

Conceiving Women: Childbirth Ideologies in Popular Literature

by

Cherie Toronchuk
B.A., University of British Columbia, 2012

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Supervisory Committee

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Supervisor

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Abstract

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North American research on childbearing demonstrates that many first-time mothers rely on educational books for information and advice concerning pregnancy and childbirth. Popular literature on childbearing advises women on a variety of topics including choosing a caregiver, prenatal testing, safety and risk, natural vs. medicated labour, and place of birth. Such information may shape women's expectations, choices, and belief systems regarding the body, obstetric technology, pregnancy and birth. These varied forces and belief systems coalesce to influence the ways in which women experience birth, thereby affecting post-natal mental, socioemotional, and physical health. Currently, however, research exploring the various messages disseminated by popular literature on pregnancy and birth is limited. In this study, the author examines four popular North American childbearing advice books for discourses related to biomedical and midwifery cultures, ways of knowing, power, and choice. Discourses are considered through a feminist intersectional framework, with particular attention paid to the ways in which childbearing ideologies are shaped by interactive biological, socio-cultural, economic, and political factors. The author explores how power matrices and the privileging of biomedical knowledge can shape conceptualizations of gender and sexuality, women's bodies, maternity care, pregnancy, labour, and birth. In addition, peripheral discourses that provide possibilities for other, non-normative narratives of birth are highlighted.

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Dedication

For the women I have met along the way - friends, mothers, mentors.
I carry your stories of courage with me.

Chapter 1: Introduction

Much can be taught through the telling of stories; indeed, the narratives we tell have the ability to educate, indoctrinate, empower, control, and encourage, among other things. This may be particularly true with respect to accounts of pregnancy and birth. As Mercer, Green-Jarvis, and Brannigan (2012) state, “women emerge from birth with a baby as well as a story” (p. 717). Birth stories are influenced by a myriad of factors, including the environment in which they unfold, women’s histories and perspectives, power and control, key players (such as caregivers, partners, and families), information, and expectations. Each aspect of a woman’s birth story is shaped by a multitude of other, intersecting, stories – the ones that she tells herself, and those that she is told by others. These stories may exert a multidirectional influence on one another; for example, North American research demonstrates that many first-time mothers rely on books for information and advice concerning pregnancy and childbirth (Clark & Gross, 2004; Declercq, Sakala, Corry, & Applebaum, 2006; Shieh, McDaniel, & Ke, 2009; Torres, De Vries, & Low, 2014). The stories told by popular literature on childbearing may shape a woman’s expectations, beliefs, and choices with respect to pregnancy, labor, and birth, thereby becoming part of her story. In this way, stories beget stories.

Where Do Our Stories Come From? What is My Story?

The stories told by books on pregnancy and birth, however, are not unbiased ones. Childbearing ideologies are steeped in socio-cultural, economic, and political dogma. In North America, matrices of power privilege a Eurocentric, biomedical approach to childbirth, often turning a blind eye to women’s diverse experiences, and to their varying needs or feelings about the pregnancy and birth (Cahill, 2000; Davis-Floyd, 1990; Kitzinger, 2005; Kitzinger, 2012; Reiger & Dempsey, 2006). For instance, research by Larkin, Begley, and Devane (2012) finds

that women who give birth in a hospital environment may be less likely to receive woman-centered care (WCC - that is, maternity care which gives priority to the desires and requirements of women, and promotes informed choice, continuity of care, and user control [Cameron, 2009; Pope, Graham, & Patel, 2001]). As a result, these women may feel alone and unsupported, and rate their care as less satisfactory than those receiving WCC (Iida, Horiuchi, & Porter, 2012; Larkin et al., 2012). Satisfaction with the labor and delivery experience, and the care received throughout, has important implications for women's post-natal socioemotional, physical, and mental health (Forssén, 2012; Goer, 1999; Mikkonen & Raphael, 2010; World Health Organization, 2014). In their longitudinal study of postpartum depression (PPD), Benoit, Westfall, Treloar, Phillips, and Jansson (2007) found that low levels of satisfaction with the birth experience increased women's risk of developing PPD. Thus, the meaning that is assigned to, and the narratives that form around, the birth experience, have the power to support, heal, define, harm, and/or challenge women.

Despite the powerful implications of the narratives that women learn about childbearing, there is little research exploring the various messages of popular literature on pregnancy and childbirth. My own experiences and interactions with women have consistently highlighted the relevancy of stories told by childbearing advice texts. As a woman of childbearing age, child and youth care graduate student, and UBC midwifery student, I have had many conversations with women around pregnancy and birth. In fact, I have found that mentioning my interest in midwifery and maternity care has often resulted in women disclosing their birth stories, or the stories of friends, sisters, and mothers. I am consistently honoured, and in awe, that so many women have trusted me with deeply personal birth stories of power, struggle, elation, and frustration; I have learned a great deal from these narratives, including the enormous potential

that the stories of others hold to foster a complex array of questions, intentions, and emotions. Both strength and fear, for example, may come into relief under certain circumstances, or in particular contexts. Indeed, the conversation that became the impetus for this thesis concerned the anxiety-provoking stories told by a popular pregnancy book, which aimed to educate childbearing women. A close friend of mine, newly pregnant with her second child, had borrowed a copy of this best-selling advice book. As an avid reader and feminist with a keen interest in the topic, I was curious what she thought of it. Her answer was decisive: “If you get pregnant, don’t *ever* read this book.” She explained how the book had scared her, providing her with information on possibilities she had not known she should be worried about. Intrigued, I began to research the text, stumbling in the process onto Naomi Wolf’s *Misconceptions*, and *Birth Matters* by Ina May Gaskin, among others. The breadth of childbearing ideologies, and the differing care provided by those who subscribed to them, surprised me; I began to understand that the stories told by pregnancy literature were, in large part, shaped by sociocultural constructs and affective politics. With this realization, I saw a need for qualitative research highlighting the ideologies of texts related to childbearing.

My thesis, grounded in critical intersectional feminist theory, explores the dominant ideologies espoused by best-selling advice books on pregnancy and birth. Specifically, I examine four popular North American childbearing advice texts for discourses related to biomedical and midwifery cultures, ways of knowing, power, and choice. In doing so, I use critical discourse analysis to contemplate the ways in which childbearing ideologies are shaped by interactive socio-cultural, economic, and political factors, among others. Throughout this thesis I refer to multiple aspects and conceptualizations of childbearing, and employ terms such as discourses, stories, scripts, practices, processes, and ideological approaches. My intention is not to use these

terms interchangeably. Although the discourses of birth literature, the social scripts of mothers, women's birth stories, the physiological processes of pregnancy/birth, and ideological approaches to birth practices, are all intertwined and influence one another, they are not a singular concept. For instance, the discourses of childbearing texts and the social scripts of mothers may reveal taken-for-granted assumptions and power interests, while women's birth stories may pay attention to subjective experiences of satisfaction, family, and care. The physiological processes of childbearing might concern biological changes, health and wellness, and the mind-body connection, while ideological approaches to birth may reflect historical processes, gender expectations, and colonialism. In order to complexify conceptualizations of pregnancy, birth, and motherhood, and highlight their relationship to sociopolitical factors, I ask questions such as: How are dominant sociopolitical ideologies reflected in popular literature on pregnancy and birth? How do such ideologies shape women's expectations and experiences of birth? How are certain types of knowledge/bodies/ways of knowing and doing privileged over others? What are the social scripts assigned to childbearing women, and how are these communicated through advice literature? The intersectional quality of these questions is congruent with my goal of amplifying the sociopolitical nature of birth through a critical discourse analysis; thus, in this study, feminist intersectionality theory is used as the critical theoretical lens through which birth discourses in popular literature are considered.

Rationale: Enhancing the Visibility of Birth Culture in a Patriarchal Technocracy

This study of dominant and marginalized discourses in childbearing literature is necessary for several reasons. As previously noted, childbearing ideologies are shaped by a number of intersecting factors, including culture, socioeconomic systems, location and context, race, gender, and power. These factors, however, are often rendered invisible in maternity care;

the forces that shape a “normal,” “standard” experience are frequently obscured by the cultural microcosm in which women live. In Canada and the USA, for instance, women who are poor or marginalized may lack access to health care, limiting their choice of caregiver, place of birth, and availability of obstetric procedures (Dillaway & Brubaker, 2006; Rudrum, 2012). This absence of choice may produce a “normal” experience that is classed and racialized, and that deviates from the standard experience of more privileged women. For middle-class, white, North American women, a normal experience is generally thought to include one or more of the following: consistent monitoring of the mother and fetus’s physical health by a doctor (or, less commonly, a midwife) throughout the pregnancy, delivery in a hospital, and the application of obstetrical interventions (such as induction, electronic fetal monitoring, intravenous catheter, pitocin, epidurals, episiotomies, vacuum/forceps extraction, Cesarean section). Adopted as standard by Western countries in the 20th century, these procedures evidence a view of childbearing as a treacherous process requiring the management of medical experts (Buitendijk, 2011; Cheyney, 2011; Kitzinger, 2005; Lee, Kirkman, & Kirkman, 2008; Viisainen, 2000).

When birth is framed as a dangerous process, a culture of fear is created in which pregnant and birthing women question the intentions and capabilities of their own bodies (Cahill, 2000; Hausman, 2005). In their study of Canadian university students, Stoll, Hall, Janssen, and Carty (2014) found that students who perceived birth as inherently risky held erroneous, overly optimistic beliefs about obstetric interventions, and had significantly more fear of the birth process. In fact, Stoll et al. (2014) report that

Students who learned about pregnancy and birth through the media alone had the highest fear scores...one media analysis found that popular birthing shows tended to over-represent the occurrence of obstetric complications and depict birth as a dangerous

event...Mass-mediated and internalized cultural norms about birth as unpredictable, risky, and in need of technological intervention perpetuate a climate of fear surrounding birth. (p. 5)

Wide cultural acceptance of these ideas builds on deeply entrenched patriarchal social norms: the female body is viewed as untrustworthy, incapable, and subordinate to the male body. Historically, these beliefs may be traced back to early European religious authorities, philosophers, and scientists, all of whom extolled the superiority of the male body (Cahill, 2000; Davis-Floyd, 2003). Such perspectives have firmly established the white, heterosexual male body as the central prototype, an ideal against which to compare and define the female body (and indeed, all other bodies). As Davis-Floyd (2003) notes,

Insofar as it deviated from the male standard, the female body was regarded as abnormal, inherently defective, and dangerously under the influence of nature, which due to its unpredictability and its occasional monstrosities, was itself regarded as inherently defective and in need of constant manipulation by man. (p. 51)

With its curves and dips, seeming unpredictability, and wildness (i.e. emotional range), the female body evokes strong images of the natural world. Under white, Cartesian, settler logic, both women and nature (and any non-white body) can be viewed as the property of men (de Finney, 2014). Manipulation and control of the female body has thus been synonymous with the domination of nature. Cartesian North American value systems rest upon the tenet that man is superior to nature, and that he must therefore control and contain it; this is accomplished through unilateral claims to “scientific,” “medical” knowledge, as well as through the use of machines and technology.

In fact, technology has become so much a part of our conceptual systems that researchers

have labeled North America a “technocracy” (Davis-Floyd, 1994; Reynolds, 1991). Technocratic beliefs and values necessitate a reconceptualization of childbearing, such that it becomes congruent with hegemonic conceptual systems. Reframing childbirth to fit within a technocratic belief system allows for the maintenance of social control, while also serving the vested interests of capitalist institutions. Birth is big business, particularly in North America. According to a recent article in the New York Times, obstetrical procedures and care in the United States account for more than \$50 billion in healthcare spending annually (Rosenthal, 2013). Within the business of obstetrics, however, not all types of care are monetarily equal. As Kitzinger (2005) reports, “estimates [are] that an elective Caesarian costs twice as much as a hospital delivery without complications, and a home birth costs half as much as a hospital birth” (p. 75). Maternity care that relies upon highly technological interventions is costly, and, despite limited evidence of improvement in outcomes for mothers and infants (Hatem, Sendall, Devane, Soltani, & Gates, 2008; Odent, 2003; Renfrew et al., 2014; Wagner, 2006) those who use such procedures receive greater compensation than those who do not. Janssen, Mitton, and Aghajanian (2015) report an average savings of \$2,338 “per birth among women planning home birth compared to hospital birth with a midwife, and \$2,541 [savings] compared to hospital birth planned with a physician” (p. 1). Furthermore, Wolf (2001) notes that

Cutting the C-section rate back to 5 percent of all births - the rate in Europe today and in the United States before the boom - would wipe out \$175 million a year in personal income for obstetricians alone, for whom the C-section boom means shorter hours at increased pay. (p.178)

Thus, within our Western (neo)liberal capitalist society, birth has become commodified as a specialized product that requires expert care.

The redefinition of pregnancy and birth as pathological processes to be managed by medical experts and the technology they wield is not only lucrative - it also establishes the medical institution as an authority through which core values of the technocracy may be communicated. Davis-Floyd (1990) rationalizes that “routinely used obstetrical procedures such as electronic fetal monitoring, episiotomies...and even the Cesarean section emerge as perfectly sensible ritual and symbolic techniques for socializing women into this technological value system” (p. 176). The elevation of science and technology is furthered by the myopic focus of obstetrical research on “clinical efficacy and a live healthy baby, to the exclusion of, and seemingly oblivious to, women’s feelings about their experience” (Larkin et al., 2012, p. 99). When maternity providers draw solely on morbidity and mortality data (reflecting conceptualizations of safety and risk) to judge the “success” of labor and delivery processes, the childbirth experience is reduced to a single outcome, from which women are almost entirely erased. The removal of women from the birth process serves the interests of the technocracy, while socializing mothers in technocratic ideology.

Clearly, birth ideologies are not created in a vacuum – they are dependent upon complex political, economic, and socio-cultural factors, among others, which create and sustain dominant conceptual models of care. At the level of the macrosystem, governing bodies and medical institutions propagate technocratic culture via the biomedical model. Within one’s microsystem, social scripts and norms may be perpetuated through the telling of stories. Core beliefs and assumptions about childbearing, for example, may be constituted in and through popular literature and images, as well as through the narratives of new mothers, as argued by Pincus (2000):

Media, including television, magazines, films, and even the Internet will always reflect

the dominant attitude toward birth. Mothers with new babies, describing encounters with and submission to obstetrical procedures, are weaving their birth stories into our culture, alarming younger women, inclining them toward medicalized births, increasing their reliance on interventions. It is indeed a vicious cycle. (p. 212)

The cycle that Pincus refers to may be conceptualized in a number of different ways. One possible conceptualization is that various discursive formations, effects, and power structures interact, mutually constituting a cycle of forces which impact women's expectations, beliefs, choices, and experiences. Birth stories may act as socializing agents, promoting or contesting technocratic and patriarchal values. These values are frequently viewed as "normal," and thus are largely invisible within Eurowestern culture. Such invisibility allows the information provided by popular texts on childbearing to assume a posture of impartiality, obscuring matrices of privilege and oppression. With this in mind, my study of birth discourses in popular literature aims to enhance the visibility of birth culture in a North American patriarchal technocracy, while also calling attention to counter-normative conceptualizations of childbearing.

Key Research Concepts: Power, Knowledge, and Privileged Bodies

There are many forces that shape and influence childbearing narratives. Key concepts examined in this study include the socio-cultural, economic, and political forces that shape notions of "women," pregnancy, and birth. These include gender, race, sexuality, socio-economic status, and context, among other things. Specifically, my research has focused on amplifying issues of power, control, and the hegemonic privileging of biomedical knowledge systems over woman-centered models of care.

But first, what is woman-centered? Complexifying gender and "femininity." With a critical eye on the male-centric conceptual model upon which most childbirth literature rests, I

now turn my scrutiny to the alternative models of midwifery and woman-centered care (WCC). WCC emerged in the UK in the 1990s, as a response to the government's Changing Childbirth report. As Pope et al. (2001) note,

Changing Childbirth proposed a radical programme of change that [was] intended to provide a clear way forward for the development of the maternity services into the next century. The Expert Maternity Group responsible for Changing Childbirth outlined key principles of the maternity services and the need for the woman (and her partner, if she wishes) to be the focus of care. The key principles are choice, continuity, and control. (p. 228)

With their focus on prioritizing the desires and requirements of women, it is tempting to characterize WCC and midwifery as archetypes of female connectedness and nurturance, and thus as more attuned to the needs of birthing women. It is certainly critical to provide women with an important alternative to biomedical care, and to center the unique voices and needs of diverse mothers. Janssen, Henderson, and Vedam (2009) note in their study of women's experiences of home birth, among those who saw midwives, "receptivity to the input, wishes, and choices of both the woman and her partner were frequently [mentioned] in women's analyses of their experiences" (p. 299). This is an undeniable strength of midwifery care which should not go unmentioned (Hatem, Sendall, Devane, Soltani, & Gates, 2008; Renfrew et al., 2014). However, models of care that are more "female" in nature must also be critically examined lest they reproduce the very gendered essentialisms they set out to counter. WCC, by virtue of its definition as woman-centered, relies upon certain assumptions of what it means to be female and what it means to not be female. For example, in emphasizing care that is more relational and holistic in nature WCC may inadvertently reify essentialist assumptions of sex and

gender, while also reifying cis-gender binaries of “male” and “female.” Problematic dichotomies between “nurturing relational female” and “rational independent male” may be recreated by alternative models of care; despite being developed in order to counter the male-centric assumptions of biomedicine, WCC may reproduce similarly narrow gender norms.

Feminists have long sought to challenge gendered norms that assign women “natural” traits. Such stereotypes define women as inherently nurturing, relational, and emotional. Many childbearing women, however, may not relate to such a narrowly inscribed view of femininity. Indeed, some birthing individuals may not identify as mothers or women at all, choosing instead to describe themselves as gender fluid, gender nonconforming, transgender, agender, gender queer, or third gender, among others.

WCC is limited by its historically homogenous, Western-centric definition of “woman”; a narrow view of gender identity may alienate some women, while privileging others. In its creation of the universalized, collective woman, WCC neglects the shifting and varied identities of women and of women’s bodies, as gender interlocks with numerous other oppressions and privileges. Samuels and Ross-Sheriff (2008) assert that “gender cannot be used as a single analytic framework without also exploring how issues of race, migration status, history, and social class, in particular, come to bear on one’s experience as a woman” (p. 5). The intersecting forces of gender, race, sexuality, socioeconomic status, ability, religion, citizenship, and geographic location, among others, have important implications for women’s health. For instance, research shows clear ethnic disparities in neonatal and maternal mortality ratios; in the United States in 2003, 30.5 Black mothers died from obstetrical causes, compared to 8.7 White mothers (Hoyert, 2007, p. 8). Given its universalization of women, WCC may not address such health inequities, or “how choice and autonomy are constrained by systems of privilege and

oppression” (Rudrum, 2012, p. 59).

Multiple systems shape the identities of women, interacting in complex ways and preventing any singular experience of womanhood or motherhood. As such, WCC, and indeed the very notions of “women” and “mothers,” create limitations that must be examined. “Mother” is not synonymous with “woman,” for example, and gender variant or gender fluid parents who give birth may feel alienated or frustrated by the constraints and implications of such labels. However, while I acknowledge the need for semantic, conceptual, and practical expansion in the field of maternity care and popular literature on childbearing, my thesis will focus on the discursive formations that target “mothers” and “women.” Thus I shall refer to mothers, women, and woman-centered care.

While WCC is undeniably limited (as most frameworks are) in its current approach to maternity care, there is a great deal of room for expansion and new possibilities. These possibilities are a salient focus of the current study. When maternity care strives to serve the unique and varying interests of birthing mothers, then “woman-centered” becomes a useful concept. With WCC’s merits and limitations in mind, my thesis engages with debates on the complexity of gender, identity, and social location, amplifies the varied needs of childbearing women, and advocates for an expanded, more inclusive, nuanced approach to woman-centered care.

Social scripts. Although the identities of childbearing women are diverse, and frequently context-specific, birthing mothers are often assigned restrictive, static social roles. Social scripts convey important information and expectations to pregnant women; in fact, social scripts on childbearing are so vital that they are built into the very structure of North American society. To illustrate, consider how books containing information on pregnancy and birth are often placed in

the ‘health’ section of one’s local library or bookstore. In Euro-American culture, the word ‘health’ tends to be associated with physiology and biology – that is, the ‘body’ side of Descartes’ mind/body dichotomy (Cahill, 2000). When we seek information related to our body, it is generally because we are *not* healthy; thus, one would go to the library’s health section to find a book on losing weight, treating cancer, managing diabetes, or high blood pressure. When a book on heart disease appears next to one on pregnancy, the two are amalgamated into a single category (i.e. ‘non’ health), positioning pregnancy as a medical process to be managed by medical systems of care. The social script for childbearing women becomes analogous to that of a patient – a pathological body to be managed, a non-expert who must yield to, and depend upon, the knowledge of an expert (Jordan, 1997; Liamputtong, 2004). In this thesis, I examine the ways in which these imbalances in power and knowing shape, and are woven into, the information presented to women in childbearing advice literature.

Power and control. Perceived as dependent upon paternalistic systems of care, pregnant women are often infantilized, and expected to behave in ways characteristic of children (Rudolfsdottir, 2000; Wolf, 2001). The covers of many childbirth advice books blatantly illustrate this expectation. If one were to use popular literature alone as a reference, one might conclude that pregnant women have a strange penchant for stuffed animals, pastel colours, syrupy images of baby-related merchandise, and “keep-sake” journals. Indeed, Wolf (2001) notes that birthing mothers are often treated as children who cannot be trusted. In examining the reasoning behind the impractical nutritional advice given by one popular advice book, Wolf (2001) concludes:

Why do this? This was my gut feeling: because we are too dumb, with only the facts presented to us, to moderate our intake like sensible bovines. I felt manipulated by the

authors as I gazed, dumbfounded, at the sheer mountains of roughage prescribed day by day...you cannot have even half a glass of wine, “except for a celebratory half glass on a birthday or anniversary, *with* a meal,” because, though the studies on moderate alcohol intake show statistical insignificance, studies also show that pregnant hard-core alcoholics deliver compromised children. We can’t be trusted with moderation. So drop that glass of white wine. Now. I understood the authors’ motivation. I simply resented what I guessed to be their core assumption: that, given the facts and left to draw sensible conclusions, a pregnant woman would veer like the sense-glutted harlot she really is into the slough of sugary desserts and the dark forest of wantonly empty bottles of Bailey’s Irish Cream. (p. 24)

Positioned as impulsive and senseless within the biomedical model of pregnancy and birth, women are not trusted to act in the fetus’s (or, though perceived as less important, their own) best interest. Consequently, women’s knowledge and agency are often subjugated or undermined, and mothers are stripped of control. When women are forced to give up control over their own bodies, they (quite literally) become disembodied from the birth process and are reduced to passive objects (Thomson & Downe, 2012). Objectification of women’s bodies, and the domination of those bodies by ‘male’ conceptual models of birth, highlights the gendered and sexual nature of childbirth; this study examines such concepts and images in the literature, considering underlying assumptions and ideologies.

Questions to Consider: How is Birth Affected by Sociopolitical and Economic Structures?

The gendered and sexualized nature of childbirth, and the privileging of biomedical knowledge systems, shape the ways in which women experience birth; all of these elements are intimately intertwined. In order to highlight these relationships, this thesis examines the

dominant discourses espoused by best-selling advice books on pregnancy and birth, and reflects upon the following questions: How are dominant sociopolitical ideologies reflected in popular literature on childbearing? How are certain types of knowledge/bodies/ways of knowing and doing privileged over others, and why? What are the social scripts assigned to childbearing women, and how are these communicated through advice literature? How is “choice” framed? How is control exercised, and by whom?

Using critical intersectional feminist theory (Collins, 1998; Crenshaw, 1991), I explore these questions, and document links between birth and sociopolitical structures in order to make birth culture more visible. In Chapter 2 (literature review), I provide a historical overview of traditional midwifery practice and the increasing medicalization of childbirth, in order to position my thesis within a historical and ideological context. It is important to understand the ideological beginnings of each model; the tensions and pressures that exist between the medical and natural birth communities are the same tensions and pressures which childbearing women live with and must work through. Chapter 2 will also provide a review of existing research on texts related to pregnancy and childbearing. Chapter 3 (methodology) presents an in-depth look at feminist intersectionality theory and critical discourse analysis, both used in this thesis. I describe how the texts were selected, the process of identifying dominant and alternative discourses, and the questions asked of the material present in the literature. Chapter 4 (analysis) presents my research findings, as I consider the recurring discourses that emerged in the texts under review. This is followed by a consideration of the counter-normative discourses present in the literature, which create the space for alternative stories and experiences. In the discussion section (Chapter 5), I summarize the main findings and examine their connection to privilege/privileged bodies, colonization, and socioeconomic status. I explore the alternative discourse of natural birth, and

problematize ideas of “natural” and “unnatural.” Finally, I conclude this thesis with a discussion of implications for future research involving childbearing advice, and promoting inclusive discourses of pregnancy, birth, and motherhood.

Chapter 2: Literature Review - Midwifery, Medicine, And Childbearing Advice

To begin, it is useful to consider the theoretical underpinnings of the midwifery and biomedical models of childbirth, which I introduced in Chapter 1. Although each model may be viewed most accurately as part of a continuum (arguably, there are doctors who provide woman-centred care, and midwives who subscribe to more interventionist philosophies), within research literature “the midwifery model [is] almost always written about as being on the opposite end of the medicalization spectrum” (Shaw, 2013, p. 529). Conceptualizing natural birth philosophies as opposite to medical models may result in the creation of false dichotomies; though I do not believe that either model should be viewed as mutually exclusive, it is important to examine the differing theoretical beliefs of each as a group, the dichotomous ways in which they are positioned in academic literature, and to consider the history from which such beliefs emerged. Here, I present an exploration of this ideological binary, and the ways in which it is produced, maintained, communicated, and expanded.

A History of Midwifery and Medicine: Power, Politics, and Privileged Bodies

In order to understand the theoretical foundations of the midwifery and technocratic models of childbirth, an examination of the history of Eurowestern maternity care is in order. If we trace women’s healthcare back to its earliest beginnings, connections between gender, power, sex, birth, religion and philosophy begin to materialize. The maxims of early European religious authorities, philosophers, and scientists, for example, all extolled the perfection and superiority of the male body (Cahill, 2000; Davis-Floyd, 2003). Viewed as the antithesis of the male form, female bodies were cast as imperfect, abnormal, wild, and inferior (Cahill, 2000; Gaskin 2011). Women’s reproductive organs, in particular, were regarded with disgust and revulsion by many philosophers and religious leaders. Aristotle (along with Augustine, Plato, and others [Gaskin,

2011]) expressed contempt for the female body, writing scathingly, “the female is, as it were, a deformed male; and menstrual discharge is semen, though in an impure condition; i.e., it lacks one constituent, and one only, the principle of Soul” (as quoted in Gaskin, 2011, p. 68).

The writings and theories of European scientific and philosophical authorities did much to shape the moral, spiritual, and scientific climate of the 15th, 16th, and 17th centuries. With the rise of Cartesian philosophy in the early 1600s, religious bans on the study of human anatomy began to fade. As Cahill (2000) explains:

Orthodox Christian doctrines had held that body and soul were one and it was therefore believed that the *body* had to be whole in order to allow the *soul* to enter heaven. Not surprisingly, the Cartesian revolution and the lifting of this religious embargo led to a far greater understanding of human anatomy and physiology. (p. 335)

The Cartesian revolution firmly established the moral acceptability of the scientific practice of studying and learning from cadavers. As a result, the 17th and 18th centuries saw explosions in anatomical knowledge, and the rise of medical practitioners with access to such knowledge (Allotey, 2011; Cahill, 2000; Shaw, 2013).

Allotey (2011) notes that during this time, “medical men assumed that the ‘science’ of anatomy was a male province” (p. 533), and, with women denied access to formal education, careers in the medical field were restricted to those of male gender. With the Medical Registration Act of 1858, British surgeons, physicians, and apothecaries succeeded in the process of professionalization, establishing themselves formally as “doctors” (Cahill, 2000). Wanting to gain clientele and promote their newly established profession, physicians began pursuing the business of obstetrics (Macdonald, 2006; Shaw, 2013; Wertz & Wertz, 1977). Until the 17th century, childbirth had been firmly situated within the private, domestic sphere; babies were born

at home, with labouring women attended by female midwives from the community (Bryers & van Teijlingen, 2010; Stojanovic, 2008).

Denied access to anatomy lectures, libraries, professional networks, and human dissections, European midwives learned their craft through apprenticeships, which generally lasted three to six years (Allotay, 2011). This hands-on experience and pragmatic knowledge, however, was disregarded and derided by many in the medical field, as practitioners (those interested in obstetrics were called men midwives) attempted to displace female midwives and secure clients for themselves. In a treatise written in 1737, midwife Sarah Stone

Proclaimed to readers that many of these ‘young gentlemen professors’ (men midwives):
 ...put on a finished assurance, with pretence that their Knowledge exceeds any Woman’s, because they have seen or gone thro’ a Course of Anatomy: and so, if the Mother, or Child, or both die, as it often happens, then they die *Secundum Artem* [literally meaning ‘according to the art,’ i.e. in accordance with best practice] for a man was there, and the Woman-midwife bears all the blame. Then it is that our young and well assur’d pretenders boast, had they been there soon, neither should have died. (as quoted in Allotay, 2011, p. 533)

The frequent deaths that Stone refers to were often linked to the overuse of medical instruments by male midwives (Cahill, 2000). Because of their non-professional status, female midwives were prohibited from owning or using “medical” tools, such as forceps (Gaskin, 2011). Intended for judicious use in emergency situations, the rampant overuse of forceps led to gruesome birth injuries, as well as maternal and fetal death. Several publications authored by midwives during the 17th and 18th centuries relate alarming first-person witness accounts of crushed fetal skulls, lacerations to the temple causing death, exposed brain matter, and maternal

hemorrhage, due to the application of forceps (Allotay, 2011).

Given the injurious, dangerous nature of forceps, and the poor outcomes experienced by mothers and infants, how did the great majority of those in the medical profession come to accept and sanction their use? The inclination toward using tools during labor and birth begins to make sense when we consider the philosophical underpinnings of medical education and practice. As noted previously, early religious authorities and scientists lauded the flawlessness and superiority of the male form, while decrying the deviance of the female body from such masculine perfection. Academically grounded within this tradition of misogyny, medical education programs framed women's bodies as defective, faulty, and incompetent. Davis-Floyd (1994) asserts that "because of their extreme deviation from the male prototype, uniquely female anatomical features such as the uterus, ovaries and breasts, and uniquely female biological processes such as menstruation, pregnancy, birth and menopause are seen as inherently subject to malfunction" (p. 1126). Macdonald (2006) goes on to note that "gender ideals of women as frail and dependent – and thus incapable of either giving or attending birth unaided by male experts – flourished during this time as well, especially among the middle and upper classes" (p. 237). Positioned as owning feeble, incapable bodies as a result of their sex, pregnant and birthing women were deemed physically defective, and thus in need of assistance and intervention from medical men. These problematic gender norms provided a focus for my own study of birth discourses and ideologies.

An understanding of childbirth as requiring the management of male medical experts formed the foundation for cultural shifts in maternity care during the 18th and 19th centuries. Patriarchal social, political, and educational systems began to redefine the meaning and practice of childbirth. Vicious smear campaigns were orchestrated, and anti-midwifery propaganda

appeared in newspapers and women's magazines (Macdonald, 2006; Worman-Ross & Mix, 2013). This very public denigration of midwifery knowledge and skill worked to undermine the competency of female midwives, simultaneously facilitating their displacement and allowing medical institutions to appropriate maternity care. As Cahill (2000) explains:

The reconceptualization of birth as a 'normal' and 'attended' life event to an 'abnormal' and 'managed' crisis was pivotal to the success of medicine. That this medicalization of pregnancy was achieved over time, more through ideological *claims* to greater medical expertise, than any demonstrable benefits to women, is of note. (p. 338)

In fact, research suggests that as birth moved from home to hospital, and the care provider shifted from midwife to obstetrician, new hazards were created for mothers and infants (Hausman, 2005; Goer, 1999; Shaw, 2013). During the 1920s, many women died from puerperal ("childbed") fever, which was rampant in hospitals due to the use of interventionist techniques (e.g. instrumental deliveries), frequent vaginal examinations, and insufficient aseptic and antiseptic procedures (Cahill, 2000; Gaskin, 2011; Stojanovic, 2008). Rather than declining, maternal and fetal mortality rates *rose*; according to Goer (1999), in the US in 1915, when the majority of births took place at home with a midwife, 60 mothers died for every 10,000 births. By 1939:

Half of all women and three-quarters of urban women gave birth in hospitals...despite the shift, the 1932 US maternal mortality rate reached 63 deaths per 10,000 births, and in cities, where hospitalization was more common, it stood at 74 deaths per 10,000 births, substantially worse than the overall rate. Meanwhile...as the shift in birth site and attendant occurred, infant deaths from birth injuries increased by 40 to 50 percent. (Goer, 1999, p. 202)

Despite medicine's monopolistic claims on obstetric knowledge, birth did not become safer in hospitals.

Indeed, many researchers feel that the medical system's (beneficial) impact on maternal and fetal health has been largely overstated. With respect to maternal and fetal mortality, Cahill (2000) notes that in the UK, the greatest decline in rates was seen during the First World War, when 60 percent of medical personnel had been drafted. Fewer medical providers attending births meant fewer interventions (e.g. forceps) during labor and delivery, and thus fewer deaths. Improvements in maternal and fetal mortality rates were also seen in the US during the 1940s and 1950s. However, as Hausman (2005) and Cahill (2000) observe, these advancements were directly linked to improvements in standard of living, nutrition, and sanitation. Interestingly, safety and risk discourses continue to favour medical care; the overstated impact of biomedicine on maternal and fetal health provided a rationale for the current study.

The Technocratic (Biomedical) Model of Birth

Despite its questionable impact upon the health outcomes of women and infants in centuries past, medical birth is the norm in much of North America and Europe today. In BC, obstetricians (OBs) and general practitioners (GPs) provide care for 95 percent of births, even though midwifery is formally recognized as a profession and midwifery care is funded through the Medical Services Plan (Rudrum, 2012). Midwifery care is associated with reduced use of interventions, and reduced surgical birth (Janssen, 2009). Given the rising rates of induction and cesarean section without a concomitant improvement in maternal or neonatal outcomes (Renfrew et al., 2014), an examination of the technocratic approach to care is warranted.

Medical discourse and the framing of risk. The technocratic model conceptualizes pregnancy and birth as medical processes (Buitendijk, 2011; Worman-Ross & Mix, 2013). As

van Teijlingen (2005) asserts:

One of the underlying motives for this approach might be that ‘one important norm within the culture of the medical profession is that judging a sick person to be well should be more avoided than judging a well person to be sick.’ Pregnancy is now considered as potentially pathological in the industrialized world...this practice is based on a science-oriented perspective, whereby risk is defined as statistical risk, and whereby solutions and improvements are based on measurements of outcome through mortality and morbidity statistics. Pregnant women are labeled as ‘high risk’ on the basis of statistical, rather than individual considerations. (p. 4)

The science-centric nature of Eurowestern culture means that as a concept, risk is understood and defined in a scientific, biological, and often medical way. Childbearing, for instance, is understood as involving *physical* risks which must be avoided in order to judge the process successful. Such an understanding of pregnancy and birth is congruent with modern Western society’s preoccupation with risk. As a culture, we are risk adverse – we seek to control, manage, and prevent risk on a daily basis. This aversion to risk may be traced back to the Enlightenment, when gains in information, knowledge, and information systems initiated a process of over-monitoring populations and individuals in the name of safety (Bryers & van Teijlingen, 2010).

Bryers and van Teijlingen (2010) explain:

The more information we have, the more we worry and the more we ‘create’ further risks. Sociologists argue that anxiety over danger (risk) is based on the fact that we now believe ourselves to be accountable for such risk, rather than being in the hands of God or fate. (p. 489)

Because the technocratic model views birth as inherently risky, and risk culture holds

childbearing women accountable for moderating this “riskiness,” decisions about labor and delivery are often made based on the perceived dangerousness of a particular choice. Danger/risk are differentially constructed - two options may be equal in physical safety (i.e. the danger or physical risk involved in each is low), but differ in terms of moral safety (i.e. one option is *perceived* as being a more responsible choice).

Perhaps nowhere is this more evident than in the debate regarding home versus hospital birth. In their updated Cochrane review on place of birth, Olsen and Clausen (2012) affirm that the largest “observational study by far, including more than half a million births, states that ‘no significant differences were found between planned home and planned hospital birth (adjusted RRs and 95% CIs) intrapartum death and neonatal death up to seven days’” (p. 6). Given that home and hospital birth are equal with respect to mortality outcomes, why does home birth tend to be framed by the medical community as an unsafe, irresponsible choice (Vedam, Stoll, Schummers, Rogers, & Paine, 2014; Vedam et al., 2012; Viisainen, 2000)? In Vedam et al.’s (2012) study of 825 Canadian obstetricians and general practitioners, a third of the physicians considered women who chose home birth to be “risk takers.” Such a perspective illustrates the medical risk discourse to be explored by this thesis: childbirth is understood as inherently risky, and hospitals are framed as environments in which this risk can be mitigated through the use of medical technology.

However, because the use of medical technology comes with its own set of potential dangers and complications, hospital birth itself is not without risk. As Jansen, Gibson, Bowles, and Leach (2013) warn, “every intervention presents the possibility of untoward effects and additional risks that engender the need for more interventions with their own inherent risks” (p. 83). The use of analgesias and anesthetics during labor, for example, is associated with a host of

troublesome side effects. A few of these include: fever, hypotension, decreased effectiveness of contractions, slower descent of the fetus, malposition of the fetal head, decreased effectiveness of maternal pushing, increased length of labor, distended bladder, and neonatal sepsis/fever/hyperthermia (Leighton & Halpern, 2002; Lieberman & O'Donoghue, 2002; Lowe, 2004; Robinson, Norwitz, Cohen, McElrath, & Lieberman, 1999). Additional technologies are required in order to negate these problematic side effects, including: Pitocin augmentation (to increase the effectiveness of contractions), catheterization, electronic fetal monitoring, intravenous fluids, instruments to assist in delivery, and cesarean section (Jansen, Gibson, Bowles, & Leach, 2013; Romano & Lethian, 2008). Thus, in attempting to manage the danger of childbirth with medical technology, new risks may emerge.

And yet, these risks (when acknowledged) are perceived as more legitimate risks for childbearing women to take. In her study on the moral dangers of choosing to birth at home, Viisainen (2000) found that medical staff used risk language to dissuade women from out-of-hospital births, such as in this excerpt:

Nurse: 'You're not really thinking of giving birth at home, are you...doesn't the safety of the baby mean anything to you? What if the placenta doesn't come off, then what? You'll bleed to death before you are in hospital.' (p. 807)

Questioning a mother's care for the safety of her child has clear moral overtones. In choosing the risks of home birth over the dangers of the hospital, this mother challenges biomedical ideology, and as a result, is stigmatized for her perceived irresponsibility. Hausman (2005) notes that

The represented risks of fetal injury or harm...continue to drive the medical management of pregnancy and childbirth as well as to insure women's complicity with its norms; the risk of doing damage to their babies...propels many women to demand highly

technological and interventionist management of pregnancy and childbirth. (p. 34)

Those who embrace the technocratic model, then, view relying upon technology as less risky than eschewing it. Medical interventions are posited as preventing negative outcomes from occurring, and birthing women who choose to forgo the use of technology are morally stigmatized for their differential weighting of risk. Thus, the framing of risk and the use of technology work simultaneously to ensure women's obedience to biomedical norms, while reinforcing the authoritative knowledge and position of medical practitioners.

The Midwifery Model of Care Practitioners (MMOCP)

Although less dominant in North America, the MMOCP provides an alternative ideological discourse about the bodies of childbearing women, and birth in general. Midwifery philosophy (which is frequently embraced by doctors and midwives alike) is based on the belief that for most women, pregnancy and birth are normal, physiologic processes (Gaskin, 2011; Kitzinger, 2005). Because childbearing women are viewed as healthy and competent, care practitioners encourage shared decision-making and informed choice, placing the "best interests and rights of the labouring woman above all" (Shaw, 2013, p. 531). Consequently, this model is characterized as woman- or client-centered. The model evidences a holistic understanding of women's bodies and women's lives, considering the psychological, socioemotional, spiritual, and political, as well as biological aspects of pregnancy and birth. There is an inherent trust in the efficiency, wellness, and capability of the female body, such that technological interventions are not routine, but rather are used/recommended in the minority of cases in which they are deemed necessary.

Evidence-informed practice: Using fewer interventions and less technology.

Interventions such as pain medication are also used less frequently, as pain is conceptualized as a

difficult yet valuable part of the labor process. In her discussion on the utility of labor pain, Lothian (2000) notes that pain

Is an important way in which nature actually helps women find their own ways of facilitating birth. In a very real sense, the pain of each contraction becomes a guide for the laboring woman. The positions and activities she chooses in response to what she feels actually help labor progress by increasing the strength and efficacy of the contractions...when the pain is entirely removed, the feedback system is disrupted and labor is likely to slow down and become less efficient. (p. 45)

Even so, for many women the removal of pain is an important component of the birth experience, with anesthesia allowing for relaxation and a more positive labour and delivery. However, as noted previously, there is a great deal of research attesting to the physiologically disruptive influence of analgesias and anesthetics on the labor process. In order to negate the troublesome side effects of these drugs, more interventions are used - this is often referred to as the “intervention cascade.” Interventions beget interventions, and each added drug, instrument, or procedure, brings with it a host of potential complications. These may lead to iatrogenic maladies (that is, injuries or illnesses caused by medical treatments) such as dysfunctional labor, wound hematoma, major puerperal infection, and admission to neonatal care units, and result in less than optimal outcomes for mothers and babies (Klein et al., 2001; Liu et al., 2007; Villar et al., 2007). Because there is an abundance of research demonstrating the injurious effects of many interventionist procedures, those who practice under the MMOCP tend to eschew their use, choosing instead to adhere to evidence-informed practice.

An excellent example of evidence-informed practice is the refusal of those who embrace the MMOCP to rely upon external fetal monitoring (EFM) throughout the course of a woman’s

labor. In many hospitals, it is standard procedure to monitor the strength of the mother's contractions and the baby's heartbeat through EFM (Torres, De Vries, & Low, 2014). This is done by using a large belt to strap the monitor tightly around the woman's abdomen. As Goer (1999) explains:

The basic premise behind EFM is that insufficient oxygen (hypoxia, asphyxia) in labor is a common cause of severe mental retardation, death, and especially cerebral palsy, and that changes in the fetal heart rate precede brain damage. Based on that premise, obstetricians reasoned that intermittent listening had been unable to prevent brain injuries because it provided too little information too late. The solution, then, became a machine that made a continuous tracing of the fetal heart rate and how it reacted to contractions.

Unfortunately, however, the premise was wrong on both accounts. (p. 87)

After its implementation (*prior* to research examining its effectiveness) in the 1970s, research on EFM began to accumulate. Currently, a large body of literature (Freeman, 1990; Haverkamp, Thompson, McFee, & Cetrulo, 1976; Haverkamp et al., 1979; Luthy et al., 1987; MacDonald, Grant, Sheridan-Pereira, Boylan, & Chalmers, 1985; Stout, & Cahill, 2011) on the efficacy and outcomes of EFM overwhelmingly concludes "there is no established evidence of its ability to improve outcomes for most mothers and babies" (Hausman, 2005, p. 27). In fact, research demonstrates that EFM is associated with significantly higher rates of instrumental or operative delivery (Goer, 1999; Gourounti, 2012; Torres, De Vries, & Low, 2014). This is largely due to the machine's tendency to provide erroneous markers of fetal distress. Goer (1999) notes that:

Few babies diagnosed with fetal distress are born in poor condition. A bedrock truth of EFM is that if the monitor says the baby is fine, the baby is almost certainly fine, but if the monitor says that the baby is not fine - that is, that she has *nonreassuring* heart rate

patterns - the baby is also probably fine. (p. 87)

The accuracy of EFM has thus been called into question, and, given its association with instrumental and surgical delivery, its widespread use challenged.

A safer, more accurate alternative to EFM, used widely by those who subscribe to the midwifery model of care, is intermittent monitoring, or intermittent auscultation of the fetal heart rate (IAFHR) (Gourounti, 2012; Prentice, & Lind, 1987). IAFHR is done by using a fetoscope or Doppler ultrasound to listen to the fetal heart rate during timed intervals (Torres, De Vries, & Low, 2014). Not only does this allow for the establishment of a baseline heart rate, it also enables the caregiver to note any accelerations or decelerations from the baseline rate. As Torres, De Vries, and Low (2014) emphasize, “for a healthy, low-risk woman in spontaneous labor, the use of IAFHR is the evidence-based approach to care and minimizes disruption to the physiologic processes of labor and birth” (p. 142). These outcomes are compatible with the midwifery model of care practitioners, and its focus on holistic health and wellness.

Midwifery discourse and the framing of risk. Because the physiological processes of labor and birth are viewed through a lens of health and normality, the MMOCP conceptualizes childbearing as a difficult, but largely safe, function of the female body. Birth itself is not viewed as inherently risky, and as a result, the maternity caregiver is not framed as needing to manage the birth process. This works to disrupt the “caregiver as expert” discourse, and allows for the co-construction of knowledge between the care provider and client; these ideas have provided a focus for my analysis. When knowledge is co-constructed, pregnant women become capable, active subjects with authority. In their study of women who chose home birth, Worman-Ross and Mix (2013) found that:

Participants reiterated that the important thing about birth is not necessarily that a woman

births at home, or naturally, or vaginally (although these are ideal, for our participants): instead, it is most important that the birthing woman is active in the process – that she is given and claims responsibility. (p. 470)

Practitioners who adopt the midwifery model strive to provide client-centered care, encouraging mothers to make decisions about pregnancy and birth, thereby providing opportunities for childbearing women to exercise their agency. Power, choice, the co-construction of knowledge, authority and agency are central concepts within this thesis, guiding the exploratory goals of my analysis.

Research demonstrates that agency is fundamentally important to birthing women (Song, West, Lundy, & Dahmen, 2012; Walsh-Gallagher, McConkey, Sinclair, & Clarke, 2013; Westfall & Benoit, 2004). In fact, for many who embrace midwifery ideology, a lack of agency is perceived as dangerous. For these women, giving birth in a hospital where authority often rests in the hands of technocratically-inclined doctors, holds significantly more risk than giving birth at home. One participant in Worman-Ross and Mix's (2013) study related her experience in the hospital:

They were like, "Yeah, these beds are uncomfortable, we're going to try to get you in and out of here as soon as possible. You *can't* get up. You'll have monitors and IVs and this is what you're going to do."...I talked to them and said I don't want an IV, I don't want a fetal monitor the whole time, and they were like, "You're at the wrong hospital." Like it wasn't an option to have it another way. (p. 466)

Authoritative restrictions can lead to feelings of powerlessness, anger, frustration, and to a sense of having one's birth co-opted by healthcare professionals. Within the MMOCP, it is these processes and their associated medical interventions and iatrogenic outcomes that are viewed as

risky (Viisainen, 2000). Thus, the midwifery model approach to care conceptualizes and weights constructs of risk much differently than the technocratic approach. The purpose of the current study is to explore these ideological dichotomies, and the ways in which they are produced, maintained, communicated, and expanded in popular culture.

Previous Research on Childbearing Advice Texts

Despite the social construction of birth ideologies, and the implications they hold for maternity care, few studies have explored the discourses espoused by childbearing information and advice books. Where research on the topic does exist, it is incomplete and occasionally vague. Rudolfsdottir (2000) provides an interesting analysis of the pregnancy pamphlets found in healthcare centers; however, given that the booklets were “distributed at the initiative of the healthcare staff” (p. 341), it is difficult to know how wide reaching and impactful such literature might be. Similarly, Pincus (2000) briefly discusses common ideologies found within childbirth advice literature, yet neglects to mention which books were chosen, or how widely available each was.

Of the studies that focused exclusively on popular literature, two found themes of power, control, and medical authority. In their feminist analysis of the *What to Expect* series, Dobris and White-Mills (2009) provide an excellent discussion of the ways in which patriarchal conceptions of motherhood and childrearing are propagated. For the purpose of their study, however, Dobris and White-Mills limit their focus to the *What to Expect* series, considering *What to Expect When You're Expecting*, *What to Expect the First Year*, and *What to Expect: The Toddler Years*. As a result, the study concentrates on the construction of motherhood in general, rather than honing in on discourses related to pregnancy and birth.

A discourse analysis of top-selling advice books is provided by Kennedy, Nardini,

McLeod-Waldo, and Ennis (2009), who find that many “popular childbirth books do not consistently support birth as a normal, physiologic process and, in fact, may act as causative factors in the growing trend of technological birth” (p. 324). Although Kennedy et al.’s work is notable for its consideration of the (mis)information books often provide, it shies away from a comprehensive examination of the political, economic, and social forces that manufacture such narratives. This study aims to contribute to the literature by providing such an examination.

Literature Review Summary

The ideological binaries of midwifery and medicine emerged from an array of historical events and affective politics, including European moral, spiritual, and scientific philosophies, the formal establishment of the medical profession, gender ideals, and the prohibition of midwives from owning “medical” tools. Academic literature continues to construct natural birth philosophies as opposite to medical models, maintaining the midwifery/medicine dichotomy: midwifery care is presented as holistic and woman-centered, while obstetric care is framed as rooted in pathology, intervention, and risk. The presence of these ideologies in childbearing advice literature, and the political and socioeconomic factors which produce and maintain them, are explored further in Chapter 4.

Chapter 3: Methodology – An Intersectional Approach to Critically Examining Birth Culture

In order to complete a comprehensive examination of birth culture, I engaged in a critical feminist analysis of contemporary pregnancy and childbearing discourses. I applied a feminist intersectionality framework to a critical discourse analysis (CDA) of childbearing advice literature. Utilizing this methodological approach allowed me to scrutinize the dominant discourses espoused by best-selling advice books on pregnancy and birth. I reviewed four popular North American advice texts, which aim to educate and prepare women for pregnancy, labor and delivery, and other facets of motherhood (e.g. breastfeeding, postpartum depression, infant care, balancing work and family life). I considered the books' discursive content in the context of the following research questions: How are dominant sociopolitical ideologies reflected in popular literature on childbearing? How are certain types of knowledge/bodies/ways of knowing and doing privileged over others, and why? What are the social scripts assigned to childbearing women, and how are these communicated through advice literature? How is "choice" framed? How was control exercised, and by whom?

Critical intersectional feminist theory equipped me with the theoretical tools to examine such questions. In this chapter, I explore feminist intersectional theory as a conceptual framework, the methodology of critical discourse analysis (CDA), my analytical processes, the study's limitations, and the use of reflexive practices to promote validity and reliability.

Theoretical Framework: Feminist Intersectionality Theory

My theoretical orientation to methodology was strongly shaped by feminist intersectionality theory (Collins, 1998; Crenshaw, 1991). Adopting a feminist intersectional approach facilitated my critical exploration of the ways in which birth is shaped by

sociopolitical, economic, and cultural factors. As Liamputtong (2004) notes, feminist writers have long been interested in examining birth culture, have “demanded the right of women to make choices about childbirth, and have criticized the ‘overmedicalisation’ of childbirth in the West” (p. 455). Feminist intersectionality theory allows pregnancy and birth to become complex and multilayered, shaped by multiple intersecting forces. No longer defined solely by outcome (i.e. a healthy baby) or singular notions of gender, the birth process begins to encompass other social formations including socioeconomic status, racialization, accessibility, sexuality, location, and beliefs about women’s bodies (Dillaway & Brubaker, 2006; Jansen, 2006; Samuels & Ross-Sheriff, 2008; Zadoroznyj, 1999). By examining the ways in which these vectors intersect, I explore the resulting matrices of identity, privilege, inclusion and exclusion, that are constituted by and that constitute pregnancy discourses. In doing so, I hope to highlight the varied experiences, identities, and stories of birthing women. Dillaway and Brubaker (2006) believe it is only through the meaningful exploration of “different groups’ experiences and the acknowledgment of intersecting social locations that we truly begin to understand a gendered experience like childbirth” (p. 18). Such a perspective acknowledges that women’s bodies are the sites of political, ideological, and material struggle; it seeks to counter hegemonic dominance by articulating diverse women’s experiences as legitimate knowledge and lived reality (Jordan, 1997). Thus, an intersectional perspective is congruent with my goal of amplifying the sociopolitical nature of birth.

Methodology: Critical Discourse Analysis

I have integrated my feminist intersectionality framework with the methodology of critical discourse analysis (CDA) to explore the broad ideas of selected texts on pregnancy and birth. Analyzing best-selling advice texts on childbearing for sociopolitical ideologies, ways of

knowing, and social scripts, is compatible with CDA, which involves “the close analysis of written or oral texts that are deemed to be politically or culturally influential to a given society” (Huckin, 1997, p. 79). Discourse, as a concept, is central to CDA, operating at the sociopolitical level to define and enforce a culture’s core values. Ideologies, social scripts, health care policies, popular literature, photographs, drawings and other images, may all function as forms of discourse, shaping how we interpret and think about various events, processes, and people. Machin and Mayr (2012) observe that “a text’s linguistic structure functions, as discourse, to highlight certain ideologies, while downplaying or concealing others” (p. 20). The information and advice provided by popular texts on pregnancy and birth functions as discourse - as ideologically-loaded messages - thus warranting the careful scrutiny of CDA. Machin and Mayr (2012) note that CDA is particularly useful for analyzing written text and images, as it can expose:

Strategies that appear normal or neutral on the surface but which may in fact be ideological and seek to shape the representation of events and persons for particular ends. The term ‘critical’ therefore means ‘denaturalizing’ the language to reveal the kinds of ideas, absences, and taken-for-granted assumptions in texts. This...allow[s] us to reveal the kinds of power interests buried in these texts. (p. 23)

CDA calls attention to *how* an author communicates a particular message by highlighting elements of the text that typically remain unnoticed by the reader. As a text’s subject matter, linguistic elements (grammar, word choice, etc.), and images are scrutinized, underlying social values and power formations are revealed. This thesis analyzes both subtle and overt power relations in texts on childbirth by paying close attention to linguistic details such as formal and informal lexical, vocabulary, and grammatical choices, which help convey authority or indicate

co-membership with the audience, thereby influencing the reader's perception of the information provided (Machin & Mayr, 2012). The attributes of images (the setting in which the subject appears, whether the subject's gaze engages the viewer, the salience of certain features, colours and settings and how these direct our attention) are also considered for the ideas and values they communicate.

Drawing on these analytical tools of CDA, I explored the discursive nature of labor and birth discourses. This exploration allowed me to trace the exercise and negotiation of power relations in popular literature on childbearing advice and education.

In my review of existing research on childbearing advice and education, several discourses on pregnancy and birth were identified. Specifically, I found that current North American sociocultural approaches to birth education largely revolve around three interwoven discourses, which were explored in the previous chapter (Chapter 2) and became the orienting concepts for my critical reading of popular childbearing texts. The first concerns the biomedical framing of pregnancy, labour and delivery as pathological, risky processes, the subsequent mistrust of the female body, and the belief that birth must be managed by medical experts. The second discourse is rooted in the first and involves the legitimation of "expert" knowledge, and the power of those who possess this knowledge. These narratives are the basis for the third discourse, which deals with knower-novice power imbalances, and control of the pregnant body. Each discourse builds upon deeply entrenched cultural values; advances in science and technology during the 20th century helped these discourses gain momentum, and technocratic belief systems allowed them to flourish. A dominant discourse-based understanding of pregnancy and childbirth is congruent with hegemonic (neo)liberal Western ideologies, which may account for the popularity of biomedical beliefs. As Davis-Floyd (2003) reminds us, the

medical system is a powerful microcosm with a vested interest in conveying the core values of society to its people; as such, dominant discourses on childbearing are used to socialize women, and the new members of society they produce, into a hegemonic value system.

Such hegemonic discourses, or birth narratives, are present in the childbearing advice texts under review. On the surface, these widely available texts provide pregnant women (and, to a lesser extent, their partners) with information on fertility, fetal development, diet, exercise, lifestyle, genetic testing, choosing a caregiver, pregnancy complications, place of birth, emotional and physical concerns, labor and delivery, and breastfeeding, among other things. The information (and the accompanying images) may be viewed as a narrative, telling stories of pregnancy, birth, womanhood, and mothering. The importance of unpacking such stories lies at the heart of feminist inquiry. Indeed, Padgett (2008) points out that discursive analysis involves “scrutinizing the transcript to identify ‘stories’ from which structural components are then delineated” (p. 34). Structural components may include language and contextual factors, such as culture, historical views on women’s bodies, and political systems. These powerful forces work “behind the scenes” to construct and promote narratives of childbearing.

In order to identify and examine the sociopolitical forces which shape narratives on childbearing, I scrutinized the content, structural, and linguistic components of popular pregnancy texts using a theoretical lens drawn from feminist intersectionality theory. The narratives of the following four advice books on pregnancy and birth were reviewed:

- *What to Expect When You’re Expecting* (2008), by Heidi Murkoff and Sharon Mazel
- *Pregnancy Day By Day, Canadian edition* (2009), edited by Maggie Blott
- *Ina May’s Guide to Childbirth* (2003), by Ina May Gaskin
- *The Girlfriends’ Guide to Pregnancy* (2007), by Vicki Iovine

These books hold significant credibility in North America's popular childbirth education genre. Moreover, in their study on sources of information influencing place of birth, Murray-Davis, McDonald, Rietsma, Coubrough, and Hutton (2014) found that childbearing advice books were among the top two resources listed as having the greatest impact on women's choices of home versus hospital birth. The books I chose to review were selected based on their prevalence and popularity in North American markets. Several factors were considered, including the number of copies present in local bookstores, availability and ratings on amazon.ca, chapters.indigo.ca, google reviews, and recommended reading lists published on parenting websites (parents.com, sheknows.com). Parents.com (which recommends *What to Expect*, *Ina May's Guide to Childbirth*, and *Pregnancy Day by Day*) is a subsidiary of *Parents* magazine, which reportedly had 13.5 million readers in 2015 (Meredith Corporation, 2015). According to Applebaum (2012), sheknows.com (which recommends *The Girlfriend's Guide* and *What to Expect*), and its associated parenting websites, attracts a combined 23 million visitors per month, and is "a one-stop destination for women seeking information and advice on everything from parenting to pets" (para. 5). In addition, *Ina May's Guide to Childbirth*, *The Girlfriend's Guide*, and *What to Expect* all consistently appear on Amazon's list of "best selling" texts on pregnancy and childbirth. *What to Expect When You're Expecting*, in particular, has established itself as the primary resource for information regarding pregnancy and birth. Chapters.indigo.ca reports that *What to Expect* is "one of USA Today's most influential books of the past 25 years," and with more than 14.5 million copies in print, is "read by more than 90% of pregnant women who read pregnancy books."

Texts were also chosen based on their intended audience; that is, I selected books that were marketed as applicable to all pregnant and childbearing women (rather than selecting books

marketed towards a specific audience, such as *Pregnancy for First Time Moms*, or *The Ultimate Guide to Pregnancy for Lesbians*). The texts range in publication date, with the oldest published in 2003, and the newest in 2011. All were published in North America, though one book (*Pregnancy Day by Day*, Canadian edition) is primarily sold in Canada. Despite the common characteristics shared by Canada and the USA (e.g. similar histories of medical and scientific knowledge development, a common history of Christian religious beliefs, both are Eurowestern, settler colonial nations with [neo]liberal capitalist values), there are distinct and important differences between our two countries. While Canada has publicly funded health care, the American medical system is highly privatized and relies upon funding from insurance companies; as a result, the American system is strongly influenced by technocratic culture and litigation fears (Gaskin, 2011; Margulis, 2013; Pfeiffer, 2010), which shape the ways in which American texts on childbearing present information regarding technological interventions. For this reason, I felt it was important to include at least one Canadian text, to allow comparisons of dominant medical discourses between countries.

Overview of The Selected Texts' Content and Ideological Approaches

All four of the texts under review provide education and advice on the following topics: choosing a healthcare provider, nutrition, prenatal screening and diagnostic tests, common pregnancy complaints, sex, choice of birth place, labor and delivery, pain, common biomedical interventions, instrumental and surgical birth, the third stage of labor (i.e. delivery of the placenta), and postpartum depression.

In addition to the above, *What to Expect* provides extensive information on a number of other topics including preconception preparation, pathologies related to medical history or age (e.g. fibroids, incompetent cervix, having a baby after 35), pregnancy “lifestyle” (e.g. cell

phones, hot tubs, household hazards, domestic violence), substances to avoid during pregnancy, exercise and healthy eating, “pampering,” working during pregnancy, childbirth education classes, “complementary and alternative medicine,” breastfeeding, multiples, the first six weeks postpartum, and what “fathers” may be wondering about. The book’s tone is a serious one, with the authors using anatomical and medical terms, and devoting much of the text to safety concerns, hazards, and sicknesses. Although placed at the back of the book, there is a significant amount of information on illness (e.g. listeriosis, measles, lyme disease, bell’s palsy), chronic conditions (e.g. cystic fibrosis), managing a “complicated” pregnancy or birth (i.e. types of miscarriage, HELLP syndrome, intrauterine growth restriction, oligohydramnios, placenta accreta, shoulder dystocia, postpartum hemorrhage), and coping with pregnancy loss, among other things.

The Girlfriends’ Guide considers a few of these topics as well, however it primarily emphasizes “pregnancy lifestyle” (the book’s back cover refers to the author as “the Carrie Bradshaw of pregnancy”). As such, it devotes a good deal of time to informing its readers on how to share the news of a pregnancy with “daddy”/friends/parents/OBs, how to care for skin, hair, and nails, exercise during pregnancy, sex during pregnancy, fashion, hair removal, what to take to the hospital, and the baby’s going-home outfit. The advice is referred to as “practical, humorous, and comforting” (front cover), “everything your doctor won’t tell you” (front cover), “indispensable” (inside front cover), and “the real skinny” on pregnancy courtesy of “your Girlfriends” (back cover). The girlfriends are described as a “sorority of women” (p. xiii), and are generally referenced throughout the text; however the experiences of women other than the author are mentioned infrequently, and when they are mentioned, their stories are told from the author’s perspective. Thus, although a “gaggle of Girlfriends” (inside cover) are reported to be

the source of information provided by the text, the narrative itself is singularly authored and rather narrow. The author relies upon informal lexical choices and colloquial language, such as “zipper deliveries” (i.e. cesarean sections; p. 175) and “McDreamy” (p. 221), strategically suggesting dialogue between equals. This “you can trust me - I’m just like you” tactic is explicit in *The Girlfriends’ Guide’s* title itself, which conveys co-membership with its readers.

There is no reference to “girlfriends” in *Ina May’s Guide to Childbirth*, and yet all the information in the book’s first half comes from a diverse group of women who, in their own words, share stories of pregnancy and birth. As a result, the book addresses several themes that are largely neglected by the other texts. For instance, many of the women speak of a moment of panic in labor, when they are unsure of how to cope with the intensity of the process and uncertain of whether or not they are capable of giving birth without drugs or interventions. One woman describes it this way:

As I approached full dilation, I lost my mind. I just did not think I was going to make it. I kept saying ‘I can’t do this anymore!’ I started to panic, and it was really scary, but Ina May talked me down and reminded me that this was all normal and that the more I said I couldn’t do it, the more I *was* doing it. The room was warm and the lights were dim. I appreciate that now...there was no way I could’ve dealt with the intensity of a hospital in that mental state. (p. 61)

Three themes covered solely by *Ina May’s Guide to Childbirth* are evident here: a normalization of the challenges many women face during labor and delivery (i.e. the text does not assume that birth is, or should be, effortless or painless), the care-provider’s ability to influence a woman’s experience (positively or negatively) as well as birth outcome, and the impact of environment. Additional information covered only by *Ina May’s Guide to Childbirth* includes the research

articles from which the book's content came, the power of the mind/body connection, orgasmic birth, models of maternity care, "routines to refuse" (i.e. non-evidence based practices, such as enemas), rare information on labor and birth (e.g. using the "pelvic press" can allow the birth of fetuses presenting forehead-first), and "what you least expect when you're expecting" (i.e. the high maternal morbidity and mortality rates in the USA, research on the dangers of commonly used induction drug Cytotec). Although the text provides a significant amount of unconventional information, it is limited in its applicability to diverse populations of women. Gaskin assumes, for example, that all women are in a position to choose their caregiver and place of birth, and does not take into account the ways in which such choices are constrained by economic factors and geographic and social location.

With the exception of *Ina May's Guide*, the texts under review define pregnancy and birth as physical, medical events, and portray those with biomedical credentials as obstetric authorities. In fact, all four books are written, co-authored, or reviewed by at least one individual or institution with medical credentials:

- *What to Expect*: The lead author is a nurse; the forward is written by an obstetrician who is advertised (on the front cover) as being on the board of the Department of Obstetrics, Gynecology, and Reproductive Sciences at the Yale University School of Medicine. On the back cover, the book is promoted as being "like a personal obstetrician to guide you." The first two pages of the text contain 14 reviews - nine of which are by individuals with medical credentials (eight doctors, and one nurse).
- *The Girlfriends' Guide*: The inside cover boasts that it is "favourably reviewed by the American Medical Association."
- *Ina May's Guide to Childbirth*: On the front cover, the book is praised by a doctor; the

back cover has four reviews, one by a doctor/reproductive scientist, who assures readers that “everything Ina May presents in this book is based on the best scientific evidence.”

- *Pregnancy Day by Day*: The front cover highlights the Canadian consultant, a doctor and assistant professor in the Department of Obstetrics and Gynecology at the University of Toronto, and the editor, a consultant obstetrician; of the book’s 18 contributors, 11 are doctors, two are consultant OB/GYNs, and two are midwives.

Credentials such as these actively work to establish the legitimacy and validity of the information contained within the texts, while at the same time reinforcing the social position of doctors as experts in pregnancy and birth.

Peripheral Discourses

My analysis of the chosen texts focuses on “identifying the social meanings reflected” (Padgett, 2008, p. 35) in the dominant discourses of pregnancy and childbirth. In this process, I also pay attention to peripheral discourses that provide possibilities for other, non-normative, less mainstream narratives of birth. These narratives act as discursive spaces where resistance to hegemonic ideologies is possible; in fact, resistance narratives may be sites of ideological tension and debate, as they bring normative discourses, power imbalances, and sociopolitical philosophies into sharp relief. By highlighting systems of inequality and privilege, counter-normative discourses may reveal the vested interests of particular groups and institutions. Because “power is transmitted and practiced through discourse” (Machin & Mayr, 2012, p. 22) resistance narratives may threaten hegemonic conceptual systems which sustain matrices of privilege and exclusion. Consequently, counter-normative discourses on pregnancy and birth are often dismissed, invalidated, or treated with disdain by those in power, who minimize resistance and maintain control by framing dominant discourses as “natural” or “common sense.” Lazar

(2007) states, “the taken-for-grantedness and normalcy of such knowledge is what mystifies or obscures the power differential and inequality at work” (p. 147). The framing of dominant discourses as “normal” knowledge exemplifies the subtlety of power relations. As Foucault (1973) points out, control is not wrought overtly by those in power; rather, citizens are encouraged to follow the status quo, and in doing so, they begin to conform to hegemonic ideologies and police themselves and each other through everyday narratives and actions. The suppression and marginalization of those who challenge taken-for-granted discourses works to obscure voices of resistance; additionally, counter-normative discourses may themselves be invisible, or flawed, particularly if they do not explicitly challenge the status quo. For these reasons, alternative accounts of childbearing may be difficult to find. However, seeking contradictions and alternative accounts of childbearing is congruent with an intersectional approach to discourse analysis, as it provides the space for consideration of a multiplicity of social dimensions, lived experiences, and knowledges. As Rudrum (2012) notes, “attention to multiple analytical dimensions moves beyond identifying how each one separately reflects or constitutes social practice, and towards theorizing how they support or contradict one another in this process” (p. 49). It was my intention to conduct my analysis in a way that allowed for realities that fall outside of the mainstream, heteronormative, largely white and middle class representations of pregnancy that prevail in childbearing texts.

Analytical Process

In order to identify both dominant and peripheral narratives regarding birth ideologies, ways of knowing, and power/control, I relied upon the methodological strategies of critical discourse analysis (CDA) to process the selected texts on pregnancy and birth. In considering the process of CDA, Huckin (1997) asserts that “it could best be characterized as an approach or

attitude toward textual analysis rather than as a step-by-step method” (p. 78). The attitude with which I approached my analysis sought to draw attention to power, oppression, privilege, and sociopolitical and economic forces. Further, I took into account “the most relevant textual and contextual factors, including historical ones, that contribute to the production and interpretation of a given text” (Huckin, 1997, p. 78). With these considerations in mind, I examined the discourses of best-selling texts on childbearing by engaging in the following methodological process:

- 1) Completed an overall reading of each book
- 2) Carried out a focused, critical reading of each book, taking note of format, content, section titles, language, tone, and images
- 3) Asked particular critical questions of the books, based on the orienting discourses identified in my review of academic literature
- 4) Identified recurring discourses by noting what the books communicated in response to my critical research questions
- 5) Transcribed excerpts/copied images that typified each discourse
- 6) Created sub-categories within discourses, based on excerpts and images
- 7) Noted links within and across discourses and books
- 8) Identified tensions, omissions and contradictions that surfaced in specific books, and within and across discourses, in order to make room for alternative stories.

Processing the literature in such a way is compatible with multiple, nuanced aims; such an approach to critical discourse analysis allows for consideration of both the formal features of the text and the ideologies underlying the information provided. As Lim (2014) notes, discourse analysis at the

Textual level focuses on showing how the text's language features (vocabulary, grammar, etc.) provide ideological structures for the knowledge/beliefs, social relations and social identities of participants in the discourse. The second part of the analysis then goes beyond the level of description to present an interpretation and explanation of how these ideologies are situated within broader institutional and societal practices that necessarily take into account unequal power relations in society. (p. 63)

With this in mind, each text was examined for the messages it conveyed around three broad themes; these themes were grounded in my initial review of existing academic literature on birth ideologies in popular parenting texts, and developed out of the orienting discourses that I identified. After developing each theme, I examined it through an intersectional lens, carefully and deliberately constructing inquiries that would ask particular critical questions of the material present in the literature. The themes and questions are as follows:

- Theme 1: Childbearing ideologies and praxis
 What topics were routinely addressed/ignored? How was information presented (wording, structure, organization, images)? Was information (in)consistent across texts? What kinds of messages did the information send? How was "risk" framed and defined? What did it mean to be pregnant/in labor/give birth? Where/when/how did one give birth?
- Theme 2: Knowing, expertise, and social scripts
 Who was framed as the knower/expert? What types of knowledge were legitimized/marginalized? How were social roles communicated and reified (i.e. how was social control established and maintained)? What/who was a mother/parent/family?
- Theme 3: Power, control, agency and choice
 How was "choice" framed? Who had authority to make decisions and give advice? Who

was represented and how? Who was not and why? What did the appearance and tone of the book convey? What did the images of women and their partners convey? How was control exercised, and by whom? How were power relations subtly and/or overtly reinforced?

The above questions and themes are mutually influential, interacting in complex ways; such multifaceted subject matter demands a layered and nuanced methodology in order to capture the intricacies of birth culture. As part of my methodology, I completed multiple readings of the texts, reading and re-reading large sections which struck me as interesting or important. I approached these re-readings by flagging sections of note during my initial overall readings, returning to them during my critical analysis. If, after my critical re-reading, I continued to feel particularly intrigued by or interested in a section, I allowed a few days to pass and then returned to it, reading it again and noting my thoughts and affective responses. I noticed that when I immersed myself fully in the data, I frequently became bogged down by it; frustrated, I would begin to overanalyze certain words or phrases that, when I returned to them later, seemed trivial. If a phrase or concept struck me as important initially, but upon returning a second or third time seemed inconsequential, I would discard it from the data and move on. If, however, it still seemed to project certain social values or birth ideologies, I included it in my analysis. I believe this process of multiple readings helped to complexify and deepen my analysis, while creating an audit trail showing a systematic, transparent process for making decisions. Further, I relied upon links within and across themes, and the use of excerpts and images to explore the complex world of pregnancy and birth.

Using such heterogeneous processes allowed me to identify the various ways in which birth and women's bodies are deeply classed, racialized, sexualized, and gendered, among other

things. These discourses exert a direct impact on pregnancy, the birth experience, social scripts, and women's identities, and have the ability to constrain or offer alternative possibilities (e.g. other narratives, or cracks in the normative ideologies). In the texts that I reviewed, I identified three dominant discourses on childbearing; each discourse developed out of focused, analytical readings of the four texts under review (i.e. these discourses were identified as I read through the data, and constitute the findings presented in the following chapter). I believe these discourse-findings reflect the social construction and current culture of childbearing in North America.

Although birth culture is a tangled web of political ideologies, social relationships, and hegemonic privilege, it is precisely this messiness and complexity that create the space for alternative discourses. While exploring the identified texts, I attended to exceptions and resistance narratives, which provided openings for stories of birth and motherhood that counter dominant norms. As Huckin (1997) reminds us, "people's notions of reality are constructed largely through interaction with others, as mediated by the use of language and other semiotic systems. Thus, 'reality' is...open to change – which raises the possibility of changing it for the better" (p. 79). Counter-normative narratives, for example, may create a reality in which childbearing women are viewed as experts on their own bodies and in their own lives, thereby legitimizing their unique knowledge and experiences. When women with a multiplicity of experiences are framed as knowers, discourses on risk and control may shift, allowing mothers to become active agents with valid needs, hopes, wisdom, and stories. Resistance and counter-normative discourses have the ability to affect change within birth culture, positioning women as active, powerful agents, capable of shifting systems of maternity care.

Validity, Reliability, Trustworthiness: Using Standpoint Analysis and Reflexive Practice

An active agent myself, I engaged with this study on several levels. As previously noted,

birth culture was examined via themes and questions concerning the literature's content, structure, and appearance. Such processes, however, may neglect issues of bias, researcher privilege and social location, as well as political context. Feminist researchers seek to bring these issues into conscious awareness through use of standpoint analysis and reflexive practice. Standpoint epistemologies draw attention to the ways in which social identities, such as gender, are constructed "in and through our everyday practices" (Naples, 2003, p. 38). As a researcher, I am aware of how my own experiences, stories, questions and perspectives contribute to, and create, some of the very discourses I seek to counter. Thus, throughout this thesis I have endeavoured to engage in standpoint analysis and reflexive practice to further my own awareness; for me, being aware means keeping in mind that women are not simply passive products of social forces – they are also active participants who 'do' gender by recreating, challenging, or redefining it in their day-to-day lives (Naples, 2003). Further, "woman" is not a homogenous or natural category - it is diverse, complex, and heavily contested. As noted in Chapter 1, feminists have long sought to challenge gendered norms that assign women "natural" traits; such stereotypes define women as inherently nurturing, relational, and emotional. Many childbearing women, however, may not relate to such a narrowly inscribed view of femininity. Some birthing individuals may not identify as women at all, preferring instead to describe themselves as gender nonconforming, agendered, gender queer, or third gender, among others. Keeping the shifting and varied identities and agency of women at the forefront of my mind was critical throughout this project, as it helped complicate my tendency to view things in black and white. This tendency was also challenged by the exceptions and resistance narratives that surfaced in certain texts; such counter-normative discourses encouraged me to stay open to the possibility of positive and productive ideas being present in the literature. Considerations such as

these have helped me “become aware of, and diminish the ways in which, domination and repression are reproduced” (Naples, 2004, p. 37) in my own research.

For example, the power that I wield, given the social status of my position as a white, working-class, midwifery student, a non-parent, and a graduate researcher, and my ability to select the questions I wished to ask, has impacted the way the selected texts were interpreted. Given that pregnancy and birth processes often invoke fierce emotion and debate, I strove to be conscientious of my work’s potential for inducing guilt, or feelings of judgment. I also needed to be wary of using the themes to reproduce good-birth/bad-birth (and therefore good woman/bad woman) dichotomies. Thomson and Downe (2012) note that such dichotomies are prevalent in academia, with much of the literature

appear[ing] to suggest that a vaginal birth is (inevitably) a positive experience, whereas obstetric intervention is likely to predispose to psychological morbidity. These views only offer a limited and restricted focus on modern childbirth, which overlook the potentially positive and rewarding experiences of a birth with technical interventions for some women. (p. 1)

My struggle against framing births within the medical system as “negative,” and births outside the medical system as “positive,” began at the outset of this project, and continued throughout the research and writing process. I found it necessary to continually bring myself back to the goals of this research project – to document birth culture, to create links between birth and sociopolitical structures, and to highlight the diverse voices and shifting identities of birthing mothers within a complex and layered social matrix.

Furthermore, while conducting this study, I sought to engage with issues of validity, reliability, and trustworthiness from a critical postmodern feminist theoretical lens. Postmodern

theorists, such as Kvale (1995), have redefined these concepts such that they are both useful and applicable to socially-situated qualitative research. Because intersectional feminist and postmodernist perspectives acknowledges multiple truths, and multiple ways of knowing, validity is understood as a tool which promotes defensible knowledge. Appraising validity through a postmodernist lens,

There is a change in emphasis from verification to falsification. The quest for absolute certain knowledge is replaced by a conception of defensible knowledge claims.

Validation becomes the issue of choosing among competing and falsifiable interpretations, of examining and providing arguments for the relative credibility of alternative knowledge claims. Validation here comes to imply the quality of the craftsmanship in research. (p. 25)

Kvale (1995) goes on to explain that quality craftsmanship in research may be partially obtained through “continually checking, questioning, and theoretically interpreting the findings” (p. 27). Thus, throughout the research process I endeavoured to continually check the credibility and trustworthiness of my findings by considering my own biases and the effect these might have on the data, asking questions of “what” and “why,” and generating theoretical questions about the social construction of birth realities.

Using such processes to promote validity is compatible with a feminist understanding of reliability. Feminists reject the traditions of empiricism, recognizing that “human experiences are unique, particularized, and not always amenable to verification...the essence of what reliability means, therefore, is more appropriately conceptualized in feminist research as the dependability of the research process” (Hall & Stevens, 1991, p. 19). Like validity, dependability is an ongoing process, assessed over the course of a research project; it is advanced via a variety of techniques

including comparison of multiple data sources, multiple data readings, researcher engagement and reflexivity, careful observation, engagement with the literature, and the creation of decision or audit trails. According to Hall and Stevens (1991),

Auditing the inquiry (i.e., determining whether decisions made are congruent with their circumstances and assessing whether interpretations and recommendations are generally supported by the data) attests to the dependability of the project. Systematically documenting the rationale, outcome, and evaluation of all actions related to data collection, sampling, analysis, and dissemination of results is therefore an important point of rigour in feminist studies. (p. 19)

In order to foster reliability/dependability in my own study, I created an audit trail of my theoretical and methodological choices. This was done by meticulously recording and reporting (in this chapter, and elsewhere) the analytical processes and steps used to conduct the current project, allowing others to see exactly how I developed and conducted my research. As Schwartz-Shea (2006) notes, the goal of an audit trail is to “make the linkages among researcher decisions, evidence generated, and inferences drawn as transparent as they can be” (p. 105).

I sought to promote transparency in other ways as well. Along with socially locating myself, and considering my own biases, transparency means admitting that this research is partial, incomplete, and screened through my own eyes (Carter, 2004; Morgan, 2004), and therefore I endeavoured to evaluate my positionality and reflexivity with respect to the research topic. Kirby et al. (2010) advise researchers to “unpack or state [their] biases so that positionality [can] be a visible part of the research” (p. 68). Along with considering my struggle against framing certain births as negative and others as positive, I practiced reflexive processes by auditing my inquiries, consistently asked “what else could this mean?” and engaged with the

literature on multiple levels (e.g., as a midwifery student, as an academic, as a female of childbearing age from a working-class family). Such practices encourage an awareness of my own preconceptions and privileges, a characteristic essential to conducting ethical research. This focus on power, positionality, and respect makes reflexive practice an appropriate choice for feminist researchers wishing to counter inequalities in qualitative investigations, while advancing validity, reliability, and trustworthiness.

Further Limitations

In reflecting on the limitations of my study, I am aware of the critiques levelled against intersectionality as a theoretical approach. Carastathis (2008), for example, argues

To the extent that a dualistic knowledge continues to inform our thinking about race and gender, it is still, on the intersectional model, implicitly the masculine that poses as the generic Black person, and the white that poses as the generic woman. (p. 28)

Constructing race and gender as separate vectors, as intersectionality sometimes does, may corroborate matrices of privilege and oppression by making certain identity determinants salient, and others invisible. For example, under intersectionality, race may be associated with individuals of colour (i.e. those who are not white), while gender may be associated with female individuals (i.e. those who are not male); this inadvertently situates the white male body as the default body, constructing it as neither racialized nor gendered. The invisibility of whiteness, combined with the separation of race and gender under some intersectionality frameworks, means that if one “has” race (but not gender), one is generically imagined as a Black male. Similarly, the invisibility of maleness means that if one “has” gender (but not race), one is assumed to be a white woman. Race and gender intersect, then, in the person of the Black woman. Carastathis (2008) notes that

The ostensible *mutual exclusivity* of the categories of race and gender is the *condition for the possibility of their intersecting*; but this is a function of the *invisibility* of their respective gendering and radicalization. These categories can be said to be analytically pure only insofar as they are unmarked, uninflected, by one another; but this purity is an impossibility, even as an abstraction. (p. 28)

Indeed, the separation of race and gender may work against the stated goal of intersectionality, which aims to highlight the ways in which oppressions and privileges inform and mutually construct one another. The fixed nature and mutual exclusivity of race and gender under some applications of intersectionality means that parts of this project may rigidify or simplify women's identities by neatly categorizing them, or making certain determinants more salient, rather than promoting a politically-situated subjectivity, “which asserts dynamic, contradictory, and unresolved dimensions of experience” (Carastathis, 2008, p. 29).

Additionally, since interviews were outside the scope of this project, my research is limited in that it cannot identify women's concerns, questions, or reactions to the messages espoused by the literature under review. It is possible that the discourses identified in the texts may have been interpreted differently by different readers, and that the messages inherent within each discourse may have had a greater or lesser impact upon childbearing women's birth ideologies, identities, and preferences.

Methodology Summary

Asking myself difficult questions and engaging in the art of reflexivity allowed me to examine my own narratives, and the discourses and matrices of identity, privilege, and oppression that intertwine to create my story. Thomson and Downe (2012) emphasize that “human beings have always been surrounded by, and embedded within narrative, and that

individuals are able to make sense of their world through telling stories” (p. 6). By integrating a feminist intersectionality framework with the methodology of critical discourse analysis, this study aims to examine the discursive narratives of popular birth literature, and to question what they tell us about our own identities and capabilities, as well as those of others. This grounding in “every day social and cultural interactions is the single most distinguishing characteristic [of qualitative research] and its greatest strength” (Kingdom, 2004, p. 4). Using critical, feminist research methodologies to explore discourses of birth within the context of sociopolitical systems, I hope to highlight the diverse voices and shifting identities of birthing women, and create a discursive space that allows for alternative conceptualizations of knowledge, pregnancy, and birth.

Chapter 4: Findings – Key Ideological Discourses of Popular Childbirth Advice Texts

With an overview of feminist intersectionality theory, critical discourse analysis, and the technocratic and midwifery models of care positioning this thesis in theoretical and ideological context, I now present my key findings. I identified three recurring discursive themes and associated sub-themes in the four texts under review. Here I provide an analysis of the data gathered from the books' content, linguistic elements, structure, and images.

Discourse I: “Doctors Promise to Stand Between You and Calamity During Pregnancy and Childbirth”

The above quote, taken from the *The Girlfriends' Guide to Pregnancy* (p. xix), exemplifies the first discourse I identified. This discourse revolves around the biomedical framing of pregnancy, labour and delivery as pathological processes, the subsequent mistrust of the female body, and the belief that birth must be managed by medical experts and the technology they wield. As noted in the history of Eurowestern maternity care (see Chapter 2), pathologization of the female body is rooted in misogynistic philosophical and scientific doctrine; such beliefs remain rampant among many in the biomedical field, guiding both perspective and obstetrical practice. In my review of the four texts, I found that birth culture, and thus, childbearing advice literature, is dominated by these technocratic ideologies, which shape the messages and information used to educate and counsel birthing women. This was achieved in the way the information was presented (structural organization, lexical choices, and images), the topics that were routinely addressed or ignored, the consistency of the information, and the way that risk was framed and defined.

Presentation of information. The structural organization, lexical choices, and images in three of the four texts under review (*The Girlfriends' Guide to Pregnancy*, *What to Expect When*

You're Expecting, Pregnancy Day by Day) worked to reify technocratic dogma on childbearing.

Structural organization. Medical discourses were prioritized in the way the texts were structured. For example, in a section called “Choosing and Working With Your Practitioner,” *What to Expect* (2008) uses a heading which lists obstetricians (OBs) first, family practitioners (FPs) second, and midwives last. In the body of the section, information on OBs and FPs is presented on page 21; curiously, rather than following this page with information about midwifery care (as the heading would suggest), the authors chose to insert a two-page box on choice of birth place, which takes up page 22, 23, and half of 24. Thus, midwifery care is not even considered until several pages *after* information on OBs and FPs is given, and information on an entirely different topic has been presented. The reader is first introduced to OB and FP care, and is then encouraged to move on to thinking about choice of birth place. In a similar vein, *Pregnancy Day by Day* (2009) lists OB/GYNs (obstetrician/gynaecologists) first, then general practitioners (GPs), and finally midwives, in its section called “Who’s Who: Your Care Providers” (p. 103).

Separating the information in such a way works literally and metaphorically to push midwifery to the margins, making doctors seem like the only appropriate choice for maternity care. Pincus (2000) notes that the structural organization of a text

Reveals an author’s instructional itinerary. For instance, most authors place descriptions of obstetricians and family practitioners *before* midwives, hospitals *before* birthing centers and homes. Ordered according to the most common practices, this predictable line-up gives readers the message that midwives come last, even while midwifery care is being described as desirable and the appropriate care for most women. (p. 211)

The strategic organization of information and its impact upon the way that information is

interpreted is not limited to the topic of care provider. In its presentation of epidural anesthesia, *Pregnancy Day by Day* devotes three pages (p. 404-406) to pictures, a pros and cons list, a box on epidural headache, and text explaining how the procedure is done, side effects, and potential problems. Although the information itself is quite thorough, its presentation reveals the authors' biomedical bias. The pros and cons list appears first; it has three distinct sections: pros, cons, and "a few very rare risks" (p. 404). Visually, the list appears to favour epidural usage, with twice as much text in the pros column than in the cons column. A closer inspection however, reveals that the cons column does not actually contain any of the common adverse effects of epidurals (e.g. hypotension, itching, shivering, fever, prolonged second stage of labor, and increased chance of needing a forceps or vacuum delivery [Herer & Blott, 2009; Leighton & Halpern, 2002; Lowe, 2004; Romano & Lothian, 2008]). Rather, these are scattered throughout the text over several pages. Moreover, one of the bullet points in the cons list reads, "a *rare* complication is patches of heaviness in the legs or feet" (p. 404, emphasis mine). In choosing to include an infrequently occurring complication on the cons list (rather than in the "rare risks" section), instead of more common side effects, the authors further promote epidural usage, insinuating that the possibility of adverse events is low.

Lexical choices. The lexical choices of *The Girlfriends' Guide to Pregnancy*, *What to Expect When You're Expecting*, and *Pregnancy Day by Day* clearly promote biomedical, technocratic birth culture. Each text frames medical doctors as the appropriate choice of care provider, through its use of language. *What to Expect* asserts that "even if your pregnancy looks pretty routine, you may still want to select an obstetrician for your care - more than 90 percent of women do" (p. 21). *The Girlfriends' Guide* refers to doctors as "run[ning] the show" (p. xix), "trusted professionals" (p. 5), "solicitous and inquiring" (p. 82), and "competent and caring" (p.

223), and advises women to “go for the traditional hospital birth with a godlike medical doctor” (p. 75). In contrast, women who choose midwifery care, or adhere to a more natural philosophy of childbearing are openly belittled by *The Girlfriends’ Guide*, which describes them as “fringe people” (p. xix), “strange” (p. 157), “flower child[ren]” (p. 157), “frontier women” with something to prove (p.231), “American Gothic counterparts” (p. 71), believing in “naive promises” (p. 176), and armed with “a pitiful arsenal of Lamaze breathing, a Yanni cassette, and [a] hapless mate” (p. 71).

The author’s derogatory attitude towards natural birth seems to be an attempt at countering the pressure that many women may feel to achieve a birth free of medical intervention or assistance. Indeed, she states

We Girlfriends want to let you in on a secret. THERE IS NO AWARD CEREMONY FOR MOTHERS AFTER DELIVERY...no medals are presented to those mothers who managed to deliver their children without pain medication...you have a choice: you can lie on a bed of nails to deliver your baby or you can lie on a bed of downy feathers. No matter what you choose, neither your doctor, your nurse, nor your baby will think any better of you for suffering because of some possibly misunderstood notion of what is best for your child. (p. 71)

Although the author’s intention may be to relieve the shame, judgment, or guilt mothers who opt for pain relief may experience from natural birth advocates, her biomedical stance is equally judgmental and exerts a similar pressure on women to conform to the ideology she touts.

Even though it is slightly more subtle in its approach, *What to Expect* clearly exhibits biomedical ideologies in its lexical choices as well. Hospital birth, for instance, is promoted through constant reminders of the pathological, dangerous nature pregnancy and birth. This is

accomplished by the use of phrases such as “medical equipment on hand” (p. 23), “emergency care can be initiated” (p. 23), “if something unexpectedly goes wrong” (p. 23), “if complications occur” (p. 24), “you, the patient” (p. 28), “to be extra cautious (always the best way to be), ask your practitioner” (p. 180), “‘caution’ should be your middle name when you’re expecting” (p. 270), and “the best birth is the one that’s safest” (p. 321). A focus on safety often intertwined with fear of, and apprehension towards, childbirth. *The Girlfriends’ Guide* calls fear of labor and delivery “the big one” and “the mother of all fears” (p. 70). On pages 70-71, the word “fear” appears 11 times, “terror” is used twice, “scared” once, and “horror” once. *The Girlfriends’ Guide* goes on to remind its readers that “your mate loves you very much and doesn’t want anything bad to happen to you. Or more to the point, he doesn’t exactly want to have you die in childbirth and leave him with a baby he hasn’t even met yet. He will insist on a doctor who’ll guarantee that you will come out of this ordeal alive and well” (p. 77).

Ina May’s Guide to Childbirth directly challenges this biomedical framing of birth as a dangerous, terrifying event. In a chapter called “What Happens in Labor,” the female body and its processes are described in positive, encouraging terms. On pages 144-145, the word “power/powerful” appears three times, “strong” is used twice, and “wondrous,” “vital,” and “sufficient” are used once. Quotes from women and midwives throughout the book corroborate this view of birth as safe and normal. A box on page 147 contains the following statement:

Forty years of experience as a midwife have not lessened my awe and respect for the efficiency and beautiful design of the female body as expressed in labor and birth. In fact, the years only increase my sense of wonder about how well our bodies can work - given the right circumstances. The outcomes of our births at The Farm Midwifery Center demonstrate how rare it is for complications and difficulties to occur when women are

properly prepared for birth and when technological interventions are kept to a minimum - that is, used only when necessary.

Despite the impressive statistics of The Farm Midwifery Center (provided for the reader in Appendix A, on pages 321-322 of *Ina May's Guide to Childbirth*), which report a 0% maternal morbidity and mortality rate for 2,844 births, the classification of pregnancy and birth as perilous events that are traumatic for women is prevalent in the other texts under review. For instance, *Pregnancy Day by Day* states, "natural birth has many advocates, but the best birth is one that delivers your baby safely with minimum trauma for both of you" (p. 311). It is also worth noting that the "panel discussion" about natural birth which appears on page 311 provides the opinions of a mother, and a doctor, but lacks the voice and perspective of a midwife. Though the book pays lip service to natural birth elsewhere, hospitals are framed as the appropriate choice of birth place, even for healthy, low-risk women. The book states, "it is generally accepted that the care of healthy women in labor who have had a straightforward pregnancy should be monitored and managed by their doctors or midwives at the hospital, with support given by the nursing staff throughout the process" (*Pregnancy Day by Day*, p. 302).

Furthermore, *Pregnancy Day by Day*, *The Girlfriends' Guide*, and *What to Expect* represent the hospital itself in strictly positive terms. *What to Expect* describes maternity rooms as "cozy and comfy" (p. 22, 276), and having

an 'at-home-in-the-hospital' look, with soft lighting, rocking chairs, pretty wallpaper, soothing pictures on the walls, curtains on the windows, and beds that look more as if they came out of a showroom than a hospital supply catalog. (p. 22)

The positive imagery continues throughout the text, with the labor and delivery floor being described as "the happiest in the hospital" (p. 276). *The Girlfriends' Guide* reiterates this

sentiment, with the author stating

I love maternity wards. I love all the new mothers, the pictures of babies on the walls, the nursery full of babies, the abundance of trained medical professionals. I cannot think of a place where I would rather be in labor, no matter how many hours lie ahead of me. You have a choice: You can walk around your own house to help your labor along, or you can walk around the hospital. At least at the hospital, you won't feel compelled to make all the beds and unload the dishwasher while you walk. (p. 220)

The convenience, technology, comfort, and glamor of the hospital are also emphasized in the book's humorous list of the "Top 10 Ways to Deliver Babies": "in a hospital room where your cell phone works," "with someone at your house, cleaning and cooking for your return," "with McDreamy as your obstetrician," and "sipping on an epidural cocktail and watching Oprah" (p. 221).

Additionally, favourable adjectives are used liberally in *What to Expect's* presentation of information regarding technology and interventions. Cesarean sections are labelled "the happiest kind" of major surgery you can have (p. 320), "family-friendly" (p. 320), and "extremely safe" (p. 321). In fact, in one and a half pages worth of information on c-sections (p. 320-321), the words 'safe' or 'safety' are mentioned seven times. On page 321, women are told that a cesarean section will allow them to deliver without "the pain of labor," will "keep your perineum intact and your vaginal muscles unstretched," and that the baby will be cosmetically more appealing ("he or she will have an initial edge in appearance over vaginally delivered babies").

In contrast to its promotion of technological interventions and medical knowledge, *What to Expect* expresses doubt and discomfort regarding more natural methods, calling them "old wives' tales" (p. 350) and positioning women's knowledge as folklore. In a section on

nonpharmacological methods of labor initiation, for example, the book lists nipple stimulation as an option (nipple stimulation causes the release of oxytocin, which in turn contracts the muscles of the uterus [Gaskin, 2003]). This option, however, is not favourably or even neutrally portrayed; although nipple stimulation is most frequently done with a breast pump or a TENS machine (a “device which delivers a low electric current through pads applied to the skin” [Gaskin, 2003]), *What to Expect* describes the technique as painful and lengthy: “interested in some nipple tweaking (ouch)? How about some nipple twisting (double ouch)...for a few hours a day (yes, hours)” (p. 351). Although the book admits that the process can release oxytocin and induce labor naturally, it warns of a “caveat: nipple stimulation - as enticing as hours of it may sound (or not) - can lead to painfully long and strong uterine contractions” (p. 351). The book fails to mention that *if* such contractions occur, the technique can very easily be stopped, and the strength of the contractions will diminish with no residual side effects. Ironically, several pages later in a section on pharmacological induction of labor, the text advises women not to worry if they are receiving Pitocin (a synthetic form of oxytocin) and it triggers “contractions that are too long or powerful. If that happens, the rate of infusion can be reduced or the process discontinued entirely” (p. 369).

The Girlfriends' Guide endorses pharmacological induction for reasons of convenience, physical appearance, and leisure, with the author stating,

I always tried to talk my doctor into inducing my labor at a time that was mutually convenient for the baby, the doctor, and me. That guaranteed that the baby would be cooked; my doctor would be fed, rested, and in town; my hair would be clean, my legs would be shaved, and my toenails would be painted. (p. 189)

Heavily gendered expectations of beauty and femininity are prevalent here, reinforcing the

apparent significance of a woman's attractiveness, even as she gives birth. In fact, these expectations are extended to the birth process itself. There is no mention of blood, pain, feces or sweat - only pedicures, shaved legs, and epidural cocktails. Electronic fetal monitoring is described as "fun" (p. 227), epidurals are "great" (p. 71), "wonderful" (p. 232) and like lying "on a bed of downy feathers" (p. 71), and the women who choose them are pronounced "the life of the champagne celebration in our rooms after the baby [is] born" (p.71). Despite their status as a major surgical procedure, c-sections are labelled "zipper deliveries" (p. 175, 177), and the author's attitude toward them is both cheerful and blasé. She states that

C-sections are safe for mother and child, and the recovery time is surprisingly short. Yes, I read the papers, and I am aware of the outrage in some quarters about the number of unnecessary C-sections that are performed in the United States. Am I resentful or indignant? Not particularly...having a healthy baby was all I really wanted and I didn't care how I got it...by the fourth child, I was begging my doctor for a C-section in the fear that if I had any more big noggins come through my vagina, my husband would be able to yodel and hear his echo down there. (p. 219)

Thus, the text condones the use of major surgical procedures (whether warranted or not) and fails to mention documented associated risks. Rationale for cesarean section and other technological interventions are claimed to be improved infant health, convenience, amusement, glamour, female beauty aesthetics, and male sexual pleasure.

Images. *The Girlfriends' Guide to Pregnancy* does not contain any images of women or birth. However, the images that appear in *What to Expect When You're Expecting* corroborate biomedical childbearing discourses, presenting women as bodies that must be managed, or acted upon. *What to Expect's* diagram of the birth process (called "A Baby is Born," p. 392) does not

show a woman at all, simply a uterus with a baby in it. The uterus appears to float in mid-air, detached from the person to whom it belongs. The baby is shown moving down the birth canal, but this process seems to occur independently of any maternal effort or participation. In the final image of the sequence, the baby's head has been born, and is actively manipulated by a gloved hand. *Pregnancy Day by Day* contains similar images of birth (p. 415, 426), although the uterus on page 426 is situated within an abdomen and shows the woman's legs and pelvic bones (it is worth noting, however, that she lacks a head). In these images, women are segmented into parts and, quite literally, disembodied. In her discussion on the representation of birthing mothers in textbooks, Kitzinger (2005) notes that women are frequently "headless, often cut up into little bits - a cervix here, a perineum there, an excised uterus over the page - and depicted as if they were simply a collection of bone, muscle, and nerve fibers" (p. 61). The texts' depiction of women as a collection of body parts reduces them to passive objects, and presents mothers as bodies that are acted upon by gloved hands.

Although *Pregnancy Day by Day* offsets its drawings of women's body parts with a photo of a mother delivering her infant (she smiles as the baby's head is crowning; p. 426), it is *Ina May's Guide to Childbirth* that portrays women most holistically. There are no diagrams of uteri giving birth. Rather, the book contains photographs of women in labor, or with their babies, as well as drawings of women from a variety of cultures in various contexts and the positions in which they give birth. It is interesting to note that nearly every labor photograph shows the woman's body in its entirety - that is, women's limbs and faces are not cropped out of the image (the exception to this is three pictures which show babies crowning: one is an unusual presentation ["sunny side up," page 58], one shows a squatting position [page 252], and one shows a mother actively helping to prevent a tear [page 255]), and women are shown labouring

without clothes on (as opposed to *What to Expect* and *Pregnancy Day by Day*, which mostly contain images of women whose breasts are covered by sheets, sports bras, or tank tops).

Topics routinely addressed/ignored. All four of the texts under review provide education and advice on the following topics: choosing a healthcare provider, nutrition during pregnancy, prenatal screening and diagnostic tests, common pregnancy complaints, sex during pregnancy, choice of birth place, labor and delivery, pain, common biomedical interventions, instrumental and surgical birth, the third stage of labor (i.e. delivery of the placenta), and postpartum depression.

Additionally, *Ina May's Guide* and *Pregnancy Day by Day* both present research on the risks of technological interventions. *The Girlfriends' Guide* and *What to Expect*, however, frequently ignore or minimize the side effects of common obstetrical procedures. *The Girlfriends' Guide* does not identify any downsides to induction of labor, and states that epidurals have only “a couple of little drawbacks” (p. 232; these are listed as a decrease in productive labor, and numbness affecting one’s pushing abilities - there is no mention of hypotension, fever, neonatal sepsis, accidental lumbar puncture, severe headaches, itching, an increased likelihood of surgical or instrumental birth, perineal trauma, or maternal paralysis [Baraz & Collis, 2005; Chaney, 1995; Leighton & Halpern, 2002; Lieberman & O’Donoghue, 2002; Lowe, 2004; Robinson, Norwitz, Cohen, McElrath, & Lieberman, 1999; Romano & Lothian, 2008; Scott & Hibbard, 1990]). In its presentation of information on chorionic villus sampling (CVS: a procedure used as a prenatal diagnostic test for chromosomal abnormalities), *What to Expect* advises readers that the test is “safe” and “reliable,” can result in bleeding but this “should not be cause for concern,” that there is “a very slight risk of infection,” and a “miscarriage rate of about 1 in 370” (all from p. 62). A miscarriage rate of 1 in 370 calculates to

a 0.003% risk, a number far lower than the 4.0-12.9% estimation given by the World Health Organization (Gaskin, 2003; Oladapo, 2006).

Further, the WHO has stated that “there is no justification for any region to have cesarean section (CS) rates higher than 10-15%...[because] above this range, higher CS rates were predominantly correlated with higher maternal mortality” (Davis-Floyd et al., 2009, p. 9). Despite this international standard, *What to Expect* urges its readers to adopt an attitude of indifferent acceptance towards soaring c-section rates, stating

A cesarean is a very safe way to deliver, and in some cases, the safest way. It’s also a more and more common way. Thirty-four percent of women are having c-sections these days, which means the chances that your baby will end up arriving via the surgical route are more than 1 in 3, even if you don’t have any predisposing factors...if the past few years are any indication of future trends, you can expect those numbers to continue climbing - and to hear more and more c-section birth stories from the recently delivered around you. (p. 320-321)

Pregnancy Day by Day provides a much more balanced perspective on cesarean deliveries, noting that a

Rate of around 10-15 percent is thought to be reasonable, although in most Western countries the rate has risen beyond 20 percent, and around 30 percent of all babies in Canada are now delivered by cesarean, an all-time high...some women may think that cesareans are safer for the baby than a vaginal birth. In fact, if you’ve had an uncomplicated pregnancy, a cesarean is hard to justify on medical grounds. (p. 438)

For those whose pregnancies warrant a cesarean, the text offers reassurance regarding the procedure’s risks and complications, noting that side effects are generally minor. Overall,

however, *Pregnancy Day by Day*, *The Girlfriends' Guide*, and *What to Expect* all tended to ignore or downplay the side effects and potential complications of technological obstetric interventions.

Consistency of information. Conflicting information and ideas, within and between texts, was rampant. Risk statistics were a particularly thorny problem. The risk of miscarriage attributable to chorionic villus sampling (CVS), for instance, varied wildly from book to book, and was frequently difficult to interpret; no two texts contained the same statistics:

- *Pregnancy Day by Day*: “The risk of miscarriage after CVS is greater than amniocentesis, but less than 1%” (p. 153; the risk of miscarriage due to amniocentesis is reported as “around 1 in 600 to 1 in 900”).
- *What to Expect*: “CVS is safe and reliable, carrying a miscarriage rate of about 1 in 370” (p.62).
- *Ina May's Guide to Childbirth*: “The rate of pregnancy loss after CVS was about four percent in a large register organized by the World Health Organization” (p. 193; this text was the only one that referenced the source of its information).
- *The Girlfriends' Guide*: “When your doctor is experienced with this procedure (and you should ask how many of these he or she has performed), the risk seems to be the same as with amnio” (p. 95; the risk of miscarriage due to amniocentesis is reported as 1 in 200).

To obscure things further, all of these numbers are different than those reported recently by the WHO.

The texts also frequently contradicted themselves. *What to Expect* was the worst offender, teeming with inconsistencies on everything from heating pads (they're dangerous/there's no proven risk; p. 79), to painting the nursery (paint odours aren't harmful/try to be out of the house

when someone is painting; p. 83), herbal teas (probably safe/stay away from them; p. 113), food chemicals (few substances proven harmful/reduce your risk where you can; p. 113), cooking from scratch (when do you ever have time to cook from scratch? [p. 108]/whenever possible, cook from scratch [p. 113]/regularly eat take-out food [p. 128]), stretch marks (nobody likes stretch marks [p.179]/be proud of your stretch marks [p. 180]), and women’s bodies (a speedy metabolism that makes gaining weight challenging is a blessing [p. 52]/celebrate your curves, you’re supposed to gain weight during pregnancy [p. 53], big is beautiful when you’re expecting/try to look slim and trim when you’re expecting [p. 211]).

What to Expect also contained a significant amount of misleading information, particularly with respect to the frequency with which biomedical technology and interventions are used in American hospitals. Women are told: you “probably won’t have to be attached to a fetal monitor for the entire duration of your labor” (p. 373), “odds are great that you’ll be able to experience an unrushed, family-friendly, noninterventionist labor and delivery within a traditional hospital setting” (p. 22), “many [doctors] recommend complementary and alternative medicine techniques to their patients” (p. 305), and that whirlpool tubs are “used in many hospitals” (p. 86). This information directly contradicts a vast body of research and anecdotal reports demonstrating that medical interventions are, in fact, the norm in most American (and many Canadian) hospitals (Albers, 2005; Declercq, Sakala, Corry, & Applebaum, 2006; Goer, 1999; Hersh, Megregian, & Emeis, 2014; Jansen et al., 2013; Kelly et al., 2013; Kitzinger, 2005; Mitford, 1992; Oden, 2005; Odent, 2003; Romano & Lothian, 2008; Rosenthal, 2013; Shaw, 2013; Stockill, 2007; Stout & Cahill, 2011; Torres, De Vries, & Low, 2014; Wagner, 2006; Wolf, 2001). Further, the authors fail to consider that hospital “amenities,” such as whirlpool tubs and alternative medicine practitioners, may not be widely available outside of urban centers,

and that women in rural regions may not have access to this type of maternity care.

Framing and defining risk. As noted in my overview of maternity care models, dominant technocratic discourses on childbearing view pregnancy and birth as inherently risky, and frame hospitals as environments in which this risk is mitigated through the use of medical technology. This discourse is evident in *The Girlfriends' Guide* and *What to Expect*, which portray relying upon technology as less risky than eschewing it. Interestingly, although *What to Expect* disseminates the message that a lack of intervention poses health risks to the fetus, and opposes women *eschewing* technology for their own preference or peace of mind, the book enthusiastically endorses *using* technological interventions (which may risk the health of the fetus) to promote maternal peace of mind. This paradox is palpable in the presentation of information on prenatal screening and diagnostic tests. The text reasons, “why go through diagnostic tests if there’s some risk involved? The best reason for prenatal diagnosis is the reassurance it almost always brings...mom and dad can quit worrying and enjoy their pregnancy” (p. 59).

The Girlfriends' Guide echoes this line of reasoning, framing the risks that occur alongside the use of medical technology (as opposed to the risks of forgoing the use of technology) as more legitimate risks for childbearing women to take. In a section called “Doctor or Midwife?,” the author vehemently states, “never elect to have a child where you have no access to medication or, God forbid, real doctors” (p. 74). Women who choose to forgo the use of technology are morally stigmatized throughout the text for their differential weighting of risk, as the author subtly questions the responsibility, compassion, and sanity of women wanting a natural birth, and implies that they care more about an idealistic experience than the health and safety of their infants. These beliefs are evident in statements such as, “having a healthy baby was all I really

wanted, and I didn't care how I got it" (p. 219), "a postscript to the home delivery section: Childbirth is as messy as a pig slaughter. Why in the world would you want to sacrifice your beautiful sheets, not to mention mattress, to such a thing?" (p. 74), and

A delivery that results in a healthy mother and baby is a gift from God, no matter how that delivery was achieved. Period. Childbirth is not like a visit to the spa: It is not designed for your personal enjoyment and fulfillment. It is not an opportunity to demonstrate your abilities or fitness. It is designed to perpetuate the species and nothing more. (p. 233)

Interestingly, the author's assertion that childbirth is not meant to be comparable to a spa experience directly contradicts her own expectations and demands of the process, as she references the comfort of drugs, lying on feather beds, champagne, epidural cocktails, shaved legs, zipper deliveries, clean and coloured hair, pedicures, and watching Oprah. References to spa-like activities are scattered throughout the text, as are explicit religious and moral comments (such as the above reference to "a gift from God"). These remarks denote an interesting cultural difference between American and Canadian birth culture: in the U.S., birth discourses tend to evidence a much more explicit Christian moral tone, whereas Canadian discourses tend to refrain from overtly religious sentiments.

Discourse II: "Ask Your Practitioner"

The first discourse involves the biomedical framing of childbearing as a pathological process, and the necessity of medical experts and technology; pregnancy and birth are viewed as a "calamity" which doctors ward off with biomedical knowledge and technological interventions, and these beliefs provide the foundation for the second discourse. The second discourse I identify concerns the legitimization of "expert" knowledge, the power of those deemed as

knowers, the marginalization of those whose knowledge is defined as invalid, and the social scripts of childbearing women. All of the texts under review, with the exception of *Ina May's Guide to Childbirth*, construct doctors as possessors of legitimate knowledge, and therefore, experts in the field of birth. With scientific obstetric knowledge framed as valid, other knowledge systems are largely devalued and pushed to the margins.

Construction of differential knowledge systems. *What to Expect* wastes no time in legitimizing obstetric knowledge, using its forward to remind women that they do not have this particular type of knowledge and as a result, they are patients who do not know much. The forward, written by an obstetrician, notes that the book will tell women “what [they] should be feeling” (p. xx), will answer questions “[they] didn’t know to ask” (p. xx), and that “the authors know just what moms-to-be and their partners need to know” (p. xxi). The knowledge that women may have is considered inconsequential by the text. This is painfully obvious in statements such as “you’re bound to be wondering: Am I pregnant? Well, read on to find out” (p. 14), “but how, you wonder, does this woman know [that she’s in labor]?...what makes her so sure she’s not going to get to the hospital...and be sent home, amid snickers from the night shift?” (p. 358), and advice to

Follow your practitioners recommendations on appointment schedules, weight gain, bed rest, exercise, medication, vitamins, and so on, unless you have a good reason why you feel you shouldn’t or can’t (in which case, talk it over with your practitioner before you follow your instincts instead). (p. 30)

Women are constantly instructed to follow the advice of their care provider, even if this advice conflicts with their own intuitive knowledge.

Within the books under review, knowing is routinely tied to the physical, concrete, and

observable, leaving little room for diverse knowledges (cultural, or otherwise), or for knowing in one's soul, spirit, or gut. This discourse becomes particularly salient when the texts consider "diagnosing pregnancy" (*What to Expect*, p. 16) - that is, knowing whether one is pregnant or not. *The Girlfriends' Guide* confidently states, "most first-timers do not consider themselves officially pregnant until their doctor tells them so" (p. 12). *Pregnancy Day by Day* normalizes the desire for "proof," "symptoms," "side effects," and "signs," and notes that women "may still be wondering if [the pregnancy] is real" (all from p. 78-79). Women who do not have physical signs of pregnancy by the second trimester are told to "keep looking at that scan picture if you need a reminder that your baby is there" (p. 169).

While the texts endorse concrete, Eurowestern technocratic knowledge, they show little tolerance for alternative ways of knowing, belittling such knowledge systems as "folklore" (*Pregnancy Day by Day*, p. 38), "old wives tales" (*What to Expect*, p. 350), and "hoodoo wisdom (you know, those sixth-sense, intuitive, hocus-pocus 'truths' that some believe in with all their hearts)" (*The Girlfriends' Guide to Pregnancy*, p. xviii). Lunaception, a natural technique for directing fertility based on the cycles of the moon, is described by *Pregnancy Day by Day* as requiring "a leap of faith and a good sense of humour" (p. 38), because it has not been scientifically tested. *What to Expect* reiterates this bias; in a section called "Do-It-Yourself Labor Induction?" the book advises

While there are plenty of natural methods you can use to try and bring on labor (and plenty of old wives' tales to go along with them), it's hard to prove that any of them will do the trick. Some women swear by them, but none of the home-grown methods passed from mom-to-be to mom-to-be has been documented as consistently effective. (p. 350)

The texts show a clear preference for scientific Eurowestern medical knowledge, constructing it

as authoritative while ignoring or minimizing other medical knowledge systems (traditional Chinese medicine, for example, is referred to by *What to Expect* as complimentary to traditional obstetric practice. This idea is explored further in Chapter 5). Most of the texts devalue diverse cultural knowledge, and marginalize folk wisdom by framing it as naive, ignorant, and backward.

The sole exception is *Ina May's Guide to Childbirth*, which opens with the following statement:

Consider this your invitation to learn about the true capacities of the female body during labor and delivery...what I mean by *true capacities of the female body* are those that are experienced by real women, whether or not these abilities are recognized by medical authorities...the most trustworthy knowledge about women's bodies combines the best of what medical science has offered over the past century or two with what women have always been able to learn about themselves before birth moved into hospitals...our capabilities go beyond medical understanding. (p. xi)

The book goes on to encourage women to add "ancient knowledge" (p. 246) to the wisdom they already possess, and reminds them that "some women come to their first birth with life experience that has prepared them well" (p. 154). Rather than belittling intangible ways of knowing, the text advises women to notice and respect their own intuitions. Unfortunately however, *Ina May's Guide* stops short of exploring other kinds of knowledge systems - other epistemological systems and worldviews - about pregnancy, birth, and motherhood that go beyond intuition. This limitation seems indicative of the book's assumptions regarding the social location of its readers; that is, the text is written for white, middle-class, Western women, and reifies scientific/intuitive knowledge binaries which do not acknowledge other scientific and

medical knowledge systems and diverse sociocultural worldviews.

Framing the knower/expert. The lexical choices of most of the texts work to reinforce the authority of those with Western medical credentials. Authors frequently rely upon formal, official-sounding language to convey expertise and hierarchical position. These were almost always anatomical or medical terms, such as “blastocyst” (*What to Expect*, p. 121), “primitive groove” (*Pregnancy Day by Day*, 74), “spontaneous abortion” (*Pregnancy Day by Day*, 94), or “leukorrhea” (*What to Expect*, p. 206). Occasionally, authors use informal lexical choices and colloquial language, strategically suggesting dialogue between equals. The author of *The Girlfriends’ Guide* relies upon this tactic, granting herself the authority to make decisions for the reader because she names herself the reader’s “girlfriend.” In a section titled “How to Select Your Obstetrician,” the author cavalierly states “did you notice how quickly we decided for you that a medical doctor will deliver your baby? We apologize if you think we are taking too much for granted, but that’s what Girlfriends do” (p. 75). The author’s lack of medical credentials force her to claim power over the reader through different means. In the end, however, she is still framed as an expert (leader of the “sorority”) with a higher level of authority and knowledge than her readers.

With obstetric authority resting in the hands of the “experts,” everyone else is, by proxy, a non-expert. Mothers are naive (“her actual advice will sound inapplicable to birthing in the twenty-first century” [*The Girlfriends’ Guide*, p. 18]), grandmothers are uninformed (“herbal remedies might be just what your grandmother ordered to bring on labor, but since no studies have been done...don’t use any without getting the green light from your practitioner” [*What to Expect*, p. 351]), and relatives and friends are imprudent:

There’s just something about a bulging belly that brings out the so-called expert in

everyone...keep in mind that most of what you hear is probably nonsense...politely inform the well-meaning stranger, friend, or relative that you have a trusted practitioner who counsels you on your pregnancy and that, even though you appreciate the thought, you can't accept advice from anyone else. (*What to Expect*, p. 214)

Ina May's Guide to Childbirth is the only text that directly challenges this invalidation of non-medical knowledge, choosing instead to remind its readers of the value of diverse knowledge and ways of knowing; the text also points out that though doctors are commonly characterized as omniscient, there is wisdom that they lack:

I was fascinated to learn that most doctors once knew that an unwelcome or upsetting presence could stall labor. They knew it in the same way that farmers knew about the birthing behaviour of animals - it was common knowledge, accumulated through observation, that was passed down from one generation to another. But when the pool of home-birth knowledge dried up, knowledge that was once common became rare or even extinct. The fact is that doctors are no longer in a good position to note that their own presence in the birth room or their hurried manner often can retard labor. We must remember that the mind/body phenomenon described in the nineteenth-century textbooks is no less true now than it was then. (p. 141)

Reminding readers of the parameters and limitations of biomedical knowledge challenges a Eurowestern construction of doctors as omniscient beings, and prompts us to think of medical practitioners as experts in a very specific way of thinking, feeling, and doing.

Social scripts assigned to childbearing women. With the majority of texts under review framing physicians as the ultimate authority on pregnancy and birth, childbearing women are largely reduced to pathological bodies in need of management, non-experts forced to yield to and

depend upon the knowledge of “experts.” The social script for childbearing women is that of a patient, and women are encouraged to assume this role. *What to Expect’s* forward, written by an OB, reminds its readers that they are “patients,” using the word five times in a page and a half (p. xx); women (and their children) are further socialized into this role, as the book suggests that mothers with older children “spend more time at quiet pursuits - ...[like] being the patient in a game of ‘hospital’ (you’ll get to lie down)” (p. 129). Social roles and power differentials within the “doctor-patient” relationship are clearly communicated to readers, as *What to Expect* advises women interviewing physicians:

Almost as important as what the interview reveals about your potential practitioner is what you reveal about yourself. Speak up and let your true patient persona shine through. You’ll be able to judge from the practitioner’s response whether he or she will be comfortable with - and responsive to - you, the patient. (p. 28)

It is interesting to note that the focus here is on whether the practitioner is comfortable with the woman, rather than on whether the woman is comfortable receiving care from the practitioner. The power differential that such a statement alludes to clearly favours the care-provider, reminding women that they must submit to the “expert/knower” if they are to fulfill the “good patient” role. *The Girlfriends’ Guide* reminds women of this obligation as well, noting that when checking into the hospital

You will find yourself seated in a wheelchair, whether you want one or not. Don’t start arguing or making a scene about the wheelchair, because it’s required by the hospital’s insurance policy. Besides, if you start out complaining and arguing, you may piss off someone upon whose mercy you will later have to rely. Shut up, sit back, and enjoy the ride. (p. 225)

Submission to hospital procedures, protocols, and staff is further enforced by the text's advice for women struggling with breastfeeding. The author urges women not to worry, because

If you don't seem to have the technique perfected immediately, some nurse is guaranteed to grab your breast in one hand and the baby's head in the other and manipulate them until she gets them both to do what she wants. Your job is to sit there as quietly as possible and watch yourself being manhandled by a total stranger. (p. 200)

Although this statement may be tongue-in-cheek, it reinforces the passivity characteristic of those in a patient role; incapable and inactive, the patient herself is viewed as an unnecessary byproduct of the expert/pathological body interaction. Frequently, this reveals itself in the texts' treatment of women in labor. For instance, *What to Expect* advises women entering the second stage of labor to "get into a pushing position (which one will depend on the bed, chair, or tub you're in, your practitioner's preferences, and, hopefully, what's most comfortable and effective for you)" (p. 391). Note that the practitioner's preferences are listed first, while the woman's comfort and bodily efficacy are listed as an afterthought that cannot be guaranteed - this typifies practitioner hegemony and the subordination of those following the patient social script.

In addition to educating women on how to be good patients, most of the books provide readers with a social script on how to be good mothers. The "good" mom is always ecstatic to be pregnant: "hearing the first lub-dub of your baby's heartbeat is definitely music to every mom-to-be's (and dad-to-be's) ears" (p. 183), "you're sure to be preoccupied with - and super excited about - the much anticipated event: your baby's arrival" (p. 308), "use the months before delivery to get used to the idea [if you're having twins]...you will get used to it - and you will become happy about it!" (p. 409), "relax and enjoy your pregnancy, even if it did come a little unexpectedly" (p. 33) (all previous from *What to Expect*), "like most women, you are probably

happy and excited about having a baby” (*Pregnancy Day by Day*, p. 327). The good mom makes her baby her top priority: “cut back in areas that are not high priority (this is something you’re going to have to do big time anyway, once you have a bigger priority - a new baby - on the agenda)” (*What to Expect*, p. 142), “the mother-to-be mind...[keeps] all brain circuits busy contemplating nursery colours and negotiating baby names” (*What to Expect*, p. 215), “your most important job right now is ‘growing’ your baby” (*Pregnancy Day by Day*, p. 97), “your baby’s welfare will be your main concern” (*Pregnancy Day by Day*, p. 119), “taking care of your baby will become your main concern and there’s unlikely to be a day that goes by where you don’t consider your baby’s well-being” (*Pregnancy Day by Day*, p. 205). The good mom is completely fulfilled by parenthood: “the fulfillment you will feel when cuddling a warm, sleeping bundle of baby (even if that cherub was howling moments before) is incomparable” (*What to Expect*, p. 249). The good mom cares only about the outcome of her birth, not the experience of it, regardless of how traumatic that experience might end up being for her: “any delivery that brings a healthy baby into the world and into your arms is a perfect delivery” (*What to Expect*, p. 321), “a healthy mother and baby, achieved under *any* conditions necessary, is the ultimate goal of labor and delivery” (*The Girlfriends’ Guide*, p.71), “focus on what’s important - delivering a healthy baby. If you achieve this aim, you’ve succeeded, no matter what happens along the way” (*Pregnancy Day by Day*, p. 311), “any woman who delivers a healthy baby has had a successful delivery, and that’s what’s most important” (*Pregnancy Day by Day*, p. 365).

The good mother is also young (“any woman over the age of 35 is categorized as high risk” [*Pregnancy Day by Day*, p. 75]) but not too young (“after about the age of twenty-one, any woman’s announcement that she is pregnant...is met with great glee” [*The Girlfriends’ Guide*, p. 17]), thin (“with the right fashion choices, you can highlight your belly while slimming your

overall silhouette” [*What to Expect*, p. 211]) but fit (“having more toned limbs will help you look and feel better” [*Pregnancy Day by Day*, p. 234]), enjoys exercising (“any workout...should be an experience you look forward to rather than dread, one you think of as fun, not as torture” [*What to Expect*, p. 211]), is attractive (“the ideal image is a woman with thick shiny hair and perfect skin that has a healthy blush” [*Pregnancy Day by Day*, p. 173]), has a husband (“it isn’t easy to nibble on fresh fruit when your darling husband’s diving headfirst into a half-gallon of ice cream” [*What to Expect*, p. 93]) who conforms to male stereotypes (“tell him what you need...and what you don’t need, [like] hearing that your rear’s looking a little wide; his leaving a trail of socks and underwear down the hallway” [*What to Expect*, p. 164]), and is financially secure (“buy meat and poultry that has been raised organically...choose organic dairy products...buy organic produce...favour domestic produce” [*What to Expect*, p. 114]).

Women who do not meet these criteria are frequently shamed for transgressing against the good mother imperative. Those who struggle with disordered eating are severely admonished, and told to “put those unhealthy habits behind you” (p. 53), “get your eating disorder under control” (p. 52), and that “when you starve yourself, you starve your baby” (p. 53, all from *What to Expect*). *The Girlfriends’ Guide* went so far as to exclude women with disordered eating from its sorority of girlfriends, while inducing shame and guilt:

If you are obese or anorexic, your weight is your own private issue, one for you and your doctor to deal with. I will also say that it should be understood that the baby’s health is more important than any other consideration, and that any woman who starves herself or eats only trash food should be permanently ostracized from the community of Girlfriends, if not from the universe. (p. 26)

Moralizing language regarding body image and weight is also prevalent in *What to Expect*,

which asserts “there’s an important difference between pounds added for self-indulgent reasons (just too many midnight dates with Ben and Jerry) and pounds gained for the best and most beautiful of reasons: your child” (p.209).

Pregnancy Day by Day offers a positive counter to the shaming narratives of the above texts, noting the complexity of a woman’s relationship with her body, and the ways in which it is influenced by sociopolitical forces:

[A woman] may have mixed feelings about her changing shape...when some fashion magazines show extremely thin women as a symbol of “beauty,” it is little wonder that the arrival of the belly can trigger a number of conflicting feelings in a pregnant woman, making her sometimes doubt her looks and knocking her self-esteem. (p. 180)

Unfortunately, the text does not do much to counter the “thin is beautiful” norm; all the images of pregnancy in *Pregnancy Day by Day* show slim women, even when the book is supposedly depicting a variety of body types (see image on p. 260).

Discourse III: “You Don’t Call the Shots”

The third discourse builds upon the first two, and deals with knower-novice power imbalances, control of the pregnant body, and the illusion of choice. As noted in the previous section, the majority of texts frame doctors alone as having the expertise and authority to make decisions and give advice related to pregnancy and birth. Women tend to be viewed through a paternalistic lens, and are often characterized as infantile and out of control. These narratives significantly impact the texts’ presentation of women’s agency and “choice.”

Paternalistic power imbalances and infantilization. Frequently treated as pathological bodies, and assigned the social script of a patient, childbearing women are perceived as dependent upon a paternalistic expert for care. As a result, several of the texts infantilize birthing

mothers; this is most noticeable in the patronizing language authors use to describe anatomical features or bodily functions. *What to Expect* constantly refers to a woman's stomach as "your tummy" (p. 132, 133) and described saliva as "icky" (p. 134), while *The Girlfriends' Guide* talks about "peepee" (p. 56), "poopoo" (p. 7, 70), and "placental yuck" (p. 184), labels the anus your "you-know-what" (p. 50), and alternately refers to the vulva/vagina as "privates" (p. 49), "peepee" (p. 53), and "down-there" (p. 196). Furthermore, both books expect pregnant women to behave in ways characteristic of children: *What to Expect* encourages mothers to combat insomnia with "that old sleepy-time standard, a glass of warm milk, [which] may be especially effective...because it reminds you of being tucked in with your teddy bear" (p. 266), admonishes women to "eat slowly, taking small bites and chewing well (your mother would be proud)" (p. 154), and notes that food cravings "may be triggered by emotional needs - the need for a little extra attention, for example...instead of requesting a middle-of-the-night pint of Chunky Monkey...you might settle for an oatmeal cookie or two and some quiet cuddling" (p. 156). *The Girlfriends' Guide* refers to its readers as "my sweet" (p. 86), and assures them that after lab tests they will receive "a Snoopy Band-Aid" (p. 90). The infantilization of birthing women is also apparent in the colours and images of several of the texts' front covers. Although the cover of *What to Expect* no longer shows a woman in a rocking chair as previous editions did (she now stands, holding her stomach), the text box is still framed by a patterned quilt in typically Eurowestern "feminine" colours (pinks, purples, yellows) and prints (florals). *The Girlfriends' Guide* has cartoon women on its front cover, and drawings of bottles and baby-related merchandise inside the book. *Ina May's Guide* is almost entirely pink and salmon-coloured, while the woman appearing on the cover of *Pregnancy Day by Day* has the word "pregnancy" stamped across her in large pink letters.

Pregnant women and control. The demotion of pregnant women to a child-like state works to frame birthing mothers as dependent, helpless, and naive. Indeed, the majority of texts treat birthing mothers as irresponsible and impulsive children who cannot be trusted. *What to Expect*, in particular, seems to feel that women are not capable of acting in a responsible manner, and attempts to corral and discipline them throughout the text: “if you’re of average weight, you now need only about an average of 300 calories more...not exactly the all-you-can-eat sundae bar you were imagining” (p. 93), “very large quantities of salt...(such as those pickles you can’t stop eating, soy sauce by the gallon on your stir-fry, and potato chips by the bagful)...aren’t good for anyone” (p. 101), “xylitol...is considered safe during pregnancy in moderation (so in other words, it’s fine to chew one pack of xylitol gum - but you might not want to chew five)” (p. 112), “if you’ve been exceeding the guidelines, feeling depressed about it won’t keep you from getting fatter (and...will only send you to the freezer for that vat of chocolate chip mint)” (p. 210), “there will be weeks when your appetite will rule and your self-control will waver, and it’ll be rocky road (by the half gallon)” (p. 168). The text is so convinced of women’s lack of inhibition that it devotes 29 pages to the topic of diet - a chapter called “Nine Months of Eating Well.” As if that weren’t enough, the book promotes an additional text for mothers - *What to Expect: Eating Well When You’re Expecting*.

A lack of inhibition is highlighted by *The Girlfriends’ Guide* as well, in a section called “I Want It and I Want It Now!” The text states that

Immediate gratification is the goal of most pregnant women. It may appear to the unenlightened that pregnant women are just whimsically indulging themselves and taking advantage of their condition. This is not entirely true. Certain sensations take on a ferocity when you are pregnant that they never had in your nonpregnant state. And God

help the person who stands between you and your satisfaction. (p. 56)

The characterization of women as wildly pursuing gratification reduces them to a juvenile state, where paternalistic control appears necessary; if pregnant women are wild and reckless, than they “need” to be reigned in by the experts upon which they rely. Apparently, childbearing women are so dependant upon their practitioners that the text compares the relationship to Stockholm Syndrome:

Utterly helpless people identify and develop a relationship with their captor because that person is all that stands between them and certain death. Sounds about right for a woman pregnant with her first child and her relationship with her doctor, don’t you think? (p. 82)

Doctors are elevated to a position of absolute authority, and this is regarded not only as appropriate, but also as being in the best interests of women and infants; if birthing mothers are helpless and cannot make responsible decisions, then doctors must step in, take control, and save women from themselves. Indeed, *What to Expect* advises women not to challenge their practitioners (if something “doesn’t correspond to what your practitioner has told you...ask for an opinion on what you’ve heard - not in a challenging way, just so you can get your facts straight” [p. 30]), and to ask for permission to do things differently if they disagree with a doctor’s methods (“if during delivery your doctor suggests the need for vacuum extraction to speed things up, you might want to ask if you can rest for several contractions [time permitting]” [p. 376]). Thus, doctors are portrayed as making judicious choices and exercising control, while women are framed as reckless and in need of control.

Paying lip service to choice and agency. At the same time as it advises women to submit to the authority and choices of their practitioner, *What to Expect* paradoxically assures women that they will have choices and agency during labor and delivery. In a discussion on birth plans,

the text states “childbirth involves more decisions than ever before, and expectant women and their partners are involved in making more of those decisions than ever before” (p. 294). Women are repeatedly told that they will be able to actively manage the pain of labor as they see fit, and deliver in whatever position they choose: “try changing positions. Walk around...crouch or squat, get down on all fours, do whatever is most comfortable and least painful for you” (p. 367). Readers are informed that squats are “useful for women who plan to deliver in the squatting position” (p. 229), and told to “check [their] inhibitions when [they] check into the hospital or birthing center and feel free to do what comes naturally, as well as what makes [them] most comfortable” (p. 275). The text does not inform women that hospital protocols and provider preferences may infringe on many of these “options” (e.g. a woman can only walk about and change positions freely if she does not have an electronic fetal monitor strapped to her; most hospital floors are not sterile, and many practitioners are opposed to getting down on their hands and knees to catch a baby, making delivering in the squatting position a questionable possibility).

Privileged assumptions. Although the majority of texts under review allocate ultimate authority and control to obstetric practitioners, all of the books assume that women have some degree of choice when it comes to selecting a care provider. *Ina May's Guide to Childbirth* advises its readers to be “smart shoppers. One of the best ways to educate yourself about the care possibilities in your area is to interview several practitioners” (p. 307). *Pregnancy Day by Day* echoes this sentiment, stating

Early in pregnancy you will need to think about who you would like to care for you during pregnancy, labor, and the postpartum period...being able to choose the type of care you receive is one of the most important aspects of pregnancy and childbirth. (p. 102)

Choice of birth place is framed as equally important, and the options assumed to be equally numerous. *What to Expect* notes, “pregnancy these days is full of personal choices. When it comes to birthing that baby, the array of options is dizzying” (p. 22). The text goes on to describe hotel-like birthing suites, and suggests that these are an option for “most” low-risk women (p. 22).

The assumption inherent within such statements on selecting a practitioner and place of birth is that the social location of readers affords them choices. However, women who are economically disadvantaged, live in rural areas, or are marginalized due to race or ability frequently lack access to the maternity care options of more privileged women. These factors, which constrain the choices of many women, are not considered by the texts. Rather, readers are given advice on choosing amongst a variety of options, which reveals the privileged expectations of authors.

Not only do authors assume that women can afford, and have access to, a variety of care providers and hospitals, they also liberally administer “lifestyle” advice. *What to Expect* includes topics such as secondhand smoke, cocaine and drug use, household hazards (lead, tap water), air pollution, and domestic violence, in a chapter called “Your Pregnancy Lifestyle.” Similarly, in a discussion on preventing preterm birth, the book lists “known risk factors...that can be controlled” (p. 46), such as inadequate nutrition, lots of standing or heavy physical labor, extreme emotional stress, alcohol and drug use, gum infection, and being under the age of 17, and cavalierly advises women to “eliminate any that apply to you” (p. 46). *Pregnancy Day by Day* echoes such recommendations, counselling women to “use your pregnancy as an opportunity to assess your lifestyle and improve your health” (p. 91).

Advising women to improve their own health reveals the authors’ biases: responsibility for

safety and well-being is placed on the individual, and the impact and constraining forces of social, political, and economic systems are largely ignored. The texts do not consider the ways in which “lifestyle” factors (e.g. lots of standing/physical labor, gum disease, unsafe housing, poor nutrition, exposure to lead, extreme stress, domestic violence) conflate with socioeconomic status (SES). In fact, with the exception of *Ina May’s Guide to Childbirth*, all of the books seemed to assume that their readers were white, heterosexual, and of mid to high SES (i.e. not socially marginalized). From ways to reduce stress (“do something about it. Identify sources of stress in your life and determine how they can be modified” [p. 142]), to healthy eating (“it takes no more time to make a roast turkey, cheese, lettuce, and tomato sandwich...than it does to stand in line for a burger” [p. 108]), to neighbourhood location (“need some time for yourself? Walking alone can give you that quiet moment you crave” [p. 225]), *What to Expect* delivers advice for the financially secure. *Pregnancy Day by Day* provides extensive information on vacations and traveling (“your growing belly shouldn’t put a stop to travel plans. Just a bit of extra planning is required to help your vacation run smoothly” [p. 28]), and includes aesthetic questions in a section called “Common Worries”:

I am 18 weeks’ pregnant and due to go on a beach vacation. My facial and body hair has grown and become very unsightly. How can I safely remove it?

I’m in the first trimester and will be going to my sister’s wedding. Can I have highlights put in my hair? (p. 27)

Along with these “common” worries, the text also discusses the safety of hair and nail products, tanning, body wraps, facials, and Botox; furthermore, it notes that “being out and about will make you tired. When you’re going out for the day, plan lots of breaks so you can sit and rest” (p. 217).

The author of *The Girlfriends' Guide* takes assumptions about socioeconomic status a step further, referencing name brands such as Bugaboo, Petunia Pickle Bottom, Dolce and Gabbana, Fendi, Juicy Couture, and 7 for All Mankind, throughout the text. Women in labor are advised, “leave your jewelry at home...you may look so naked without your earrings and pendant that your mate might...go out and buy you a little bauble as a reward for your valour in the delivery room!” (p. 194). Alongside such suggestions, the author demonstrates her own privilege as she relates her experiences and concerns, and those of her girlfriends. There are numerous references to eating out, beauty salons, Little-Black-Dress-Parties, online shopping, Orlando vacations, “my waxer” (p. 148), “my diamond stud earrings” (p. 168), cleaning ladies, beach houses, and pedicures. Spending time and money on one’s appearance is deemed particularly important:

Around the third trimester, you will be tempted to ignore the pedicures, not just because they become impossible to do yourself, but because you rarely see your own feet anymore...but this is when pedicures become particularly important, because your toes are usually right in your obstetrician’s face during internal exams, and even more so during long hours of labor and delivery...One Girlfriend took this advice so much to heart that when her water broke, she immediately ran for the nail polish. She sat on a staircase to paint her toes so that she could reach them all. Then she slipped on some rubber sandals and left for the hospital. By the time she finished checking in and getting to a room, her pedicure was dry. Now that’s a woman with standards! (p. 34)

While assuming that her readers have a specific level of financial security, and an equally specific social location, the author simultaneously claims that *The Girlfriends' Guide* is “for every pregnant woman” (p. xvii). The text’s forward works to universalize mothers, as the author welcomes women to the “sorority,” and states that “only another mother knows what each of us

has gone through to qualify for membership” (p. xii). Such a statement alludes to the assumption that all childbearing women’s experiences are similar; using this line of reasoning, the experience of a wealthy, married, white woman with access to healthcare and a plethora of birthing options is analogous to the experience of a single lesbian mother, a mother in a wheelchair on Medicaid, or a black mother. The author fails to consider how systemic factors, such as racism, directly impact poverty rates, access to healthcare, and pregnancy and birth outcomes. In fact, the author’s lack of awareness of systemic factors and the experiences of marginalized women is glaringly evident in her inaccurate statements on maternal mortality: “remember all those old Westerns when the poor women died in childbirth? You almost never hear about that happening anymore, thanks to God, clean water, and the American Medical Association” (p. xix); “it is almost unheard of in this day and age for women to die in childbirth” (p. 162). *Ina May’s Guide to Childbirth* directly conflicts such assertions, noting that maternal mortality rates in the United States have not declined since 1982, and that

Maternal death rates are sharply higher for African-American women, who die at four times the rate of the general population. Even worse, this difference has increased in recent years (from 3.4 times greater risk of dying than white women in 1987 to 4.1 times greater risk of dying in 1990). Hispanic women have a seventy percent higher risk of death than white women. The problem with all these numbers is that they are gross underestimates. For African American women in New York city in 2008, the rate was an incredible 79 per 100,000 births (compared to 13.3 deaths per 100,000 in the general population). (p. 275)

In Canada, a lack of consistent reporting and tracking means that there are no maternal mortality data for Indigenous population groups. However, as Verstraeten, Mijovic-Kondejewski, Takeda,

Tanaka, and Olson (2015) report, “the inconsistent data that exist for infant mortality rates demonstrate persistent and sizeable disparities between the Aboriginal and non-Aboriginal populations, with Aboriginal infant mortality being approximately twice that of the overall Canadian rate” (p. E26). These alarming differences in maternal and infant mortality are not discussed by *The Girlfriends’ Guide*, *What to Expect*, or *Pregnancy Day by Day*, which devote themselves to the concerns and representation of married, able-bodied, financially secure, heterosexual, white women.

The books’ covers and inner images primarily represent women of privileged social location. The front covers of *What to Expect*, *The Girlfriends’ Guide*, and *Pregnancy Day by Day* all contain images of slim, young, able-bodied, attractive, smiling, white women; the cover of *Ina May’s Guide to Childbirth* shows a photograph of a white baby. The back cover of *Pregnancy Day by Day* has five photographs on it: one of a heterosexual white couple, embracing and smiling while looking at a pregnancy test, one close-up of a white pregnant abdomen and hand wearing a wedding ring, an image of three white women exercising, a picture of a white woman smiling at a bowl of fruit, and an image of a smiling black woman in a hospital gown being handed her baby by a white male doctor. *What to Expect* does not contain any photographs, choosing instead to include drawings of women. All of the women are slim, young, and most appear to be white, although a few are shaded slightly darker than the others and given coarser looking hair (p. 221, 224). The large majority of images (16, to be exact) show women exercising. *Pregnancy Day by Day* frequently shows slim women exercising as well, however it is more ethnically diverse - women, men, and infants of a variety of skin tones appear throughout the text. Despite this small step toward diversity, representations of heterosexual, nuclear families dominate the text.

All the images of couples that appear in *What to Expect* and *Pregnancy Day by Day* (neither *The Girlfriends' Guide*, nor *Ina May's Guide to Childbirth* contained any images) are heteronormative. *Pregnancy Day by Day* does contain an image of two women, sitting on a bed smiling at one another, however the caption underneath it reads: "having a close female friend or relative with you during labor, even if it's only at home in the early stages, may prove to be a great help to you and your partner" (p. 261). Moreover, *The Girlfriends' Guide*, *What to Expect*, and *Pregnancy Day by Day*, all exemplify heteronormativity with respect to their lexical choices and the information they provide. These texts all refer to the "dad," "daddy," "father," "your guy," and "hubby." Where "partner," "mate," or "spouse" are used, they are always followed by the pronoun "he." *What to Expect* devotes an entire chapter to dads, called "Fathers Are Expectant Too" (p. 472), which reproduces traditional male gender norms at every turn: "your spouse spends more energy lying down on the sofa building a baby than you do bodybuilding at the gym" (p. 474); "remember to put the seat down after every use...keep the hallway free of obstacles (your briefcase, your sneakers, that magazine)" (p. 474); "lose the aftershave...and get your onion ring fix out of her sniffing range" (p. 473). It also provides "resources for dads," such as "fathermag.com, fathersforum.com, fatherville.com" (p. 476).

The Girlfriends' Guide offers information on how to share the news of a pregnancy with "daddy" (p. 13), and *Pregnancy Day by Day* contains information boxes called "Focus On Dads" which appear repeatedly throughout the text (p. 137, 199, 259, 332). In its first chapter, *Pregnancy Day by Day* states, "at ovulation, an enlarged follicle in the ovary ruptures to release the mature egg, ready to be fertilized in a fallopian tube by your partner's sperm" (p. 32); it goes on to state that "sexual intercourse timed to coincide with ovulation is most likely to lead to a successful pregnancy" (p. 32). Further evidence of heteronormativity is found in *The Girlfriends'*

Guide's discussion on choosing a male vs. female obstetrician:

Many of my Girlfriends...were happy with their choice of female obstetricians because they felt less inhibited during physical exams and delivery...in addition, there can be real pressure on a woman to maintain her attractiveness around men, since many of us learned this lesson early in life, and some aspects of pregnancy can make a woman feel less than attractive when exposed to her male doctor. (p. 78)

The assumption here, of course, is that all childbearing women, female obstetricians, and male obstetricians, are heterosexual. Interestingly, *What to Expect* admits to its blatantly heteronormative assumptions in a box labelled "This Book's for You:"

As you read...you'll notice many references to traditional family relationships - "wives," "husbands," "spouses." These references are not meant to exclude expectant mothers (and their families) who may be somewhat "untraditional" - for example, those who are single, or have same-sex partners...Rather, these terms are a way of avoiding phrases (for instance, "your husband or significant other") that are more inclusive but also a mouthful to read. Please mentally edit out any phrase that doesn't fit and replace it with one that's right for you and your situation. (p. 32)

The authors attempt to justify the book's exclusivity on the basis of convenience; rather than taking an inclusive approach and using the word "partner" or "family," the text chooses to place the onus on the reader, asking them to force the book to apply to their "situation" (p. 32, 474). Framing the lives and families of birthing mothers as tedious "situations" is not only insulting, it also projects the message that it is acceptable to discriminate against those who differ from the white/heterosexual/able-bodied norm on the basis of convenience. The privileged authors cannot bear the tediousness of using language that is descriptive of a variety of birthing mother's

experiences; as a result, the traditional, white nuclear family remains at the center of *What to Expect's* epistemological approach, thereby furthering singular conceptualizations of families and mothers that are heteronormative, sexist, and racist.

Resistance Narratives and Counter-Normative Discourses

Although the three discourses discussed so far dominate *What to Expect*, *The Girlfriends' Guide*, and *Pregnancy Day by Day*, each text also contains alternative, less singular accounts of childbearing. These accounts might evidence resistance, as they challenge the status quo and create the space for alternative stories and experiences. Several of the books, for example, directly acknowledge or question conventional norms about mothers and mothering. In a section called "Fear of Not Doing Pregnancy Right," *The Girlfriends' Guide* acknowledges that there are "standards of proper behaviour for pregnant women...unfortunately, many of us, through our inexperience and insecurity, buy into a whole litany of rules that are not only burdensome and unnecessary, but also guaranteed to make any woman feel inadequate" (p. 67). The book notes that pregnancy might not be pleasant or emotionally fulfilling, and that women may experience emotions other than ecstasy upon learning that they are pregnant. *What to Expect* challenges the definition of mothering as an inherent, instinctual skill, and informs readers that "most women aren't born mothers - any more than men are born fathers - instinctively knowing how to soothe a crying baby, change a diaper, or give a bath. Motherhood - parenthood, for that matter - is a learned art" (p. 355).

The Girlfriends' Guide gives voice to struggles of motherhood, identity, and control, recognizing that some women "start to feel like a vessel rather than a person because their whole identities seem wrapped up in gestating" (p. 17). When women are treated as vessels rather than people, their identities are dissolved and they become public property, their bodies policed by

those who retain agency. The author's frustration with the public policing of pregnant women is palpable:

Just wait until you run into the Pregnancy Police at a party or restaurant. God forbid if you should have a glass of wine with dinner or participate in a champagne toast, even with a notarized letter of permission from your doctor. The PP will either look witheringly at you or actually come up to you and lecture you about fetal alcohol syndrome. Almost all of the Girlfriends - none of whom, I hasten to add, drank more than a total of four or five glasses of wine or champagne over their entire pregnancy - found themselves more than once lamely trying to defend their imbibing to total strangers...I am just saying that pregnancy is hard enough. What with the societal stigmas against hot tubs, aspirin, coffee, and artificial sweeteners...a single drink late in pregnancy seems allowable, if not downright deserved. (p. 69)

Such a statement implies that childbearing women retain their personhood, are able to exercise restraint, and are therefore not in need of public policing or paternalistic control. In fact, *The Girlfriends' Guide* acknowledges that women may attempt to maintain control over their bodies in any way they can:

My observation is that a lot of my Girlfriends who continue to exercise rigorously during pregnancy are frantically trying to take back control of a life that they think is spinning out on them. Their bodies are distorting in more ways than they ever imagined, their emotions seem out of control, and they are frightened of giving birth and becoming a parent. No one can blame you for trying to get a grip on things by acting as if nothing strange were happening. (p. 104)

Although this statement may be indicative of the pressure many women feel to conform to

feminine beauty aesthetics, it may also be viewed as a resistance narrative which treats women as agents who actively respond to the changes in their lives.

Women are also presented as active agents in segments of *Pregnancy Day by Day*. In a section on diet and “eating for two,” a nutritionist notes “the best advice is to use your common sense. Studies show that pregnant women who eat according to their appetite naturally eat the proper amount and gain a healthy amount of weight” (p. 80). Rather than placing control solely in the hands of practitioners, the text acknowledges that women are capable of acting in a responsible manner, and may govern themselves (at least partially). At times, *Pregnancy Day by Day* encouraged women to exert their agency and actively participate in the labor and delivery process:

You may feel like grunting and making noises when bearing down, or you may prefer to breathe deeply and quietly; you should do whatever you find helpful and works best...pushing your baby out into the world takes a huge amount of effort and energy, but you have the ability and are very capable of doing this. (p. 425)

When women’s efforts and struggles are acknowledged and respected, dominant discourses on pregnancy and birth may be challenged or refuted. Counter-normative discourses position women as active, powerful agents, at once both knowledgeable and competent; in the discursive space created by such exceptions, a multiplicity of stories, experiences, identities, and ways of knowing about birth and motherhood may unfold.

Analysis Summary

Current North American discourses on childbearing in popular literature reflect dichotomies reminiscent of midwifery and medical ideologies: women are constructed as educated, self-advocating, powerful agents with voice, or as naive, impulsive, risky bodies to be

managed and disciplined by medical practitioners. Popular texts on pregnancy and birth enforce the rigidity of these binaries, placing women in one category or the other. And yet, the diversity of women's lives, bodies, and families prevents any singular experience of pregnancy, labour or birth. The multiplicity of mothers' stories and identities necessitates increasingly fluid boundaries between categories, and indeed, alternative conceptualizations of birthing women. In the following chapter (Chapter 5), I link these themes to a discussion of current literature, and explore possibilities for more productive and inclusive discourses.

Chapter 5: Discussion

Education and advice literature on pregnancy and birth projects specific social values and ideologies, steeped in the particular discourses of medical authority explored in the previous chapter. As my findings demonstrate, these dominant discourses operate to construct a culture of childbearing that is congruent with hegemonic North American conceptual systems of gender and femininity, health, bodies, medicine, science, choice and power. In this chapter, I consider each dominant discourse in relation to current literature and examine connections to privilege/privileged bodies, colonization, and socioeconomic status. I explore the counter-normative discourse of natural birth, and problematize ideas of “natural” and “unnatural.” I conclude with a discussion of implications for future research involving childbearing advice, stories, and women’s experiences of pregnancy and birth, as well as promoting inclusive discourses.

Discourse I: Childbearing is Risky And Must Be Managed By Medical Experts and Technology

The first discourse I identified in my analysis defined childbearing as a risky process, the female body as pathological and prone to malfunction, and birth as requiring technological intervention and the management of medical experts. Rooted in misogynistic philosophical and scientific doctrine, these biological directives guide obstetrical perspective and practice. As I found, contemporary North American birth culture, and thus childbearing advice literature, is dominated by obstetric-technocratic ideologies, which shape the messages and information used to educate and advise birthing women.

My findings demonstrate that the primary messages projected by the majority of texts under review worked to reify technocratic dogma on childbearing. To be pregnant, in labor, or

giving birth, was to be in a dangerous liminal state, where one's body was inept, untrustworthy, and prone to malfunction. These are not new ideas - the medical institution has long considered the reproductive functions of women's bodies to be pathological. In their historical account of biomedicine's relationship with the female body, Ehrenreich and English (2005) write:

The theories which guided doctor's practice from the late nineteenth century to the early twentieth century held that woman's *normal* state was to be sick. This was not advanced as an empirical observation, but as physiological fact. Medicine had "discovered" that female functions were inherently pathological. Menstruation, that perennial source of alarm to the male imagination, provided both the evidence and the explanation. (p. 101)

Ehrenreich and English go on to note that the uterus, ovaries, and other parts of the female reproductive system, were

Blamed for all possible female disorders, from headaches to sore throats and indigestion. Dr. M. E. Dirix wrote in 1869: 'Thus, women are treated for diseases of the stomach, liver, kidneys, heart, lungs, etc.: yet, in most instances, these diseases will be found on due investigation, to be, in reality, no diseases at all, but merely the sympathetic reactions or the symptoms of one disease, namely, a disease of the womb.' (p. 110)

Equating the womb with pathology meant that medical attempts at explaining pregnancy and birth were rooted in theories of female weakness and bodily malfunction. As I have argued, these biological and moral imperatives continue to shape dominant discourses on childbearing: medical practitioners are framed as the appropriate care providers for pregnant women, hospitals are designated environments in which birth takes place, and technological interventions are promoted as tools which mitigate danger and risk.

Understanding childbearing within a framework of risk and pathology frequently led the

texts to define births as successful if they resulted in healthy babies. That is, a healthy infant was purported to be the only labour and delivery outcome of importance. Most of the books advised mothers that if their infant was lucky enough to come through the birth process unscathed, they should respond with gratitude and jubilation, regardless of any disappointment over how the birth had gone, or trauma/upset over what had been done to their bodies. In questioning the care she received during the birth of her daughter, feminist researcher Stockill (2007) notes, “I was soon to learn that the birth of a healthy infant renders ineffective all complaints about the management of labour; it was dismissed as ungrateful moaning. After all, anything could have happened” (p. 572). If a woman wanted a natural birth and ended up with a cesarean section, *What to Expect* told her “don’t be disappointed” (Murkoff & Mazel, 2008, p. 325), and encouraged her to express appreciation for the medical staff and technology that had provided her with a healthy baby. *What to Expect* informed her that her delivery was “a perfect delivery” (Murkoff & Mazel, 2008, p. 321) because it had brought a healthy infant into the world.

Within this discourse, the mother’s health (mental, physical, emotional, spiritual) is always presented as subordinate to the infant’s physical health. This mandate was substantiated by the linguistic structure of texts like *What to Expect*, which stated, “what’s best for your baby - and best for you - is what matters” (p. 325). Note that the best interests of the infant are considered first, while those of the mother are listed second; the use of the em dash indicates a break in the authors’ conclusion, removing the mother’s best interests from the main sentence structure, and situating them instead as an afterthought. Such a perspective is reminiscent of pro-life ideology, where the rights of the fetus are believed to trump the best interests of the mother, and women who prioritize or acknowledge their own rights/needs are framed as “selfish” (Sheldon, 1993). Similarly, women who acknowledge the ways in which a birth may have negatively impacted

their mental, emotional, spiritual, or physical health are characterized as self-centred, ungrateful, and uncaring - in short, as bad mothers. Admitting that one is disappointed or adversely affected by one's birth experience becomes analogous to not loving, or not caring about the health of, one's child. The social script available to childbearing women mandates that "good mothers" care only about the health of their children, and are not "selfishly" concerned with their own bodies or experiences (unless, of course, this concern for one's body is related to female beauty aesthetics). Offending against the "good mother" norm carries the risk of being labelled a "bad mother"; indeed, one of my key findings discussed in the previous chapter showed that several of the texts used peer pressure, contempt, guilt, and shame, in an attempt to induce women to comply with the "good mother" social script.

Discourse II: Medical Knowledge is The Only Legitimate Knowledge

With the majority of texts under review constructing doctors as experts in the field of birth, scientific obstetric knowledge was continually validated, while other knowledge systems were largely devalued and pushed to the margins. As I noted, this cultural construction of medical practitioners as possessors of legitimate knowledge is rooted in historical events fraught with racism, sexism, and exploitation of the economically disadvantaged. With the onset of the Enlightenment and the rise of the medical profession, interest in anatomy and physiology mounted, and significant gains were made in understanding the human body. These advances in scientific knowledge, however, were achieved at the expense of marginalized populations, who were targeted for non-consensual, exploitative and often torturous medical and scientific research. Recently-revealed federal archives show that scientific and medical experiments were routinely conducted on Indigenous children in residential schools, and medical research on reproductive practices and sterilization were performed without consent on girls and young

women (TRC, 2015). Similarly, Washington (2006) asserts that “dangerous, involuntary, and non therapeutic experimentation upon African Americans has been practiced widely and documented extensively at least since the eighteenth century” (p. 7). She goes on to describe the gynaecological experiments of Dr. James Marion Sims, a revered surgeon who developed and refined his surgical techniques on Black female slaves during the 1840s:

Each surgical scene was a violent struggle between the slaves and physicians and each woman’s body was a bloodied battleground. Each naked, unanesthetized slave woman had to be forcibly restrained by the other physicians through her shrieks of agony as Sims determinedly sliced, then sutured her genitalia. (p. 2)

Women who were poor also suffered for “science” at the hands of Dr. Sims; as Ehrenreich and English (2005) note, “after moving to New York, Sims continued his experimentation on indigent Irish women in the wards of the New York Women’s Hospital” (p. 112). These horrific experiments positioned radicalized women’s bodies and reproductive systems as disposable medical objects; they were useful only to advance the anatomic and scientific knowledge of the medical profession, and assisted doctors in developing tools and procedures with which to “cure” the (white, wealthy) female body.

With a patent on anatomic medical knowledge and techniques, doctors were elevated to the rank of “knower.” Indeed, after the Enlightenment, science, anatomy, physiology, and the laws of nature were deemed valid knowledge, and attained status as the only legitimate way of knowing. As Jordan (1997) reminds us, a “consequence of the legitimation of one kind of knowing as authoritative is the devaluing, often the dismissal, of all other kinds of knowing. Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naïve” (p. 56). A compelling example of this devaluing is found in the colonization of

Aboriginal midwifery knowledge systems. In her article on the Inuulitsivik Maternities (community birthing centres), Douglas (2009) states

In the period before European contact, Inuit childbirth existed within the matrix of traditional Inuit epistemology of knowledge, drawing on Inuit views of the relationship between themselves and the natural world, and their sense of both who and where they were...in traditional Inuit society, decisions, including decisions regarding childbirth, were made through consensus, not through either an authoritative body of knowledge or a professional elite...midwives were culturally very important, second only to a mother in an Inuk's life, but all women possessed some knowledge of midwifery; so did many men. (p. 113)

In the 19th century, Inuit ways of knowing about birth were marginalized by the colonizing forces of colonial agents, missionaries, explorers, and fur traders (Douglas, 2009), all of whom espoused strong Eurowestern epistemologies. These philosophies held that Eurocentric religious, sociopolitical, cultural, and medical beliefs comprised knowledge and “truth,” and that only Eurowestern individuals could hold the title of knower. Beliefs and information that fell outside this Eurocentric epistemology were not only denied status as knowledge - they were frequently made illegal (TRC, 2015). Strega (2005) notes that

The foundation of Eurocentric thought is Enlightenment epistemology. The Enlightenment is the period in European thought when the demarcation between science and non-science was established, and when “science” and “knowledge” began to have the same meaning. This division between scientific knowledge and all other kinds of knowledge is hierarchical; science is the “best” kind of knowledge, superior to various forms of unreliable and unverifiable non-scientific knowledge, such as philosophy,

folklore, mythology, poetry, old wives' tales, and oral traditions. (p. 202)

The hierarchy of knowledge that Strega refers to is readily apparent in popular texts on pregnancy and birth; as my findings demonstrate, the majority of books under review repeatedly classified non-scientific knowledge as fallible, foolish, potentially harmful, or as a complimentary “addition to traditional obstetrical care” (Murkoff & Mazel, 2008, p. 85). The framing of alternative knowledge systems as *complimentary additions* to dominant medical epistemology suggests that non-Western scientific ways of knowing are not legitimate, complete systems on their own. Non-Western scientific knowledge (along with other well-established community, cultural, or informal knowledge systems) is reduced to an addendum, with its wisdom, techniques, and therapies presented as secondary, second-class options.

This hierarchical attitude towards alternative knowledge systems directly aligns with colonial ideologies of racism, sexism, and heteropatriarchy, which continue to constitute “truth,” and the ways in which truth is discovered. Strega (2005) asserts

The claim that only rational, objective, and abstract thought can lead to truth is a specifically White masculine claim. It rests on a hierarchical system of dualisms between White male and coloured (classed) female, in which the White male element is privileged over the coloured (classed) female element. This dualism is everywhere in Western/Eurocentric thought, and it is always oppositional and hierarchical, never neutral. It maintains its position by its capacity to define itself as a universal standard against which the subjective, the emotional, the aesthetic, the natural, the (coloured, classed) feminine must be judged. (p. 203)

Under contemporary iterations of this ideology, the universal standard of biomedicine (a culture in and of itself) acts as the benchmark against which all other scientific and cultural approaches

to health and illness are measured. Approaches which favour natural, spiritual, and/or emotional knowledge are weighed and found wanting. A key finding of my analysis was that midwifery knowledge was framed as incomplete, flaky, radical, or inferior by several of the texts reviewed for this study. With its emphasis on natural processes, and a more holistic understanding of women's bodies, women's lives, pregnancy and birth, midwifery ways of knowing offend against the technocratic, biomedical norm. For its "feminine," "non-objective" approach, midwifery is denied status as a legitimate system of knowledge, and presented instead as a fringe alternative to mainstream obstetrical care; this works to relegate midwifery knowledge to the margins, and reifies current understandings of medical practitioners as legitimate knowers, and ultimately, experts in pregnancy and birth.

Discourse III: You Have Neither Power Nor Control, But You Have "Choice"

As I demonstrated in my data analysis, doctors alone are routinely framed as possessing the only legitimate knowledge in Eurowestern birthing culture, and as having the expertise and authority to make decisions and give advice related to childbearing. The power differential this creates is fundamental to the medical practitioner-pregnant woman relationship; the demotion of pregnant women to the status of novice/non-expert works to position birthing mothers as uninformed and naive, and therefore dependent upon paternalistic systems of care. My analysis indicated that birthing women are cast as child-like and offered advice which suggests that they are impulsive, cannot be trusted, and are in need of control. Much of the literature reviewed for this study reflected these beliefs, addressing women as though they were not capable of acting in a responsible manner, and attempting to corral and discipline their wild and reckless behaviour.

Although the majority of the texts under review depicted women as out of control, and largely powerless to moderate their own behaviour, select books offered an equally concerning

counter to this idea. The “lifestyle” advice meted out by some of the texts assigned women control over certain facets of their (and their fetuses’) health and well-being, particularly those with stigmatizing or moral ties; cigarette smoking, marijuana use, cocaine/other drug use, and obesity, were framed as consumer choices, engaged in at the leisure of the individual and firmly under a woman’s control. According to *What to Expect*, a woman could mitigate, or even eliminate, these risk factors if she worked hard enough and was willing to put in “some extra effort” (Murkoff & Mazel, 2008, p. 50). Perhaps most disturbing, however, was *What to Expect*’s placement of domestic violence into this “lifestyle” category. As Rudrum (2012) notes,

Categorizing women facing violence as needing ‘lifestyle advice’ implies that with some words of encouragement women will be able to stop experiencing violence and, in doing so, normalize their health status. Labelling a health concern as lifestyle is an individualizing practice: it locates the concern within individual women’s behaviours and experiences. (p. 62)

When the focus is placed on individual women’s behaviours and experiences, sexualized and gender-based violence is minimized by the same patriarchal ideologies which sustain pathological conceptualizations of women’s bodies, and promote damaging medical and technological interventions in maternity care.

As with gender-based violence, most of the texts reviewed for this study placed the responsibility for safety and health on women as individuals, and ignored structural and sociopolitical factors that might influence “lifestyle,” such as poverty, availability of food, neighbourhood design and location, housing safety, working hours, job demands, lack of extended health care (dental and eye care, mental health services), accessibility of childcare, and government welfare amounts, among other things. Instead, women were counselled to “assess

[their] lifestyle and improve [their] health” (Herer & Blott, 2009). Advising women to improve their own health reveals the authors’ biases: responsibility for safety and well-being is placed on the individual, and the constraining impact of social, political, and economic systems are disregarded. This focus on individual mothers may do little to improve the health of women and infants, for, as Rudrum (2012) reminds us,

‘Numerous factors may not be modifiable by the individual but instead require attention to the breadth of socioeconomic factors that affect women’s health’ (p.73). The focus on interventions at the individual level is misplaced: many factors shaping negative outcomes are social, economic, and political in nature. (p. 62)

Assigning childbearing women responsibility for “lifestyle” factors shifts attention away from larger systems of power, privilege, and oppression, and portrays health disparities as the result of poor decision-making on the part of minoritized women, such as economically disadvantaged, Indigenous and racialized women.

Failure to consider the ways in which “choice” is constrained by structural and systemic forces was also evident in the assumption, made by all of the texts, that the social location of readers afforded them choice of practitioner. As identified in my findings, women were frequently advised to interview several caregivers and select the one they felt most comfortable with. In Canada, both midwifery and medical services are covered by MSP; however, geographic and social location - among other factors - restrict practitioner choice for many women. Rudrum (2012) writes that

Rural and small communities are disproportionately affected by lack of access to care that is local, comprehensive and appropriate. The closure of hospitals in small communities and the shortage of physicians and other providers impede

access... additionally, ethnicity and power overlap with these rural concerns: Aboriginal communities, including reserves, are often rural, and smaller communities have less access to health care decision-making bodies. (p. 51)

Rurality, ethnicity, and socioeconomic status likely constrain the choices of American women as well. Pincus (2000) acknowledges that

Only women who live in an area offering many kinds of practitioners, who are not bound by regulations of their health maintenance organizations or by restrictive insurance policies, who have time and money to look around, who have a supportive community around them, or who have the ability and luck to identify and live out their desires for autonomy may have their babies the way they want. Few women in the United States enjoy these opportunities (p. 211)

Clearly, some women have less choice than others. For many birthing women, choice may be nothing more than an illusion.

Nevertheless, my analysis determined that all of the childbearing advice texts reviewed maintained the illusion of choice, assuring women that they would have numerous options during pregnancy, labor and delivery. These options included choice of caregiver, birthplace, method of fetal monitoring during labor, degree of intervention, and birthing position. The texts' in-depth consideration of these options, however, typically included a statement (or several) which made risk salient. Alluding to the risky nature of birth works to reinforce its classification as a pathological process, the woman's role as a patient, and the control and authority of medical professionals. The "something might go wrong" discourse was frequently used to remind women that their preferences and choices were trivial, liable to be overridden at any moment by any practitioner who thought it necessary. Thus, "choice" was always conditional, contingent upon

and subject to approval by medical staff and institutional policies.

In order to make these contingencies more palatable, women were frequently assured that their preferences would only be disregarded if an emergency arose and obstetric control became medically necessary. But is this representation of choice accurate? Research on choice and control in labor finds that women's birth plans are often regarded by hospital staff as puerile, amusing, or idealistic (Carlton, Callister, Christians, & Walker, 2009; Kaufman, 2007; Lothian, 2006; Simkin, 2007; Stockill, 2007). Simkin (2007) states

In my extensive travels around North America, speaking with maternity care professionals and paraprofessionals, I encountered mostly negative attitudes, ranging from making women who write birth plans the brunt of jokes (“the next cesarean”; “we’ll see how long this lasts”), to open hostility toward women who bring them into the hospital (“why does she even come to the hospital if she knows it all?”), to humouring the women (“it’s fine for her to write a birth plan, but we’ll do what we think is best”). (p. 50)

Stockill (2007) relates encountering similar attitudes towards her own birth plan during the labor and delivery of her first child: “the well-meaning staff had read my birth-plan but treated it as the over-indulgent whims of a middle-class woman” (p. 572). The preferences of marginalized women may be further disregarded. Research by Roth and Henley (2012) demonstrates that “highly educated women and non-Hispanic white women have more opportunities to realize their preferences than less educated women and women of colour because they tend to have...better communication with care providers, and stronger provider-patient relationships” (p. 222). The impact of power differentials, social scripts, and social location become clear in practitioners’ responses to birthing mothers’ preferences. These matrices of privilege and power beg the

question: is choice in childbirth simply an illusion propagated by popular literature? In their study of informed choice and intervention in childbirth, McAra-Couper, Jones, and Smythe (2011) note that self-determination, agency, the right to choose, and the choices available, are all socially constructed and constrained:

Choice in childbirth, as in all other choices, does not exist in isolation or in a vacuum, but is situated within a social and cultural context. Lothian (2008) goes so far as to claim that choice in childbirth, promulgated by a discourse of autonomy and agency, is an illusion and a myth, because choice is primarily shaped by medical institutions and health professionals. (p. 83)

As my analysis has demonstrated, *What to Expect, Pregnancy Day by Day*, and *The Girlfriends' Guide* all advised women to submit to the authority and choices of practitioners and medical staff, and to hospital protocols and procedures. Thus, the texts' assurances of choice during labor and delivery are something of a paradox, and may be intended to placate women by offering fantasies of agency and control.

Problematizing The Counter-Normative Discourse of Natural Birth: Natural Birth

Ideology as Rhetorical Strategy in *Ina May's Guide to Childbirth*

Having critiqued the techno-medical model upon which most childbirth literature rests, I now turn my scrutiny to the counter-normative discourse of natural birth. Popular literature based on natural, midwifery-informed models works to counter biomedical power imbalances by offering a more client-centered approach to care. Of course, such texts may be as ideologically loaded as those informed by the biomedical model. With her midwifery background, Ina May Gaskin falls decidedly in the natural childbirth camp. Her perspective in *Ina May's Guide to Childbirth*, however, is far from inflexible as she invites readers to learn about "women's real

capacities in labor and birth and...how these can mesh with the most effective use of modern birth technology” (p. xi). The goal of Gaskin’s book is an educational one – to provide a resource containing accurate, thorough (and often unmentioned) information, encouraging pregnant women to make informed decisions regarding maternity care, labor, and birth. Her perspective, however, is not without bias. Gaskin’s affinity for nature and natural processes reveals a socio-political predisposition that at once both empowers and patronizes women; these tensions are reflected in several of the book’s key points and themes. In this section, I begin by expanding upon midwifery epistemology; next, I examine naturalist ideology and praxis. I conclude by problematizing constructions of “natural,” “unnatural,” and the aligning of femininity with nature.

Midwifery epistemology. As noted in the previous chapter’s discussion, birth without technological intervention is a key theme in *Ina May’s Guide to Childbirth*. Out of the literature examined for this study, Gaskin’s book was the sole text rooted in midwifery philosophies. She builds a convincing case for natural birth, explicating why she believes in the ideology so fiercely. Childbearing is presented as a normal, non-pathological affair, influenced by mental processes, emotions, and environment. The appropriateness of the hospital as a setting in which *all* births take place is questioned as Gaskin explores the techno-medical model of maternity care. Gaskin clearly feels that many common interventions pose more risks to women than benefits, and her position is supported by the research she references. Even so, she understands that some women may feel unsafe giving birth outside of a hospital; for these women, she provides suggestions and advice for maximizing the chances of a non-interventionist birth in the hospital.

Although *Ina May’s Guide to Childbirth* clearly aims to promote non-interventionist birth

practices, it is far more concerned with the right of childbearing women to make informed choices regarding their maternity care. Gaskin's book provides extensive information on many commonly used medical interventions. She encourages the reader to seek information from other sources as well. By encouraging women to actively seek out information, rather than relying solely on their caregiver or hospital to provide it, Gaskin evidences a view of birthing mothers as capable agents, and demonstrates an unyielding confidence in their choices and abilities.

Naturalist ideology and praxis: Knowledge, agency, and challenging medical (mal)practice. Gaskin's confidence in birthing mothers stems from her naturalist ideology; because childbearing is viewed as a normal process for most women, the pregnant female body is seen as healthy and competent. Birth is considered a process which the body is fully capable of, a "normal physiological process that human and all other mammalian females have experienced for as long as we have existed" (Gaskin, 2003, p. 172).

Natal wisdom: Women as experts. Placing human females in the same category as other female mammals lends childbearing an innate, primal quality; it frames women's bodies as possessing an ancient, evolutionary knowledge of birth. Belief in the collective ancestral knowledge of the female body is a hallmark of naturalist philosophy. Indeed, in *Ina May's Guide to Childbirth*, Gaskin advises women to call upon this natal wisdom by allowing their "inner primate" to do the work of labor:

Given that all other primates are known to cope well with labor and birth, while 'civilized' humans often aren't, it seems that we would be wise to emulate other female primates as much as possible...in labor with my first baby...[I] imagined that I was a mountain lion. Emulating an animal made it easier for me to access that power that I instinctively knew that I needed during labor. I often suggest to pregnant women that

they imagine themselves to be a large mammal when they are in labor. Many say it helps them to find the wild woman within and to tap into the ancient knowledge that is the potential of all women. (p. 245)

This validation of uniquely female ways of knowing offers a refreshing alternative to conventional sociopolitical views of women's bodies as frail and incoherent. By positioning the pregnant body as well designed and reliable, and highlighting positive birth stories, Gaskin seeks to counter hegemonic dominance by substantiating women's experiences as knowledge.

Framing women's experience as wisdom is a hallmark of embodied knowledge theory. Developed within the field of psychology as a counterpoint to positivism, embodied knowledge theory refers to "a way of knowing that goes beyond the intellectual, logical and rational modes of thinking that have traditionally been defined as knowledge, and includes emotions, culture, physical sensation and life experiences" (Leitch, 2006, p. 552). Due to its emotional, corporeal nature, birth may be framed as embodied knowledge. Women who have given birth possess unique and powerful ways of knowing that are not always authenticated through traditional techno-medical approaches to childbearing. When knowledge is co-constructed as in midwifery praxis, women become their own experts, possessing wisdom and unique ways of understanding and approaching pregnancy and birth. This approach works to level the expert/non-expert power imbalance characteristic of much popular literature on childbearing, allocating authority to Gaskin, her readers, midwives, and communities of women.

Medical (mal)practice: Culture, power, and politics. Gaskin's questioning of techno-medical ideology is not restricted to authoritative knowledge systems. She also disputes the widely propagated suggestion that biomedicine is consistently based on best practice standards. She builds a convincing case, providing plenty of research to back her claim that the techno-

medical model does not always serve the best interests of mothers and infants. One particularly worrisome example of this is the continued use of Cytotec (i.e. misoprostol) to induce labor. Initially developed to prevent ulcers, the drug lacks approval from the FDA for use in pregnant women; in fact, its manufacturer has stated it does not plan to seek FDA approval for its use as a labor induction agent (Wing, Lovett, & Paul, 1998). Gaskin uneasily notes that:

There is not even a manufacturer's recommended dose for labor induction with Cytotec, which means that OB/GYNs prescribing the drug choose their own dosage regimens, often based on factors having nothing to do with the mother's or baby's safety. One group of OB/GYN researchers decided to place the entire 100-microgram tablet in women's vaginas (the drug was tested in *oral* dosages to prevent ulcers) to induce labor, commenting they selected 100 micrograms 'because of the ease of obtaining such a dose.' One assumes they later gave up the 100-microgram dose for induction after a consensus of researchers decided there had been too many catastrophic uterine ruptures associated with it. While they were correct that it is sloppy to cut tablets into halves and quarters, their decision to prescribe the 100-microgram dose at all seems incredibly cavalier – especially given the reports of worrisome maternal or fetal symptoms at half or a quarter of a 100-microgram tablet that had been published prior to this study. (p. 212)

The worrisome side effects Gaskin refers to come from forty-nine studies examining 5,439 women whose doctors used Cytotec to induce labor, and include maternal death, neonatal death, ruptured uteri, and emergency hysterectomies due to profuse bleeding (Gaskin, 2003). With such alarming outcomes, why does Cytotec remain the induction method of choice in so many North American hospitals? Although safer, less invasive methods of induction exist (e.g. sweeping the membranes, ingesting castor oil, breast stimulation), these do not work as quickly as drugs like

Cytotec; unfortunately, practitioners may be lured into using Cytotec due to its ability to shorten their working hours. Research done by The Center for Disease Control and Prevention (CDC) has “documented a significant rise in the frequency of births from Mondays to Fridays. One of the reasons for Cytotec’s popularity is apparently its efficacy in helping obstetricians schedule their maternity patients to give birth during daylight hours on weekdays” (Gaskin, 2003, p. 213; see also http://www.cdc.gov/nchs/data/statab/natfinal2003.annvol1_16.pdf, Table 1-16).

Clearly, the practices and procedures considered acceptable by medical institutions and regulatory bodies are not always backed by scientific research, nor based on best practice standards. Methods of care may be chosen based on convenience, economics, institutional pressure, or because they are widely-accepted (despite their lack of research support), routinely used techniques (e.g. episiotomies, use of the electronic fetal monitor). Many obstetric practices, then, are social and economic processes. Indeed, within *Ina May’s Guide to Childbirth*, medicine itself begins to emerge as a socio-political process, a culture impacted by collective systems of power, ethical ideologies, and economic gains and restrictions.

Naturally occurring problems: Unnatural minds, narrow norms, and masked realities. Although the text provides potent reminders of medicine’s often unrecognized status as a culture, Gaskin fails to consider the ways in which midwifery and the naturalist birth movement are also cultural constructions. Ideas of “natural” and (by proxy) “unnatural” are used as rhetorical strategy throughout Gaskin’s book; these philosophies may seem straightforward, however the sociopolitical ideologies they represent warrant closer scrutiny.

What is “natural”? “Natural birth,” as conceptualized by Gaskin, is birth that occurs without any form of technological intervention (i.e. no anesthesia, forceps, or vacuum used, no episiotomy given, etc.). However, in her consideration of the midwifery model of care’s

approach to initiating labor, Gaskin lists several self-help methods of induction, including sexual intercourse, breast stimulation, castor oil, and sweeping the membranes. These nonpharmacological suggestions lack the invasiveness and risk characteristic of medical forms of induction; nevertheless, they represent a calculated attempt to intervene in the labor and birth process, and thus may be classified as “interventions,” calling into question whether the birth that follows is, in fact, “natural.” Evidently, “natural birth” is a slippery concept, and difficult to define with precision.

So what *is* natural? In *Ina May’s Guide to Childbirth*, natural is characterized as that which occurs in, or can be traced back to, the non-human world. As I demonstrated in the previous section, the natal wisdom that Gaskin believes all women possess has links to our evolutionary heritage. In the process of labor, women are to call upon, or access, the primordial side of their being in order to facilitate natural birth. Gaskin puts it this way:

Letting the primate in you do the work of labor is a short way of saying not to let your over-busy mind interfere with the ancient wisdom of your body. To give you an idea of what I mean, here are some things that monkeys and apes don’t do in labor that many women do – and that interfere with labor:

- Monkeys don’t think of technology as necessary to birth-giving
 - Monkeys don’t obsess about their bodies being inadequate
 - Monkeys don’t do math about their dilation to speculate how long labor might take
 - Monkeys in labor get into the position that feels best, not the one they’re told to assume
- (p. 243).

Clearly, the idea here is that the processes which occur during primate birth are natural ones, and that women, as mammals with familial ties to primates, can and should emulate these birthing behaviours.

Natural bodies, unnatural minds. This focus on the primal, physical side of women's bodies sets up an interesting dichotomy of which Gaskin seems unaware. On the one hand, she touts the importance of the mind-body connection, and the brain's involvement in the birth process. Women are encouraged to actively engage with labor and birth by making decisions, listening to their own intuition, and exerting agency; presumably, such engagement requires a modicum of cortical activity. On the other hand, however, Gaskin warns that an "over-busy mind" may interfere with the *ancient wisdom* of the *body*. In doing so, she inadvertently amalgamates physicality and naturalness, thus characterizing the mind as unnatural. This reifies, rather than challenges, Descartes' mind/body dichotomy, and, given the book's naturalist perspective, defines women according to their physical wisdom and abilities. Such a classification is reductionist and problematically essentialist, since women have historically been defined by, and valued for, their bodies rather than their minds.

Indeed, throughout the text, women's bodies are praised for their capabilities and associated with natural imagery. The book includes 41 stories of birth, each written by a labouring mother, and many of these stories contain references to the ocean, caves, horses, lions, bulls, and primates. Femininity becomes synonymous with the natural world and wildness; somewhat ironically, these ideas are reminiscent of the patriarchal beliefs of early European religious authorities, philosophers, and scientists (see Chapter 1). Historically, aligning femininity with nature and wildness resulted in misogynistic sociopolitical views, whereby the female body was "othered," and deemed in need of control by masculine forces. Wide cultural

acceptance of these ideas builds on deeply entrenched patriarchal social norms: the “naturally wild” female body is viewed as untrustworthy, incapable, and subordinate to the rational, self-determined, intellectual male mind and body. Such norms create a culture of fear in which pregnant and birthing women question the intentions and capabilities of their own bodies (Cahill, 2000; Gaskin, 2011; Hausman, 2005), and promote a view of childbearing as requiring the management of medical experts. Thus, although *Ina May’s Guide to Childbirth* frames the wildness of the female body as a valuable attribute, the association of femininity with nature/the natural world inadvertently corroborates dominant medical discourses of birth.

Naturally narrow norms? Gaskin’s views on the female body and naturalist ideology may also reify traditional gender norms. Naturalist philosophy, by virtue of its definition as woman-centered, relies upon certain assumptions of what it means to be female, and what it means to not be female. For example, in emphasizing care that is more relational and holistic in nature, woman-centered care (WCC) may inadvertently endorse essentialist assumptions of sex and gender, while also validating cis-gender binaries of “male” and “female” which I discussed in Chapter 1. Multiple systems interact in complex ways to shape the identities of women, and this precludes any singular experience of womanhood or motherhood. As such, naturalist philosophies, and indeed, the very notions of “women” and “mothers,” create limitations that must be examined. “Mother” is not synonymous with “woman,” for example, and gender variant or gender fluid parents who give birth may feel alienated or frustrated by the constraints and implications of such labels.

Gaskin’s lexical choices in *Ina May’s Guide to Childbirth* may alienate readers who do not identify with traditional gender or parental norms, or with resolute naturalist ideology. In fact, some of the language used in “Part I: Birth Stories” is blatantly outdated, a remnant of

naturalist philosophy's 1970s Bohemian revival. In the stories written before 1985, several women refer to their vaginas as "the gates of life" or "yoni," contractions are labeled "rushes," and when experiencing contractions, one woman mentions getting "very high with it." The use of such terminology may work to diminish the power and value of a more holistic approach to birth by making it seem cheesy or "out-there." Outdated language may alienate women who feel uncomfortable embracing a philosophy that seems best suited to earth-mothers and fringe spiritual communities.

Masked physical realities? Speaking of birth in a cheesy or "out there" way may also come across as patronizing or condescending. In attempting to positively reframe the way women think about labor, Gaskin may inadvertently mask its physical reality:

In my early days as a midwife, I felt free to change some of the language surrounding birth as a way to help women cope with labor pain. I have a master's degree in English and was aware of how language can condition our response to a physical/emotional/spiritual process such as labor. I began to use the word *rush* instead of *contraction*. Why use a word that suggests tightness and hard muscles when successful labor will require expansion of the cervix, I thought. (p. 33)

Although the word "rush" may relate better to the energy of labor, the muscles of the uterus *are* contracting and squeezing, and attempting to sugarcoat this fact may leave women unprepared for the intensity of labor and birth. In her book *Misconceptions*, Wolf (2001) discusses the need for honest information describing birth's potency, not to frighten women, but to prepare them for the challenges they may face. She states:

A rural Central American midwife who spoke at the New School Midwifery Conference in New York in 1999, and whose practice was highly successful, claimed that women in

labor need to be told they will be going into battle: “‘Be brave. This will be tough and you can do it. Be brave.’ They need to be warriors for themselves and their babies.” No one informed me even remotely in our birth classes about the kind of courage you need to tap into during labor. Yet women who are prepared psychologically and physically for extreme pain – prepared, perhaps, to do battle – may well be better able to manage the trial of labor with less fear – and possibly with fewer medical interventions. (p. 93)

Giving women honest and accurate information is not at odds with Gaskin’s naturalist cause; in fact, as Wolf notes, women who are well prepared for labor may be better able to manage its intensity, and therefore may be more likely to achieve a natural birth (Beaton & Gupton, 1990; Bradley, 1995). Thus, providing information that is free of minimization or misrepresentation may facilitate Gaskin’s goal of encouraging and informing a diverse array of childbearing women.

Examining the counter-normative discourses contained within *Ina May’s Guide to Childbirth* allows us to question the ways in which naturalist philosophies affirm women’s ways of knowing, and impact upon experiences of the body/self in pregnancy and birth. Although naturalist ideology allows childbearing women to experience themselves as powerful agents full of wisdom and expertise, it may also reify the mind-body dichotomy, and patriarchal sociopolitical views of the female body. Further, North American midwifery ideologies are rooted in white, Eurowestern epistemological histories. As a result, they may exclude other worldviews and belief systems about pregnancy and birth - none of which are addressed in *Ina May’s Guide to Childbirth*, or any of the other texts - thereby minimizing the unique knowledge and practice systems of other ethnic groups, including Indigenous people and increasingly diverse cultural communities in Canada and the USA. Given the growing rates of immigration,

and the fact that Indigenous and new immigrant communities have the highest pregnancy and birth rates (Statistics Canada, 2011; Todd, 2013), the lack of representation of multiple knowledge systems is particularly problematic.

At once both positive and problematic, conceptualizations of “natural” and “unnatural” lie at the heart of Gaskin’s theoretical orientation, and thus are used as rhetorical strategy throughout *Ina May’s Guide to Childbirth*. The idiom of nature works discursively through Gaskin’s voice; however, Gaskin also succeeds in creating a discursive space that allows for alternative conceptualizations of knowledge, pregnancy, and birth. Further expanding these discursive spaces, and rupturing absolutist, dominant ideologies is critical to the field of maternity care. Additional options and approaches that are inclusive of multiple needs and value systems would facilitate a break down of rigid dichotomies, allowing practitioners to better serve the diverse women, infants, and families in their communities.

Peripheral Discourses and Alternative Accounts of Childbearing

As my findings demonstrated, several of the texts acknowledged counter-normative narratives related to motherhood, identity, and agency. At times, these narratives acted as discursive spaces where resistance to hegemonic ideologies was possible. In noting that motherhood is a learned skill, for example, *What to Expect* highlights and resists the traditional Eurowestern definition of women as inherently maternal and nurturing. Questioning deeply entrenched gender roles in this way brings sociopolitical philosophies into sharp relief; as the authors reassure readers that women aren’t born mothers any more than men are born fathers, they call attention to underlying assumptions regarding “feminine” and “masculine” characteristics that are both sexist and heteronormative. Acknowledging that women can learn to be mothers in the same way that men can learn to be fathers directly challenges the status quo,

creating a discursive space where alternative accounts of mothering are possible. That is, women can create for themselves a new definition of what it means to be a mother within their particular body, family, community, culture, or knowledge system. In their exploration of the rhetoric of motherhood, Dobris and White-Mills (2009) assert that

Alternative visions can and have changed the rhetorical landscape. For example, when Dr. Spock comforted mothers in the 1940s by assuring them that it was okay to soothe their crying babies without spoiling them, women by the millions were able to adopt a new archetype of parenting. In the 21st century, feminists can seek to de-center the patriarchal voice in parenting literature by providing alternative feminist discourses, thus supplanting the traditional views of women and mothering. (p. 35)

In challenging hegemonic views of women and mothering, *What to Expect* de-centers the patriarchal voice of childbearing literature, if only for a moment, and provides an alternative account of motherhood that is both productive and inclusive.

Concluding Thoughts: Implications for Future Research and Promoting Inclusive Discourses

This study explored the discourses espoused by popular literature on pregnancy, labour, and birth, paying particular attention to the ways in which these discourses are informed by political, socio-cultural, and economic forces. Ideological binaries, and the messages these project regarding women's bodies, identities, and capabilities, continue to be constructed as fixed and mutually exclusive, limiting their applicability and inclusivity of diverse women's voices and experiences. Peripheral accounts of childbearing may act as sites of ideological tension and debate, bringing normative discourses and power imbalances into sharp relief, and creating the space for alternative constructions of womanhood, motherhood, pregnancy and birth. However,

many counter-normative discourses are restricted by their Western (neo)liberal principles. The construct of “choice” in maternity care, for example, may disregard the larger systemic forces of poverty, racism, sexism and rurality, among other things. As a result of the information contained within childbearing education texts, women may expect to encounter a variety of maternity care options that may or may not be available to them. Future research involving childbearing advice may wish to focus on identifying women’s reactions, expectations, and concerns related to the messages of popular texts on pregnancy and birth. In particular, it may be useful to consider the ways in which birth discourses are interpreted, accepted, or redefined by minoritized women, such as Indigenous and racialized women, those who are economically disadvantaged, those who face religious/language/cultural barriers, those who have a disability, or who for other reasons are not represented in mainstream literature on childbearing.

The diversity of women’s lives, bodies, and families prevents any singular experience, and thus any singular definition or model of pregnancy, labour or birth. Consequently, ideological binaries must be ruptured in order to expand discursive spaces and allow for more productive and inclusive practices related to childbearing. When conceptualizations of pregnancy and birth are expanded, more holistic ways of thinking and learning about birth may be promoted. As Tiren (1999) notes,

Holistic care is not, or not only, about complimentary and alternative practices. It is far more to do with the notion of *integration*, both of aspects of care of the individual and of the health services. In order to care holistically for an individual we must appreciate the composite totality that constitutes that individual and differentiates them from others. (p. 128)

Models of holistic maternity care move beyond the use of alternative therapies to consider the

socioemotional, cultural, biological, relational, spiritual, psychological, sexual, economic, and geographic facets of women's lives, and the ways in which these may influence pregnancy and birth. As such, holistically based models accommodate diverse worldviews and belief systems, while providing safe, reliable care for a spectrum of women. Advancing a holistic culture of birth requires more than an expansion of conceptual models and theory – it necessitates shifts in praxis and accessibility. Increasing the availability of childbearing texts that are more varied, contain accurate information, and are written for an audience beyond the 30-something, heterosexual, married, able-bodied white woman, may help to reframe childbearing as a diverse, cultural process. When pregnancy and birth are understood in this way, discourses may reflect a multiplicity of women's stories and identities, and true client-centered care may be promoted.

References

- Albers, L. L. (2005). Overtreatment of normal childbirth in U.S. hospitals. *Birth*, 32(1), 67-68.
- Allan, K. D. *Patricia Hill Collins: Intersecting oppressions*. Retrieved from www.sagepub.com/upmdata/13299_Chapter_16_Web_Byte_Patricia_Hill_Collins.pdf
- Allotay, J. (2011). English midwives' responses to the medicalization of childbirth (1671-1795). *Midwifery*, 27, 532-538.
- American College of Nurse Midwives. (2010). Intermittent auscultation for intrapartum fetal heart rate surveillance. *Journal of Midwifery & Women's Health*, 55(4), 397-403.
- Applebaum, M. (2012, February 27). *SheKnows content is queen: Lifestyle site and sister brands connect 23 million women*. Retrieved from <http://www.adweek.com/sa-article/sheknows-content-queen-138540>
- Baraz, R., & Collis, R. E. (2005). The management of accidental dural puncture during labour epidural analgesia: A survey of UK practice. *Anaesthesia*, 60(7), 673-679.
- Beaton, J., & Gupton, A. (1990). Childbirth expectations: A qualitative analysis. *Midwifery*, 6, 133-139.
- Benoit, C., Westfall, R., Treloar, A. E. B., Phillips, R., & Jansson, M. (2007). Social factors linked to postpartum depression: A mixed-methods longitudinal study. *Journal of Mental Health*, 16(6), 719-730.
- Bradley, L. P. (1995). Changing American birth through childbirth education. *Patient Education and Counselling*, 25, 75-82.
- Bryers, H. M., & van Teijlingen, E. (2010). Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care. *Midwifery*, 26, 488-496.

- Buitendijk, S. (2011). Gender issues in determining the service and research agenda for pregnancy and birth care: The case of home birth in the Netherlands. *Interdisciplinary Science Reviews*, 36(2), 193-202.
- Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: A historical analysis. *Journal of Advanced Nursing*, 33(3), 334-342.
- Cameron, J. (2009). Woman centred maternity care and professional positioning: A response to Dornan. *International Journal of Nursing Studies*, 46, 288-290.
- Canada. (2015). *Truth and Reconciliation Commission of Canada report*. Winnipeg: Truth and reconciliation commission. Retrieved from <http://www.trc.ca/websites/trcinstitution/index.php?p=890>
- Carastathis, A. (2008). The invisibility of privilege: A critique of intersectional models of identity. *Les Ateliers De L'Ethique*, 3(2), 23-38.
- Carlton, T., Callister, L. C., Christiaens, G., & Walker, D. (2009). Nurses' perceptions of caring for childbearing women in nurse-managed birthing units. *MCN: The American Journal of Maternal/Child Nursing*, 34(1), 50-56.
- Carter, B. (2004). How do you analyze qualitative data? In T. Lavender, G. Edwards & Z. Alfievic (Eds.), *Demystifying qualitative research in pregnancy and childbirth* (pp. 87-107). Wiltshire, UK: Cromwell Press.
- Chaney, M. A. (1995). Side effects of intrathecal and epidural opioids. *Canadian Journal of Anesthesia*, 42(10), 891-903.
- Cheyney, M. (2011). *Born at home: The biological, cultural and political dimensions of maternity care in the United States*. Wadsworth, CA: Cengage Learning.

- Clarke, P. E., Gross, H., & Psychol, C. (2004). Women's behaviour, beliefs and information sources about physical exercise in pregnancy. *Midwifery*, 20, 133-141.
- Collins, P. H. (1998). It's all in the family: Intersections of gender, race, and nation. *Hypatia*, 13(3), 62-82.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of colour. *Stanford Law Review*, 43(6), 1241-1299.
- Davis-Floyd, R. E. (1990). The role of obstetrical rituals in the resolution of cultural anomaly. *Social Science and Medicine*, 31(2), 175-189.
- Davis-Floyd, R. E. (1994). The technocratic body: American childbirth as cultural expression. *Social Science and Medicine*, 38(8), 1125-1140.
- Davis-Floyd, R. E. (2003). *Birth as an american rite of passage*. Los Angeles, CA: UCP.
- Davis-Floyd, R. E., Barclay, L., Daviss, B-A., & Tritten, J. (Eds.). (2009). *Birth models that work*. Los Angeles, CA: University of California Press.
- Declercq, E., Sakala, C., Corry, M. P., & Applebaum, S. (2006). *Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences*. New York, NY: Childbirth Connection.
- de Finney, S. (2014). Under the shadow of the empire: Indigenous girls' presencing as decolonizing force. *Girlhood Studies*, 7(1), 8-26.
- Dillaway, H., & Brubaker, S. J. (2006). Intersectionality and childbirth: How women from different social locations discuss epidural use. *Race, Gender & Class*, 13(3-4), 16-41.
- Dobris, C. A., & White-Mills, K. (2009). Rhetorical visions of motherhood: A feminist analysis of the *What to Expect* series. *Women and Language*, 29(1), 26-36.

- Douglas, V. K. (2010). The Inuulitsivik maternities: Culturally appropriate midwifery and epistemological accommodation. *Nursing Inquiry*, 17(2), 111-117.
- Ehrenreich, B., & English, D. (2005). *For her own good: Two centuries of the experts' advice to women*. New York, NY: Anchor Books.
- Forssén, A. (2012). Lifelong significance of disempowering experiences in prenatal and maternity care: Interviews with elderly Swedish women. *Qualitative Health Research*, 22(11), 1535-1546.
- Foucault, M. (1973). *The birth of the clinic: An archaeology of medical perception* [(original work published in 1963)]. New York, NY: Pantheon.
- Freeman, R. (1990). Intrapartum fetal monitoring - a disappointing story. *The New England Journal of Medicine*, 322, 624-626.
- Gaskin, I. M. (2003). *Ina May's guide to childbirth*. New York, NY: Bantam Dell.
- Gaskin, I. M. (2011). *Birth matters: A midwife's manifesta*. New York, NY: Seven Stories Press.
- Goer, H. (1999). *The thinking woman's guide to a better birth*. New York, NY: Penguin Putnam.
- Gourounti, K. (2012). Cochrane review finds that use of cardiotocograph on admission to labour ward, rather than intermittent auscultation of the fetal heart rate, may increase risk of caesarean in low-risk women. *Evidence Based Nursing*, 15(4), 106-107.
- Gremillion, H. (2004). Unpacking essentialisms in therapy: Lessons for feminist approaches from narrative work. *Journal of Constructivist Psychology*, 17, 173-200.
- Hall, J. M., & Stevens, P. E. (1991). Rigor in feminist research. *Advances in Nursing Science*, 13(3), 16-29.

- Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, 4. 1-126, doi: 10.1002/14651858.CD004667.pub2.
- Hausman, B. L. (2005). Risky business: Framing childbirth in hospital settings. *Journal of Medical Humanities*, 26(1), 23-38.
- Haverkamp, A. D., Thompson, H. E., McFee, J. G., & Cetrulo, C. (1976). The evaluation of continuous fetal heart rate monitoring in high-risk pregnancy. *American Journal of Obstetrics and Gynecology*, 125, 310-320.
- Haverkamp, A., Orleans, M., Langendoerfer, S., McFee, J., Murphy, J., & Thompson, H. E. (1979). A controlled trial on the differential effects of intrapartum fetal monitoring. *American Journal of Obstetrics and Gynecology*, 134, 399-412.
- Herer, E., & Blott, M. (2009). *Pregnancy day by day*. Toronto, ON: Dorling Kindersley Canada.
- Hersh, S., Megregian, M., & Emeis, C. (2014). Intermittent auscultation of the fetal heart rate during labor: An opportunity for shared decision making. *Journal of Midwifery & Women's Health*, 00(0xxx), 1-6.
- Hoyert, D. L. (2007). Maternal mortality and related concepts. National Center for Health and Statistics. *Vital and Health Statistics*, 3(33), 1-13. Retrieved from http://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf
- Huckin, T. (1997). Critical discourse analysis. In T. Miller (Ed.), *Functional approaches to written text: Classroom applications* (pp. 78-92). Washington, DC: U.S. Department of Education.

- Iida, M., Horiuchi, S., & Porter, S. E. (2012). The relationship between women-centered care and women's birth experiences: A comparison between birth centres, clinics, and hospitals in Japan. *Midwifery, 28*, 458-465.
- Irvine, V. (2007). *The girlfriends' guide to pregnancy*. New York, NY: Pocket Books.
- Jansen, I. (2006). Decision making in childbirth: The influence of traditional structure in a Ghanaian village. *International Nursing Review, 53*, 41-46.
- Jansen, L., Gibson, M., Bowles, B. C., & Leach, J. (2013). First do no harm: Interventions during childbirth. *The Journal of Perinatal Education, 22*(2), 83-92.
- Janssen, P. A., Henderson, A. D., & Vedam, S. (2009). The experience of planned home birth: Views of the first 500 women. *Birth, 36*(4), 297-304.
- Janssen, P. A., Mitton, C., & Aghajanian, J. (2015). Costs of planned home vs. hospital birth in British Columbia attended by registered midwives and physicians. *PLOS ONE, 10*(7), 1-11.
- Jordan, B. (1997). Authoritative knowledge and its construction. In R. E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and authoritative knowledge: Cross-cultural perspectives* (pp. 55-75). Berkeley, LA: UCP.
- Kaufman, T. (2007). Evolution of the birth plan. *The Journal of Perinatal Education, 16*(3), 47-52.
- Kelly, S., Sprague, A., Fell, D. B., Murphy, P., Aelicks, N., Guo, Y., et al. (2013). Examining caesarean section rates in Canada using the Robson Classification System. *Journal of Obstetrics and Gynaecology Canada, 35*(3), 206-214.
- Kennedy, H. P., Nardini, K., McLeod-Waldo, R., & Ennis, L. (2009). Top-selling childbirth advice books: A discourse analysis. *Birth, 36*(4), 318-324.

- Kingdom, C. (2004). Why carry out qualitative research? In T. Lavender, G. Edwards & Z. Alfievic (Eds.), *Demystifying research in pregnancy and childbirth* (pp. 48-62). Wiltshire, UK: Cromwell Press.
- Kirby, S. L., Greaves, L., & Reid, C. (2010). *Experience research social change: Methods beyond the mainstream*. Toronto, ON: University of Toronto Press.
- Kitzinger, S. (2005). *The politics of birth*. London, UK: Elsevier.
- Kitzinger, S. (2012). Rediscovering the social model of childbirth. *Birth*, 39(4), 301-304.
- Klein, M. C., Grzybowski, S., Harris, S., Liston, R., Spence, A., Le, G., et al. (2001). Epidural analgesia use as a marker for physician approach to birth: Implications for maternal and newborn outcomes. *Birth*, 28, 243-248.
- Kvale, S. (1995). The social construction of validity. *Qualitative Inquiry*, 1(1), 19-40.
- Larkin, P., Begley, C. M., & Devane, D. (2012). 'Not enough people to look after you': An exploration of women's experiences of childbirth in the republic of Ireland. *Midwifery*, 28, 98-105.
- Lazar, M. M. (2007). Feminist critical discourse analysis: Articulating a feminist discourse praxis. *Critical Discourse Studies*, 4(2), 141-164.
- Lee, S. M., Kirkman, A., & Kirkman, M. (2008). Disciplinary discourses: Rates of Cesarean section explained by medicine, midwifery, and feminism. *Health Care for Women International*, 29, 448-467.
- Leighton, B. L., & Halpern, S. H. (2002). Epidural analgesia: Effects on labor progress and maternal and neonatal outcome. *Seminars in Perinatology*, 26(2), 122-135.

- Leitch, R. (2006). Limitations of language: Developing arts-based creative narrative in stories of teachers' identities. *Teachers and Teaching: Theory and Practice*, 12(5), 549-569.
- Liamputtong, P. (2004). Giving birth in the hospital: Childbirth experiences of Thai women in Northern Thailand. *Health Care for Women International*, 25, 454-480.
- Lieberman, E., & O'Donoghue, C. (2002). Unintended effects of epidural analgesia during labor: A systematic review. *American Journal of Obstetrics and Gynecology*, 186(5), S31-S68.
- Lim, L. (2014). Ideology, rationality, and reproduction in education: A critical discourse analysis. *Discourse: Studies in the Cultural Politics of Education*, 35(1), 61-76, doi: 10.1080/01596306.2012.739467
- Liu, S., Liston, R., Joseph, K., Heamen, M., Suave, R., & Kramer, M. (2007). Maternal mortality and severe morbidity associated with low-risk planned cesarean delivery versus planned vaginal delivery at term. *Canadian Medical Association Journal*, 176, 455-460.
- Lothian, J. A. (2000). Why natural childbirth? *The Journal of Perinatal Education*, 9(4), 45.
- Lothian, J. (2006). Birth plans: The good, the bad, and the future. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35, 295-303.
- Lowe, N. K. (2004). Context and process of informed consent for pharmacologic strategies in labor pain care. *Journal of Midwifery & Women's Health*, 49(3), 250-259.
- Luthy, D. A., Shy, K. K., van Belle, G., Larson, E. B., Hughes, J. P., Benedetti, T. J., et al. (1987). A randomized trial of electronic fetal monitoring in preterm labor. *Obstetrics and Gynecology*, 69, 687-695.

- MacDonald, D., Grant, A., Sheridan-Pereira, M., Boylan, P., & Chalmers, I. (1985). The Dublin randomized controlled trial of intrapartum fetal heart rate monitoring. *American Journal of Obstetrics and Gynecology*, 152(5), 524-539.
- Macdonald, M. (2006). Gender expectations: Natural bodies and natural births in the new midwifery in Canada. *Medical Anthropology Quarterly*, 20(2), 235-256.
- Machin, D., & Mayr, A. (2012). *How to do critical discourse analysis*. London, UK: Sage Publications.
- Margulis, J. (2013). *The business of baby*. New York, NY: Scribner.
- McAra-Couper, J., Jones, M., & Smythe, L. (2011). Caesarean-section, my body, my choice: The construction of 'informed choice' in relation to intervention in childbirth. *Feminism & Psychology*, 22(2), 81-97.
- Mercer, J., Green-Jervis, C., & Brannigan, C. (2012). The legacy of a self-reported negative birth experience. *British Journal of Midwifery*, 20(10), 717-722.
- Meredith Corporation. (2015). *Parents: Healthy kids, happy families*. Retrieved from <http://www.meredith.com/brand/parents>
- Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts*. Toronto, ON: York University School of Health Policy and Management.
- Mitford, J. (1992). *The American way of birth*. Toronto, ON: Penguin.
- Morgan, J. (2004). Planning your research. In T. Lavender, G. Edwards & Z. Alfievic (Eds.), *Demystifying research in pregnancy and childbirth* (pp. 48-62). Wiltshire, UK: Cromwell Press.

- Murkoff, H., & Mazel, S. (2008). *What to expect when you're expecting*. New York, NY: Workman Publishing Company.
- Murray-Davis, B., McDonald, H., Rietsma, A., Coubrough, M., & Hutton, E. (2014). Deciding on home or hospital birth: Results of the Ontario choice of birthplace survey. *Midwifery*, 30, 869-876.
- Naples, N. A. (2003). *Feminism and method*. New York, NY: Routledge.
- Oden, M. (2005). The freedom to birth - the use of Cytotec to induce labor: A non-evidence based intervention. *The Journal of Perinatal Education*, 18(2), 48-51.
- Odent, M. (2003). *Birth and breastfeeding: Rediscovering the needs of women during pregnancy and childbirth*. Sussex, UK: Clairview.
- Oladapo, O. T. (2006). *Amniocentesis and chorionic villus sampling for prenatal diagnosis: RHL commentary*. Retrieved from http://apps.who.int/rhl/pregnancy_childbirth/fetal_disorders/prenatal_diagnosis/ofcom1/en/
- Olsen, O., & Clausen, J. A. (2012). Planned hospital birth versus planned home birth. *Cochrane Database of Systematic Reviews*, 9, 1-30.
- Padgett, D. K. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage Publications.
- Pfeiffer, M. B. (2010, May 8). C-section rates tick upward as doctors fear being sued. *Poughkeepsie Journal*. Retrieved from <http://archive.poughkeepsiejournal.com/article/20100509/NEWS01/5090346/C-section-rates-tick-upward-doctors-fear-being-sued>

- Pincus, J. (2000). Childbirth advice literature as it relates to two childbearing ideologies. *Birth*, 27(3), 209-213.
- Pope, R., Graham, L., & Patel, S. (2001). Woman-centred care. *International Journal of Nursing Studies*, 38, 227-238.
- Potter, J. E., Berquo, E., Perpetuo, I., Leal, O., Hopkins, K., Souza, M., et al. (2001). Unwanted cesarean sections among public and private patients in Brazil: Prospective study. *British Medical Journal*, 323, 1155-1158.
- Prentice, A., & Lind, T. (1987). Fetal heart rate monitoring during labor - too frequent intervention, too little benefit? *The Lancet*, 330(8572), 1375-1377.
- Reiger, K., & Dempsey, R. (2006). Performing birth in a culture of fear: An embodied crisis of late modernity. *Health Sociology Review*, 15(4), 364-373.
- Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., ...Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*, 384(9948), 1129-1145.
- Reynolds, P. C. (1991). *Stealing fire: The mythology of the technocracy*. Palo Alto, CA: Iconic Anthropology Press.
- Robinson, J. N., Norwitz, E. R., Cohen, A. P., McElrath, T. F., & Lieberman, E. S. (1999). Epidural analgesia and third- or fourth-degree lacerations in nulliparas. *Obstetrics and Gynecology*, 94(2), 259-262.
- Romano, A. M., & Lothian, J. A. (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37, 94-105.

- Rosenthal, E. (2013, June 30). American way of birth, costliest in world. *The New York Times*. Retrieved from http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?pagewanted=all&_r=0
- Roth, L. M., & Henley, M. M. (2012). Unequal motherhood: Racial-ethnic and socioeconomic disparities in cesarean sections in the United States. *Social Problems, 59*(2), 207-227.
- Rudolfsdottir, A. G. (2000). 'I am not a patient, and I am not a child': The institutionalization and experience of pregnancy. *Feminism and Psychology, 10*(3), 337-350.
- Rudrum, S. (2012). An intersectional critical discourse analysis of maternity care policy recommendations in British Columbia. In O. Hankivsky (Ed.), *An intersectionality-based policy analysis framework* (pp. 47-66). Vancouver, BC: SFU Institute for Intersectionality Research and Policy.
- Samuels, G. M., & Ross-Sheriff, F. (2008). Identity, oppression, and power: Feminisms and intersectionality theory. *Affilia: Journal of Women and Social Work, 23*(1), 5-9.
- Schwartz-Shea, P. (2006). Judging quality: Evaluative criteria and epistemic communities. In D. Yanow, & P. Schwartz-Shea (Eds.), *Interpretation and method: Empirical research methods and the interpretive turn* (pp. 89-114). Armonk, NY: M.E. Sharp Inc.
- Scott, D. B., & Hibbard, B. M. (1990). Serious non-fatal complications associated with extradural block in obstetric practice. *British Journal of Anaesthesia, 64*(5), 537-541.
- Shaw, J. C. (2013). The medicalization of birth and midwifery as resistance. *Health Care for Women International, 34*(6), 522-436.
- Sheldon, S. (1993). "Who is the mother to make the judgment?": The constructions of woman in English abortion law. *Feminist Legal Studies, 1*(1), 3-22.

- Shieh, C., McDaniel, A., & Ke, I. (2009). Information-seeking and its predictors in low-income pregnant women. *Journal of Midwifery & Women's Health, 54*(5), 364-372.
- Simkin, P. (2007). Birth plans: After 25 years, women still want to be heard [commentary]. *Birth, 34*(1), 49-51.
- Song, F. W., West, J. E., Lundy, L., & Dahmen, N. S. (2012). Women, pregnancy, and health information online: The making of informed patients and ideal mothers. *Gender and Society, 26*(5), 773-798.
- Stockill, C. (2007). Trust the experts? A commentary on choice and control in childbirth. *Feminism & Psychology, 17*(4), 571-577.
- Stojanovic, J. (2008). Midwifery in New Zealand, 1904-1971. *Contemporary Nurse, 30*, 156-167.
- Stoll, K., Hall, W., Janssen, P., & Carty, E. (2014). Why are young Canadians afraid of birth? A survey study of childbirth fear and birth preferences among Canadian university students. *Midwifery, 30*(2), 220-226.
- Stout, M. J., & Cahill, A. G. (2011). Electronic fetal monitoring: Past, present, and future. *Clinics in Perinatology, 38*(1), 127-142.
- Strega, S. (2005). The view from the poststructural margins: Epistemology and methodology reconsidered. In L. Brown & S. Strega (Eds.), *Research as resistance: Critical, Indigenous, and anti-oppressive approaches* (pp. 199-235). Toronto, ON: Canadian Scholars' Press/Women's Press.
- Thomson, G., & Downe, S. (2012). A hero's tale of childbirth. *Midwifery, 29*(7), 765-771.

- Torres, J., De Vries, R., & Low, L. K. (2014). Consumer information on fetal heart rate monitoring during labor: A content analysis. *Journal of Perinatal and Neonatal Nursing*, 28(2), 135-143.
- van Teijlingen. (2005). A critical analysis of the medical model as used in the study of pregnancy and childbirth. *Sociological Research Online*, 10(2), 1.1-18.2. doi: 10.5153/sro.1034
- Vedam, S., Schummers, L., Stoll, K., Rogers, J., Klein, M. C., Fairbrother, N.,...Kaczorowski, J. (2012). The Canadian birth place study: Describing maternity practice and providers' exposure to home birth. *Midwifery*, 28, 600-608.
- Vedam, S. Stoll, K., Schummers, L., Rogers, J., & Paine, L. L. (2014). Home birth in North America: Attitudes and practice of US certified nurse-midwives and Canadian registered midwives. *Journal of Midwifery and Women's Health*, 59, 141-152.
- Verstraeten, B. S. E., Mijovic-Kondejewski, J., Takeda, J., Tanaka, S., & Olson, D. M. (2015). Canada's pregnancy-related mortality rates: Doing well but room for improvement. *Clinical and investigative medicine*, 38(1), E15-E36.
- Viisainen, K. (2000). The moral dangers of home birth: Parents' perceptions of risks in home birth in Finland. *Sociology of Health & Illness*, 22(6), 792-814.
- Villar, J., Carroli, G. C., Zavaleta, N., Donnor, A., Wojdyla, D., Faundes, A., et al. (2007). Maternal and neonatal individual risks and benefits associated with cesarean delivery: Multicentre prospective study. *British Medical Journal*, , May 2, 2014.
- Wagner, M. (2006). *Born in the USA: How a broken maternity system must be fixed to put mothers and infants first*. Los Angeles, CA: UCP.

- Walsh-Gallagher, D., McConkey, R., Sinclair, M., & Clarke, R. (2013). Normalizing birth for women with a disability: The challenges facing practitioners. *Midwifery, 29*, 294-299.
- Washington, H. A. (2006). *Medical apartheid: The dark history of medical experimentation on black Americans from Colonial times to the present*. New York, NY: Doubleday.
- Wertz, R. W., & Wertz, D. C. (1977). *Lying-in: A history of childbirth in America*. New York, NY: The Free Press.
- Westfall, R. E., & Benoit, C. (2004). The rhetoric of “natural” in natural childbirth: Childbearing women’s perspectives on prolonged pregnancy and induction of labour. *Social Science & Medicine, 59*, 1397-1408.
- Wing, D. A., Lovett, K., & Paul, R. H. (1998). Disruption of prior uterine incision following misoprostol for labor induction in women with previous cesarean delivery. *Obstetrics and Gynecology, 91*, 828-830.
- Wolf, N. (2003). *Misconceptions: Truth, lies, and the unexpected on the journey to motherhood*. New York, NY: Anchor.
- World Health Organization. (2014). *The prevention and elimination of disrespect and abuse during facility-based childbirth*. Retrieved from http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1
- Worman-Ross, K., & Mix, T. L. (2013). “I wanted empowerment, healing, and respect”: Homebirth as challenge to medical hegemony. *Sociological Spectrum, 33*(5), 453-481.
- Zadoroznyj, M. (1999). Social class, social selves and social control in childbirth. *Sociology of Health and Illness, 21*(3), 267-289.