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Recentering the Voices of Birthing People and Birth Workers; Narratives of Childbirth

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Abstract

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By Natalie Rose McGrath

Childbirth is a universal life event and yet, when looked at across cultures and demographics, it is incredibly diverse in its characteristics. Although we know this to be true, the childbirth experience is drastically under-researched within the larger umbrella of human experience. In addition, the presence and/or absence of agency throughout the childbirth experience is rarely studied within academia and is relatively absent in anthropological research. Rather, when engaged in a research setting, childbirth is approached with the intention of uncovering quantitative information, ranging from the rate of C-sections within a particular hospital to the number of patients who have an epidural; rarely are the narratives or socio-behavioral aspects of the childbirth experience investigated or discussed within academia. This study directs attention toward the voices of birthing-people and midwives in order to reject the purely medical context from which childbirth is most often approached. Through interviews with thirteen birthing-people and five birth workers, this study illuminates how the event of childbirth is understood and experienced differently depending on culture, context, and one's racial and/or ethnic identity. The research uncovers the ways in which a birthing-person's sense of agency during labor is instrumental to their health and well-being – and how agency can arise or be thwarted based on myriad factors. It also looks at how birth workers can, and do, play an important role in advocating for and centering the agency of the birthing- person. Lastly, this study identifies how pain, anxiety, and fear are expressed, or sublimated, during childbirth, and the ways in which agency promotion can improve a birthing-person's level of comfort and emotional well-being throughout labor. The outcomes of this study suggest that it would be beneficial to consider agency as an appropriate focal metric of justice, specifically within the context of the childbirth experience within the United States. If the goal is to improve agency among birthing-people, accessibility, and the freedom to attain essential resources like prenatal appointments, hospital translators, and community/familial support, must be addressed.

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Chapter One: Introduction

Background and Study Overview

Childbirth is a universal life event and yet, when looked at across cultures and demographics, it is incredibly diverse in its characteristics. It is often described as a paradox: an event that is full of joy, love and accomplishment while also containing fear, pain, and discontent.

This study directs attention toward the voices of birthing-people and midwives in order to reject the purely medical context from which childbirth is most often approached. Through interviews with thirteen birthing-people and five birth workers, this study illuminates how the event of childbirth is understood and experienced differently depending on culture, context, and one's racial and/or ethnic identity. The research uncovers the ways in which a birthing-person's sense of agency during labor is instrumental to their health and well-being – and how agency can arise or be thwarted based on myriad factors. It also looks at how birth workers can, and do, play an important role in advocating for and centering the agency of the birthing- person. In addition, the expectation or desire for a "good" or "natural" birth and how this informs perceptions of agency, the labor experience, and further reflections or discussions of the birthing event postpartum are explored. Lastly, this study identifies how pain, anxiety, and fear are expressed, or sublimated, during childbirth, and the ways in which agency promotion can improve a birthing- person's level of comfort and emotional well-being throughout labor. The opportunity to practice cultural traditions – from song, to prayer, to the food that is consumed post-partum – can improve a birthing person's sense of agency throughout the childbirth experience.

How can the healthcare system, and actors within it, better support the making of space for these traditions during the birthing experience? How does a sense of agency manifest

depending on the individual? How can we come to respect the needs and desires of birthing-people beyond the outcome of a healthy baby? These are some of the questions that are explored in the following chapters.

The answers to these questions were sought by engaging with and interviewing birth workers and birthing-people delivering babies across the United States. People from a diverse collection of belief systems, personal identities and life experiences are incorporated into this study in order to understand what unites the childbirth experience across cultures and to identify what is required to support a sense of agency among birthing-people of various racial, ethnic, and cultural backgrounds.

Rationale and Anthropological Locations

The childbirth experience is drastically under-researched within the larger umbrella of human experience. In addition, the presence and/or absence of agency throughout the childbirth experience is rarely studied within academia and is relatively absent in anthropological research. Rather, when engaged in a research setting, childbirth is approached with the intention of uncovering quantitative information, ranging from the rate of C-sections within a particular hospital to the number of patients who have an epidural; rarely are the narratives or socio-behavioral aspects of the childbirth experience investigated or discussed within academia. Gaining a better understanding of the childbirth experience from a cross-cultural perspective has the potential to aid healthcare professionals, birth workers, and other caregivers in improving the childbirth experience across the United States.

Midwives and doulas were chosen as an important population to study within the context of the childbirth experience as they are trained in providing and supporting a more holistic labor and delivery process for their patients. Their insights into the socio-behavioral, contextual, and

environmental factors that influence the childbirth experience have been overshadowed by the healthcare industry for centuries. The midwifery perspective is made a focal point throughout the study for this very reason.

Positionality

It is essential that I share my own personal lens from which I approach this research. I am a white, cis female individual from a major U.S. city, who has never had to worry about my access to adequate healthcare and medical resources. I have never given birth and am neither a healthcare professional nor a doula. With all of this in mind, it is not my intention, in conducting this research, to advocate for any particular birth experience or setting, whether that be in-hospital or at-home births, midwife attending, or not. My goal is to bring attention to a topic that I feel has been overshadowed and overlooked. The primary element of my research was listening - an essential component of supporting agency across disciplines, but, very importantly, essential to improving the childbirth experience in our country. I want to know what receives the most value during a birth experience, what practices support a sense of control, and how child birthers wish to be cared for. I want to understand and suggest how actors within our healthcare system can improve the childbirth experience, and how the birthing-person's needs and desires can be considered and tended to in a more equitable, meaningful way.

Chapter Two: Literature Review

Working Definition of Agency

Agency is defined within the context of this study, and within the context of health ethics more generally, as the capacity to establish authentic pursuits, to make your own decisions, and to act freely. Researcher Ismaili M'hamdi established three major conditions for agency: capacity, control, and freedom (Ismaili M'hamdi, 2021). Their framework for agency will be applied within the context of this study as well. Capacity refers to the ability to know that the reason you are acting is authentic; capacity is a condition of agency that is established internally (Ismaili M'hamdi, 2021). Control, on the other hand, is a condition of agency that can be established internally or externally and refers to one's decision-making power and authority in a particular situation (Ismaili M'hamdi, 2021). The basic definition of control has to do with the 'locus of control,' which is established depending on an individual's relationship with themselves and the world and refers to the amount of control an individual feels they possess over the events occurring in their life (Ismaili M'hamdi, 2021). The condition of freedom refers to: "the availability of the right set of liberties, opportunities and material goods which are required to realize a goal one has reason to value and experiences sufficient control over" (Ismaili M'hamdi, 2021, p. 2). Ismaili M'hamdi provides a helpful example of the relationship between freedom and agency: "For example, a mother-to-be may formulate, as a result of her health agency capacity, the goal to adequately prepare for pregnancy. She therefore values taking folic acid. She might also experience the daily use of folic acid as a task within her control. Still, she might be limited in her liberty, opportunity, or resources to buy folic acid. These external conditions hamper her 'real freedom' to achieve her health-goal" (Ismaili M'hamdi, 2021) An individual's sense of agency is inextricably tied to issues related to accessibility, equity, and

health justice. Health justice is a framework or a call to action, that refers to those working within public health to uproot discriminatory social structures, stereotypes, stigmas, inequitable legal systems, and biases that are denying specifically low-income and racial minorities the opportunity to live long, happy, and sustainable lives (Benfer, 2015). Possessing a sense of agency is a subjective issue; its definition is always up for debate. However, when considering the previous description of agency, there are many instances in which the inaccessibility of important resources inhibits an individual's sense of agency. The following paper outlines the presence and absence of agency during childbirth and its many connections with health justice.

The Role of Agency and Control During Childbirth

The degree of agency and control desired by a birthing person during childbirth is not a monolith. Anne Drapkin Lyerly, the author of *A Good Birth,* articulates that control, and a sense of agency, have a variety of potential manifestations for people during labor (Lyerly, 2014). Often these differences surround choices related to the level of involvement of relatives during labor, gaining knowledge on childbirth, going to childbirth preparation classes, and receiving substantial prenatal care (Lyerly, 2014). Lyerly writes that people feel in control when prepared for the event of labor, knowing they hold the information needed to have a satisfactory birth (Lyerly, 2014). On the other hand, some individuals rely more on a physician to direct them during childbirth and be the primary decision-makers (Lyerly, 2014). In the case of Callister's study comparing the childbirth experience of Mormons and Orthodox Jews, the opportunity to make decisions regarding the progression of their labor and the degree of interventions was less central to the making of a positive childbirth experience (Callister, 1999). It was more important that they were able to follow the directions of birthing professionals throughout their labor and delivery process (Callister, 1999).

Patterns of Control

Leona VandeVusse, an assistant professor and nurse-midwife, generated data on the presence and absence of control during labor (VandeVusse, 1999). While searching for related research, this article appeared to be one of the only datasets that thoroughly examines this idea. VandeVusse explored the ways in which a sense of control is best assisted and supported in a birthing-person throughout childbirth (VandeVusse, 1999). A central finding from this study is the understanding that: "More often than not, women were recipients of others' control, particularly when routine procedures were applied. They reported they wanted to be active participants in decision-making, but they rarely expressed the desire to make all the decisions" (VandeVusse, 1999, p. 45). This study found that for the birthing person, simply knowing that the caregiver is bringing you into the decision process provides great comfort (VandeVusse, 1999). It signifies to the birthing-person that they can step in and request a pause or further explanation during a vaginal examination, for instance (VandeVusse, 1999).

Control is defined in the context of VandeVusse's research as "any of the women's personal expressions that included the exercise of restraint or direction over, or holding back or in check" (VandeVusse, 1999, p.44). One of the first patterns of control explored in VandeVusse's study is unilateral control. Unilateral decisions were made by caregivers and usually led to displays of discomfort and negative emotions in the birthing-person (VandeVusse, 1999). When unilateral decision-making occurred, the caregiver was either met with signs of refusal, adaptation, or agreement from the birthing-person (VandeVusse, 1999). An example is provided within VandeVusse's study of an instance in which a woman refused to continue her examination because she was uncomfortable. When the woman contested the caregiver's examination approach, she was met with feelings of guilt about being so direct with her provider

(VandeVusse, 1999). Many women reported that when they conveyed their discomfort or questioned the occurrence of certain procedures or examinations, little explanation was provided by the physician in terms of why the procedure was being done (VandeVusse, 1999). In addition, VandeVusse reported instances in which women: "first objected and tried to provide additional information for consideration by the caregiver, but they eventually adapted to the caregiver's control" (VandeVusse, 1999, p.45). Many women saw themselves as knowledgeable on both the subject of childbirth and their own bodies. After expressing a request for fewer interventions during labor, women reported feeling as though their obstetrician believed they were ignorant and did not have the authority to advocate for a particular direction of care during childbirth (VandeVusse, 1999). VandaVusse's study found that in situations of unilateral decision-making, women were made to feel like the unknowing patient; they were made to feel as if the progression of their pregnancy and childbirth was completely out of their control (VandeVusse, 1999). Lastly, VandaVusse concludes that the continuous use of electronic fetal monitoring is often an example of unilateral decision-making by the nurse or physician. The inability to excuse oneself to use the restroom during the early stages of labor was a source of great emotional distress and embarrassment for many women (VandeVusse, 1999). Issues related to the presence of electronic fetal monitoring will be explored further in the results section of this paper as it was found to be an outcome of this study as well.

VandeVusse's study also gathered data on instances of shared control between the woman giving birth and her caregiver (VandeVusse, 1999). VandaVusse found that joint decision-making was associated with greater positive emotions and that birthing-people generally preferred collaborating with their caregivers on the kind of care they received (VandeVusse, 199). Joint decision-making was established between birthing-people and their

caregivers through explanations and requests (VandeVusse, 1999). Requests regarding consent, support, or additional aid can be made by either the birthing person or the caregiver throughout the labor process (VandeVusse, 1999). These requests often prompt discussions surrounding the kind of care an individual is receiving and why, which opens the door for joint decision-making to occur (VandeVusse, 1999). In addition, women reported high levels of satisfaction with their childbirth when they were provided with information from their caregivers (VandeVusse, 1999). This allowed them to make informed decisions regarding their labor progression (VandeVusse, 1999). VandaVusse also found that people were: “more willing to accept interventions when given explanations and allowed simple choices, even about the timing of unwanted or uncomfortable interventions” (VandaVusse, 1999, p.47). In these scenarios, people feel as though their wishes and needs are being honored. The concept of “honoring” a birthing-person while in labor will reappear within the findings of this study as well, specifically within the context of midwifery-provided care.

Control and Fear

A study conducted by Demirel Gulbahitayar in a state hospital in the Central Anatolia Region analyzed the relationship between the fear of childbirth and a woman’s perception of control throughout her labor and delivery process. With a sample size of over 700 women, Gulbahitayar found that: “The high level of perception of support and control at birth decreases the fear of childbirth and increases the satisfaction levels of puerperal women in vaginal and cesarean births" (Gulbahtiyar, 2021, p.1). To measure levels of perceived control and fear during childbirth, this study employed various surveys and questionnaires. They used the Perceived Support and Control Birth Scale (SCIB) developed by Ford and Ayers, and the Wijma Delivery

Expectancy/Experience Questionnaire. Both scales were adjusted for the cultural context in which the country of Turkey operates.

This study found that a higher education status, the absence of divorce, and planned pregnancies, were associated with increased levels of control during delivery and less fear surrounding childbirth (Gulbahtiyar, 2021). In addition, those that had a vaginal birth with no medical interventions also reported feeling a greater sense of control during their labor and delivery process (Gulbahtiyar, 2021). Lastly, Gulbahtiyar found there was no significant difference in perceived levels of control in terms of: "the puerperal women's ages and modes of delivery, the healthcare providers who assisted the vaginal delivery, and the time of onset of postpartum breastfeeding" (Gulbahtiyar, 2021, p.3). In addition, those who were able to interact with their baby within the first twenty minutes after delivery "had a stronger feeling of support and control during delivery" than those who interacted with their babies for the first time after the twenty-minute period (Gulbahtiyar, 2021, p.3). This portion of Gulbahtiyar's study found that maternal satisfaction is improved, and fear is reduced when the individual needs of the childbearing woman are met (Gulbahtiyar, 2021).

Control, Social Proximity, and Stress Management

Gulbahtiyar's study concluded that fear of childbirth decreases when women have established systems of social support and are in the presence of supportive partners (Gulbahtiyar, 2021). To further develop this conclusion, one may benefit from consulting the Social Baseline Theory. James Coan and David Sbarra define the theory as the following:

> "The human brain expects access to relationships characterized by interdependence, shared goals, and joint attention [6]. Violations of this expectation increase cognitive and physiological effort as the brain perceives fewer available resources and prepares the body to either conserve or more heavily invest its own energy. This increase in cognitive and

> physiological effort is frequently accompanied by distress, both acute and chronic, with all the negative sequelae for health and well-being that implies" (Coan & Sbarra, 2015).

Within the article on the Social Baseline Theory, Coan describes the bodily impact of social proximity: "Social proximity and interaction attenuate cardiovascular arousal, facilitate the development of nonanxious temperament, inhibit the release of stress hormones, reduce threat-related neural activation, and generally promote health and longevity" (Coan & Sbarra, 2015, p.88). Gulbahtiyar demonstrated that being in the presence of partners, family members, and providers that you trust, can greatly improve the childbirth experience, making it a more comfortable and empowering process (Gulbahtiyar, 2021). A study produced by researcher Katherine Hinic in 2017 found that: “there was a negative correlation between childbirth satisfaction and perceived stress levels” (Hinic, 2017, p.211). To promote a satisfactory experience for birthing-people, reducing stress is essential (Hinic, 2017).

Cognitive-Based Training provides an additional way to reduce the effect of traumatic situations and long-term stressors. The practice is called cognitive reappraisal. Moodie et al. describe cognitive reappraisal as: “a type of cognitive change that involves modifying the meaning of the situation in order to alter an emotion" (Moodie, 2020, p.388). Unsatisfactory and traumatic experiences during childbirth can have a substantial negative impact on maternal mental health and the care a mother is able to provide for her child postpartum (Gulbahtiyar, 2021). Changing the perception of an event through cognitive reappraisal can adjust and improve the way an individual views and reacts to stimuli and particular situations that might bring discomfort or pain (Moodie, 2020). One may consider the practice of cognitive reappraisal as the process of retrospectively regaining control over one’s previous experiences. As conveyed in the paragraphs above, having a sense of control during childbirth can decrease fear and improve maternal satisfaction (Gulbahtiyar, 2021).

One of the main methods to support cognitive reappraisal is analytical meditation (Moodie, 2020). The methods that support cognitive reappraisal are vast and are therefore not outlined in this paper, however, they deserve further investigation. With all of this in mind, changing how we view traumatic or painful life experiences can have a substantial impact on our emotional state and can provide us with the opportunity to heal and recover from our past, and tend to our future. The practice of reappraisal may become important before heading into one's second childbirth experience after having a traumatic first experience.

Redirecting attention or shifting focus is another strategy that can be employed to aid in the emotional regulation processes of birthing-people, especially those in labor (Moodie, 2020). It was found that intentionally shifting focus away from unpleasant or discomforting stimuli can improve one's emotional state (Moodie, 2020). In the case of childbirth and the experience of labor, this method of emotional regulation has not been studied. However, when considering how to improve the childbirth experience, redirecting one's attention away from the anxiety, fear, or pain of the process, and shifting one's focus to more pleasant stimuli, might aid in the progression of labor and grant birthing-people a greater sense of control and agency throughout the childbirth experience.

The Medicalization of Childbirth

The term "medicalization" can be defined as: "a process through which problems or non-medical experiences are defined and managed as medical problems or diseases" (Ranjbar, 2017, p.419). Within the United States, and across the globe, modern medicine has become a large aspect of people's everyday lives. Due to its growing ubiquity, we are rarely critical of medical intervention within the arena of childbirth. Within the following paragraphs, I will underline the ways in which childbirth is not a medical event, but an event that has the potential to require

medical interventions in particular situations, situations that can be both in and out of the birthing-person's control.

There are times in which medical interventions, like epidurals and cesarean sections, become essential to the survival of both the birthing person and the baby. However, childbirth is not an innately pathological event. The researcher Rabuzzi writes: "Childbirth has emotional, cultural, and spiritual dimensions beyond the physical experience. Thus, it cannot be described adequately or comprehensively by quantitative means alone. Rather, childbirth is a life experience endowed with personal meaning and cultural significance" (Rabuzzi, 1994). Often, childbirth is treated like any medical procedure would, in a sterile room with fluorescent lights and white coats. Treating childbirth like you would a disease is incredibly harmful to the psychology of the mother or birthing-parent (Ranjbar, 2017). Ranjbar, a researcher at the Iran University of Medical Sciences writes: "by attaching a disease label to natural phenomena, medical professionals expand the scope of their authority, regardless of whether they have the capacity to effectively manage these phenomena" (Ranjbar, 2017, p.419).

Birth was considered to exist almost entirely within female-dominated or domestic spaces up until the 17th century. Even entering the 20th century, it was uncommon to give birth in a hospital setting (Johanson, 2002). However, as antiseptics became more widely used in hospital settings, making childbirth a safer endeavor, the rate of in-hospital births began to rise (Johanson, 2002). Throughout the 20th century, the maternal mortality rate in the West severely decreased (Johanson, 2002). Experts often attribute this decrease in the maternal mortality rate to new public health developments including but not limited to improved sanitation, nutrition, and overall cleanliness (Johanson, 2002). Even though increased public health efforts and developments are said to be responsible for the decrease in maternal mortality rates in the West,

medical professionals were able to fully permeate the area of childbirth, prenatal, and postpartum care (Johanson, 2002). With the greater involvement of medical professionals within the area of childbirth, the use of analgesia, intravenous injections, anesthesia, cesarean sections, and blood transfusions during labor increased rapidly over the 20th century (Johanson, 2002). Today, however, the World Health Organization (WHO) has demonstrated that: "almost 15% of all women develop complications serious enough to require rapid and skilled intervention if they are to survive without lifelong disabilities" (Johanson, 2002, p.892). This data point is only in reference to the complications women might face due to difficult births and does not include negative effects related to the health of the child. Calculating and comparing infant mortality rates is complex, especially because many countries have different parameters for measuring it. However, within the United States, infant deaths primarily occur due to premature births or after one month of age. The event of childbirth, and complications that occur during labor, are not the major contributors to the high rate of infant mortality within the United States (Texas A&M University, 2016). In addition, the use of advanced technology and monitoring systems have been reviewed for their applicability and benefit during low-risk pregnancies. It was concluded that: "In the United States, Canada, and recently England, major reviews of the evidence have concluded that electronic fetal monitoring should be reserved for high-risk pregnancies. Use of electronic fetal monitoring has increased worldwide, however, in both low and high-risk groups" (Johanson, 2002, p.892). Over the past hundred years, medical professionals have established their presence and prestige within the arena of childbirth. It is time we begin to seriously question the less favorable and potentially negative aspects of moving the care of childbirth from the domestic sphere into a medical one.

As the rates of screening and monitoring pregnancies have increased, so have the fears and concerns of birthing-people regarding their pregnancy and labor experience. When one becomes a "passive recipient" of healthcare, one is practically being told to have less faith and trust in their innate abilities as pregnant people (Johanson, 2002). The overmedicalization of the childbirth experience has stripped away power from the birthing-person and has redistributed it to insurance companies and physicians (Johanson, 2002). It has been found that: "Long term morbidity after childbirth can be substantial, and this is particularly related to instrumental and cesarean delivery. Specific concerns relate to painful intercourse and urinary and anal incontinence" (Johanson, 2002, p.893). While the medical profession's primary interest is in delivering a healthy baby, the needs of the birthing-person are lost. Physicians are motivated to deliver a child as quickly, painlessly, and efficiently as possible, and this attitude toward childbirth has been centered across the Western world and beyond. It is essential for the emotional and physical health of any birthing-person that their needs and experience be re-centered within the area of childbirth.

It is important to acknowledge the legal pressure that obstetricians and gynecologists face simply for practicing their profession. It is possible that the high rate of medical interventions that we see doctors and nurses employing during childbirth could be more of a defensive act. Although this is true of all medical practices today, the field of obstetrics is also highly litigated, and most cases are founded in a "failure to intervene" or "delay in intervention," rarely does litigation arise because of "unnecessary intervention" (Johanson, 2002). Maybe it is not the physicians that should be blamed for the high rate of unnecessary medical intervention in childbirth, but the insurance companies and larger healthcare systems that should be placed under greater scrutiny.

The medicalization of childbirth has also affected the practice of midwifery. With the introduction of advanced monitoring systems and biotechnology, people's perceptions of the professional skills of midwives has been altered (Johanson, 2002). Now it might be seen as a weakness to be without these technologies, even when considering pregnancies that are categorized as low-risk. In terms of the management of these low-risk pregnancies, the presence of an obstetrician is not a necessity (Johanson, 2002). Even though the majority of pregnancies are in fact low-risk, we continue to subject birthing-people to potentially stress-inducing interventions. In addition, not only can medical equipment be stress-inducing, but many of these advanced technologies prompt expecting individuals to question their own body's ability to give birth to a healthy child in the first place. In summary, unnecessary medical interventions can get in the way of an empowered birth experience.

Childbirth is an incredibly significant rite of passage for any person. During the process of giving birth, one is reentering the world with a new label of “mother” or “parent”. Taking power and agency away from the birthing person and questioning their abilities to deliver a healthy baby has become a hallmark of obstetric care. As a culture, we must begin to distance pathology from pregnancy.

Childbirth from a Cross-cultural Perspective

Culture is defined by nursing theorist Madeleine Leininger as: “the learned, shared and transmitted values, beliefs, and norms and life way practices of a particular group that guides their thinking, decisions and actions in patterned ways” (Kusemwa, 2023, para.1). Taking a cross-cultural perspective refers to the practice of locating and examining the ways in which human behavior converges and diverges depending on one’s cultural background and identity. The transcultural nursing theory, which was originally developed by Leininger, underlines how:

"the values and beliefs passed down to that patient from generation to generation can have as much of an effect on that patient's health and reaction to treatment as the patient's environment and social life" (*Nursing Theory*, n.d., para.3). Actions that should be taken within the healthcare field in response to this statement will be explored in the following sections.

The experience of childbirth is deeply influenced by cultural traditions, practices, and expectations: "Women's perceptions of the childbirth experience vary widely depending on the cultural context. The quality of care a childbearing woman receives is deeply influenced by the cultural understanding the nurse brings to their health care interaction" (Katchner, 2003, p.112). There are many aspects of birth that might differ depending on one's cultural background and the context in which they give birth. Everything from the administration of pain medication to the food that is consumed after the baby is delivered is tied to cultural expectations and belief systems (Kartchner, 2003). Lynn Clark Callister, a professor of nursing at Brigham Young University, is one of the preeminent researchers within the small but significant group of people investigating childbirth from a cross-cultural perspective. Understanding people's perceptions of the childbirth experience is a crucial aspect of nursing knowledge. The priority, throughout her research, is to center the voices of childbearing people and not just those who are caring for them. This is important because perceived healthcare needs are often largely informed by the patient's cultural context, ranging from their spiritual background to their degree of exposure to childbirth (Callister, 1999). Knowing a patient's culturally informed perception of childbirth allows their provider to support the birthing-person in their journey toward self-actualization throughout pregnancy, labor, and into the post-partum period.

The Influence of Spirituality

Religiosity impacts how childbirth is experienced, especially regarding how people choose to cope with the pain associated with childbirth. For many religious people, procreation and childrearing carry incredible significance (Callister, 2003). In addition, procreation is essential to the survival of religious faiths and belief systems. Phrases like, "be fruitful and multiply" is a common sentiment among religious folks, particularly those of the Christian faith (Callister, 1999, p.282). In Callister's study exploring the childbirth experience of Mormon and Orthodox Jewish women, one woman of the Jewish faith highlighted how having children helps ensure that her community will continue to grow: "The soul requires a physical body, and thus the raising of many children ensures descendants to continue the worship of God." (Callister, 1999, p.282). Due to the centering of procreation within many religious cultures, the maternal role within a family is highly coveted and valued (Callister, 199). A Jewish woman spoke on this sentiment in a manner that encompasses much of the rhetoric around childbirth within religious communities:

> "Having a baby is not only a physical and biological experience. It is all that, but it's much more than that. It is a very high spiritual experience because the whole purpose of the world is bringing down a child, bringing down a soul. If God gives you a soul, you become the caretaker of this soul. I mean, God gives this into your hands. You feel God's presence most tangibly when you have gone through birth" (Callister, 1999, p.288).

Many researchers have found that the occurrence of significant life events has the potential to increase one's degree of religiosity, and as displayed in the quotation above, childbirth is no exception. After a child is born, it is natural for the birthing-person to become overjoyed by the outcome of a healthy and happy baby. The experience of this kind of unfettered joy can promote a deeper connection with one's religion, as God has entrusted them with the life of another human (Callister, 199). In addition, feeling a sense of accomplishment and power after giving birth can promote a state of reverence for the beauty of life and creation.

The Presence of Family

Kartchner and Callister write in their article, "Giving Birth: Voices of Chinese Women" that in Chinese culture: "Extended family members take great interest in this typically "once-in-a-lifetime" event, and mothers or mothers-in-law are the main source of information (Kartchner, 1999, p.113). Seeking support from family is based on the cultural understanding that family members have a moral duty to care for their sick (Wong & Pang, 2000). For many birthing-people across cultures, experiential knowledge displayed by family members on childbirth is highly valued and trusted (Kartchner, 1999). Similarly, in both Mormon and Orthodox Jewish cultures, seeking the advice of a friend or an elder within your community is common practice when preparing for childbirth (Callister, 1999). Many cultural and religious groups, including those belonging to the Mormon and Jewish faith, vocalize the comfort and security they feel when connected to others throughout pregnancy or childbirth, whether that be an aunt, mother, or partner (Callister, 1999).

There is great variety among cultural groups in terms of how birthing-people are supported by their family members during labor. For instance, the presence of Orthodox Jewish husbands during the birth of their child is less common when compared to other religious, ethnic and/or cultural groups (Callister, 1999). Due to specific Jewish laws related to modesty and purity: "An Orthodox Jewish husband is prohibited from observing his wife when she is immodestly exposed (tsnuit or modesty laws) and from touching her when there is vaginal bleeding (niddah or law of family purity)" (Callister, 1999, p.287). When Orthodox Jewish men attend the births of their partners, it is common practice for them to either stand behind a curtain within the same room as their partner or to stand behind the birthing-person at the head of the bed (Callister, 1999). Although it might seem difficult to provide support for the birthing person when you (the partner) are unable to touch and oftentimes see the birthing-person, Jewish

women in Callister's study still reported feeling a sense of support from their husbands while in labor (Callister, 1999).

Among religious people, a pattern occurs regarding the role of the woman and the man during childbirth. For Mormon women, husbands provide reassurance, support, and comfort through their interactions with the spiritual realm (Callister, 1999). Women see their role during childbirth as tending to the physical body, while their partners are focused on the spiritual aspects of the childbirth experience (Callister, 1999). The male partner in a Mormon relationship might offer priesthood blessings to their wife, while a man of the Orthodox Jewish faith might support their partner by praying and meeting with the rabbi to receive spiritual guidance (Callister, 1999). Although the way support is provided by partners and family members during labor might differ, it is almost universally understood that having a family member present, or someone who you love, trust, and share life with at the scene of the delivery, is essential to the comfort a birthing-person may experience while having a child.

The Significance of Historical and Economic Contexts

Often the shifts and trends that occur within cultures are dictated by political and economic decisions. An example of this within the context of the culture surrounding pregnancy and childbirth is the implementation of The One Child Policy in China. This policy deeply influenced the way in which Chinese people approached pregnancy and childbirth (Kartchner, 2003). As The One Child Policy attempted to slow population growth, greater meaning was ascribed to the event of both marriage and childbirth as these life decisions became increasingly more deliberate and intentional (Kartchner, 2003).

Labor Pain

> *"Cultural connotations of the female body do not equate to the actual individual female body, but cultural norms are always lived and enacted, such that these norms have real effects on the lived body and its encounters with other bodies" (Sorensdotter and Siwe, 2016)*

Zbrowski, an anthropologist and major theorist in pain studies suggests that: "each culture has its own language of distress when experiencing pain" (Callister, 2003, p.207). The pain experience, which is physiological and psychological, is both culturally informed and individually defined (Callister, 2003, p.146). As global migration and the diversity index within the United States continues to increase, those working within the healthcare system, from nurses to physicians and midwives, must prioritize the development of cultural sensitivity practices within their work and the way they provide care and patient support.

Labor pain is both physically and emotionally distinct from other forms of pain. It is a rhythmic experience caused by the contraction of the uterine muscles that simultaneously involves the release of endorphins and oxytocin (Whitburn, 2014). In addition, there are three major stages of labor. The first stage can last for over 24hrs and is considered the most painful (Whitburn, 2014). It primarily involves uterine contractions and the progressive dilation of the cervix in preparation for the baby's arrival (Whitburn, 2014). The second stage of labor is considered the pushing stage as the baby is hopefully making its way through the birth canal (Whitburn, 2014). The third and final stage involves the expulsion of the placenta. There are also affective states of labor, which are rarely addressed by doctors, clinicians, and other biomedical professionals (Whitburn, 2014). Affective states are a crucial aspect of maintaining a positive feedback loop during labor (Whitburn, 2014). They are related to the production of oxytocin in the body which then allows for contractions to occur (Mathur, 2020). This positive feedback loop will be discussed in further detail within the following chapter on agency and control during

childbirth as: “Fear can disrupt this loop, causing labor to stall or contractions to be more painful” (Mathur, 2020, p.2). Finding ways to promote a sense of control and agency in birthing-people has the potential to ease some of the fears associated with childbirth and allow for a more positive and comfortable experience with labor pain (Jensen, 2022). It is important to not group the pain experienced during labor with other purely pathological associations with pain. However, labor pain is *not* distinct from other forms of pain in terms of the variability that exists within the pain experience. Nurses and midwives should be trained in pain management practices that are culturally informed to best address the needs of their patients.

Labor Pain Behaviors and Perceptions

As expressed above, there is great variety in the expression of labor pain, both on individual and cultural levels (Whitburn, 2017). Some people exhibit more inward behaviors, desiring to experience pain privately, while others are verbally expressive when in labor and are more communicative about their pain (Mathur, 2020). The severity of labor pain is the dominant positionality in which labor is researched and described. There is very little scientific literature that explores the experience of labor pain beyond this point (Whitburn, 2017). Broadly speaking, the dominant culture within the United States sees pain as negative and therefore an experience that should be avoided (Mathur, 2020). Researchers have commented on the recurring analogies made in the United States between labor pain and: “being stabbed in the abdomen with a machete” (Mathur, 2020, p.5). More religious individuals have tied the pain experience and the experience of others during childbirth as a communal punishment for Eve eating the apple in the Garden of Eden (Mathur, 2020). Others use analogies of common objects to highlight the severity of the pain they experienced while in labor:

> "Typical responses equated the baby to a watermelon, bowling ball, or skillet and the woman's vagina to a straw, lemon, or walnut: "Because it's like trying to push something the size of a watermelon from the size of like a lemon" (female). Thirty-eight respondents gave descriptions of labor pain but did not answer why labor is painful: "Because it … just seems painful" (female)" (Mathur, 2020, p.5).

In Vani A. Mathur's mixed-method analysis that examines the perceptions and management of labor pain across cultures and racial identities, it was found that most individuals that participated in the study focused on the sensory aspects of labor when asked why labor is painful (Mathur, 2020). The article concludes that the focus on the sensory dimensions of pain: "highlights a lack of understanding of the biopsychosocial interactions involved in labor pain and points to a potential educational target for future intervention" (Mathur, 2020, p.7). In addition, when responding to the question of why labor is painful, both male and female respondents focused on women's bodies as inherently sexual beings (Mathur, 2020). This was made clear to the researchers due to the general interest participants had in the second stage of labor (Mathur, 2020). Mathur tied this focus to cultural obsessions with vaginal tearing and stretching during labor, which relates to the larger cultural fascination in the United States with female sex organs and the reduction of women into being purely sexual beings in the service of male pleasure (Mathur 2020). Providing more deliberate education on the biopsychosocial elements of labor pain might improve a birthing-person's sense of agency as they are armored with a stronger understanding of what their body is experiencing during labor.

Some women report that feeling extreme pain during labor is simply an indication of their strength and endurance (Mathur, 2020). Many people view the childbirth experience with pain as a self-actualizing experience. One woman was quoted saying: "It makes you realize how strong you are… and it makes you feel more confident as a woman and as a mother" (Mathur, 2020, p.5). Pain during labor is also a sensation that is expected. As a result, many women see the experience of pain during labor as a sign that everything is progressing as it should (Mathur,

2020). On the more extreme end, an additional justification for the experience of severe pain during labor, which is often brought forth by more religious individuals, is the understanding that childbirth pain is a form of birth control (Mathur, 2020). It is believed that individuals will recall how intense their labor pain was and that will incentivize them to have fewer children.

Mathur found in her study that most respondents believed that medical intervention and treatment are appropriate and should be advised in the management of labor pain (Mathur, 2020). In addition, most respondents agreed that women have varying levels of tolerance to pain. Due to this understanding, the interlocutors felt that women were entitled to medical treatment to ease labor pain if they so desire (Mathur, 2020).

In concluding this section, it is important to highlight that: "an accurate understanding of labor can decrease fear, increase self-efficacy, and decrease pain for women in labor" (Lowe, 2002, p.16). The psychological, social, and environmental aspects of the labor pain experience must be understood by physicians, nurses, and birth workers to gain a better understanding of how to manage labor pain and respect the desires of birthing-people.

Racial Bias in Labor Pain Perceptions and Management

Racial bias within the United States regarding the experience of labor pain is overwhelmingly present (Mathur, 2020). A mixed-method analysis analyzed perceptions of labor pain across racial and ethnic groups and: "Quantitative results document stereotypical beliefs that women of color experience less labor pain than white women" (Mathur, 2020, p.1). Despite this belief, African American and Hispanic women report experiencing high levels of labor pain (Mathur, 2020). This bias is tied to the conception of the Black woman as the "Strong Black Woman/Superwoman who is resilient in the face of extreme adversity" (Mathur, 2020, p.8). As a result of this harmful stereotype, the labor pain expressed and experienced by Black

and Hispanic women is both undermined and undertreated (Mathur, 2020). Due to these extreme biases related to the pain management needs of Black and Hispanic individuals, an article published by the Journal *Anesthesiology* found that: "Black and Hispanic women in labor are less likely than non-Hispanic white women to receive epidural analgesia. These differences remain after accounting for differences in insurance coverage, provider practice, and clinical characteristics" (Laurent, 2007, p.19). The cultural beliefs surrounding the experience of labor pain in African-American and Hispanic women within the United States are likely contributing to the inequities in pain medication administration among these populations, causing unnecessary suffering for many individuals (Laurent, 2007).

Within the context of labor and delivery, the perspective of the nurses, midwives, and clinicians have a large hand in how pain is addressed and managed. The increasing maternal mortality rates and inequitable labor and delivery outcomes among African-American women are of growing concern within the United States (Howard, 2023). Beyond labor and delivery outcomes, pathologies go undiagnosed among populations that express pain differently from the dominant white population within the United States (Mathur, 2020). This is especially common among Hispanics and African American populations who are often misdiagnosed due to cultural differences in the way pain is expressed (Mathur, 2020). The expression of pain during childbirth is not immune to these differences. Bringing women of color into the conversation regarding the pain they are experiencing and how it should be managed is crucial. Greater attention must be paid to these issues to improve the capacity of women of color to have a sense of agency throughout the childbirth experience.

Mastering Pain

Beyond the use of pain medication, for many birthing-people, being able to "master" pain during labor becomes an incredibly important coping strategy (Callister, 2003). It is understood that for many individuals who have given birth: "mastering pain was viewed as a self-actualizing experience" (Callister, 2003, p.208). Gaining the confidence and self-assurance that one can overcome the pain they are experiencing, and that they can persevere through the next contraction, is a symbol of their strength and potential, and improves their sense of control throughout childbirth. Callister writes in her article, "Cultural Influences on Pain Perceptions and Behaviors," that: "Maternal self-efficacy or confidence in women's ability to cope makes a difference in the ability to manage the pain of childbirth" (Callister, 2003, p.209). Knowing that pain is something that can be overcome better equips individuals to have a sense of agency and endure their labor.

Another way to "master" pain is to accept its inevitability. This coping strategy appears to be common among religious individuals: "Women who were active in their religious faith seemed to accept pain as an inevitable and important part of life" (Callister, 2003, p.208). Contextualizing pain within the larger circumstances of life is another way people find a sense of comfort while in labor. In China, for instance: "Most urban women give birth unmedicated in hospitals. Perhaps this is because the labor period for Chinese women is not considered the defining moment of motherhood but a "short and painful, but necessary step on their journey to motherhood" (Callister, 1999, p.148). The way pain is contextualized and compartmentalized in Chinese culture significantly influences the administration of pain medication during labor. This is just one example of how the kind of care an individual receives is often dictated by cultural understandings and expectations.

Antonia M. Villarruel, a nurse, and professor at the University of Pennsylvania, published an ethnographic study in 1995 titled "Mexican-American cultural meanings, expressions, self-care and dependent-care actions associated with experiences of pain" (Villarruel, 1995). In this study, she examined the experience of acute pain among Mexican Americans. Through her research, she uncovered just how central meaning-making is when coping with the pain experience (Villarruel, 1995). In the process of doing this work, she identified the following themes: "(a) Pain is an encompassing period of suffering, (b) pain is both expected and accepted as part of life, and (c) the primacy of caring in the face of pain and suffering is the essence of family" (Villaurruel, 1995, p.430). By accepting pain as an innate aspect of human life, individuals are equipped to better cope with the discomfort and fear associated with the pain experience (Villaurruel, 1995). The process of mastering pain can be one of empowerment or acceptance, both of which appear to be equally helpful coping strategies for those in labor. Caregivers should discuss with their patients, before delivery, to make pain management plans. Developing a pain management plan not only provides insight into how an individual might understand and experience pain, but it also can promote a greater sense of control and autonomy among birthing-people.

Chapter Three: Methods

The research portion of this study can be broken up into two different parts. The first and primary mode of data collection in this study was semi-informal interviews. All interviews were conducted virtually over Zoom. The oral consent form and interview guides can be found in Appendix I, II, and II. The second mode of data collection involved an optional exit survey provided to interlocutors after they completed their interviews. The survey included questions related to both the identity of the interviewee and logistical questions related to the context of their childbirth and the type(s) of delivery. Tables 1.1 and 1.2 display the responses from the survey.

Recruitment Criteria

Throughout the research process, two major groups were identified and interviewed: birth workers, which include nurse-midwives, midwives, doulas, and birthing-people. Birth workers who work in hospitals, and/or for patients giving birth at home, and/or in birthing centers, all within the United States, were included. Physicians and non-midwife nurses were excluded from this study to center the voices of birth workers and the unique perspective they bring to the childbirth experience: a perspective that has been ignored and even rejected by medical professionals for centuries (Gorman, 2019). Midwives and doulas are trained to view childbirth as a holistic experience. Their primary focus is on the needs and desires of a birthing-person and to provide them with the appropriate information to have a positive childbirth. Due to patient overload, obstetricians are often occupied with multiple births at a time (The American College of Obstetricians and Gynecologists, 2019). As a result, they are unable to give birthing-people the same consistent level of care and focus. When exploring the question of agency during childbirth, it seems appropriate to center the voices of midwives and doulas who often work

closest with the experiences and desires of birthing-people. In addition, individuals who gave birth in the United States, either in a hospital, at home, or in a birthing center, were interviewed. All childbirth types and experiences were welcome to participate in the study. Tables 1.1 and 1.2 provide background information on the identity and childbirth experiences of the birthing-people included in this study. Pseudonyms were used to protect their identity. The columns that contain question marks refer to questions that were left unanswered.

Table 1.1 Childbirth Details of Interlocutors

	Riya	**Maggie**	**Neha**	**Elena**	**Leah**	**Lotte**	**Hannah**
Hospital birth	2	N/A	2	2	2	N/A	N/A
Home birth	N/A	N/A	N/A	2	N/A	2	3
Birthing Center	N/A	2	N/A	N/A	N/A	N/A	N/A
Midwifery Unit	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of Births	2	2	2	2	2	2	3
Vaginal Birth	2	2	2	2	N/A	2	3
Assisted Vaginal Birth	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cesarean Section Birth	N/A	N/A	N/A	N/A	2	N/A	N/A
Vaginal Birth after C-Section (VBAC)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
"Natural" Birth	2	2	N/A	N/A	N/A	2	3

Induction	N/A	N/A	twice	twice	N/A	N/A	N/A
Epidural	N/A	N/A	twice	twice	N/A	N/A	N/A
Pain Medication	N/A	N/A		twice	received during operation	N/A	N/A
Provider - Obstetrician	first birth	N/A	all births	all births	first and second birth	N/A	N/A
Provider - Midwife	second birth	all births	N/A	N/A	N/A	all births	all births
Provider - Nurse-Midwife	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Provider - Doula	N/A	N/A	N/A	N/A	N/A	all births	all births
Sex of Provider - Male	No	No	No	No	Yes	No	No
Sex of Provider – Female	Yes	Yes	Yes	Yes	No	Yes	Yes

	Diana	**Maya**	**Angel**	**Sadie**	**Fatima**	**Josephina**
Hospital birth	4	1	N/A	1	1	1
Home birth	N/A	N/A	N/A	N/A	N/A	2
Birthing Center	N/A	N/A	2	N/A	N/A	N/A
Midwifery Unit	N/A	N/A	N/A	N/A	N/A	N/A
Number of Births	4	1	2	1	1	3
Vaginal Birth	4	1	2	1	N/A	3
Assisted Vaginal Birth	2	N/A	N/A	N/A	N/A	1

Cesarean Section Birth	N/A	N/A	N/A	N/A	1	N/A
Vaginal Birth after C-Section (VBAC)	N/A	N/A	N/A	N/A	N/A	N/A
"Natural" Birth	N/A	N/A	2	N/A	N/A	2
Induction	2	1	N/A	N/A	1	1
Epidural	1	1	N/A	twice during the same delivery	1	1
Pain Medication	twice	once	N/A	once	once	once
Provider - Obstetrician	first three births	first and only birth	N/A	N/A	first and only birth	first birth
Provider - Midwife	for fourth birth	N/A	N/A	first and only birth	first and only birth	all births
Provider - Nurse-Midwife	N/A	N/A	first and second birth	N/A	N/A	N/A
Provider - Doula	N/A	N/A	N/A	N/A	N/A	all births
Sex of Provider(s) - Male	No	No	No	No	No	Yes
Sex of Provider(s)	Yes	Yes	Yes	Yes	Yes	Yes

Table 1.2. Demographic Details of Interlocutors

	Riya	**Maggie**	**Neha**	**Elena**	**Leah**	**Lotte**	**Hannah**
Age	36	32	54	34	37	34	63
Religious Background	Born Hindu/non practicing	Catholic	Born Hindu/non practicing	Catholic	Jewish	?	?
Racial Identity	Indian (South Asian)	White	South African Indian	White	White	?	?
Ethnic Background	Indian (South Asian)	European ancestry	Indian	Broadly European	Jewish	?	?

	Diana	**Maya**	**Angel**	**Sadie**	**Fatima**	**Josephina**
Age	64	?	54	41	32	43

Religious Background	Presbyterian	Jewish	N/A	N/A	Muslim	N/A
Racial Identity	White	White	White	Caucasian	Middle Eastern	Hispanic
Ethnic Background	Eastern European	Jewish	German, Hungarian, and Finnish ancestry	Non-Hispanic	Turkish	Mexican

Recruitment Methods

Individuals were recruited to participate in this study using the snowball sampling method. The American Psychological Association defines this method as: "a technique to identify and recruit candidates for a study in which existing participants recommend additional potential participants, who themselves are observed and asked to nominate others, and so on until a sufficient number of participants is obtained" (The American Psychological Association, n.d.). In addition, midwifery centers and individuals working within midwifery centers were directly contacted via email for recruitment purposes. Many of the individuals who participated in this study practice midwifery or gave birth within the state of Georgia or New York. However, individuals included in this study spanned the major geographic areas within the United States of America.

Additional Definitions

Before proceeding any further, it is important to define race and ethnicity within the context of this study. Race is defined as a social construct that categorizes humans into groups based on physical traits. Ethnicity is defined as large groups of people grouped by cultural background (religion, tradition, language, etc.) or national origin. Both race and ethnicity are self-reported in the optional exit survey. I will be using these categories as covariates, as

differences in racial and ethnic identity are not of direct interest within this study. However, discussions of race and ethnicity are employed in some cases to better understand the childbirth experience, whether that be related to cultural traditions surrounding the event, who attended the birth, or how much control they felt they had over the experience.

In addition, I will be using the term birthing-people to refer to those who are biologically capable of bearing children. This term is more inclusive as it encompasses the experiences of transgender individuals, along with women who are not able to deliver a child. One might argue that childbirth is primarily a women's issue and that using the term birthing-people is not necessary. Although the vast majority of individuals who birth children are women, many individuals who give birth that do not identify as women and continue to be excluded from discussions on childbirth. As this study is interested in agency, health justice, and an empowered childbirth experience, it would be counterproductive to the aim of this thesis to not use a more inclusive term, like birthing-people.

Lastly, the term birth worker refers to both doulas and midwives. Midwives are trained medical professionals that deliver babies and provide prenatal and early-postpartum services, ranging from education on childbirth to the development of birth plans (Wallis, 2023). However, within the field of midwifery, there are varying skill levels. For instance, Certified Nurse Midwives (CNMs) can perform wellness exams, prescribe medications, order epidurals, and operate electronic fetal monitors and other medical equipment (Wallis, 2023).

A Doula is the birthing-person's companion throughout labor and into early postpartum. They provide non-medical assistance to support labor and bring comfort to the birthing-person, often through breathing practices, massage, and helping move the birthing person into new positions during labor (Wallis, 2023). During the postpartum period, doulas will also support

families at home. They will often provide lactation support and help the birthing person rest and recover after labor (Wallis, 2023).

Depending on an individual's needs, some will opt to only have a midwife at their birth, while others desire additional assistance from a doula, obstetrician, or both. It is important to note that midwives and doulas do not operate in a vacuum. They often consult with obstetricians and refer birthing-people to other medical professionals when necessary.

Chapter Four: Findings Among Birthing-People

Recentering the Voices of Birthing-People

Studies have found that around fifty percent of women living in the United States experience a fear of childbirth during pregnancy (Horsager-Boehrer, 2017). The percentage is cut in half when considering the fear of childbirth on a global scale (Horsager-Boehrer, 2017). This fear can stem from the belief that as the birthing-person they will have little control over the event of their child's birth (Wigert et al., 2019). The assumption is made, often after hearing negative birth stories, that the experiences and outcomes of childbirth are up to chance (Wigert et al., 2019). Fortunately, this assumption is not entirely true. Although the American hospital system makes it difficult to feel like the autonomous beings that we are, there are ways birthing-people can improve their sense of agency throughout the experience of childbirth and gain a greater sense of control and ownership over the event. The following paragraphs will explore the ways in which people were made to feel a sense of agency throughout their childbirth experience, how this was accomplished, and what specific aspects of their experience made them feel this sense of control. This chapter will also explore the factors of the childbirth experience that made birthing-people feel out of control and even dehumanized.

Thirteen women were interviewed for this study on their childbirth experience. The interview began with broader questions such as: Where does your birth story begin and what mattered to you most during labor? As the interviews progressed, questions such as: What did you feel you had control over during labor and what aspects of your identity and/or culture helped you cope with the childbirth experience, were also discussed. This study is also concerned with how factors such as race, culture, ethnicity, language, and religion affect the experience,

presence, and/or absence of agency during labor. Lastly, throughout the following paragraphs, pseudonyms are used to protect the identities of the interviewees.

How Agency Is Experienced by the Birthing-Person

The Choice to Deliver Outside of a Hospital

For many women, the decision to deliver their child outside of a hospital setting was informed by previous experiences with the healthcare system. Maggie delivered her child two years ago with midwives in an unmedicated birthing center within a hospital. Maggie's choice to deliver outside of a traditional hospital was driven by her previous experiences with the American medical system:

> "Being a cancer survivor, and going through cancer when I was 17, I've been through a lot in the medical scenario in comparison to your average 32-year-old. It completely shaped my mindset about going into pregnancy and prepping for labor and delivery. I was just very adamant about not wanting to have a similar experience where I was connected to an IV and connected to an IV pole, forced to be in one of those very uncomfortable small hospital beds. I've been there and done that, I guess. I felt like if I could have more control over my experience and have more of a voice throughout the process that that was ideal for me. And I feel like I've been through a lot. So, I have a pretty high pain tolerance, I like to think, you know, many, many surgeries, many things because of my cancer that have kind of shaped that decision."

For some mothers, being in a hospital setting can feel heavy and uncomfortable. Maggie did not want to experience her first passage into motherhood attached to the same monitors and devices that she had been tethered to throughout her cancer treatment. The decision to step out of a medicalized setting to deliver her first child, and having the resources and opportunities to do so, was a large contributor to the sense of control that she was able to experience during her child's birth. Considering what Maggie shared during her interview, one can conclude that those who deeply associate hospitals with sickness or affliction should have the opportunity to experience childbirth outside of that setting.

Maggie is not alone in having negative associations and experiences within hospitals affect her decision to deliver her child elsewhere. Before having her first child in New York City, Hannah was working in a hospital:

> "I was working as a labor and delivery nurse and was surrounded by hyper-medicalized births. I was totally confirmed, working in labor and delivery, that it was the last place I would want to give birth. The experiences I saw weren't all bad, some were actually beautiful, but there were some really ugly ones too: inductions for the convenience of the physician, unnecessary episiotomies, C-section percentages off the charts, breaking the water to hurry things up. There was so much invasion."

From her previous experiences in hospitals, Hannah knew that the ability to be an agent of her childbirth experience may be limited, so she made the decision to deliver all three of her children at home. During the interview, she articulated a few major decisions that granted her a great sense of agency during her childbirth, all of which were more accessible to her because she delivered her children at home. For instance, in addition to being able to decide when and what to eat and her activity level, Hannah felt that having the choice of when to call the midwife into her delivery space was essential to her understanding of agency during childbirth: "I don't think it would be safe to give birth off in the woods alone. But oh, man, do I really see the appeal in that. There's a way that it's really private [the event of childbirth], I mean not private, I think I mean, internal. It's very focused." Being in control of who entered and exited the delivery space was very important to Hannah. Giving birth at home allowed her to dictate the presence or absence of others within her environment and provided her with an opportunity to create a space closest to that which the forest could provide. Hannah also mentioned:

> "It's really important that I had control over the space. Being at home is just as important during the delivery as it is post-partum. Not having the transition from the hospital to the birthing center to my home felt really valuable to me because you are in this hall during the transition period, and you are so vulnerable. Your hormones are going crazy. Fluid is coming out of every orifice. Even something as simple as putting on a reasonable thing to wear to get down in the elevator to get into some kind of vehicle that transports you back to your home; that's very overwhelming to me."

Having the choice to deliver your child outside of the hospital also allows individuals to stay in one comfortable room throughout their entire labor, delivery, and immediate postpartum experience. In addition, one does not have to worry about being *presentable* or visible to the public during an incredibly vulnerable stage of the post-partum experience, especially when the birthing person's physical condition is still relatively unfamiliar to them.

Hannah's choice to deliver outside of the hospital was also made with the childbirth experiences of her mother in mind. She mentioned that during her mother's labor: "she was fully anesthetized, fully out. She breastfed and had no memory of that initial moment, so that link was totally broken, but I was able to repair her experience through my experience with childbirth." Throughout many interviews with birthing-people, the childbirth experiences and outcomes of their mother, sisters, aunts, and other family members were brought into the conversation, usually unprompted. An additional measure in which one can become aware of their agency during childbirth is to feel as though they can repair harmful or traumatic childbirth experiences on an intergenerational level. As the provider, creating space for birthing-people to reflect on their intergenerational relationships with childbirth may be beneficial, especially when considering additional ways in which birthing-people can feel empowered throughout their childbirth experience.

Between Lotte's first and second childbirth, she decided to become a doula. After gaining knowledge of the hospital system, Lotte was able to establish a clearer understanding of her preferences in terms of the type of care she desired. In addition, she mentioned that: "It felt important to me to not have my provider answering to a larger institution." For both Hannah and Lotte, exposure to childbirth within a hospital setting largely informed their decisions to deliver at home. This demonstrates how becoming more knowledgeable on an issue and gaining

information can allow individuals to make their own decisions and become agents of their childbirth experience.

Josephina knew that she wanted an unmedicated birth. Heading into her first childbirth, she was fearful of the pain associated with the experience. Josephina was under the impression that if she were to give birth in a hospital, she would be persuaded to take the pain medication that would've been readily accessible: "I really wanted an unmedicated birth. I felt like if I was in a hospital, and they offered it to me, maybe I would say yes." Leading up to her first childbirth experience, Josephina decided to plan for a home birth in part because she didn't want pain medications to be available to her, and she wanted to adhere to her original birth plan. She was also under the impression that if she were to deliver in a hospital, the following would also be true: "I liked the fact that if I wanted to eat, my midwife would let me eat. I know they don't want that in a hospital. They also don't let you film in the hospital anymore because of liability. It was the freedom to do whatever I wanted. If I wanted to go in the shower, if I wanted to get naked, I could do whatever I wanted whenever I wanted. This was just so appealing to me." Lastly, Josephina mentioned that the logistical aspects of birthing at home are much simpler, and this appealed to her as well:

> "One thing that was really cool was when I had my second, my son was sleeping in the room next door. I labored and had her, and he just slept through the whole thing. Then my husband went and woke him up and brought him to me. Whereas, with the third, when I was going to the hospital, we had to call the grandparents. We had to get their backpacks, drop the kids off, and take care of all the logistical thing you don't even think of."

Delivering her second baby at home allowed Josephina to focus entirely on her childbirth experience, and not on the logistical details or issues that might arise when delivering in the hospital. In addition, because her son was only a few doors away, she was able to invite her son into the room to see the newborn at the exact moment she desired. Josephina also mentioned during her interview that her second childbirth experience, due to its simplicity and ease, healed

many aspects of her first childbirth experience that was accompanied by months of postpartum depression. Gaining control over what may seem like small aspects of the event of childbirth contribute to the health and contentment of many birthing-people. Having her family close by, and knowing she could see her son when it felt most appropriate, provided Josephina with a sense of agency that helped her through the healing process after her first childbirth, an event that she felt was shrouded in shame and guilt. It is important to note, that for other women, like Lotte, the choice to deliver outside of a hospital is less of a choice and more of a necessity. Lotte and her immediate family, which at that time included her husband and daughter, moved far from her relatives and friends when she was pregnant with her second child. As a result, their social network, and those who were available, willing, and trustworthy enough to take care of their daughter during her second birth, were limited. Since many women do not want their children to watch them in labor, in addition to the fact that hospitals often place a limit on the number of people that can be in the delivery room, Lotte had to find a solution to combat her lack of childcare. Delivering at home seemed to be the best option, as her husband could monitor their child while she was in labor and be present for Lotte when she needed his assistance.

The Choice to Have a Midwife

For some women, delivering a baby in a hospital was non-negotiable. Knowing that Western medicine was at her provider's fingertips at all times brought Riya, a first-time mother from Colorado, a great sense of comfort. However, after her first childbirth in a hospital, and the quality of care she received because of an ectopic pregnancy, Riya made the informed decision to hire a midwife for her second pregnancy:

> "I think for a lot of people, myself included, when you go to a hospital to give birth, it's the first time you've been in that type of medical context and it's really intense. It's pretty scary. Childbirth is really scary for women. Before I had my second son a few months ago, a year before that, I actually experienced an ectopic pregnancy which almost killed me. Being in that same medical context around pregnancy was a very delicate place to be in. I think a lot of times in the OB

> space, it's treated very clinically when really these are people's feelings and emotions, and big things are happening for the first time in their lives."

Riya describes her first childbirth experience as, "A fight from the beginning." She found the pressure from physicians and nurses to medicate to be almost unbearable, especially when her goal was to have an unmedicated delivery. While in labor with her first child, a shift occurred, and a nurse named Susan, who also assists births as a midwife, was assigned to her room. Riya describes her as being a "godsend," and when she voiced her desire for an unmedicated birth, Riya remembers Susan saying: "That's great. We're going to do everything we can to make sure that you have the birth that you want, you can labor here for as long as you want. I'm sure a lot of people have told you a lot of things about what you need to be doing, and I'm here to tell you that you don't need to do any of that." Riya felt that at this moment that somebody was finally listening to her: "She made me feel like I could make my own decisions." Riya's story demonstrates how monumental a listening voice can be when having a negative experience with childbirth. Due to this positive experience, Riya hired a midwife to assist her second childbirth. She found that the midwife helped distance her previous experience with the hospital as a place of sickness and trauma, an association she had formed after undergoing treatment for an ectopic pregnancy. For those that doubt the validity of midwifery, Riya articulated: "It's important to know that there is a middle ground. It does not have to be considered a separate woo-woo thing." The "alternative" culture surrounding midwifery might be keeping expecting mothers from using them as a resource.

During Lotte's first childbirth, and leading up to the event itself, her main concern was surviving the event; she experienced explicit anxiety around dying during childbirth. To calm her anxieties, Lotte sought guidance from midwives. In the process of seeking their guidance and

attending prenatal appointments, Lotte started to see the childbirth experience less as something that was happening *to her*, and more as an event she could become the director of:

> "The midwifery practice really opened my eyes to how I can be treated by a provider. All the medical care I received before then was completely different. They revolutionized how I engage with myself and engage with the world in terms of my care. They were always giving me the information and asking me what I wanted to do. I did not know that this was a possibility. Up until this point I thought that doctors just tell you what to do, and as the patient you must follow their orders."

Both the act of seeking out a midwife and the knowledge they provided, allowed Lotte to put aside her fears of childbirth, and focus on how she could become an agent of the process and take ownership of the experience. During her interview, she recalled that: "What was most important to me was that I felt like I owned my agency in the process. Leading up to the event I was so aware that I could have agency, and I really wanted to put that in practice."

The choice to have a midwife is also influenced by the opportunity to have a "maestro" of the childbirth experience, someone who can attend to the flow of the space and help dictate who exits and enters the room depending on the desires of the birthing person. For Josephina, the midwife helped her navigate the presence of both her mother and husband during the birth of her second child, which was at home: "My mom and my midwife were both really comforting. Quite a few times I told my husband, I want you to leave, or can you go get my mom. My midwife was just so calming. I always say, I just wanted to crawl inside her. She is a beautiful and warm person." For many birthing-people, the midwife inhabits a unique space between family figure and provider. In inhabiting that space, a midwife can comfort the birthing person while reinforcing the boundaries they set.

It is important to note that the midwifery role can be occupied by other people and relationships within the life of a birthing-person. While experiencing an incredibly traumatic and

painful C-section, Leah, a mother of two, found the presence of her husband to be essential, not only for her comfort but as a critical communicator between her and the surgeons:

> "I felt like he was in control, and I didn't have to worry about being in control. Knowing that somebody else that I trusted could be in control was the most important aspect of my birth. He was incredible. He could see the fear in my eyes when I couldn't really communicate, and he communicated for me. He [Leah's husband] was able to see that something was wrong. Having a partner who can speak for you is super important."

Access to midwives is limited, and they often require additional costs and commitments. When considering how to improve a birthing person's sense of agency, it can be helpful to consider the role of a birthing partner, whether that be a husband, wife, mother, sister, etc., and how they can also be trained and informed on how to be better advocates for the needs and desires of the birthing person.

We should be conscious of the fact that midwives and doulas do not always know what is best. There are times in which they might overstep boundaries or be inattentive to the needs of birthing-people. For example, when Lotte was in labor at home, she found the presence of her midwife to be overbearing: "I have these moments that I carry with me that I feel sad about. During my second childbirth, I wish I had told my midwife and doula to leave me alone. They essentially moved into my house during labor. I really knew I needed space, and I didn't ask for it because I felt uncomfortable asking for that. But there was this tiny voice in me that knew I just needed to be alone." Even though Lotte's midwife and doula made efforts to make her feel comfortable and in control, the work of the midwife to achieve these goals can fall short.

Childbirth Education Courses and Birth Plans

Childbirth education courses and birth plans, which are well supported by midwives, were shown in this study to help improve the birthing person's sense of agency during childbirth.

For Maggie, setting expectations for her childbirth allowed her to have a more successful and positive experience, especially as she looked back on the event post-partum:

> "I really wanted to strive for a water birth. So, for me, that was plan A. Of course, everything doesn't go to plan so they tell you in your birthing plan to come up with scenarios of what you would like, how you would want support, and where you absolutely don't want the midwives to intervene. And so, for me, unless I'm at a death experience, or the baby is at high risk, I wanted to avoid a C section at all costs. So, I said I wanted the midwives to intervene to help me avoid that from happening. Those are the types of things they make you think about, and they give you resources of sample birth plans people have made, and you have to physically send them a copy of it. The midwives review it prior to the event so that whoever is delivering the baby knows what your plan and wishes are. The fact that you had to send that into them was really cool to me. And your partner or whoever was going to be in the room with you had to be involved in creating that birth plan as well. So, for me, that was my husband and my mom. We reviewed the birth plan and worked through it together to make sure we were all on the same page. I think that's really important. Even if you don't deliver in an unmedicated facility like me, I've recommended that to other people, to create a birth plan. Even if your doctors don't ask for it, maybe still give it to them. Right, like why not? Go ahead and like, share your thoughts and wishes of how you'd like this to happen. So that's some advice I give to people in learning through my experience."

A major driver in the creation of a birth plan is articulating to your providers what you desire for your childbirth experience. A birth plan can provide guidelines for how the providers can best cater to one's perspectives and needs. In doing so, the agency of the birthing person is improved as what they find important is actualized to the best of the provider's ability. In addition, creating a birth plan provides the opportunity to develop alternative birth plans. For instance, if the course of labor must be adjusted or redirected, the childbirth experience is still deemed a success and is viewed positively by the birthing person. Maggie articulated that:

> "You can come up with a plan and it's going to change, right? But if you try to prepare for scenarios, then it gives you a little bit of an option. Did I plan to have a water birth? Yeah. And it changed, but knowing there were backup plans I already had written out and talked about made me feel like either way, it was successful, you know, if some of the things in between change, that didn't really matter."

Establishing alternative birth plans is an essential tool in the protection of a birthing person's agency throughout the childbirth experience.

Josephina, a mother of three, mentioned with great enthusiasm the mp3s she listened to throughout her second and third births, and how they helped her progress during labor:

> "With my second birth, for hypnobirthing, they gave me mp3s. I would listen to them before bed and then you're supposed to play them during your birth. There was this one mp3 that was a relaxation mp3. It has you meditate, and I thought that that was the one that I was going to want to listen to. But when I went into labor, I did not want to listen to that one. I wanted to listen to the one that was full of affirmations, which, before I had gone into labor, felt so stupid to me; it was so cheesy. It was like, your body's beautiful, it's opening. I would listen to it, and think it was stupid, and then when I went into labor, that was all I wanted to hear. I just listened to that on loop, and it would end, and I would tell my husband to put it on again. I just kept playing it and playing it, and I listened to it during my third labor as well."

Josephina discovered the practice of hypnobirthing while preparing for her second birth. After her first childbirth experience, Josephina was not satisfied with the education and information she received from the natural birth community; she found their terminology to be judgmental and exclusive. Hypnobirthing, which "uses positive affirmations, suggestions, and visualizations to relax the body, guide thoughts, and control breathing" allowed Josephina to better prepare for her second childbirth (Isidro-Cloudas, 2022). The mp3s provided her with a sense of control and comfort as she directed her husband on when to play the tapes, when to continue them, and when she desired silence. The practice of listening to these mp3s before childbirth granted Josephina a stronger sense of agency as she approached and entered labor. It became clear to her that others were receptive to her auditory needs and wanted to support her throughout delivery. It is important to note that the practice of hypnobirthing is not widely known, and education on the topic is not generally accessible to the public. In addition, one must pay out-of-pocket for many of these resources, especially if one wanted to work with a hypnobirthing specialist. Barriers to access to these resources that have the potential to improve one's sense of agency throughout childbirth will be explored in greater detail within the final section of this chapter.

When considering the positives of having alternate birth plans, it is important to note that one must possess an open mind when it comes to altering their birth plan. Within the natural birth community, avoiding medical intervention is paramount. The judgment that is often directed onto those who receive medical assistance during childbirth is harmful and can prevent

people from both requesting and receiving the care they need. When Josephina first found hypnobirthing, she was surprised by the way this practice prioritizes all the desires of a birthing person, whether they are in favor of a "natural" birth or a medicated birth. What matters most within the practice of hypnobirthing is that decisions are made on the terms of the birthing person. Josephina's third birth was complex. After her second baby was born, she was diagnosed with an ectopic pregnancy, which placed her in a high-risk category. Because her pregnancy was considered high-risk, she wanted her labor to be monitored in the hospital, but to still try to have an unmedicated experience. After challenging hours laboring in the hospital, Josephina began to panic. The doctors, receptive to her needs and current emotional state, offered her an epidural:

> "They asked me, do you want an epidural? And for me at the time, the epidural wasn't for the pain. It was because I needed something to distract me from how scared I was that my baby was going to be preterm. So I said, yes, that's fine, bring the epidural. At this point, I'd been laboring for three hours. So the doctors put the needle in, and as he's doing this, I'm able to breathe again, I feel my anxieties going away because I'm able to focus on getting the epidural."

Before the anesthesiologist was able to fully insert the needle and provide the epidural, Josephina felt like she needed to and was able to push again. In turn, without even fully receiving the medication, Josephina felt equipped and calm enough to continue laboring:

> "As soon as I was able to get my mind off how scared I was, my body was ready. She was born two pushes later. Afterwards, I felt really happy that I listened to myself, that I didn't let what I had previously thought or what people had previously made me feel interfere with what I needed. I am so happy I was able to change my mindset and do things on my terms. My terms meant getting an epidural. I feel like a lot times, when you're in the natural birth community, epidurals and the hospital are always synonymous with getting your choices taken away. I wish more moms who liked midwifery, who liked natural births, got more of a chance to talk about the fact that having interventions and being in the hospital can also be part of a positive plan."

For Josephina, possessing the knowledge that shifting directions during childbirth, and accepting medical interventions, is not something to be shameful of, was essential to her return to calm and the progression of her labor. When examining childbirth education courses and practices, we must question the presence of absolutist thinking as it may work to limit a birthing person's

sense of agency. In addition, one could argue that the epidural Josephina received in this moment, which never actually fully went into effect, allowed Josephina to shift her focus away from the pain she was experiencing, and redirect her attention toward a more positive stimulus. This conclusion is informed by the research presented by Moodie et. al on emotional regulation, which is described in greater detail within the literature review.

From Lotte's unique perspective as both a doula and a mother, childbirth preparation courses are essential, primarily because they educate the birthing person on what is available to them and present them with options heading into labor. During Lotte's interview, she mentioned the importance of darkness during her labor; the absence of light calmed her. Knowing that she could request for the nurses to remove the light from the delivery room protected her sense of agency and comforted her during a vulnerable period of labor: "During my first birth, we were in traffic for an hour heading to the hospital. I was basically just in the dark, hiding my face, because I did not want to look at the car lights or look outside. When we got to the hospital, I asked them to turn the lights off. They also brought a spotlight in, and I told them to put that away as well. It was horrible." Being a doula, Lotte has the knowledge that: "You do have to fight sometimes." Gaining an understanding of what is in the control of the birthing person through childbirth education and preparatory courses is essential. Without these courses, one might not be aware of the power of their voice and opinion and would therefore have a difficult time exhibiting agency.

Of course, there are levels to knowing. Many women interviewed for this study acknowledged that it was never their goal to know all the ins and outs of childbirth or even specifically their experience. For Elena, it was important that her provider triage information before it gets to her: "Personally, I feel most empowered when I have knowledge, but not too

much. I need somebody to triage information for me and to set the guardrails for the spectrum of what is normal." Elena then provided an example of when a pediatrician, who had only met her once before this moment, provided her with too much information:

> "This pediatrician came in and scared the bejesus out of me. He said that because I tested positive for strep B, that my baby was at a heightened risk for all these things. He said that I needed to watch her breathing really carefully at night. Meanwhile, I was just thinking about how tired I was. I just wanted to sleep. I didn't want to be responsible for my baby not breathing if I didn't catch it. I felt so anxious that I asked to stay at the hospital another night. Later that day, my original doctor came in and was really upset because this pediatrician had scared me. She mentioned that he's not very good at triaging information and presenting it in a helpful way. I think that's a good example of the fact that even though it was my second, and even though I knew what to expect, somebody could still come in and present information that could make me feel so terrified. It made me feel like I couldn't adequately take care of my kid."

As exemplified in this quotation, providing information that may be alarming or frightening to the birthing person can lead to self-doubt. One is not empowered to be an agent of their experience if one doubts their abilities to adequately take care of their child and be a good mother. When considering the power of knowledge in promoting a birthing person's sense of agency, it is worth considering the significance of how information is shared and to what level of detail.

It is important to note that education on the topic of childbirth can also occur interpersonally and within one's community; formal childbirth preparation courses within hospitals or birthing centers are certainly not the only way knowledge is transmitted surrounding childbirth. Many women interviewed for this study mentioned the enjoyment associated with sharing their own birth experiences and listening to the birth stories of other parents within their community. However, many people voiced frustrations around the higher frequency of sharing negative aspects or experiences with childbirth compared to the more positive and uplifting aspects of one's childbirth experience. One could argue that this trend may be attributed to the sensationalism of violence and harm within the mass media produced and circulated in the

United States. People are generally drawn to stories on destruction, conflict, and struggle, or this is at least what we have gotten used to. In addition, fear was a dominant emotion expressed among many childbearing women as they approached their delivery date. This fear was often prompted by stories of birth trauma that were routinely shared among relatives and friends. Prioritizing and highlighting dialogue on the topic of childbirth that is not based in fear and anxiety may help move people's perceptions of childbirth from a place of alarm and panic to one of encouragement and confidence. The ability to better manage one's emotions and beliefs surrounding childbirth can help establish and protect one's sense of agency and control over the childbirth experience more generally.

Building Trust

Establishing trust between birthing-people and their caregivers is essential in the promotion of a birthing person's sense of agency. In establishing a trusting relationship, many of the women interviewed for this study voiced the importance of prenatal appointments with their providers. For Maggie, prenatal appointments with midwives were incredibly gratifying:

> "Getting to see them [the midwives], you could tell, just through the appointments throughout my pregnancy, that it was a very self-guided hands-off approach, as much as you wanted, you know, as far as support, guidance, questions, how intrusive they were, was up to you. And so that was very comforting for me because that was what I was hoping and expecting for going into delivery."

The final stages of Maggie's labor were very difficult. While positioned in her birthing tub, she began to doubt her ability to deliver her baby. The midwife was attentive to her doubts, and listened to her concerns:

> "I was so uncomfortable in the water and started to doubt myself. I was saying things like, I don't have a choice, right? I am stuck here and must deliver my baby in this tub. My midwife said, well, you've got a minute between contractions. If you want to get out of the tub, you have to get out now. She said, it's okay to stay in or you can go to the bed, whatever you want to do. And so, I decided to get out. I quickly moved to the queen size bed and laid on my left side, and I pushed him out there. It was really wild. He was 10 pounds, three ounces."

Listening to the needs of the birthing person, and providing them with options during moments of distress, is crucial when trying to maintain the agency of the birthing person throughout childbirth. In addition, it is important to note that, because of Maggie's prenatal visits with the midwives, she could convey that she wanted a hands-off and self-guided approach to childbirth. Instead of directing Maggie, and telling her exactly how she should proceed, the midwife suggested alternatives that might help her regain a sense of comfort and control.

Riya also mentioned that being able to consult with the same midwife before, during, and after her labor was essential in building trust in her midwife: "I never felt like it was an inconvenience for me to ask as many questions as I needed to ask. I think because midwives are so focused on getting a woman through their entire prenatal and postnatal journey, they are really tuned into what a woman is going through." Spending consistent and dedicated amounts of time with one's caregiver helps to develop trust in their abilities to know you and your body. Speaking up, asking questions, and demonstrating needs become possible for the birthing person when they trust in their provider.

Elena, a mother of two who delivered both of her children without midwives, voiced how crucial communication was when gaining a sense of trust in her providers:

> "One of the things that that I really appreciated was that the doctors, the nurses, the anesthesiologist, they all did a really good job of talking me through what was going to happen. They said things like, you might feel this, let me know if you feel this, etc. And for me that really helped improve my sense of agency as I understood what the parameters for a "normal" birth were. In that moment, as somebody experiencing everything for the first time, I mean, it's painful, and it's messy, and your body is doing crazy things that it's never done before. It was really helpful to be given those guardrails."

Precise and straightforward communication from her providers regarding the progression of her labor helped Elena maintain a sense of control while undergoing a completely new experience. Elena never desired to have a natural birth. However, receiving an epidural for the first time can

be quite jarring. Elena appreciated how her providers guided her through the sensations she would be experiencing if she had not received the medication:

> "Because of the epidural, it was weird to be pushing and not really feel anything. In those moments, it was really helpful to again, have the doctor walking me through everything and telling me what I was probably feeling. I felt there was a lot of trust between me and my doctor and my nurses. I knew they could really help me. They would let me know, like, be aware of this, or if you are experiencing this, let us know, and we can change things. In the end everything was pretty uncomplicated and straightforward."

As Riya articulated above, part of trusting your provider is knowing that you can ask them questions regarding your childbirth experience. Elena was comforted by the inquisitive nature of her providers, and found their interest in her pregnancy to be reassuring:

> "I felt like they went above and beyond to like, make me feel like we were friends or that we had a connection. They asked me, what's the baby's name? And how's your pregnancy been? Questions that I think went beyond the typical list of what you're supposed to ask. In building that relationship, I felt like they were setting me up to feel comfortable to ask further questions when I needed. They were acting like educators or teachers. They would give me the appropriate amount of information, and because we had established a good relationship, if I needed more information, I felt like I could ask for it."

Through consistent communication with her providers, Elena established trust in their abilities and was even comforted by their presence and direction. In establishing this sense of trust, Elena felt she could inquire about her labor and better understand her progression toward delivery, making her a more active participant throughout her childbirth experience.

For some individuals, to develop trust in their provider or midwife, they must feel as though their provider or midwife has trust in *them* and *their ability* to deliver a healthy child. Josephina's relationship with her obstetrician was built upon his trust in her ability to persevere through her difficult labor:

> *"*When I was provided with the Pitocin and epidural during my first pregnancy, I still felt like I had complete agency. I really wanted a vaginal birth; I did not want a C-section. It terrified me because of the pain and recovery period; it would make my birth so much harder. My obstetrician (OB), who is amazing, I absolutely love him. He let me labor. Even with my son towards the end [of the labor], his heartbeat was irregular, and I was running a fever. My OB turns to me, and he says, okay, I know you don't want a C-section, and I am doing everything I can to not give you a C-section. So, what I am going to have to do is give you an episiotomy and a vacuum extraction.

> Is that okay with you? This was my first birth, and I wanted it to be natural, but it became anything but; it felt like I had every single intervention. Even so, I still feel like he really respected what I wanted. I said yes, so I had the episiotomy and a vacuum extraction. I wanted a vaginal birth, and I got my vaginal birth. My mom told me afterwards that any other OB would have done a C section at that point. The fact that he was so respectful of me wanting a vaginal birth, and the fact that he sat there and waited with me, trying to get the baby out without intervention until we kind of couldn't, that was really important me. I always felt that I was listened to."

Josephina's obstetrician was conscious of her needs throughout her labor and upheld his trust in her to continue laboring safely. In addition, knowing that her obstetrician was keeping her informed on the progression of her labor kept Josephina in a position of control. It is important to note that Josephina's obstetrician was able to trust her so deeply because he had met with her several times before her delivery, and had gotten to know her needs, preferences, and communication style. Prioritizing prenatal appointments within our healthcare system builds trust between providers and their patients, which in turn has the potential to protect a birthing person's sense of agency during labor.

The Presence of Family and Community During Labor

The presence of large groups during an individual's labor or during the postpartum period has roots in cultural traditions and expectations surrounding the childbirth experience. Broadly speaking, becoming more informed on cross-cultural differences as it relates to childbirth is essential in the promotion and protection of a birthing-person's sense of agency and control. The following paragraphs explore various cultural traditions that support the presence of family and community both during and after childbirth, and why their presence is important within the context of agency promotion in birthing-people.

Many women interviewed for this study mentioned how the individualistic culture within the United States made their postpartum period far more difficult than expected. In many ways, the childbirth experience in the United States is limited to that of the mother and child and does

not involve the presence of relatives and other community members. For Josephina, having extended family present at her first birth was crucial:

> "I think what's really hard is a lot of my cultural traditions as a first-generation Mexican person have been stripped away by the United States. It's a matriarchal society. It's a community-based society. When my mother went into labor, all the women, her aunts, mother, and sisters, all came and helped her through the birth, and then helped her afterward. They also brought her food. Because of this, I think, I had big groups at my births. That was part of what I incorporated. But for my third birth, because it was high risk, it was just my husband, and that was really hard for me. I kept thinking, I wish more people were here. I wanted my women, you know, my sister, my mom. It was always a huge comfort to me, and it was really scary not having them there for that third one."

In addition, a few individuals mentioned a period of loneliness that followed the birth of their child and the subsequent desire to gather friends and family around them. Josephina had consistently difficult post-partum periods as it relates to loneliness:

> "Then afterward, when I had all my children, everyone I knew worked full time, including my mom and my aunt, so I was alone. I didn't have anybody, I was home alone with depression, and trying to make myself meals, and crying there was nobody there. I feel like our individualistic society here in the United States has taken away from communities that *are* so community-based, and that actually really hinders a mother's experience."

An example of the positive impact of community during the postpartum period can be found within the Jewish tradition. For Leah, her son's bris provided an unexpected source of community support and aided in the period of loneliness that can begin post-partum:

> *"*Having people around was really important in those early days. The bris brought people together, and the presence of family and friends made me feel supported. There are certain Jewish traditions, whether it was Shabbat, or the bris, or anything really that brought people together, that felt so needed. Especially during the early postpartum period when I really just wanted to turn my brain off and feel like the people around me were not judging the way I looked."

For many of the white and/or non-religious individuals that were interviewed for this study, defining ways in which culture and community provided comfort during labor and/or the postpartum period was difficult. However, toward the end of Lotte's interview, she recalled a series of interactions she had with her ancestors that pushed her to persevere through the final stage of labor:

> "I don't have a strong relationship with my cultural background. But I did have a moment where I was in so much pain, and so close to birth, and I was literally begging, I was saying that I couldn't do it anymore and that I was going to die. Then suddenly, I had this moment where I felt the presence of other's around me lifting me up. They told me I was going to finish this, that I was going to have my baby. And to this day I still believe those were my ancestors who came to my side."

The presence of others can have a substantial impact on the outcome of an individual's childbirth experience. Lotte, even though she is not familiar with her cultural heritage, she found great value in connecting with ancestral beings and was uplifted by their visit during this challenging period. Elena also grew up in a white European household and felt a similar lack of engagement in her cultural background growing up. After having children, Elena attributed the loneliness she experienced during her early post-partum period to an absence of community, elders, and friends who could have potentially empathized with her position as a new mother:

> "I did not grow up around kids or childbirth or anything like that. Because of this, and because I was one of the first of my friend to give birth, I felt very alone in the experience in a lot of ways. I didn't have a village or community of people supporting me. I didn't have people who cared for me talking me through what to expect. And so, I think that for my first birth especially, it was so important to have a birthing team who was able to communicate all of that to me and draw from their own experiences, because I just had none of that beforehand."

To fill the gap in care that Elena sensed she was experiencing, particularly concerning community support, she leaned into the guidance and experiences of her providers. Going through the childbirth experience and early post-partum period alone can be incredibly challenging for birthing-people. Prioritizing the cultivation of community and connectedness within the context of the childbirth experience has the potential to improve the mental state of birthing-people.

Neha delivered her children far from many of her family members, and during the process, she yearned for the presence of elders and other family members who have had children and could share their wisdom. In addition, delivering her children outside of her home country made

it difficult to practice cultural traditions that she might have engaged in if she was in the presence of family:

> "Because I gave birth here, without family, I didn't really have the chance to participate in specific cultural traditions. Yes, I had a baby shower. But it was my friends coming around. You tend to gravitate towards women who have other children and young families to support each other. But there wasn't anything that culturally that I did that I took from my past or my family traditions, because I didn't have that here. You hear about Chinese women, and how they are almost taken away, and put on a special diet. In that scenario, it's all about you, getting your body back and nurturing your body right aftee birth. They have this whole system of how to care for women. It's really a family thing. I kind of learned that after the fact and was thinking, oh, that would have been nice to have."

Many women interviewed for this study mentioned the apparent lack of empathy and concern for birthing-people after they deliver their children. In addition, many mothers shared the understanding that in the United States, people's questions and general concerns are primarily directed toward the health of the newborn, and not that of the mother. Neha was particularly drawn to the cultural traditions surrounding the post-partum care provided to mothers in traditional Chinese culture. She is aware of the attention women belonging to traditional Chinese culture receive post-partum and is conscious of the fact that the continual presence of family members during this vulnerable period might help assuage loneliness.

The presence of community and connection throughout the childbirth experience and during the post-partum period relates to one's sense of agency. Researchers Coan and Gulbahitayar provided two perspectives on the impact of social proximity, which is unraveled in greater detail within the literature review. They both found a link between social proximity and stress management. In addition, Gulbahitayar concluded that fear of childbirth decreases when women have established systems of social support and are in the presence of supportive partners. As demonstrated by many of the women interviewed in this study, being in the presence of family members, loved ones, and trusted providers during childbirth decreases fear and improves

the childbirth experience, allowing labor to become a more comfortable and empowering process.

How Agency is Inhibited in a Birthing-Person

The Pressure to Deliver Unmedicated

The natural birth community has a strong hold over the decision-making of many birthing-people that requires further examination. Around half of the women interviewed for this study considered having a natural childbirth. Many factors influenced the interviewees' decisions to consult natural childbirth methods. One of the major reasons people considered natural childbirth was due to the influence of their family members. Josephina, a first-generation Mexican American, said that many of her childbirth goals were informed by her culture and upbringing: "I am first generation born in the U.S., so I grew up in a home where everybody breastfed, where you try not to use a lot of medications. It was very homeopathic. It really influenced what I wanted as I went into my births." Considering Josephina's background, it was not unusual to consider an unmedicated labor; in fact, it was somewhat expected of her. Josephina's mother, a nurse and advocate for homeopathic methods and unmedicated childbirths, brought Josephina to her sister's birth eight years later, and Josephina watched:

> "She invited me to be at the birth. I was eight years old. I was like, yeah, let's do this. So, my mom went into labor, we went to the hospital. I was standing right next to the doctor as he [the doctor] was catching her. I was able to watch my sister be born, and that definitely shaped a lot of how I saw birth. It was unmedicated, but all my mom's births had been, so I just always had that in my mind, in the sense that I wanted to also do it without medication."

Looking back on the event during her interview, Josephina was hesitant to consider it a purely positive experience. After going through complications with her own births, she has become increasingly skeptical of the teachings within the natural birth community and her mother's affinity to homeopathic methods: "I think the only negative part of it [watching her mom's labor]

is that my mom is really extreme about not wanting medication, and so part of me felt like a failure when I accepted medication during my first labor. When I went to the hospital, I ended up having Pitocin and an epidural. I felt like I had failed because I had to get this medication. Everyone I knew hadn't done that." Within the natural childbirth community, one can feel extreme pressure to deliver without any medical intervention. Many women shared that they feared judgment from other members of the natural birth community if they were to accept medical interventions during their childbirth.

Josephina mentioned that her interactions with healthcare providers during her first childbirth were generally positive. However, throughout her postpartum period, she had a difficult time coping with her choice to accept medical intervention, even though it was what she wanted at that moment:

> "I always felt like everyone was listening to me. I was making my own decisions. But then when it was over, I was mad at my body for not doing what it was supposed to do and the fact that I had to make those decisions [to receive an epidural and Pitocin]. I understood that they had to be made for my baby to be safe, but I kept thinking afterward about how other moms it and I could do couldn't. As a result, my postpartum period was really bad. I had bad postpartum depression, anxiety, and OCD."

Pressure to deliver without medication from the natural birth community left Josephina with a great sense of shame and discomfort. When she should have been celebrating the birth of her first child, she was caught up in comparing her own experience with that of others. In preparation for her second childbirth, Josephina decided to shift her focus away from the natural birth community: "I felt like I needed a community that didn't have expectations that I was worried I wasn't gonna be able to meet. I was looking for people that were more open and conveyed that I had options, that I could change the direction of my labor, and that it didn't have to go one way; that there are many ways success can look." Placing limitations on what can be considered a positive or successful childbirth experience inhibits a birthing person's sense of agency. In

addition, placing greater value in a childbirth experience that is unmedicated restricts a birthing person in terms of what is deemed acceptable or worthy.

Although pressure from the natural birth community was responsible for the guilt and shame Josephina experienced postpartum, the cultural context of her upbringing as a Mexican American also influenced her perception of the experience and her use of medications:

> "A lot of people will leave a traumatic birth and kind of blame it on the hospital, and blame the doctors, and for me, this is where we go into my cultural background. My parents are from Mexico. I was raised in a Latino household. I am the eldest Latina daughter, and for me, I placed a lot of blame on myself. My mom had all natural births, and there were three of us. My grandma had all of her kids at home, in Mexico, on a dirt floor. So going into the second birth, I really had to work against those instincts that it was my fault, or I had done something wrong, or I wasn't good enough."

When considering the pressure to deliver without medication, one's family lineage as it relates to childbirth can have a substantial influence on how an individual envisions their own childbirth experience. The pressure to avoid medications from one's family members can also limit an individual's sense of agency as they desire to perform as their ancestors did and demonstrate a similar level of perceived strength and resiliency. This is an unproductive way of thinking that can limit one's sense of agency and ability to ask for assistance when desired. To improve the agency of birthing-people, value judgments based on the presence or absence of medical intervention during childbirth must be eliminated.

Diana, as the youngest daughter, and a mother of four, shared a similar pressure to deliver her children without medication, primarily because her sister did so. To this day, Diana looks up to her eldest sister, and recalls wanting to experience childbirth with a similar level of strength and toughness that her sister was able to exhibit:

> "I have an older sister who had children. She is very stoic. She was kind of my role model, and so was my mom really. They both didn't get medication when giving birth to their children. Somehow, I felt like it was a failure if I needed pain medication. At least that's what I picked up. Of course, it was never explicitly said. But they told me things like the baby was going to be

> drugged if I got medication, and that she was not going to be able to feed well. Things like that, which scared me to be honest, and made me feel ill-prepared for the experience."

It is important to note that the influence of family on the choice to deliver without medication can also be a positive one. During her interview, Lotte remarked: "I knew I had a really high pain tolerance, and I also knew my mom had given birth with no medication. So, I felt confident in that. But I told myself it was totally fine if I did choose to have medication." Knowing one's family history and lineage as it relates to childbirth can grant an individual a greater sense of confidence in their abilities to deliver their child safely, without putting unnecessary pressure on themselves to deliver without medication.

The Absence of Communication

When women were left in the dark regarding the progression of their labor or the course of their treatment postpartum, their sense of agency was challenged. During Neha's labor with her second child, both the delivery process and her postpartum experience left her with a great sense of betrayal on the part of her providers:

> "She [the obstetrician] kept saying, you know, to push and push and then at one point, she said to me, he's turned around, he's sunny side up, so the head is hitting your pelvic bone. They don't come out the same way when they're turned. She just kept making me push and push. And then at one point, I pushed really, really hard, and I heard a pop. I said to her [the obstetrician], what was that? Because you're so numb. You don't feel anything in a way. There's so much pain and you don't know what's going on down there, and I'd been pushing for hours and was probably swollen. She didn't really say anything about it. I thought I had split. The noise was so bizarre. And she was like, no, no, no, it's, it's fine. It's fine. I'm gonna take care of it. I'm gonna like, you know, we'll sew you up. I'll take care of you."

After giving birth to her second child, Neha's obstetrician left immediately for vacation. Neha was left in the hospital, alone in her room with a newborn, unable to walk. The day after Neha delivered, the nurses repeatedly told her to get up and try walking. She told them she was in too much pain: "The way they were treating me, it felt like I wasn't being a good patient. I was in so much pain." Many hours later, the nurse discovered that she had split her pelvis:

> "At that point, I was terrified. What does that mean? I've split my pelvis? One of the obstetricians treated it like some kind of medical discovery. She was in awe of the seven-centimeter gap in my pelvis. I remember being so emotional. I remember crying. I got mad at her because it was my body. I wasn't some sort of medical phenomenon she was experiencing. She couldn't even explain to me what had caused it."

In telling this story, Neha recalled that the doctor who she had established a relationship with, the one who had delivered both of her children, never checked up on her even though she witnessed the loud popping noise after Neha's second child was born. In addition, no one from the hospital guided her on who to see to improve her condition; Neha recalls doing all her own research on how to heal her condition. She finally received the care she needed when a friend from her child's school connected her with the head of trauma at The Hospital of Special Surgery in New York City. There she was met with six doctors who informed her of the impact of the trauma and provided her with guidance on how to best recover from the incident: "I was treated in that hospital as a human being, as a person. Whereas at the other hospital, I was patient number 10. I remember I was in so much pain afterward and no one knew what it was. They provided no support. The number one thing was that they needed to free up the bed. We felt very alone after that." Throughout her interview, Neha mentioned how lucky she felt to have access to the doctors at the Hospital of Special Surgery. Had she not known the family who connected her with the trauma surgeon, her condition would've worsened, and she would've been in pain for a much longer period. It is apparent that in the United States, having access to suitable healthcare is a privilege. Neha knew that many individuals who had similar experiences during childbirth were not granted the same opportunity simply due to the limits of their social network.

In preparing for her first childbirth, Fatima made it clear to her obstetrician and midwife that she wanted to have a vaginal delivery. The prospect of a C-section frightened her. Knowing this, Fatima's obstetrician allowed her to keep pushing but warned her of a potential C-section if her labor did not progress. During her interview, Fatima discussed how the doctor's

communication regarding the C-section was essential in protecting her sense of agency and comfort during labor. However, she still found herself in tears while accepting the fact that she had to have a C-section. Fatima said: "I did not feel like I was informed on what was going on. I still don't exactly know what went wrong with my labor." The absence of communication between Fatima and her doctors left her uninformed, and as a result, fearful of the impending procedure. When one is preoccupied with fear, it is difficult to access a sense of agency.

Leah had her first child at a teaching hospital in New York City. She ended up having her son a lot earlier than anticipated because he was pushing a nerve that was causing her to experience tremendous amounts of pain:

> "I thought, this is not safe, something's wrong with me, please take this baby out of me. So, they took him out early. However, I don't know how this happened, but I ended up in a traditional operating room where they do normal surgeries, and not in the room where C-sections often happen. The traditional operating room that I was placed in had cameras everywhere. The room had many huge screens that were all facing the operating table so that all of the students could see what was going on. I had no idea going into this experience, that this is what it was going to be like. At first, they wouldn't let Mike [Leah's husband] in the room. I remember fighting and screaming at the doctors and telling them that my husband had to be with me and should be let into the room. They finally let him in because we knew somebody on the board of the hospital, and they called. The fact that we knew somebody who could make that happen was a miracle, but most people would not have that option. When they finally let him into the operating room where I was having *our* child, all these cameras were on me, I couldn't see what was happening, and I started hyperventilating. There were probably about twenty people in the space. It was very intense. I was screaming, turn of the cameras, I don't want to see what is happening inside of my body."

When I asked Leah if she was aware of the potential presence of other medical students, invasive cameras, and countless pieces of medical machinery, she responded by saying that she was not made aware of the extent to which they were going to be present when heading into the operation:

> "The reason that they had people in the room was because of my previous history and because of everything I had experienced leading up to that moment, there was concern that something was going to happen. I had doctors from the gastro ward, obstetricians, and other surgical teams; they were all there together. I didn't know that this was going to happen. And they were all just sitting there, none of them were involved. They were all just sitting there watching."

When Leah decided to deliver at the teaching hospital, she knew she may have some visitors in the operating room. However, being welcomed by over twenty people in her operation room, all watching her undergo an incredibly emotional and vulnerable experience, was undoubtedly jarring and anxiety-inducing. When reflecting on the experience, Leah felt that while lying on the operation table and meeting her child for the first time, she became a body to observe or a medical phenomenon. She felt as though the hospital exploited her for their viewing and educational purposes. The presence of invasive cameras and countless medical professionals challenged Leah's sense of agency as she delivered her first son. Even though individuals who undergo C-sections generally have less control over the delivery process, they still deserve to have a sense of ownership over the experience.

Issues Related to Access

In the United States, access to childbirth preparation courses, and midwife and/or doula services is incredibly limited. Many of the women interviewed for this study acknowledged the privilege of their position and how that contributed to the accessibility of important resources throughout their childbirth experience. During her interview, Riya articulated the inequities in access to childbirth education and preparation courses:

> "I do think this is an access issue as well. We had the financial means and time to take a class that was tailored to what we wanted to do. We also took the one that was offered through the hospital, which I believe was free. It definitely had a more diverse selection of people, but it felt like almost a waste of time. It didn't make me feel any better. In some ways, it made me more stressed about the whole thing. I'm like, so this is the one most people are taking, because they have access to it. Right? It's free. And then there's this other one that I found that cost money and took quite a bit of time. Not everyone has access to that. But the classes gave us the information that really helped us get through our first labor. I just think about how many women go in not knowing anything. You know, they throw all these things out. You don't know what's going on. You're in pain, and you just say yes. How can we be advocates for ourselves during such a delicate situation?

Having knowledge of the childbirth experience and what is available to you is critical when considering the ability to advocate for yourself. If one is unable to advocate for their needs, their sense of agency is hindered.

When asking the women interviewed for this study what they wish every birthing person could have access to, many mentioned the need to have somebody near who knows you well, is knowledgeable on childbirth, and can advocate for you and your desires throughout labor. Josephina remarked: “I wish that everyone would have access to…well…it’s hard, I don’t want to say doula, because there are bad doulas. I feel like everyone needs to have someone who completely understands them. Who understands their needs their wants and is very well-versed in birthing. And I don't even mean like having to take classes or anything.” Strengthening the presence of midwives and doulas in hospitals can aid in establishing a more comfortable and inclusive environment for birthing-people; a substantial aspect of their model of care involves forming a close bond between themselves and their patients.

Chapter Five: Findings Among Birth Workers

Recentering the Voices of Midwives

"To be a midwife is to be a safe keeper of the birthing experience."
- Anonymous

To gain a better understanding of how best to support birthing-people before, during, and after labor, we must also begin to center the voices of midwives. The midwifery perspective has been overshadowed by biomedicine and the American healthcare system. Although midwifery care is looked down upon by the medical profession, midwives and doulas work closest with the experience of child-bearing individuals, from providing essential prenatal care and guidance to advocating for their needs during labor and regularly visiting newborns postpartum. For many people, delivering a healthy baby is only part of what comprises a "good" birth. However, this aspect of the childbirth experience is of utmost importance in the minds of many obstetricians. While the health of the baby is prioritized, The United States continues to exhibit a shameful maternal mortality rate, which is particularly high among Black and Hispanic individuals. The Centers for Disease Control and Prevention (CDC) reports that: "The United States continues to be an outlier among industrialized nations, with a maternal mortality rate several times higher than other high-income countries" (Taylor, 2022). In addition, the CDC reports that: "In 2020, the maternal mortality rate for non-Hispanic Black women was 55.3 deaths per 100,000 live births, 2.9 times the rate for non-Hispanic White women. Rates for non-Hispanic Black women were significantly higher than rates for non-Hispanic White and Hispanic women" (Hoyert, 2022). The United States is lacking culturally competent systems of care from which to approach and address the disparities in maternal mortality rates among Black, Hispanic, and White women. For the American healthcare system to create a more holistic and culturally

competent system of care, the needs and aspirations of the birthing person must be prioritized, and the agency of the birthing person must be addressed. Although improvements in biomedical technologies, surgeries, and medicines have been incredibly important within the context of high-risk births and survival, the childbirth experience from the birthing person's perspective continues to be neglected. To decrease the maternal mortality rate within the United States and improve the childbirth experience overall, we must turn to the knowledge and experience of midwives and doulas, those who engage closest with the emotional, spiritual, and psychological dimensions of the experience.

The Role of the Midwife in Promoting a Sense of Agency

After interviewing three midwives and two doulas practicing across the United States, three central elements of the midwifery/doula model of care, I identified three elements. education, communication, and advocacy. All three of these elements are tied to the promotion of agency among birthing-people: education, communication, and advocacy. In addition, every midwife and doula expressed the understanding that the event of childbirth should belong to the birthing person. The following paragraphs explore three key elements of the midwifery/doula model of care and how they may aid in the development and promotion of agency within birthing-people.

Promoting Agency Through Education

A midwife is not only an individual who is trained in labor and delivery services, but they are primary educators of the childbirth experience. Many midwives value childbirth education courses, the creation of a birth plan, and regular prenatal visits, as critical ways in which a birthing person's sense of agency can be improved regarding the childbirth experience.

Part of the childbirth education process is setting expectations for one's childbirth experience. One way to set these expectations is to uncover how the individual envisions their childbirth experience by creating a birth plan, which can be used as an additional communication tool. One midwife describes her childbirth planning meetings with the following priorities in mind:

> "I ask them, what is your goal? Tell me your goal and I will support that goal. It's your decision, not my decision. I give them the frames. I tell them this is what happens if you do this, this will happen if you do that, and these are the consequences and stuff like that. They (women in labor) look at me and ask, 'what should I do?' I tell them I am not deciding for you, that I am here to support you."

An aspect of the childbirth planning process is understanding the potential benefits and consequences of medications, procedures, and/or medical interventions. Midwives understand that by creating these knowledge bases around childbirth, agency is improved. One cannot feel as though they are an agent of their childbirth experience without being made aware of the options available to them during labor and delivery. Developing a birth plan creates an opportunity for birthing-people to learn what is accessible to them during labor, to ask questions of the midwife, to know what to anticipate, and to be skeptics of the information they are receiving from their healthcare providers, family members, and other caregivers.

A doula who works primarily with Latinx and immigrant populations in San Francisco, often informs her patients that they should prepare home-cooked meals, sandwiches, warm food, and familiar flavors to bring to the hospital. She tells her patients: "I promise, you will not like the food, it's not what you're used to." Not only is food essential for replenishing the calories expended throughout labor, but specific flavors and familiar tastes can help individuals feel more comfortable within a Western and at times completely foreign environment. Many of the mothers coming to this doula for assistance speak little English and are often without permanent or secure living situations. Food can serve as a point of connection to one's home, a reminder of family,

warmth, and support, creating a more familiar and comfortable environment. Doulas and midwives are responsible for educating birthing-people on what they are allowed to bring into the hospital or laboring space. Knowing that you, as the birthing person, have the choice to bring comfort into the birthing space by way of food, drink, or other physical items, is part of the work of midwives and doulas that improves a birthing person's sense of agency.

Knowing that you can advocate for yourself and ask important questions about the quality and direction of your care is an essential first step. However, a lot of women don't know that they can ask questions of their healthcare providers. In addition, many birthing-people are lacking the knowledge base from which to understand what to ask. One doula said:

> "Nurses and doctors encourage people to have C-sections. I feel like the power over them is huge. Families feel that because they are the doctors or the nurses, they can make the decisions for them. I always encourage them to speak up, to ask questions about the pill they are receiving, what are the consequences, and ask, "Why are you giving me that."

Many doulas see their role as someone who can help set expectations for the childbirth experience and provide a space for the birthing person to uncover how they envision their labor. Possessing an understanding that you, as the birthing person, can make decisions around your birth experience, is a crucial first step in the education process. One is unable to advocate for their needs, resist medical intervention (specifically in the case of low-risk births), or consume a warm meal made by their partner if they are not made aware of their potential as decision makers throughout the childbirth process. Education related to individual empowerment, decision-making, and planning, is an essential first step in promoting agency among birthing- people.

Midwives and doulas regularly referenced childbirth preparation courses as essential to the promotion of agency in birthing-people. Apart from the traditional childbirth education courses that teach breathing techniques and mindfulness, one doula highlighted a self-care course that she developed for expecting mothers. This course was designed with low-income

individuals, under-resourced individuals, and immigrant women in mind. When the overall survival of your family becomes the overwhelming priority, the individual needs of the mother are disregarded as she is considered the primary caregiver within the family. She is often the one to eat last, bathe last, and sleep less, carrying the primary physical and emotional burden of taking care of her family. The goal of this self-care course is to teach pregnant women how to effectively allocate time for their personal needs and desires. This doula emphasized that self-care is not a privilege but a necessity, especially during pregnancy and the postpartum period when the body is particularly vulnerable. Through these courses, immigrant women, specifically Hispanic individuals within the context of this interview, who are often hesitant or fearful to practice their own culturally relevant rituals surrounding self-care, are validated, and supported in these endeavors. The doula articulated:

> "I feel like in Latino culture, we believe that we are superwomen, that we have to do it no matter what. [After delivering your baby] You come back home, that's it. But it is important they take care of themselves. They have to keep doing their believing no matter what, even if you're in the U.S. You can still shower with herbs, you can do your ritual, whatever you want to do before breastfeeding, you can still talk to your baby, you can still advocate for the baby."

By validating oneself care rituals and beliefs, women of all backgrounds are made more comfortable despite the intimidations and confusion of the American hospital system. Women must be made aware of the agency and decision-making power that they possess regarding not only their childbirth experience but their experience postpartum. Through education and empowerment, it is the birth workers who activate this sense of agency. In addition, one may be under the impression that it is not the responsibility of the hospital to provide a space for pregnancy, childbirth, and postpartum-related rituals. However, to push back on this belief, one doula offers a story of a mother who is without her own bathroom and private space in which to perform these essential rituals that aid her passage into motherhood: "One mom lived with five different families. She told me she was worried about having her herb shower. She said I want to

have a shower with herbs for my body but there is no space in my home. There are different families in one house. Five different families living within one house." To improve comfort and a sense of control over their childbirth and postpartum experience, the obstetric unit or labor ward of a hospital must begin to prioritize the needs of birthing-people from diverse backgrounds who have manifold expectations and traditions associated with a successful childbirth experience.

Not only does education on the childbirth experience aid in the promotion of agency among birthing- people, but it can also help interrupt the fear, tension, and pain cycle that can occur during labor. One nurse-midwife noted the influence that education has on interrupting this cycle:

> "There's the fear, tension, pain cycle, and the more that we're afraid of an event and the more that we're tense, this can heighten the sensation of pain. I always see my role as a birth worker as somebody who can help them through the laboring process and help them break that cycle. If they are experiencing fear, practicing calming techniques, and providing them with the resources and tools to provide some comfort measures, whether that be medication pharmacologically or whether that be some non-pharm techniques. I also think education is crucial. It is important to provide anticipatory guidance. For instance, whenever I would admit a patient for labor, I would say, hey, you may see me come in here and ask you to turn to the physician really quickly, or you may see me come in here and start to get an oxygen mask for you. I always say that sometimes babies show us signs in labor that they're not loving what's happening. I'm here to help address that. And I found that providing anticipatory guidance took away some of that fear. I think it's all about how we can break that fear-tension cycle to decrease the sensation of pain. Labor is painful, no matter which way you slice it. But again, I think if you are anticipating that it's going to be painful, if you have the tools in your toolbox to help you cope with the pain, then maybe it can be a more positive experience."

Education, and the deliberate decision to inform birthing-people on how their labor may progress, or the way a caregiver may get involved, can help individuals acclimate to the unpredictable aspects of childbirth that many people fear.

It is important to note that every childbearing person does not have the same inclination to seek out information regarding the more specific and potential occurrences or outcomes of their childbirth experience. For some individuals, the familiar saying *ignorance is bliss* seems to

apply. However, one nurse-midwife noted that for those who choose to not seek out information on aspects of the childbirth experience, she is worried that they might unintentionally be left without the knowledge that they *can* make decisions about their childbirth experience and that they *can* advocate for their aspirations or needs during labor.

> "There are some people who don't take a class, whether it be because they don't have access to a class, or maybe they simply aren't interested. And you [the nurse-midwife] do feel like you lose that sense of agency because you don't know what to expect. So again, as the birth worker, it's our job to make sure that we provide that guidance. Sometimes I give a crash course in birth as I am starting the IVs. I say, okay, here's what we can expect, because you deserve to know what your body is capable of and what might go on in your body."

Additionally, many midwives inform birthing-people on how to plan and prepare childcare in advance of their due date. Again, demonstrating knowledge around what, in many ways, is in the birthing person's control, and not simply conveying what should be feared, avoided, or challenged within the American hospital system is crucial.

Promoting Agency Through Communication and Affect

There are critical ways in which midwives promote a birthing person's sense of agency through specific word choice, positive affirmations, and openly listening to their desires. For instance, when asking for consent from a patient, a midwife suggested that a caregiver should ask with the expectation of receiving a "no" not a "yes." Making space for women to say *no* is a central aspect of how midwives and doulas establish and honor the individual agency of birthing-people, restoring their sense of ownership over the event.

Another central communication tactic employed by midwives to improve the birthing person's sense of agency is to ask questions. One nurse-midwife articulated the following questions that she directs to birthing-people at prenatal appointments or before labor has progressed:

> "Asking people, you know, what are your goals? What are your pain management goals? How did you prepare for birth? Did you take classes? Did you do any special training? Are you just coming in blind, and you know, hoping for the best? That's okay. I think it's really important to ask people what they want. That should be standard. It's not. But shouldn't it be?"

Demonstrating interest to the desires of birthing-people and how they wish to experience childbirth is essential in the promotion of their individual agency. Once the midwife prompts these questions, it becomes clearer to the parties involved that childbirth is a collaborative event.

Careful word choice is important to the midwifery model of care. There were phrases used by midwives, often associated with providing support and care during labor, that were employed throughout the interviews and arose in multiple conversations with different caregivers. One nurse-midwife saw her role as being the one to "walk alongside" the birthing person throughout their labor. To "walk alongside" a birthing person, many of the midwives articulated that you must be able to honor the needs and wishes of someone in labor. The desire to be in control as the caregiver must be partially suspended. The act of "honoring" the birthing person was a central aspect of many of the responses received when asking the midwives what they deemed to be their role during childbirth. Honoring birthing-people often involves protecting their need for rest or protecting the flow and progression of their labor. A few nurse-midwives who deliver babies in hospital settings reported their role as the protector. They view the routine checks performed by physicians during labor and the adjustments of IVs and fetal monitors to be harmful interrupters of the flow of labor. Many of the midwives interviewed for this study articulated that labor is an incredibly rhythmic experience. Interrupting the flow of labor can distract the birthing person and hinder their ability to push effectively, removing aspects of their ownership over the childbirth experience. Some midwives mentioned occasions in which they physically barricaded the door with their bodies to keep a physician or nurse from intervening.

It is important to note that midwives have differing views on how they provide support and guidance for the birthing person. The action of "walking alongside" as well as "honoring" and "protecting" the birthing person throughout their childbirth experience are all invariably connected in the desire to return control and ownership to the birthing person regarding their childbirth experience. However, although rarer, some midwives see their role as "shaping" the childbirth experience. Compared to the phrasing of "walking alongside," the term "shaping" suggests a much more hands-on and directive approach to the role of the midwife. In addition, there is great variety in what people desire to receive from their midwife. Acknowledging the heterogeneous nature of the midwifery profession is essential when understanding the variety of needs that may be presented by the birthing person depending on their background and past experiences with childbirth. Those who see their role as "shaping" the childbirth experience place greater emphasis on directing the birthing person's labor. These midwives may be more present and verbal during labor, directing the birthing person on when to shift their positioning and how to engage in mindful practices during labor. Other midwives will choose to take a more reserved approach and will teach the birthing person's partner how to become the main source of support and guidance during labor. Although there are varying pedagogies within midwifery practices, all the midwives interviewed in this study identified that their top priority is listening to the needs and concerns of the birthing person before anything else. Meeting the needs and desires of every birthing person safely and through open communication is an essential aspect of returning agency to the birthing person prior to and during labor.

Often there are significant communication barriers. These barriers can range from language differences to broader cultural and religious differences. To facilitate communication between the midwife or doula and the birthing person, there must be trust. Often, trust in *your*

own kind is easier to establish, especially if you belong to a minority and/or marginalized group. One doula articulated the power of similarity in establishing trust between the caregiver and the birthing person:

> "I noticed that they [expecting mothers] don't really like to have another person [doula or midwife] if they cannot see themselves in the other person. When I come to them and I ask them if they want me to be their doula, they say, oh yes you speak Spanish, you understand my language, why not! When I ask why they didn't have a doula before they say that it is because the doulas, they are aware of are different from them and from a different culture: 'They don't understand my [the expecting mother] language, they don't understand what I am going through.'"

For some individuals, being able to see yourself in your caregiver and sharing aspects of your identity is crucial when accepting the guidance of and establishing trust in one's provider or caregiver. Knowing that someone has experienced life events similar to your own, whether that be related to one's ethnic background or home country, can aid in the development of trust and the promotion of successful and empowering modes of communication between the birthing person and their caregiver, whether that be a nurse, midwife, doula, or physician. The same doula who articulated the power of similarity in her interview told an additional story of relevance to this issue:

> "Four months ago, I was attending a birth. This was the mother's third baby, but I did not know that. [While in the early stages of labor, the mother said] Oh, I had another baby before this one. I was surprised and asked why she didn't tell me. She said it was because the baby passed away, and she said she was afraid that this baby is going to pass away because of what happened to her in the past. She told me this during her labor, and I had already known her for three months. This showed that our relationship still wasn't strong enough. But can you imagine how she would share this if it was a stranger who was helping deliver her baby? Could you imagine if there was a language barrier?"

When attempting to promote a sense of agency among birthing-people, thorough, open, and effective communication is essential. However, as articulated above, effective communication cannot occur if there isn't trust between the two individuals, especially when considering an event as potentially life-altering and traumatic as childbirth. Even though this doula shared her native language, cultural background, and many prenatal visits with this mother, the mother was

still unable to become completely vulnerable until she was physically in labor, and her body was reminded of her past trauma. Establishing trust between the patient and the providers is essential when hoping to create an open flow of communication between all parties involved in the event of childbirth.

Promoting Agency Through Advocacy

Many midwives and doulas promote the agency of birthing-people by advocating for their desires and needs. Being an advocate for a birthing person can take a variety of forms. For some, this can mean intervening and helping to redirect the course of labor to support the desires of the birthing person. In other moments, being an advocate can involve validating the needs of birthing-people, from the physical items and aesthetic pieces of their labor and delivery room to affirming their choices to resist the use of fetal monitors and other medical interventions in low-risk situations. One nurse-midwife advocated in her interview for the promotion of agency in birthing-people through supporting their participation and ownership of the event:

> "I think a good birth for a birthing person is one where they feel like they were an active participant, that it wasn't something that happened to them, that it was something that they did, and that they felt heard and empowered to make decisions that they felt were best for them and further, their baby. I think that's a good birth. You know, I think we can look at all the outcomes and make sure that everything was, you know, safe and, and right, healthy, and happy, etc. But I think it boils down to that, that feeling of empowerment and that feeling of being involved in the birthing process, because I've seen so many births, births where, you know, I've gone in and asked people what are your goals? And they say, I'm just here to have a baby. I think that's an aspect of American culture. We've been taught so long that birth is just like, you show up, and then you have a baby. And that's it. Right? One of my favorite quotes is the day you have a baby, you don't just meet a baby, you meet the new version of yourself, and that's 100% true. It's something I never realized until I was a mom myself. But I think that all has to come to play, that feeling of like, you're allowed to be who you need to be. That's a good birth."

From the perspective of this nurse-midwife and the other birth workers interviewed in this study, advocating for the active involvement of the birthing person throughout a potentially once-in-a-lifetime experience is essential. Part of supporting this passage into motherhood as a midwife is making it clear to nurses and physicians, along with the birthing person, that this passage can and

should be honored; It is not selfish to want to have a positive experience during childbirth that expands beyond the outcome of a healthy baby.

It was repeatedly stated throughout several interviews with midwives that intravenous therapy (IV) and fetal monitors are a central symbol of biomedical control over the childbirth experience in the United States. Not only do fetal monitors help establish the superiority of biomedicine over the body, but they can remove an aspect of the birthing person's agency and sense of ownership over the childbirth experience. The purpose of fetal monitors is to measure the baby's heart rate and the birthing person's contractions. They are attached either internally or externally. They become especially important when observing the pattern of a baby's irregular heartbeat. An irregular heartbeat may be a sign that there is a lack of oxygen reaching the baby, and that an issue may be arising within the uterus (Hopkins, 2019). Although electronic fetal monitoring can reassure birthing-people of their child's health during labor, The Cleveland Clinic highlights that for low-risk pregnancies, along with healthy and unmedicated pregnancies, electronic fetal monitoring is not a necessity (Cleveland Clinic, n.d.). Even though electronic fetal monitoring is not essential in many birth situations, several midwives mentioned its overuse in hospital settings. In addition, midwives noted that attaching a birthing person to this equipment significantly limits their ability to move around and get out of bed during labor. Limiting one's range of movement can affect an individual's sense of agency and creates an artificially imposed dependency on technology. The inability to leave the hospital bed to use the restroom or walk through the birth unit to help induce labor places a false sense of reliance on an entity outside of the birthing person's own body. Both midwives and doulas view the high rate of employment of this technology as a harmful demonstration of a lack of trust in a birthing-person's innate abilities.

IVs are used during labor to administer fluids, pain medications, or induction hormones like Pitocin. Throughout the interviews with midwives, many articulated the routine use and restricting nature of this equipment. One midwife noted that the IV “only provides a teaspoon of sugar over eight hours.” As childbirth requires an incredible amount of energy, the fluids provided through IVs are not enough to support the nutrient needs of a birthing person. In addition, when receiving IVs, one is not able to eat or drink. Limiting areas in which birthing-people may turn for a sense of comfort and control, like foods and beverages, has the potential to hinder one's sense of agency. Even though the use of IVs in childbirth settings has become somewhat ubiquitous: “The American Congress of Obstetricians and Gynecologists (ACOG), the World Health Organization (WHO), and the American Society of Anesthesiologists (ASA) all recommend offering and encouraging fluids by mouth to laboring people in place of a routine IV. And yet, many people still routinely receive IV fluids in labor and birth” (Terreri, 2018). Placing additional and often unnecessary restrictions on movement, hydration, and sources of comfort, is not productive in the promotion of a birthing person's sense of agency. Midwives often find themselves in the position of advocating for the agency, comfort, and desires of the birthing person, specifically within the context of electronic fetal monitors and IVs.

Throughout many interviews, midwives expressed the frustration that hospitals do not pay enough attention to the cultivation of comfortable spaces for their patients. As a result, it is common for midwives to advocate for altering the physical space of the hospital room to create a more pleasant and warm environment for the birthing person. To achieve this welcoming and homier space, midwives noted that they bring in their own supply of string lights, tapestries, and pillows, adding more color and vibrancy to a traditionally white-walled and fluorescently lit delivery room. In addition, hospitals often center the bed within the room, making it appear as

though the bed is the primary place in which labor can and should take place. One midwife suggested that hospitals should move the bed to the side of the room. This provides more space for the birthing person to walk around and act on their own accord, allowing them to take more comfortable positions on the floor or on a birthing ball if they desire. Creating more space for movement not only promotes the agency of a birthing person, but can also aid in the progression of labor. Another nurse-midwife noted that she will ask to hide some of the unessential medical equipment in a closet or cover the cold metal machines with a patterned blanket. She mentioned that many people have negative associations with hospital settings, and often conflate the space with sickness, death, and dying. Removing medical equipment from sight within the delivery room can aid in the creation of a more positive, comfortable, and uplifting space in which a birthing person can enter a new stage of life and take ownership of the experience.

Midwives also suggested connections between the provisioning of meaningful physical items and the promotion of comfort and well-being throughout the labor and delivery process. Many noted that warm foods and drinks, specifically in Hispanic and some Asian traditions, are an important part of the healing and recovery process after childbirth. It was mentioned that some mothers, also belonging to Asian cultures, would make food for their daughters to be delivered after labor. Often, they delivered soups and red raspberry leaf tea. However, midwives and doulas expressed that there are many barriers in place to discourage birthing-people and their families from bringing food and drink into the birthing suite. Women were first advised in the mid-20th century to fast prior to childbirth as they received general anesthesia before labor; this procedure was routine at the time to avoid aspiration (Beggs, 2002). Even though practices around childbirth in hospitals have shifted away from the administration of general anesthesia, remnants of this dated practice persist (Beggs, 2002). Today, there is great debate surrounding

the consumption of food and liquids during childbirth, especially in relation to low-risk pregnancies (Dekker, 2022). However, there is no conclusive data that demonstrates eating around the event of childbirth is unhealthy or should be avoided (Dekker, 2022). In fact, in a study produced by Rooks et al. in 1989, when people were given the choice to eat and drink during labor, only 5% chose not to (Dekker, 2022). As childbirth is often compared to running a marathon, this is no surprise. Many of the birth workers interviewed for this study shared that discouraging birthing-people from consuming food limits the capacity of some individuals to heal and feel as though they have entered the recovery phase after childbirth. The inability to make these decisions surrounding postpartum care has the potential to limit one's sense of agency and ownership over their childbirth experience. Often midwives are the ones to advocate for the necessity of these items against the wishes of nurses and physicians.

One midwife who practices has attended many home births throughout her career told a story of a woman who chose to play gospel music throughout her home during labor. While telling her story, the midwife underlined how the ability to play one's own music aloud during childbirth is somewhat contingent upon not having a hospital birth. Giving birth at home grants the birthing person greater control over the more minute but influential aspects of their childbirth. When aesthetics and particular sensory inputs like music are important to the individual in labor, the midwife must advocate for these needs when working in a hospital setting. Other midwives reported that women often turn to scripture, bible verses, and folk stories to provide greater comfort and ease. This outlet is more accessible within a hospital environment.

On some occasions, especially when language is not shared between the birthing person and the physician, it becomes the responsibility of midwives to advocate for what the birthing person *does not* desire to experience during childbirth. One doula described an experience she

had with a birthing person who was encountering the United States medical system for the first time during the birth of her first child. It is important to note that the birthing person did not speak English and the doula was translating what she vocalized:

> "I remember one time one of the nurses brought a huge yoga ball. The mother told me she didn't want to use the ball, and that she was afraid of falling on it. I told the nurse that she did not want to use the ball and told the mother that she could get up and move around as she pleased. The nurse kept on encouraging the use of the ball, and I kept saying she didn't want to use it. The nurse said she didn't hear her and was asking if I was just suggesting she didn't want it. I said I was translating for her what I heard. It was sad, but I try not to dwell on those negative moments."

Protecting the decision-making powers of every birthing person is a key aspect of the work of doulas and midwives in the promotion of agency. There is an apparent lack of empathy and understanding regarding the comfort of the birthing person from the perspective of this nurse. Completely disregarding the doula's translation of the birthing person's preferences is shameful. In this situation, it became this doula's role to advocate for the birthing person's right to resist suggestions made by healthcare professionals. In addition, many of the individuals this doula works with recently immigrated to the United States, are without permanent housing and do not have relatives nearby to provide comfort and support. As a result, this doula often sees herself as the primary or only advocate for birthing-people. She often refers to herself as "another mother or sister" to a birthing person, working beyond the point of advocate and supporter, and into the realm of birth partner, family member, or even sister.

Chapter Six: Conclusions

The knowledge gleaned from this study has shed light on how a sense of agency is both promoted and inhibited within a birthing person throughout the childbirth experience and into early post-partum. Among birthing-people, many of the interlocutors shared that they were not aware of their capacity to have agency during childbirth. Considering their previous experiences with physicians and medical care, many birthing-people were not informed or conscious of the fact that they could have control over aspects of their labor progression and the degree of medical intervention that they were exposed to, for instance. It was found that establishing the understanding that as the birthing-person you have the capacity and ability to be agents of your childbirth experience was incredibly important when considering how to promote and advocate for the agency of birthing- people. Midwives and doulas shared that it was often their responsibility to demonstrate to patients that they could make decisions regarding the administration of pain medication or the use of fetal monitors.

Building trust between the birthing-person and their provider, whether that be a midwife, obstetrician, or doula, was shown to be integral to the development of a sense of agency in birthing-people. Interestingly, from the perspective of the birthing-person, knowing your provider also has trust in your body and the ability to deliver a healthy baby was shown to be just as important. In addition, developing birth plans and alternative birth plans with providers and other birth partners allowed people to feel in control and cope with deviations from their original birth plan. Developing a birth plan was also shown to be valued among birthing-people because it designated time with their provider to consider, outline, and actualize their needs and desires leading up to their labor. As a result, demonstrating one’s hopes for their childbirth experience and them being received and considered by their providers aided in the promotion of a sense of

agency among the birthing-people interviewed in this study. In addition, preparing and allowing oneself, as the birthing person, to accept the often-inevitable shifts and changes that occur during labor was crucial for many mothers when understanding that their childbirth experience was not a failure and that deviations from an original birth plan can provide the opportunity to demonstrate strength and resiliency.

Attending childbirth education courses and seeking information on the experience of childbirth helped many interlocutors access a sense of agency during childbirth. Many women reported that the sense of control and agency they gained due to the knowledge they acquired from their providers and childbirth education courses made them feel more capable to ask questions, demonstrate their needs, and request assistance from partners and other caregivers during labor. In addition, effective communication between caregivers and birthing-people was also essential in the development of a sense of agency among birthing-people. Beginning at prenatal appointments and continuing into the post-partum period, a lack of communication between healthcare providers and their patients leads to feelings of inadequacy and loneliness among birthing-people. In addition, sensing a lack of communication between oneself and their providers was shown to make birthing-people feel helpless and misunderstood, which also inhibited their sense of agency throughout childbirth and into the recovery period post-partum. This was especially true among mothers who suffered both physical, emotional, and mental ailments during the early post-partum period.

Having a say in where you deliver your child and who attends your childbirth, including the decision to have a midwife, was an additional way interlocutors reported having a sense of agency and control over their childbirth experience. Often associated with decisions related to the birth location was possessing a certain level of freedom. The interlocutors reported they

found great value in the following freedoms, which were often granted within the context of home births: playing music or tapes during labor, filming their child's birth, directing the flow of individuals in and out of the delivery room, and having both outdoor and indoor space to walk and move through contractions.

Being around others and potentially large groups during labor and throughout the post-partum period was of considerable value for many of the interlocutors. Social proximity, and the act of being around others and in community during labor granted birthing-people a stronger sense of attachment to their ancestry and identity, and the strength of the women in their lives. In addition, social proximity helped birthing-people feel supported throughout labor and into the early post-partum period as friends and relatives were present to affirm their experiences, provide meals, and help take care of the newborn. The presence of both family members and healthcare providers who conveyed their support through words of encouragement helped many birthing-people feel more capable and comfortable during childbirth. While receiving these external affirmations, birthing-people felt more confident to proceed with their labor and provide care for their newborn, which aided in both their sense of confidence and control throughout the childbirth experience. For some birthing-people, however, being relatively alone and in silence was much preferred to being in the presence of large groups, as these individuals viewed the childbirth experience as a much more internal event. There was no clear pattern of cultural and/or religious backgrounds that preferred silence and more intimate childbirth experiences; this preference was primarily observed on the individual level. However, interlocutors shared that having the choice to decide how many individuals are present at their labor provided an additional scenario in which they could exercise their sense of agency.

Agency was hindered among birthing-people when they felt pressure to closely follow the philosophies of the natural birth community. Interlocutors mentioned that this pressure arose either because they feared the judgment directed towards them from the community, or because their mother or siblings had delivered naturally, and they desired to exhibit a similar level of strength and "womanhood." In addition, both midwives and doulas mentioned that they often witnessed agency being taken away from birthing-people when physicians or nurses pressured their patients to accept an epidural or to be induced, often without an explanation from their provider. Birth workers also noted that the overuse of fetal monitors and the presence of additional medical equipment and cameras limited the birthing-persons freedom of movement and comfort level within the delivery room, which then hindered their sense of agency throughout the childbirth experience. Lastly, agency was inhibited among birthing-people who did not have access to particular resources. These resources range from supportive family members, parents, and siblings, to midwives, doulas, and effective childbirth education courses. The inaccessibility of these resources can be attributed to one's immigration status, socioeconomic status, and other impending life circumstances or responsibilities.

It is apparent from my study that exposure to childbirth, by way of informal conversations, cultural and religious rituals, or attending the childbirth of a family member or friend, is uncommon within the United States. Almost all the interlocutors engaged in this study reported that they felt relatively ignorant of the childbirth experience and what it would entail both physically and emotionally, even up to the date of their delivery. This suggests that the childbirth experience is underrepresented and underappreciated within the culture of the United States, which is likely contributing to the lack of discussion around agency during childbirth as well.

Chapter Seven: Discussion and Limitations

Limitations

Although the number of people interviewed for this study was substantial, the claims would be strengthened with a greater number of interlocutors. In addition, the focus was primarily on the care provided by midwives and doulas and did not include the first-person perspectives of nurses and physicians. If one were to expand this research, putting midwives and doulas in conversation with nurses and physicians would be beneficial. However, the choice to center the perspectives of midwives and doulas was intentional, as their perspectives have been silenced for decades, and their model of care is continually misunderstood and underrepresented. Lastly, there are ethical boundaries in place that make it difficult to observe childbirth first-hand as a researcher. While still respecting these boundaries, one could conduct participant observation in birthing classes, or examine childbirth preparation booklets or Facebook groups. To expand on the data gathered from interviews, it could be beneficial to consult these primary resources.

Accessibility Concerns

The question of accessibility is directly related to issues of health justice and equity. Because having access to particular resources is essential in the promotion and development of a sense of agency among birthing-people, health justice, and equity are then directly tied to questions of agency as well. The relationship between health equity, accessibility, and agency, forms a triangle. The outcomes of this study suggest that it would be beneficial to consider agency as an appropriate focal metric of justice, specifically within the context of the childbirth experience within the United States (M'hamdi, 2021). Midwives, doulas, hospital translators, and

other birth workers, who were found to be critical advocates, educators, and communicators throughout the childbirth experience, are relatively low in numbers and often require out-of-pocket costs (hospital translators are free, but do not meet demonstrated need) (Graziadei-Shup, 2021). Access to prenatal and maternity services, which includes appointments with obstetricians and midwives to develop birth plans, is also becoming more and more difficult to access, specifically in poor and rural communities (Treisman, 2022). In addition, childbirth education courses, especially those that exist outside of the hospital system and those catering to more alternative birthing styles, require hundreds of dollars to attend (Lindberg, 2023). As barriers to affordable and accessible care persist, the maternal mortality rate within the United States increased by 40% between the years 2019 and 2020 (Hoyert, 2023). This increase is especially devasting among Hispanic and African American individuals (Howard, 2023). If the goal is to improve agency among birthing-people, accessibility, and the freedom to attain essential resources, must be addressed.

Recommendations

The Role of Culturally Competent Care in Improving the Agency of Birthing-People

Culturally competent care can be defined as: “the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt, 2002, para.1). Providing culturally competent care within the context of childbirth in the United States is complex. This is especially true when one considers how the event of childbirth has become medicalized in this country. The majority of childbirths in the United States take place within a hospital, and the hospital system functions almost entirely within a biomedical framework. Historically, there has been very little space to integrate non-Western diagnostic and healing practices within these contexts. More research is

needed in terms of how to better integrate cultural practices and traditions within the healthcare field in the United States, specifically by those called to deliver a child and support a new mother. The United States Census uses the Diversity Index (DI): "to measure the probability that two people chosen at random will be from different racial and ethnic groups." Within the United States this probability has grown substantially: "Using the same Diversity Index calculation from 2020 and 2010 redistricting data, the chance that two people chosen at random will be from different racial or ethnic groups has increased to 61.1% in 2020 from 54.9% in 2010." (Tableau, 2023) The rate of cultural diversity is only increasing in the United States. Healthcare workers in this country must be prepared for this shift and are trained in cultural literacy. For a birthing person to have a sense of agency throughout childbirth, understanding, as their provider, the influence that culture and identity *might* have on their desired childbirth experience and birth plan is imperative. Birthing-people must be made to feel like their expectations and needs are tended to and met to the best of the provider's ability.

Along with promoting culturally competent systems of care, this paragraph provides preliminary suggestions related to how the agency of birthing-people can be improved during childbirth and into the post-partum period. Prenatal appointments should be universally covered by insurance as they support birthing-people and their providers in establishing trust and confidence in one another. In addition, prenatal appointments are also essential in the development of birth plans and alternate birth plans. Secondly, hospitals and birthing centers should provide free, recorded, and in-person childbirth education courses that cover the broad spectrum of birthing styles, techniques, and philosophies. Lastly, when considering how to improve the agency of birthing-people, ensuring that every birthing-person feels like there is an

individual in the delivery room that understands their needs and can advocate for them is essential.

Conclusionary Remarks

In concluding this section, I would like to thank all the women that shared their birth stories with me, from the moments of pure joy and triumph to the mental, emotional, and physical challenges that they experienced during childbirth. Throughout the interview process, I was struck by the vulnerability people displayed, and the gratitude that was directed toward this research and the goals of the project. Many women shared that they were thankful for the opportunity to share their childbirth experience and that being granted a space in which to share their experiences was rare. The understanding among birthing-people that sharing birth stories is a rare occurrence suggests a variety of issues within our cultural understandings of childbirth, specifically within the United States. Women's bodies are both hypersexualized and heavily censored and policed. In addition, reproductive and women's health is not only stigmatized and mythologized but is dominated by sexual prejudice and high rates of misdiagnoses and physician negligence. We must continue to prioritize the voices of birthing-people and facilitate conversations on even the most minute aspects of the childbirth experience, which can be essential in the making of a positive and "good" birth.

Appendix I

Oral Consent Form

Title: Recentering the Voices of Birthing People and Birth Workers; Narratives of Childbirth

IRB #: 00004947

Principal Investigator: Dr. Chikako Ozawa-de Silva, PhD, Department of Anthropology

Faculty Advisor: Dr. Chikako Ozawa-de Silva

Introduction and Study Overview

Thank you for your interest in our research study on birth stories. We would like to tell you what you need to think about before you choose whether or not to join the study. It is your choice. If you choose to join, you can change your mind later on and leave the study.

I am interested in how the event of childbirth is understood, expressed, and experienced depending on culture, context, racial identity and/or ethnic background. The research is engaging in questions related to the presence or absence of agency during childbirth, in addition to how agency is promoted or inhibited within the birthing person from the prenatal period to post-partum. An additional purpose of this study is to gain a better understanding of how pain, anxiety, and fear is expressed, or not expressed, during childbirth. Lastly, I am interested in taking a cross-cultural perspective on how a pregnant-persons expectations or desires for a "good" or "natural" birth may inform their labor experience and further reflections on the event postpartum. This study will take six-seven months to complete.

If you join, you will be asked questions related to the aforementioned issues and topics. You will then be asked to answer the questions from your point of view and personal experience. Your interview period will last no longer than forty-five minutes.

You may not benefit from joining the study. This study is designed to learn more about how labor pain and the notion of a "good birth" is understood and experienced by birthing people and midwives who occupy various cultural contexts and familiarities. The study results may be used to help others in the future.

One of the potential risks of participating in this study are related to emotional and psychological vulnerability or discomfort. However, it is the participant that decides how vulnerable they choose to be in their responses. This aspect of the interview is completely in the participant's control. There is also the risk of a breach in confidentiality. However, we have taken may steps to mitigate this risk including de-identifying data and keeping all data and analysis tools within a locked device so that one's information is protected and secure.

Storing and Sharing your Information

We will store all the data and information that you provide using a code. We need this code so that we can keep track of your data over time. This code will not include information that can

identify you. Specifically, it will not include your name, initials, date of birth, or medical record number. We will keep a file that links this code to your identifiers in a secure location separate from the data.

We will not allow your name and any other fact that might point to you to appear when we present or publish the results of this study.

Your data may be useful for other research being done by investigators at Emory or elsewhere. We may share the data linked by the study code, with other researchers at Emory, or with researchers at other institutions that maintain at least the same level of data security that we maintain at Emory. We will not share the link between the study code and your identity.

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 Compliance]. Study funders may also look at your study records. 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.

People Who will Use/Disclose Your Information:

The following people and groups will use and disclose your information in connection with the research study:

- The Principal Investigator and the research staff will use and disclose your information to conduct the study.
- Emory may use and disclose your information to run normal business operations.
- The Principal Investigator and research staff will share your information with other people and groups to help conduct the study or to provide oversight for the study.
- The following people and groups will use your information to make sure the research is done correctly and safely:
    - Emory offices that are part of the Human Research Participant Protection Program and those that are involved in study administration and billing. These include the Emory IRB, the Emory Research and Healthcare Compliance Offices, and the Emory Office for Clinical Research.
    - Government agencies that regulate the research including Office for Human Research Protections
    - Research monitors and reviewer.
    - Accreditation agencies.
- Sometimes a Principal Investigator or other researcher moves to a different institution. If this happens, your information may be shared with that new institution and their oversight offices. Information will be shared securely and under a legal agreement to ensure it continues to be used under the terms of this consent.

Contact Information

If you have questions about the study procedures, appointments, research-related injuries or bad reactions, or other questions or concerns about the research or your part in it, contact Natalie McGrath

This study has been reviewed by an ethics committee to ensure the protection of research participants. If you have questions about your **rights as a research participant**, or if you have **complaints** about the research or an issue you would rather discuss with someone outside the research team, contact the Emory Institutional Review Board at 404-712-0720 or 877-503-9797 or irb@emory.edu.

To tell the IRB about your experience as a research participant, fill out the Research Participant Survey at **https://tinyurl.com/ycewgkke.**

Consent

Do you have any questions about anything I just said? Were there any parts that seemed unclear?

Do you agree to take part in the study?

Participant agrees to participate: Yes No

If Yes:

_____
Name of Participant

Signature of Person Conducting Informed Consent Discussion Date Time

Natalie McGrath
Name of Person Conducting Informed Consent Discussion

Appendix II

Interview Guide for Birthing-People

1. What adjectives would you use to describe the labor experience?
2. Have you given birth more than once?
    a. If yes, where have you given birth in the past?
        i. Describe…
            1. Context
            2. Environment (birthing center, home birth, hospital, etc.)
    b. What kind of delivery did you have?
        i. Describe…
            1. cesarean, epidural, vaginal etc.
3. What previous exposure have you had to birth?
    a. Were you present for the birth of any of your siblings, family members, or other members of your community?
4. How would you define a "good" birth?
    a. If you have given birth before, would you define it as such?
5. Where would you begin telling your birth story?
6. What mattered to you during your labor?
        i. Describe…
            1. Control/Agency
            2. Safety/Comfortability
            3. Decisions-made
7. How could your labor experience be improved?
        i. Describe…
            1. Setting
            2. Support
            3. Control
8. What did you hope you would be able to control about your labor experience before giving birth?
9. What did you feel you had control over while in labor?
    a. What did that control look like?
    b. What did you feel was in your power?
10. How were decisions made on the use of pain medication during labor?
    a. How do you feel about how these decisions were made?
    b. How/who weighed in on these decisions?
11. Were there any cultural traditions embedded or incorporated into any aspect of your pregnancy labor, or postpartum experience?
    a. If yes, what purpose did they serve? Please elaborate.
    b. If yes, were any of these traditions help ease pain or discomfort, either physical or psychological, during your labor?
11. Did you seek out any of your providers (midwife, doula, obstetrician, etc.) based

on commonalities related to cultural background or identity.

a. What informed this decision for you?
b. Do you think this choice has affected the quality of care you have received? in terms of shared identity and life experiences?

Sample Interview Questions (closing)

1. What would you like to see change about how pain is managed during labor?
2. What do you hope everyone could have access to when giving labor?
3. Would you be comfortable elaborating on _____?
    a. This is an opportunity for the researcher to follow-up with the interviewee on issues/moments that would benefit from further inquiry.

3. From your perspective, is there anything I didn't ask about but should've? Anything you want to ask me? If you have any questions?

Appendix III

Interview Guide for Birth Workers

1. What is your role as a midwife/doula/nurse-midwife?
    a. Describe…
        i. Antepartum (during pregnancy)
        ii. During labor
        iii. Postpartum
2. Why did you become a birth worker? How are you connected to this profession?
3. How would you define a "good" birth?
    a. Generally, how would you say your clients define a "good" birth?
4. How do you see fear and anxiety playing into the experience of pain, and why?
    a. Describe…
        i. Doubt
        ii. Control/Agency
5. How do you think a birthing person's sense of control impacts the experience of pain?
6. How do you promote or support the birthing person's sense of control or agency during their labor experience?
7. How does one's sense of control, or where it might manifest, differ from person to person?
8. Are there any cultural traditions embedded or incorporated into any aspect of your pregnancy labor, or postpartum services?
    a. If yes, what purpose did they serve? Please elaborate.
    b. If yes, are any of these traditions used to ease maternal pain or discomfort, either physical or psychological?
    c. Do any of these traditions or services address or improve the birthing person's agency or control over their labor experience?

8. Do you think people ever seek you (midwife) out based on any commonalities, whether that be related to cultural background or identity?
        i. If yes, why?

Sample Interview Questions (closing)

4. What would you like to see change about how pain is managed during labor?
5. What do you hope everyone could have access to when giving labor?
6. Would you be comfortable elaborating on _____?
    b. This is an opportunity for the researcher to follow-up with the interviewee on issues/moments that would benefit from further inquiry.

3. From your perspective, is there anything I didn't ask about but should've? Anything you want to ask me? If you have any questions?

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