comfortable and I was stuck in the bed. So I was just like I can't – I want to figure out how to solve it, but I couldn't.
I just kept saying yeah, I'm really uncomfortable right now. I think I was verbalizing what was going on more for myself to ground myself. I'm not trying to complain, like I'm really trying to talk myself through what I'm physically feeling so that my head doesn't get away from me and think that oh, no, what's happening.	
I would lay my hands flat on the bed and talk about what is happening right now to myself. Because it feels like you're shifting the focus or getting back to what's happening now versus your feelings about all the what-ifs. So it felt like taking a breath, like it felt like a relief, not because of the pain, but because you're letting yourself just stay here instead of going somewhere else, which is what I needed in certain moments.	

Working with Pain	Falling Apart from Pain
I would start crying. I would look up at my mom and she's like it's okay, it's okay, it's okay. That's always how she is. It would just kind of bring me back into like you're fine, you're in the moment. That was helpful, especially just because the pain was just so intense and I couldn't get relief and I couldn't get comfortable and I was stuck in the bed.	
Even as she was coming out, it hurt, but it had like a means to an end, and it was like so much pain and joy coming simultaneously. Like she's coming out, and it hurts and it was so interesting that when they let me touch her head, it really did help keep me going because that's so exciting that it can kind of table the pain.	
Sharon G2P2 2-hour spontaneous labor	
By the time we got into the car, I was in a lot of pain. I was just really trying to clear my mind and keep breathing and not be too thoughtful. Just really keep myself calm and try to manage the pain.	Well, I was a mess. I was just like naked and dripping wet and in such pain and sweaty from the steam from the tub. I'm not sure I can handle the pain. I'm not sure I can even move my body into a position where I can push. I'm not sure that I can cope with what I need to do.
I was trying to sort of keep my head in the game, to breathe through it and manage my own pain and direct everyone else in what they needed to do again. But it was all happening so fast.	And I was feeling more – the pain was what really got me, I think. I couldn't control the pain as well, and then I just felt like then I fell apart a little bit. I started to worry. I wasn't able to keep myself calm and keep myself composed. And I had to leave my little zone of privacy.
I think I probably would have appreciated different positions. It may have been less painful standing up this time. I don't know.	When I got there, I was in full screaming mode at that point because I was in a lot of pain. I didn't feel like I was in control at that point. My body was in control, and this baby was in control, and he was coming, like it or not.

Working with Pain	Falling Apart from Pain
And I kept calling out to him all the things he needed to put in the car. "I need a bucket to puke in. I need a towel. Don't forget the camera." All the while, I guess I was in the right mind to be able to think of all the things I needed, but I was maybe focusing on that to take away from the pain and the out of controlness that I felt in my own body.	I had to do it. I had to do something active to help him to be born. At that point, it was just such intense pain that I didn't think I could do it, but I had to. But thankfully, I had lots of people around me, like it or not. I wasn't sure that I could handle the pain, that I could make all those things happen. I think it was mostly the pain versus anything else because it was just so overwhelming.
Nydia G1P1 Spontaneous 23-hour labor	
Yeah, I mean, in the beginning when the contractions weren't so bad and we were walking the halls and just kind of hanging out, I thought, okay, this is fine, I'm doing what little that I can do and we're getting through it and my husband was really great about massage and helping me breathe.	And it's hard to have a level head when you're in pain and not in control and it's taking forever. So I knew deep down that I wasn't going to have a C-section, that I was going to be able to get through it, but it wasn't – those weren't thoughts that were helpful.
I felt like the pain was very manageable at that point, like I just felt, I guess, that I was doing the thing that I was taught to do and that was pretty controlling feeling.	I felt like everybody is ignoring us, I'm in pain, I have this stupid monitor on me, and I can't go anywhere and I can't do anything and so I as soon as I took it off, actually I had kind of like a panic attack. I started balling, which is not good when you're having contractions. It hurts pretty bad.
Now, once we got most of her head out, like right before she started crowning, I thought, we can do this. I can get this out fast. And everybody said that crowning was the worst part, that's the most painful, I don't even remember that. It didn't faze me at all at that point. I was like okay, we're there, let's do it.	When I hit transition, obviously, I started to think, I don't know if I can do this, maybe I should have gotten an epidural. I don't think I can do this naturally. The pain was really intense, and it was progressing very fast, so it was kind of – just a lot of unknowns. And again, a lot of stuff that I had no control over. I kept looking at the clock thinking this is dragging on forever.

Working with pain	Falling Apart from Pain
Yes, exactly. I was like bring on the pain. I don't even care; we are to the point of no return. Let's go.	I haven't gotten an epidural yet. I was able to have rational thoughts, but at some point during transition and the first hour or two of pushing, that's when all of the irrational things like I'm going to have a C-section, I don't have enough energy, I don't think I can do this, that kind of thoughts crept in. And it's hard to have a level head when you're in pain and not in control and it's taking forever.
I feel awesome about that part, I can totally do it again. When I was in the process, I thought oh, my God, what am I doing? This is not a good idea. I get why people get epidurals and I'm going to get an epidural next time. But now it makes me feel accomplished. I don't like bragging about it, but I think it's awesome.	I kept thinking my energy is draining, I don't know if I'm going to be able to do this. I'm well educated about the birthing process, so it's like I knew that I had the capability, like my body knew what to do, everything was probably fine, but it's hard to focus on that when you're in a lot of pain and you're really tired.
Margaret G1P1 Spontaneous 12-hour labor	
[You are in a bubble in labor]. It's actually very quiet and like surprisingly calm. I don't know if that's your body's coping mechanism with pain.	Well, particularly like at the end, it was like the worst pain ever. I read online what to expect. One comment my husband read was it feels like you're trying to poop out a cement block. It literally felt like that.
...Its your body's coping mechanism with pain. because I didn't have anything. I really wanted to know what my body would do in the response to pain. I would describe it like as if everything were just like flying around and you were in the middle of it and there was like a bubble around you.	I couldn't even, they had to hold my legs up and if they relaxed their arm, it was awful. I was like yelling do not move your arm, do not let it go. So there was this period of time where it was just like unbearable, like she wasn't coming out and my contractions were slowing down and I don't understand what's going on.
I haven't done anything harder than that pain wise, but it wasn't the hardest thing I thought. Like I remember being consciously aware that it wasn't as bad as I anticipated, and I guess I was just like okay, it's like having a period and back pain times 10.	It's like you're adding to the contraction pain the pushing pain.

Working with Pain	Falling Apart From Pain
So I think I kind of psyched myself out that it was going to be unbearable because everyone is like so pro-epidural and no pain. Am I just really strong or something?	
I think it just depended on who you are as a person. If you're somebody who understands that pain is a part of life, then it makes you stronger.	
I mean; somebody who would say no pain no gain, so I think some people are more designed that way. I think it is learned, but it is a part of who you are. Maybe she'll be like that, I don't know.	
You know, in, like, a weird, backwards way cuz I was in the worst pain ever, but— it's just good.	
So I honestly was thinking, this is terrible, but it's not as terrible as I thought. Yes, it's a ten, but I don't need somebody to take that away. I wanted to experience birthing a child. I didn't want it to be, like, dulled or [Laughter]—or, um, modified, or changed, or anything like that.	
Catherine G5P5 Spontaneous 12-hour labor	
I would also visualize a leaf just kind of floating down. I found myself visualizing those two things and taking deep breaths. The contractions would last about two or three deep breaths. They would go a little beyond that, but that was the cramping part – the pain part.	
Hypnobabies doesn't want you to say pain or any of that, but I've had enough babies. I know what it's like. But that helped me just knowing – just being able to use those visualizations to just relax myself.	

Working with Pain	Falling Apart from Pain
I would try to relax my body. That does help. It's hard to do, because first instinct is to just tense up, for me at least, when I feel the pain coming. But just relaxing helps and just letting it happen. Oh! And trying to remind myself that this was a good thing, that it wasn't fun but it's what needed to happen to bring my baby. It helped basically until I hit transition. Then not much helped.	
Gabriela G3P3 Spontaneous 8-hour labor	
He would support me, he held my hand and caressed my head. And he would say, you can do it, you can. He squeezed my hand when I would feel the pain, because I would squeeze his hand.	They need to take down the clock! It was like a minute was not going by, it was very disturbing. I wanted the time to pass, to pass, to pass and to feel a little less pain, but no, it was the opposite. The pain kept getting stronger and the time was not moving forward.
The only thing you want is to concentrate on the pain and you can only think about the pain and not in what anyone else is saying.	When the pain started coming every 5 minutes, for two and a half hours. I was very discouraged, it is like...[thinking] very negative things. I wondered why I was thinking that.
When they told me the baby was coming, I felt such confidence and it was the more I could push. The pains were stronger than before, but I had faith, I said to myself, enough!	I felt it in my body. When I had a pain, instead of relaxing, I would...With the pressure, I felt so angry, my body was very hard, very hard [tense]. I would feel the baby moving up.
When I felt the pain come on stronger, they were more and more and more strong than before, but it was so the baby was coming. It was a moment that I said, I have to do this. I trusted in myself so much! And in my husband's help.	It was in that moment that I was so negative, I wanted so many things, I never would be able to tell my husband. I think that is part of the birth, that when you have pains, you think [negative things]....The pain was coming every second and I was so discouraged.
If I wanted a natural birth, there was nothing to be done but relax myself, breathe deeply each time I had a pain. The breathing helped tremendously.	Because of the pain, I said, if you are not going to help me, and I have to wait, I want to go home to have the baby at home. It was so uncomfortable. I felt bad with the pain, and it was making me more angry that they would say, Oh, your birth is still a long ways away.

Working with Pain	Falling Apart from Pain
I felt a sadness and happiness in the same moment. There was so much pain and no one was paying any attention, and all that pressure, tha tis what made me feel that way. Maybe that happens to all women.	I thought, I am the one with the pain, not any of you. I wanted to go home. I told my husband, but I don't think they would have let us out. Who knows.
She was talking to me, and I would say, I don't' want to talk, and she said, I am sorry, is it really painful? And I would say yes, we were sad, were laughing, and not wanting to laugh. That is what it was like.	I was scared and nervous because I knew what was coming and that I was going to start feeling pain, more pain. I was trying to relax, and not think about labor, asking God to help me.
But I asked myself, why am I doing that. And I started to relax again. And then I started to feel the baby moving down. I wanted to yell, but no, I didn't yell.	It was very hard, I thought the baby wasn't coming, I just had pain but not the real, true pains to bring him out.
	When it started to hurt more, the doctors came to check and they said, its not time yet, you are only 5 centimeters. I said, I cannot bear this. I want to go home, it will be better there.
	I felt the pain, and the nurses said, not yet, but I would say, I know that it is yes [the baby coming]. I said yes and they said no and I became discouraged, thinking about a lot of things. Is he going to be born, will I be able to do it, what am I going to feel? There were a lot of worries.
	So I kept thinking, if they are going to say no, I am going to go home, I am going to take my pains and go home so that the baby could be born there.
	I didn't want any more children, I wanted them to take him out, anything to not have any more pain.
Julia G3P3 Spontaneous 6-hour labor	
We were home and I felt pain but it was not that strong. Around 8 pm, they were stronger and I said I think this is it, but I was smiling. I never had nerves or crying.	we arrived, and he [husband] fixed all the paperwork because I didn't want to know anything from anything, because I was feeling the stronger pains by then.
When I would get a pain, I would laugh and laugh. I was filled with emotion and not sadness, when I thought about the pains.	It was around 10:30, around 11 he finished fixing all the papers and I didn't know what time it was anymore because of the pain. The hours got away from me.

Working with Pain	Falling Apart from Pain
With each pain I had an emotion that made me laugh, and smile, because I thought, well, if I act badly, I don't want to alarm my husband.	It didn't take long, but in those moments I was asking God, because it was only 2 contractions but they were very, very strong.
This baby was very different, because I felt relaxed, with each pain, I would smile, he would ask me "what is wrong?" I was thinking about God a lot [asking God to help me].	
It was happiness with each pain, that is how I felt. I felt the pain but at the same time, and emotion, a happiness that the baby would be born soon and I would have him in my arms.	
It was like, well, when I was standing and I would get pain, I would grab my back and start laughing. But when I laid down, I was still laughing, but that is when I had the strongest pain, and it is when I almost was unable to contain[myself], I couldn't bear it laying down.	
It was very strong, and my mind went away, I couldn't think about anything else except the pain, in how to do my breathing. Thank God I went to a class and they taught us the breathing.	
I felt a very strong pain, and the only thing I could remember was God. I couldn't think about anything else, because the pain was very, very strong.	
Anita G2P2 Induction of labor 60-hours	
Maybe then my mind said there's relief here. I just let go or something. At that point, I don't remember the pain being there, I was sitting there calmly.	I know there were times when my doula was trying to like hug me and I didn't want her to touch me. But I was in a lot of pain then and that was probably related to the pain. But I didn't want to be touched. I just wanted it to get better.

Working with Pain	Falling Apart from Pain
I was scared that the pain would hit me so bad that I wouldn't be able to sit still while he was putting in the epidural, but I didn't move, and I didn't have pain to make me move, or if I did, I was blocking it or controlling it or whatever.	It was no longer me and the contraction working together. We were kind of working against each other. And I was like okay, wait a minute. I've got to get control over this again. I was doing so good, and now, we're not together, we're not in synch.
My body wasn't as tight. I was starting to kind of prepare for the pain to come because the intensity had backed off and it slowed down slightly, not that much, but I knew how it was going to come and what it felt like at what point, so I was trying to get myself in better positions.	It became so strong, I think that's when I started to cry and even laying down I couldn't lay there. The contraction would come and I would jump out of bed because lying in bed seemed like even worse torture.
So when she would say something to me, I'd think about what she was saying and that was kind of it at that moment until a contraction would hit again and I'd go back to the pain. She just brought me from the pain back to what she was saying often.	Some contractions were small and then others were large, and I'd get control of the small one and the larger one would come and I'd be like oh my God, I don't have control again.
I tried to bear down thinking, okay, we're going – we're good, we're going to have this baby, everything is in progress now.	They were trying to get me to change positions, but if I didn't move before the contraction started, I was just paralyzed in that spot until it was over.
Like before that, I could say, oh, I'm feeling a contraction, okay, it's coming, it's coming, let me get myself into position, let me breathe, let me – I kind of talked myself through it.	I was on Pitocin, which was making it even worse. I was, oh, my God, something has to stop, like for me to get back on track to where I was.
Once she broke my water, there was a lot of meconium, so the water birth was out. I was on 12 of Pitocin at that point. And the pain just got unbearable. It just got crazy unbearable.	And I told them, I need you to turn the Pitocin off or something needs to stop for me to get back to my space. Of course, they weren't going to turn off the Pitocin. They were trying to see if I was going to delivery quickly and nothing was working. I didn't even want to negotiate anymore. I was, give me my epidural

Working with Pain	Falling Apart from Pain
They were getting a little stronger sometimes and I was dealing with it. I'd just kind of stop and breathe and think about it and keep moving.	It was weird. She was trying so many things to kind of relieve the pain a little bit. But I think the pain had so much control over me instead of me working with the contraction that I couldn't decipher whether it was good or bad or whether it was better or worse. It was just pain. I positioned myself slightly different so that I could tolerate it a little bit more, and if I didn't position myself that way, then it was just excruciating to where I just – I wanted to stop everything. I can really think about why it was better after, but at that time I couldn't think about if it was or not or I just couldn't think because it just consumed me. I didn't like it because I'm not usually the person that cares to cry in front of people. I don't like expressing all those emotions, so I didn't like that at all. But after a while, I let it happen because you can't stop the pain from coming, so I might as well cry and let it out and hopefully be done with the crying. That's when the pain was getting out of control and I – it was coming fast and I didn't have time to get my mind around it, like okay, get ready for it, this is what we're going to do to prepare for it. Let me try to get in this position. It wasn't giving me enough time to actually get ready to kind of go with it. Instead I was fighting it. So I wanted to at least turn it down[the Pitocin] or turn it off and let my body tell me that it's coming.

Working with Pain	Falling Apart from Pain
	At that point, I couldn't talk myself through it. It was just – it's here, and that's it. So either I had to be in a position ready for it before it even got there, or you just kind of dealt with it. I mean, that's what made me say just turn it off.
	She was rubbing my back, I didn't want her to touch me. She was trying to give me a hug, I didn't want anything. The pain was too excruciating for me to get through it. And I think she stayed in there with me while I got my epidural as well.
	So then I woke up to more pain on one side, just on my side, that got really unbearable. I had a more inexperienced nurses, so she was so involved with cleaning me up instead of calling anesthesia that I got a little frustrated with her and kind of snapped on her.
	When they broke my water, she was really trying to get me to bring the baby down[with different positions]. But I was in so much pain; I wasn't really trying to listen to her.

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