A SOCIAL WORK EXPLORATION OF DISTRESS IN CHILDBIRTH

by © Christiana Kate MacDougall Fleming

A Dissertation submitted

to the School of Graduate Studies in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

School of Social Work

Memorial University of Newfoundland

October, 2017

St. John's Newfoundland and Labrador

ABSTRACT

Emerging evidence suggests childbirth is often experienced as a distressing life event. Currently there is very little social work literature regarding childbirth, and the non-obstetrical focused childbirth literature from other disciplines often ignores or pathologizes the experiences of those who express distress in relation to childbirth. Social work's silence in this area contributes to the continued uncritical acceptance of dominant childbirth discourses, and the oppression and marginalization of those whose experiences are outside dominant understandings of childbirth.

This study was carried out in response to this void in the social work knowledge and practice base. It used a feminist narrative inquiry and analysis to explore the question, "What are individuals' experiences of distress in childbirth?" Using a conceptual framework consistent with a commitment to human rights and social justice, this study paid specific attention to how experiences of distress are produced through an analysis of discourse, power/knowledge, agency, and the body.

Fifteen women were interviewed for this study. Their individual interviews were examined for themes related to intrapersonal experience, interpersonal experience, culture, and structural/institutional domains. The results of this study show how oppressive, gender-based discourses can interact with mechanisms of power and associated ideas of agency, to create distress among women during childbirth. Interpreted themes pertaining to Discourse were: (1) Good Mothers, (2) Good Mothers and Good Patient, (3) Women as Over-dramatic, (4) Women as Diva, and (5) Women as

Heterosexual. With respect to themes identified within Power/Knowledge, I uncovered: (1) Disciplinary Power, (2) Regimes of truth/Subjugated Knowledge, and (3) Resistance.

The participants demonstrated the various ways in which their identities and social locations affected their birth experiences. The themes pertaining to Gender and Intersections of Identity were: (1) Women as Invisible or Secondary, (2) Invisibility of Whiteness and Other Privileged Identities, (3) Exceptions of the Invisibility of Privilege, and (4) Awareness of Marginalization. The participants who had problematic childbirth experiences took up the concepts of Distress and Emotion variously, and I interpreted the themes within this section as: (1) Hormones, (2) Distress as a Sign Something Has Gone Wrong, (3) Distress as Normal and Helpful, (4) Emotional Pain and Distress as Pathology and Mental Illness, and (5) The Language of Trauma.

The participants' narratives also disrupted the dominant view of birth stories. Themes in Childbirth and Narrative included: (1) Narratives Reflecting the Nonlinear Structure of Childbirth, (2) Inclusion of Previous Birth Stories in the Narratives, (3) Use of Narrative Devices in Childbirth Stories, and (4) Iterative Knowledge Production

Additionally, the findings of this study shed light on the theme of Emotional Labour and Caring Work as it related to the work birthing women undertook during childbirth, and explored the often conflicting and polarized expectations of women and views of childbirth that birthing women navigated during childbirth. Interpreted themes related to Polarities were: (1) Medical (with interventions) and Natural (no interventions) Childbirth, (2) Expecting Women to Make Decisions versus Not Allowing Women Input into Decisions, (3) The Homework Paradox, and (4) Breastfeeding. The findings of this study also point to factors that might lessen the effects of distress in childbirth. Themes

identified in How to Help were: (1) Recognize that Childbirth is a Regular Event that is Special; (2) The Importance of support from Others including a discussion of the themes of; (a) Community and Partners, (b) Relationship with Physicians, and (c) Angels Among us; and (3) Someone to Talk To.

The findings of this study are positioned within the emerging field of human rights in childbirth as it fits within the guiding principles of the International Federation of Social Workers. As social work is concerned with improving human rights of all people, these findings have implications for a broad range of social work practice, theory, and research.

ACKNOWLEDGEMENTS

I want to thank the members of my cohort, especially Fred and Michele, for the moral support you provided. We shared many late nights during our residencies in Newfoundland, laughing and crying about our course work, and always writing, writing, writing. You will find your suggestions, guidance, and feedback on early versions of the work reflected in these pages.

Finally, I want to acknowledge and thank my family. To my parents William and Patricia, thank you for always supporting my education and encouraging me to dream big. My father never misses a chance to brag about his children, and my mother has only ever been supportive of my choices; choices I am aware she did not have the opportunity to make for herself in her own life.

To my daughters Bailey, Amelia, and Sophie who, without complaint, sacrificed having their mother available during important life experiences. You asked insightful questions that made me think, brought me coffee and cookies when I was writing, and always cheered me on when I was getting tired. Thank you for being such wonderful people.

Of course, I owe a great debt of gratitude to my partner David, who is a partner in every sense. David encouraged me to return to complete my studies despite being out of the academy for 15 years. He gladly took over complete care of our home and children when I was away for my residencies, and during the years that followed. Thank you for reading drafts of my work, listening to my stress-filled wonderings about my future, and for always believing I would be successful.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

Appendix A   Literature Regarding Distress and Trauma In Childbirth

Appendix B   Invitation to Participate Letter

Appendix C   Telephone Script

Appendix D   Information Letter for Participants

Appendix E   Memorial University ICEHR Informed Consent Form

Appendix F   Interview Guide

Appendix G   Memorial University ICEHR Approval Letter

CHAPTER 1

CREATING A CONTEXT FOR MY RESEARCH

There is growing evidence that childbirth is often experienced as a distressing life event (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Bailham & Joseph, 2003; Beck, 2004a, 2004b; Beck & Driscoll, 2006; Beck, Driscoll, & Watson, 2013; Creedy, Shochet, & Horsfall, 2000; Czarnocka & Slade, 2000; Gamble & Creedy, 2000; Harris & Ayers, 2012; C. Kitzinger & Kitzinger, 2007; S. Kitzinger, 2006b; Leeds & Hargreaves, 2008; Lyons, 1998; McKenzie-McHarg, 2004; Polachek, Harari, Baum, & Strous, 2012; Soet, Brack, & DiIorio, 2003; Wijma, Söderquist, & Wijma, 1997). However, social work research does not reflect an interest in this topic. Currently there is very little social work literature regarding childbirth (Schneider, 2009) and the non-obstetrical (non-physician) focused childbirth literature from other disciplines (e.g. psychology, nursing, midwifery) often ignores or pathologizes the lived experiences of those who express distress in relation to childbirth. Given this, social work's silence in the area of childbirth contributes to the continued uncritical acceptance of dominant childbirth discourse, and the oppression and marginalization of those whose childbirth experiences are outside dominant understandings about childbirth.

In this dissertation I argue that social work should study the topic of childbirth (Averitt Taylor, 2014; Cacciatore, 2009; Schneider, 2009, 2012), particularly distressing childbirth experiences. This work represents my intended contribution to the social work knowledge base regarding childbirth, through a focus on distressing childbirth experiences. My hope is that social workers may be better able to evaluate, critique, and

make positive contributions to research, policy, and practice related to childbirth which ultimately will contribute to improved care for those who give birth, reduced emotional suffering during childbirth, and a related increase in satisfaction with birth experiences. My research question is, "What are individuals' experiences of distress in childbirth?" with a particular interest in exploring how social location influences understandings and discursive constructions of distress in childbirth experiences. The purpose of the research, therefore, is to address a void in the social work knowledge base, provide new awareness, insights, and theory concerning experiences of distress during childbirth, and to highlight why increasing this knowledge base is important for social workers' practice and the people with whom they work.

It is important to begin with a note about the language I am using to describe those who give birth. The literature on childbirth generally defines childbearing people as women (and I will discuss this further in the conceptual framework and the literature review sections to follow). I do not wish to talk about "women's" experiences as this excludes those who do not identify as cis women (cis people are those whose experiences of their gender matches the gender they were assigned at birth) and makes invisible the experiences of those who have any gender other than that of cis woman when we talk about childbirth. This centring of cis women as normative for women occurs in the area of childbirth in the following ways: trans women cannot yet biologically carry a pregnancy (Adams, 2010) and yet are women; and not all people who can have pregnancies identify as women (for example, gender queer people, and trans men can be pregnant).

I identify as a woman, and a cis woman specifically, and upon entering this topic, I personally viewed childbirth as a gendered experience. However, my values as a feminist and as a feminist researcher require me to constantly question the assumptions I have about people and experiences. Doing this research disrupted my understanding of childbirth as strictly a female domain, and I hope this study will continue to challenge taken-for-granted assumptions about childbirth and gender. And so, just as I began this research by exploring how my own intersecting identities influenced what I might have been able to see or might have been ignorant of, so too I begin this dissertation by positioning myself in the topic of distress in childbirth. I do this so that I make overt the position from which I am exploring the topic. I recognize that this view of myself would have been written differently in the past, and I am aware that I may understand myself differently in the future.

Positioning Myself in Relation to Experiences of Distress in Childbirth

My life, like all lives, has been and is shaped by a variety of intersecting privileges, marginalizations, challenges, and opportunities. Because I am skeptical of the idea of objectivity, as are many feminist researchers, I believe that perspective is always situated and as such I disclose my various and intersecting positions so that you, the reader, may make your own decisions about, and hold me accountable for, what I may or may not be able to see in this work (Gannon & Davies, 2007; Harding, 1991; D. E. Smith, 1990; Ussher, 2011). I entered this project from my own social location, which shaped my understandings of the literature, how I interacted and engaged with research participants, and how they may have engaged and interacted with me. I was aware that

my experiences and the participants' experiences of childbirth might share some similarities and differences.

I have always self-identified and been identified by others as female. I have had three pregnancies, which resulted in three live children. At times, especially after the birth of my second child, I have struggled with feelings of sadness and of being overwhelmed. However, I have never been officially labeled as depressed or mentally ill. One of my childbirth experiences involved significant difficulties and complications, which resulted in me experiencing physical pain, emotional distress, and ongoing medical and surgical interventions for a year after the birth. At the time, and still today, I believe this happened because my own voice, my telling of my experience, and what I knew was true, were ignored and subordinated to knowledges of the physicians involved in my care.

While I have had this difficult experience, I have also had many experiences of unearned privilege. My first and only language is English, and my accent is recognizable as Atlantic Canadian, meaning people assume I was born in Canada, even though I was not. Although I had insurance issues complicated by immigration status for one of my pregnancies, I was able to access care and resolve insurance matters "after the fact." English was the dominant language in all the communities where I gave birth, which meant that I was able to communicate with all staff free from any barriers to understanding on my part, and without having difficulty being understood by others.

I am also White, which brought and continues to bring with it automatic and unearned privilege. Looking back, I can see that my whiteness affected my desire to see myself, and be seen by others, as not racist, which contributed to difficulties I had in voicing my concerns assertively with my physician, who was a racialized woman. To be

4

clear, I mention this not to suggest that any shortcomings on my physician's part were related to race, but more as a reflection on where my own mind was at that time. I suspect that because of my fear of being seen as racist I was less assertive and vocal in my concerns than I likely would have been if my physician had been White. I was probably even worried that the concerns I did have were not legitimate but were instead a reflection of some deep seated, unacknowledged racial bias I held. As someone who identified as a feminist, I was also keen to have a female physician and wanted to be positive about women in medical roles. This probably also played a role in my less than assertive stance with my physician. As I now reflect on this experience, I do believe that there were problems in my care that had long-term consequences for me. Overall, at the time I struggled with separating problems with the system that was hurting me from the individuals who were acting within the system.

Despite my difficulties, I had supportive relationships that helped to mitigate my negative experiences. I married who and when I wanted, not with protest but celebration. Because heterosexual marriages are celebrated and considered normative, my partner was welcomed spontaneously into the birth experiences. I also had and continue to have supportive extended family relationships, as well as personal relationships with people who could access power in the healthcare system, which provided me with a better outcome than I would have had without these personal connections. My childbirth experiences have also been shaped by my age, my middle class status, my experiences living with a chronic and (for the most part) invisible illness, my high level of medical literacy, and other factors of which I may or may not be aware.

My intent here is not to simply list my social location as an absolving act (Brown, 2012), but to position myself openly and transparently as I enter the literature and the research experience. My own experiences of childbirth were varied across my three pregnancies. However, I, like many researchers, became interested in exploring the idea of distress in childbirth through my own experiences and through hearing about the birth experiences of other women in my personal and professional life. I became particularly interested in how it seemed that so many women that I interacted with, both personally and professionally, found childbirth to be very distressing (often the term "traumatic" was used) and yet, how many women said that they felt they were alone in having this experience.

Finally, I also came to this undertaking as a social worker with twenty years of experience working with individuals and families. I have worked primarily with adult women, who have often voiced the belief that their emotional distress is a symptom of illness, or a sign of personal failings or shortcomings. While I never want to minimize or argue with their own understandings of their experiences, I also wondered (and continue to wonder) how much of their distress may (also) have been a manifestation of the systemic marginalization of their lived experiences, and a lack of recognition of and responsiveness to their needs. As a social worker, the experience of having my own knowledge about my lived experience of childbirth marginalized and dismissed and seeing a similar dynamic in the lives of other women, encouraged me to find a way to make sense of how this might come to happen. It was also important to me to add to social work's knowledge base in a way that privileges the lived experiences and

knowledge of those who have given birth, while at the same time being aware that these subjective experiences are also socially shaped (Brown, 2012; Houston, 2001).

The Importance of Distress in Childbirth as a Topic for Social Work

Childbirth is often experienced as a major life event (Bachman & Lind, 1997; Lundgren, 2011; Thomson, 2011) and there is a growing body of evidence suggesting more women experience childbirth as a significantly distressing experience than earlier childbirth literature reflects (Alder et al., 2006; Beck, 2004a, 2004b; Beck & Driscoll, 2006; Beck et al., 2013; Creedy et al., 2000; Czarnocka & Slade, 2000; Gamble & Creedy, 2000; Harris & Ayers, 2012; C. Kitzinger & Kitzinger, 2007; S. Kitzinger, 2006b; Leeds & Hargreaves, 2008; Lyons, 1998; McKenzie-McHarg, 2004; Polachek et al., 2012; Soet et al., 2003; Wijma et al., 1997). However, the social work literature reflects a paucity of specific social work knowledge concerning childbirth experiences, outside of interventions in pre and postnatal counselling, and concerns related to birthrates, and maternal and infant mortality (Averitt Taylor, 2014; Cacciatore, 2009; Schneider, 2009, 2012).

The topic of distress in childbirth is an important area of investigation for social work research. Concerns about both protecting the rights of women in childbirth and preventing human rights violations in childbirth is a growing area of social action (Burns-Pieper, 2016; Schiller, 2015, 2016a, 2016a). Human rights advocates in childbirth groups are paying close attention to the stories women tell about their birth experiences, and the contexts in which these stories are told. That is, this human rights work centres subjugated knowledge while fighting for social change (Schiller, 2015, 2016a, 2016b).

Likewise, social work researchers claim a commitment to producing knowledge that as Foucault (1977h) explains, centres and highlights subjugated knowledges. These experiences can identify and respond to service gaps (Bogolub, 2010; Canadian Association of Social Workers – Association canadienne de travailleuses et travailleurs sociaux [CASW-ACTS], 2005a, 2005b).

Human rights are linked with social justice (Truell, 2016) and social work has a mandate to be committed to social justice concerns by protecting the human rights of all people (International Federation of Social Workers [IFSW], 2016a). For example, the International Federation of Social Workers which serves as a "global voice for the profession" (IFSW, 2016a) states its mandate (which informs the mandates of member social work organizations around the world) is to serve as an "organisation striving for social justice, human rights and social development through the promotion of social work, best practice models and the facilitation of international cooperation" (IFSW, 2016a).

Given this commitment to social justice and human rights, social workers are obligated to be concerned about how we know what we know about childbirth, as if knowledge is missing about childbirth experiences, the services provided for those giving birth are based on incomplete and inadequate knowledge. When practices around childbirth reflect the dominant views of medicine and ignore the lived experiences of those giving birth, the groundwork is laid for human rights violations in childbirth (Schiller, 2015). As experiences of distress related to reproduction have historically been made invisible or pathologized (J. Smith & Morrow, 2012; Ussher, 2006), the centring and legitimizing of this lived experience is an important step in, and contribution to,

creating services that are responsive to the needs of those giving birth and thus becomes

part of the fight for reproductive rights for childbearing people (Schiller, 2015).

Highlighting and ending human rights violations in childbirth is an important form

of seeking social justice in the area of reproduction. Schiller (2015, 2016b) provides a

compelling discussion linking the centring of women's experiences and wishes in

childbirth within the broader fight for human rights. Feminist researchers argue that a

central rationalization for women's oppression is their childbearing capacity, which leads

to specific control and regulation of women (Lindemann, 2012; Schiller, 2015, 2016b).

Schiller (2015, 2016b) provides numerous examples of global human rights violations

during childbirth that result in significant emotional distress and/or psychological trauma

for the woman giving birth including issues such as; Indigenous women being removed

from their cultures and communities to give birth alone, criminal charges being placed

against women who give birth at home and the midwives who support them, and women

around the world having procedures performed on them without consent in non-

emergency situations, such as having their perineum cut.

These examples reflect the distress and suffering often associated with childbirth

experiences and serve as examples of how ignoring the importance of childbirth as a site

of human rights abuses perpetuates women's continued experience of gender-based

oppression. Hayes-Klein (2016) made the argument clear in a recent international

conference on human rights and childbirth:

> The disrespect and abuse of women in childbirth, and the generation of children
>
> being born by surgery, are not soft human rights issues. The right to respectful,
>
> non-violent support in childbirth is not the request for a "positive birth

experience." Framing these issues in terms of "birth experience" runs the risk of trivializing them, and creating a false dichotomy between the "experience" of care, versus health and safety. The issues that we are talking about here are, in fact, about health and safety, and are a matter of life and death. (Hayes-Klein, 2016)

Knowledge regarding childbirth needs to centre the voices of a diversity of people representing various intersections of identity, and must include a consideration of how social location shapes people's childbirth experiences. It is important to reflect on how similarities and differences in these experiences may relate to descriptions offered in the childbirth literature.

Historically and currently, women's reproduction is and has been highly scrutinized, legalized, and controlled (and this now extends beyond women's reproduction to all people who can become pregnant) (Ladd-Taylor, 2014; Plant, 2014; Rich, 1995; A. Smith, 2005). While the extent of this regulation is great, the specifics of the regulation vary across time, place, race, and other social makers. For example, in North America, White women's reproduction was scrutinized, often through a withholding of contraception, in attempts to populate North America with White people; whereas because of the racist aspects of eugenics, women of colour and Indigenous women were at risk of being subjected to forced sterilization (Ross & Solinger, 2017). However, it is also important to note that not all people through history have regulated women's reproduction. For example, Many Indigenous traditions had rituals and rules regarding childbirth and reproduction which were arguably less damaging to women, however, one product of colonialism was the importation of the European model of

10

controlling and regulating childbirth and distancing women from their own experiences and knowledges (Brant, 2014; Ladd-Taylor, 2014; Rich, 1995; A. Smith, 2005).

In order to regulate birthing people, information about childbirth must also be regulated and controlled (Palladino, 2015; Pollock, 1999). Centring the experiences of those who give birth serves as a means to talk back to the public narratives in a way that may open up new avenues for resistance to the regulation of birthing bodies (Palladino, 2015; Pollock, 1999; Schiller, 2015). In this centring, those who give birth may be seen as more than simply birthing bodies, and instead as full people who should also have rights, access to services that meet their needs, and choice in how they have their pregnancies and deliveries. Paying attention to the experiences of those who have given birth is part of the movement to expand reproductive rights discourse beyond simply the right to not give birth (through contraception and abortion) and extends concerns to the right to have children and to have reproductive needs and concerns addressed in a more all-encompassing framework (Hayes-Klein, 2016; Ladd-Taylor, 2014; Schiller, 2015; A. Smith, 2005). As others have argued, (see Callister, 2004; Palladino, 2015; Schiller, 2015, 2016) listening to and learning from birth stories from the perspective of those giving birth is necessary to understand where the flaws in the current system lie and how we might make changes required to mitigate the harm done within the current system.

Knowledge about distress in childbirth also requires a contextualizing of the experiences of those giving birth, by exploring issues such as how people's experiences of distress become defined by dominant discourses, and a consideration of what is missing and lost when meaning is constructed through dominance (Brant, 2014; Palladino, 2015). Thus, in order to improve social work practice with people who have

given birth, the social work knowledge base regarding childbirth needs to be developed and expanded. This research is my contribution to beginning to address this void.

Social workers, especially those in hospitals or public health agencies, who work with childbearing individuals and the professionals involved in childbirth, are in the position to challenge dominant and uninspected assumptions about childbirth. As social workers we may be able to act as a bridge between those giving birth and the medical professionals involved with birth (such as nurses, midwives, physicians), so that assumptions about childbirth may begin to reflect the experiences and needs of those giving birth; a goal that is in line with the social work values of advocacy and social change (Cacciatore, 2009; CASW-ACTS, 2005a, 2005b). In regards to women and experiences of distress, throughout history women have often been left with two choices—voice their distress and risk the often serious results that arise when distress is pathologized, or deny distress and in doing so deny one's own experiences (Burstow, 2006; Chesler, 2005; Plant, 2014; Rich, 1995; Ussher, 2011). Those women who have expressed distress about their health and, specifically, sexual or reproductive health, have frequently been pathologized and experienced negative consequences. For example, women who identify distress related to reproduction and reproductive health have been institutionalized, over medicated, and confined (Burstow, 2006; Burstow & Weitz, 1988; J. Smith & Morrow, 2012; Ussher, 1992, 2006, 2011). Conversely, some women may see these pathologizing effects and decide not to discuss their distress; a response that can further silence women and the continue the subjugation of their experienced-based knowledge (Chesler, 2005; Rich, 1995; Ussher, 2006, 2011).

Social workers need to develop theory, practice skills, and advocacy methods that respect people's experience of childbirth, and do so in a way that centres and honours their experiences, including experiences of distress, to allow social workers to work with the distress that may be associated with childbirth (Cacciatore, 2009). Currently social work's involvement in the perinatal time leaves out considerations of distress in childbirth itself, and instead focuses on supporting families with material difficulties, relationship problems, and managing high risk pregnancy and newborn complications (see for example, Bachman & Lind, 1997; Taubman-Ben-Ari et al., 2008). While these activities are useful they are not sufficient.

I argue that the voices of people who have given birth will provide a fuller and more complete understanding of childbirth. In turn, these narratives will aid social workers in providing support to those who are experiencing childbirth related distress as their experiences will be centred, depathologized, honoured, and given voice. Centring the voices of those who have given birth also allows for an exploration of how understandings of experiences of distress may be shaped and limited by the dominance of medical and psychological discourse (Brant, 2014; Liegghio, 2013; Palladino, 2015; D. E. Smith, 1975). Expanding the available discourse around childbirth allows a broader repertoire of experience to be understood. This will help people to make their own meaning regarding their childbirth experiences and will allow social workers to work with people who have given birth to prevent the distress that might be caused when individuals' experiences do not match what is currently discursively available to be understood about childbirth.

An Outline of the Research

This qualitative research project used a feminist narrative[1] methodology. My study was designed to understand and interpret how individuals experience distress in childbirth, and how they understand these experiences. I was interested in what these experiences of distress, and individuals' understandings of these experiences, tell us about childbirth as a life event, about what is missing from our understandings about distress in childbirth, and about what the limits are regarding what is available to be known about childbirth. Additionally, using an intersectional framework, this study aimed to uncover how social location influences experiences of distress and understandings about experiences of distress in childbirth.

For my field research, I interviewed fifteen women (all participants identified as women) from Nova Scotia and New Brunswick, Canada. I chose this specific region because I live on the border between the two provinces, and as such I was able to access many communities of various sizes and socioeconomic makeup. The two provinces together have a population of roughly 1.6 million ("Atlantic Canada Opportunities Agency," 2015). The region's population is highly educated, being home to a combined eighteen universities (private and public), and nineteen colleges (private and public) ("Atlantic Canada Opportunities Agency," 2012). The area is predominantly White

[1] Throughout the writing of this work I struggled with whether my methodology was "feminist narrative" or "narrative feminist". The first implies that the fundamental methodology is narrative with a feminist lens. The second implies that the fundamental methodology is feminist with a narrative approach. For this undertaking, I have decided to use the first – "feminist narrative" – as the core methodology is a narrative one. However, feminist ethics and a feminist approach are embedded in and threaded throughout the weaving of this project.

(approximately 95%), with a smaller Indigenous and Metis population (roughly 2.5%), and with the remaining population representing various visible racial minorities (Statistics Canada, 2009a, 2009b). The region has an aging population and a low level of population growth, and has a below average per person contribution to the economy (Polese, 2015). In summary, the area covered in this research (Nova Scotia and New Brunswick) is a highly educated, predominantly White, relatively old, and economically poor region of Canada.

Interviews were carried out using a guided interview process with general, open-ended questions and prompts (e.g. "Please tell me about your childbirth experience"). This feminist narrative approach allowed for the discovery of the messages and assumptions participants had about childbirth, which allowed to surface both dominant understandings as well as challenges to dominant ideas about childbirth and distress in childbirth (Arvay, 2003; Barbour, 2008; Hydén, 2013; Riessman, 2013; Squire, 2013).

An Overview of Subsequent Chapters

In the following chapter I outline the conceptual framework that structures this work. I discuss Foucault's notion of discourse, power, and knowledge as particularly helpful for this project. I also include discussions of pathology, as well as agency, and the body. As discussed above, the concept of gender is complex, and yet is central to this research topic. As such, I consider the concept of gender not only to critique binary views of gender, but I also explore how gender is taken up by the various feminisms informing my work. The conceptual framework concludes by outlining how the concepts of emotion, distress, childbirth, and narrative are employed in this project.

In the third chapter of this dissertation, I critically review general academic literature of the last twenty years regarding distress in childbirth, and the social work literature specific to childbirth. In this literature review, I deconstruct how the literature reflects certain assumptions about who gives birth, about distress, and about power, and I provide a critique of each of these major assumptions.

The fourth chapter focuses on the research design, and includes a discussion of how feminist narrative inquiry and analysis was useful in exploring my research question. Included in this section is a discussion of the research design, methodological fit, and means of evaluation. In the subsequent chapter I outline my methods of data generation and analysis, including information on data collection (recruitment, consent, and the interview process); preparing the data for analysis, including my methods for transcription and member checking; and explain the processes I used for interpreting the data, including how I identified and interpreted the stories, and how I present my written work.

In Chapters 6, 7, and 8, I present the findings of the research woven together with a discussion about the accounts of the participants. In Chapter 6 I discuss how discourses about women and mothers reflect and challenge dominant discourse of goodness, women as overdramatic and as divas, and explores how women are constructed in relation to their sexuality. Next, the ways in which power/knowledge shaped childbirth experiences is explored through an examination of themes of disciplinary power, regimes of truth and subjugated knowledges, and sites of resistance. The way in which participants attempted to exercise agency, and the interplay of discourse, power/knowledge, and agency is discussed.

In Chapter 7 I move to explore how the body is storied in the participants' narratives, and investigate how gender intersects with other aspects of identity exploring the ways in which women were secondary in birth experiences, the invisibility of privileged identities to the participants, times when privilege was identified by participants, and participants' awareness of their own marginalization. This follows with a discussion of distress and emotion in participant's narratives. Discourses of hormones and other ideas about distress and emotion are explored as is the use of the discourse of trauma in participants' stories. The chapter concludes with a reflection on how childbirth is experienced as non-linear and is not temporally bound in participant's narratives, and reflects on the usefulness of narratives as a way of sharing and producing knowledge. It is in this section that a discussion of the inclusion of breastfeeding concerns arises as a finding of this study of childbirth experiences.

Chapter 8 concludes the interpretation and discussions of the findings by exploring issues outside of the central conceptual framework regarding what causes distress in childbirth and what helps to prevent or reduce distress. This chapter includes a discussion of the emotional labour and caring work involved in childbirth and explores many of the polarities that participants found themselves attempting to navigate during childbirth. These polarities include binary understandings of childbirth as either a medical or natural event, competing expectations of women regarding their role in decision making, and considers how much preparatory work women are expected to take on prior to childbirth. The chapter also includes a discussion of the competing messages women are given about breastfeeding and the distress this caused for participants. Participants also had advice for how to help women in childbirth, recommending that childbirth

should be seen as a regular and yet special event, and that support from others is vitally important in childbirth. The chapter concludes with a discussion of the theme "someone to talk to", a common refrain in the participants' stories indicating the need for additional support for childbearing people.

In Chapter 9 I present the limitations of this study, discuss the implications of this research for social work in hospitals, mental health and public health settings, and in communities. I provide recommendations for social work practice, research, and theory, and offer my concluding thoughts.

CHAPTER 2

MY CONCEPTUAL FRAMEWORK

In this research, I seek to increase understandings about experiences of distress in childbirth in a way that moves beyond taken-for-granted assumptions associated with childbirth, to create space for new knowledges to emerge. My ontology and epistemology reflect my view that an objective and complex reality may exist outside of discourse and awareness, but that this reality is subject to multiple interpretations related to the complexities of social life, and thus, this reality cannot be known with certainty (Bhaskar, 1998; Burr, 2015; Clark, 2008; Fleetwood, 2005; Houston, 2001; Weedon, 1997). I assume that while certain ideas and statements rise to prominence to become seen as truths, all ideas, concepts, and their associated ascribed meanings, are produced and constructed through talk, text, and nonverbal means, such that all we are able to know can be viewed as flexible, relational, and co-constructed (Foucault, 1972; Lincoln, Lynhan, & Guba, 2011; Weedon, 1997). Therefore, as I enter my research regarding distress in childbirth, I undertake this study using a conceptual framework concerned with the mechanisms that produce multiple situated understandings of truth. I do this so that this work might help to uncover some of the power/knowledge and discourse mechanisms that serve to silence some voices, so that these voices might be highlighted, with the goal of improving the lives of oppressed and marginalized people (Burr, 2015; Clark, 2008; Houston, 2001).

The ways in which we can come to know; how we come to be; and how this knowledge and these subjects are created, experienced, maintained, and challenged, requires a consideration of numerous concepts. For the purpose of this research, I believe

it is important to address the relationship between discourse, knowledge and power, and

the influence of the interplay between knowledge and power on experiences of distress.

Additionally, a clear position regarding agency and the body is necessary. As childbirth is

a highly gendered topic, I want to have a perspective on my research that allows for a

discussion and examination of gender assumptions while not re-inscribing problematic

essentialist notions of gender. Finally, as I am considering experiences of distress in

childbirth through the use of a narrative methodology, I need to discuss how I engage

with the concepts of distress, emotion, childbirth, and narrative in this project.

Discourse

In considering how some ideas come to be seen as true while others remain in the

shadows, it is helpful to consider Foucault's concept of discourse. Foucault (1972)

expanded the idea of discourse beyond a linguistic term merely denoting verbal

performance, to include all that is produced by the verbal performance and social

(discursive) practices, and includes a consideration of the historical context of these

verbal performances and social practices. Foucault (1972, 1982) explained how in his

view of discourse, whole groups of objects come to be formed *through* discourse (such as

patient, criminal, and mother) rather than discourse simply reflecting through language

and ideas groups of objects that already exist. Discourse establishes what is available to

be thought of and talked about in any given time and place, as well as determining who

has the authority to talk about it (Foucault, 1972). The ability to talk about things (for

example, the patient as an object) depends on these objects being brought into existence

through discourse. It is not that these objects existed independent from, and antecedent to,

awareness—instead Foucault posited that the object does not exist to be discussed until

the historical conditions reflecting "a complex group of relations" are such that discourse can create it (Foucault, 1972, p. 49; see also Weedon, 1997). Foucault, (1977e) explained that discourse can be used to maintain or expand the dominant understanding, and also serve as a tool of resistance to dominance.

While it may be that certain discourses become dominant, Foucault (1972) argued for a concerted effort to question and examine these stating:

We must question those ready-made syntheses, those groupings that we normally accept before any examination, those links whose validity is recognized from the outset; we must oust those forms and obscure forces by which we usually link the discourse of one man with that of another; they must be driven out from the darkness in which they reign. And instead of according them unqualified, spontaneous value, we must accept, in the name of methodological rigour, that, in the first instance, they concern only a population of dispersed events. (p. 24)

The view of discourse as tied to both dominance and resistance, has been useful for social workers seeking to disrupt the taken-for-granted, unquestioned assumptions associated with marginalization and oppression. Foucault's discourse enables those who are so inclined to trace dominance through discourse and resist this dominance through discourse, so that new knowledges can be highlighted and linked to improved material conditions (Fook, 2012; Heron, 2005).

With respect to experiences of distress in childbirth, this view of discourse is helpful in understanding how certain bodies become identified as patients, mothers, parents, doctors, midwives, nurses, and so forth; each associated with specific claims to specific practices. It highlights how certain ideas (such as the view of birth as a medical

21

event) associated with childbirth become dominant, while others (such as the view of birth as a natural event) are created in resistance to these dominant practices. We can also understand how experiences such as emotions become defined through discourse as either pathological or acceptable (Cosgrove, 2000; Liegghio, 2013; Michener, 1998; Poole & Ward, 2013), and how these valuations of emotions are connected to pregnancy and childbearing bodies differently through history (Ussher, 2010, 1992; O'Reilly, 2004a). The way in which some discourses become dominant while some are relegated as subordinate (opening up possibilities for resistance) leads to an examination of ideas regarding power, knowledge, and truth.

Power and Knowledge

Foucault's concepts of "regimes of truth" and "subjugated knowledges" are relevant to this research as they help explain how some knowledges determine what is available to be considered true about childbirth experiences while other forms of knowledge are marginalized and discredited (Foucault, 1977g).

Introducing the idea of "regime of truth", Foucault (1977g) explained how a society determines the types of discourse which it treats as truth; the rules for determining true from false; the rules for acquiring and developing what is considered true; and the status conferred upon those who are given the authority to say what is true. Specific kinds of power are attached to that which is deemed to be true (Foucault, 1977g). As the regime of truth is linked to the kind of power that creates truth, so too the concept of subjugated knowledges is connected to those forms of knowledge that are dismissed. Foucault (1977h) explained subjugated knowledges are:

a whole set of knowledges that have been disqualified as inadequate to their task

or insufficiently elaborated: naïve knowledges, located low down on the

hierarchy, beneath the required level of cognition or scientificity. (p. 82)

Foucault (1977h) saw the importance of subjugated knowledges, explaining that

criticisms of regimes of truth occur through paying attention to and bringing forth these

subjugated knowledges. Thus, he argued that power and knowledge are intimately

connected.

Foucault, (1977b, 1977d) viewed power and knowledge as indivisible from each

other, as invisible "mechanisms of power" create what is knowable and create knowledge,

so that this knowledge then orders peoples' lives in a way that reinforces power. It is the

invisibility of these mechanisms that serves to reinforce the power they exert, and on

which the maintenance of power relies (Foucault, 1977d). Importantly, Foucault also

argued that:

the exercise of power itself creates and causes to emerge new objects of

knowledge and accumulates new bodies of information…The exercise of power

perpetually creates knowledge and, conversely, knowledge constantly induces

effects of power. (Foucault, 1977d)

Foucault viewed power as more than an obstructive and repressive force, which serves

only to deny access or withhold rewards; he argued that power is productive, always

producing knowledge and discourse, and is present throughout the entire social body

(Foucault, 1977a, 1977g). Foucault also argued that power does not belong solely to the

privileged, as resistance is a form of power that exists wherever dominant power is

exercised, thus encouraging the rejection of dominator/dominated binary (Foucault,

1977c, 1982). This research study uses this view of power; where power is something that is exercised rather than possessed, and is exercised variously depending on one's position within social structures (Foucault, 1982).

Foucault's insights into "disciplinary power" (Foucault, 1977b, p. 170) also provide an important analytical tool for understanding childbirth experiences. Foucault explained that disciplinary power uses hierarchical observation—"the gaze" (1977f, p. 155), normalizing judgment, and the two in combination (in the form of examination), to regulate the behaviour of great numbers of people with very little centralized effort (such as inmates in a prison, patients on a psychiatric unit, or in this case, pregnant people) (Foucault, 1977b, 1977f). In this view, the examination serves as the evaluation, the punishment, and the reward simultaneously. For example, a pregnant woman who is told by her obstetrician that her baby is not growing as quickly as growth charts predict, is likely to be discursively constructed as a "bad mother", which may result in her taking steps to change, monitor, and evaluate her own behaviour, so that she can fit within the "good mother" framing (Forssén, 2012; Ussher, 2006). Indeed, numerous pregnancy self-help books are heavily influenced by this self-disciplining, self-monitoring ideology (Ussher, 2006). For example, The Sensible Guide to a Healthy Pregnancy, published by the Government of Canada (Public Health Agency of Canada, 2011) includes self-disciplining prenatal advice for women regarding their potential baby's health and the potential mother's weight, stating that even prior to pregnancy:

> Healthy eating plays a very important role in a healthy pregnancy. You need to eat foods from a variety of sources to make sure you get all the vitamins, minerals and nutrients you and your developing baby need. Eating well will also help you feel

24

better, give you more energy and help keep your weight in check. It will also

contribute to your baby's healthy growth and development. (Public Health

Agency of Canada, p. 2)

The document also reminds women that good mothers never have alcohol while they are

pregnant or indeed even prior to becoming pregnant, issuing the following strong caution

against the use of alcohol:

No one knows how much alcohol it takes to harm a developing baby. …

Whether you are trying to get pregnant or are pregnant already, stop drinking

alcohol. No alcohol is the best (and the safest!) choice for having a healthy baby.

(Public Health Agency of Canada, p. 10, emphasis in original)

This statement demonstrates how women are constructed and disciplined in relation to

their identity as mothers, even before they are mothers, pregnant, or possibly even

considering becoming pregnant.

For the topic of experiences of distress in childbirth, Foucault's ideas regarding

power and knowledge are applicable. The actions taken upon and by those who bear

children reflect how medical knowledge maintains dominance in the child birthing

process, how other knowledges have become subjugated and are now related to processes

of resistance through alternative childbirth processes, and how childbearing people come

to monitor themselves and their actions through internalized dominance and disciplining

of the self. However, Foucault's view of discourse and power, while helpful for social

workers and appropriate for this research project, is not uncontested. Many have raised

the concern that there is no or very limited ability to account for personal and social

action and change if only discourse and power operate to construct reality (Benhabib,

1995; Clegg, 2006; Hartsock, 1990; Weedon, 1997). How does one make sense of personal agency in this view? This is the question addressed in the next section.

Agency

Agency is a central concern in much of feminist theorizing (Salem, 2013) and specifically within feminist discussion about childbirth and other issues related to women's reproduction (Fegan, 2012; Schiller, 2015; Ussher, 2006). For example, many criticisms of the medical model of childbirth centre on the removal of the pregnant person's agency, as the person becomes a mere vessel carrying another human being, and in doing so loses the moral and often legal right to make decisions regarding one's own bodily integrity (Fegan, 2012; Schiller, 2015; Ussher, 2006). Many feminists have argued that postmodern theoretical ideas create conditions where agency, individual action, and social change are made impossible (e.g., Alaimo & Hekman, 2008; Bacchi, 2005; Benhabib, 1995; Clegg, 2006; Hartsock, 1990). Foucault's interest in discourse makes his work susceptible to this same criticism (Alaimo & Hekman, 2008; McLaren, 2002). However, Foucault did not simply concern himself with the discursive, as he also included considerations of the material and non-discursive arenas, including making space for agentic action. Bacchi (2005) explains two traditions around the issue of subject agency—the view of subjects as users of discourse, and the view of subjects as constituted in discourse, with Foucault being in the second category. However, Foucault himself seems to unsettle this reading stating, "My role – and that is too emphatic a word – is to show people that they are much freer than they feel…To change something in the minds of people – that is the role of the intellectual" (Foucault, 1988, p. 10). Indeed,

Foucault's idea of subjugated knowledges and resistance are impossible without an ability to observe, evaluate, and challenge dominant discourse; acts that require a degree of agency (Gannon & Davies, 2007; McLaren, 2002). Foucault's (1982) discussion of how power is "exercised" allows us to see how he made room for agentic action stating, "Power exists only when it is put into action" (p. 788). I take this to mean that in order for power to be exercised, there must be one who is exercising the power—this is the agentic self. However, it can also be said that the agentic self can exercise power through not taking action, and by remaining silent (Parpart, 2010).

It is important that this view of agency does not limit itself to overt action; action that can be seen, heard and observed by others. Indeed the choice to remain quiet, and even to act in a way that may be seen by others as passive can also be a way to assert agency and agency exercised in this way may be associated with those occupying marginalized social locations (Parpart, 2010). Indeed doing what one must do to survive an oppressive world, even when this means staying still and quiet, and not speaking up, are still agentic actions directed towards minimizing harm in a dangerous world (Parpart, 2010). This research project aims to centre personal experiences as well as examine how experiences are shaped by and shape discourse. Thus the view of agency I take up reflects critical concerns with individual actions (and lack of action) and experiences while still appreciating the role of discourse in shaping agency (Fegan, 2012; Hair & Fine, 2012; Houston, 2001).

The Body

Related to the idea of agency is the body. While I am interested in the discursive elements that shape childbirth experiences and knowledges, I am also aware that giving

birth is an embodied experience. In the move towards the discursive the body been made

secondary to the consideration of text and talk (Chadwick, 2017). However, I believe it is

especially important to include an understanding of the materiality of the body, when

exploring sexist oppression in health care, reproductive care, and reproduction (Alaimo &

Hekman, 2008). These two sites of interest—the embodied/material and the discursive—

require me to consider how I take up the idea of the body in my conceptual framework. In

line with my appreciation of postmodern and poststructural suspicions of binaries, I reject

the binary of material versus discursive (Alaimo & Hekman, 2008). Thus for this project,

I take up the material-discursive view of the body, as I am curious about "the day-to-day

impact of the discursive construction of experience on material life" (Ussher, 1997a, p. 7;

see also Ussher, 2010).

Capturing embodied experiences through research is rife with difficulty as

participants in most research approaches (including this one) must still rely on

language—text and talk—to convey their bodily experiences, and a focus on discourse

risks removing the body from consideration even in such an embodied experience as

childbirth (Chadwick, 2017). Thus, in addition to having participants talk about their

bodies, we should listen to and for how bodies show in the telling of the participants'

stories, describing how the story is told through the body (Chadwick, 2017; Frank, 2013).

Kristeva (1984) encouraged a consideration of the subject in relation to the body

where there is a subject who speaks of the body and through the body in such a manner as

to add meaning to language beyond what the words communicate. In this research, this

understanding of embodied telling is reflected in how the text of the stories are shared

with the reader. The poetic form the excerpts take represents the embodied storytelling of

the participants. The lines of the stories may erupt only to die mid-sentence, sentences may not end but seep into each other, and ideas bleed into each other during the telling. It is important to represent these embodied stories in a way that reflects the subjective action taken in sharing stories, even if this means that the reader is left without tidy sentence structure and neat beginnings and endings in the transcripts (Chadwick, 2017). Indeed, this messiness in representation mirrors the messiness of experiences of birth, and the way in which birth acts as a site of rupture in neat understandings of body and discourse.

I am interested in challenging and examining the discursive constructions and constrictions inscribed on childbearing bodies, and I am also interested in the material consequences of these discourses, and on the embodied experiences of childbirth. This material-discursive conceptual framing of the body, allows a position where I can critique the pathologizing discourses of medicine and psychology and their effects on those who have had distressing childbirth experiences, while at the same time not dismissing this distress (Ussher, 2006, 2010). The material-discursive conceptualization of the body is especially applicable for analysis of issues such as sexuality, physical and mental health, and reproduction (Miedema, Stoppard, & Anderson, 2000; Thomas-MacLean & Miedema, 2012; Ussher, 1997a, 2006).

Integrating Discourse, Power, Knowledge, Agency, and the Body

I believe the subject, which in this research means those who give birth, is constituted through discourse, with identity constructions shaped by dominant discourse, and also within these constraints of discourse, subjects can achieve and maintain identities through actively negotiating and resisting these constraints (Butler, 1995;

Fegan, 2012; McLaren, 2002; Salem, 2013; Stapleton & Wilson, 2004). Identities and their associated agency, are both constrained through discourse *and* contest discourse. In this view, the subject exists but it exists and is constituted within discourse and power relations; and agency is exercised, through discourse and through challenges to discursive limitations (Foucault, 1982; N. Fraser, 1995; Gannon & Davies, 2007; Hair & Fine, 2012; Parker, 2014; Weedon, 1997). These challenges to discursive limitations are the sites of resistance. Thus, in order to challenge dominant discourse one needs to practice a deliberate effort towards increasing awareness of how one is constituted through discourse (Fegan, 2012; Heron, 2005; Stapleton & Wilson, 2004).

Foucault's ideas of the relationship between knowledge and power, the above consideration of agency, and the way in which bodies exist in this world, caution and urge us to be aware of the mechanisms of power that exist, how the types of knowledge that are created are determined by these mechanisms, and how we may resist them when they cause harm. A first step in creating social change is an awareness of the possibility of the existence of other types of knowledges. As social workers interested in improving the discursive and material conditions of childbirth, we must question the fundamental assumptions associated with experiences of childbirth. These include the idea that childbirth is strictly a woman's domain, that the concept of woman is useful, and the very assumptions about gender that underlie dominant reproductive health knowledge. We must examine and question some of these assumptions about the gendering of childbirth and the limits of gender as an analytical focus.

Gender and Feminisms

The concept of gender informs power relations, and while I believe the gender female/woman is a worthy site of entry into an analysis, I am also cognizant of the need to disrupt the dominant gender discourse. Any choice of focus has implications of exclusion for those who are not the focus, and by choosing a research topic dominantly portrayed as a female experience, I am exercising power in a specific way, with implications for those who have any gender other than female (such as trans male, gender queer, non-binary, gender fluid, and others) (Butler, 1995; Gannon & Davies, 2007). My intent is not to reinforce artificial and problematic gender binaries of male and female by focusing on the category of woman. However, while binary categories (such as male and female) may be socially constructed and problematic, rejecting the use of these constituted categories is also not necessarily required, as researchers can use these categories to disrupt the subordination caused by them (Alaimo & Hekman, 2008; Butler, 1995, 1999, 2004; Gannon & Davies, 2007; Heyes, 2003). I do not want to erase or make invisible the various genders in this world (including the female gender), and I am aware there is a risk of erasing other genders due to the centralizing of female in the topic of childbirth. However, I am also uncomfortable with erasing women from discussions of childbirth given the historical and ongoing gender specific oppression of women due, in part, to their ability (as a group) to give birth (Cosgrove, 2000; Palley, 2016; Schiller, 2015). Furthermore, I do not want to assume all women share universal experiences, and thus justify the prioritizing of gender above other social markers. How then, do I take up the concept "woman" in my consideration of childbirth experiences? I look to two

overlapping perspectives taken up within the broad range of feminisms[2] to address this concern: intersectionality and postmodern feminism.

Postmodern and intersectional feminisms recognize that there is no single female identity or standpoint[3]. Crenshaw's (1989, 1991) intersectionality originated as a deliberate Black feminist challenge to the centring of whiteness in legal and academic feminism, and the resulting exclusion of Black women from legal claims of discrimination.[4] Crenshaw (1989, 1991) demonstrated how white dominance resulted in forcing Black women to identify primarily with either their race or their gender, not recognizing the reality that women exist at the intersection of race, class, and gender (Alaimo & Hekman, 2008; Bilge, 2013; Cho, Crenshaw, & McCall, 2013a; Collins, 2000; Crenshaw, 1989, 1991; Hankivsky, 2012; Salem, 2013). Thus, intersectionality eschews the idea of a universal female subject and instead calls for attention to multiple and various standpoints that reflect the interaction of race, class, and gender. Intersectionality

---

[2] There are numerous feminisms and their names and definitions vary across time, space, and author. Some examples of various feminisms, in addition to the ones discussed above include (but are not limited to) cultural feminism, global feminism, indigenous feminism, Islamic feminism, liberal feminism, Latina feminism, Marxist feminism, multicultural feminism, postcolonial feminism, radical feminism, socialist feminism, and womanism.

[3] There are various standpoint epistemologies including those associated with Collins (2000), Harding, (1991), Hartsock (1990), and D. E. Smith (1987). Standpoint epistemologies are controversial, having been associated with (as a source of, or response to) imperialism, racism, oppression, erasure, and hierarchy within feminist research (Brown, 2012; Butler, 1999, 2004; Gannon & Davies, 2007; Kim, 2007).

[4] It is important to highlight the deliberate introduction of intersectionality. Bilge (2013) shows intersectionality has been argued to have occurred spontaneously, emanating from various sources. This discredits the importance of intersectionality as a deliberate response to the problematic centring of whiteness in feminism and maleness in antiracist activism and scholarship.

has a foot in critical theory (through critical legal studies) and postmodernism, acting as a bridge between the two theoretical frameworks. While intersectionality incorporates the idea of standpoint(s), it does so as a means to understand how power works in particular situations, placing its focus less on issues of identity, and more on the power relations that result in structural inequalities (Bilge, 2013; Brown, 2012; Carbado, 2013; Cho, Crenshaw, & McCall, 2013). In this way intersectional feminism, and its associated view of women as a vastly diverse group with vastly different experiences of oppression and privilege, fits with the understanding of power as operating in and through identity, while also creating identity, and the subsequent varying material and local experiences associated with these intersections of identity (McCall, 2014; McLaren, 2002). Intersectionality enables us to see how subjects are discursively created and also erased.

As suggested earlier, centring the category "women" assumes a commonality of experience based on gender that ignores or subordinates other aspects of identity, continuing the dominance of certain groups who stand as normative (typically the White, middleclass, heterosexual, cis gender woman serving as the normative view of women) (Alcoff & Potter, 1993; Hankivsky, 2012; Mohanty, 1988; Salem, 2013). Intersectionality insists that one aspect of identity cannot stand isolated from other intersecting aspects of identity (Collins, 2000; Crenshaw, 1991; Hankivsky, 2012; Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). Using an intersectional framework we can see that childbirth experiences vary among those who exist at diverse margins of intersections and privilege. Thus, an analysis of childbirth that only considers one aspect of identity (for example, childbirth as a female experience disregarding other social locations) will be not only

lacking in important insights, but also contribute to continued oppression (Hankivsky, 2012; Johnson, 2007; Moreton-Robinson, 2000).

Postmodern[5] and poststructural[6] feminisms also call for scrutiny into the gender assumptions underlying the category of woman. Within postmodern and poststructural feminism, the category of gender is sometimes viewed as oppressive rather than helpful as it reinforces constraining essentialist ideas regarding gender (Butler, 1999, 2004; Franks, 2002; Nagoshi & Brzuzy, 2010). As Butler (1999) stated, "feminist critique ought also to understand how the category of 'women,' the subject of feminism, is produced and restrained by the very structures of power through which emancipation is sought" (p. 5). Womanhood, or female identity, is problematized as being overly concerned with physical bodies (Butler, 1995; Heyes, 2003; Nagoshi & Brzuzy, 2010). The category of woman/female is also associated with assumed heterosexual attraction to males, and with expectations of female submission to males due to hegemonic ideas regarding the emotional and physical vulnerability of women (Nagoshi & Brzuzy, 2010; Ussher, 2012a). Moreover, the pressure to conform with a socially constructed idea of gender

---

[5] Because postmodern theory is skeptical of any categorically defined representations as reality, postmodernism itself resists definition. For this project my use of the term postmodern reflects my understanding that "the criteria which theories use to establish what is true or false, good or bad, are not universal and objective. They are, rather, internal to the structures of the discourses themselves and thus historical and subject to change" and that postmodern feminists take the position that these discourses tend to be androcentric and Eurocentric (Weedon, 1997, p. 172; see also Parton & O'Byrne, 2000).

[6] In a similar vein to the difficulty with defining postmodernism, a clear distinction between postmodernism and poststructuralism is elusive, and there is significant overlap between the two (Agger, 1991). A useful, if somewhat blunt, summary is that poststructuralism concerns itself with knowledge and language, and postmodernism focuses on society, culture, and history (Agger, 1991). Obviously, these two categories are not mutually exclusive.

based on bodies is a central form of oppression for those who experience gender outside

of gender binaries of male and female (Nagoshi & Brzuzy, 2010).

However, postmodern and poststructural inspired understandings of feminisms

have been critiqued by feminists from various backgrounds and varieties of feminisms

(McLaren, 2002). One concern with rejecting gender as a meaningful construct is in

removing all common ground associated with identity, feminist researchers are left with

the problem of only singular, individual epistemologies (Benhabib, 1995; Gannon &

Davies, 2007). By removing gender's contribution to commonality and connectedness,

the conditions required for the political work fighting the systematic oppression of

women have been erased (Alaimo & Hekman, 2008; K. R. Allen & Baber, 1992;

Benhabib, 1995; Franks, 2002; Gannon & Davies, 2007; McLaren, 2002; Nagoshi &

Brzuzy, 2010; Ussher, 1997a). Additionally, removing gender as a meaningful category

can be seen as anti-feminist, as it removes the need to address the subordination of

women marginalized and harmed due to their status as women and girls on a global scale

(Franks, 2002). Thus, discounting of the category of gender may be most harmful to those

women and girls who live outside the Western world, and may once again centre a

privileged form of feminism (Franks, 2002).

For my research then, I struggle with the question of how to undertake research in

a way that acknowledges the problematic exclusions associated with social constructions

of gender, while at the same time recognizing enough collective commonality so that I

can move beyond only individual epistemologies. That is, how can I talk about

experiences of distress in childbirth, without erasing and oppressing those who have had

childbirth experiences but are not women, in a way such that the language does not

become a barrier to communication, nor does it serve as a barrier to inclusion?

While the language may be cumbersome, it is important to create a place that does not continue cissexism and gender-based oppression. In fact, the lack of a smooth and easy language reflects the way the cissexism continues to oppress those who reject gender binaries or who are transgender (Butler, 2004, p. 30). While, as a feminist researcher concerned with sexist oppression, I may enter the research at the site of gender, I move beyond this entry as defined by the binary of male/female, man/woman and expand it to include a discussion of all genders of people who have given birth. This is in line with current movements in reproductive health fields to be inclusive in the use of language reflecting a broader understanding of reproductive health needs ("4 ways to be gender inclusive when discussing abortion," 2014; "Abortion Access for All," n.d.; Chastine, 2015; Morse, 2012; Walks, 2014). In this way:

> an open coalition, then, will affirm identities that are alternately instituted and relinquished according to the purposes at hand; it will be an open assemblage that permits of multiple convergences and divergences without obedience to a normative telos of definitional closure. (Butler, 1999, p. 22)

In summary, while the term woman and the idea of gender can be seen to be problematic I will not discard these constructs. Instead I draw attention to the idea that the category women includes women as they exist at the intersections of race, class, sexuality, and other social locations. I do so as I believe there is knowledge to be gained through explorations of, and relationships between individual uniqueness and the collective. I include in my definition of women cis and trans women. I recognize that not all those who may be assumed by others to be women experience their own gender as female, and

36

that some trans men and some people who reject gender binaries can give birth. So then, the phrase "people who have given birth", "those who have experienced distress", and simply "experiences of distress" will be used in this proposed research.

Distress

The concept of distress reflects how power and knowledge shape and are shaped by discourse. The ideas associated with distress reflect shifting dynamics of dominance and resistance and it is imperative that as a central concept for this research I use a term that reflects my political position in this discourse. I take up the term distress, informed by the intersecting and overlapping areas of Mad studies, antipsychiatry, critical psychiatry, and critical psychology[7] (Beresford, 2005; Breggin, 1994; Burstow & Weitz, 1988; LeFrançois, Menzies, & Reaume, 2013; Parker, 2014; Szasz, 1961; Tew, 2005; Ussher, 2006), and with a specific orientation based upon the extensive feminist literature on women and madness (Burstow, 2006; Burstow & Weitz, 1988; Caplan, 1992, 2012; Chan, 2012; Chesler, 2005; Cosgrove, 2000; Ehrenreich, 2010; Ehrenreich & English, 2005; D. E. Smith, 1975; Ussher, 2012a; Williams, 2005). While these areas have many areas of agreement and disagreement, a common theme among the various political and philosophical views is the questioning of the biological dominance and individualized pathology associated with emotional distress (Beresford, 2005).

In this research, I take a similar view regarding individuals' experiences of

---

[7] Due to the overlapping nature of the areas comprising Mad studies, it is difficult to assign specific individuals to specific areas. The examples provided represent writers/thinkers/activists from various branches of Mad Studies and should not be considered exhaustive. Rather this brief list demonstrates how various writers/thinkers/activists have contributed to the knowledge base across and within the various branches of Mad studies.

emotional distress. I understand emotional distress as an inherent part of life, an aspect of life that is worth considering without automatically pathologizing. I also believe that emotional distress acts as focusing force—a source of information which illuminates where things have gone wrong, where harm has been done, or something important has been lost or threatened (Cosgrove, 2000; J. L. Herman, 1997). That is, emotional distress can serve as a sign that one must undertake a "consideration of oppression and discrimination operating at individual and societal levels. It highlights the barriers thus created and their effects in segregating, excluding, subordinating and marginalising mental health service users" (Beresford, 2005, p. 66).

The term *distress* is defined in the Oxford English Dictionary (Oxford English Dictionary, 2000), a historical dictionary of English, as "the action or fact of straining or pressing tightly, strain, stress, pressure; … pressure employed to produce action, constraint, compulsion" and also "the sore pressure or strain of adversity, trouble, sickness, pain, or sorrow; anguish or affliction affecting the body, spirit, or community." Its etymological definition from the Old English *destresse* means "circumstance that causes anxiety or hardship"; the Vulgar Latin *districtia* meaning "restraint, affliction, narrowness"; the Latin *districlus* meaning to "draw apart, hinder"; and from Medieval Latin meaning "compel, coerce" (Harper, 2001; para 1-2).

Distress is also related to the term strain. Strain as a noun, refers to damage done by tightening; a "line of descent, lineage, breed, ancestry"; the acquisition of a treasure; "a begetting procreation" (for example, "this strain of salmon…") (Harper, 2001, para. 1-2). Strain as a verb means to "tie, bind, fasten gird"; from the Old English *estreindre* meaning, to bind tightly, clasp, squeeze; from Latin *stringere*, meaning "draw tight, bind

38

tight, compress, press together", to "tighten; make taught"; and also to exert oneself and to overexert a body part (Harper, 2001, para. 4).

From the above we can see the term distress is associated with tight pressure and pressing towards productive action, and this action causes anxiety or hardship. It is also associated with a sense of tightness and narrowness and a resulting drawing apart of that which was once together. Additionally, it is associated with the idea of progeny and procreation. Thus the term fits well with a discussion of childbirth. It captures the essence of the anxiety and hardship that many experience in childbirth, in a way that does not pathologize the experience. It dances with the idea of rupture which can be associated on a bodily level with the opening and drawing apart of the physical body during childbirth, and also of the parting of the parent and infant from one entity to become two. Finally, its linkage to reproduction through its association with strain as lineage contributes to its effectiveness in encapsulating the concepts of interest to me in this undertaking.

Some authors have explored maternal distress[8] in childbirth but often the terminology used is one of trauma rather than of distress (for some examples, see Fairbrother & Woody, 2007; Ford, Ayers, & Bradley, 2010; Hall, 2013; Harris & Ayers, 2012; Lyons, 1998; McKenzie-McHarg, 2004). Trauma as a concept has some usefulness of its own. It is associated with extremes of distress; it pays attention to both a problematic event and the problematic results of the event (Barnhart, 1988); and is understood in dominant discourse, from medicine to its everyday usage, requiring little

---

[8] Here I refer to maternal distress because I have only found literature that considers childbirth related distress in a way that assumes that those giving birth are women and mothers.

explanation. However, critical trauma studies (Burstow, 2003, 2005; Casper & Wertheimer, 2016; Tseris, 2013; Wertheimer & Casper, 2016) explores several reasons why trauma is a problematic concept—points I find compelling, and which I outline below.

Because of the dominance of medical discourse, the concept of trauma is readily understood (and used) by people in their everyday lives in a such a way that distress is medicalized and individualized and comes to be understood as individual dysfunction (Burstow, 2003, 2005; Lafrance & McKenzie-Mohr, 2013; Tew, 2005; Tseris, 2013; Ussher, 1997b; Wertheimer & Casper, 2016). Another important critique of the concept of trauma is that the dominant understanding of trauma comes from a White, Western, settler perspective, erasing the historical and current trauma of Indigenous peoples, displaced people, and racialized people (Banner, 2016; McKenzie-Mohr, 2008). Thus, the individualized construction of trauma ignores the important political, cultural, and social aspects of experiences and effects of trauma, and also removes the inducement for action ameliorating and eliminating trauma beyond simply symptom reduction (Burstow, 2005; McKenzie-Mohr, 2008). And so, because I hope to move discussions away from trauma as a representation of individual pathology, I must be skeptical of the utility of the concept of trauma as central to my work.

Pathology and Pathologization

Pathology mostly references medical diseases and implies a maladaptive response to an event or experience, which is linked to a higher than expected level of emotional distress and a potential to generate additional harm as a result of further decline (Lloyd-Williams, Reeve, & Kissane, 2008). In this way, pathology is linked to a medical model

of illness rather than to social factors. The process whereby a response is deemed to be pathological is pathologization. The view of distress as pathological often becomes tied to diagnoses of mental illness (such as depression and post-traumatic stress disorder) and is linked to psychopathology and the chemical/biological models of emotional and mental distress while minimizing social contributions to suffering (Cosgrove, 2000; Horwitz, 2007; Lloyd-Williams et al., 2008; Tew, 2005, 2008). In this view, normal (expected) and even potentially helpful responses and reactions to stressful life events are deemed abnormal and harmful (Horwitz, 2007).

Pathology is dominant in trauma discourse, especially given trauma's confluence with the diagnostic label of post-traumatic stress disorder (PTSD) (American Psychiatric Association & American Psychiatric Association, 2000). Many writers have disrupted this pathologization, demonstrating that trauma and traumatic effects ("symptoms" in the trauma discourse) may be regularly occurring and rampant in women's experiences (Burstow, 2005; J. L. Herman, 1997; Lafrance & McKenzie-Mohr, 2013; Tseris, 2013). These effects are not viewed as pathological but as helpful survival skills, and as important motivators for social action and social change (Banner, 2016; J. L. Herman, 1997). As Burstow (2005) reminded, "while the world may look safe to White, heterosexual, able-bodied, middle- and upper-class adult males (e.g. most psychiatrists), it is not safe for a great many others" (p.435). Herman (1997) has a similar view, "only the fortunate find [traumatic events] unusual" (p. 33). Therefore the concept of trauma, and its association with events and experiences which are assumed to be outside the norm, becomes another way of pathologizing the very existence of all those who are not so fortunate as to find the world a safe place.

41

Distress or Trauma?

And so I am torn; do I add my voice to the resistance movement by using trauma as a concept, while taking it up differently in an attempt to interrogate or (re)claim it; or do I put aside trauma as a useful concept and instead choose distress as a tool for this undertaking? Given that I find distress is a useful concept for this project (as outlined above); that it possibly incorporates a broader range of experiences than the concept of trauma allows; and that denies medical dominance and the resulting pathologization and marginalization, I have decided to use the term distress as a central concept in my consideration of the emotional experiences associated with childbirth.

Emotion

Emotion, for many years, was a subjugated form of knowing in science and research (Hesse-Biber, 2007; Holmes, 2004; Jaggar, 1989). The binary of thought and emotion was clear in the positivist paradigm, with thought reigning supreme, with emotion being subject to suspicion, and emotionality being associated with subordinated groups (Hesse-Biber, 2007; Jaggar, 1989; McLaren, 2002; Weedon, 1997). Where thought was masculine (and therefore good and reliable), emotion was feminine (and thus untrustworthy and unpredictable) (Jaggar, 1989; McLaren, 2002; Ussher, 1997b; Widdowfield, 2000). Jaggar (1989) provided a useful and influential conceptualization of emotions as socially constructed, influenced by such things as culture, available linguistic and conceptual resources, and historical location. She viewed emotions as not only a way in which we engage actively with the world, but also as a means to construct our world (Jaggar, 1989). Emotion and observation are iteratively related—where observation influences and shapes emotion, and also where emotion shapes and influences

42

observation—and a recognition that both of these process are influenced by a person's

social location including identities of race, class, and gender (Jaggar, 1989). Many

feminist writers (Campbell & Wasco, 2000; Hesse-Biber, 2007, 2008; Holmes, 2004;

Jaggar, 1989; Longino, 2007; Mehrotra, 2014; Nussbaum, 2003; Widdowfield, 2000)

sought to invite emotion into scientific discourse as another legitimate means of knowing

and producing knowledge, For example, Mehrotra (2014) encouraged this move stating:

> I am asserting the need to acknowledge and evaluate the potential of emotionality
>
> as part of our research work and proposing that we think seriously about how to
>
> engage with it as part of the labor involved with our feminist research efforts. (p.
>
> 268)

A deliberate inclusion of emotion is important. Even though feminist research

attends to issues of subjectivity in research, reflexivity, the role of the researcher, and the

importance of experience, it has still tended to marginalize emotions per se as part of the

research process (Mehrotra, 2014). Additionally, it has been argued, and I concur, that

including the emotional responses and experiences of the researcher and participants is a

move towards increased rigour in analysis (Widdowfield, 2000). Thus, for this project,

the information associated with emotion will be privileged along with logic and reason. In

this view, emotion and reason/logic are not seen as polar opposites but instead as

overlapping and symbiotic forms of knowledge (Nussbaum, 2003). Emotion is

incorporated in the methodology[9], and by focusing on the emotion of distress, emotion is a central topic of concern in my interest in childbirth experiences.

Childbirth

Childbirth, as a concept, can be taken up variously, as a natural event, as a clearly delimited medical event, a natural part of life, and as part of pregnancy and the post pregnancy period (Chase, 2001; O'Reilly, 2004b). The dominant view of childbirth reflects medical discourse, where childbirth is defined through the field of medicine and seen as a medical event (O'Reilly, 2004b). O'Reilly (2004b) explains the discursive construction of childbirth as a medical event: "the construction of birth is both the product and process of its official medical definition" (p. 30). The view of childbirth as a medical event is limited. It makes invisible the various experiences and meanings of childbirth, where all varieties of childbirth (e.g., vaginal, cesarean, assisted, natural, surgical, at home, in a hospital), all types of birthing people, and all birth outcomes become homogenized into a neat and sterile word that negates the complexity and pluralities of birth experiences (O'Reilly, 2004b). Nonetheless, I am also careful in this disrupting of dominant childbirth discourse, not to centre "natural" childbirth, as an act of resistance to the medical model. Centring a natural discourse, runs the same risk of creating a dogmatic environment where only certain experiences of childbirth are considered (O'Reilly, 2004b).

---

[9] The role of emotion in the specific methodology of feminist narrative inquiry and analysis will be discussed further in the feminist narrative inquiry and analysis section of this work.

I will consider childbirth not only as an event but also as an experience in its own right, distinct from pregnancy and the postpartum period. And I recognize and embrace this artificial distinction, as childbirth does not always have a clear beginning and end. In rejecting the idea of a childbirth as an event with a clear beginning and end, I am disrupting dominant ideas of childbirth, and instead centring the experience of childbirth as a lived event that may defy the call for clearly delimitated markers (O'Reilly, 2004b). For the purposes of this research, "childbirth experiences" I intended to define childbirth experiences broadly and to refer to any experience a person may have, during labour (as the participant defines it), delivery, and the time period immediately following the birth. However, as the research participants told their stories it became apparent that their childbirth stories and experiences reflected even broader understandings and temporal locations, including experiences such as previous pregnancies, deliveries, and pregnancy losses; breastfeeding struggles; and including experiences many months prior to and after delivery. Indeed many participants embedded their birth stories within the context of the their entire reproductive lives. All types of birth (medicated, un-medicated, cesarean section, vaginal, with or without interventions), birth outcomes (healthy parent and child, medically complicated births, stillborn infant), and birth locations (hospital, birthing centre, clinic, home or elsewhere) will be included in this definition (Schneider, 2009). As this research is focused on the experiences of childbirth rather than the event of childbirth, I believe the difficulty in determining the exact boundaries of the childbirth definition is not a significant concern, and instead represents a strength of this approach. Respecting the permeability of the margins of events is considered to be an integral part

of a research process that privileges subjective experiences, such as a research process focused on narratives (Squire, 2013).

Narrative

Narratives are stories told by people that reflect perspective (who is telling the story), context (the larger environment in which the story is told and the story teller is situated), and frame (the outlook of the storyteller, including ideas related to culture and background) (Andrews, 2013; Riessman, 2002; C. P. Smith, 2000). Beyond this, the idea of narrative has been taken up differently at different times and for different reasons with no established overarching definition that fits all purposes (Bold, 2012; Davis, 2002; McCance, McKenna, & Boore, 2001; Mishler, 1995; Riessman, 2002; Riessman & Quinney, 2005; Squire, Andrews, & Tamboukou, 2013). Within the various understandings of narrative, a narrative is typically viewed as representing either an event or an experience (Franzosi, 1998; Mishler, 1995; Parton & O'Byrne, 2000; Squire, 2013; Squire et al., 2013). Narratives that represent events—specific moments in history of special importance, and the telling of these events as narrative—are seen as a way to understand the events and the meaning of these events in people's lives (Davis, 2002; Mishler, 1995; Riessman & Quinney, 2005; Squire et al., 2013). This event-based approach to narrative is considered problematic by some who argue that it is based on a temporal understanding, and privileges the view that narratives are a reflection of an objective reality (Mishler, 1995). This privileging is based on White, Western, masculinist ideas of time, sequences, and order (that is, narratives have a beginning, middle, end with associated actions) (C. P. Smith, 2000; Squire et al., 2013). The event-based approach to narrative often assumes a particular reality, and tends to focus on the

story structure and content, with a passive listener and an active teller (Squire, 2013; Squire et al., 2013). Thus, while childbirth can be seen as "an event", I will not be centring an event-based approach to the narrative analysis.

Conversely, the experienced-based view of narrative allows for shared creation of meaning through the act and interaction of telling and hearing stories, recognizing that stories change across time and tellings, and that the meanings associated with these tellings also change (Squire et al., 2013). In the experience-based narrative, narrative moves beyond serving as a way to disseminate knowledge and becomes a way of making meaning and creating new knowledges. It is associated with the ideas of iterative knowledge production, reflexivity, embodied knowledge, and local narratives (Squire, 2013; Squire, et al., 2013). The experience-based narrative allows more easily for a consideration of how narratives are limited by and resist dominant social stories. In the experienced-based focus, narrative is seen as a changing, co-constructed, and contextualized telling rather than as a reflection of historical fact (Andrews, 2013; Hydén, 2013; Squire, 2013; Squire et al., 2013).

There is likely to be some overlapping of experience-based and event-based approaches. While a narrative may focus on an experience or an event, details about the event and the personal reflection on the event may enter the narrative. For the purposes of my work, I intend to make use of the experience-based approach to narrative, understanding that experiences of distress in childbirth are influenced by social location, historical position, and through conversation. Even though those sharing their childbirth narratives may make use of temporal structure, I am, nonetheless, interested in "narrative fluidity and contradiction…unconscious as well as conscious meanings, and…the power

relations within which narratives become possible" (Squire et al., 2013, loc. 208). This understanding of narrative incorporates the ideas outlined in the above conceptual framework. As I enter the childbirth literature I am interested in how power, knowledge, and discourse shape how people, and their childbirth experiences, come to be understood in the literature, and how childbirth becomes storied in the literature.

Summary

The conceptual framework presented here serves as the foundation for my review of the literature and for my research design and discussion. In the following chapter I explore the research literature regarding emotional distress associated with childbirth using this framework to understand what is currently present and missing from understandings regarding experiences of distress in childbirth. I investigate how power and discourse shape what is available to be known about childbirth experiences, critique how gender is discursively created in the childbirth literature, and consider how experiences of distress are taken up and interpreted by those studying childbirth distress and childbirth trauma. My analysis of the literature demonstrates how a feminist narrative approach to inquiry and analysis addresses the voids in the literature and disrupts taken for granted ideas about distress in childbirth.

CHAPTER 3

A CRITICAL REVIEW OF THE LITERATURE

Three questions structured my review of the literature regarding emotional distress in childbirth: What are the assumptions in the literature about women who give birth?[10] What assumptions about childbirth distress/emotion are reflected in the literature? How does power work to shape discourse around the birth experiences? Thus, in this literature review I aim to uncover how issues of voice and privilege, and assumptions about distress in childbirth, come to create what is available to be considered as dominant truth in knowledge about childbirth.

My Choice of Literature and Research on Distressing Childbirth Experiences

I undertook the literature review in two parts. First, I reviewed of the general academic literature specifically regarding experiences of distress in childbirth. The indexes, Academic Search Primer, ProQuest Social Sciences Premium Collection, Women's Studies International, CINAHL Plus, the Cochrane Library, Pub Med, PsychINFO, as well as the Canadian Journal of Midwifery Research were searched for articles published in English since 1995 using the keywords childbirth, distress, and trauma (and their suggested related words as appropriate). I excluded journal articles if the word trauma or distress was related to physical trauma only (e.g. respiratory distress, pelvic floor trauma), or if they did not have a childbirth focus (e.g. distress related to postpartum depression without consideration of childbirth itself).

---

[10] The literature reviewed presented childbirth as a strictly women's issue, and so in this literature review I refer to "woman and women" when discussing the literature.

Second, I uncovered only one article written by a social worker (Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009) in the initial literature search, the social work literature was searched for the more general topic of childbirth. I gathered social work literature using Social Work Abstracts, PsychINFO, Applied Social Sciences Index and Abstracts (ASSIA), Social Service Abstracts, Sociological Abstracts, and ProQuest Dissertations from 1995 to present. Articles were included if there was at least one author with a social work degree, or the articles listed social work as key word or subject, and the article mentioned childbirth specifically (that is, it did not just have a perinatal or postpartum focus). I reviewed the references for all included journal articles and found works that were significant for this project which were included in the literature review as well.

The resulting list of academic papers included scholarship from Australia, Benin, Canada, the Gambia, Germany, Iran, Israel, the Netherlands, New Zealand, Nigeria, Norway, Romania, South Africa, Sweden, the United Kingdom, and the United States. I also included in this literature review a selection of books and several book chapters according to relevance (a focus on distress) and representing a variety of disciplines (nursing, psychology, feminist studies, anthropology). The final literature reviewed consisted of 80 journal articles, two doctoral dissertations, three chapters from edited books, and three books.[11]

In reviewing the literature I discovered a dearth of social work specific research regarding childbirth emotional distress. I believe this represents both an unfortunate absence of important analysis as well as an exciting opportunity to expand both the social

---

[11] See Appendix A for a complete list of the literature reviewed.

work knowledge base and the knowledge base regarding childbirth distress from an alternative critical perspective. The majority of the literature presents childbirth as a female experience without exploring the intersections of gender with other social markers that might influence childbirth experiences. Additionally, the dominance of the psychological view of emotional distress is marked in the literature, reflecting how power operates through discourse to structure what can be known about childbirth experiences. Thus, expanding the social work knowledge base regarding childbirth distress and incorporating this knowledge is important, as I believe that social work research can provide a much needed disruption of these dominant ideas.

Distress in Childbirth

My review of the literature reveals a growing acceptance of the idea that women can experience distress during childbirth. The research links distress (often conceptualized as trauma, post-traumatic stress disorder, or post-traumatic stress symptoms) with descriptions of the woman giving birth, such as being poor, having a pre-existing mental illness, and personal coping style (Table 1); qualities of the birth experience itself, such as emergency procedures (Table 2); and the woman's internal experiences during childbirth, such as her thoughts, emotions, and interpretations about childbirth (Table 3).

Table 1

Descriptions of the Woman that are Associated with Distress

Cause of Distress	Research Supporting
Nuliparity (first birth	Ayers, Harris, Sawyer, Parfitt, & Ford, 2009; Boorman,

experience)	Devilly, Gamble, Creedy, & Fenwick, 2014; Soet et al., 2003; Wijma et al., 1997
Low socioeconomic status	Fottrell et al., 2010; Soet et al., 2003; Wijma et al., 1997
Poor social supports prior to delivery	Lemola, Stadlmayr, & Grob, 2007; Robb, 2011; Soet et al., 2003
A pre-partum history of mental health difficulties (including trait anxiety)	Boorman et al., 2014; Cohen, Ansara, Schei, Stuckless, & Stewart, 2004; Czarnocka & Slade, 2000; Fairbrother & Woody, 2007; Keogh, Ayers, & Francis, 2002; Söderquist, Wijma, & Wijma, 2006; Soet et al., 2003; van Son, Verkerk, van der Hart, Komproe, & Pop, 2005; Verreault et al., 2012; Wijma et al., 1997; Zaers, Waschke, & Ehlert, 2008
A history of sexual trauma	Ayers et al., 2009; S. Kitzinger, 2006b, 2006a; Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; McKenzie-McHarg, 2004; McKenzie-McHarg, Crockett, Olander, & Ayers, 2014; Reynolds, 1997; Soet et al., 2003; Verreault et al., 2012
Fear of childbirth	Anderson, 2011; Anderson & Gill, 2014; Lundgren, 2011; Nilsson et al., 2010; Söderquist et al., 2006; Thomson & Downe, 2008; Wijma et al., 1997
Maternal orientation, coping style, and belief in ability to	Baron, Cusumano, Evans, Hodne, & Logan, 2004; Berentson-Shaw, Scott, & Jose, 2009; Van Bussel,

handle the childbirth	Spitz, & Demyttenaere, 2010
experience	

Table 2

Aspects of the Childbirth Experience that are Associated with Distress

Cause of Distress	Research Supporting
Pain during delivery	Allen, 1998; Briddon, Slade, Isaac, & Wrench, 2011; Czarnocka & Slade, 2000; Nilsson, Bondas, & Lundgren, 2010; Soet et al., 2003
Instrumental vaginal delivery (including episiotomy and/or vaginal tear requiring suturing), unplanned delivery complications, and caesarian section (planned or emergency)	Adewuya, Ologun, & Ibigbami, 2006; Andersen, Melvaer, Videbech, Lamont, & Joergensen, 2012; Ayers et al., 2009; Baker, Choi, Henshaw, & Tree, 2005; Beck, 2004a; Boorman et al., 2014; Fenwick, Gamble, & Mawson, 2003; S. Kitzinger, 2006b; Priddis, Dahlen, & Schmied, 2013; Ryding, Wijma, & Wijma, 2000; Söderquist et al., 2006; Soet et al., 2003; Ukpong & Owolabi, 2006
Inadequate care for the mother from partner and/or staff at the birth	Allen, 1998; Anderson, 2011; Anderson & Gill, 2014; Baker et al., 2005; Beck, 2004a,

	2011; Creedy, Shochet, & Horsfall, 2000; Czarnocka & Slade, 2000; Ford, Ayers, & Bradley, 2010; Hall, 2013; Harris & Ayers, 2012; Kitzinger, 2006; Lundgren, 2011; Moyzakitis, 2004; Nilsson et al., 2010; Niner et al., 2013; Soet et al., 2003; Taghizadeh, Arbabi, Kazemnejad, Irajpour, & Lopez, 2014; Thomson, 2011; Thomson & Downe, 2008; Wijma et al., 1997
Low Apgar score for the newborn	Fairbrother & Woody, 2007
Giving birth to a low birth weight infant	Kersting et al., 2004
The death of the baby or having a stillbirth	Fottrell et al., 2010; Sawyer et al., 2011; Turton, Hughes, Evans, & Fainman, 2001
Preeclampsia	Van Pampus, Wolf, Schultz, Neeleman, & Aarnoudse, 2004
Racial discrimination during childbirth	Niner et al., 2013

Table 3

Internal Experiences of the Woman During Childbirth that are Associated with Distress

Cause of Distress	Research Supporting

Peripartum[12] dissociation, numbing or a sense of leaving the body	Ayers et al., 2009; Harris & Ayers, 2012; Lev-Wiesel et al., 2009; Lundgren, 2011; Nilsson et al., 2010; Olde et al., 2005; Thomson & Downe, 2008; van Son et al., 2005
Viewing the birth as a negative experience	C. A. Anderson, 2011; Briddon et al., 2011; Dale-Hewitt, Slade, Wright, Cree, & Tully, 2012; Lemola et al., 2007; Olde et al., 2005; Wijma et al., 1997
Fear for one's own life or the life of the baby	Alcorn, O'Donovan, Patrick, Creedy, & Devily, 2010; Allen, 1998; Beck, 2004a; Nilsson et al., 2010; Niner, Kokanovic, & Cuthbert, 2013; Soet et al., 2003; Wijma et al., 1997; Zaers et al., 2008
Memory disorganization	Briddon et al., 2011
Feeling apart/disconnected from/ not central to the birth experience	S. Kitzinger, 2006b; Moyzakitis, 2004; Nilsson et al., 2010; Thomson & Downe, 2008
Experiencing a language barrier during childbirth	Niner et al., 2013

_____

[12] Peripartum refers to the time before and after birth (Merriam-Webster, 2017).

A sense of loss of control	Adewuya et al., 2006; Baker et al., 2005; Beck, 2004a; Czarnocka & Slade, 2000; Elmir, Schmied, Wilkes, & Jackson, 2010; Fenwick et al., 2003; Harris & Ayers, 2012; Keogh et al., 2002; S. Kitzinger, 2006b; Moyzakitis, 2004; Somera, Feeley, & Ciofani, 2010
A mismatch between expectations and the reality of childbirth	S. Allen, 1998; Anton & David, 2013; Soet et al., 2003; Thomson, 2011; Thomson & Downe, 2008; Verreault et al., 2012
Feeling disempowered or helpless	Beck, 2011; Forssén, 2012; Soet et al., 2003; Thomson & Downe, 2008
Dignity violations or feeling dehumanized	Beck, 2004a; Forssén, 2012; S. Kitzinger, 2006b; Thomson, 2011; Thomson & Downe, 2008
Postpartum depression	Beck, Gable, Sakala, & Declercq, 2011; Olde et al., 2005; Zaers et al., 2008

The research clearly supports the notion that a variety of factors may be associated with distress in childbirth. While researchers considered the numerous medical, social, and relational factors contributing to distress, women tend to be represented in the literature in a less nuanced manner,.

Assumptions About Distress

Much of the research takes a psychopathological view of distress equating it with trauma, with 58 of the 83 journal articles reviewed referring to a psychological trauma or diagnosis in their titles. The dominance of an individualized psychological view of distress, and its conflation with trauma and with post-traumatic stress disorder, is evident in the focus of many research papers. Despite agreement that between one third and one half of women report their childbirth experiences to be traumatic (Alcorn et al., 2010; Beck et al., 2013; Creedy et al., 2000; Czarnocka & Slade, 2000; Elmir et al., 2010; Ford et al., 2010; O'Donovan et al., 2014; Skari et al., 2002; Soet et al., 2003; Ukpong & Owolabi, 2006), much effort is spent in determining if women's subjective experiences of trauma can be trusted. Several studies assessed the credibility of subjective experiences of distress, reducing women's experiences to symptom checklists, and matching these against the diagnostic criteria for PTSD (e.g. Ayers et al., 2009; Creedy et al., 2000; Czarnocka & Slade, 2000; Soet et al., 2003; van Son et al., 2005; Wijma et al., 1997). In the end, according to the quantitative research the accepted rate for childbirth related trauma falls between 1.5 and 5.6%, representing a vast reduction from the one third to over one half of women who report subjective experiences of trauma and/or distress in childbirth (Adewuya et al., 2006; Alcorn et al., 2010; Andersen et al., 2012; Ayers et al., 2009; Ayers & Pickering, 2001; Cohen et al., 2004; Creedy et al., 2000; Czarnocka & Slade, 2000; Davies, Slade, Wright, & Stewart, 2008; Fairbrother & Woody, 2007; Ford et al., 2010; Lev-Wiesel et al., 2009; Olde et al., 2005; Söderquist et al., 2006; van Son et al., 2005; T. White, Matthey, Boyd, & Barnett, 2006; Wijma et al., 1997; Zaers et al., 2008).

57

There is some psychologically oriented research that relies on women's subjective reports of distress as a deliberate countering to the way in which women's experiences are silenced in the general childbirth literature, typically arguing for better treatment of women in childbirth, and for postpartum psychological treatment. But this approach often remains diagnostically focused, even in its centring and advocacy. Beck (2004a, 2004b, 2011; Beck & Driscoll, 2006; Beck et al., 2013, 2011) who appears highly influential in the childbirth trauma literature, provides a clear example of this approach, relying heavily on diagnostic categories of PTSD and postpartum depression in her work.

However, fourteen studies (and one related social work dissertation) took a different approach to examining experiences of distress in childbirth (Amoros, Callister, & Sarkisyan, 2010; Baker et al., 2005; Chadwick, Cooper, & Harries, 2014; Fenwick et al., 2003; Halvorsen, Nerum, Øian, & Sørlie, 2013; Moyzakitis, 2004; Nilsson et al., 2010; Niner et al., 2013; Robb, 2011; Ryding et al., 2000; Sawyer et al., 2011; Schneider, 2009, 2012; J. Smith & Morrow, 2012; Somera et al., 2010). These works all deliberately centred the subjective experiences of the participants without filtering women's voices through the mesh of psychological language and diagnostic categories. While women's experiences were centred in these works, for the most part experiences of distress were not. Of these fourteen studies, only two, Chadwick and colleagues (2014) and Moyzakitis (2004), focused on experiences of distress in childbirth, while the remaining included distress related themes in their findings. Eleven of the fourteen used interviews, with Schnieder (2009, 2012) (the only social work research represented here) and Fenwick and colleagues (2003) employing survey questionnaires. Most focused on a specific group of women. Four of the works specifically focused on experiences of caesarean births

(Fenwick et al., 2003; Robb, 2011; Ryding et al., 2000; Somera et al., 2010). One study investigated experiences of childbirth in women with rape histories (Halvorsen et al., 2013) and one study interviewed women with intense fear of childbirth resulting from previous birth experiences (Nilsson et al., 2010). Four studies centred on certain ethnic, cultural and/or racial groups (these were sometimes combined) (Amoros et al., 2010; Chadwick et al., 2014; Niner et al., 2013; Sawyer et al., 2011). Only three studies did not specify any social location, life event, or specific identity when designing the research (Baker et al., 2005; Moyzakitis, 2004; Schneider, 2009, 2012). All of these works used thematic analysis to deepen understandings about experiences in childbirth. For the purposes of this research, what remains lacking is a focus on distress and a social work specific focus on the how social location and identity might relate to distress in childbirth from a non-pathologizing lens.

Aside from the research of Schneider (2009, 2012), the social work research on childbirth reflects a similar psychologically-minded and pathology focused approach. Bachman and Lind (1997), Walther (1997), and Taubman-Ben-Ari and colleagues (2008) examined perinatal distress with approaches heavily influenced by psychology and medicine, focusing on the social worker's skills in differential diagnosis of pregnancy related mental illness (Walther, 1997), the role of social worker on a perinatal team dealing with medical and emotional complications in pregnancy (Bachman & Lind, 1997), and marital relationships negatively affected by childbirth (Taubman-Ben-Ari et al., 2008). These papers were heavily oriented towards both medical and psychological frameworks and emphasized diagnoses and diagnosing. While they paid some attention to social contributions to perinatal psychopathology, all of the papers neglected any

59

discussion of how social location might reflect greater discrimination and resulting

distress. Taubman-Ben-Ari and colleagues (2008) mirrored the distrust of women's

subjective experiences of distress. Their study relied on women's self-report, which the

authors viewed as a shortcoming of their study, stating:

> Several possible limitations of this study should be noted. First, it relies
>
> exclusively on mothers' self-reports. Future studies might include additional
>
> measures (derived either from reports of husbands and grandparents or from
>
> observational methods). (Taubman-Ben-Ari et al, 2008, p. 195)

Their recommendation that studies concerned with new mothers' perception of their own

coping should look to grandparents and husbands for collateral information is highly

heteronormative, reflects an assumption of normative kinship family models, and

demonstrates the skepticism with which women's understandings of their own

experiences are viewed in the literature.

The message throughout the literature is one where women's subjective

experiences are not to be trusted, and where the truth lies not within subjective

experiences and reports of distress, but within the taxonomy of diagnosis and the

objective rigour of scientific inquiry. Those who carry the status of psychological and

medical professional have the loudest voice in the childbirth literature and therefore have

more ability to shape the discourse surrounding experiences of distress in childbirth. By

equating distress with trauma, and support with diagnosis, many people's experiences of

distress are made invisible and many are left without supports, resources, and

understandings that may help alleviate some of the distress that may be associated with

childbirth. However, even within the studies that centred subjective experiences, there

was little attention paid to how power and discourse influence and shape subjective experiences.

Assumptions About Women

As stated previously, the childbirth literature reviewed in this research presented childbirth as a strictly women's issue, where gender was always assumed to be female. In addition to assuming a female gender, the majority of the research takes a non-intersectional, universal view of women, typically disregarding race, ethnicity, class, sexuality, and other social locations, unless a specific social location was the topic of interest. Authors frequently made efforts to minimize variation and complicating factors within their samples, resulting in exclusion criteria including outlined in Table 4.

Table 4

Exclusion Criteria for Studies Exploring Distress in Childbirth

Exclusion Criteria	Research Using Exclusion Criteria
Not speaking the dominant language	Adewuya et al., 2006; Alcorn et al., 2010; Anderson, 2011; Anderson & Gill, 2014; Boorman et al., 2014; Briddon et al., 2011; Cohen et al., 2004; Creedy et al., 2000; Czarnocka & Slade, 2000; Dale-Hewitt et al., 2012; Devilly, Gullo, Alcorn, & O'Donovan, 2014; Ford et al., 2010; Garthus-Niegel et al., 2014; Halvorsen, Nerum, Øian, & Sørlie, 2013; Harris & Ayers, 2012; Maclean, McDermott, & May, 2000; Nilsson et al., 2010; O'Donovan et al., 2014; Olde et al., 2005; Söderquist et al., 2006; Somera et al., 2010; Van

	Bussel et al., 2010; Verreault et al., 2012; White, Matthey, Boyd, & Barnett, 2006
Being less than 18 years of age	Alcorn et al., 2010; Berentson-Shaw et al., 2009; Bernier, Jarry-Boileau, Tarabulsy, & Miljkovitch, 2010; Callahan & Hynan, 2002; Cohen et al., 2004; Creedy et al., 2000; Czarnocka & Slade, 2000; DeMier et al., 2000; Devilly et al., 2014; Ford et al., 2010; Hall, 2013; Harris & Ayers, 2012; Keogh et al., 2002; Lev-Wiesel et al., 2009; Maclean et al., 2000; Taghizadeh et al., 2014; Van Bussel et al., 2010; Verreault et al., 2012
Receiving past or present treatment for a diagnosis of a mental illness	Boorman et al., 2014; Halvorsen et al., 2013; Lev-Wiesel et al., 2009; Maclean et al., 2000; Taghizadeh et al., 2014; Ukpong & Owolabi, 2006
Complications in the pregnancy or delivery	(Bernier et al., 2010; Briddon et al., 2011; Cohen et al., 2004; Creedy et al., 2000; Czarnocka & Slade, 2000; Dale-Hewitt et al., 2012; Fairbrother & Woody, 2007; Ford et al., 2010; Keogh et al., 2002; Lev-Wiesel et al., 2009; Skari et al., 2002; Söderquist et al., 2006; Somera et al., 2010; Ukpong & Owolabi, 2006; Van Bussel et al., 2010; T. White et al., 2006)

An intersectional analysis of the literature requires an examination of how race, class, and other social locations are reflected in (or absent from) the literature. Most studies did not look for differences across social location. For example, many studies omitted any consideration of race and ethnicity (Table 5).

Table 5

Studies That Did Not Consider Race or Ethnicity

Author(s)	Year
Allen	1998
Beck	2004
Boorman et al.	2014
Callahan & Hynan,	2002
Creedy et al.	2000
Czarnocka & Slade	2000
Dale-Hewitt et al.	2012
Fenwick et al.	2003
Garthus-Niegel et al.	2014
Hall	2013
Lemola et al.	2007
Lundgren	2011
Maclean et al.	2000
Moyzakitis	2004
Nilsson et al.	2010

Olde et al.	2005
Skari et al.	2002
Söderquist et al.	2006
Thomson	2011
van Son et al.	2005
Wijma et al.	1997
Zaers et al.	2008

The discursive practices attached to white supremacy[13] mean that when race is not identified it is typical for whiteness to be assumed (Aveling, 2004; Case, 2012; Moreton-Robinson, 2000). While I do not want to recreate this by concluding that authors are assuming whiteness, I am suspicious that in these works whiteness is centred as normative. However, race is often mentioned even as its meaning remains unclear, and other markers such as nationality may stand in for, or be confounded with race. For example, Van Bussel and colleagues (2010) described the participants in their study as mostly Belgium women (91.7%), and in the results section, the authors reported finding no significance with regards to sociodemographic variables (apart from age and number of children). While the meaning of "Belgium women" was not defined, the conclusion stated the majority of participants were "Caucasian". The reader might wonder if "Belgium" and "Caucasian" are two different variables, or if the meaning was that

---

[13] Here white supremacy is not about fringe political movements and hate groups, but instead white supremacy is discussed in relation to hegemonic understandings of white superiority and entitlements that are maintained through daily activities and economic, cultural and political systems (Aanerud, 2007; Akom, 2008; Twine & Gallagher, 2008).

Belgium women are White women. Were the remaining 8.3% of women (the non-Belgium women) considered non-Belgium due to their racialized (i.e. non "Caucasian") identity, migration status, or some other reason? Several other studies reflect a similar approach of making race invisible, or of making whiteness non-racialized (see also Anton & David, 2013; Devilly et al., 2014; O'Donovan et al., 2014; Somera et al., 2010; T. White et al., 2006). Additionally, many authors collected demographic information regarding the participants' social locations, but the demographic variation was not studied for possible influence on experiences of distress (e.g. Baker et al., 2005; Baron et al., 2004; Briddon et al., 2011; Fairbrother & Woody, 2007; Ford et al., 2010; Halvorsen et al., 2013; Harris & Ayers, 2012; Keogh et al., 2002; O'Donovan et al., 2014; Thomson & Downe, 2008; Verreault et al., 2012). These studies represent missed opportunities for intersectional analysis as the relationship between various social locations and experiences of distress were not considered (Murphy et al., 2009).

Perhaps in attempts to address this missed opportunity, several studies rejected the idea of the universal woman and instead explored the experiences of specific groups of women—displaced women (Niner et al., 2013), Gambian women of various ethnicities (Sawyer et al., 2011), Nigerian women (Adewuya et al., 2006; Ukpong & Owolabi, 2006), Iranian women (Taghizadeh et al., 2014), Beninese women (Fottrell et al., 2010), South African women (Chadwick et al., 2014), Swedish women (Forssén, 2012), and adolescent women (C. A. Anderson, 2011; C. A. Anderson & Gill, 2014). Race, culture, migration status, and age were taken up variously in these studies, reflecting the assumption that these identities carried some importance in childbirth experiences.

Within the studies that explored childbirth distress in specific groups of women, the intersections of multiple sites of oppression were sometimes considered. For example, Anderson (2011) noted Hispanic adolescent mothers experienced less distress than White adolescent mothers, postulating this was due to differing cultural expectations and responses to teenage mothering between the two groups, thus highlighting an analysis of different experiences associated with gender, race, and age. Similarly, Niner and colleagues (2013) looked specifically at the experiences of displaced Karen women from Burma in Australia. This article illustrated that women's experiences in childbirth were clearly associated with language barriers, racism, and the historical trauma associated with living in refugee camps. The authors reported different experiences of distress between younger mothers and older mothers, rejecting the idea of displaced Karen women as a homogenous group, and looking instead at the intersections of age, ethnicity, race, and migration experiences.

The (predominantly non-social work) literature reflects the assumption that women have a commonality of experience in childbirth unless they are marked as Other. For example, if race is mentioned in the title of a paper it is typically used to connote "not White." Unless race is specified, whiteness is presumed due to its hegemonic centring. This is despite the fact that many papers did discuss specific ethnic groups. For example, Anton and David's (2013) study of Romanian women, Olde and colleagues' (2005) study of Dutch women, Wijma and colleagues' (1997) work with Swedish women, and Zaers and colleagues' (2008) German research all represent ethnic and national groups traditionally considered White, and ignored race as potentially impacting childbirth experiences. The only exception to this was Forssén, (2012) who included "Swedish

women" as a descriptor in her title and mentioned in her paper that four out of ten participants were Sami women. However the work included no further discussion of race or ethnicity beyond this demographic information.

What we see in this literature review is that race is only considered when the subjects are not White, age is only considered when participants are adolescents, culture and language are only considered when it is not the dominant culture and language, and gender is always assumed to be female. Thus, these studies reproduce the White, 20-30 year old, middleclass, educated, cis gender, heterosexual person from the global North, as centred and serving as a representation of birthing people, and the studies that serve as exceptions to this still create otherness through response to this centring.

The social work literature regarding childbirth generally (not specifically distress in childbirth) was examined for assumptions made about women with similar results. Much of the work omitted any consideration of social locations, or intersections of oppression and privilege, reflecting a universal view of women (see Bachman & Lind, 1997; Cacciatore, 2009; Walther, 1997). While Taubman-Ben-Ari and colleagues (2008) specifically focused on Israeli women's marital adaptation after their children's births, this research reflected the assumption of heterosexual marriage with traditional gender roles as the only environment where childbirth is a concern, and did not consider any other social locations for their influence on women's experiences. Two dissertations (Long, 1997; Schneider, 2009) explored the topic of childbirth from a social work perspective, but neither had a focus on childbirth related distress.

In reviewing the literature it appears Schneider's (2009) dissertation has the most in common with my research, but is distinct in several fundamental ways. It focuses on

meaning making from childbirth experiences, and as such has a focus different from this research which is concerned specifically on emotional distress in childbirth and the ways in which emotional distress in childbirth is produced. Additionally, Schneider (2009) used survey questionnaires to elicit participants' written narratives, whereas I used in-depth, guided interviews. The result is a very different form of data than Schneider's (2009) and data that lends itself to a very different form of data analysis. This represents significant differences in epistemology, theory, methodology, method and focus between Schneider's (2009, 2012) work and my own. Similar to this research, Schneider (2009, 2012) recognized the lack of racial and economic diversity as a limit to previous studies and conceived that her study's methodology would address this through diverse sampling. However, it seems this was not the case and the participants in her research ended up recreating the very shortcoming she sought to address. Her participants were all older than 25 years old, and 111 out of 119 (93%) participants had at least a high school education, spoke English, were White, and born in United States.

Long (1997) focused her doctoral dissertation on how information about pregnancy and childbirth is transmitted intergenerationally among Native American women. However, the work did not address the actual experience of childbirth (potentially including childbirth distress); instead the analysis focused on the mechanisms for the intergenerational transfer of information about childbirth, where the means of information transfer (rather than the means of discourse development) was the focus. While these two studies help to bring childbirth into focus for social work, there remains a void regarding a social work analysis specifically focusing on childbirth distress.

Power

Power operates in the way assumptions about women and distress come together to shape what we can know about childbirth, and yet power was rarely addressed in the childbirth literature. When raised, it was typically in terms of empowerment and powerlessness, with the message that women need to be given more power in the childbirth process (see Baron et al., 2004; Beck, 2004a, 2004b, 2011; Chadwick et al., 2014; S. Kitzinger, 2006b; Moyzakitis, 2004; Soet et al., 2003; Thomson & Downe, 2008). For example, Moyzakitis (2004) identified power in terms of powerlessness, viewing an imbalance of power between the delivering woman and the health care professionals as a source of distress. She also linked power to knowledge and argued the exclusion of women's knowledge, as separate and less than the authoritative knowledge of medical staff, is a source of distress (Moyzakitis, 2004). The analysis reflects a hierarchical view of power, where power is a limited resource. This view is limited as it ignores the ways in which power is relational and operates to constitute childbirth experiences.

Four articles, including the social work research by Tester and McNicoll (2006) as well the work of Baker and colleagues (2005), Forssén (2012), and Nilsson and colleagues (2010), stepped outside the hierarchical view of power, and discussed Foucault's ideas of discipline, with specific attention to the ways in which women are disciplined and discipline themselves to construct their childbirth experiences. Tester and McNicoll (2006) employed Foucault's concept of clinical gaze in their examination of how the practice of medicine and the institutions of hospitals, both introduced through colonization, "severely challenged Inuit concepts of health and sickness" (p. 89). They

69

demonstrated how locating illness within hospitals under the purview of the medical gaze marginalized shamanistic understandings of illness, where illness was connected to the broader social, spiritual and cultural circumstances. The authors discussed how childbirth acted as a site of resistance, where physicians accepted that Inuit women were equipped to navigate childbirth processes in a manner that was superior to the physicians' and thus permitted the Inuit midwives to be involved in the childbirth processes. The authors also pointed out, however, that while physicians might have consented to midwives' assistance in the childbirth process, the midwives' involvement was still organized within medical hierarchy—the physician would "allow" a midwife to be present at certain times, and physicians would "educate" midwives about childbirth and postnatal care. This work by Tester and McNicoll (2006) takes up power, colonization, and childbirth in an interactive an interdependent way, however, childbirth is not the focus but discussed merely as an interesting exception to the rule of medical dominance in colonization.

Forssén (2012) argued that disciplining of the self, operated to regulate women in their childbirth experiences. She included an analysis of the role the obstetrical examination plays in reinforcing the self-disciplining behaviours of pregnant women. Nilsson and colleagues (2010) included the related idea of surveillance, and attended to the physical space of the obstetrical unit in their analysis of how power operates in the childbirth experience. These authors employed Foucault's metaphor of the panopticon, demonstrating how the birth room itself becomes part of a "greater system of power and dominance" in obstetrical care (Nilsson et al., 2010, p. 306).

Building on the idea of surveillance and the birthing room as a prison, Baker and colleagues' (2005) qualitative study of women's experiences of maternity care, is titled "I

felt as though I'd been in jail". The authors embraced the idea of disciplinary power in their discussion of distress in childbirth. Here Baker and colleagues (2005) argued that centring of medical expertise and relegating women's experienced-based knowledge to the periphery, results in the silencing of women in childbirth, acting as evidence of how women are persuaded to behave in particular ways in the birthing experience through this disciplinary power.

The rarity of such discussions of power in the childbirth literature demonstrates the invisibility of mechanisms of power. The dominance of medical and psychological discourse, and the automatic suspicion that is cast upon subjective experiences of childbirth so that they are not seen as credible, invisibly shapes and determines what is available as truth and knowledge about childbirth. This leaves experienced-based and subjective knowledges as subjugated knowledges within the field of childbirth.

Summary of the Literature Review

The overarching message throughout the current literature is that distress in childbirth deserves recognition once it reaches the point of scientifically determined pathology. And yet this can only be determined scientifically if many of the lived experiences that may contribute to distress (race, depression and anxiety, language differences, age, and others) have either been eliminated from study, or marginalized as other. I want to be clear—I am not suggesting that we should pathologize and diagnose those one-third to one-half of women who report trauma and distress but escape diagnosis. Instead, I believe the dominance of psychiatric/psychological diagnosis only allows certain forms of distress to be considered valid and thus worthy of attention. This should alarm social workers, and yet my search of the childbirth and social work

literature did not uncover any social work specific knowledge or research regarding distress in childbirth.

The social work literature mostly ignores childbirth and yet it is an area that requires further attention by social workers (Schneider, 2009, 2012). This includes a specific focus on distressing childbirth experiences. The social work literature that does incorporate childbirth into its analysis fails to challenge the assumptions about those who have childbirth experiences, the assumptions about the nature of distress, how these assumptions shape childbirth experiences, and what is available to be known about childbirth experiences. That is, it lacks an intersectional framework, tends towards a universal view of women, relies heavily of psychological frameworks, and ignores issues of power.

Social *in*justice in reproduction unfairly burdens those who live at the intersections of marginalized social locations (Averitt Taylor, 2014; Price, 2010; Spring, 2014). Social workers are obliged to uphold "the right of all people to have access to resources to meet basic human needs" and advocating for "fair and equitable access to public services and benefits" (CASW – ACTS, 2005a, 2005b). Addressing social work's gap in knowledge regarding childbirth, by privileging and centring the experiences of those who have given birth as legitimate and necessary knowledge, while critically examining discursive shaping of childbirth knowledge, falls within the social work commitment to social justice. Problems arise when experiences of childbirth that are taken as truth represent dominant medical, psychological, and pathologizing discourse, and deliberately exclude those who may complicate research due to their difference from the desired White, middleclass, young adult, female, dominant language speaking, able-

bodied, sane, position. In this situation, knowledge is lacking, and services may be designed to meet and respond to the needs of only those who are represented in the research, resulting in the continued and increased marginalization of all those who are seen as Other.

I believe that the gaps in understanding, evidenced in the above literature review, can best be addressed using a feminist narrative methodology to inquire about experiences of distress in childbirth. The following chapter outlines this feminist narrative methodology, designed to address the question, "What are individuals' experiences of distress in childbirth?" and establishes the criteria for evaluating this research.

CHAPTER 4

RESEARCH DESIGN

The methodology for this research was informed by my conceptual framework and by the preceding review of the literature. I chose to use a feminist narrative approach to inquiry and analysis as this approach privileges subjugated knowledges and allows for an exploration of how discourse shapes understanding and experiences. In this privileging, knowledge is created that highlights the lived experiences and social conditions associated with marginalization, challenges dominant stories, and creates a focus for social change (Clandinin, 2013; Frank, 2005). By focusing on experience, a feminist narrative approach rejects the ideas of a single truth, and instead seeks deeper meaning through both commonalties well as particularities of experience. Through centring the emotion of distress, my feminist narrative inquiry and analysis allowed for a challenge to dominant ideas regarding emotional pain and in doing so politicized the concept of trauma. And finally, as a feminist approach, my research considered gender and its intersections with other social markers and material realities in my exploration of childbirth.

The Purpose

This research study had two purposes. First, this study explored experiences of distress in childbirth from a perspective which allowed hidden, taken-for-grated ideas about childbirth distress to be illuminated. Thus, dominance was disrupted and subordinate and subjugated knowledges about childbirth were made visible. Secondly, my goal in undertaking this research as a social work researcher, and as a social work practitioner, was to add to the social work specific knowledge base that informs our

praxis. I believe social work has an opportunity to improve services to those living with and through distressing childbirth experiences. I also believe in order to do this, social work needs its own research and insights into these experiences and the needs of those with whom we might potentially work.

Qualitative approaches are best suited to this type of research, as they allow deeper understandings of the complexity of lived experiences in a way that quantitative approaches cannot (Polkinghorne, 2005). Qualitative inquiry applies especially when "research topics … appear to defy simple quantification [as] the qualitative researcher may recognize several nuances of attitude and behavior that might escape researchers using other methods" (Rubin & Babbie, 2011, p. 435) and qualitative methods allow information to emerge that the interviewer may not have thought of when designing a research question (Allsop, 2013). Qualitative research design has flexibility as an asset, being more amenable to modification even once the project has started (Allsop, 2013; Rubin & Babbie, 2011). In a qualitative study the researcher takes the position of assuming the need to develop deeper understandings of the phenomenon and "its subjective meanings as it occurs in its natural environment" (Rubin & Babbie, 2011, p.183). By developing these deeper understandings, the researcher seeks to uncover themes and patterns from more unstructured observations and interactions (Allsop, 2013; Polkinghorne, 2005; Rubin & Babbie, 2011). Thus, a qualitative research design was the best fit to uncover what is missing from understandings of experiences of distress associated with childbirth, on a very specific, albeit non-generalizable level.

This research study asked the question "What are individuals' experiences of distress in childbirth" in order to increase understanding about these experiences and to

explore how these experiences were both discursively constructed and discursively constrained. While the findings from this qualitative study were not intended to be generalizable, they provide important insights, and they act as a launching off point for further study; once themes and/or new insights are identified they can be used to create questions for further investigation. The strength of this feminist narrative qualitative study was its ability to gather a depth of information with many specific details and meanings. These meanings contributed to new understandings of the everyday occurrence of childbirth.

Research Design

A feminist narrative inquiry and analysis is a qualitative research approach that was best suited to address the research question. Furthermore, a feminist narrative inquiry and analysis exploring experiences of distress in childbirth fit with the conceptual framework outlined earlier. This methodology allowed a consideration of how participants constructed their identities through self-narratives, in a manner reflecting an orientation towards maintaining a "coherent sense of identity across different contexts and accounts" (Stapleton & Wilson, 2004) and in doing so provided opportunity to highlight discursive reproductions of dominance. Thus an analysis of childbirth narratives allowed for an examination of how constructs related to distress, and to the narrators' identities (such as gender, class, race, and sexuality), came to be constituted though childbirth and also how they constituted childbirth experience and discourse. That is, childbirth narratives provided a site of analysis of both meaning and discourse. In doing so, the feminist narrative inquiry and analysis I undertook, paid attention to the both the material and discursive understandings of the body. It allowed for a disruption of binary

oppositions that reflected dominant ideas of race, class, and gender, while at the same time reflecting a recognition of the importance of maintaining class, race, gender, and other social locations within the scope of the analysis (Pamphilon, 1999; Warhol, 2012).

Feminist narrative inquiry and analysis enables the co-constructions of knowledges as the researcher moves between data collection and analysis (Brown Wilson, 2009). Researchers using feminist narrative inquiry and analysis as a methodology, seek to change power relationships, reject ideas of neutrality and objectivity, and incorporate reflexivity (Morris, 2005). For my research, feminist narrative methodology made space for people's voices to be heard and allowed for connections between these voices in a way that may illuminate and challenge existing dominant narratives around childbirth.

A concern with approaches centring experiences and looking to marginalized voices for truth is they recreate the very search for a truth emblematic of positivism. Scott (1991) explains:

> When experience is taken as the origin of knowledge, the vision of the individual subject (the person who had the experience or the historian who recounts it) becomes the bedrock of evidence on which explanation is built. Questions about the constructed nature of experience, and how subjects are constituted as different in the first place, about how one's vision is structured—about language (or discourse) and history—are left aside. (p. 777)

Experience has no special epistemic privilege. Because experience is interpreted through a filter of thought and understanding which is influenced by (if not bounded by) the world in which one lives, experienced-based knowledge is likely to (at least partially) represent dominant knowledge (Berger & Luckmann, 1967; Brown, 2012; Fegan, 2012;

77

Polkinghorne, 2005; Scott, 1991; Stone-Mediatore, 2003). And while I believe in the critical political power of experienced-based knowledge, I also agree this knowledge may reflect dominant discourse. The approach that I have used addressed this concern with balancing the importance of experience as an underappreciated site of interest, while recognizing the limits of experienced-based knowledge. Here, narratives were analyzed for subjugated knowledge as well as for reflections of dominant narratives, with an interest in how participants navigated these realities (Stone-Mediatore, 2003). However, feminist narrative inquiry and analysis necessarily only highlights the subjugated knowledges it seeks out. The researcher can only highlight the voices of those who participate, and these may or may not represent various sites of privilege and marginalization. A general weakness of narrative research approaches is that narratives are a reflection on and retelling of the past and they speak to dominant structures, rather than calling for their dismantling. However, the feminist approach to narrative I used took up the interaction of analysis of the themes and structures, and served as a tool to highlight power structures that constrain and define narratives. In this way, narratives could be taken up to assist with dismantling oppressive discourses and institutions as the information gained can be used to create new awareness of knowledges resulting in social change (Frank, 2008).

The Creation of Feminist Research and Narrative Analysis

Knowledge production, dissemination, and meaning making through storytelling have been with us as long as stories have existed. While narrative is linked to the oral tradition within the Indigenous viewpoint through storytelling, oral history, and storywork, as important means of connections across history, time, and people

78

(Archibald, 2008; Moreton-Robinson, 2000; Native Women's Association of Canada [NWAC], 2013; Struthers & Peden-McAlpine, 2005); academic interest in narratives began only as recently as the 1960s (Davis, 2002; Holstein & Gubrium, 2011; Riessman & Quinney, 2005; C. P. Smith, 2000; Squire et al., 2013). The various rights movements of the 1960s and 1970s influenced the academic interest in narratives through their rejection of dominant stories standing as normative, and insistence on the voices of the marginalized being heard (Davis, 2002; Holstein & Gubrium, 2011; Riessman & Quinney, 2005; C. P. Smith, 2000; Squire et al., 2013).

Feminist research. Feminist research methodologies began as a challenge to androcentric bias in research, reflecting the belief that women's experiences had not been omitted by oversight but instead had been "suppressed, trivialized, ignored, or reduced to the status of gossip and folk wisdom by dominant research traditions institutionalized in academic settings and scientific disciplines" (K. Anderson, Armitage, Jack, & Wittner, 2004; Hesse-Biber, 2008). Feminist researchers of various branches within feminism began to write about how their own stories intersected with those of their participants and viewed narrative as more than a way to exchange information (Kimpson, 2005; Padgett, 2008). They were also interested in the idea of research participants as active agents in the narrative and research process, exploring subjective meanings and experiences that had been ignored or silenced in previous research, allowing for new insights and awareness into social processes (Holstein & Gubrium, 2011; Pinnegar & Daynes, 2007; Riessman, 2013). Thus, the focus and goal of some feminist narrative analysis is to examine current theories and develop new theory about subjugated knowledges that more fully reflect marginalized lives (Chase, 2005; Kimpson, 2005).

Narrative analysis. Narrative analysis can take many forms. The focus of narrative analysis may be on themes, structures, function, on the interplay between the story and the storytelling, and may focus on a single event, an entire life, or an experience (Chase, 2005; Holstein & Gubrium, 2011; Riessman, 2013; Squire et al., 2013).[14] Narrative analysis can be divided into two analytic categories; those that analyze the themes of narratives, and those that analyze the structures of narratives (Holstein & Gubrium, 2011; Riessman, 2008; Squire et al., 2013). Thematic narrative analyses focus on the storied content of personal narratives with plots and themes as the focus of analysis, whereas structural approaches to narrative analysis, focus on the practice and structure of narrative, often making use of discourse and conversation analysis (Holstein & Gubrium, 2011). It is also possible to combine the two approaches. In the combined approach, the researcher selects aspects of each form of analysis resulting in a thematic/structural narrative analysis (Holstein & Gubrium, 2011). Here the researcher "focuses on the way storytelling operates in and relation to its social environment" (Holstein & Gubrium, 2011, p. 8). The emphasis is on the interaction of the themes and structures and includes an analysis of how relations of power shape narratives (Andrews, 2013; Holstein & Gubrium, 2011). The thematic/structural approach includes an analysis of narrative resources—that is, what is available to be said as determined through

---

[14] In addition to feminist narrative analysis, there are a wide variety of other forms of narrative analysis. Various approaches focus on different aspects of the narrative and are associated with various disciplines and influences (Chase, 2005). These disciplines and influences include literary criticism, history, psychology, sociology, anthropology, sociolinguistics, philosophy, education, nursing, legal studies, and occupational therapy, (Chase, 2005; Creswell, Hanson, Plano, & Morales, 2007; Davis, 2002; Polkinghorne, 2007; Riessman, 2013; Riessman & Quinney, 2005).

institutions of power (Frank, 2008; Holstein & Gubrium, 2011; Pamphilon, 1999).

Feminist narrative inquiry and analysis. A feminist narrative approach that combines a thematic and structural analysis is consistent with the epistemological stance that underlies this research and thus was used in this study of the discursive construction of experiences of distress in childbirth. This approach involves an iterative and shared understanding that is contextualized, considers power in relation to knowledge and discourse reflected in narratives, and privileges subjugated knowledges. This approach to feminist narrative analysis is undertaken in multiple and interactive phases. In feminist narrative methodology, the process of data collection, interpretation, and analysis are not divided into concrete stages, but instead these occur in an iterative manner throughout the research process (Brown Wilson, 2009; Hydén, 2013). Thus when defining the methodology I use the term "narrative inquiry and analysis" in an effort to reflect my understanding of, and commitment to, narrative as a method as well as an outcome, rather than viewing narrative as something static, and as a product for consumption through analysis (Georgakopoulou, 2006).

Trustworthiness in Feminist Narrative Inquiry and Analysis

As there are many varieties of narrative research, there is no consensus among narrative researchers regarding which criteria is best to evaluate the rigour of the design. (Clandinin & Connelly, 2000; Connelly & Clandinin, 1990; Polkinghorne, 2007; Riessman, 2002, 2013). I have chosen to engage with the work of Lincoln and Guba (1985) and Creswell and Poth (2017). Lincoln and Guba introduced the idea of trustworthiness as the central concept for research evaluation and even though the concept of trustworthiness is no longer new, their criteria for evaluation are well established and

remain popular in qualitative research (Creswell & Poth, 2017). While the evaluation criteria they proposed are not specific to narrative research, they can apply to narrative research. More recently, Creswell and Poth (2017) have proposed a comprehensive method for evaluating qualitative research using the "lens strategy" (p. 259) wherein the research is evaluated through the researcher's lens, the participant's lens, and the reader's lens. Thus, the trustworthiness of this proposed research is assessed through a consideration of the credibility, transferability, confirmability, and dependability of my processes and findings (Lincoln & Guba, 1985) and the criteria for assessing these criteria makes use of the various lenses proposed by Creswell and Poth (2017).

Credibility

Credibility is the degree of fit between the respondents' views and the researcher's description and interpretations of these views (Creswell & Miller, 2000; Lincoln & Guba, 1985; Padgett, 2008). When using a feminist narrative approach to data analysis, my own story no doubt informed my analysis. While a narrative strategy aims to centre and privilege the participants' experience, I interpreted the data and determined which narratives represented the findings of the research (Borland, 2004; Clandinin & Caine, 2013; Cooper & Burnett, 2006; Ellis & Berger, 2002; Frank, 2005; Kimpson, 2005; Pamphilon, 1999; Polkinghorne, 2007). Riessman (2002) explains that the particular narratives and themes that a researcher chooses to write about are linked to the evolving research question, the theoretical frameworks taken up by the researcher, the researcher's values and beliefs, and the researcher's own life history. In considering this risk to credibility, Creswell and Poth (2017) propose as part of the researcher's lens, that the researcher commit to a process of reflexivity, wherein the researcher discloses her

"biases, values, and experiences" (p. 261). In this research I strived to make myself evident in the work, both in my writing and in my interviews with participants. For example, disclosing some of my own history with participants as appropriate and explaining to the participants and to the reader/reviewer why I was asking specific follow-up questions.

Referring to the participant's lens, Creswell and Poth (2017) also recommend member checking as a means towards minimizing threats to credibility. Use of member checking is an important aspect to credibility, allowing the participants to respond to what the researcher has written, and provide changes, correction, and additions that contribute to a rich description that reflects what the participants want to say (Lincoln & Guba, 1985). In this research, member checking was used in the transcription and interpretation stages when participants were offered the opportunity to review and provide feedback up to the level of the individual narratives. The point of this proposed research was not to find a single truth (either mine or the participants'), but to gain insight into participants' experiences and how those experiences are constructed. Researcher and participant agreement was not necessary, and this was discussed with participants as part of their ongoing consent (Clandinin & Connelly, 2000; Padgett, 2008). In addition to member checking, prolonged engagement with participants also helped to address any credibility threats (Creswell & Poth, 2017). I spent time with the participants in their homes playing with their children; I attended playgroups and drop-ins; and I got to know many of the participants beyond the time we spent together in the interviews.

A threat to credibility in this proposed research was the risk of seeking and re-inscribing essentialist female identity and experiences of childbirth by assuming

commonality of experience despite a lack of racial and other sites of diversity in the participants. I have attempted to mitigate this risk by being clear that a lack of diversity is a limitation of this study. Credibility may also have been challenged if any of my own essentialist notions of women and childbirth (of which I may not have been aware) were woven into the research, preventing me from asking certain questions, hearing certain information, and causing me to miss out on potential meanings and connections in my analysis. Through debriefing with other researchers, journaling, and consultation with mentors, I worked to avoid making assumptions that might have been associated with associated essentialist notions (Creswell & Miller, 2000; Cresswell & Poth, 2017; Lincoln & Guba, 1985).

An idea associated with credibility is truthfulness. Narrative analysis assumes it is possible for multiple points of view to be 'truthful', and as such is not intended to represent a single ahistorical truth. Therefore the normative question of the truthfulness, as a single possibility, is not pursued in narrative analysis. Instead the focus is on how the narrative is helpful in producing insights from narratives that others might relate to (Barbour, 2008; Clandinin & Connelly, 2000; Franzosi, 1998; Kong, Mahoney, & Plummer, 2003; Parton & O'Byrne, 2000; Polkinghorne, 2007; Riessman, 2002). Riessman (2013) explains:

> Verification of the 'facts' of lives is less salient than understanding the changing meanings of events for the individuals involved, and how these, in turn, are located in history and culture. (p. 182)

If a participant told a story that differed from another's version there was still useful information to be had. As the researcher I considered how the participant came to tell the

story this way; what information was added, left out, or changed; and what this represented in terms of meaning making and understandings (Brown, 2012). Indeed, stories that varied greatly from each other were also an important aspect of credibility (Creswell & Poth, 2017). Using the researcher's lens, Creswell and Poth (2017) explain that negative case analysis involves identifying stories and themes that conflict with the main findings, recognizing that not all data will fit neatly into specific codes or themes. For example, in this study, the story of "angels among us" contributed to the credibility of this study, serving as a counter-story to the stories of participants being marginalized in the birth experience.

While feminist narrative research is not concerned with discovering an ultimate truth, it still retains a requirement that its findings are not fabricated and disconnected from any sense of collective reality. For this study, an audit trail including transcripts, tables for data analysis, and all drafts of analysis have been created and kept so that the veracity of the data can be evaluated (Creswell & Poth, 2017).

Transferability

Transferability refers to how the findings of the study are described in rich detail, so that the reader/reviewer may decide if the information provided might apply in different contexts (Creswell & Poth, 2017; Given & Saumure, 2008; Lincoln & Guba, 1985). This is different from the idea of generalizability where the goal is to extend and apply the findings of the research to a broader population, which is not a concern of this type of research, and the focus was generating and reporting on depth over breath of detail in context (Bold, 2012; Given & Saumure, 2008; Padgett, 2008; Polkinghorne, 2005). Instead, issues such as the study's capability to "stimulate thought, improve

practices and policies, and incite further research" are measures of success with respect to transferability (Padgett, 2008, p. 183). To build in transferability I endeavoured to do two things: first, I generated and reported rich thick descriptions of the findings in context so the reader/reviewer can evaluate if the findings and recommendations are sufficiently similar to another context; second, I provided a transparent description of how the participants were recruited to maximize the range of information about distress and childbirth that can be obtained from and about a specific historical and geographic context by purposely selecting locations and informants that differ. I did not strive for representativeness but for sufficient diversity to allow for transferability (Creswell & Poth, 2017).

Confirmability

Padgett (2008) explains, "confirmability is achieved by demonstrating that the study's finding were not imagined or concocted but, rather, firmly linked to the data" (p. 181). In addition to providing an audit trail as discussed above, in assessing confirmability it is necessary that all findings match the data and that all claims can be supported by the data (Given & Saumure, 2008; Polkinghorne, 2005). Sensitivity to addressing confirmability requires an awareness of the risk of shaping the conversation, and the resulting narrative text, in a way that reflects the researcher's interests and biases, and is linked again with the researcher's reflexivity (Creswell, & Poth, 2017). It is necessary, using the researcher's lens, that I outline to the reader what approach to interpretation I took throughout the project. In line with feminist approaches, I believe that as a researcher I can never step outside of my own perspective and its associated biases and knowledge gaps. While I may always be working to become increasingly more

aware of the biases and fill these gaps, I believe that I will never "transcend [my own] historical and situated embeddedness: thus textual interpretations are always perspectival" (Polkinghorne, 2007, p. 483). As the researcher, I mitigated this threat to confirmability by reminding myself, and my participants, that the participants have sole access to their experiences and the meanings they associate with their experiences (Polkinghorne, 2007). For example, statements checking-in with participants to confirm understanding and meaning and acknowledging there is a risk of shaping the conversation were steps I took to address confirmability. Debriefing with my supervisor and appropriate committee members also served as a mechanism for ensuring that the interpretation was not straying far afield from the text (Creswell & Poth, 2017; Lincoln & Guba, 1985).

Because a researcher using narrative analysis makes claims based upon textual evidence, as stated above, I have attempted to clearly articulate to the reader what assumptions I made about the nature of the narratives and their textual representations (Polkinghorne, 2007). This means that I have articulated to the reader that I do not view narratives as a representation of absolute truths, but rather as a co-constructed telling and interpretation of an important experience (Bold, 2012; Clandinin, 2013; Pinnegar & Daynes, 2007). The transparency required for confirmability is also of central importance in evaluating the dependability of the research project.

Dependability

Dependability refers to how the research procedures are documented and traceable (Given & Saumure, 2008; Padgett, 2008). As mentioned above, and in order to assist with maintaining transparency required for addressing dependability and confirmability, I created an audit trail, documenting each step taken in the data collection and analysis,

including raw data, field notes, memos, and the coding used in my analysis (Creswell &

Miller, 2000; Lincoln & Guba, 1985; Padgett, 2008). I have been transparent in

explaining my decisions and the steps taken behind the specific choices made in my

research, for example, how and why certain narratives were chosen as representative

narratives. It is important that, as the researcher, I present an accurate and full description

of the experience being studied (Given & Saumure, 2008).

This chapter explored the feminist narrative inquiry and analysis methodology that

was used in this study and outlined the means for evaluating the research design. The

following chapter outlines the methods I employed in generating and preparing the data

for analysis using this methodology.

CHAPTER 5

DATA GENERATION AND ANALYSIS

This chapter outlines the operational details of the research beginning with recruitment, following with data collection and data preparation, and concluding with the methods used for interpreting the data.

Data Collection

Recruitment

As discussed in Chapter 3, much of the research on the topic of childbirth-related distress excludes many participants whose life experiences may contribute to distress. Thus, it was important for me to have broad inclusion criteria in my recruitment. I recruited participants who had given birth within the last year, were at least 16 years of age at the time of conception, spoke English, and were able to provide their own consent. This time frame allowed participants to reflect on their recent experiences with relatively fresh recollections, while permitting comparisons to be made between narratives occurring within a specific time frame. As the focus of the project was not the people/participants, but the experience of distress in childbirth, purposive selection was used to seek out participants who could provide details of a variety of experiences in childbirth[15] (Polkinghorne, 2005). While the criteria for inclusion in this study was that the participant had given birth in the last year, once they began telling their stories many women included previous pregnancy and birth experiences as well. A feminist narrative

---

[15] The recruitment methods used were not specific to feminist narrative inquiry and analysis, but are common methods for finding participants for various qualitative approaches (Polkinghorne, 2005).

approach minimizes the constraints placed on the stories the participants choose to tell as the participants are trusted to decide for themselves what is important to be included or excluded from the interview (Barbour, 2008; Hydén, 2013; Riessman, 2002; Squire, 2013). Thus these stories are also included in the data and analysis.

I sought out various experiences across social locations, as well as various types of birth (types of birth includes such conditions as hospital birth, home birth, midwife assisted, physician assisted, vaginal, caesarean, and other factors that affect the birth experience). As I wanted to obtain in-depth stories about each person's childbirth experience, it was important that I recruited participants who were comfortable engaging in in-depth conversational processes and who were motivated and interested in the project (Hole, 2004).

I began with recruitment through one particular family resource centre and then expanded recruitment sites to broaden representation among participants with no expectation that my sample would be representative of the population individuals birthing in Atlantic Canada. Participants were recruited from various sites including community organizations such as health care services, family resource centres, and doula organizations; community groups representing specific racial and ethnic communities, including four agencies that provide services to Indigenous women; local informal parent and infant play groups; and through word of mouth referrals among participants and among those who became aware of my research through other means. Representatives from these organizations (and those who made informal word of mouth referrals) were given an "Invitation to Participate" letter regarding the project that included my contact information (Appendix B). Personnel at the partnering agencies provided this information

to all potential participants. Potential participants were then able to contact me directly

regarding their interest in becoming involved as participants in this project. The staff at

partner organizations did not know who may or may not have decided to participate

unless the participants themselves disclosed this information. I also attended several

gatherings of potential participants (such as a new parents group) in order to describe this

study and answer questions of potential participants. When I attended these gatherings I

left behind the Invitation to Participate letter so that individuals could contact me directly.

Participants were provided with my cell phone number, which was password

protected and had password protected voice mail, as well as my email addresses. My cell

phone had an answering message asking potential participants to leave their contact

information and a convenient time for me to contact them. I returned potential

participants calls and responses to email inquiries. I provided a brief overview of the

research via email (Appendix D), which I asked the potential participant to review. I then

called back or emailed within a few days to see if they remained interested in the

research. One potential participant decided she did not meet the criteria of the study and

two potential participants did not respond to my follow up email. All other potential

participants who were contacted continued to express interest, and so a mutually agreed

upon time and location was arranged for the interviews.

Fifteen people participated this study. This number of participants allowed for a

balance between a number of participants that was neither too large nor too small. The

selection represented a diversity of experiences and allowed a thick and rich exploration

of various influences on childbirth experiences, while at the same time it was small

enough for detailed microanalysis required in narrative approaches, and accommodated

the pragmatic considerations of the research (such as time, expense, and travel) (Creswell, Hanson, Plano, & Morales, 2007; Polkinghorne, 2005; Riessman, 2002; Sandelowski, 1995; Squire, 2013).

Organizational Consent

Ethics approval was obtained through the Memorial University Interdisciplinary Committee on Ethics in Human Research (ICEHR). The ICEHR process required that I obtain specific and additional ethics approval from any agency that required its own ethics approval in order to take part in research with their organization (Memorial University of Newfoundland [MUN], 2015). Thus I also sought and received approval from the Nova Scotia Health Authority Research Ethics Board (in order to partner with Nova Scotia Health for recruitment). Additionally I sought and received informal approval of the directors and/or organizers from the other agencies and organizations who were involved in recruitment.

Participant Informed Consent

During the face-to-face interviews, prior to the commencement of the interview, and before the turning on the audio recorder, I once again explained the intent and expectations of the project to the potential participants. At that time they were reminded that participation was voluntary and confidential. All participants had read Information Letter previously sent to them. I read aloud the Informed Consent Form (Appendix E) and answered all participants' questions.

Privacy and Confidentiality

Discussions regarding privacy were part of the consent process. Steps were taken to ensure that the privacy and confidentiality of participants was maximized through

secure data storage, use of pseudonyms, changing or excluding potentially identifying data, and meeting with participants in locations which were private, such as their own home (Josselson, 2007). Legal limits to confidentiality were also discussed at the outset of the interviews, such as my status as a mandated reporter of suspected abuse of children, and my commitment to take steps to ensure safety of anyone who may be expressing intention of lethal self-injury (Josselson, 2007).

Interviews

Interviews were carried out in the participant's home with the following exceptions: one participant wanted to meet at her local family resources centre where private space was provided, one participant met at my home, another met at her workplace in a private office, and one participant met with me at my workplace in my private office as she had requested. When we met at participants' homes there were either no other adults or older children present or we met in a room apart from others who were home. Due to the nature of the topic, participants' babies were often with them during the interviews, either nursing, eating, napping, or quietly playing while the interview unfolded. Interruptions to address the babies' needs were frequent, and the recorder was left running through these interruptions. Participants continued to tell their stories while attending to their babies. Each interview was recorded and transcribed. All participants chose a unique pseudonym for me to use in representing their interviews.

Interviews and their resultant transcripts served as the data for this research study. In this feminist narrative research the questions asked and the direction of the narratives were left open, with the goal of discovery and to allow unanticipated topics and discussions to emerge unencumbered by a strict interview schedule (Barbour, 2008;

Hydén, 2013; Riessman, 2002; Squire, 2013).[16] However, in order to support a reasonable

level of focus during the interviews, I made use of a self-created interview guide

(Appendix F) which was used to investigate what messages and assumptions people had

entering childbirth; to understand what these messages and assumptions reflected about

dominant understandings of childbirth; to explore how participants' own experiences

agreed with and challenged these assumptions; as well as to elicit what subjugated

knowledges participants expressed and saw as important additions to knowledge about

childbirth (Arvay, 2003).

Each interview began with the prompt, *"Please tell me your birth story"* and

follow-up questions were used (if the topic did not emerge unprompted) to probe for

further detail and deeper understanding. For example, the following prompts and

questions were often used to explore ideas that were raised or were absent in the

participants' childbirth stories:

What was giving birth like for you—consider physical, emotional, social, spiritual

aspects of childbirth?

How was childbirth like you expected? How was childbirth different than you

expected it to be?

Describe some of your family traditions, cultural traditions, and/or religious

beliefs about birth and how they influenced your expectations.

In what ways, if any, did you feel good, positive, or satisfied about your birth

---

[16] Very specific, predetermined questions run the risk of closing off areas of inquiry that
may emerge, as the researcher may become more focused on answering her question
rather than discovering a subjective truth (Barbour, 2008).

experience? In what ways, if any, did you feel poorly, negatively, or distressed by your birth experience?

Do you have any advice or messages you would give to those who are going to experience labour and delivery?

The interviews also served as the beginning of analysis (Riessman & Quinney, 2005). In the feminist narrative approach, interviewing is about more than asking questions and gathering information. It requires the researcher to be aware and conscious of her role in the construction of the narrative as all narratives are seen as co-constructions where the shape and content of the narrative involves the teller, the listener, and the interaction between the two (Clandinin, 2013; Clandinin & Connelly, 2000; Davis, 2002; Guba & Lincoln, 2004; Hole, 2004; Huisman, 2008; Hydén, 2013; Pinnegar & Daynes, 2007; Riessman, 2008; Riessman & Quinney, 2005; Squire, 2013). Thus, telling and hearing the story was the first step in the co-construction and interpretation of the narrative.

Feminist narrative researchers believe that storytelling is a process of co-construction, where stories are woven within the interaction of telling, listening, and conversation, rather than a representation of truth through the recounting of a specific time or event (Hydén, 2013; Patterson, 2013; Pinnegar & Daynes, 2007) and it is essential to be aware that the researcher, to a large extent, structures the interview. There is a risk that the researcher will structure the interview in such a way as to have the participants tell a particular story and so a commitment to reflexivity as a researcher was also essential. I have chosen to discuss my process as one of reflexivity rather than using the common qualitative terminology and process of bracketing.

While the idea of bracketing originated within phenomenology, where researchers were called upon to put aside and look beyond their preconceived notions, it has more recently become a term open to various interpretations and applications across a variety of qualitative methodologies[17] (Tufford & Newman, 2012). One of the controversies regarding bracketing is premised on the question of whether researchers can ever truly set aside their own preconceptions (Tufford & Newman, 2012) and this is a premise for which I too have some skepticism. Thus, I feel it is more in line with my own ideas of subjectivity and bias to be clear in my research that I have reflected deeply and frequently on the research process—to question how I might be influencing the interviews (not to deny that I have an influence) and to do my best to be fair in my analysis—without leading the reader to believe that I have removed myself from the research process. This reflexive stance is in line with the feminist narrative methodology that views stories as co-constructions of events and understandings, rather than as one-sided tellings of events (H. Fraser, 2004; Riessman, 2008).

In keeping this reflexive stance, I needed to be aware of my own assumptions, values, beliefs, and experiences and be mindful of how my own history and interests might influence the questions I asked and how I interpreted the responses (Burck, 2005; Tufford & Newman, 2012). Thus, how I asked questions, listened for responses, and interacted with the participants was of central importance (Burck, 2005; Polkinghorne,

---

[17] This includes disagreement regarding what bracketing should include (beliefs, values, assumptions), when bracketing should occur (before interacting with participants, during the interview and/or analysis phases), who is included in the bracketing (researcher, participant, or both), and the methods of bracketing (memo writing, interviews with colleagues, reflexive journaling) (Tufford & Newman, 2012).

2007). One way I reduced the shaping as the researcher, was to ask probing questions that searched for deeper meanings behind words that might have reflected taken-for-granted ideas and prevailing theories (K. Anderson et al., 2004; Brown, 2012) rather than seeking a particular truth (Burck, 2005), or assuming an understanding that fit with my own experience. For example, ideas about being "hormonal" or "too emotional", and the phrase "power struggles" were ideas and concepts that entered into various participants' telling of their stories, and that I explored in greater depth during the interviews.

Additionally, if I wanted to explore a topic raised by the participant that may have touched on some preconceived ideas I had (either through my own experience, reading, or interviews with the participants) I would preface the question with a disclosure regarding why I was following up. For example, at times I would say, "this is an idea that keeps coming up with other women (or in the childbirth literature) and I'm wondering what you have to say about this idea." Similarly, if a topic was of particular interest to me, given my own philosophical and theoretical position, I would make this overt as well, before asking follow-up questions. Both silence and questions act to shape what is discussed in the interview. No decision is neutral and so I chose to act on the principle of transparency and reflexivity with the participants and in the analysis.

Emotion and curiosity work together in the co-construction of narratives. Accordingly the listening should occur not only on a cognitive level, but on an emotional level as well. Thus, I attended to my own internal emotional experience and my thoughts about what the participants were saying during the interviews (Davis, 2002; H. Fraser, 2004; Harrison, MacGibbon, & Morton, 2001; Hole, 2004; Josselson, 2007). The emotions communicated by the participants and elicited through the interview were seen

97

as important sources of embodied knowledge which pointed to areas of information and possible future conversation and analysis (K. Anderson et al., 2004; Bold, 2012; H. Fraser, 2004). It was important that I paid attention to not only what happened in the narrative, but also to how the participants felt about it—what emotions they experienced at a particular time, and the emotions that were elicited in the telling (K. Anderson et al., 2004).

In addition to paying attention to what participants said, it was also important that I paid attention to what participants did not say—what they left out, or expressed difficulty articulating (Alvesson & Sköldberg, 2009; Best, 2003; Brown, 2012; Hydén, 2013; Squire, 2013). Participants' questions such as, "You know what I mean?" frequently occurred, and I treated these not only as seeking validation of understanding, but also as a signal of things that were difficult to articulate due to the inability of language to reflect subtleties of experiences (Devault, 1990). Hesitations and confirming questions also served as a sign that what was being said was important—the fact that participants made the concerted effort to ensure understanding meant something important was being communicated (Best, 2003).

Field notes and a journal were kept during all stages of the research project. In this journal I made notes during the interview, as I was listening to participants' stories, noting ideas and statements for further discussion. Often times, sometimes quite some time after the interview, I would think of how a particular idea or moment in the interview was linked to the existing literature on childbirth (either agreeing or contesting it), linked to other participants' experiences (again through both similarities and differences), and to the conceptual framework which undergirds this research. I noted

these moments of insight in the field journal and referred back to them frequently during the interview and analysis phase of the research. These journal notes and reflections also informed my analysis and the findings of this research.

Preparing the Data for Analysis

Transcripts and Member Checking

Interview recordings were given to a hired transcriber who transferred the interviews from an audio file into a word processing document. These new documents were returned to me as unedited, unformatted text, consisting of large blocks of text with only basic punctuation. I proceeded to edit these documents in order to create the final transcripts.

Transcribing is in itself a form of interpretation as the researcher makes decisions about what to select and omit from the transcript, and this is also the point where the researcher may start to notice themes emerging or ideas becoming clearer (H. Fraser, 2004; Hole, 2004; McCance et al., 2001; Polkinghorne, 2005; Riessman, 2002, 2013; C. P. Smith, 2000). Transcription includes not only what is spoken, but also how it is spoken (for example, using italics to indicate emphasis, and including symbols representing pauses and breaks in conversation)(Hole, 2004). Therefore, due to the importance of the nuances of the interview that may be included or excluded based on the decisions of the researcher, I worked to refine the transcriptions by editing the transcripts while listening to the original interviews, and made the final decision regarding what to include and exclude from the transcript. At this stage attention was paid to the nuances of the narrative, including paraverbal utterances and sounds, pauses, and incomplete sentences (H. Fraser, 2004; Riessman, 2002, 2013).

The transcript was formatted to reflect the flow of speech, where each phrase or clause was given its own line, so that the final transcript looked more like a poem rather than prose (H. Fraser, 2004; Riessman, 2013). Sentences did not always end neatly, instead often merging into new ideas. The punctuation I used in the final transcripts reflects this manner of speaking, where it might seem as if a period is missing, but to add a period (or other grammatically correct punctuation) would not reflect the style of speech the participant demonstrated. At this stage, any names that were included in the interviews were removed and replaced with the participants' chosen pseudonyms or with generic titles (for example, husbands' names were replaced with [husband]).

Participants were offered the opportunity to assess the accuracy of the transcriptions and provide feedback (Borland, 2004; H. Fraser, 2004; Polkinghorne, 2007; Riessman, 2002). Seven participants provided feedback on the transcripts, and the remaining eight did not respond to my offer. The feedback provided indicated that the participants were satisfied with the decisions made during the transcription process as no significant changes were requested. Any minor changes requested by the participants were incorporated in my endeavor to have the written narratives reflect the stories the participants desired to tell. The participants who did not provide feedback on the transcripts may have chosen not to review the transcriptions for many reasons, for example perhaps the time and energy commitment required or the potential discomfort with revisiting difficult material acted as barriers to reviewing the materials (H. Fraser, 2004).

Finding the Stories

Using the word processing documents that were prepared in the previous step, the long transcriptions were broken into specific stories or narrative segments to aid the analysis and divisions of the narrative into sets of ideas (H. Fraser, 2004; Riessman, 2013). Every interview contained multiple stories which sometimes had clear boundaries, with obvious beginnings and endings, and which sometimes were more difficult to tease out (Blix, Hamran, & Normann, 2013; Riessman, 2013). It was therefore important in this gathering of narratives that I exercised caution as to not "prune out moments of excess, ambiguity and multivocality within people's stories" (Chadwick, 2014, p. 49; see also Riessman, 2013). I paid attention to the silences, breaks, laughter, humour, pauses, false starts, and uncertainties in the narratives, as these were often the sites that represent the emergence of counter-narratives.

In order to make the individual stories easier to find within the large transcripts, each story segment was marked, in highlighted text, with "Story starts" and "Story ends" and this process was repeated for the entirety of each transcript. I then assigned each story a name based on the main message of the story. Sometimes the name was a theme, and other times the story was named using the direct words of the participant (for example, the title for the story "A Checklist Would be Nice" was lifted directly from the participant's interview)(H. Fraser, 2004).

Next, I created a spreadsheet notebook for each interview, titled with the participant's pseudonym. The entire edited transcript was cut and pasted into one page of this spreadsheet and numbers were added to each line. Each individual story within the transcript was assigned its own page within the notebook, and each of these pages in the

101

notebook was identified by the story's name. The lines of these stories were also assigned a number. In the end there were 15 notebooks (one for each interview) and the number of pages within each notebook (each page representing a story) ranged from seven to 19. These became my source of data. Each story was then cut and pasted back into a word processing document for ease of analysis, as the word processing software was more useful for marking up and inserting notes and comments.

A summary analysis was completed for each interview and this analysis was sent to any participant who had provided feedback on the initial transcript, with the invitation to provide further feedback on the analysis. Four participants provided feedback on the analyses and any feedback was incorporated into the final work. All feedback provided was minor, for example, requesting changes in wording or clarifying details and timelines.

Interpreting the Data

Interpreting the Stories

In the interpretation stage, specific types of stories, themes, and contradictions were identified. An examination of the structure of the narratives was undertaken by considering how each story was told (Andrews, 2013). Fraser (2004) and Riessman (2013) explain that narratives may be linear (with a beginning, middle, and resolved ending), or circular (ending back where it began without a sense of resolution), and they may be thematically organized rather than temporarily organized. Stories may also seem to have been rehearsed and familiar, or seem unsure and novel, appearing to have developed in an uncertain way through the telling (Clandinin & Connelly, 2000; H.

Fraser, 2004). Thus, how the stories were structured became part of the analysis and findings.

Additionally, individual narratives were analyzed across different domains of experience. Because feminist researchers believe that research is one way that the personal and the political are linked, this approach to research seeks a balance between individualized understandings and broader social and structural issues related to everyday life and oppression (Fraser, 2004). Thus, in analyzing the narrative segments I deliberately searched for a various domains of understanding representing a broad spectrum ranging from micro to macro level areas of exploration and interest. These included intrapersonal experience (self-talk, mind/bodily experiences), interpersonal experience (those segments that involve others, e.g. "I told her…"), across and within culture[18] (ideas related to folklore, popular culture, and common sense), and structural/institutional domains (references to laws; social systems, such as healthcare systems or legal systems; and issues of gender, class, and race) (H. Fraser, 2004; Pamphilon, 1999; Riessman, 2012). Colour coding was used to identify any domains reflected in the stories. For example, text which represented the interpersonal domain was highlighted in red; blue was used to indicated the structural domain, and so forth.

---

[18] Culture here includes but is not limited to ethnicity. While ethnicity may be part of culture, or have an influence culture, culture is also understood to include customs and practices, the taken-for-granted ideas and knowledges that individuals (and groups) hold, shared values and beliefs, and the ideas and rules that govern interactions with the self and the world (Hair & O'Donoghue, 2009). It is further understood that culture is not a static unchanging force, but is constructed, dynamic, and variable among those who identify as and with cultural groups. How culture is experienced will vary according to the various intersecting identities of the participant (Hair & O'Donoghue, 2009).

Themes also emerged from the data that I found difficult to categorize in any of these areas. Such thematic eruptions were considered for their uniqueness and for their commonalties (H. Fraser, 2004). In this way, this feminist narrative approach seeks to deliberately focus analysis on specific sites and domains, while allowing the research to remain flexible and open to whatever places the data calls upon the researcher to explore and consider.

The goal of feminist narrative inquiry and analysis is not to find universally generalizable themes and understandings of experience; by maintaining that there are multiple situated truths, we can see that the story of each individual participant can provide insight and understanding about experiences of distress in childbirth (Bold, 2012; Chadwick, 2014; Clandinin & Caine, 2013; Connelly & Clandinin, 1990; Hole, 2004; Pinnegar & Daynes, 2007; Riessman, 2002). And yet, it is worth considering that patterns among narratives may emerge that deserve further exploration (Clandinin & Connelly, 2000; H. Fraser, 2004; Mishler, 1995; Polkinghorne, 2005). Thus after each individual interview narrative and its sub-stories were analyzed, a similar analysis was undertaken across narratives in order to identify any commonalities and differences among participants (Clandinin & Connelly, 2000; H. Fraser, 2004).

Narratives with similar plots were clustered together for analysis. From these clusters certain narratives were chosen for further, more detailed analysis. Particular narratives were chosen for their ability to illustrate how participants interact with and are affected by dominant discourse; to demonstrate how ideas and behaviours are reproduced; to highlight assumptions and how these affect experiences; to provide new information about discourses; and to keep a critical perspective—that is, stories that illustrated the

material reality of oppression (H. Fraser, 2004; McCance et al., 2001). A file was created for each emerging theme and appropriate narrative segments from the interviews were cut and pasted into the new document. From these new files, specific sections of the interviews were chosen to reflect and represent the findings. My reasoning for each decision was noted and is reflected in the findings section of this research (Fraser, 2004).

Writing

Finally, I wrote the academic narrative analysis of the stories, which this work represents. There were multiple possibilities for how the stories could be represented (Clandinin & Connelly, 2000; H. Fraser, 2004). In this process I continued to check my written analysis against the original stories and against the objective of the research to be sure my analysis was reflective, fair, and relevant (H. Fraser, 2004). As a researcher who is committed to reciprocity, writing the narrative analysis also involves sharing the knowledge in a meaningful way (Harrison et al., 2001). As I moved forward in the research process this involved providing access to the written academic work, as well creating and providing other means of sharing the knowledge gained, as requested by the participants and communities with which I am now involved.

In the conceptual framework of this work, I discussed the importance of the relationship between language and gender and the interplay of the two. I chose to use the term individuals instead of women earlier in this work in order to recognize that people of various genders give birth. However, as I now move forward into the findings of this research it is important to shift my language again.

For all of those who participated in this research, the issue of gender never arose, other than in discussions that assumed a gender as female/woman. Thus, this study is a

study about women who gave birth. I do not use the language of "cis women" because that was not how the participants identified themselves. While it may be that in future iterations of this research, it will become more common for women who give birth to self-identify as cis women, this was not the case for this research project. I state this not to erase or exclude transwomen as part of the world of women, but to honour the identity that those who participated in the research used to make meaning of their own gendered experience.

CHAPTER 6

INTERPRETATION AND DISCUSSION OF THE FINDINGS: THEMES

RELATED TO CORE CONCEPTS

The following three chapters explore the findings of this research. In Chapter 6 and 7, I discuss how the participants' narratives interact with the conceptual framework that undergirds this work. In Chapter 6, I explore how issues of discourse, power/knowledge, agency, and the interaction between these three concepts are reflected in the participants' narratives. In the following chapter, I focus on the concepts of the body, gender and intersections of identity, distress and emotion, and childbirth narratives that emerged in the stories the women told. In Chapter 8 I attend to the themes that emerged organically in the women's stories through their telling, including emotional labour, breastfeeding, difficulties experienced in decision making, and advice for other women and professionals.

Each theme was reflected in many (sometimes all) of the participants' stories, and yet to include an excerpt from each story for each topic would result in an unwieldy and overwhelming collection of narratives. Thus, particular stories are chosen as illustrations and the criteria for choosing each story is shared. It was important that each participant be reflected in this work, in her own words, and so at least one story has been chosen from each participant as illustrative of the topic of discussion. The decisions regarding which stories to share were not easily made. I want(ed) to honour the complexity and personal sharing inherent in each woman's story, however the nature of this research methodology

requires a compartmentalizing, a chopping up of stories so that they can be more easily consumed by the reader.

In the process of carrying out this research I have often thought of J. K. Rowling's work of fiction about Harry Potter. In the Harry Potter novels, Harry's mentor Dumbledore has a magical tool called the Pensieve. Dumbledore places his wand to the (participant's) temple and pulls his wand back, bringing with it a long silvery thread that contains the (participant's) memory, which he then places in a magic bowl—the Pensieve. Using this magic bowl Dumbledore can enter a memory and see the experience for himself. He does not experience it as lived, but yet he experiences it as more than simply a story. It is an interactive way to inhabit a story while remaining apart from it so that he can learn from the memory. I often felt like Dumbledore—taking memories, interacting with someone else's stories, and using them for my own purposes. Dumbledore seemed to treat these memories as valuable and precious. And I too see these stories as valuable and precious. Thus, my struggle with choosing particular stories, and taking these stories apart to be shared and experienced differently than perhaps the participants may have experienced them. It, at times, felt sacrilegious.

Participant Demographics

Fifteen women participated in this research project. Their ages ranged from 18 to 43 years old. The women came from a variety of regions across Atlantic Canada, including rural communities, small towns, suburban communities, and urban centres. All women gave birth in hospitals. Five participants had a pre-existing mental health diagnosis (depression or anxiety) that they disclosed to me during the interviews. Nine participants had had older children and/or pregnancies that they mentioned, and six

participants were involved with this project as a result of their first pregnancy[19]. All participants were in coupled relationships. Fourteen are in heterosexual relationships, and one participant is in a same sex marriage. Participants described themselves as ranging from poor to middleclass. All participants identified as White.

The lack of racial diversity among this group of women is disappointing. While I recruited broadly and included many agencies providing services to racialized groups, only White women responded to call for participants. However, through my recruitment efforts and follow up calls I was informed several times that many of the local racial minority communities were suffering from "research fatigue"; an effect of living in a relatively small geographic area with many universities and other research organizations all vying for their information. This research fatigue might be associated with the very nature of this project. While White women have a history of being viewed as idealized objects who are the weak/passive vessels that need to be "delivered of" their babies, and who now perhaps want to be seen as central and express agency in "delivering" their babies, the history of reproduction and research into reproduction has been different for racialized women (Ross & Solinger, 2017). It is fair to assume racialized women have been even more aware of the surveillance and control upon their bodies and the pathologizing of reproduction through violent social process such as eugenics, forced sterilization, and the removal of their children (Ross & Solinger, 2017). Perhaps many women of colour want researchers to leave them alone. Perhaps more attention from

---

[19] It is possible that some of these participants had previous pregnancies that they did not disclose to me.

109

researchers and medical practitioners and social workers is not seen as likely to be helpful given the specific histories of their communities. This research project is implicated in the problematic tokenization of racialized people as participants in order to claim diversity in research studies. And so while this research represents diversity across many types of birth experiences, and across many social locations, it is a study that will not represent racial diversity.

Main Findings Relating to the Conceptual Framework

The following results represent examples of how the core concepts that underlie this research showed up in the participants' narratives. There were not always clear distinctions among the various topics discussed below, and often concepts inform each other and intermingle in the stories the women told. However, the following draws attention to how these ideas such as power/knowledge, gender, and emotion shaped the stories women told about their birth experiences and the birth experiences themselves.

Discourse

Foucault's (1972, 1977e) discourse is helpful in illuminating how certain ideas about childbirth and motherhood become dominant, while taken for granted assumptions about birth and motherhood remain unexamined and unexplored. In the following examples I explore the discursive constructions of "good mothering" and how this discourse influences women's view of themselves and their behaviour. In the stories the participants told, being a good mother was sometimes at odds with being a good patient or healthcare user, and women were expected to navigate this minefield of expectations. I also explore the gendered discourses that construct women who display certain emotions and behaviours as overly dramatic and divas. Finally, this section demonstrates how

pregnant women were discursively constructed as heterosexual and explore how disrupting this view of women was associated with continuous efforts to be fully seen.

Good mothers. Nicole was 18 years old when she became pregnant for the second time. Her first pregnancy had ended in a miscarriage, and so she and her partner were excited when they discovered she was once again pregnant. Nicole enjoyed her pregnancy and felt good about her delivery. However, very soon after delivering her baby, Nicole began to experience difficulties that would stay with her until the present day. Nicole saw her early difficulties with bonding and with breastfeeding as the beginning of her emotional struggles with being a new mother. Nicole continued to struggle with low mood, feelings of regret, and found herself less and less able to cope with the demands of caring for a new baby.

Three days after her discharge from the hospital, Nicole experienced a gallbladder attack causing severe physical pain. Nicole continued to find herself overwhelmed by her own health needs and caring for a new baby. She did not want to spend time with her baby and relied on her family and her partner's family to provide the baby's care. Nicole was referred to the local mental health clinic by her public health nurse and saw the crisis worker who attempted to provide supportive counselling to Nicole. However, Nicole's mood did not improve and she was referred to the maternal mental health program in the closest major city. However, due to some sort of mix up, and despite driving to and staying in the city, Nicole was never contacted by the specialty program. She eventually gave up trying to connect with them and returned home. Finally, feeling overwhelmed and seeking a way out of the permanence of motherhood, Nicole attempted to take her own life.

Nicole explained that the pressure placed on women to put the needs of their baby above their own (as evidenced in this case through pressure to breastfeed) contributed to her feeling overwhelmed and panicking at the idea of motherhood. This sense of being overwhelmed and trapped is what eventually led to her attempt to take her own life.

> I just felt that the nurses were trying to force me to do it.
> I understand everybody says, "Breast is the best" but to an extent.
> Whatever the child needs to eat, they are going to eat.
> I felt like I was letting my daughter down because I wasn't giving her what is called "the best."
> I felt like in the future she is going to have health problems because of it and… yeah.
>
> I believe that is what started to bring me down is that I felt like I was going to let her down
> And then getting home just knowing that I had this little bundle of pee and poop to take care of now,
> I didn't know what to do.
> Being a first time mom and being young, I expected it to be a breeze
> but the crying agitates me
> and it is much better now where my medication is kicking in.
>
> (Nicole, 178-191)

Despite Nicole's lack of an emotional connection with her daughter, and her plans to allow the baby to be adopted by her grandparents, Nicole continues to work to perform the emotional work of good motherhood, telling her child she loves her so as not to undermine her daughter's self-esteem,

> My mood. I used to get, like I said, I used to get very agitated with her
> and I would have to look at my boyfriend and tell him that he needed to take her because I had to go.
> She cries now and it doesn't bother me.
> I can feed her and change her and I talk to her now.
> I used to never talk to her.
> I tell her I love her.
>
> CMF: Do you?
>
> I don't [pause].

CMF: That's a tough one eh? It's tough to talk about openly and honestly.

It is a tough question because I have no feelings towards her
and I don't think I love her
but I feel like I have to tell her I do
because if she doesn't hear it then when she is older she is going to think
"Mommy doesn't love me."

CMF: You know it is important for a child to feel loved even if you don't feel the
love, that is what you are saying, is that fair?
I don't want to put words in your mouth.

That is perfectly fair.

<div align="right">(Nicole, 195-214)</div>

Nicole wondered if her outcome would be different if her poor, socially isolated,

and rural culture allowed for different parenting approaches. Nicole wants and plans to

continue to be involved in her daughter's life, even if she is adopted. However she cannot

take on parenting responsibilities. In her view of family the baby must be given away to

parents who can provide the care she needs. Dominant discursive constructions of family

that define it in the stereotypical nuclear family with mom, dad, and baby created barriers

to Nicole and her baby having a family system that would work better for both of them.

Indeed, it seemed as if Nicole's extended family was coming together to raise this baby in

a shared and extended way, with the grandparents assuming legal authority for the baby,

while Nicole remained involved. Nicole also wondered if a more flexible approach to

shared parenting might have eased some of her own emotional pain.

I don't think that I would be so down about the fact
that I feel like I have to have a bonding with my daughter
because I know that she would be around all of our family all the time.

I have felt so much failure.
Since the day she was home,

<div align="center">113</div>

I felt like I failed because of the not breastfeeding.

(Nicole, 313-314 & 318-320)

Nicole's story is a powerful illustration of the demands placed on women to sacrifice their needs for their baby's. Discursive constructions of good mothers link goodness with sacrifice (Chadwick, 2014; Lindemann, 2012; Ussher, 2006, 2010, 2011). And in Nicole's case she very nearly sacrificed herself in a very literal way. The pressure to subvert her needs as a young woman to the role and demands of good motherhood came at too high a cost for Nicole. And yet the guilt she experienced in her decision to allow her baby to be adopted was so strong that she felt she could not live with the pain of the guilt, remorse, shame, and fear that would now be associated with a lifetime of either mothering or not mothering. Participants in this study also shared stories of navigating the interaction between the desire to be both good mothers and good patients.

Good mother and good patient. Participants experienced difficulties navigating the demands required of being a good mother and a good patient. Birthing women are expected to be subservient to the medical staff involved in birth, and mothers are expected to be both subservient to the doctors caring for their children (Lindemann, 2012; Schiller, 2016b) and also to advocate for their children's needs. Garcia's story below serves as an example of how attempts to fulfill the requirements of good mothering are at odds with the demands of being a good patient. While good mothers sacrifice themselves and prioritize the needs of their children, good patients (good healthcare service users) do not create a burden on the system. Those mothers who require too much attention and demand too much care for their children are constructed as problems (A. Herman &

114

Jackson, 2010). Garcia felt this as she navigated the healthcare system with a high risk pregnancy and then a chronically sick infant.

Garcia had two previous pregnancies. She first became pregnant after taking fertility treatments. This pregnancy was lost in a miscarriage. She became pregnant again, but this pregnancy was lost due to a medical error. After the second pregnancy loss Garcia had weight loss surgery and eventually became pregnant without fertility treatment. Due to Garcia's previous pregnancy losses, she described herself as very anxious throughout much of the pregnancy, taking and retaking pregnancy test every day to ensure she had not miscarried; losing sleep worrying about her ability to have a healthy pregnancy; and seeking reassurance from her prenatal clinic that she and her pregnancy were fine.

Garcia had a difficult pregnancy with nausea made worse in part because of the weight loss surgery, which led her to further worry that there was something wrong with the pregnancy. An early ultrasound found an abnormality in the baby's gallbladder, which further worried Garcia, although eventually the problem fixed itself. However, between the time of the ultrasound that identified the problem and the ultrasound that reassured her it was fixed, Garcia spent considerable time and energy researching the possible causes and consequences of the abnormality. In her searching she found much information on the internet to cause her to worry. Garcia ended going off work early, five weeks prior to delivery, due to the baby sitting uncomfortably low in her pelvis and pushing on Garcia's already unnaturally small stomach.

Throughout much of Garcia's story she described feeling like she was unwelcome in the spaces where she was told she was supposed to be—like she was a bother. During

the final part of her pregnancy Garcia would go to the labour and delivery unit (after being sent by her doctor) to check her contractions, only to be sent home, feeling like the nursing staff were cold and unwelcoming.

> Even with the pregnancy,
> I would call my OB and he would send me to Labour and Delivery
> and I would get there and it's
> "You are here again".
>
> <div align="right">(Garcia, 495-498)</div>

Garcia felt similarly bothersome at her local emergency department. Since her birth Garcia's daughter has had numerous infections necessitating visits to the emergency department for after-hours care. Often Garcia felt like staff saw her as overreacting, or as irresponsible for bringing her baby so frequently.

> I feel like they think I am bothering them
> but I feel like I am there for legitimate reasons.
> She is sick.
> I don't go in for nothing.
> There is always a reason why I am there. I am not sure.
> Is it because I am there often.
> It is not because I chose to have a sick baby.
> I feel like I have been penalized because she has been ill.
>
> <div align="right">(Garcia, 483-490)</div>

Garcia was caught in the paradox of trying to do the right thing—to be a good mother means taking a sick baby to the hospital, but not too much, and apparently not every time she is sick. To be a good patient means to tell the doctor what you are experiencing and follow the doctor's orders, but not if it means going to labour and delivery when the nursing staff don't want you there. Garcia is not the only woman I interviewed forced to endure the stereotype of women as over-dramatic.

Women as over-dramatic. Participants were often able to read subtle and not so subtle indicators from health care staff that their behaviours were not appropriate. Women

116

often felt that if they were seen to be seeking help too frequently they would be viewed as overly dramatic. Being overly dramatic is a highly gendered notion, pointing to the ways in which women's emotions are discursively constructed as pathological. Being overly dramatic is associated with the old idea of hysteria (and the current idea of histrionic personality disorder). The gendered nature of these diagnoses is well documented (American Psychiatric Association & American Psychiatric Association, 2000; Chesler, 2005; Lindemann, 2012; McKenzie-Mohr & Lafrance, 2014; Ussher, 2011).

Carrie was 43 years old when she discovered she was pregnant. A year prior to her pregnancy, Carrie had an endometrial ablation, and was told by her doctor she would be unable to become pregnant. Her pregnancy came as a surprise to Carrie and her husband, as they already had two teenage children, however they welcomed the idea of adding to their family, and Carrie took as much care as she could to have a healthy pregnancy. Because of the procedure Carrie had done, her medical team was not sure how her body would respond to a pregnancy and so she was considered to have a high risk pregnancy and was thus monitored closely. Despite her age and the risk, Carrie had a healthy pregnancy. However, Carrie developed partial placenta previa (where the placenta partly blocks the cervix, creating a risk for hemorrhaging during birth) and a C-section was planned and scheduled for her delivery one week before her due date.

About two weeks before her scheduled C-section Carrie noticed bleeding and began to have regular contractions. She went to the hospital where she was checked out. At that time the medical team were not worried about the bleeding or contractions, although Carrie was less sure that everything was fine. She was worried that something was wrong with her pregnancy. As it would turned out, Carrie was correct. A few days

later she hemorrhaged suddenly and required a very dramatic emergency C-section.

Despite her (valid) concerns about her pregnancy Carrie understood that women who seek

reassurance and advice from medical staff run the risk of being constructed as

problematic within obstetrical care. Carrie was careful to seek reassurance only if she

absolutely needed it so that she would not be branded as a neurotic, overly dramatic

woman.

> I guess I felt like they didn't want me to stay.
> That is why I decided to leave.
> I do remembering thinking there was this other woman in the room across the hall from me…
> but I just remember that they seemed to think, the way they responded to her,
> that she was being overly dramatic.
> They didn't seem to think she needed to be there.
>
> (Carrie, 679-696)

This construction of help seeking as being overly dramatic came to reside in

Carrie and she began to wonder if she was acting irrationally. Foucault's (1977b, 1977f)

disciplinary power was at work here, causing Carrie to discipline herself and her own

behaviour through the invisible mechanisms of power that order not only pregnant

women's behaviour but even their view of themselves. Carrie understood what was

expected of her, without it ever being explicitly stated—she should leave the unit and not

bother the staff any more.

> So, I remember thinking maybe I don't need to be here.
> Maybe I am being overly dramatic because they did check me,
> I had the ultrasound that Friday.
> The obstetrician that done the internal
> and they were giving me the option to leave
> so I felt like maybe they wanted me to leave.
>
> Yes, sorta like you are inconveniencing.
> I think that is part of the way I am anyway.

I don't like to bother anybody.

<div style="text-align: right;">(Carrie, 697-702 & 720-722)</div>

Woman as diva. Related to the idea of being overly dramatic is the gendered notion of being a "diva." A diva is by definition a female operatic singer (Oxford English Dictionary, 2000). As opera is a dramatic performance, the connection between being too dramatic and being a diva are clear. It is also associated with prima donna, another word that has been taken from the stage to be used to describe overly dramatic and demanding women (Oxford English Dictionary, 2000). The term diva, in the stories the women tell, is used as a discursive weapon to regulate women's behaviour.

Charlie shared the stories of her two birth experiences. During her first delivery she felt ignored and not taken seriously. After about 36 hours of labouring along with frequent contractions, and two trips to the hospital where she was checked and sent home (in stormy weather, on bad roads, in the middle of the night), Charlie finally returned to the hospital for the last time. She was told again that because she was only 1 cm dilated she was not in labour. However, in an effort to speed things along the staff broke Charlie's water. Suddenly everything changed when there was meconium in the amniotic fluid. Where before Charlie had been ignored, she was now under the watchful eye of her labour and delivery nurse. Now that she was being noticed, she was noticed only to be mocked and made fun of. Despite the now pressured and tense situation, Charlie was accused of being a diva by the nurse caring for her while she was being induced to deliver her baby who was in distress.

> And then, I was lying there, just going through the contractions
> and she was like, she said, "I knew it",
> I was like, "Knew what?"
> She said, "You did put makeup on this morning, didn't you!"

<div style="text-align: center;">119</div>

I said, "No?"
She said, "You're lying, you did, you are one of those diva mothers."
And I was like, "I have eyelash extensions,
I don't know what you are talking about or why you are even saying this to me."
Then she also started talking to me about her friend who is a vet.
Because she said, "Oh I see here you are a vet."
And I was like, "Yeah."
And she said "Oh my friend is a vet too
and I always tease him about not being a real doctor."
I was like looking at her, is she seriously insulting me right now.

<div align="right">(Charlie, 278-289)</div>

One can only wonder about the nurse's intentions, but what she did was insult her patient's personal grooming practices and her profession. Being called a diva positioned Charlie in an inferior position, perhaps so she would not begin to act like a diva and begin insisting on having her needs listened to and met in the birth experience.

Because discursive practices so efficiently shape our behaviour, discursive weapons do not always need to be wielded by others. Morgan's story below indicates how these discourses become internalized in ways that people begin to order their own lives in ways that reinforce power (Foucault, 1977b, 1977d; Lindemann, 2012). Morgan's story reflects her use of both the over dramatic and diva discourses as she went about regulating her own behaviour in the labour and delivery room.

Morgan had a difficult childbirth after a difficult pregnancy. She had sudden complications with her pregnancy when her son's heart rate went dangerously low. She was rushed into the delivery room and was informed that her son's life was in immediate peril. Morgan, fearing for her own life as well as her son's, asked if she would survive the emergency C-section that was about to be performed. The nurse caring for her responded with "I don't know." Happily, both Morgan and her son survived the harrowing birth experience. Her son's heartbeat suddenly stabilized and she did not require the C-section.

Once her son's heartbeat stabilized, the situation changed and the team proceeded

with a routine approach to delivery. Morgan reflected on struggling to have her needs met

after the crisis had passed, during the now relatively calm delivery. As everyone involved

in her care seemed to go back to their usual business of delivering the baby, Morgan

wondered if she had imagined the crisis—if she was being dramatic.

> And nobody talks about it afterwards.
> Like nobody.
> It was weird because I kept trying to try and bring it up
> like to validate myself that I had just *been* through something
> and it is like they didn't even hear me.
>
> (Morgan, 526-530 & 535-538)

Once the crisis had passed and it was obvious her son was going to be fine she

began to wonder if maybe some of her other wishes and needs for her childbirth

experience could be honoured, but she was afraid to ask for fear of being seen as a diva.

> I did have some wishes and it was funny because we were laughing
> because when everything was okay, I am like,
> "Is it too late to say what my wishes are?"
>
> They were kind of joking because it sounded so superficial after just what had
> happened
> and I even said that.
> I said, "I kind of feel like I am being a little shallow here or whatever
> but I have certain wishes.
> Is it okay to ask for those?"
>
> There were certain things that I wanted,
> I wanted him on my chest this time because nobody gave me the option last time.
> I didn't even know that was an option,
> just cord milking and just some of those little things that I really wanted to do.
>
> Thank goodness I said something though
> but I was a little nervous to say something
> because I didn't want to seem like, I don't know,
> I don't know what the word is.
> I didn't want to seem silly, I guess, after everything that just, you know.
> I felt like a diva a little bit, you know what I mean?

A little bit like a diva.
Wow, God forbid you have some wishes after you almost just kicked the bucket, or thought you were going to kick the bucket. (laughter)

(Morgan, 605-607; 611-614; 630-633; & 641-648)

Morgan's story powerfully illustrates how discursive constructions of women's gender create a very narrow corridor of acceptable behaviour. Morgan's laughter in her recounting of this event, and her frustrated "God forbid" statement indicate that in the sharing of this story with me she was experiencing some anger, perhaps at the outrageous position in which she was placed and through humour she avoids being shunned as an angry women. She feared for her life, but she and her baby survived, and yet suddenly everyone was acting as if nothing dramatic had happened. Everything was back to normal. And yet, she was unsure if she could act normal and make a normal request or would that seem too diva-ish given the dramatic events of the past few moments. The frustration apparent in her telling of her experience is justified, signalling the unreasonable predicament she found herself in in the labour and delivery room.

Women as heterosexual. All of the participants were in heterosexual relationships except for Sally who was married to her female partner. As a same sex couple Sally and her wife created ruptures in the discursive constructions of pregnant women as heterosexual and in partnership with men. The couple had undergone IVF treatments and had conceived twins. The couple decided that Sally would be the one to carry the pregnancy but Sally described the pregnancy and birth as a shared experience frequently using "we" language in her childbirth story.

We are a couple.
She is Momma-C, is what we call her when we are referring to her in front of the girls.

122

They may choose to call her something else but yeah, she is their other mother.
We are partners in everything.
Yeah, if people call us partners or whatever, we don't…
But when I am referring to her, I do call her my wife.

I think it is the closeness of [Wife] and I that to me,
it is a journey that we took together,
that we decided to get pregnant and she has been so supportive all along the way.
She never missed a prenatal appointment so it is very much,
we decided to have these babies so it is not all about me I guess.
But I think that sometimes because she is a female that it is easier when I refer to
us that it is a we.
We are a partnership and that it is not …
Even though I did the physical part of having the babies it was still a very
conscious decision for us to have them together.

(Sally, 247-252 & 260-267)

Sally's story demonstrates how dominant ideas of gender are linked with

sexuality. In dominant discourse "woman" is assumed to be heterosexual and thus Sally's

experience as a lesbian (her description) and her wife's experience as a birth partner were

consistently ignored, erased, and made invisible. This pattern of erasure followed Sally

through her entire pre and postnatal experience, including the birth itself. From being

asked her husband's name at the first call to book an appointment, to consistently

asserting her wife's next of kin status as 'wife' and not 'friend' at each check-in, to being

asked who would cut the cord, to her wife not being offered the same skin-to-skin contact

a male partner would be offered (and which they had specifically requested in their

ignored birth plan), to needing to justify the non-issue of contraception after birth, Sally

and her wife's status as a 'real' married couple and the rights and authority granted to

different sex couples were denied.

The message that their relationship was not as valid as that of a heterosexual

couple began very early in the pregnancy.

So we knew right at eight weeks that we were having twins.
So I knew there was no point in me seeing just a regular family doctor.
The [receptionist] was very negative and "Oh, you had that done, well you will need to have a referral done."
And she asked me several times what my husband's name was,
even though I explained to her that I was in a same sex relationship.
That was our first negative experience in our process of being pregnant and having the girls.

<div align="right">(Sally, 14-19)</div>

The erasure of their marriage and relationship was carried into the delivery room.

After the girls were all checked out and okay,
they offered if we wanted skin-to-skin contact with somebody else,
so of course [Wife] said yes
because we had discussed that before that she would want to do that.
But for some reason the doctors would only give her one baby,
they wouldn't give her both at the same time.
Sometimes I find that hard because they had given me both babies for skin-to-skin
so I don't quite understand why that wasn't offered to her.
But of course at the time, I was focused on what was going on with me
so I am not really seeing what is going on with that.
But I know for [Wife] that was a big frustration
and that she felt that if she was the dad then she would have been offered to hold both babies.
But because she wasn't, I don't know if some of the doctors didn't know our history,
didn't know that we were together or something,
but she wasn't offered to hold both babies.
So that ended up causing some issues further for her emotionally.

<div align="right">(Sally, 130-145)</div>

Upon reflecting on their story with me, Sally expressed her frustration with the continued erasure of their relationship.

For the longest time, [Wife] listed in my next-of-kin, when you go to the hospital, was listed as my friend.
Every time I went for an appointment, I corrected them,
"No, she is my spouse, my wife."
Nobody ever took the time to correct it in the computer system.
So every time I went to check in to the hospital for an appointment,
which was every week towards the end, I had to go through this.
"[Wife], your friend, is your next of kin?"
"No, she is my wife."

<div align="center">124</div>

Every time that had to happen.
I don't know if partly in my file that is what is what printed off so nobody realized but it should have been known.

<div align="right">(Sally, 819-830)</div>

Sally's frustration is understandable and eminently reasonable. Sally is an activist for LGBTQ rights and saw her birth as an opportunity to increase awareness, understanding, and acceptance of same sex couples having children. However, it seemed as if her work in this regard never ended. Indeed, when I first met with Sally she explained that she was hoping to "check some diversity boxes" in my research, expressing her awareness of how LBGBTQ knowledge and experiences are erased and made invisible in childbirth discourses. Sally was one of many participants who had their own knowledge ignored and subjugated in their childbirth experience.

Power/Knowledge

In Chapter 2, Conceptual Framework, Foucault's (1977b, 1977d, 1977g, 1977h) power/knowledge was presented as useful for understanding what sorts of knowledges come to have status as truth claims while other forms of knowledge are denied status as authoritative knowledge. The women who participated in this research experienced the material reality of these regimes of truth when their own knowledge of their experiences was discredited and subjugated to those of the medical teams involved in their care. The ways in which medical knowledge becomes dominant are subtle and often invisible (Lindemann, 2012, 2015a). Exploring participants' narratives provides insight into how disciplinary power orders the lives of women in pregnancy, childbirth, and the postpartum period. However, the stories of the women interviewed also show sites of resistance,

where these mechanisms of power become seen or sensed and women resist their disciplining influences.

Disciplinary power. Disciplinary power, in this research refers to the *medical gaze* (that is the process whereby the medical experts are the subjects of the gaze examining the woman/patient who is the object of the gaze) combined with normalizing judgments which together become the examination (Foucault, 1977b, 1977f). In this study these disciplinary powers are not simply metaphorical; physicians literally examine women and evaluate them. In Foucault's (1977b) disciplinary power the examination serves to regulate a great number of people in a highly efficient manner. Pregnant women, women in the throes of childbirth, and new mothers, experience this regulation in a very real way.

Garcia shared her experience of finding support as a new mother in online support groups as well as though her family resource centre. In Garcia's story she, and the other women she connected with, struggled with wanting their emotional pain to be seen, and to be seen as valid, and yet she was desperately afraid of being judged by herself and others as bad mothers, as mentally ill mothers. In this struggle for validity Garcia and her friends have found their own help outside of the medical system, a space of support outside the gaze of professional eyes—Facebook.

> It is nice to meet other moms, to have those resources.
> If I am having a really bad night and it is 3 in the morning,
> Facebook is a wonderful thing that has a chat program.
> We have a private group on Facebook of just these moms
> and we can go post and no one can see anything.
> I have the resource [centre] so I feel that is helpful to know there is somebody there
> when I need somebody there.

126

And the coordinators of that group are really helpful because they have other resources.
I have gone to a group and just had a really bad day
and I didn't talk very much and I will leave
and I will come to a Facebook message from them saying,
"I noticed you were quiet today, is everything okay, is there anything I can do?"
I have gone out to coffee with them just to get out
because they can truly see that I just needed a friend I guess.
So it is really nice to have that.
I don't know where I would be without that group.

(Garcia, 1199-1219)

When Garcia said, "no one can see anything" she was pointing us in the direction where we can see who the gazers are. Of course someone saw something. That is why the platform was helpful. Women saw each other's pain. Who did not see into this secret society were doctors, nurses, and social workers. Underlying all this fear of "bad mothering" was the fear of losing a child—of having a social worker arrive on your doorstep to remove your baby because you are unfit to care for them. This fear was so powerful that for a while it prevented Garcia from seeking help with her distress.

It is a huge fear.
I know I am doing nothing wrong that they would take her
but the fear is still there.
I can't get rid of it.
I don't think it is going to go away.

(Garcia, 1258-1262)

Regimes of truth/subjugated knowledges. Foucault (1977g), in his regime of truth, explicates how certain types of knowledge and discourse become to be seen as true. In this research medical discourses are dominant and those who wield medical knowledge are permitted the authority of truth. Conversely, other types of discourses and knowledge about women, pregnancy and birth are relegated to the realm of subjugated knowledges (Chadwick, 2014). In this case, the awareness women had about their own bodies, about

their own pregnancies, and about their own needs and desires were frequently dismissed.

To be clear, this dismissal did not just happen by others. While medical staff may have

dismissed women's knowledges, women also frequently dismissed their own knowledge,

deferring to the medical authorities, even when their own knowledge more accurately

predicted and reflected their material outcomes.

Sally's case provides a good example of the power of regimes of truth to regulate

what can been seen as true or valid, even when two authorities provide different versions

of truth. Sally was pregnant with twins and the obstetrician who was originally

responsible for her medical care had planned with Sally and her wife to deliver the twins

via a C-section, a plan Sally and her wife were in full agreement with. However, at an

appointment one day Sally found out that her obstetrician was leaving the practice and her

care would now be taken over by another obstetrician. This new physician was very clear

with Sally that she would not provide a C-section and that Sally would be delivering the

twins vaginally. The confusion between the two approaches, both being presented as

evidenced-based and the best approach, was overwhelming and confusing for Sally.

> Towards the end though she went on leave for a little while and we ended up
> having Dr. B follow us.
> That was a big change because they have very different personalities but that was
> fine.
> But the biggest thing that changed was Dr. A had us put down for a scheduled C-
> section.
> As soon as Dr. B took over, that option was changed.
> I was never asked if that if what I would like to have done but was basically told
> that,
> "Well it doesn't matter, I'm your doctor, I'm going to be delivering. You don't
> need to have a C-section."
> In the end, it turns out I was much happier with that
> but I did feel that decision was just taken away from me
> without being discussed why really she felt so strongly the way she did.
> When preparing up to that, I prepared myself mentally for a C-section,

so that was a big change but we dealt with that.

<div align="right">(Sally, 29-37)</div>

In this story, medical expertise was seen as the only valid knowledge and was given full authority. What is especially troubling is how this pattern continued even when two medical experts had completely opposite opinions about what a safe childbirth would look like. Even though the two doctors were at odds about the best approach to childbirth, Sally's own ideas about whether she would deliver vaginally or by C-section were not only ignored, they were never sought out by either doctor. Foucault's (1977g) regime of truth also illustrates the process whereby subjugated knowledges in childbirth (for example, Sally's knowledge) became legitimized by attaching the subjugated knowledge to medical expertise.

The ideas Sally was able to express about what she did or did not want in childbirth (not breaking the waters due to the risk of cords being around the babies' necks) were dismissed as invalid and unimportant. However, once the person with authority (the doctor of the day) examined the babies and the cords, and agreed that the cords were unusually long (as had been Sally's fear), then both the physician and Sally felt the fear was justified.

> To me, in my mind, having your water broken was a really bad idea
> and it can cause a lot of problems.
> But there was just, "Nope, that is what we do, that is what we are doing."
> And then sometimes I get very passive,
> so I am just like, "Whatever, I don't care, you are the doctor,
> you know best so just do what you need to do" kind of thing.
> Because I want two healthy babies.
> But definitely in the back of my mind throughout the entire process was,
> "What is going to happen if that happens?"
> Same as with Dr. A, she had discussed that even if we did try a natural vaginal birth
> that she would rather do it in the O.R. so that she was right there ready to go.

Dr. B said, "No, we don't need to do that."
So then of course I am thinking,
"What if they have to move me? What is going to happen?
How long does it take to get from the delivery room to the O.R.?
What can go wrong in those few minutes in between?
What if there is a cord wrapped around Baby B?
What if there is this or that wrong?"
That entire time was definitely always in the back of my mind.

There was lots of time [to make a decision], yeah.
And I do think though if I had have been Dr. B's patient all along,
she may have had some of those discussions with me earlier
but because I hadn't seen her all along, she is very much,
"This is way I do things, this is the way it is going to go and that's that."

One of my biggest fears going in was,
I don't know why, but all along I had nightmares about cords, cords being
wrapped around babies,
that is a big fear of mine.
Having two increases the risk and so that was my nightmare
that I have two babies but they are not both going to be born okay.
It was just kind of like, "Well that's ridiculous, you'll be fine, don't worry about
it".
That's a fear, you know, of mine and it stayed right along.
And the funny thing is, is afterwards, of course they are pulling everything out,
the placenta and everything
and I just felt like she was pulling forever.
So I said to her, I said, "What do the umbilical cords look like?"
She said, "Well there is a lot of cord, this is the most cord I have ever seen
and there is two, there is a lot of cord."
I wonder if part of my body was like, there is extra cord and we don't know why,
and I don't know if that contributed to my fear or why,
but it was.
And I mean even Dr. B said to me when I went for my six week checkup
because I asked her again about the cords and I said,
"You said something about them being really long"
and she said, "Yeah, that was the most cord I have ever seen anybody have."
That told me that my fear was real,
I really did have a right and reason to be fearful of the cord.

                                    (Sally, 353-379; 585-589; & 958-978)

We can see how Sally was caught within this discursive practice of medical

authority, as even Sally herself was more able to give her own fears credence when they

were assessed to be valid by her doctor—after the fact. Sally, even while struggling to be seen as a valid authority on her own body and her own embodied experience, struggled with feelings of uncertainty until her doctor was in agreement with her assessment of risk. This demonstrates how regimes of truth operate through invisible mechanisms of power, where women are taught to doubt their own knowledge and defer to professional authority as part of their role as women, patients, and mothers through messages of goodness.

> There were a total of 16 people in the delivery room
> so that was a major issue for myself and for [Wife].
> Because I just felt like I was on display and I know that the doctors will say that,
> "Oh those people were necessary"
> and I am not arguing that some of them weren't necessary
> but I do believe that some of them should have been asked to wait out in the hall
> or someplace close by or whatever.
> Because it was very overwhelming for four hours
> to have sixteen people staring at you
> while you are trying to give birth.
> And just felt like nothing was private, nothing was intimate,
> nothing was the way that I had thought it was going to be.
> That for me was a big stressor.
> I didn't feel comfortable.
> I couldn't look around the room.
> I just focused on [Wife] the entire time
> because every time I looked I would see somebody who I hadn't seen before
> staring at me.
>
> (Sally, 61-80)

Sally wanted to be a good patient so she did not complain about the circus in her birthing suite. Sally wanted to do a good job of labour and be a good mom, which meant getting the babies out in "the best way"—as defined by the medical staff. She wanted to be a good same-sex couple, which meant being willing to talk about and experience discomfort in the name of educating others. Ideas of goodness are a highly gendered

notion, where women perform their gender, in part, through acts of goodness (Ussher, 2011).

Julie tried to resist regimes of medical dominance, demanding her knowledge of her own body to be considered important. Julie shared her stories of her three pregnancies. The first she describes as a good experience, with a 13-hour labour and a baby born healthy. The second pregnancy Julie calls her "nightmarish labour." During this pregnancy Julie had concerns all through her pregnancy that something was wrong. Despite being consistently reassured by those providing her care that she and the baby were fine, her baby died during childbirth. Julie's third pregnancy was a high-risk pregnancy, which ended with Julie remaining healthy and delivering a baby who needed to spend over a month in the neonatal intensive care unit (NICU) for breathing difficulties.

Julie's resistance to the dominance of medical discourse interacted with her desire to be (and to be seen as) a good patient and a good woman. She continued to fight for her knowledge of her own body and of her baby's needs to be considered. Julie was committed to breastfeeding and did not back down on this even in the face of pressure from nursing staff to bottle-feed.

> Well, it did feel, it did feel like there was a competition.
> There was a competition of who is right and who is wrong.
> But there wasn't a right or wrong, there was just a different way of doing things.
> Then they were like,
> "We really don't know how much he is drinking out of your breast,
> so maybe you shouldn't breastfeed him."
> And I am looking at them,
> "What do you mean?
> I want him to get used to this because this is what I am going to have when I go home."
> "Well, we don't know how much milk is coming out."

"Well, I could tell you.
In twenty minutes, I can pump sixteen ounces out of one breast."
And they were like, "No you can't."
I would go to my room, put the pump on, pump twenty minutes
and come back with a full bottle of eight ounces
and a almost a second bottle full just from breast
and they were like,
"That is not possible, you must have pumped both."
I was like, "I am not going to argue with you,
this came from one breast."
Like really.

<div align="right">(Julie, 641-660)</div>

Julie was finally able to win the breastfeeding battle by enlisting the one source of

medical authority that would out rank the nurses—the physician.

And the gynecologist was there and she looked at the nurse and she goes,
"Well you are talking about Julie here.
Nothing is normal about Julie.
Her lungs are not at the right place and her kidneys are not at the right place
and her uterus just miraculously fixed itself.
So if she says she pumped two bottles in twenty minutes
then she pumped two bottles in twenty minutes.
It is what it is."
And then she walked out
And then nurse looked at me like "huh."

<div align="right">(Julie, 671-679)</div>

Julie's experience with the NICU left her feeling greatly distressed. She felt

disbelieved, ignored, and often in competition with the nursing staff. Julie had previously

experienced a positive relationship with the staff during her prenatal stay and when

dealing with the death of her son. However, now that Julie was a NICU mom, there was a

shift in tone and treatment towards parents, and this was shocking and destabilizing for

Julie. Issues of turf, timelines, and expertise came into play to negatively affect the

experience of her time on the NICU. Julie was no longer a grieving mother; she was now

a nosy, know-it-all NICU mom who had her own opinions about how her baby should be

cared for. She was a mom who wanted to feed her son when he was hungry rather than on the NICU schedule.

Regimes of truth exist in partnership with subjugated knowledges. Just as Julie did, many women who participated in this research often used their power of resistance to challenge many dominant ideas about childbirth in order to highlight and give voice to their subjugated knowledges.

Resistance. While power shows up in dominance, power also operates through resistance (Foucault, 1977c, 1982). Rachel's experience below illustrates how the women in this study engaged with their power of resistance to disrupt some of the taken for granted knowledges they encountered, and insisted on spaces where they were able to exercise agency.

Rachel's views on breastfeeding, and the pressures to breastfeed, highlight breastfeeding as a site where women are highly subject to the disciplinary power of medicine and pediatrics—where breastfeeding becomes a means to evaluate the goodness of the mother. Rachel experienced this exercise of power in her prenatal classes and argued persuasively how this disciplining of women needs to be disrupted.

> And like I mentioned before, if you are starting to make women feel like failures,
> you are doing something wrong.
> You know, that is not okay.
>
> I remember this instance in my prenatal class where the teacher,
> who was a really great woman
> and she had so much energy and love and humor,
> and she did a good job at the class,
> but she didn't present bottle feeding as an option…
>
> She was handing out brochures to everyone,
> "Here's a breastfeeding brochure"

And there was one woman who sat in her chair and didn't put her hand up at all to get a brochure.
So the teacher has the brochure and she is holding it up to her.
And this woman is just frozen.
She said, "Oh, I am going to bottle feed"
and they sat there for five seconds…

Yeah, it was a total stand-off.
The women is looking at her like, you know, this look on her face,
"Why are you still holding this in front of me?"
That is really rude.
And finally her husband took it just to be, you know, as the peacekeeper
and I think that is not okay to do to someone.

There is such this pressure to do it right that I just know, it turned me off.
I found it really offensive.
And really, I don't know, patronizing and demeaning to be told,
"This is the way you feed your child."

Before having kids I felt that everyone should at least try to breastfeed,
and then if it doesn't work there's bottle feeding as a back-up plan.
After having kids, my opinion changed to be
"Every mom should feed their baby either breast or bottle, or both, whatever works best in their situation."

$\qquad\qquad$ (Rachel, 436-445; 461-461; 473-480; & 492-498)

Rachel was suspicious of the message that breastfeeding is liberating for women.

Instead Rachel argued that a shift in focus from what is best for the baby, to a focus on

what is best for the woman would be a more truly liberating focus.

I don't know,
there could be an argument made for bottles being kind of liberating for women.
What about combining breast and bottle?
Even a woman who says,
"I have to go back to work",
"Well you can pump."
Well, okay fine, then your workplace has to have a place for you to do that,
and that is not a fun thing to do.
Just say, "I am going to disappear for half an hour to crouch in this windowless room
with this weird robotic thing,"
"Why?"
"Because I am empowered, that is why"… (laughter)

Rachel also voiced her frustration with the way in which women are regulated through judgment, beginning in pregnancy and persisting through various stages of motherhood. Her awareness of and frustration with the regulation of women was evidence of her resistance to these controlling forces.

> There are all these messages,
> This is the right way to be a mom,
> And this is the right way to do things
> And you have a fulltime job
> And you are a mom.
> You are expected to do both fulltime.
> You supposed to be a full-mom and a full member of the work force.
> And you aren't supposed to compromise either one or you are failing
> And that is really unfair too.
> I mean, I don't have a job
> But I see working mothers as friends
> And they are really stressed out about it
> Because they are not doing it well.
> I think, you can't do it well
> Because there aren't enough hours in the day to be a perfect mom
> and a perfect…
> You know.

Agency

Women performed acts of resistance by taking agentic action. However for many participants, having opportunities to express agency in childbirth removed from them was a source of distress. Many women discussed the distress associated with not feeling they had a say in the decisions about their care. In Morgan's case she was not even given the option to save her own life as she had no opportunity to give consent for the C-section that would save her son's life, but would risk her own. Had Morgan been given the choice, she believed she would not have consented to the surgery. She was clear that if

she had to choose between her unborn son's life and her own life, she would have chosen to save her own life first. Morgan explained that this is because she has another child, a spouse, and a father who needed her.

> Going down the hall that was part of my fear.
> My husband, my daughter and my dad, those three people were just like,
> I felt sorry for them.
>
> CMF: That they would lose you?
>
> Yes. It would be hard on them.
>
> CMF: It would be hard.
>
> Very hard.
>
> <div align="right">(Morgan, 88-97)</div>

The pressure on women to sacrifice their needs for those of their child are ingrained in ideas of good mothering, however it is unreasonable to not allow women to make decisions about sacrificing their own life.

Mavis' story centred around distress resulting from a birth experience where she felt she had no opportunity to exert her agency in the birth process. Mavis' story was one of expectations crashing against reality and the emotional turmoil and loss of identity that results from a loss of agency. She wanted a childbirth experience without medication and with few interventions, and ended up with a highly medicalized childbirth. She wanted a vaginal delivery and ended up with a C-section. Mavis expected to breastfeed easily and ended up with ongoing difficulty with breastfeeding. Mavis described her childbirth experience as one of feeling overwhelming helplessness and powerlessness. Her plan for herself and her baby "went out the window" and instead of her plan for a gentle hypno-birth, with vaginal delivery and no drugs, she felt overwhelmed by pain stress and

hormones. Her worldview was shattered and she was left feeling devastated and despondent.

Mavis' story began with telling me what she had hoped for in her childbirth. While she did not enjoy being pregnant (in fact, she describes the experience as "miserable") she believed that since her pregnancy was terrible she would likely have an easy birth. However as her due date came and went, and her obstetrical appointments became more frequent, her hopes of her gentle hypno-birth quickly vanished. At 41 weeks of pregnancy her physician decided she needed to be induced due to low amniotic fluid. Thus began Mavis' highly medicalized birth experience. The induction did not work, as the baby could not tolerate the drugs due to low amniotic fluid. Mavis was given an amnioinfusion[20] to help things along, which also did not work. Mavis was left to labour on her own, hooked up to (eventually) three IV towers. She was given an epidural under the threat that she did not want to be unconscious should she require an emergency C-section.

> So at this point, I opted for an epidural,
> Um, because the conversation started to circulate around a C-section
> And I didn't want to be in a situation
> where I was rushed into an emergency C-section and having to be put under.
> I opted for the epidural, which resulted in the third IV tower
> that I was now sort of carrying around with me.
> I just started to feel really helpless and really sort of lost in the process, you know?
>
> As far as feeling empowered to make a decision.
> It just was so medicalized, you know? Um,

---

[20] "Amnioinfusion is a procedure in which normal saline or lactated Ringer's solution is placed into the uterus after sufficient cervical opening and rupture of membranes" (Birthsource, 2016).

As far as natural childbirth, it was, all that had kind of gone out the window.

(Mavis, 113-120)

Mavis felt "lost in the process." Her identity as a full person was now subsumed under her identity as a body needing to deliver (or be delivered of) a baby.

Decisions needed to be made—to continue to labour or to have a C-section. Mavis' narrative demonstrated the illusion of agency granted to women giving birth in a neoliberal healthcare system[21] where the biological processes of birth and death must be bent to the needs of institutions. In this model of healthcare there is sourceless shadow of agency; a suggestion that choices exist where none actually do (Hayes-Klein, 2016; Schiller, 2016b).

> This was the other interesting part of that conversation too,
> Was that it was Thanksgiving weekend.
> This was now Friday of Thanksgiving weekend
> and everyone was kind of going home.
> And this was at 5:30 at night and as far as my doctor was concerned, she…
> If I wasn't going to do a C-section, she was going home and we were going to just let it sort of play out,
> But that it would likely end in a C-section.
>
> So, we kind of made the decision at that point while the staff was on
> to go ahead and do a C-section.
> And within twenty minutes, I was prepped and ready for surgery.
> Even though it was a blur, I still remember very specific pieces of all that,
> You know smells and feeling and the air that was around me,
> The nurses that would be kind of circulating around me

---

[21] Neoliberal healthcare refers to a healthcare system that is based on the principles of individualism; free market and privatization; and deregulation and decentralization (McGregor, 2001). In the neoliberal model of healthcare patients are viewed as consumers of a health product and service, and the individualized focus places heavy emphasis on the patient to be highly informed and to exercise a high level of agency. (Noseworthy, Phibbs, & Benn, 2013). In regards to childbirth, the neoliberal model is problematic in that it removes the recognition of the complexities of vulnerability, identity, and social connection that are inherent in birth experiences (Noseworthy et al., 2013)

But it felt very out-of-body at the same time.
It felt like I was just kind of existing
and I was going to have a baby (fingers snapped) in twenty minutes.

<div align="right">(Mavis, 136-150)</div>

In hearing Mavis' story, one wonders what "let it play out" could possibly mean? Mavis surely had no agency in this decision, as there was no real decision to be made, other than the sort of "take it or leave it" choice children are given about a dinner they do not like, or probationers are given about attending court ordered appointments.

It makes sense that many women when asked what advice they would have for women in childbirth, encouraged women to take more agentic action during their experiences. Like many of the women interviewed for this study, Cali's advice for women going through childbirth focused on encouraging women to assert their agency, to demand to be taken seriously, and to have their own knowledge of their own bodies respected.

Yeah, ask lots of questions.
If you have a feeling something is wrong, don't stop, go with your gut feeling
because it is mother's intuition.
I should have demanded right then and there an ultrasound
and Dr. C said if she had of been there, that is the first thing she would have done.
Because, if it was in the twenty minutes of doing, you know,
monitoring his heart rate, monitoring his movements, that first twenty minutes,
there was some kind of concerns there
then she wouldn't have left it,
she would have done it right then and there.

<div align="right">(Cali, 397-406)</div>

This often repeated advice to women demonstrates the responsibility placed on women by themselves and by others to assert their needs through demands to be taken seriously and to have their knowledge respected. The frequency with which this advice was given illustrates how dominant ideas of individual responsibility are within childbirth

discourse. Placing the onus on women giving birth to demand their rights, in the middle of a highly stressful and physically overwhelming experience, allows those operating within the neoliberal healthcare model to shift responsibility and blame onto those who are going through arguably the most highly vulnerable life experience. In doing so the healthcare system is absolved of the responsibility to do better, and provide a more humane service to women.

The Interplay of Discourse, Power/Knowledge, and Agency

It may be very difficult for women to assert their agency in a way where they can insist on being seen as credible. Their knowledge of their own body is subjugated to the medical expertise of the care team. When women, such as the women in this study, insist on being seen as a valid source of information they can quickly become dismissed as emotional, and overly dramatic. It is interesting that a main contributor to Carrie's medical emergency was her fear of being seen as over-dramatic, like Morgan and Charlie experienced. This fear was based on her experience of seeing other pregnant women being constructed in this way and thus having their embodied knowledge dismissed. So it seems that pregnant women who ask for help are seen as not requiring help (because they are dramatic) and yet not asking for help also means not getting the help you seek. This reflects the paradox of personal responsibility that pregnant women can find themselves trapped in while negotiating how to be exactly the right kind of woman patient. Women must find just the right balance of being assertive enough to get taken seriously while not so assertive that they are seen as a problem. It appears to be a delicate balance between being concerned enough about your pregnancy so that you are a "good" mother/patient, but not so overly concerned that you are seen as "overly dramatic."

The idea of being dramatic is a highly gendered notion, a term employed in the description of women often associated with their reproductive lives and experiences (menstruation, pregnancy, menopause) (Chesler, 2005; Ussher, 2011). Women are seen as inherently more emotional (dramatic) than men and thus their experiences and embodied knowledge are regarded as less trustworthy. This discursive construction of the emotional/mad hormonal woman becomes a way to subjugate their knowledge and experience of their own bodies. However, in the following chapter I will demonstrate the paradox of decision making in which pregnant and labouring women find themselves caught. In this paradox of decision making women in childbirth are responsible for making decisions about their healthcare that they feel unqualified to make, while at the same time those decisions they are able to make are taken away from them.

Perhaps the advice for care providers should be to consider where these ideas of women (especially pregnant women) as dramatic come from, and a call for professionals to resist the temptation to engage in this dominant discourse about women (especially pregnant women) that suggest they are always just a little bit mad. Perhaps medical staff could learn and understand that pregnant women are constantly running the gauntlet of judgment and evaluation of their pregnant mothering. Pregnant women must be careful not to care too much or risk being seen as dramatic, and yet must also be careful to not be seen caring too little or risk being seen as negligent. Perhaps a medical unit in a hospital ostensibly dedicated to the care of pregnant women could be a place where these discursive constructions of women as mad and bad could be challenged.

This chapter explored the interplay between the participants' childbirth narratives and the concepts that informed this research. Examples of Foucault's' discourse and

142

power/knowledge emerged in the interviews in ways which illuminate how these forces shaped childbirth experiences. Participants' narratives reflected a concern with agency, or a lack thereof, which allowed an exploration of how power/knowledge, and discourse interact with ideas of agency to create or minimize distress in childbirth. A similar discussion and analysis is undertaken in the following chapter with respect to the remaining themes related to the conceptual framework for this study; the body, gender and intersections of identity, distress and emotion, and childbirth narratives.

CHAPTER 7

CONTINUING THE INTERPRETATION AND DISCUSSION OF THE

FINDINGS RELATED TO CORE CONCEPTS

This chapter continues the analysis of the themes related to the conceptual framework from Chapter 6. The body; gender and intersections of identity, including privileged and marginalized identities; various conceptualizations of distress and emotion; the idea of childbirth as an experience rather than an events; and they manner in which narratives are used to convey meaning are explored in this chapter.

The Body

Childbirth is a highly embodied experience and so the body is central in women's childbirth stories. In the participants' narratives the idea of the body is taken up as either something distinct from the self, where labour is a discursive experience, or as the self where labour is a material experience. Those in the first category tended to talk about their bodies as a third party involved in childbirth whereas those in the second category were more likely to talk about themselves when talking about what was happening to their bodies in childbirth.

Anne provided an example of how she felt her body as distinct from herself. Anne described her experience with childbirth as a first time labouring woman. She began her story talking about her early labour and her fears that she would not be able to tolerate the pain and physical demands of giving birth. Even though staff described her as a "trooper" she dismissed this view of herself (which was associated with strength) and instead

reframed herself as simply coping as best she could by responding to the demands of her

body.

> They brought us right up.
> The lady was great.
> She is like, "I'll go get a wheelchair".
> I am like, "No, I cannot sit down, it hurts too bad".
> Apparently I was a trooper for walking up there
> but no way was I sitting down.
>
> <div align="right">(Anne, 28-32)</div>

Patricia demonstrated a similar view of the body as separate entity, something out

of control:

> Even though I felt completely out of control.
> It was completely beyond my control.
> I mean you've had kids, you have given birth.
> There is no control. You have no control over that situation at all.
> But even given that situation of complete uncontrol, lack of control,
> I felt like I had control over something.
>
> <div align="right">(Patricia, 632-637)</div>

Patricia repeats the idea that she had no control six times in six lines. She was referring to

the sense of control she gained by being actively involved in decision about how her

labour progressed even while she felt she had no control over the physiological process of

delivering a baby.

Charlie provided a different view of the body, seeing her bodily experience as a

core part of who she was and knew about herself during labour.

> I went into labour on Friday at five
> And then you know they say don't go to the hospital until your contractions are 5 minutes apart.
> So Saturday morning I went in to [Town A] and the nurse was, she was wretched to me
> and mom even thought, "She's awful."
> She said, she's like, "Yeah, but you are only 1 cm dilated, so you are not *technically* in labour."
> So by this point I had been contracting for,

can I swear on this?…
I don't give a *shit* what your definition of labour is,
I am like "This is friggin' laborious!"
I have been up, *contracting*, for the last twelve hours!
So I thought "Who are you to tell me that I am not in labour".
She was just like, "Go home."
And I was like, it is fine if you send me home but you don't have to be such a…
you know.
Anyway, she was not nice.

<div align="right">(Charlie, 192-208)</div>

Charlie did not say "my body" has been contracting, she said "I have been contracting" demonstrating that for her there was no separation between her body and her self during labour. Similarly Rachel did not see labour as something happening to her body but as something happening to her.

I woke up and it was a mess.
There was blood everywhere
but I wasn't in any more pain than I had been the past few days.
So, at the point I think I was sort of numb.
I was like, "Hey look I'm covered in blood, isn't this fun,
I am never doing this again."
I called the hospital
and they said, "Hi"
And I actually said, "I'm covered in blood"
And they say "Yeah."
Which was kinda funny to hear because usually you never hear,
"I'm covered in blood – yeah."
But they said, "Okay, it looks like things are happening now"
But they still didn't think I was ready.
They said, "Just some capillaries are breaking,
you may as well come in for an examination
but don't worry about it, just sometime this morning".

<div align="right">(Rachel, 91-107)</div>

The veering away from expectations created a shock when Rachel found out she had been actively in labour, dilating considerably while she laboured at home.

So everyone had showers
And then a long breakfast
And we got trundled up and went in.

<div align="center">146</div>

They asked how things had been going
and so I told them the story of having contractions for two days
and it has been awful,
And so they did the internal exam and they,
"Okay, you are five cm along"
And I just burst out crying because I had no idea that was happening.
And I said "I am still ten minutes apart
and that shouldn't be happening"
And they said "Well, it is happening anyway."
And a few hours later she was born.

<div align="right">(Rachel, 109-121)</div>

Gender and Intersections of Identity

In the interviews conducted for this research all participants were asked if they had any thoughts on how their particular identities influenced their childbirth experience, and were asked to consider aspects such as race, class, and disability. Most women did not believe that there was anything in particular about them that had a significant impact on their birth experience. This lack of recognition of identity (as White, able-bodied, heterosexual, and middleclass women) on experience reflects the invisibly of privilege to those who carry privilege—one of the benefits of privilege is the ability to ignore, deny, and remain oblivious to it. However there were some exceptions to this. Two women spoke about their awareness of privilege and how it affected their birth experience. Furthermore, those women who identified as having some area of marginalization spoke about how these marginalized identities affected their birth experience. However, a common theme among many participants, especially those who carried considerable privilege, was feeling marginalized and invisible due to their gendered status as pregnant women in the childbirth experience.

Women as invisible or as secondary

Women with privilege are used to being seen, and so they are not used to being invisible, even as their privilege may be invisible to them (Frankenberg, 1993). Perhaps this is where some of the shock comes for the White, middle class, heterosexual, able-bodied women who participated in this research. Many women complained of feeling invisible or of having medical staff consider their concerns secondary to the concerns about their babies. Expecting to be have one's needs centred is a reflection of privilege. However, the shock of not being seen as central to the birth experience was troubling for many women who participated in this research.

Sarah George provided an example of how women become invisible during childbirth and especially once the baby is born. Sarah George had hemorrhaged during her childbirth and her baby also needed to go to the NICU. In this situation she was caught between the busyness/business of the hospital and the need to get her baby to the NICU, so that she was left alone and forgotten, in stirrups on the delivery table.

> So they took her to NICU, they took my husband with them with her.
> And the nurse was like, "I'll be right back" and
> I was like, "…Okay…?"
> [Husband] gave me my phone before he left so I could text and tell people she was finally born.
> And a friend of mine was up with her baby, and they were like "I'll be back in a second."
> And I talked to her for fifteen minutes on the table with my feet in stirrups
> after like basically just bleeding to death.
> I lost a litre and a half of blood, and was next to trans[fusing]…
> The nurse said, "Oh you can get up…" (sing song voice).
> I am shivering, freezing on the table.
> She said, "I am sorry, it is just a hectic night, and we've delivered all kinds of babies."
> I am like, "Ummm, Can you come back and finish me or something?
> Like get me cleaned up?" (laughing)
>
> (Sarah George, 102-119)

Charlie also spoke about feeling like she became an object in the room rather than a person with a voice and knowledge about her own experience.

> I had an awesome nurse during the day
> And then the nurse that was coming on at night came in
> and I remember just looking at my nurse and being like,
> She pointed to, she didn't look me, and she goes
> "She is lucky that my daughter just made the soccer team
> because otherwise this would have been a really rough night for her."
> And I was like, "Oh my god, are you kidding me right now?"
> Then, she took over and she said to me at one point,
> I was shaky and it was from the epidural,
> and I was like, "It is from the epidural"
> And I was so hot, they were trying to get the fever down.
> She was like, "No, you are cold, you are shaking."
> I was like, "No, I am really not, I am really hot."
> Then she covered me in four hot heated blankets, wrapped me
> and I thought I was going to die.
>
> (Charlie, 263-276)

Charlie's experiences, even of her own physiological comfort, were repeatedly ignored and subjugated to that of the nurse's interpretation of her experience. Charlie saw many similarities between the birth experiences of her two children, finding them both to be emotionally distressing. Charlie's experience of feeling secondary instead of central to the birth experience was a common feature of both births, and each time this invisibility was associated with emotional distress. In Charlie's understanding of her experience, the staff's lack of care for the woman can be seen an effect of the routinization of childbirth in hospitals, where women must fit into a specified frame of experience or else they cease to exist. Women giving birth only exist as patients, as bodies with physiological characteristics to be measured and monitored (e.g., centimeters dilated, blood pressure readings) and become defined by these biological measures. In this routinized assembly

line of health care it is all too easy to fall off the assembly line for not meeting the

standard of experience, as Charlie shows,

> I felt that, like even though you had all these health care people and stuff,
> It felt to me like nobody was really there for *you*.

<div align="right">(Charlie, 318-319)</div>

While many of the participants remarked on their invisibility within the healthcare

system, their own identity as anything other than simply "woman" was often invisible

even to themselves.

Invisibility of whiteness and other privileged identities

As stated previously, all participants in this study identified as White women. And

yet most did not consider their whiteness to be remarkable even while they did find other

social markers as important. Patricia and Morgan both spoke of being overweight as

contributing negatively to their experiences in pregnancy and childbirth. Nella and Elise

both mentioned being athletes as factors they felt positively influenced childbirth. And

Carrie considered her religious and spiritual life to be of central importance to her identity

and experience. Perhaps in all of these cases, these identities markers were seen as

"other" in some manner, whereas whiteness remained invisible. That is whiteness was

centred and taken-for-granted and therefore unremarkable to these participants and thus

did not require mentioning.

Exceptions to the invisibility of privilege

Rachel serves as an exception to invisibility of privilege as she did discuss race

and class privilege as something that she was aware she carried. Rachel discussed her

position as a White, educated, middleclass woman. Her areas of privilege, including

education, allowed her to see the disciplinary dynamics of power at play, and allowed her

the space to resist them as well.

> I am pretty educated.
> My husband is very educated.
> The best thing I learned in school was how to educate myself about things
> and how to acquire knowledge in a useful way.
> And so I have no problem seeking out and absorbing information
> but also… being critical of it I guess
> And not going with anything I found on the internet (pause)
> "Oh it's on the internet, it must be true" (pause)
> Okay well what are the sources and where is this coming from?
> Is it a reputable site, a medical journal, or is this just some random story?
>
> I think that helped a lot
> Because I think the less education people have
> the more overall susceptibility they have to (pause) rumour.
> I hate to say things so general.
> But there is a tendency for that.
> It doesn't mean, if you don't learn, it doesn't mean you're dumb,
> It just means you haven't been taught to assess information the way that people
> who have gone to school have.
> That's all.
>
> (Rachel, 644-661)

Rachel's position as a White, middleclass woman allowed her to adjudicate the

quality of information that she accessed, and the safety to resist some of the disciplinary

messages promulgated about her gender. Her resistance became part of her identity, in a

way that might have been more perilous for another woman who was, for example,

racialized, poor, and less educated. Rachel also reflected on her whiteness and how this

influenced her birth experience.

> So, I am American,
> so if I gave birth in the states, I would probably say my race
> because I am White, right.
> But I'm here and everybody's White,
> so I have no idea what a Black person's experience would be like in [town]
> or at the hospital or whatever.
> I don't know what a Black person's experiences would be like in Canada

I don't know any Black people in Canada, like none.
I used to have a Black friend and she moved away
and I never asked her because I feel like she gets these dumb questions all the time
and I don't want to burden her with that
and so we just hung out sometimes.

So people say white privilege.
If you don't notice it, you probably have it.
You are not thinking about how race affects your day-to-day life
then you have white privilege.

It didn't occur to me at all as like
What race is the doctor or what race are these nurses?

We all looked the same,
we all spoke the same.

No, I am curious if you were to interview, a bunch of people in Chicago,
or even Toronto or any of those cities
that might affect a little
but I certainly didn't experience it.

<div align="right">(Rachel, 667-675; 681-684; 690; 694-696; & 707-710)</div>

In her narrative, Rachel reflected the manner in which her small town, and Canada as a nation, are discursively constructed as a White space, and in this whiteness is invisible and unmarked. However, Canada and Rachel's small town are not only White spaces and this story reflects the process whereby Whiteness is centred as normative and those with any and every racial identity other than White in these spaces are marked as Other.

The most in-depth discussion of privilege came with Mavis, who had spent some time reflecting on how her privilege had not shielded her from the emotional pain she suffered with childbirth, in the way that privilege had typically shielded her throughout her life. As a young, White, middleclass, able-bodied, heterosexual, professional woman, Mavis was structurally protected from many experiences of oppression, a reality she readily acknowledged in the interview and throughout her childbirth experience.

Reflecting on her practice as a social worker of often directing clients to seek help, and

yet being reluctant to do so herself, Mavis shared,

> But in my head I was thinking, "No, no, I am stronger than that.
> I am better."
> All that stuff that started kind of from privilege
> and also just from a very, White, middle-classed family does often,
> sweep the problems under the rug; don't talk about all those things.
> My mother didn't get it.
> [Husband]'s mother certainly didn't get it.
> They had all kinds of children, they've survived.
> You are not the first person to have a child, buck up.
> So there was that kind of piece happening.
>
> <div align="right">(Mavis, 516-525)</div>

Mavis was reflecting on her place of privilege and the requirement she believed

comes with privilege to deal with problems on your own. In her world, White middleclass

people do not need help with their problems. They buck up. And yet "bucking up" was

not working for Mavis, which again caused her to reflect on her identity and how she was

now experiencing herself differently in relationship to others from different backgrounds.

> So I do think that has played a role in how I sort of then made sense of my experience.
> Because if I am not one thing, well what am I?
> You know, as far as this strong woman that was supposed to be able to deliver this baby?
> What does that make me?
> And also how I thought other people perceived me afterwards.
> Like, "Oh, you had a C-section,"
> Some people understand that is hard thing
> and some people seem to think it was like the easier way out.
> So it was a very strange place to exist there.
> Um (sigh) so yeah, uh (pause)
> I, I became surprised about certain things around children, having a new child, afterwards,
> Like, going to [family resource centre] for example,
> Being around mothers who maybe weren't as (pause) um financially, let's say.
> …
> Yeah, some class stuff
> And hearing them talk about breastfeeding.

I was, I was, I was under the assumption that if you were, you know, less well-off,
That maybe you would chose formula
because you weren't educated enough to know the benefits of breastfeeding.
And talking to mothers who were, you know, coming to [family resource centre]
and asking for diapers because they couldn't afford diapers,
were big proponents of breastfeeding.
And I just remember being so surprised by that.
And finding these places of surprise was so interesting to me you know
And just how people sort of take to parenting differently.

(Mavis, 554-578)

Mavis' hesitations and false starts ("mothers who maybe weren't as…um financially, let's say") demonstrated the difficulty talking about biases and prejudices associated with privilege. Her comment could be read in many ways: as patronizing and superior, as euphemistic so as not to offend, or as a reflection her own cultural expectations of self. Mavis, as a social worker, would be trained to resist these stereotypes, and yet she was honest in sharing them. For Mavis the realities of childbirth and the struggles associated with being a new mother acted as a bridge between her and other mothers with whom she would not have had social relationships with if she had not struggled after the birth of her son. She had come to view the struggles of childbirth and parenting as a commonality that crossed the cleavages of class.

It, it, (sigh) (pause) I mean the whole thing just sort of blew me away that like,
I was struggling so much, who am I?
I am struggling so much and here I have everything that I could possibly want in life.
I have a great job.
I'm educated and I can't get my shit together and be a good mother.
I have barely been able to have a shower and these people are talking like,
they don't drink pop, they don't drink coffee and I am like,
"I would have assumed you would have drank a whole two liters of Pepsi!"
That was in my head.
I was kind of trying to make a joke about things
but at the same time it was very reflective of some deep-seeded sort of assumption
that I had about (pause) people.

CMF: Poor people.

Poor people.
People who needed things.
Um and just finding surprise in that.
And also I remember seeing a surgeon at [family resource centre]
who had a baby not long after I had him.
She was at [family resource centre] looking for some support around being a new
mother
And I thought, "Well here she is, a surgeon, very educated,
on the other end of the spectrum and she is seeking support."
So then I started thinking, "That's the common-denominator isn't it?"
That when we have a child, we are all kind of starting from a place of unknown,
You don't know what kind of freight train is heading toward your life when you
have your baby.
So does (pause) how much does privilege play into that?
And I would say, not a lot.

(Mavis, 586-612)

Speaking from a place of privilege, Mavis came to see that her privilege did not

protect her as she thought it would. However, it is also a privileged position to say that

privilege likely does not matter much. Mavis was honest in her sharing about her own

biases about those who live in poverty and it is likely that this experience will break down

some of these biases which will benefit her and her clients when she re-enters her work as

a social worker. However, Mavis offered us a glimpse into how discursive practices about

poverty circulate and the impact it may have on interactions with birthing mothers.

Despite her education as a social worker and the profession's associated code of ethics

which calls for respect and a recognition of the inherent worth of every individual

(CASW - ACTS, 2005b), Mavis associated low income with a lack of education in

general, a lack of education about best practices for infant care (nursing), about healthy

diet, and poor impulse control (drinking litres of pop a day).

The romanticizing of poverty and the strength and fortitude of those who are poor,

serves no one but the privileged. However, the desire to feel better about our own

privilege is understandable and perhaps was evident as Mavis tried to make sense of this

all.

> It's like, life is not easy.
> It doesn't matter where you are at when you bring a child into the world.
> You know, emotionally, mentally, financially, everyone has struggles.
> What keeps you awake at night?
> What's the stress you have?
> Or I look at my brother who has had a lot of troubles in his life
> and could have very easily been my client at prison.
> He has a beautiful little girl and he is a fantastic father to her
> but yet he still has his issues.
> So, I just kept trying to remind myself, not only of my privilege
> but that didn't need to be, (pause) I didn't, I didn't even justify my pain,
> I didn't need to sort of say, "Well, you just have to get over it."
> It was like you need to talk about it, you need to be aware of it
> and hopefully use it to be more understanding towards other people.
>
> (Mavis, 646-658)

Awareness of marginalization

As much as privilege was invisible, marginalization was felt and experienced by

women who somehow fell outside the White, heterosexual, 20-30 year old, middleclass

idea about women on which women's reproductive healthcare is centered.

As mentioned earlier, Sally was married to her female partner. The couple had

undergone IVF treatments to conceive and while Sally was the pregnant parent, both

women in the couple were highly involved in the shared experience of pregnancy and

childbirth. Sally and her partner repeatedly felt the sting of having their relationship

ignored and erased by the medical teams involved in their care. Despite Sally's clear

statement on her relationship and the partnership in parenting, her position as other than

part of a married heterosexual couple meant she continuously had to partake in the work of asserting her identity and insisting on her identity being respected.

Where Sally experienced the pain of having her relationship dismissed and erased, Sarah George felt the irritation of having her marginalized status judged by the care team. Sarah George, who was having her third baby at age 27 and who appears younger than her age, wondered if ageist, working class stereotypes of young women with high rates of birth contributed to the poor care she received in the hospital.

> [I was] 27. So I wasn't young, really
> But it just felt like they were like, "Oh, you are just popping out another baby."
> (Sarah George, 683-684)

She attempted to resist the judgments associated with her marginalized age and class position by aligning herself with the desirable position of the middleclass woman and the stereotypical middleclass lifestyle. She emphasized her status as married to the father of all three babies and remarked that they own their own home, in an effort to establish herself as respectable.

> I don't know if they thought we were young and just didn't take us seriously.
> It's their third baby in five years, it is kind of like,
> "Oh another one who is going to pop out babies."
> I know that sounds bad,
> but we are a married couple, we own our house,
> we are providing for our children.
> Other than it just felt we were like, you don't know what you are doing lady.
>
> Popping babies out left, right and center.
> That is what popped into my head
> But I don't know if she was just having hard night
> because maybe she was and it was busy.
>
> Anybody with a lot of kids, it's like, pop them out for something to do,
> just like (trails off)
> (Sarah George, 673-679; 704-707; & 711)

157

While Sarah George did not believe her age had an impact on her birth experience outside the way she was constructed by the staff, Nicole had the opposite experience. As a teenage pregnant and mothering woman, Nicole viewed her marginalized status as a young mother to be the main contributing factor to her extreme emotional distress.

As discussed earlier, after the birth of her daughter Nicole felt so unprepared for the demands of motherhood that she attempted to take her own life.

> The overdose, I thought to myself I knew I wasn't ready for it.
> Hearing her cry agitates me a lot
> And this one day when I came home from [City] she would not stop crying.
> Everything we did, she wouldn't stop crying and I just didn't want to deal with it anymore.
> So I went to the washroom, took the pills and yeah (pause)
> I knew I wasn't ready to have a child.
> I fully admit it.
>
> (Nicole, 127-136)

In addition to being young, Nicole also identified as being economically poor, and living in a remote rural area. The intersections of these marginalized identities made her especially vulnerable to the distress associated with the demands of motherhood.

There is work associated with having a marginalized status. Cali and Morgan are both survivors of sexual assault. While living with a history of sexual assault is an invisible status, it nonetheless carried weight of emotional distress and the additional labour of navigating a system that, at times, made them feel specifically vulnerable, demonstrating the labour of childbirth includes not only the bodily process of contractions, but also other forms of work. Cali experienced difficulty in seeking help with pain she suffered following childbirth. She described herself as "a private person" and later in her narrative explained that she is private in part, due to her experiences of

sexual assault. Due to her history of assault she needed to be examined by female

physicians and was not comfortable with male doctors and staff.

> Because I know when it came to the point
> where respiratory therapy was supposed to come up,
> because I work so closely with them, and my first instincts,
> I know there is two gentleman, now there is only one
> and I did say, "If it is a man can you take the baby out of the room
> because I can't have him in the room with me."
> Not because of him personally speaking,
> But just feeling comfortable being that exposed and having a man in the room
> And that is why I even said to Dr. B,
> "I think you are a wonderful doctor but I hope you are not on when I give birth."
> (Cali, 496-504 & 506-511)

Cali linked the childbirth experience and the vulnerability and physical exposure

that are part of childbirth with her experience of being sexually assaulted. Cali's status as

a sexual assault survivor positions her to give important advice for professionals working

with women during childbirth. It is important to remain aware that many women have a

history of sexual assault, and Cali believed (and advised) that women should not have to

repeatedly disclose their sexual assault history in order to be treated respectfully (such as

when requesting female staff if possible) and to have their needs met.

> You shouldn't have to just, you know,
> put a sticker on a chart in a way too,
> to make that person stand out.
> If it was a general practice.
>
> Because I have been very fortunate even though I have been assaulted,
> my family doesn't know.
> I kept that to myself.
> But for some reason I have great coping skills so I said,
> "I will work through that myself"
> But if I didn't have that and I had to disclose,
> I think that could have brought me back, right?
> And it could have brought everything back up to the forefront
> and being that exposed, having a child,
> I think it could have really done some damage to myself or anybody

159

if I or they had to disclose that.

<div align="right">(Cali, 523-526 & 530-540)</div>

Similarly, Morgan spoke to the labour of repeated disclosure. While Morgan did not find her history of sexual assault entered the birth experience, she found her history as a woman who had had an abortion to be problematic. Morgan found the lack of privacy and care in the hospital to be troubling and advocated that women's needs, including privacy needs, be given priority over the demands of the hospital staff's needs for documentation. For example, while Morgan was not uncomfortable speaking about her abortion, she was aware that other women might not feel the same. She believed that regardless of personal feelings on the issue, patients in hospitals are entitled to confidentiality in their medical care.

> In front of your partner, and you really don't want to think about ten times during stay,
> having your new baby.
> You know, sometimes it is not an easy decision for people.
> It is a really awful decision and it is an awful experience.
> It is not a good time at all.
> That is something else that we both were talking about.
> They just shouldn't do that.
> It is very personal.
> And really, at the end of the day, who cares.
>
> What if it was your dad or your mom or somebody.
> Yeah. It is very personal and that is an extremely controversial and personal thing.
> What if you had a mom who is completely against it or something?
> And it just can really, it could damage relationships I would think.
>
> They could judge you or they will always be like
> "How could you ever do that?" Or those kind of comments.
> So, I just don't think it should even be an option to say those sorts of things.
>
> <div align="right">(Morgan, 445-453; 465-468, & 472-474)</div>

While in this study all participants identified as White women, whiteness along with other privileges for the most part were invisible. Those who were aware of privilege

<div align="center">160</div>

still demonstrated difficulty expressing an understanding of where the limits of this awareness lay. Discussions of privilege, while providing insight into the desire of some White women to take responsible action with their privilege, often continued to romanticize or recreate problematic images of whiteness and class privilege. Those women whose identities aligned with an area of marginalization or who existed at the intersections of various marginalizations were unable to ignore the influence of their identity on their birth experiences. Often the distress they experienced in childbirth was directly caused by the manner in which healthcare interacted with those with marginalized identities. In these cases, distress could be seen as being caused by outside forces, resulting in negative effects on individuals. However, participants had various ways of describing and understanding the distress they experienced in childbirth.

Distress and Emotion

There was a blurring of understandings about distress in the women's stories. As I will illustrate below, sometimes distress was tied to ideas of hormones—where there was an acknowledgement of emotions as valid, but with the hedging that perhaps their expression was out of proportion to the issue creating the distress. Sometimes participants viewed their distress as a sign that something had gone wrong, highlighting a situation where worry, fear, and sadness, were helpful emotions motivating the participant towards necessary action. In the view of distress as a sign something as gone wrong, some women found their distress to be helpful in acknowledging a loss and making meaning from their loss to improve their lives moving forward. Other times emotional pain and distress was viewed as mental illness. In this view distress was seen as an experience that needed to be feared, treated, hidden, and eradicated.

161

Hormones

The idea of emotional distress as caused by hormones demonstrates how the dominant discourse of medicine and biology can be used to diminish women's concerns. Despite the various aspects of childbirth that can possibly cause emotional pain, biomedical discourses still circulate among women to explain their suffering (Chadwick, 2014). Chief among these is the discourse of hormones as an explanation of why women experience unpleasant emotions during pregnancy, childbirth, and the postpartum time (Ussher, 2010, 2011).

Morgan's interview provided an example of the powerful influence of the biological view of hormones as responsible for pregnant women's emotional distress. Not only had Morgan gone through some very difficult experiences in childbirth, during her pregnancy she and her husband had had serious martial difficulties which meant she experienced considerable stress and little help during her pregnancy. Additionally she had significant physical pain during her pregnancy. However given all of these stressors, Morgan made sense of her increased distressing emotions using the discourse of hormones.

> They change your outlook. You know.
> The way I was thinking when this all first happened,
> my brain space is just so much different than it is now.
> It was scary and fear-based and a little depressing.
> You know, I cried my whole pregnancy.
> I am not a huge crier.
> I am like, what the hell is going on? I cried a lot.
> I did have some stresses but still.
> I have always had stressors my whole life sort of thing but yeah.
> Now I just feel much more in control of myself and my emotions.
> There was no controlling them before.
>
> Because when the emotions would take over, mixed with stress.

It was never just a for no reason emotion.
Something I always did say during my pregnancy,
"Nothing I am going through or none of my reactions are not based on something
that has happened" sort of thing.
They were just a lot.
I cried all the time.

(Morgan, 152-162 & 170-175)

Julie also used the medical discourse of hormones to explain the emotional

distress she experienced with her third childbirth experience. By taking up the discourse

of hormones, a bio-medically sanctioned understanding of extreme emotions, perhaps

women can sidestep being castigated as a diva, or dramatic, or some other negative label.

However, this framing still constructs women as subject to their unpredictable bodies

rather than as active agents responding reasonably to external stressors. Julie experienced

considerable stress and heightened emotions during the time her son was born. Delivering

a pre-term baby considered to be very high risk due to a previously ruptured uterus,

painful memories and recollections of the death of her son, being in the same hospital,

labour and delivery suite, and the NICU where she nearly died and her son did die,

recovering from serious surgery, and now having a pre-term infant with breathing

difficulties in the NICU, and feeling ignored and dehumanized by NICU staff, all

contributed to her feelings of distress. And yet, in making sense of her "emotional" state

Julie called on the biological discourse of women's hormones.

Well they always say when you are over-emotional when you are pregnant
It's because your hormones are not balanced, right,
I have heard that so many times.
So there are sometimes when I am just standing there
and I would just stand there and start crying for no reason
and I would be okay,
it is just the hormones
and after I would be like breathe in and breathe out
and I would be fine

163

and eventually that just stopped happening. Right?
So my hormones must have replaced themselves (laughing)
because I don't know what else could have caused that.

<div align="right">(Julie, 705-716)</div>

I asked Julie to explain more what she meant by "over-emotional".

Uh (pause) I will give you an example,
When I was pregnant for my daughter, I was eating peas, peas in a pod
and I opened the pea in the pod and there was a worm eating my pea.
And I got so upset at the worm, I started crying
because I couldn't control the fact that the worm was eating my pea.

So that's what I would consider over-emotional
because it is not something that would normally bother me

So when I was in the hospital,
when I came in to see him that first night and she had already done his bath,
I couldn't hold back the tears,
I couldn't hold back the heartbreak
and I couldn't hold back...
Like, I couldn't compose myself because (pause)
I was over-emotional
Because (pause) I (pause) there was no control there
where normally there is control.
So, that is what I would consider over-emotional.

Like you can't chose to say,
"I don't want to cry right now", and be composed
because there are so many emotions right now that are affecting you
that the tears just, just roll down your face.

<div align="right">(Julie, 722-729; 741-749; & 758-761)</div>

During the interview I attempted to draw out how the biological view of "hormones"

might not fit with this experience.

CMF: And do you feel that missing your baby's first bath and first night
is equivalent to the worm eating the pea?

No, It's different.
It is completely different
It's different, but it's still emotions I could not control.

<div align="right">(Julie, 763-769)</div>

164

It seems that the biological discourse of women expressing emotions as "hormonal" was so strong that even though Julie could see that these two examples were very dissimilar, the model must still apply to her experience. This is another example of Foucault's (1972, 1977e) discourse, where one's experience is shaped by what is available to be known about the experience. Julie (like many women) was so immersed in the medical and biological understanding of women's emotional lives as "hormonal" that even when the social conditions that created emotional distress were brought into focus there was no way to make sense of the suffering other than through a biological (and pathological) lens.

However, some of the stories the participants told reflected a non-biological view of distress. In these stories distress was viewed as a sort of warning signal that something had (or was about to go) wrong.

Distress as a sign something has gone wrong

The non-biological view of distress treats distress as one of many emotions, where emotions are seen as an important source of information about events and experiences in the participants' lives. In Nella's story, emotional distress provided information to Nella about possible harm to her baby.

Nella's interview focused on the birth of her second baby. Nella laboured for a long time with little progression. She became worried about her baby, wondering if she should push for a C-section, and eventually suggested the use of vacuum extraction to help the baby be born. Eventually her baby was delivered with the aid of a vacuum as he had been stuck under Nella's pelvis. Nella was aware that there was a risk that damage had been done to the nerves in his arm by pulling him out. But Nella would not know

165

what, if any, damage had been done until her son was seen by a specialist; an appointment she waited anxiously to have booked.

Nella waited anxiously for the follow-up call with the specialist, which took months to arrive. These were months she spent worrying about the health of her baby and second guessing her decisions made in childbirth. She talked about how the stress of waiting was quietly driving her "crazy."

> I had the baby and then,
> I was fine and I discharged a day later
> and the baby came with me
> and the doctor checked the shoulder
> but then they kept saying I would get this call from the [city hospital]
> to have a follow-up to make sure there was no nerve damage
> and that took three and a half months.
> It was a long wait
> and I found within that three and a half months for me personally
> that was the time I was most vulnerable to a lot of things
> because of all the formula changes, the stress, the no sleep.
> So, it was always in the back of my mind,
> I was always worried.
>
> Because then you start thinking, okay,
> well if he does have some nerve damage, obviously I can deal with it.
> So, I wonder what is out there for people with this problem,
> so then you start looking at stuff like that.
> Some people wouldn't but that is my personality.
> I am always thinking ahead but some people would just be like,
> I'll wait and see and I'm not going to get anxious about it.
> It was not that I was driving myself crazy
> but in a way, quietly, I would be.
>
> (Nella, 77-88; 525-533)

Mavis' story also provided a clear example of how emotional distress was experienced in reaction to things going wrong in childbirth, where she felt helpless and terrified as her plan for a gentle vaginal birth changed drastically and quickly.

166

At that point we decided that I would have a membrane sweep[22]
and see if I could go home and still approach it as naturally as possible.
She did that, and then she said, which I wish she had have done it in the reverse order,
She said "Let's just check all your fluids and do an ultrasound while you're here."
After my membranes were swept, she did that
and it turned out that I had really low fluids
And she was not happy at the idea of me going home at that point.

That was my first feeling of sort of helplessness.
Because here is a professional, a specialist, telling you, you know,
"I don't like what I am seeing."
And the plan you had in place, the plan you were kind of hoping for
is no longer going to be the plan you were, you know, anticipating.
You just start to feel like, I just started to feel like I needed to take their word for it,
that I had no kind of option in it.
And it just became very medicalized very quickly.
So that meant she wanted to do an induction to get things rolling
which really kind of terrified me to be honest.
That was sort of my last hope was to have an induction.

(Mavis, 19-36)

After her troublesome childbirth Mavis spent a few days in the hospital recovering from her C-section. The few days in hospital were difficult for Mavis. The baby had difficulty latching for breastfeeding, but a visiting friend who had had a C-section reassured her that she would begin to feel like herself again soon. However things got progressively worse once Mavis returned home.

But those early days in the hospital were nowhere near
the emotions that I started to feel when I finally got home from the hospital
and realized (becoming tearful),
First off, how much pain it was to have had this C-section
And to have a new baby and to have all these sort of hormones and stress.
Just (pause) my world was just shook, that is the only way I can describe it.
I just would lay there and cry all day long.

---

[22] A membrane sweep is done by the health care provider to encourage labour to begin. It involves "sweeping" the finger around the cervix to separate the membrane from the cervix (Sally Sago, 2016).

And then all night I would cry.
And I would have a shower and I would stand in the shower
and I could just cry because I was in so much pain
and I couldn't (pause) I had a baby that did not want to latch.
I felt like I did everything wrong.
I felt like I missed out on what I wanted from childbirth
but I also felt like because I missed that window of recovery with him
that for some reason that is why he is not breastfeeding
and that's why he's not (pause) I don't feel connected to him.
I felt very despondent in those early days and even beyond the early days.
It was like six weeks of this, I don't feel right, I don't feel right.

(Mavis, 212-227)

The emotional pain Mavis experienced in childbirth and the postpartum time

could be traced directly back to the series of things that went wrong from her perspective.

Her sense of loss and confusion, disappointment and betrayal, was evident in her telling

of her birth story. For Mavis distress was clearly a sign of things gone wrong.

Distress as normal and helpful

Not all women saw distress as something to be avoided. For some, distress was

seen as simply part of childbirth. For others, distress was viewed as a way to take

meaning away from painful life events. In this view, distress was seen as a natural part of

life that marked an important, albeit sometimes painful, experience.

Elise viewed the distress associated with childbirth as an innate part of the birth

experience. Elise actively worked to resist building expectations about her pregnancy and

childbirth, as she believed she would be better positioned to deal with childbirth if she

kept her expectations to a minimum. Instead Elise allowed herself to be flexible,

believing this would serve her better in her pregnancy and childbirth. Expectations, and

the resistance to expectations, about the discomforts of pregnancy, the pain of birth,

breastfeeding, and caring for a newborn all showed up in Elise's story. In navigating

168

these, Elise seemed to take the "Goldilocks approach" of seeking just enough information so that she could make informed decisions without being overwhelmed by information and becoming too attached to any one idea about what childbirth would be like.

Elise's labour and delivery went smoothly. She laboured at home, visited the hospital, returned home, eventually returned to the hospital, laboured for a few more hours, pushed for about three hours, and vaginally delivered a healthy baby boy. Her labour was an intense experience associated with a high level of mixed emotions, marking the birth of her son as an important life event.

> When I started pushing and I am sure it was a mixture of tiredness and just overwhelmed,
> I was pretty emotional.
> I wouldn't say full out cried but I was weeping,
> probably because I was in pain and I was tired
> and then I was feeling nauseated because I was just so overtired and pain and pushing.
> I remember that and I remember when he finally came out, it was just relief.
> Huge relief and when they handed him to me,
> I know I cried a little bit and just emotional.
> All this happened and also just so happy that I was done.
> So a lot of mixed emotions, never felt anger.
> Of course you hear people getting angry at your husband, never felt that, never anything.
> It was mostly just exhaustion and happiness and tired and sick
> and yeah.
>
> (Elise, 101-113)

In her story Elise reflected the view of emotions, even strong and unpleasant emotions, as a natural, healthy part of life and life's experiences. Elise expressed an open and accepting attitude about the highly emotional nature of childbirth. Her pain, her exhaustion, her weeping, were all viewed as healthy parts of a life changing event and experience.

169

Morgan also saw childbirth distress as something that added to her life. Much of what she experienced was problematic and she would have preferred to have had a different experience, but in almost losing her son and her own life, Morgan made meaning for her life going forward. Despite the emotional pain that resulted from Morgan's difficult birth experience, she found some appreciation for the birth experience, stating it had allowed her to be a better mom.

> I am thankful for that experience.
> I really, really am.
> I think whenever things do get a little hard,
> I will just think about that and how quickly things could have been a lot different.
>
> Like when he drives me up the wall,
> I just go back to it.
> I think about it and like, how important is this?
> How important is whatever we are upset about, you know?
> Considering no day is given to anybody.
>
> (Morgan, 233-236 & 249-253)

Julie also found meaning in her tragedy of losing her son during her second childbirth experience. Julie's story was one of being saved. Julie shared in her story that during her second delivery, the way her unborn baby moved during her uterine rupture likely saved her life while costing him his own. Julie felt deep gratitude towards her deceased son for saving her life.

> I said it hurts,
> I can't move.
> And he said, "If you don't pull yourself up, he is operating on you
> whether you are under or not."
> And I looked at him and said, "I'll try but I can't."
> I kept trying but it wasn't working
> and then I had this kinda glimpse of ...
> there was something letting me go, the energy,
> I had felt a weird energy in my belly

throughout the whole pregnancy.

There was just,
You know how you have a feeling of something
it is more than you can handle.
It is, I don't know...
There was so much energy it would drain me.
It would pull all my energy into my belly
and then at that moment, I am on the operating table
and this energy just lifts me up.

Like, I don't remember using my arms.
But the doctor turned around for a second
and turned back and said,
"That's perfect, don't move anymore."
And I don't remember moving myself at all,
And he is like, "Okay, I am putting you under now,
the doctor is cleaning you, he is cutting,
take a deep breath."

And at that moment
I knew that my son had passed
and that I would be okay.

And when everyone around me was really sad he was gone,
I was happy I was still here.
And it is really selfish
because I really miss my little boy and I wish he would be here with me too,
But if it wouldn't be for him, maybe I wouldn't be here anymore.
If it wouldn't be for that baby being who he was and doing whatever he did for me
to be able to move myself up on that table,
I probably wouldn't be here right now because, you know.
And I mean they gave me 3 or 4 units of blood
because I had lost that much blood and um,
but there were no major arteries that ripped.
And they couldn't believe it
because it was intense damage.

So, I am really sad that my baby boy is not here,
It breaks my heart,
I even still have dreams about it,
But I am happy to be here.

<div align="right">(Julie, 1149-1185 & 1205-1223)</div>

Beyond her physical life-saving, Julie saw her son as her angel who has saved her life on a more existential level. Prior to his birth and death, she had no motivation for life, found little joy in each day, and felt selfish, describing three or four years of intense depression after the end of her previous relationship. After the death, of her son Julie found she had a new appreciation for life and a deeper sense of meaning.

> And then everything that happened
> and it just made me realize
> there is more to it out there than what I was living.
>
> There is more to life than just every day,
> You know, get up, go to work, cook, clean.
> There is more to life than that.
> There's more to life than buying things.
> There is more to life than oh, I have to have this.
> There is more to life, like,
> We will go for a walk in nature and it's like now I can actually appreciate it
> because I see it.
>
> I am not focused in my brain on what I am going to do next.
> I live more in the moment and it not something I used to do.
>
> (Julie, 1314-1329)

Now in her day to day life Julie experiences the presence of her son through various signs—a feather falling from the sky, ladybugs in the house—and feels her son is sending her messages about what is important in life. These moments of closeness with her son allow her to stop and reflect of what has meaning for her. She expressed deep gratitude to her son for these messages.

While distress was seen in these cases as a helpful way to find meaning in loss, or as a normal part of birth, there was still a tension between accepting distress as part of life and as pathology or mental illness.

Emotional pain and distress as pathology and mental illness

Garcia gave voice to the paradox of distress as normal versus pathological as she tried to understand her own sadness and anxiety. She had found a supportive group of other mothers at her family resource centre and in online spaces. In these spaces where women shared their experiences, Garcia saw she was not alone. If others were experiencing similar emotions she felt less mentally ill and more mentally healthy. It was not that her suffering disappeared but that her suffering fit, it made sense in the context of other women. Garcia could see that emotional suffering and pain was not inherently pathological.

> Postpartum depression or anxiety, is not viewed upon as normal.
> You are made to feel like something is wrong with you.
> I feel like a bad mom
> and I know I can say from my groups I go to that is the consensus of all us.
> We feel like we are bad moms
> and we are not doing enough.
> I have said to myself, maybe I should have waited,
> maybe I wasn't ready to be a mom.
> I don't think it would have changed anything.
> I think I would have dealt with this the same way,
> whether it was today or five years from now.
> I just wish there was a more normalized view.
> Mental health is always looked upon bad,
> whether it is anxiety or other mental disorders
> but I wish that people just understood that it is normal
> because it is normal.
> I feel like it is not normal right now
> because I am dealing with it
> but I just wish it wasn't looked upon so badly.
> It has such a negative view
> and that is why I don't tell people about it.
> Because I just feel like I am going to be looked upon like I am not normal
> and there is something wrong with me.
>
> (Garcia, 1032-1054)

Garcia nicely illuminated the tension that arises when biomedical understandings of mental illness and emotional suffering are dominant. If it was normal to feel what these women were feeling, then those emotions were by definition not pathological—not mental illness. However, in the dominant biomedical view of emotional experience, mental illness and pathology are the only way to make sense of emotional pain. Garcia and her group of comrades were trapped in this, wanting their suffering to be seen and to be seen as valid, and yet being desperately afraid of being judged by themselves and others as bad mothers, as mentally ill mothers.

> I can say it would be really nice if it was more normalized
> because I am living it,
> I don't want to tell people
> because I feel like I am being judged
> and I hate that feeling.
> I am going to be worried that somebody is judging me
> or that there is always the worry
> that someone will feel I am such a bad mom
> and I won't lie,
> they will take [baby],
> I had that feeling in the beginning
> when it first started
> that if I admit there is something wrong,
> maybe there is something really wrong with me
> and they are going to take your baby
> and I still feel that.
>
> (Garcia, 1237-1253)

The dominance of the view of emotional distress as individual pathology, and the ability of the medical and mental health professions to label and diagnose individual pathology made it difficult for women to know what they were experiencing and what they should have done about their distress. Both Garcia and Mavis provided insight into how these discursive practices of diagnosis can shape women's experiences rather than reflect women's experiences.

174

Despite all of the anxiety provoking situations involved in Garcia's pregnancies and birth experiences, and in her postpartum time, Garcia herself succumbed to supplementing her own words and knowledge of herself to those of the medical professionals involved in her care, describing her experience with "postpartum depression."

> So I did develop postpartum depression.
> With all of her medical issues, just one after another,
> It was just one thing would happen
> and then it would be something else
> And as you see today, it is still happening.
> Nine months later,
> I am in and out of the hospital,
> She has constant infections,
> Her reflux or something is happening,
> Unexplained fevers of like 104.
> So I am constantly dealing with medical issues
> and I feel like I really have not been able to enjoy her
> which really sucks because (pause)
> I enjoy the moments I do get
> but I feel like it is just one thing after another.
>
> (Garcia, 362-377)

However, Garcia demonstrated some resistance to this label of depression—perhaps because during the interview she had spent considerable time talking with me about her feelings of anxiety, and had been using the word "anxiety" repeatedly. She began to show her resistance to this diagnostic label through voicing her frustration with her doctor, and by looking for help elsewhere.

> I am dealing with a lot of anxiety and my postpartum,
> I tried to explain to my doctor,
> it is less depression,
> it is more anxiety.
> Every little thing, I am saying,
> "something has to be wrong".
> So that is really hard to deal with.
> I don't know how I am dealing

I am not dealing with it.

I am starting to see a therapist actually.
She has had to cancel a few of my appointments because she was ill,
so I am starting to see her next week
which I am hoping will help
because medication hasn't done anything for me.
It's, "we'll switch it to this, we'll switch it to this, we'll try this",
nothing is working
because she is treating me for depression
and it is not depression,
it is anxiety.

And I feel like (pause)
I have a new doctor now,
my doctor went out on mat leave about the same time I did, well a few months
in and she is not really listening to what I have to say,
so I feel like she is not trying to treat my anxiety at all.
She doesn't want to hear anything about it.
She just tries a new antidepressant.
She had switched me on to something when I told her it was anxiety.
I went back to her and I was a head case.
She said the medication she put me on could cause extreme anxiety.
It tells me there she wasn't really listening to my anxiety
because she put me on something that caused worse anxiety.
It has been hard to deal with.

(Garcia 379-412)

Mavis also struggled with knowing how to define her own emotional experience. Whereas Garcia felt her diagnosis did not match her experience, and was infuriated that her doctor would put her on medication that exacerbated her anxiety, Mavis was not sure if her experience warranted a diagnosis and wondered what diagnosis would mean for her. She was aware of the discursive practices that shape suffering into a medical event requiring surveillance and treatment, and in the case of mental illness, the great possibility of being stigmatized.

Mavis began to apply her assessment skills to herself, employing a mental checklist to decide if she was depressed, suicidal, and mentally ill. And yet, Mavis was

also acutely aware of how a diagnosis/label of mental illness can negatively shape both

one's own understanding of their suffering, and other's understandings of you as a

person. The discourse of mental illness was not one Mavis was keen to have applied to

her, by herself or others. Mavis was torn. On the one hand she desperately wanted for

someone to see her pain and offer help. On the other hand she was being very cautious so

as not to appear mentally ill to the visiting public health nurse.

> And then of course, cause, do you pathologize crying?
> At what point do we say this is something else and we put a label on it?
> And I remember kind of going through my head everyday thinking,
> "Do I need to seek help for this?"
> And I remember the nurse saying to me, you know, "Do you think it is postpartum?"
> Well, I don't know.
> I don't know if it is postpartum.
> "Well, do you have thoughts of suicide?"
> No, not sitting here, you know, thinking about suicide
> but I can see how people get to that place.
> So you start to conceptualize things totally differently.
>
> You know, here I was, I worked with people
> who all the time were self-harming or worse,
> You know, trying to take their own lives and helping them come to make meaning with that.
> It was totally different.
> And when they would say things to me,
> "Well, yeah, I have chronic fleeting thoughts of suicide,"
> I didn't really get that like from an emotional stand point
> until I was in that place where,
> "No, I don't want to die, I don't want to die, I don't want to take my life"
> And I would never,
> And if I had, I knew that I would reach out.
> But I started to understand how people who have chronic pain
> and chronic thoughts of, you know, hopelessness,
> That takes you to weird places.

<div align="right">(Mavis, 461-480)</div>

Mavis' sense of self was disrupted by how similar her emotional experience was

to those of her clients. For the first time she understood hopelessness (and what might be

discursively constructed as suicidality) in a visceral, embodied way. She was also

profoundly aware and afraid of the consequences of the label.

> And that is what I kept thinking in my head,
> If I say this is what it is and I label it something,
> What will that mean?
> And that started to unravel for me, you know?
> In a way that I was totally catastrophizing the situation too,
> Because I would think, maybe I won't ever be able to work again,
> Maybe if I put a label on it and I have to go on medication
> and I have to change my approach to breastfeeding, and (pause)
> It just unraveled this whole big picture for me
> which I knew came from a place of being educated on the issue.
>
> (Mavis, 485-495)

Mavis was speaking to the consequences of labels. Not just the external

consequences, but the internal consequences as well. If mental illness made sense to her,

would she become mentally ill and further lose herself and her identity in this?

Extremes of emotional distress become diagnosed as mental illness and in this

troublesome emotional experiences can gain credibility within the biomedical worldview.

The extreme version of emotional distress often became framed as "trauma" and, as

discussed in the literature review in Chapter 3, the discourse of trauma is frequently used

to explain and assign value to women's suffering in childbirth.

The language of trauma

Six of the fifteen participants used the language of trauma in their stories. The use

of the word trauma was associated with creating a sense that something significantly

problematic had been experienced (Beck, 2004a, 2004b, 2011; Beck & Driscoll, 2006;

Beck et al., 2013, 2011). It was associated with strong emotions of fear, guilt, and loss,

where one's ability to cope in a specific moment in time felt overwhelmed by the current

emotion. Rachel took a view of trauma that was more in line with critical trauma studies,

wherein trauma is seen as attached to problematic discourses of individualism and

personal responsibility for suffering (Burstow, 2003, 2005; J. L. Herman, 1997). Rachel

resisted the individualistic view of suffering, instead viewing suffering as a result of what

happens when people have experiences that overwhelm their ability to cope.

> …a lot of people say, "God doesn't give you anything that you can't handle"
> And I think that is a really horrible thing to say to someone too.
> It's like well, what about people who have PTSD?
> Obviously God gave them something that they couldn't handle
> and now their brain is rebelling
> and they are in trauma.
> They have been through traumatic situations.
> That's a situation where they couldn't handle it.
> How do you define it?
> I'm fine, therefore, I've weathered the storm?
> Well, for some people the storm was a little too big
> and I think it is rude to tell them,
> that was your fault
> because that obviously (trails off)
>
> (Rachel, 718-719 & 727-738)

Rachel is clear that she does not want to blame victims for their suffering. She

also recognizes that some distressing experiences are going to have a longer term

impact—that this is normal. In contrast, Patricia embraced the use of trauma as a means

of communicating individual distress (see for example, Ayers et al., 2009; Ayers &

Pickering, 2001; Beck et al., 2013). Patricia described herself throughout the interview as

a highly educated woman, who relied on her skills in research to help her make informed

decisions about her pregnancy, childbirth, and mothering. From her interview and self-

reported experience it seems clear her education and middleclass status protected her

from some of the dehumanizing aspects of maternal care. Specifically, Patricia's

knowledge gained through her own preparation research allowed her to see herself as a

partner in her childbirth experience, rather than subordinate to medical staff. However,

179

despite her extensive preparatory work, Patricia shared how fear and a lack of

understanding about her baby's health was traumatic. It happened when she was told that

her baby would be put in an incubator due to jaundice. Not aware of what this meant,

Patricia drew conclusions about what this meant for her and her baby. While these

conclusions turned out to be false, the misunderstanding caused great emotional distress,

> He was extremely jaundice.
> He ended up in an incubator, that was traumatic for me.
> That is not really birth, its post-birth
> but that I found really traumatic because I didn't find they explained it well.
> I actually sat down with the nurses at the hospital and talked with them about that
> because, you know, when you are a brand new mom with this little tiny infant
> and you are told your baby has to go in an incubator, their numbers are off
> they have to go it,
> and when they find out they are jaundice they hop,
> it is something they want to treat right now.
> And in my mind, I heard the baby has to go to an incubator,
> I thought they were taking him away and putting him in the NICU
> and there is something really wrong.
> They don't, they bring the incubator to your room and it is all done in you room
> but they hadn't worded it that way.
> They didn't say, "we are going to bring you an incubator
> and put it by your bed with the baby in it."
> It was, "the baby has to go in an incubator".
> That is the point at which all the stress of it came crashing down, I lost it.
> That was a bad day.
>
> (Patricia, 45-58)

While Patricia's son did not have ongoing difficulties, she experienced thinking

about "what might have been" as traumatic. Her baby had difficulty nursing and Patricia

finally determined her son had a tongue-tie. Similarly thinking about a potential future

that might have required a medical procedure was also traumatic for Patricia.

> When she fixed it, it was anterior tongue tie so it was at the back of his tongue,
> and she said it was severe enough it would have caused a speech impediment
> had we not caught it
> and he would have had to have it done at three or four years old.

Can you imagine how traumatic for a three or four year-old that would have been
to have done.
It was traumatic for me, I cried.

<div align="right">(Patricia, 163-167)</div>

For Cali the news of her son's difficulties was not so easily dealt with as there
were ongoing health effects for her son. Shortly after his birth Cali discovered her son
was deaf. She wondered if something she did or did not do in her pregnancy and delivery
caused his deafness.

So I was wondering, okay, what are the adverse effects because of this.
They seemed to think everything was completely fine
and then when we found out that he was deaf, I started questioning.
Should I have been really stern and said, "I want the C-section"?
Was it something I did?
Was it something that they did?
And I don't think we will ever find that out.

<div align="right">(Cali, 85-91)</div>

Cali linked the experiences she had during the relatively few hours of childbirth
with longer term struggles with emotional distress, for which she continued to seek
counselling. In dealing with the discovery of her son's deafness, Cali found attempts by
those around her to reassure her through statements such as "it is going to be okay" were
not helpful. In fact everything was not okay. She continued to struggle with low mood,
feelings of guilt, and the realities of having a son who was deaf. Cali used the
terminology of "trauma" to describe the difficulties she experienced. Using this word
gave a certain weight to the importance of her experiences and of her emotional and
physical pain. And her worries about her son, his birth, and the physical pain she
experienced after childbirth, became entangled with her previous experience of the
trauma of her sexual assault.

First I thought, okay, is this normal, this pain,

<div align="center">181</div>

everything, the trauma that I went through
And when it lasted more than a couple of days,
I thought, okay, something is going on, something is wrong
But I am a very private person so it took me two weeks before I even went to the
hospital.
It took to the point until I couldn't almost stand up and actually go.

(Cali, 305-310)

As a survivor of sexual assault, Cali's need for privacy meant she delayed seeking

medical help (Halvorsen et al., 2013; McKenzie-McHarg et al., 2014).

Well for me when I think about everything that I went through
In terms of you know, the pushing, the body, my whole insides,
everything kind of changed.
Everything felt, didn't feel normal, right?
How I was feeling afterwards, all the pain afterwards.
And then for me the traumatic experience about my son.
What did all this cause on him?
If I had of pushed harder, all of that.
So not only my own personal but then worrying about him as well.
…
And for me too, being that exposed.
Because I have been sexually assaulted.

(Cali, 475-491)

Here Cali linked the childbirth experience and the vulnerability and physical

exposure that were part of childbirth with her experience of being sexually assaulted. One

trauma informed and influenced the other. Childbirth and the postpartum period brought

up old traumatic events, and old traumatic events influenced the birth experience (S.

Kitzinger, 2006b; McKenzie-McHarg et al., 2014). This linking of past, present, and

future in a nonlinear way was common throughout the childbirth narratives of the

participants. Indeed, many narratives were not linearly structured, representing the

experienced-based, rather than event-focused nature of childbirth and childbirth

narratives.

Childbirth and Narrative

Narratives are not neat and tidy. The childbirth narratives shared by the

participants reflected the experienced-based view of narrative, illustrating the difficulty

defining childbirth as a strictly temporarily ordered event with a beginning, middle, and

end. Participants combined past, present and future, often traveling back and forth

through time and telling. In telling their stories, participants viewed their birth stories as

the prize claimed for surviving the ordeal of birth.

> Yes, something will happen, something will go wrong
> But there will be a surprise.
> There will be things you don't expect,
> You can't prepare for everything.
> But you kind of don't want to, you know?
> Because if it was textbook, it would be underwhelming (pause)
> "Yeah, I went in there and phase one, phase two" (pause)
> Nobody says that, right?
> "I went in and it happened just how I thought it would."
> Yes, that would be kind of boring.
> "I guess I have a baby now, okay".
> "Yeah, I guess I will go home" (pause)
> Then you don't have a story.
> You will be surprised, it will add to your story.
> It might be an awful story
> But then you can bond with people.
>
> (Rachel, 923-932; 937-938; & 943-946)

Stories were seen as valuable in their own right and stories were used as metaphor

to add a depth of understanding to experiences difficult to explain through s strict

reporting of events. And finally, as discussed in Chapters 4 and 5, in these childbirth

narratives knowledge was not just shared by participants and harvested by me as the

researcher, but instead knowledge and meaning was created as the participants and I

engaged in back and forth conversation about their stories (H. Fraser, 2004; Riessman,

2008).

Narratives reflecting the nonlinear structure of childbirth

Participants often expressed hesitation in choosing where to begin their childbirth story. This mirrored their lived experiences of not knowing (or disagreeing with medical staff) whether or not their labour had begun, resisting the idea that childbirth has a clear beginning point (O'Reilly, 2004b). This uncertainty with where to begin also reflected participants' hesitations with how to behave during that time when it was unclear if labour had begun. Some participants began with the time after the baby was born and then worked their way back to delivery, and labour. Still other women began with the days leading up to delivery—the final days of pregnancy, while others began by orienting to the months before delivery or even before they became pregnant. For example, Patricia was unsure where to begin:

> Do you want to start just with birth or back in pregnancy?
>
> CMF: You tell me, wherever you think it is important to start.
>
> I have been off work for over a year and the baby is only six months old.
> I had a hard time with pregnancy.
>
> <div align="right">(Patricia, 3-10)</div>

Carrie also provided an example of flexible timelines with regards to childbirth narratives.

> I think I will have to start just a little bit ahead
> because it will pertain to the birth experience.
> I am 43 and so this pregnancy was a surprise,
> maybe it wouldn't have been for another 43 year old, but anyway,
> I am 43 and so this a surprise for us because,
> mainly because, not even my age,
> but I had an ablation in 2013, endometrial ablation
> and so didn't really think that we could even get pregnant.
>
> <div align="right">(Carrie, 9-15)</div>

And Rachel who started with the last week of her pregnancy:

184

Okay, so we are talking about her,
so that is my second birth.
A lot of the things I sort of knew what to except.
I knew the last month would be hard, labour and delivery, and such
But I didn't know it would be harder, you know,
Because I kept hearing from other people,
the second or the third one,
Because you are all loosened up.
It didn't really felt like that.
The last week right before I gave birth was awful.
I was crying every other day
and then labour actually lasted longer with this one than my first
which I felt was really unfair for the universe to do me. (Laughter…)

<div align="right">(Rachel, 1-13)</div>

Like Rachel, who mentioned her first birth, many women also began by referencing previous birth or pregnancy experiences.

Inclusion of previous birth stories in the narratives

For women who had lost pregnancies or babies, the fear and physical changes to their bodies influenced how their most recent pregnancy and childbirth was experienced. Julie shared her first childbirth story in a very neat beginning, middle, end, abbreviated story. She then began to tell the story of her second birth, and after telling that harrowing tale, told the story of her most recent birth.

I am going to start from the beginning
because it kind of goes,
So I had my daughter in 2006,
She was born natural, no C-section, epidural,
everything was good,
She got stuck a little bit on the side
but 13 hours later she was born.
So it was great, it was a good experience.

And then in 2013,
I got pregnant again with my son, F,
And that was my nightmarish labour.

<div align="right">(Julie, 9-22)</div>

<div align="center">185</div>

Comments like "it kind of goes" as Julie says above, may perhaps suggest the story is a rendition of a well-rehearsed story. In telling their birth stories all the women for whom this was not their first pregnancy referenced their previous pregnancies and birth experiences. Those women with previous births frequently compared the labour and deliveries to each other, often weaving stories in an out across each birth experiences. Garcia provided a clear example of how previous births and pregnancies interacted with more recent experiences. There are implications for practitioners working with birthing mothers who've experienced distressing prior births (these will be discussed in Chapter 9).

> I think for me to explain my birth story
> and why this caused me a lot of anxiety and things,
> goes along with my previous,
>
> So I have had two pregnancies prior to [baby]
> that I underwent with a fertility specialist to try to get pregnant
> So I took Clomid[23] for months and months and months
> and I had a miscarriage very early on
> And then I got pregnant the second time
> and I was very, very anxious because I had miscarried my first pregnancy,
> So every little thing bothered me and I started getting a lot of cramping,
> So cramping was normal and everyone kept saying, "Oh it is nothing, that is normal, that's normal"
> But one day it really felt like it was too much
> so I went to the hospital
> and I was told they thought I was having an ectopic pregnancy.
>
> I kinda met with a bunch of doctors
> and everyone explained things
> and we went on our way,
> and I went to an ultrasound
> and I was told it was an ectopic pregnancy

[23] Clomid is medication used to treat infertility. It is taken by women to increase their chance of becoming pregnant (Mayo Clinic, 2016a).

and that they were going to terminate
and they did not give me a lot of information on what would happen,
just they were going to give me a medication.

So, I did receive Methotrexate[24]
and about half an hour later I got very, very sick.

They admitted me to the hospital
And about 3 or 4 hours later I went into surgery because my sats[25] were dropping
And they thought my ectopic had burst.

I woke up from surgery the next day
to be told that they never found an ectopic pregnancy,
They did not know what was happening,
I was going to go for a follow-up ultrasound,

So I had bad news that night,
I was losing my pregnancy that I had just went months and months trying to get,
I had surgery,
"What do you mean I didn't have an ectopic?"

So I went to the follow-up ultrasound
and I was sitting there with my boyfriend
and we were watching and no one was saying anything
but I could see the screen and I started asking questions,
I said, "Well what is going on".

I was seeing one of the specialists at the [hospital] and she said,
"Just one second"
and she was very sweet
and I knew her very well
But by this point because I had fertility treatments
and saw them for months and months,
she turned around and took my hand and said,
"I don't know how to tell you this but you are pregnant with twins."

And I knew that
because I could see it on the screen myself.
But then she had to have a very unpleasant conversation with me,

---

[24] Methotrexate is a drug used to end an ectopic pregnancy (Medscape, 2016).

[25] "Sats" refers to oxygen saturation, the amount of oxygen carried in the blood (Mayo Clinic, 2016b).

that I had Methotrexate given to me two days prior
So I did lose that pregnancy.

It was never ectopic,
I was misdiagnosed.

So, I lost a pregnancy
because somebody made a mistake
which was very hard to deal with.
I think I probably still am dealing with it
and that was in 2011.
So it has been a while.

Blessing in disguise,
my fertility specialist at the time had talked to me about weight loss surgery
because I was very obese
which is why I had started going to see them
because I was not able to get pregnant
and I had weight issues.

I came home from the hospital after all of that ordeal
to a call from the weight loss surgeon
who is supposed to take five years,
took me a month.

So, I went on to have weight loss surgery
and I lost 160 pounds
and I naturally was able to conceive [baby].
That was a huge thing for us
to not have to do the Clomid cycle all over again
because I would not wish that upon my worst enemy.

We had the pregnancy
when I was very, very high anxiety during my entire pregnancy.
I think I peed on sticks every day for probably about a month.
I bought a lot of pregnancy tests
because I was convinced that something wrong was going to happen,
every little cramp, I was like,
"I am miscarrying, I am miscarrying."

I think that so many times, I did not sleep
because I thought for sure
there was no way I was going to have a baby.
It was going to happen again.

(Garcia 1-108)

188

Garcia's story served as an example of how childbirth stories cannot simply be disentangled from each other without losing important meaning and understanding of what giving birth means to women. Garcia contextualized her most recent pregnancy and childbirth within the frame of two previous lost pregnancies—one by miscarriage and one by a medical error, and it was also tangled in the weight loss surgery, which paradoxically allowed her to get pregnant without further medical intervention.

In addition to using non-linear approaches to narratives reflecting an experienced-based understanding of childbirth, participants also used other narrative devices to share meaning, including metaphor and embedded stories.

Use of narrative devices in childbirth stories

Some participants used stories within stories, and metaphors (such as Julie's story of the worm eating her pea) to help illustrate the points they were making. Rachel in particular made use of several storytelling strategies with great effect. First, as Rachel was discussing the question of how to reassure women about childbirth she developed a synthesis of the apparently paradoxical views of having expectation versus not making decisions about childbirth. She advised women to become comfortable with not knowing what to expect, rather than trying to prepare ahead for something one cannot really prepare for. In explaining her synthesis of this paradox, Rachel shared a story of an interaction she had had with a woman at the grocery store as an illustration.

> I ran into this woman a week before I gave birth,
> I was huge.
> And I was going to pick up groceries and she saw me and she said,
> "Oh any day now eh?"
> And I was like, "I was due yesterday we are just seeing what happens"
> and tried to make light of it.
> And she said, "Well, don't worry about it, it's going to be fine."

189

And I said, "How do you know? You don't know that!
I might have a really awful birth.
You don't know that.
How do you know it is going to be fine?"

She sort of thought about it,
she has had three kids, they are all grown,
and she sort of thinks, she said,
"Well, it will be whatever it is. You will get through it and you will have a baby".
That was the best peace I have ever got,
It stayed with me.
The rest of the week and all the way during birth,
I had her voice in my head, it's like
"It will be whatever it is, you will get through it and you will have a baby"
And that is all anyone needs to know,
You will get through it.
I guess some people don't
but most people do,
Most people get through it
and then most people have a baby.

<div align="right">(Rachel, 263-291)</div>

Rachel's also shared her thoughts about living with the uncertainties associated

with childbirth and the importance of stories as a helpful tool in making sense of the

difficulties experienced in childbirth. In her narrative, Rachel used metaphors to illustrate

the importance of being open and flexible in dealing with uncertainty, comparing the

unpredictability of childbirth to the unpredictability of other important life events.

When I got married, I said "Okay, I need to ask you advice about getting married"
And she said, "Something will go wrong, it's just going to happen.
Hopefully it will be small, it might be big.
But you will have a fun time at the wedding."
And she said "There has never been a wedding where absolutely everything goes right,
Something will go wrong."
I was like okay
And that was really great because I remember getting to the reception
And we had set up a photo booth table
and there was a whiteboard with pens
And there was a decorated table where people could write notes and there was no camera…

"Why is there no camera here?"
So some people had to go and get it
And you know what?
That was okay,
Especially after the third glass of wine, forget the photo booth.[26]

(Rachel, 892-908)

In the end, Rachel saw the birth story as the prize one gets for going through childbirth. This view of the story as a prize fits within the broader theoretical views of narrative studies, where stories are seen variously as sacred possessions, medicine, currency, and as a means of coming together and finding commonality among experience (Shuman, 2005), and speaks to the importance of sharing and hearing stories—a central tenant underlying this very research project.

While stories may be seen as a prize or currency, they were also viewed as possessing a certain form of transformative power. An interaction with Carrie I recorded in my field journal illustrates this point. When meeting with Carrie, after the interview, when the tape had been turned off and I was at the door ready to leave, Carrie took a moment to speak with me about the importance of stories. She felt that childbirth stories are very important but she wondered if they were too powerful to share with women who had not given birth. In this hesitation, Carrie also demonstrated her awareness of the power of narratives to shape understandings and the caution that must be taken with stories so that they do no harm.

Interactions such as this one with Carrie were common in the interviews. Questions were not simply asked and answered. Instead new ideas emerged from discussion as a result of back and forth wondering between me and the participants. This

---

[26] Rachel added in member checking that the cameras never arrived at the wedding.

191

iterative production of knowledge is in line with feminist narrative approaches and contributed to a depth and richness that could not be obtained through adherence to a strict interview guide and structured questions (Barbour, 2008; Hydén, 2013; Riessman, 2002; Squire, 2013).

Iterative knowledge production

There were many moments in the interviews with participants where ideas emerged that I had not intended to discuss but that nonetheless seemed important and relevant for this research. For example, in my interview with Cali, she was speaking about her belief that women are considered secondary to the baby in the childbirth experience, and she hesitantly expressed her discomfort and disagreement with this position. This is an area that I feel strongly about as well, and so I made the deliberate decision to expose this bias/belief that I hold. Partly I did this to encourage her to continue to explore a topic that is somewhat taboo (to put the woman's needs ahead of the baby's needs) and partly I did this so that the participant was aware of my own position in this. I clearly identified the "good mother" discourse we were disrupting by talking about putting women's needs at the front of childbirth discussions. This likely shaped the direction of the interview as we went on to discuss the topic for a significant portion of the interview.

> CMF: We never just assume we all want what is best, we have to say that.
> So that is part of me doing the good mom thing.
> And yet, I also, as a woman want what is best for other women.
>
> Exactly and to me, if you don't treat the woman first,
> then the baby is not going to be healthy either.
> Because if the mother is not healthy, mentally, emotionally, psychologically
> then the baby is not going to be healthy.
> They are not going to be able to truly care for their baby.

And in the hospital I had so much stress and pressure put on me for breastfeeding that I couldn't do anything else.

CMF: We forget there is a human behind those boobs.

Laughter

Exactly. Yeah. I felt like a cow.

CMF: You felt like a cow?

I felt like a cow, all I am good for is milk.

CMF: So again, this idea of "I'm an incubator, I am a feeding machine, I am a cow" that your humanity gets lost in that.

It does. I know from where I stand in my position
with the [healthcare work I do], even though, yes,
We are looking at the fetus as well, the unborn child,
But our main focus is the woman and it has to be done.
Even though, in the back of our heads, like you said,
you are still concerned about the baby as well.
But we have to treat the woman first and that is best practice for us.

CMF: Now, is that kind of a controversial stand do you think?

It is.

(Cali, 885-918)

However, it would be a mistake to believe that shaping only happens by asking or directing certain questions. My silence, or my holding back of my own beliefs could have also shaped the interview, as I wonder if my silence, or a soft prompt of "tell me more about this" on this controversial topic could have acted as a deterrent to further discussion, given the risk the participant was taking in raising a sensitive topic. As discussed in Chapter 5 silence and questions both shape interviews and in feminist narrative methodology the aim is not to be neutral but to be transparent in my positionality (H. Fraser, 2004; Riessman, 2008; Tufford & Newman, 2012).

193

Breastfeeding was another unanticipated topic of discussion that emerged within the interviews and that was not reflected in my general outline for interview questions. For many women, childbirth stories did not end with the delivery of their baby, or even with returning home from the hospital. Nine of the 15 participants included significant discussions regarding difficulties with breastfeeding as part of their stories of childbirth distress, and another four participants mentioned breastfeeding difficulties but these were not the focus of any specific story in their narrative. Only two participants did not mention breastfeeding in their childbirth narratives.

The specific themes associated with breastfeeding related distress will be expanded upon in the following chapter as breastfeeding emerged from many of the interviews as an important theme and focus of consideration in childbirth narratives. But the inclusion of breastfeeding narratives within childbirth narratives demonstrates that childbirth is represented as an experience rather than as a temporally ordered event. Discussions and decisions about breastfeeding occurred often before labour and delivery; breastfeeding would often begin while women were still in the labour and delivery room; and breastfeeding continued through the hospital stay and beyond once the women returned home with their babies. In this way, breastfeeding became an experience central to childbirth that transcended time and place. Struggles with breastfeeding, beyond the material difficulties associated with nursing, became symbolic of struggles throughout the childbirth experience; struggles with being invisible, with having women's needs subjugated to the needs of neoliberal healthcare and to the needs of their babies, and struggles with exercising agency in decision making.

Summary

This chapter discussed childbirth as an embodied experience and reviewed how participants live at the intersections of various privileges and marginalizations. These intersecting identities shaped childbirth experiences in ways that were both seen and invisible to participants. Participants' identities were often associated with the emotional distress they experienced in childbirth, and this chapter reviewed how concepts of distress were taken up variously by the different research participants. Finally, this chapter reviewed childbirth through a narrative lens, exploring how narratives reflected an experience based view of childbirth, and made use of various narrative devices to illustrate this point.

The following chapter continues the discussion of the results of this research. Chapter 8 focuses on the themes that emerged organically from the participants' childbirth stories. These themes include breastfeeding as a site of distress, and the emotional labour associated with childbirth. Chapter 8 also explores the many polarities and paradoxes women were expected to navigate during childbirth and the distress associated with this tightrope walk. Finally, in Chapter 8 I share the participants' ideas and advice for pregnant and childbearing women, and for those who may want to improve the lived experiences of women during childbirth.

CHAPTER 8

INTERPRETATION AND DISCUSSION OF FINDINGS: WHAT CONTRIBUTES TO DISTRESS IN CHILDBIRTH AND WHAT HELPS

This chapter provides an analysis and discussion of various themes that emerged from participants' childbirth stories. These themes include the emotional labour associated with childbirth and the various polarities women reported navigating in childbirth. The chapter also explores how breastfeeding is linked with dominant discursive construction of women's embodied experiences of distress and their constructions of themselves as good mothers. Finally, this chapter concludes with a discussion of what was helpful for women in childbirth and participants' advice for those wanting to work with women to improve childbirth experiences.

Emotional Labour and Caring Work

Emotional labour refers to the work of caring that health care professionals, specifically nurses, undertake as part of their jobs (Carter & Guittar, 2014; Huynh, Alderson, & Thompson, 2008). The concept of emotional labour reflects the notion that the technical aspects of nursing are not sufficient to the work nursing entails. Huynh and colleagues (2008) explain, "Nurses confront human suffering on a daily basis and are expected to provide genuine caring to alleviate patients' distress rather than simple task-oriented responses" (pp. 195-196) and further explain that "emotional labour refers to a worker's endeavor to display emotions according to embedded social and cultural norms rather than what he or she actually feels" (p. 196). That is, emotional labour is the work involved in expressing socially appropriate emotions instead of displaying the emotions one is experiencing in the context of caring for another.

In many of the stories the participants told, nurses were not the only ones who were involved in emotional labour. The women shared numerous stories of working hard to express empathy and appreciation of nursing staff, even when their own internal experiences were emotions of anger, frustration, and sadness. It seems ironically cruel that this work of caring for others is visible when it is being performed by nurses and yet is invisible when being performed by patients (Carter & Guittar, 2014). The gendered nature of both nursing and mothering also reflects the extra labour women are expected to perform by presenting only an "appropriate" range of emotions in stressful situations such as childbirth (Hochschild, 2012).[27]

Both Nella and Mavis shared their experiences of tending to the emotions of the nurses and doctors involved with their care, and the distress this caused for them in their childbirth experiences. In her interview Nella discussed how her birth experience began on an unpleasant and confusing note, when she realized the staff involved in her care were dealing with another emotionally distressing situation elsewhere in the hospital. Nella immediately began to work to respond to the emotional needs of her care team, despite needing to have her own emotions cared for while she was experiencing a slowly progressing labour.

> But one thing I found was odd, or distressing,
> since that is what we are here discussing,
> is the practitioner that was working with me and the nurses,

---

[27] Hochschild, (2012) refers to paid emotional performances of caring as "emotional labour" and to unpaid emotional performances of caring as "emotional work." For the purposes of this discussion the paid element of the emotional caring is not the focus, and so emotional work and emotional labour are both included and the terms are used interchangeably.

there was something else happening in the hospital.
There was a patient, it was a very sad story,
I honestly did not catch all of what was happening
because obviously I was concentrated on my own moment,
but the doctor started crying about this other story
which was, you know.
I was trying to be as empathetic as I could and understand what was going on,
and obviously things weren't moving along quite quickly
so I guess it was a time filler for everybody to be focused on this other event.
But it made it difficult I think for myself, it did for sure,
and afterwards my husband brought it up
because he thought it was odd.

(Nella, 30-44)

However, Nella worked hard to be empathetic to the staff, even continuing her emotional

work long after her pregnancy labour had ended.

Afterwards, I was thinking, you know,
"Try and think of it as if was my workplace.
Put yourself in her shoes, Nella,
so that you can be empathetic to what was maybe happening." Right?
So, I am like, Okay, I am going to put myself in that doctor's shoes for a moment
and maybe it was a patient that she had been seeing regularly,
Like I don't know.
I don't know what the history was,
maybe, it was six or seven o'clock in the morning
and maybe she is just emotional in the morning.
I don't know.

(Nella, 935-944)

Gender and social class intersect in emotional work (Hochschild, 2012). As

discussed in the previous chapter, Mavis was quite aware of her social class expectations

as a middleclass woman experiencing childbirth and we saw Mavis discuss how her class

status led to expectations that she suppress any distress, to "sweep the problems under the

rug, don't talk about all those things" (Mavis, 520). This denial of distress was also

evident in the emotional work she carried out as a patient on the maternity unit.

Mavis delivered her baby boy who was immediately whisked away to the nursery.

Despite assurances Mavis would have skin-to-skin time with her baby (the last remaining

vestige of her so desperately desired natural birth) she did not see her son again for more

than three hours. In the intervening time, Mavis played the part of the dutiful patient and

proper middleclass woman, making small talk so as to not make the recovery room nurse

uncomfortable.

> I get into recovery,
> I had done one of my clinical placements at the hospital
> so I knew the nursing staff that was looking,
> one of the nurses that was looking after me in recovery
> and we were just talking about everything but "Where's my baby"
> I just remember it being so weird,
> We were taking about if she had eyelash extensions and I was laying there
> thinking,
> "I feel so exposed",
> But I am trying to be nice to these nurses who came in from a long weekend.
> Um, so it was just a very bizarre thing.
>
> (Mavis, 164-172)

Similarly, Julie found herself needing to tend to the social worker while she

herself was trying to cope with the sudden death of her baby;

> So for [the social worker]
> She's probably just kind of trying to learn as she goes
> So maybe she doesn't know how to react
> She doesn't know how to, what questions to ask,
> So yeah, I found that a little difficult
> I found sometimes she would come talk to me
> and I would be the one helping her understand things
> more than her trying to help me
>
> 'Cause I had to explain how I was feeling
> And then she would look at me and she would be,
> it's like she was puzzled
> because she didn't know how to react to that kind of grief, right?
>
> Julie (1791-1798 & 1819-1822)

Hochschild (2012) discusses the way in which certain jobs (such as nursing) become attached to and defined by emotional performances—where performances of emotional caring become as much art of the job as the physical care provided. However, as Foucault (1972, 1977b) showed, all sorts of objects are created through discourse, and so we can see that it is not just doctors and nurses but also patients who are discursively constructed. In these discursive constructions of women as patients and as medical staff, women's work—giving birth and tending to those giving birth—includes discursively constructed parameters about emotional expression. Mavis and Nella understood these parameters and expectations without ever being told they were to behave in a certain way. They quickly learned that part of the role of labouring and postpartum women is to care for those who are caring for them.

In addition to caring for the hospital staff, women in the throes of labour and delivery and in the postpartum time also took on the work of caring for their family members. While Carrie was dealing with the reality of and emotions associated with fearing for her own life, and the life of her baby, she was additionally troubled by the effect her medical emergency had on her older son and daughter. The distress she felt (and continues to feel) regarding the emotional impact her dramatic birth experience had on her two older children was evident in Carrie's tearful telling of her concerns for her children.

> I remember seeing blood on the walls and it just,
> because they were rushing, and moving so quickly,
> it was a pretty scary thing and for [my daughter] to be in there and to see that,
> I felt really badly about that (becoming tearful)
>
> (Tearful, crying) I guess I just didn't want her to think that at forty-three,
> she could have lost her mother or sister

because that is a young age, I think,
to have to be concerned about that.

<div align="right">(Carrie, 408-411 & 416-419)</div>

And regarding her son:

(Tearful) I think it was actually more [difficult] on him
and we were going to talk to someone about it afterwards
but he didn't want to
and as time went by, it didn't seem like it was necessary anymore
but I know initially he just seemed really standoffish for a long time.

I think he thought she was going to die (pause)
He was always saying, "Is she breathing, is she breathing?".
If anything out of the ordinary.
He never wanted to hold her,
he was scared that was going to hurt her.
Maybe he would have been like that anyway
but it just seemed a little more so to me.

<div align="right">(Carrie, 425-429 & 438-444)</div>

Just as Carrie spent time worrying about the effects of the birth on her other children, Nella spent time and energy worrying about her husband. The labour of worrying about her husband's emotional needs began in childbirth and continued for three months after her son's birth while she and her husband waited to hear about the medical appointment that would tell them if their son had permanent damage to his arm caused by the birth.

Nella spent the waiting time worrying about the stress the uncertainty about her son's health was causing her husband. Nella, as she did in the delivery room, felt responsible for attending to the emotional needs of others – in this case it was her husband who she felt she needed to care for. Like other women in this study, this labour of caring for others occurred while Nella was also managing her own emotional responses of anxiety and worry.

So that is something else you deal with.
How does your partner react to all this stuff and what is happening?
He was worried about his arm.
I was trying to be, "Oh well, you know, don't worry about it,
we'll just deal with it when it comes."
And really I was like,
"Jesus Christ, I know, why don't they just hurry up!"
So, yeah, it did weigh on me.
…
So I was like okay I need to, you know, be the strong one here.

(Nella, 538-555)

Patricia, who was somehow aware of the labour of caring for others, cleverly took

prophylactic action, contracting out the emotional labour of caring for her husband during

childbirth to her doulas[28].

And [the doulas] were amazing.
They come to see you leading up to the birth and then they are there and yeah,
Okay, [husband] will say, "Well you shouldn't have to worry about me."
Well part of my worry of giving birth was *him*.
Because I knew he wouldn't leave unless he absolutely had to.
I know him. He wouldn't eat. He wouldn't sleep.
He would be right there as long as he possibly could.
I know birth can be a very long process and I was really worried that he wouldn't eat
And they would chase him,
"Go eat, she will be fine for a little while, go eat, I won't leave her,
don't worry, go have a smoke, go have a coffee, go eat".
And that was good because I didn't have to worry.
I know they were there not just to look after me but to look after us
which is really good and they were very good.
Because the doulas were there, the nurses tended to come in less
and my doctor he came in like once or twice all day
because he knew that I just didn't need him, right.
Yeah, I mean they were really good.
(Patricia, 303-318)

---

[28] "A doula is a personal support worker who is hired by families to support their experiences in pregnancy, through labour and birth, and in the immediate year following the newborns arrival." ("DTC," n.d.)

Patricia voiced her awareness of caring labour as a highly gendered activity, naming this

emotional work as a "woman thing" and recognizing that the energy required for this

caring labour could distract from the work of childbirth.

> It's a woman thing isn't it?
> That's what we do.
> We worry about our people.
> We worry about our husbands.
> We worry about our kids. We worry about (pause)
> …
> But that is part of our nature, is to worry
> And we can't focus inward on ourselves and what we need to do to give birth
> if we are worried about everybody else around us.
>
> (Patricia, 322-330)

Caring for others during childbirth was some of the invisible labour women

performed. Additional invisible labour was associated with the work involved in trying to

navigate paradoxical and polarized discourses regarding childbirth. Women told stories of

significant emotional distress associated with traversing this contentious terrain. In the

participants' stories outlined below, pregnant, labouring, and postpartum women

struggled with navigating the expectations for women to speak up and be silent; to make

decisions and to defer decisions to medical authorities; and to always centre the needs of

their babies through breastfeeding or pay the costs associated with breaches of these

expected and demanded behaviours.

Polarities

An overriding theme of many of the participants' stories was one of feeling caught

in various binaries and polarities regarding childbirth. These include the polarized

constructions of childbirth as either a natural or medical event; polarized positions among

medical staff about the role of women in decision making in childbirth; polarized

expectations about what knowledge women should be expected to know about childbirth; and contradictory messages about the importance of breastfeeding.

Discussions about natural and medical childbirth were frequent, suggesting that there are only two kinds of birth experience, even though women faced a variety of childbirth experiences that did not fit neatly into this binary model (Chadwick, 2009). In this research, polarities positioning childbirth as either natural or medical pressured some women to align themselves with one approach over the other. This polar thinking about childbirth created distress when women strongly aligned with one approach over the other, only to be faced with a different set of experiences than they had hoped for.

Medical (with interventions) and Natural (no interventions) Childbirth

Sally provided insight into the power the medical/natural binary holds in defining childbirth and in its role in how women make decisions about what sort of childbirth they desire. Sally was faced with contradictory messages about vaginal birth and C-section delivery from the two physicians involved in her care.

> Basically because I didn't know, well which one is better?
> I am really stuck going, "Well what is better for me and my babies?"
> Because one doctor says this and then one doctor says something completely different.
>
> (Sally, 391-393)

Unlike Sally who was confused by the contradictory information provided by her two doctors, Mavis was clearly aligned with wanting a "natural childbirth" which meant for her, no medication or medical interventions. The emotional distress she experienced in childbirth was closely related to the rupture between her desire for a "natural birth" and the reality she experienced when she had multiple medical interventions cumulating in a C-section.

[The obstetrician] let us go home and kind of pack our bags
and I just remember kind of meditating on that whole process and thinking,
"Okay this is how it's meant to be and how this baby needs to come out safely
and I am still going to have my natural childbirth with or without drugs.
I'm going to deliver this baby vaginally."
And, uh, so I went home and my mom took me to the hospital
because my husband had to go back to work and finalize some stuff,
so my mom took me to the hospital
and I was laying there while they were getting me ready for this induction.
I was getting quite emotional about the whole thing
But I was just was sort of taking it in stride too
'cause I knew that I have made this decision, you know,
the doctor sort of said this is the best route.
Okay.
So I sort of come to terms with that at that point.

(Mavis, 38-51)

In this excerpt we can see Mavis desperately clinging to the natural discourse, even as she

worked to redefine it, as her birth began to involve more and more interventions.

Patricia spent considerable time and energy in her pregnancy reading about the

risks and benefits of natural and medical childbirths. In her story, she reflected the binary

approach to labeling childbirth, explaining how her research led to her wanting a natural

childbirth

In our medical, hell-bent on medicine culture we have lost that natural process
which was one of the reasons I really wanted to work with the midwives.
I wanted that natural process, that warm and cozy, surround by people you trust,
not a cold, sterile hospital type of thing.

(Patricia, 422-425)

Conversely, Anne desired a more medically involved childbirth and feared she

would be required to give birth without any pain relief. Anne explained her emotional

distress was based on her fear of pain, and the pressures she felt to continue to labour at

home without pain relief.

[The doctor] came in and she did the same thing.
"This is your first child, you are young. It is really early.

205

It is going to be hours. We don't want to keep you."
They wanted me to go home.
They said, "We'll give you some Morphine and we will send you on your way."
I was getting really nervous because I knew I wanted an epidural.
I wasn't good with pain and I had a friend who they kept sending her home
and by the time she got to the hospital they said,
"No it is too late to give you an epidural."
I was really worried about that.
I was really nervous because I wanted to stay there.
Nobody wants to be to be in a hospital
but I felt comfortable there because I was afraid to go home

(Anne, 41-46)

The ease with which participants discussed the natural and medical divide, either to align with one side or the other, or to try to negotiate some sort of middle ground between the two extremes, reflects the manner in which the master narrative of childbirth as a disembodied medical event remains central (Chadwick, 2009, 2014). In this master narrative the medical view of childbirth is dominant and the natural view exists as resistance to this dominant discourse; but in this resistance natural discourses continue to reinforce the medical discourse as dominant (Chadwick, 2009). What is missing in many participants' stories is a subjective telling of their embodied experience outside of these binary discursive constructions. Anne hinted at the inadequacies this binary in her view of childbirth describing her experience as "a natural delivery." Anne viewed her delivery as "natural" despite having morphine, nitrous oxide, fentanyl, a membrane sweep, fetal monitoring, an epidural, and an episiotomy. However, for Anne the natural discourse fit for her because she did not require a C-section.

And that half hour made all the difference
and I was able to have a natural delivery.
I didn't have to have a C-section.

(Anne, 120-121)

Anne's narrative highlights the absurdity of the duelling discourses, and leads one to wonder what sort of knowledge is missing when women have only these discourses of dominance and resistance to help make meaning of an embodied and emotionally powerful life experience (Chadwick, 2009; Schiller, 2016b).

Expecting Women to Make Decisions vs. Not allowing Women Input Into Decisions.

Participants also found themselves trapped in polarities about decision making. Some women felt pressured to make decisions about their birth experience that they felt were beyond their capacity to make, while other women felt they were not allowed to have the involvement they wanted in making decisions about the birth. The various approaches to decision making that medical staff endorsed left many women feeling confused about their own role and frustrated with the overall experience.

Nella had the experience of feeling like she was asked to make decisions that she was not comfortable making. She felt her delivery was not progressing, and started to worry about her baby. Because she believed the care team was distracted (dealing with the sad situation mentioned earlier) she felt she needed to draw their attention to her slow progress. She asked the medical team if they could intervene in some way to help the labour along. Nella felt alone in making the decision to ask for assistance in delivering her baby, believing that she should never have been placed in the position of needing to be the one to alert the medical team to concerns about her baby's safety. In the end, Nella believed she made the correct suggestion (assistance with delivery) and the right decision (to accept this assistance), but she remained frustrated that she was placed in this position to begin with.

And [the doctor] did say after she was like,

207

"I am glad I asked you, you made a really good call
because if I didn't suction him out the way I did,
I don't know what would have happened."
The shoulder was clearly stuck.
So she was like, "I am glad that you made that decision."
So I was happy about that but then again I was like, "Wasn't that her call to
make?"

I suggested [the vacuum extraction]
Because I just said, you know what,
I've tried this way, you have had me on squat bar,
you have had me this way, that way,
it was moving along well until it was like,
and she was like, "I can see the head",
and then it was just like nothing.
Right.

(Nella 146-152 & 217-224)

Nella emotionally carried the responsibility for her son's potential nerve damage,

wondering if her suggestion and ultimate decision to be more aggressive in delivery

caused harm to her baby. She believed that the physician abdicated her role as decision

maker (or as one to make expert suggestions) to Nella and in doing so unfairly shifted the

burden of responsibility from the medical team to Nella.

Where Nella felt she was left on her own to make important decisions about

childbirth, Sally felt she had no say in what would happen to her in childbirth. Sally,

caught in between the dueling doctors' views on vaginal birth versus C-section, explained

how she was never included in the decision about what her birth would look like.

I definitely would have preferred for [the doctor] to have explained to me the pros
and cons
and why all of a sudden it was being changed

She did explain to me afterwards but it was never,
"What would you prefer?" or
"This is why I feel this way as a doctor, this is my medical experience as a
doctor."
It was never explained to me.

208

> Some consultation with me would have been very nice to have, you know,
> "Here are the following reason why, here are the risks of having the C-section,
> here are the risks of having the vaginal birth" kind of thing.
>
> <div align="right">(Sally, 298-299 & 307-313)</div>

Sally's story serves as an example of how the dominant of the view of childbirth as a medical event creates a situation where the person giving birth is seen as outside any consideration of importance. In this view of birth, birth becomes a choice between two sorts of medical treatment, rather than an important and emotionally significant life event.

Because in Sally's story birth was seen as a medical event, Sally was required to meet with a nurse prior to delivery to sign a consent form. Signing the consent happened after a brief review of the risks and benefits of various procedures that might be required during birth. While Sally had no say in whether she would have a vaginal delivery or a C-section she did have strong ideas about other procedures. Sally clearly did not want certain procedures performed on her, specifically having her waters broken. Indeed, Sally explained that during the delivery she reiterated her position against having her waters broken, only to be told she was "silly" for feeling this way. Eventually, during her delivery, Sally succumbed to the pressures to be a good patient, a good mother, and stopped resisting having her waters broken.

> I did say "No" because I did say,
> "No I did not want my water broken."
> I did say no, for sure.
>
> CMF: And what happened?
>
> She broke my water anyway but I ended up,
> that is when I just got passive.
> At that point, when I realized that it didn't matter…
> I'm going to cry… (becoming tearful)
> It didn't matter what I said,
> [They said] "This is how we do it, this is how it goes, this is what happens next."

<div align="center">209</div>

And there was no, "Why do you feel that way?"
I said, "I feel this way, I don't want my water broken, it scares me."
"Oh, don't be so silly, this is what happens, this is what goes on, don't worry about it.
It is the next step, it will help bring on labour."
That was that and then I just went,
"Okay, maybe I don't know anything, maybe you are right"
And just went, "Okay" and kind of put my hands up in the air
And at that at point kind of gave up fighting for what I wanted in a way.

and if she had of asked me to sign a form for her to break my water,
I would have refused to sign the form.

(Patricia, 598-614 & 618-619)

In telling her story Sally was clear that her lack of resistance should not be considered the same as consent, and to this day Sally asserts that she did not give consent to have her body, her vagina and cervix, violated in this way. Many women have likened childbirth with rape (Elmir et al., 2010; S. Kitzinger, 2006a, 2006b; Reynolds, 1997) and Sally's experience of lack of consent illuminates the similarities between these experiences of bodily and agentic violation.

While medical events are typically associated with the technicalities of informed consent, protection of personal health information, and documentation, two of these three components were ignored in Sally's experience, where the documentation of her consent seemed to be the only matter of importance. In Sally's story we see how informed consent was documented (during the meeting with the nurse days before she was scheduled for her C-section) as having occurred without *actually* occurring. Neoliberalism relies on streamlined practices (such as all pregnant women meeting with a nurse to go over the informed consent forms prior to labour). Documentation is a key aspect of this approach and frequently *becomes* the practice rather than reflecting the practice (The Canadian

Medical Protective Association, n.d.). That is, Sally's informed consent was achieved

because the informed consent document was signed. Sally's case demonstrates how the

requirement of medical institutions such as hospitals to document informed consent

becomes more important than the experience of shared and informed decision making.

The Homework Paradox

Many women expressed another concern related to decision making, being

expected to do homework in order to be prepared for childbirth. In listening to the

participants' narratives this idea of preparation through homework arose repeatedly as

another paradox women were expected to navigate in childbirth wherein participants felt

they were expected to be self-educated and prepared for childbirth, while at the same time

being careful not to overstep the bounds of lay knowledge in a way that would challenge

the medical professionals involved in their care. Julie and Anne provide examples of the

two ends of the homework paradox; Julie's preparation and knowledge seemed to act as

an irritant to medical staff, whereas Anne's lack of preparation through homework left her

in the position where she did not received adequate postpartum care.

Julie, as we saw in Chapter 6, had prepared for her high risk pregnancy. She had

spent months in the hospital awaiting her son's birth and spent the time preparing for

many possible scenarios so that she would be in a position to care for her son when he

was born. However, her homework and preparedness was not only not appreciated by the

nursing staff, her knowledge was seen as a threat and challenge to the NICU staff. In

Chapter 6 we saw how Julie felt she was in competition with the nurses on the NICU:

> Well, it did feel, it did feel like there was a competition.
> There was a competition of who is right and who is wrong.

<div align="right">(Julie, 641-642)</div>

Julie experienced this competition as a rejection of her knowledge, and she was very troubled by this, feeling betrayed and abandoned by those with whom she had had a warm relationship prior to the birth of her son.

> I was really quite confused and surprised
> because I expected to have the same service (pause)
> once he was born as I was getting before he was born
> But it was a completely different experience, right?
> I wasn't that mommy that lost her baby anymore;
> I was the new mommy that thinks she knows everything. Ummmm
> That is the impression I got
>
> I am just another mom that thinks she knows everything.
> Well, I have done my studies, and you know what I mean?
> Like I had lots of time to Google stuff when I was there
> and I Googled what it is to take care of a preemie;
> I Googled what the [oxygen] saturation means.
> I know the internet is not a doctor and I can't get a degree by Googling stuff
> But I did learn, right?
> I can take things lightly and I can take things seriously.
> But it's just, I studied and I learned, you know,
> like I wanted to be ready for him.
>
> <div align="right">(Julie, 517-523 & 532-543)</div>

Julie picked up on the messages that she was not responsible for preparing for her birth experience and for the care of her baby in the postpartum time. She was a woman with expertise she had learned in preparing for her high-risk pregnancy. She felt her Google knowledge was directly and indirectly minimized by nursing staff and she was left to struggle to know her role in her son's care.

Anne however, had the opposite experience. In Anne's story she voiced her experience of having her physical care needs being invisible to nursing staff as she was left alone in days after the birth. She voiced her frustration with the system that ignored her. In trying to make sense of the lack of care she received, Anne pondered if it was because she had not done her research:

I just found it frustrating because [the nurses] knew there was certain and special care

and they didn't provide it.

I guess you could do the research and it could be my fault that,

I mean every hospital has specific cares and they could do tours,

so I could have went on a tour and said,

"If this were to happen what would you do"

So then I would know, but I didn't do anything like that.

I mean, that could be partially my fault too

but it was frustrating that I had two days there that my pee could have been better

and you know, it would just help

and then she also said, "We have the padsicles"

where they freeze the pads to help because I had very, very large swelling.

I had a lot of swelling down there

and they finally gave that to me and that was amazing.

(Anne, 230-239)

We see how Anne's frustration with a system that ignored her quickly turned to a consideration of her own role in her suffering, reflecting the dominant view in neoliberal healthcare of individual responsibility (McCabe, 2016). In this view patients are expected to know what they need and to advocate for their needs to be met. They are expected to do their homework, to prepare. In Anne's story, she wonders if she should have known about the various aspects of perineal care. But as a person giving birth for the first time, it is reasonable to assume that she would need skilled help and education to know how to care for her perineum.

Pregnant and birthing women in this study found themselves caught in various intersecting paradoxes. Pressures to align with the limited and adversarial discourses of natural and medical birth affected what sorts of decisions women were allowed to make regarding childbirth, and in making these decisions women had to walk the tightrope of being informed but not too informed, and speaking up but not demanding too much. The mental gymnastics required to navigate this terrain contributed to the emotional distress

213

experienced by women during childbirth. These mental gymnastics continued after birth, as women entered the new, yet no less contested, terrain of breastfeeding.

Breastfeeding

As discussed in Chapter 6, many discourses circulate in the childbirth arena that construct women as "good mothers" and breastfeeding became a frequent site where this discursive construction was evident in women's stories. Women were caught in a confusing discursive space where breastfeeding was linked with good mothering, and yet good mothers might not be able to breastfeed. Participants shared their experiences with the receiving the message that all women are expected to breastfeed because "breast is best." The women in this study believed in this message, and in desperately wanting to be good mothers, all tried to breastfeed. For some women breastfeeding went well with little difficulty. For other women, breastfeeding was very challenging. When breastfeeding was challenging the women stuck with their efforts through physical and emotional distress, operating in response to the message that good mothers persevere in order to provide the best source of nutrition for their babies. Anne's story illustrates the pressure women were under to breastfeed, the difficulty with breastfeeding, and the sense of triumph experienced by women who managed to be able to breastfeed their babies despite difficulties.

> I had no idea what I was doing and they didn't help at all.
> I had no idea.
> All they told me was every three hours you feed him and that was horrible
> Because [Baby] didn't want to wake up every three hours.
> We had to wake him up and they said strip him, keep him in his diaper,
> make him awake and feed him.
> He was tired. He wanted to sleep. We were forcing this on him.
> He didn't want to feed.

He was falling asleep and it was just a vicious cycle every three hours trying to do that.

<div align="right">(Anne, 167-172)</div>

Anne felt left alone in her struggles with getting her baby to feed. She did not know if he was getting enough nourishment. Anne's story reflected her feelings of desperation as she tried to do what was best for her new baby without the support of the care team. Fearing for her baby's health Anne supplemented with formula. Finally, she came to the attention of the lactation consultants and was then informed that she had made a bad decision.

> Obviously, my milk wasn't in, so it was only colostrum.
> It was only a small and I don't know, we just keep thinking,
> "Is he full, is he not, what is going on?"
> They kept us there for two nights and we had no idea if he was full.
> So you know, nobody was helping us so we just thought,
> "Well, he needs formula because I don't think he is getting enough."
> We asked for some formula and we gave him some of that
> and then I can remember the next day, my second day there,
> they had nurse lactation consultations,
> So they said, "Oh you can go up and see them."
> Finally, we had some help there and we told them we had given him formula
> and they were like,
> "Why are you giving him formula? He's not going to want to feed now,
> you gave him too much formula."
> And we were like "We didn't know, we didn't think he was getting enough,
> nobody was helping us."
> That was really frustrating because he didn't need it.

<div align="right">(Anne, 167- 185)</div>

Anne was left alone to figure out how to breastfeed. She struggled with breastfeeding until she became fearful she was hurting her baby, and decided to supplement with formula. When she finally received the breastfeeding help she so desperately wanted, she felt blamed for making a poor decision. It is at this point that Anne's story began to shift and she began to talk about some of the strength it took for

her to stay committed to breastfeeding, despite this minefield of expectations and lack of

support she experienced. Interestingly, she minimized her role in her success with

breastfeeding and gave her husband much of the credit for her perseverance.

> I think for the first two weeks I did follow-ups with them
> just to make sure everything was fine and he was eating.
> I found breastfeeding really hard, very painful.
> I figured I would because I read that it was really hard.
> I looked at my husband and I said "You need to push me.
> I am going to look at you and I am going to say I want to quit,
> I am going to want to give up and I need you to say 'no'.
> I need you to do this for me."
> I said "I will give it until three months"
> And he is four months now and it is a breeze, it is amazing,
> I am so happy I stuck with it
> but it was frustrating that they didn't help in hospital
>
> (Anne, 181-197)

The participants who struggled with breastfeeding felt their struggles reflected

negatively on their ability to be good mothers. The fear of not being able to breastfeed

was experienced as a profound concern for Patricia in the early days after the birth of her

baby:

> [The lactation consultant] came and saw us once on Monday
> and we had already given in and given him a bottle by then
> So she was like, "Oh" you know.
> And every nurse had a different suggestion and a different (pause)
> That I found very traumatic because I figured in my mind breastfeeding was,
> "Oh yeah, here ya go, have a boob, go", right, you're done.
> So to not be able to breastfeed was very hard, that stressed me out a lot.
>
> (Patricia, 96-101)

Some women, like Patricia, were not able to breastfeed despite trying repeatedly

to do so. When women finally gave up on breastfeeding they were faced with the pain

associated with not complying with the dominant discourse of good mothering through

breastfeeding. That is, they felt they were no longer good mothers.

Cali, who was unable to breastfeed despite her repeated efforts, viewed the external and internal pressures to breastfeed as linked to the middleclass identity and ideas of good mothering.

> In the group of women that we have play dates with,
> I was, at first, until another woman came along,
> I was the only woman who wasn't breastfeeding
> and that felt awkward on its own
> because their whole mentality was breastfeeding is the best,
> "Oh, you are feeding him formula?"
> So, kind of, you are looked down upon if you feed your child formula
> And some women, like my mom, never had any breast milk,
> so it wasn't an option for her.
> Whereas, I had an abundance of milk but I couldn't do it in a healthy way for myself.
>
> (Cali 846-853)

When women had proven to medical staff that they had fulfilled the obligation to persevere with breastfeeding, those involved in the care and support of participants who could not breastfeed would suddenly shift away from the "breast is best" messages. Women who (staff had decided) could not breastfeed began to offer reassurance that formula feeding did not equate with poor mothering. The sudden about-face in this discursive construction of good mothering left women feeling unsure, guilty, and confused by their inability to breastfeed and what this meant for their ability to be good mothers. Suddenly good mothering was not accomplished through breastfeeding but through a realistic appraisal of breastfeeding success.

Garcia struggled with the connection between good mothering and breastfeeding. She believed what she was told about the importance of breastfeeding, but could not breastfeed. She resisted messages from her health care team to use formula, afraid this would undermine her ability to be a good mother. For Garcia the mixed messages about

217

breastfeeding were the beginning of the emotional distress that would stay with her for months after the birth of her baby.

Garcia was committed to breastfeeding and her baby had a good latch soon after the birth, which Garcia felt very relieved about. However, the good times did not last, and Garcia and her baby had difficulty with breastfeeding, causing Garcia further anxiety. She persevered through months of visits to the breastfeeding clinic before finally giving in to the pressure to supplement with formula, a decision that still bothers her.

> We were patients of the breastfeeding clinic for fourteen and a half weeks.
> We went once or twice a week because she was not gaining any weight.
> So then I got anxiety because I was trying to breastfeed her
> and doing what I felt was best for her
> but it wasn't working and I was pressured to supplement
> and I really didn't want to supplement.
> So, I had a lot of stress, I feel, put on me afterwards of (pause)
> I was doing something wrong.
>
> (Garcia, 336-363)

Messages about the importance of breastfeeding are a central part of prenatal and postnatal counselling. Women are strongly encouraged (some might say coerced) to breastfeed. However, as in Garcia's case above, when the baby is not gaining weight as quickly as a growth charts suggest it should, suddenly the message changes to one where a good mother supplements breast milk with formula. Foucault's (1977a) disciplinary power is helpful in seeing how invisible mechanism of power operate to control women's behaviours as mothers. Garcia clearly knew she needed to follow medical advice in order to be a good mother, but she became trapped in advice that contradicted itself. "Breastfeed at all costs" suddenly became "Supplement because your baby isn't growing fast enough." Wanting to be a good mother, following the rules of good mothering, and then having the rules change, would most likely be anxiety provoking in any situation.

218

Garcia's example also illustrates how breastfeeding serves as more than a discussion about feeding. Breastfeeding is about women's bodies. The breasts are part of the woman. If breastfeeding is failing, then the woman's body is failing. If our view of ourselves is attached to our body, then feelings of more general failure will surface. The fear of failure as a person tends to make one anxious, resulting in emotional distress.

Rachel offered a suggestion to the breastfeeding dilemma; she believed women need to be given more information about breastfeeding so that they can make informed choices about breastfeeding, taking into consideration both the benefits and difficulties associated with breastfeeding.

> I went to the prenatal classes, they were "Rah Rah breastfeeding",
> which is how my husband and I were,
> "Well of course we will do breastfeeding.
> Why would you not do breastfeeding?"
> Oh my God, I was shaking and sobbing, it was so painful.
> Then you have these comments which are not helpful to say the least.
> "If you're doing it right, it shouldn't hurt"
>
> And I think, "You know what? That is really not helpful to say to someone."
> That is actually real mean to say to someone
> Because it makes them feel like a failure.
> There is sense of like,
> If you cannot totally breastfeed your kid,
> from zero to six months purely
> then you are a failure as a mother.
>
> (Rachel, 335-341 & 348-354)

Cali also had advice about centring women in the birth experience. Her own experience of feeling pressured to breastfeed despite her own pain and poor health serves as an example of how women are treated as secondary in the childbirth arena. In her story, the primary focus is on helping the baby breastfeed, and Cali was present only as the body with the breast.

219

At one point, I had three nurses on my breast
and [Baby] was screaming bloody murder.
He was red in the face and they weren't paying attention to him,
My stress level, they were just trying to get him to latch
and to the point where my friend spoke up and said,
"I think she needs a break."
I mean he was just, you could tell, he was screaming, he wasn't comfortable,
he wasn't enjoying this whole process,
I was a nervous wreck because he is upset.
I am not able to do what I am supposed to be able to do as a mother.
They are kind of giving me a hard time and yeah,
so it wasn't fun.

(Cali, 754-765)

In response to all these pressures, Cali insisted that women should be centered by respecting their ability to make a choice about breastfeeding. When breastfeeding is put forward as the only option, rather than as one of several options, the message is clear that breastfeeding is the only way to perform good mothering.

Asking the mom, "What is it that you want to do?"
There is not even that question.
It is just breastfeeding.
You know, "How comfortable are you with breastfeeding?
How comfortable are you with formula feeding?
How can we help you?"
Not this pressure of you have to breastfeed.

(Cali, 809-815)

The linking of breastfeeding with goodness in mothering leaves women who cannot breastfeed wondering about their ability to be good mothers. And while it seems that reassurance may be given after the fact to women who cannot breastfeed, the damage to women's view of themselves as good mothers is often already done.

If I am not successful,
I am not a good mom, you know,
if I don't breastfeed my child.

(Cali, 840-842)

Binaries exist in a multiplicity of locations and discourses regarding childbirth. Indeed, the conceptualization of childbirth itself falls into mutually exclusive constructions, where childbirth is seen as either normal, unremarkable, an everyday event; or conversely as a serious medical event, a time of risk and caution, and an extraordinary occurrence (Schiller, 2015). This polarity reflects the previously discussed portrayal of childbirth as natural or medical. Yet the women's stories in this research seem to demonstrate that even when childbirth is seen as medical and requiring intervention it is also seen as an unremarkable, everyday event. As we have seen in the previous stories, this paradox showed up in the participants' narratives in two ways: when childbirth was viewed as a medical event, women felt erased from and invisible in the childbirth experience, where all focus moved to the baby and the woman delivering the baby was decentred and marginalized; when childbirth was seen as an everyday unremarkable event, women's needs were also marginalized as women were assumed to somehow have had the knowledge they needed to deal with this everyday experience. In both readings of childbirth, women in this study felt ignored and forgotten in the childbirth experience, resulting in emotional distress.

How to Help

In reflecting on the negative experiences outlined above, the participants had many suggestions for what might be helpful in preventing or ameliorating distressing childbirth experiences. Their advice often involved finding a synthesis between the apparent polarities that arose in childbirth experiences.

Recognize That Childbirth is a Regular Event That is Special

Participants experienced childbirth differently and outside of the polarized

understandings of birth as either medical or natural and gave voice to the ways in which

this polarized view of childbirth created distress. From the participants' stories, it seems

when birth was viewed as a medical event it was constructed as an event of some

importance. However, when childbirth was constructed as a natural experience it was

viewed as less important, resulting in a lack of care and attention to the women giving

birth. Participants voiced their craving for this binary to be disrupted. Participants asked

to be seen as central to an important life event and experience. That is, the women

interviewed wanted their experience of giving birth to be seen and treated as special and

wanted to be seen as deserving of care and attention in the experience.

Morgan clearly reiterated this position, advising staff to treat childbirth as a

special experience—a special day, and linked the invisibility of the importance of a

positive birth experience to gender.

> It is just expected, you know, for women to just be, this is part of what you do.
> It is part of what you do.
> Men can't give birth but it would be nice if there was just a little bit more,
> I don't know what the word is, something.
> It should be a little bit more important, a little bit more talked about.
> My first birth, one of the nurses literally yawned the whole time.
>
> I totally felt like a number.
> I thought about reporting her afterwards
> because I thought, "You just don't do that!"
>
> (Morgan, 705-710 & 723-725)

Morgan seemed to suspect that birth experiences would more likely be seen as important

if men gave birth, pointing to how the birth site reflects gender-based oppression. Perhaps

it was because Morgan believed she was going to die in childbirth that she also linked the

222

importance of empathetic attending to birth as similar to behaving empathically when

dealing with death.

> And you know, you are lucky to be part of these people's lives in these important times,
> whether it is dying, birthing, sickness.
> You know, you are lucky to be part of that.
> Feel blessed to be part of that and focus on that.
> It is also to be influencing in a positive way even if someone is dying
> then any medical professional that comes into that situation
> should be impacting it in a positive way.
>
> (Morgan, 769-774)

Charlie also linked birth and death. As a veterinarian, Charlie spoke about the

importance of staff being sensitive to the needs of people undergoing routine yet

emotionally challenging life events:

> And I know that when you do something every day,
> it becomes normal to you
> but like, I would never go in to a client where I was euthanizing their animal.
> …
> And be like, "Oh get over it, I do this every day."
> …
> I would never even dream of…
> Because it is part of their family and they are saying goodbye and it is like,
> just because it is something I go through every day and have to deal with,
> it doesn't make it any less important.
> You've chosen, you've chosen a profession where this is what you are doing.
>
> (Charlie, 379-394)

The excerpts above begin to hint at the vulnerability women experience during

birth. The highly emotional nature of birth combines with physical vulnerability to

position women as needing care and sensitivity as they navigate this important life event

and experience. And yet, Sarah George experienced being repeatedly ignored despite

having been in one of the most vulnerable positions a person can be in—spread-eagled

with feet in stirrups, while the medical staff took her baby to the NICU and dealt with

other labouring women on the unit. Her advice mirrored Morgan's; begging staff to

remember the woman is an important person in need of care.

> To that person that is delivering [the babies], it's like another [day]
> and that made me so mad.
> "You are like the twelfth woman to deliver tonight."
> I'm like, "I don't care if I'm the twelfth person to deliver.
> This is your job.
> I am just as important as the first person that delivered and you need to make an effort."
> I can't believe they left me on that table, and she was like,
> "If you need anything call, push the buzzer."
> I am like, "I'm bleeding to death here and I am not going to be able to push the buzzer lady."
>
> (Sarah George, 746-754)

The anger is Sarah George's story demonstrates the indignities and inhumanity she

experienced as she was forgotten and abandoned on the delivery table.

> Charlie's advice for those caring for birthing women was similar to the advice

given by many other women and she combined both the concern for women with the

recognition of childbirth as a meaningful experience.

> I want people to recognize
> that it is a pretty huge experience for every woman that is going through childbirth
> and everybody might have different needs (pause)
> and to really talk to them and see what they need in that situation.
> You know what I mean?
> And be there for them.
> It is like, don't just stick them in a room and you know,
> You know, don't tell them that they are not technically in labour,
> we don't want to hear technicalities.
> You know what I mean?
> Like reassure them what they are going through is normal yet it is still huge.
> Do you know what I mean?
>
> (Charlie, 512-523)

In this story Charlie was searching for some synthesis between the polar views of

the medical/important and natural/unimportant divide. Her frequent use of "you know

what I mean" indicates that what she was trying to express is not easily put into words

because it disrupts the binaries that have come to define childbirth (Devault, 1990).

Charlie's comments above reflect her view of birth as a medical event (which was

Charlie's experience as she developed HELLP syndrome[29]) while searching for a way in

which she could maintain her status as person rather than patient, and where staff could

resist the neoliberal pressures to treat birthing women as objects on a healthcare assembly

line (McCabe, 2016).

Finally, Nella had similarly reasonable advice for those working with women

during childbirth; find a way to treat women and childbirth like they are special and

important.

> I think for practitioners,
> I think people who have been doing it for a very long time
> are very comfortable with what they are doing
> and sometimes I think this with a lot of different professions,
> but what they are doing might be the first time for the person who is laying on the
> bed having the baby and it is a very, like you said, special experience.
> To them, it is just, you know, one more delivery but to,
> I don't know, I don't know how to say it,
> like, don't forget about that part of it.
> Their part of it, yes, definitely, is to deliver the baby
> and maybe that is where a doula comes in to play.
> You know, maybe I should have a doula.
>
> (Nella, 852-862)

In her saying this, Nella wonders if the way to ensure women and birth are seen as special

is to hire a doula to care for them while the medical team cares for their baby, seemingly

resigned to the idea that caring for birthing people is not the role of medical professionals.

---

[29] "HELLP syndrome is a life-threatening pregnancy complication usually considered to be a variant of preeclampsia. Both conditions usually occur during the later stages of pregnancy, or sometimes after childbirth" (Preeclampsia Foundation, 2016).

Okay, it is not the doctor's job to console me.
Right? The doctor is here purely for his or her job of delivery this baby,
that is not their job to make me feel happy inside.

(Nella, 910-912)

Linking this back to the emotional labour women perform in childbirth, Nella suddenly

became aware that asking to be cared for in childbirth could be seen as a criticism of her

husband or male partners in general, and took steps to remedy any hurt that could arise

from this. Still, she restated her idea that contracting out caring labour (the doula) might

be a good decision for women.

You know, not that I think that my husband failed in that department
but really.
…
He was hitting my face with the face like this (tapping forehead)
and I was like, "Can you just leave your hands off?"
You know what I mean?
Like, "Just stop doing that."
So, I guess, maybe if there was [someone to take care of me]
but I don't know if I would really see the value in the doula
like before I had the baby.

(Nella, 868-879)

Nella spoke to the importance of attending to the woman in the room who is living

through a very physically and emotionally overwhelming and challenging experience.

And while Nella voiced that she now believes that caring for a labouring woman's

emotional needs is outside the duties of the physician (belonging instead to the doula),

she believed it would still be helpful to have someone in the room dedicated to

communicating with the labouring woman what is happening to her body and to the baby.

Yeah, or just like so that somebody could, even one of the nurses,
if they weren't all really busy to stand there and say,
"Okay, the baby is out, the baby is good,
we are going to take him over and clean him up."
You know.
…

226

Yeah, that's all. I don't need a lot. Just a little bit. Right?
…
That's it.

<div align="right">(Nella, 892-904)</div>

Nella was reflecting on the role of others in supporting women in labour and delivery, and in the postpartum time. While the emotional labour of caring is (should be) part of the role of healthcare teams, the participants in this study provided many indicators that this was not sufficient for the needs of women in childbirth.

The Importance of Support From Others

Participants in this study provided information about factors that mitigated distressing experiences in childbirth. Positive relationships and helpful interactions with others before, during, and after birth was a frequent topic in participants' stories. Supportive and helpful others included social groups and communities important to participants, romantic partners, helpful physicians, and nurses who responded to women with compassion and care.

Community and partners. As a woman with a deep Christian faith, Carrie is active in her church community. This supportive community figured heavily in her story, demonstrating the important role social groups might play in helping women with distressing childbirth experiences. Carrie viewed her survival of her medical emergency as a sign of a loving God taking care of her, and a caring faith community who were supporting her and her family.

> I know that my spirituality did [influence my childbirth experience]
> because, you know, you both got your phones in there,
> and I wasn't texting anyone
> but [husband] had been texting while I had been lying there on the table all morning,
> so I heard the constant (laughter),

<div align="center">227</div>

"Like can you turn the ringer off?"
Constant responses, but you know.
He was asking people to pray and I know that I felt very reassured by that.
I said to him, "Would you let [Minister] know"
And just certain people that I knew from our church even outside of my family
group,
"Would you let them know?"
And I just felt like they would have that direct line that I needed right then.
So yeah that played into it for sure.

<div align="right">(Carrie, 562-564)</div>

While Carrie's faith community did not prevent her distress, it mitigated the effect her problematic experience had on her and her family. Carrie felt supported and cared for and knew that her other children were also being supported and cared for, relieving her of some of the work of mothering so that she could focus on her own recovery and her new baby.

While many participants discussed their partners as either problematic or well-meaning but ultimately unhelpful (like Nella previously), there were some exceptions to this, where partners were identified as a primarily helpful support in childbirth. Earlier in Chapter 6 I discussed Sally's partnership with her wife and the importance of this relationship during Sally's pregnancy, childbirth and postpartum time. Sally and her wife used "we" language in discussing their childbirth experience. Sally's experience of closeness and support in a same sex relationship reflects the research by Ussher (2011), who found that women in same-sex relationships experienced more support and less emotional distress related to their reproductive health (premenstrual symptoms and childbirth) than women in heterosexual pairings. While Anne was in a heterosexual marriage, throughout her narrative she often referred not only to herself but instead to herself and her husband, that is, her narrative also included many "we" statements rather

than "I" statements. I asked Anne about this and she spoke to the importance of having a

caring, involved and supportive partner.

> I hear of other women when they talk about their stories
> and the husband is not in the picture at all, at all.
> Or I have even heard so many stories,
> so much that the husband looks at the mother and says
> "This is your job, I am not going to help you."
> Why? It's not like that.
> As soon as [Husband] comes home from work he takes [Baby]
> and when I would feed he would help me and you know,
> In the beginning when I was saying breastfeed was very painful,
> I would just sit there and cry and [Husband] would help me
> and give me that push that I asked him to give me.
> It is a "we" and I am very lucky for that.
> Very lucky.
>
> (Anne, 472-482)

Even in describing her delivery, Anne used "we" language.

> We just kept pushing and pushing
> and then [the doctor] came back again and nothing had progressed
>
> (Anne, 112).

The love and tenderness the couple has for each other was clear in this story and

the two were obviously in a partnership with parenting. However, Anne's use of the

discourse of being "lucky" provides some insight into an option that is available to men

and that is unavailable to women. It seems as if men are able to opt in or out of parenting

more easily than women (Statistics Canada, 2015; U.S. Department of Commerce, 2015).

Having an involved male partner is associated with being lucky because men do not have

to be involved in the care of their children. One wonders, how often are discourses of luck

used in connection with discussions of having involved and caring mothers? Anne could

see that her parenting partnership was indeed different from the default expectations of

male parenting.

Relationship with physicians. Having a birth experience that veered away from expectations was often a source of childbirth related distress for participants. One factor that helped prevent distress or minimize distress when unanticipated events occurred was a positive relationship with the physician caring for the participant during labour and delivery.

Patricia wanted a "natural childbirth", however, like many women, she ended up having childbirth with many interventions. To begin, she was not allowed to work with a midwife as she had hoped, because her body mass index[30] was three points over the cut off. She ended up being induced after feeling exhausted from suffering with contractions that did not cause her cervix to dilate for several days. It was crucially important to Patricia to ensure that her physician, with whom she had built a trusting relationship, would be available to handle her labour and delivery.

> It got to the point where the contractions were two minutes apart.
> When they checked me, I wasn't dilated so they sent me home.
> It was just like, "ahhhh…" and then just you know,
> they would go to two or three hours apart
> and then they would stop for two or three hours and then they would come back
> and it was like that all week.
> So it was just, I had an appointment on Monday and [the doctor] said,
> "Okay, enough is enough, you can't keep, you know,
> your due date was the next Sunday I think.
> I am on staff; I'm here, not just on call,
> I'm here Thursday and Friday, so if we bring you in"
> Because he started his shift at midnight on Thursday morning
> so he was on twelve a.m. on Thursday
> through to eleven-fifty-nine p.m. or whatever on Friday.
> That was his shift.
> So he said, you know,

---

[30] Body mass index (or BMI) is a measure used by healthcare providers and others to classify weight as underweight, normal weight, overweight, or obese ("BMI for Adults," 2016).

"I am in these two days so if we bring you in,
we induce you around lunchtime on Wednesday,
by the time you are ready to give birth I am here, I can guarantee that I am here."
Because his thing was, after he got off from his two day long shift
he was off the weekend and wasn't going to be there.
He wasn't on call and wasn't going to be there
and I really wanted my doctor at that point.
I had built up a rapport with him.
So it was like, "Okay, let's do that then."
Because I was ensuring that we had him because I didn't know who was going to be on.
So that is why we ended up inducing.

<div align="right">(Patricia, 460-481)</div>

Eventually Patricia's baby was delivered with forceps because the baby was stuck. Despite the change from a "natural" delivery to an induced labour with epidural, ending in a forceps delivery, Patricia was happy with the process. Patricia's satisfaction with her labour and delivery rested on her experience of feeling good about her relationship with her physician. Patricia felt her doctor knew she wanted to be able to make decisions about her childbirth and so she was included in decision making.

I think if I had a different doctor, it would have been a horrible experience.
To be perfectly honest with you
because I don't think (pause)
A couple of times that I went in with false labour
I had other doctors that weren't so nice,
weren't so understanding and weren't so respectful.
I think if I had ended up in that situation with another doctor
it would have been a very bad birth.
All in all when I look back on it, it wasn't that bad.
It wasn't what I wanted. It didn't go the way I wanted it to.
It wasn't what I planned but it could have been a lot worse.

<div align="right">(Patricia, 553-559)</div>

Because of the pre-existing positive relationship Patricia had with her physician, she saw herself as having a voice in decision making. While Patricia took credit for her own work in preparing for childbirth she also credited her physician with allowing her to have a say

in her the decisions about her birth experience. Patricia's relationship with her physician points to the way in which power operates in maternal care—even when women have a voice, they also need to be "given a voice", or heard, by their physician. While decisions may be made in consultation, power in decision making remains something that is given to women by their physicians (Tester & McNicoll, 2006). For Patricia, believing her physician would allow her to make informed decisions protected her from the long term negative emotional effects other women experienced when their birth experiences differed from the plans they had made for birth.

However, Patricia did not see her control of decision making as being something given to her by her physician—she took credit for this, demonstrating how she worked deliberately to exercise her agency throughout her pregnancy and delivery (McCabe, 2016). Patricia felt positively about her relationship with her doctor because she believed he would consult with her, and this positive view of her physician was a central factor of importance. However in reading her story, it seems as if Patricia did not have much actual say in what happened to her. Her doctor, apparently knowing the importance of the relationship, assured her he could attend her birth if she allowed him to induce her on a specific day, and if she chose to continue on without being induced he would be off work for the weekend. While Patricia's story is similar to the situation Mavis found herself in (as discussed in Chapter 6) the difference seems to be that Mavis was aware of the coercive forces at play, while Patricia trusted her doctor and so did not see him as coercive, or their relationship as hierarchical rather than a partnership. Elise's story, on the other hand, reflects her experience of and belief in her relationship with her physician as a true partnership.

Elise's story reflected a similar view of the importance of a positive and trusting relationship between the birthing woman and the physician. Elise's relationship with her general practitioner, who delivered her baby, was crucial in contributing to a positive birth experience. In this trusting relationship Elise felt free to inform herself about childbirth, while deferring to suggestions her physician might have for her during the delivery. Elsie felt her physician took a partnership approach with Elsie where the doctor's suggestions were just that, suggestions, not mandates or threats associated with discourses of risk or harm.

> Yeah. I have had this doctor since I was a teenager.
> …
> Oh yeah and I mean yeah, she did all my prenatal care.
> She has been there since the beginning so having her there was very, very helpful.
> She knew me.
> She knows how I kind of think and knew what I was hoping to have during the birth.
> I knew if she said, "Okay, this is what we need to do" then I trusted,
> I trusted her.
>
> (Elise, 210-220)

Elise described her childbirth as a positive experience and believed this was so due to the excellent care she received from the staff who were with her during delivery and postpartum.

> Probably the most positive was just the staff.
> The nurses that I had and of course my doctor, everyone was great.
> They knew exactly what to say at the right time
> and I knew at the time that my wellbeing was their top priority.
> They took very good care of me.
> And afterwards when we were in the hospital,
> the nurses were great to help me with either breastfeeding or answer questions
> or whatever I needed that was all very positive
> and I was hoping for that
> because that just makes things easier when you know you can rely on the people there to help you.
>
> (Elise, 339-348)

233

The relationship with the physician and staff contributed to Elise's positive birth experience. In the geographic area where this study took place, the availability of midwife attended home birth was very limited, and most women gave birth in hospitals, and so the role of the medical staff is crucial in determining how women will experience childbirth. In this study, stories of poor care, feeling invisible or unimportant to staff, and frustration with the medical system were frequent. Without diminishing the importance of paying attention to these problems in how women are treated in childbirth, it is important to highlight some of the positive experiences women had with those professionals who truly cared for them.

Angels among us. Sarah George suffered through a host of indignities during her childbirth experience. Most of Sarah George's stories of distress reflected her experience in a neoliberal health care system where care was depersonalized and financial concerns were paramount (McCabe, 2016). She experienced the doctors and nurses involved in her care as rushed, distracted, impatient, and indifferent. She reported that they refused to take the time to hear her birth plan and that they ignored her own knowledge of her body and her history of precipitous deliveries. Sarah George was rushed from floor to floor, from labour to delivery, as her baby was born much faster than the staff anticipated. In response to the speedy delivery, Sarah George was left on the delivery table. Despite all of this, what distressed and astounded Sarah George the most was her experience of not being listened to or noticed as a person instead of as a number.

Yet, in amongst this distress, Sarah George told the story of the one staff member who saw her—paradoxically at times when she was crying though pretending not to see her. In hearing Sarah George's story, it is confusing that one of the greatest kindnesses

234

she felt during her birth experience was of a nurse pretending to deliberately and actively

ignore her.

> There was one fabulous nurse.
> She wasn't old and ready to retire (pause)
> [She said] "I'm not going to talk to you,
> I am just going to walk by and pretend that I don't see you"
> Because every time she would talk to me, I would just bawl
> and she is the reason why we got transferred to [hospital A]
>
> She did a lot of talking to [the various hospitals involved] calling [hospital A],
> getting [hospital A] to call.
> If it wasn't for her, I probably wouldn't of [been transferred],
> Well [the baby] ended up being in [hospital A] for three weeks.
> So we would have been down there for a month
> if it hadn't have been for that one sweet lady
> that was probably tired of looking at me bawling in the corner because I was just.
> (Sarah George, 204-208 & 247-252)

That nurse was the woman who showed Sarah George respect and empathy in their daily

dealings, mostly while Sarah George fed her daughter in the NICU.

> Afterwards, coming back and like "How are you?"
> It meant a lot down there when she would come in and be like, "How's it going?"
> I mean I would bawl, I was blubbering but it was like home,
> like she seemed like she cared how I actually felt,
> not just, there's another NICU mom.
> (Sarah George, 798-802)

Sarah George mentioned this nurse a number of times. Perhaps this image of someone

who cared for her allowed her to hold onto the idea that she mattered to someone, so that

she would not become flooded with the distress and rage she felt at having her birthing

experience endangered by the very people who were meant to show sensitivity and care.

Similarly Anne felt saved by a nurse who intervened between her and the

neoliberal health system determined to send Anne home despite her fears of labour and

delivery. Upon arriving at the hospital Anne was informed that her cervix was only one

centimeter dilated (which according to a biomedical definition meant she was not officially in labour) and talk began to circulate about sending Anne home, something that she did not want. Luckily, a perceptive nurse saw Anne's anxiety and argued successfully for Anne to stay.

> I was really nervous because I wanted to stay there.
> Nobody wants to be to be in a hospital
> but I felt comfortable there because I was afraid to go home
> because I didn't know when the proper time was to go in
> because I was already in so much pain.
> I guess the nurse seen this and when they gave me my Morphine, it did nothing and I just asked them,
> "When is this going to kick in, it has been ten minutes and I don't feel it?"
> And she just looked at me and she said,
> "You are in active labour, it is not going to work, we need to give you something stronger".
> The nurse actually looked at the resident and said, "No, I am not sending her home".
> She said, "I have a really bad feeling about this and I just feel like she is going to go fast."
> She looked at me and she said, "Don't worry, I am not going to send you home".
> She was like an angel for me.
> I was so happy.

<div align="right">(Anne, 45-56)</div>

This nurse took Anne's emotional needs into account, and this validation of Anne's anxiety and fears felt so important to Anne that she viewed this nurse as "an angel." Indeed, it seems unusual that in the neoliberal healthcare environment, Anne's emotional needs were placed above the financial and workload demands of the institution. This speaks to the importance of valuing, centring, and responding to the emotional needs of women when they are in labour—a very vulnerable time for women. It also demonstrates that it is possible to treat women in childbirth with dignity, care, and compassion.

Someone to Talk To

Having someone to talk to about their childbirth experience was a suggestion and request put forth by the participants. The vulnerability women experienced, their desire to be and be seen as good mothers, their invisibility and erasure by others during birth, and their struggles with understanding and making meaning of what they had just experienced, left women feeling shocked and isolated. The idea that "someone to talk to" would be helpful demonstrates that women want to be recentred, seen, and valued in the birth experience.

Elise echoed the wish of many participants to have more emotional support after the delivery. Elise gave special importance to connecting with women who have embodied knowledge of childbirth and the postpartum time, recognizing there is a specific kind of knowledge about childbirth available only to those who have shared this highly embodied experience.

> Just having people to talk to is great.
> I know I enjoyed after I gave birth just nurses popping in or a doctor popping in just even saying "How ya doing?"
> and "Is there anything, do you have any questions, do you want to talk about anything?"
> I mean husbands are great but they don't know what just happened.
> Especially if it is a female and especially being someone who has gone through this,
> The more people within the first few days after giving birth to talk to I found was very helpful.
> They understand how you are feeling
> and I was feeling a little, of course, overwhelmed
> and wondering am I going to develop some kind of depression, is this normal, how I should be feeling?
> Like why am I bleeding so much?
> Just talking to a lot of people.
> Especially if they have been through it was very helpful
> so I say the more people you can talk to the better.
> …I remember talking to the nurses and even to my mom

and just being like, this is how I am feeling, is this okay?
and just being reassured that it is totally okay the way that you are feeling.
…
Because it is very overwhelming those first twenty-four to forty-eight hours,
especially with your first.
I had no idea what I was doing
and should I be holding this way to feed him?
There was just a million and one questions you have
and just being able to talk to as many professionals as you can is wonderful.

(Elise, 481-532)

Elise's desire to have someone to debrief with, to ask questions of, and to seek reassurance from demonstrates that even in positive birth experiences, women are often left to figure things out alone. There is an assumption that women either have the knowledge they need or have others to provide it (assuming, for example, a mother, sister, aunt is filling this role). However, the reality for many women today is that they do not have a close family network available to stop in and visit and provide advice and relief (McCabe, 2016). While not all participants suggested social workers might take on this supportive role, several did name social work as a profession suited to this work.

As a social worker, Mavis had advice for what social workers could be doing to better meet the needs of those giving birth, suggesting that social workers are in the right position to check in with new parents not just about services in the community, but about their own mental health and coping.

So we didn't reach out to women who had "normal" [births]
like in and out of the hospital
but I think that women struggle, they want to know right out of the gate, you know,
what there is as far as supports in the community go
and the nursing staff is great but it is very,
I think it would have been fantastic
if the social workers at the hospital made contact with the mothers,
with that idea of like "Here are some of the supports in the community"
and even just to say like, "How are you feeling?" you know,

238

"You are going home tomorrow, are you feeling prepared for that?"
Because the nursing staff is just like,
"Okay, your stitches are good, you are good to go, you are good to go."
But there was no check-in mentally.

<div align="right">(Mavis, 702-711)</div>

Mavis also saw a role for social workers in the community after mothers are discharged from the hospital. Most mothers know of social workers as the people who will take your baby away, and the nurse as the one who comes to check on baby and mother. Mavis recommended a role where social workers visit new parents in the same way that public health nurses do, but with a focus on mental wellness and emotional support, without requiring a diagnosis to receive mental health support.

And then as far as in the community goes,
I mean it's hard to say because I had a lot of support with nursing staff
but it is interesting because I thought, you know,
Is there a place for social workers in this world of postpartum support and not just [child protection]?
Not just like, "Okay we are at your because you are neglecting your child."
So yeah, until I became a social worker,
I didn't even know how many places social workers worked.
But I have never been in contact with a social worker
throughout this sort of six months of being postpartum
apart from you.

And I think, too, if someone had of came in to my house, like the nurses did,
but came in and helped me make sense of some of those emotions
in a way that was more, narrative based,
I might have made connections sooner and said,
"Do I need to get help or do I not need to get help?
Is this the kind of help that I need?"
Just having someone objectively help me work through some of these things.

<div align="right">(Mavis, 715-723 & 727-733)</div>

Cali also believed there is an important role for social workers in the childbirth experience; having someone to talk to about what has happened, as a way to understand and make meaning of childbirth as an event and as a life changing experience.

<div align="center">239</div>

After he was born, to have somebody come in and talk to me
because I was literally a mess.
When I found out that he wasn't hearing,
that he was deaf but I held it in, of course,
because it would have been helpful to have someone to talk to at that point
to kind of just talk about my concerns, talk about how I thought it was my fault
or that I had failed him in some way, that I didn't push enough.
I think at that point I think it would be beneficial to have a social worker there,
especially during the trauma, because there is trauma attached to that
and depending on the person and how they cope.
I mean, they could go into a depression, you know, the postpartum?
All of that stuff I think is contributed.
And if they don't have a connection to somebody to talk about this,
whether it is in the hospital or outside the hospital,
even given a phone number, anything
but there was none of that.
There was no, "Okay if you need any further support
or if you are having any, you know, feelings or things that are bothering you,
you can call this person or you can connect with."
There was none of that.
It would be ideal if you could have the social worker in hospital
to kind of check in with new moms just to see.
"Do you have any concerns? What are you feeling right now?
Is there anything I can help you with?
Or is there anything that you just need to talk about?"
Because for me, everybody around me kept saying,
"Oh everything is going to be okay, everything is going to be okay."
So, I said, "Well okay, nobody wants to really listen to me."
They just want to kind of push it aside.

(Cali, 413-465)

While Nicole did not name social work per se as a source of support with childbirth when asked what might have been helpful, Nicole was quick to identify more formalized social support as something that might have mitigated her crisis. Nicole lived in a rural area and described herself as economically poor. She could not drive to the nearest family resource centre on a regular basis. The support she received from public health was not sufficient and their advice eventually took her farther away from home (without providing the help promised).

I think that connecting with other mothers would have helped a lot.
I know that they have a program,
I believe [family resource centre] that does that, but I was never able to get to them.
So even just having like a session at the hospital wouldn't be a bad idea.
I also believe that having the opportunity to get talked to about postpartum depression
Because the public health nurse, she did talk about it a lot
but she never really told me like the specific things of it,
Like this is how you are going to feel if you end up having it.
At first I didn't know what was wrong with me.
I started having panic attacks.
I didn't know why, I was so upset.
In the long run if you talk more about the postpartum depression
and also don't put yourself in a spot
that you think everything is going to be perfect after delivery
because it definitely isn't.

(Nicole, 498-511)

Social workers, especially those with mental health training and experience, involved in postpartum care could act as an additional support. Interventions centred around addressing not only diagnosed mental health needs but also the messages and demands placed on mothers might have a role in reducing the emotional pain experienced by women who, for whatever reason, are not able to see themselves as meeting these demands. The importance of this sort of intervention and support should not be underestimated. The participants in this study reported feeling depressed, anxious, confused, guilty, judged (by themselves and others), and overwhelmed. These emotional reactions can have serious and long lasting consequences for birthing people. Indeed, Mavis who had multiple social supports and various privileges at times found herself considering death as an escape from her emotional suffering. For Nicole, who had fewer protective factors and felt utterly overwhelmed by mothering and disconnected from her baby, death seemed to be the only option that she could see for herself and she very

241

nearly died as a result of her distress. The other participants, who perhaps did not find themselves consumed with thoughts of death, nevertheless also reported suffering greatly after their problematic birth experiences. I believe social workers have an obligation to do a better job of both supporting birthing people and insisting that birthing people deserve this support and in the following chapter I explain how social work professional associations might also consider this a professional obligation.

Summary

This chapter explored various themes that emerged from the participants' narratives explaining childbirth related distress. The work of caring for others, navigating various expectations and messages about childbirth, and distress associated with breastfeeding were common contributors to women's emotional distress in childbirth. The participants in this study also provided information on what helped to mitigate emotional distress in childbirth and this chapter reviewed how supportive others, including partners, community, medical staff, and physicians, all played helpful roles for women in childbirth. Finally, this chapter concluded by putting forward participants' suggestions for further help and support. Many participants recommended that birthing women should be given more opportunities to be connected with and be supported by professionals with the goal of helping women make meaning of and deal with the various physical, mental, social, and emotional effects of childbirth. Given social work's role in other arenas providing this sort of support and service, social work has a role to play with birthing people as well.

In the following chapter I reflect on the what this analysis of the participants' stories means in relation to social work's ethics and values, and I discuss how social work

might begin to interact with the area of childbirth, making recommendations for

expanding the role of social work practice, theory, and research into the childbirth arena.

CHAPTER 9

IMPLICATIONS FOR SOCIAL WORK AND CONCLUDING THOUGHTS

This chapter offers recommendations for social work practice, theory, and
research arising from the findings presented in the previous three chapters. A discussion
of the limitations of this study is also included, along with recommendations for areas of
further research. Finally, this chapter concludes with some final thoughts summarizing
the entirety of this work.

Social work positions itself as a social justice profession and there has been
discussion regarding whether social work can also call itself a human rights profession.
Social work has a problematic history in its association with activities that worked against
the human rights of individuals and groups including abuses that specifically targeted
women and women's reproductive lives (Murdach, 2011). Defining certain familial
relationships as normative, policing of family form and function, removing Indigenous
children from their communities to be placed with White families, and social work's
involvement with eugenics are just a few examples of the ways in which social work is
implicated in human rights abuses (Healy, 2008; Murdach, 2011; Solas, 2008). Beyond
these offences, the human rights framework itself has also been critiqued for reflecting
individualistic, Western, patriarchal and privileged value (Ife, 2008; Nipperess, 2013).
Human rights have also been critiqued by social workers for lacking a map to action, even
as social workers desire the means to take action towards social justice (Nipperess, 2013).

However, the official values of social work are strongly aligned with human rights
in that all social work codes recognize the inherent worth and dignity of the person
(Healy, 2008; Nipperess, 2013). Additionally, the history of social work is linked with

historically important human rights movements, often even prior to and as these movements began to be framed as human rights issues, including women's suffrage, international child welfare, civil rights, the reduction of racial discrimination, the antiapartheid movement, working to reduce trafficking of women and children, prison reform and the humane treatment of offenders, involvement with the league of Nations, immigrant education and immigration reform, health care, housing, advocating for peace and the prevention of war, and progressive education (Healy, 2008; Nipperess, 2013).

Social work, however, seemed to be less involved with the development of human rights as an international framework through the Universal Declaration of Human rights (Healy, 2008). Healy (2008) argues this was due to social work at the time focusing on "action-oriented human needs efforts, leaving human rights policy to others" (p. 745) pointing to the disconnect between the social work value of promoting human rights and the conflicting demands of bureaucratic institutions and governments where, still today, social workers find pressures towards expediency and a focus on needs rather than rights (Healy, 2008; Ife, 2008; Murdach, 2011; Nipperess, 2013; Solas, 2008). More recently, since the IFSW issued its policy statement on human rights in 1988, social work seems to have once again aligned itself with a professional commitment to human rights despite continuing to have a relatively low profile in the global human rights movement (Healy, 2008).

A full discussion of whether or not social work should be a profession defined by a focus on human rights is beyond the scope of this study. However, I believe that a social justice focus that includes a human rights perspective is a helpful framework for exploring how social work should take up the issue of childbirth related distress. I take

this position because currently much of the work being done around the world to reduce

the harm done to women in childbirth aligns itself with social justice and human rights

perspectives. For example, groups and agencies such as Human Rights in Childbirth,

Birth Trauma Canada, Birthrights, Humanize Birth, and Birth Anarchy all use a human

rights perspective in their activism. Indeed, much of this work comes out of the

scholarship and activism of the reproductive justice movement (Price, 2010; Ross &

Solinger, 2017; A. Smith, 2005). Reproductive justice applies the lens of intersectionality

to reproductive rights (which fall under the broader category of human rights) and social

justice to create a new field of scholarship and activism call reproductive justice (Price,

2010; Ross & Solinger, 2017; A. Smith, 2005). Reproductive justice as a framework for

theory and action was developed by women of colour in the United States in the mid

1990s. The movement has at its core the claim, "all fertile persons and persons who

reproduce and become parents require a safe a dignified context for these most

fundamental human experiences" (p. 9) and highlights how people experience their

reproductive lives and oppression in their reproductive lives differently in relation to their

social location (Ross & Solinger, 2017).

In using a human rights and social justice framework to consider the implications

of this study for social work, I rely on the International Federation of Social Workers

(IFSW) as a reference point for exploring the various policy and practice implications of

promoting and ensuring human rights in childbirth, and seeking social justice for birthing

people. The IFSW serves as a "global voice for the profession" and provides support and

guidance to 116 member countries, situating the IFSW as a cross-cultural and

international focusing force for the profession of social work (IFSW, 2016a). A focus on

human rights and social justice forms the foundation of the International Federation of Social Worker's (IFSW) Statement of Ethical Principles and the IFSW policy on women (IFSW, 2012, 2016b). Indeed, the IFSW's statement on women is also very much in line with a reproductive justice framework, including a consideration of intersectionality, social justice, and human rights in its Statement on Women:

> The commitment of the social work profession to social justice requires attention to women's rights as intrinsic to advancing human rights. Intersectionality—how gender combines with other key social characteristics and statuses related to oppression, such as race, ethnicity, national origin, culture, religion, caste or class, age, gender identity and sexual expression, and (dis)ability—is also essential to understanding the situations of women and girls and to working professionally with them (Crenshaw, 1994; Hill Collins, 1999; Samuels & Ross-Sheriff, 2008). (IFSW, 2012b, 2.2.1)

I believe there is reason enough for social workers to be informed, directed, and guided by these social justice and human rights principles as they apply in the area of reproduction, and so this chapter will explore the following questions: "How do social work principles, as reflected in the IFSW statement of ethics and policies, apply to the findings of this research?" and "What are the implications for viewing childbirth distress as a site of social justice work and human rights concerns for social work practice, theory, and research?"

A Social Work Perspective of Rights in Childbirth

There is a tension within the social work profession between the view of the social workers as advocates for social justice and human rights versus as agents of social control

247

(Murdach, 2011). As discussed in Chapter 3's review of the literature, the social work literature regarding childbirth predominantly reflects the social control approach, through pathologizing and risk discourses. Because pregnant women are linked with the welfare of others (infants), this social control through pathology and risk discourses reflects the longstanding tension arising from social work's desire to balance the rights of the individual with the best interests of the community (CASW – ACTS, 2005b; Murdach, 2011). However, this tension between the rights of individuals and others produces a conundrum when we consider the sphere of childbirth: how we should view pregnant, laboring, and birthing women? Are pregnant women and their fetuses/babies two entities or one? Whose rights are paramount: the woman's, with her right to self-determination and bodily autonomy (who may make decisions that professionals disapprove of); or the vulnerable infant (whose status as human/citizen is an ongoing legal debate) who may carry the effects of these decisions? Advocates for women's rights in childbirth call for a disruption in this model, viewing the pregnant, labouring and birthing woman and baby as both one-and-the-same while at the same time as distinct entities (Schiller, 2015, 2016b). Pregnant and labouring women break apart the very idea of the individual, where the woman and baby must be seen in a unique way from other stages of personhood, and where the wellbeing of both is dependent on and affected by each other (Lindemann, 2012; Schiller, 2016b). In this model, childbirth rights advocates argue that women must be centered and trusted to make decisions for their own bodies, pregnancies, and their own babies.

Even though one or two social workers have peripherally touched on this topic in their research, social work as a profession has not taken up emotional distress and trauma

in childbirth as an area of interest. The IFSW, in their statement of ethical principles

provides guidance on how we might begin to consider this as a social work issue.

Specifically regarding human rights and human dignity, the IFSW makes the following

statement:

> Social work is based on respect for the inherent worth and dignity of all people,
> and the rights that follow from this. Social workers should uphold and defend each
> person's physical, psychological, emotional and spiritual integrity and well-being.
> This means:
>
>> 1. Respecting the right to self-determination – Social workers should
>> respect and promote people's right to make their own choices and
>> decisions, irrespective of their values and life choices, provided this does
>> not threaten the rights and legitimate interests of others. (IFSW, 2012, sect.
>> 4)

The statement demonstrates the social work value of self-determination. And yet, we have

seen how women's self-determination in childbirth is undermined. While often the

discourse of risk to others (in this case the fetus) are employed to support the removal of

self-determination, the removal of women's right to make their own decisions about their

care and interventions can also occur when there is no risk (Schiller, 2016b). Take for

example, Patricia who had no input into whether she would have a C-section or vaginal

birth and who asked not to have her waters broken though they were broken anyway.

There was no emergency nor even urgency in her birth situation. There was time to

consult about decisions (surgical versus vaginal birth), and there was certainly time to

honour decisions that had been discussed (breaking the water).

249

If social workers are to "uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being" (IFSW, 2012, sect. 4) we must, as a profession, pay attention to the effects that negative birth experiences have on women's wellbeing. The previous two chapters have demonstrated the physical, psychological, and emotional effects that negative birth experience have on women. The women's stories are full of guilt, hurt, sadness, shame, anger, fear, embarrassment, and physical pain. Certainty social work has a role in defending women against these experiences and supporting them when these experiences occur whether intended, unintended, or unavoidable.

The IFSW, in its policy statement on women, begins with a rationale for why the rights and needs of women are deserving of special and unique consideration by social workers, recognizing that childbirth is a central concern:

Because women bear the world's children and do the majority of child- and family-care related work in all societies, *self-determination in child-bearing and access to the full range of reproductive health care services are essential,* but international aid for these services is currently declining or restricted in use. (IFSW, 2016b, sect. 1.1, emphasis added)

And the IFSW goes on to say: "Women of all ages and at all stages of the life cycle deserve protection from discrimination in all forms, including the elimination of all forms of gender-specific discrimination and violence" (IFSW, 2016b, sect. 5.1). The IFSW considers reproduction a site and source of gender-based oppression, and the policy statement continues:

IFSW will work to improve the health status of women of all ages. Social workers

are commonly involved in the delivery of women's health care, including

maternal and child health, mental and behavioral health care services, and sexual

and reproductive health care, including the care and prevention of HIV/AIDS and

other sexually transmitted diseases. Improving the health and well-being of

women requires attention to physical, mental, emotional, and social well-being

and the provision of gender-sensitive prevention, intervention, and long-term care

services. (IFSW, 2016b, sect. 5.6, emphasis added)

And,

IFSW endorses women's self-determination in all health care decisions as a core

professional value, including all decisions regarding sexual activity and

reproduction. *Social workers understand that women have the right to receive*

competent and safe reproductive and sexual health care services free from

government, institutional, professional, familial, or other interpersonal limitation

or coercion. (IFSW, 2016b, sect. 5,7, emphsis added)

Childbirth itself, and the peripartum period, cannot and must not be excluded from the

social work commitment to sexual and reproductive justice. If pregnancy and parenting

are considered central to women's health and human rights, so too must childbirth and its

associated experiences be considered central.

The IFSW uses the language of freedom from coercion in its discussion of self-

determination. The stories the women told in the previous two chapters are replete with

incidents of coercion. In Mavis' story the idea of letting labour "play out" was not used to

give her the assurance of time and choice. Indeed, it was used as a threat that if she did

not go along with the physicians' recommendation she would be left to labour alone, with

251

ideas of risk and abandonment attached to the message. Mavis was coerced into making

decisions she did not want to make, and was left with significant ongoing emotional and

psychological distress as a result. Numerous women in this study spoke of feeling coerced

into breastfeeding, demonstrating that dominant messages of goodness and sacrifice can

be as coercive as physical force when women are struggling to make decision for

themselves and their children (Lindemann, 2015a). Carrie and Garcia both spoke of

feeling pressured to leave or not go to the hospital even though they had concerns about

their pregnancies and labour. Both women shared stories of feeling let down and

manipulated by the system ostensibly designed to serve them. The anger, humiliation, and

anxiety they are left with are related to these experiences.

In addition to a human rights focus, the IFSW in its Statement of Ethical

Principles also defines its commitment to social justice lens, stating:

"Social workers have a responsibility to promote social justice, in relation to society

generally, and in relation to the people with whom they work" (IFSW, 2016 b, 4.2).

Explaining how this means social workers are called on to challenge discrimination, the

IFSW goes on to state:

> Social workers have a responsibility to challenge negative discrimination on the
>
> basis of characteristics such as ability, age, culture, gender or sex, marital status,
>
> socio-economic status, political opinions, skin colour, racial or other physical
>
> characteristics, sexual orientation, or spiritual beliefs. (IFSW, 2012, sect. 4.2.1)

The analysis in Chapters 6 and 7 demonstrated how women face discrimination in

childbirth due to their gender, and also risk being discriminated against due to class, age,

and sexual orientation. The manner in which women are discursively constructed as

unreliable and over-emotional create an environment where women have difficulty having their needs and rights acknowledged and met (Lindemann, 2012). The findings of this study show that women who fall outside the normative view of women as middleclass, straight, between 20-30 years old, and White found themselves faced with additional and intersecting sites of marginalization. As the IFSW states, social workers have a duty to fight against discrimination, even when the discrimination is invisible to the individuals and systems who are responsible for the discrimination.

A first step in fighting discrimination is to highlight it, and social workers within the framework of the IFSW are called upon to do just that. As women are particularly and uniquely vulnerable in childbirth, it is not surprising that multiple sites of discrimination become evident when women are giving birth. In the narratives of the participants in this study we saw how rural women were separated from family and support networks during childbirth, and could not access services to address their mental health concerns; young and working class women were ignored and mistreated by medical staff who made assumptions about why young women have babies; lesbian women were required to repeatedly insist on their marital and relationships status being seen as valid resulting in same sex spouses missing opportunities to be involved in birth experiences. These are all forms of discrimination that should be of interest to social workers. While social workers must intervene at the level where discrimination happens we must also work to prevent the systemic and structural forces that create the discrimination. Along these lines, the IFSW states, "Social workers have a duty to bring to the attention of their employers, policy makers, politicians and the general public situations where resources are

inadequate or where distribution of resources, policies and practices are oppressive, unfair or harmful" (IFSW, 2012, sect. 1).

Challenging unjust policies and practices requires social workers to be aware of how women of various social locations experience harm in childbirth. Ignoring childbirth as a site of discrimination removes the ability to fight for fairer, more humane practices that are in line with the rights of women, and contributes to the individually enacted and systemically produced discrimination women face in childbirth. Recognizing this gap in awareness allows social workers to become involved in the area and begin to fight to change policies and practices that harm birthing women. Insisting on valid informed consent that involves shared decision making; respecting the wishes of women who state what they will and will not consent to during childbirth; providing supportive, accessible, and non-pathologizing support to women before, during, and after childbirth; and reconsidering how dominant mental health discourses serve to further oppress women, are all ways in which social workers can advocate for and insist on more just policies and practices.

Women often face a barrier in having their needs and rights respected in childbirth because they are not always seen as fully human (IFSW, 2016b, sect.1.1.2; Lindemann, 2012). Pregnant and labouring women are often seen as vessels holding a more precious being, and many women who have become mothers find themselves as entities whose purpose is to sacrifice their own needs and rights for those of their child (Lindemann, 2015; Schiller, 2015, 2016b). This is seen in the oft repeated statement women utter when trying to come to terms with their childbirth experiences, "all that matters is a healthy

baby" (Cohen Shabot, 2016; Lindemann, 2012; Schiller, 2015, 2016b). This study shows that a healthy baby is not all that matters.

When women cease to matter as fully human and only matter in relation to their babies, their human rights easily become invisible and ignored. A recent media interview with obstetrician, Dr. Andrew Kotaska, regarding women's maltreatment in childbirth reflects this very thinking:

I think it's relatively new to concentrate on a mother's experience in labour…This [is a] final adjustment in sort of our ethical evolution from the way childbirth was in the '50s and '60s, to a mature acceptance of women's autonomy, even when that entails some extra risk. (as cited in Burns-Pieper, 2016)

In this interview, Dr. Kotaska demonstrates that women have been an afterthought (if a thought at all) in childbirth. However, women do not choose to give up their humanity when they become pregnant and again, the IFSW speaks to the importance of treating each person as a whole, stating "Social workers should be concerned with *the whole person*, within the family, community, societal and natural environments, and should *seek to recognize all aspects of a person's life*" (IFSW, 2012, sect. 4.1.3, emphasis added). Social workers must recognize that people giving birth are people; people with full and complex lives, people with relationships, with families, and communities, but people nonetheless who need to be seen as complete and valuable in their own right (Lindemann, 2012). Sarah George deserved to not be left alone, spread eagle, in stirrups, while her baby was taken to another floor. Morgan deserved the chance to ask to have her life saved. The women who struggled with breastfeeding deserved to be seen and to see themselves as more than merely infant food sources. The women who had concerns about

their bodies while they were pregnant deserved to be seen as people with legitimate medical questions and concerns and to have those addressed, rather than being dismissed as overreacting, dramatic women. Women are people in their own right; they are not just a means to an end. These are the very things social work should be tackling in our work in the field, in our research, and in our theorizing.

Implications for Social Work Practice, Theory, and Research

Implications for Social Work Practice

Social workers work in hospitals, maternity units, public health, mental health clinics and programs, child welfare, family resource centres, sexual health programs, and a variety of other governmental and grass roots organizations where they are in contact with women who have given birth. Given that about 84% of women give birth, and one third to one half of those women report finding their childbirth experience to be traumatic (Alcorn et al., 2010; Beck et al., 2013; Creedy et al., 2000; Czarnocka & Slade, 2000; Elmir et al., 2010; Ford et al., 2010; O'Donovan et al., 2014; Schiller, 2016b; Skari et al., 2002; Soet et al., 2003; Ukpong & Owolabi, 2006), it is certain that social workers across many sites of practice are already working with women who have had difficult childbirth experiences, even though social workers may not pay attention to these issues. As the IFSW states, "Social workers are involved in the broadest range of professional activities that are critical to the well-being of women and girls. Specific efforts include the delivery of health and mental health care services and public health programs" (IFSW, 2016b, Sect. 1.1.3) and instructs social workers to "commit themselves to enhancing the well being of women and girls as an essential aspect of the profession's ethical and practice commitment to human rights" (IFSW, 2016b, sect. 1.1.2). In practice this means both

expanding and deepening social workers understanding and appreciation of the importance childbirth holds in women's emotional and psychological lives.

Social work in hospitals. Social workers in practice in hospital settings and who have influence at policy levels have need to advocate for women to have valid informed consent, privacy, and confidentiality during labour and delivery. Applying the concept of validity here, in terms of informed consent, reflects the manner in which informed consent is viewed within the positivist epistemology of science and medicine. The language of valid informed consent reflects those actions which are observable and measurable (see for example, The Canadian Medical Protective Association, n.d.). Even within this framework there is likely to be disagreements about valid informed consent, for example, disagreements about if the information shared, of the patient understood the information, and whether or not alternative options were also presented. However, even within this medical definition of valid informed consent, it seems as if those criteria that are used to measure compliance with informed consent procedures are missing from many women's stories.

In the medical model, valid informed consent involves three factors: it must be voluntary (the process cannot involve coercion), the patient must have capacity, and the patient must be provided with all relevant information (The Canadian Medical Protective Association, n.d.). Privacy and confidentiality means women are not questioned about their reproductive and sexual history in the presence of others, including partners and family (such as when Morgan was asked about her abortion history in front of her husband). Social workers may be involved in increasing education among medical teams about informed consent and privacy, including women's rights to refuse treatment and to

make decisions without coercion, and can work with women to file complaints when informed consent has not been adequately carried out or privacy has been breached. The issue of ensuring meaningful informed consent may not be a new issue to social workers, and yet this study indicates that there remains a need for social workers to be vigilant in ensuring the values of transparency, compassion, and partnership are reflected in informed consent practices in order to meet the needs and rights of women in their birth experiences.

Social workers can also work with hospital medical staff to provide education about the importance of contextualizing childbirth within a woman's life. For example, women with histories of sexual assault may be especially vulnerable to childbirth distress and problems with breastfeeding (Halvorsen et al., 2013; S. Kitzinger, 2006b; McKenzie-McHarg et al., 2014) and women should not have to disclose their histories (which can be potentially re-traumatizing) in order to receive compassionate care (as Cali was required to so). Given the high number of women who experience sexual assault in their lifetime (Sexual Assault Centre Hamilton Area, n.d.; Statistics Canada, 2013), it is reasonable to assume that all women are deserving of sensitivity to this issue during childbirth. This trauma informed practice approach is increasingly being seen as helpful (Bremness & Polzin, 2014; Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; Muskett, 2014). As providers cannot always tell if someone has had a past traumatic experience, trauma informed approaches recommend that everyone should be treated with the same gentleness and compassion one would (hopefully) show towards a person who has a known trauma history (Elliott et al., 2005). If maternity care providers (including maternal health social workers) begin from this position, there is a greater likelihood that

258

further emotional harm can be prevented when interacting with systems (such as the healthcare system) (Elliott et al., 2005). Thus, treating all women with respect, privacy, compassion, and dignity fits within a trauma informed model and will result in improved care for all women during childbirth, regardless of their trauma history.

Advocating for informed consent, privacy, and sensitivity may place social workers at odds with their employers, as may helping patients file complaints against the hospitals that employ them, both of which may not be politically appreciated. However the current neoliberal healthcare operates using a risk model, and part of what is current in this model of healthcare is a concern with ensuring patient safety. While some may argue this is strictly an attempt to avoid litigation, social workers working within this risk culture can use patient safety tools to advocate for their clients. Patient complaints, in the patient safety model, are supposed to be used as educational opportunities to improve patient care rather than opportunities to place individual blame (Accreditation Canada, 2013). Reporting breaches in informed consent may encourage hospitals to take steps to improve the consent conversations (or lack thereof) that are occurring between women and their healthcare providers, so that women can truly be partners in making decisions about what happens to their bodies.

Hospital social workers may become involved with birthing women when something goes wrong—a sudden death or serious illness or when child welfare concerns become apparent (Bachman & Lind, 1997; Masson & Dickens, 2015). I argue that social workers should broaden this base to include contact with all individuals who have given birth to see how they feel about their childbirth experience and ask if they were able to exercise control over what happened to their bodies. Many participants in this study

voiced their desire to have had someone to talk to; to debrief with and help make meaning and understanding about what they had just experienced. Social workers in hospitals are especially well situated to carry out this role. Social workers work in health care but we are not medical professionals. We are not invested in the details of medical procedures or standards of obstetrical care. As such, we can take up a more open, less defensive stance when women voice their concerns or complaints about how they experienced childbirth.

However, it is crucial for hospital social workers to be well versed in and understanding of the various factors contributing to distress in childbirth so as not to cause further suffering, as we saw with Julie who felt the need to tend to the emotional needs of her social worker (Lindemann, 2015b). Social workers can use social work specific research, such as this study, to better position themselves to provide compassionate and meaningful care for childbearing people.

Social work in mental health. Social workers working as mental health clinicians, therapists, crisis workers, or other social work roles in community mental health services should become aware of the importance of childbirth experiences on women's emotional and psychological heath. While social workers working in mental health fields may be expected to be aware of the dominant psychiatric understandings of childbirth distress as it relates to post-partum depression, postpartum anxiety, and postpartum psychosis, it is equally important that social workers working in mental health fields also understand emotional distress associated with childbirth through postmodern, feminist, anti-oppressive, and other critical understandings of emotional distress. Narrative and other postmodern approaches to counselling may be helpful in assisting

women if they struggle with the transitions associated with childbirth (Combs &

Freedman, 2012; Lindemann, 2014; M. White, 1990).

For example, it is important for social workers to recognize that birth experiences

are not linearly understood, and may be informed by past birth experiences (as evidenced

in the participants' stories)(S. Kitzinger, 2006b; Simkin, 1991, 1992). Social workers

using such approaches can help women have conversations where they can unpack some

of the assumptions about goodness, motherhood, and emotions that begin to circulate

once a woman gives birth (Combs & Freedman, 2012). Helping women to both embrace

their new role as mothers, while resisting the pressure to subvert their whole identity to

that of mother, may also be helpful in resisting many of the dominant message that

women are exposed to and internalize in their reproductive lives. Critical and anti-

oppressive approaches in counselling and intervention (see for example Baines, 2011; M.

White, 1990) can also be helpful in resisting the erasure of women's rights in

reproductive spaces.

Social work in community-based public health. Given the stories in this

research and in other non-social work research about the impact of childbirth distress on

women, I argue that all people who have given birth should be offered a visit from a

social worker, just as women are offered a public health nurse visit to check on the baby

and "the mom". Women who are visited are visited as "moms", often even being referred

to in this way, as if these women do not have identities other than as a mother (Schiller,

2016b). This framing of women as "moms" is problematic in that it reflects the goal of

these visits—to ensure motherhood is going well. What is missing is ensuring that women

are doing well. Again, social workers, without their narrow focus on medical concerns

and medical expertise are better positioned to view women after delivery as women who may need their own support for themselves. In this view, social workers would not be supporting women so that they can be effective "good" mothers, but because they are deserving, in their own right, of support. This support may also serve to improve the lives of children, but even if it does not, women deserve their own support, and to have their own humanity honoured.

Social workers in this role can follow up on the work begun in hospital, if the woman gave birth in hospital, or can review these same issues if not. As in hospitals and mental health services, social workers working with women through public health type of approaches should also be available to have discussion about distress that are not automatically linked to mental illness discourses. Given the fear women may have about social workers removing their babies (as we saw in Garcia's case) it is important for social workers in this role not to reinforce, indeed to disrupt, these pathological views of distress, so that women can be encouraged to receive the services that might mitigate their suffering. Checking in with women about their social, emotional, psychological, and material needs soon after birth respects that different women may have different needs. Some women may not desire or require further support, while other women may benefit from and desire ongoing support with their life transition.

Social work in communities. Working with women in their communities to advocate for services that centre the needs of women, supporting women as they want to be supported, rather than as dominant discursive understandings of motherhood suggest, is also a valuable role for social workers practicing with women who have given birth. Working with women to provide the support they want and need will likely look different

262

in different communities. Social workers in community agencies such as family resource centres, women's shelters, sexual health clinics, and other spaces should work with women to identify what will be most helpful to women during pregnancy, birth, and postpartum times. Types of support may include support with breastfeeding, support with formula feeding, social connections, food and nutrition security, financial and employment support, and any other needs women may express. Because women who give birth do not cease to have complex lives once a child emerges from them, community agencies should be positioned to respond to the complexity of needs women have. Dealing with a distressing pregnancy and childbirth may add to the pressures women are already facing in their lives. Sensitivity and awareness to the issue of childbirth distress is crucial in assisting women as they navigate complex lives with the additional emotional and psychological distress of their childbirth. Women in this study often found reassurance in hearing that their experience was common enough that it warranted a research project. The normalizing of distress related to childbirth can be carried out across sites. And while working to reduce distress should be a primary goal, helping women feel understood and "normal" when distress does occur is also a crucial intervention in women's lives.

Implications for Social Work Theory and Research

This research serves as an entry for the field of social work into the topic of distress in childbirth and provides a better understanding of the complex intersecting factors that shape experiences of distress in childbirth. Despite the evidence that childbirth is often experienced as a distressing life event to date, social work has remained relatively silent on the topic (Alder et al., 2006; Bailham & Joseph, 2003; Beck,

2004a, 2004b; Beck & Driscoll, 2006; Beck et al., 2013; Creedy et al., 2000; Czarnocka & Slade, 2000; Gamble & Creedy, 2000; Harris & Ayers, 2012; C. Kitzinger & Kitzinger, 2007; S. Kitzinger, 2006b; Leeds & Hargreaves, 2008; Lyons, 1998; McKenzie-McHarg, 2004; Polachek et al., 2012; Soet et al., 2003; Wijma et al., 1997). Social work's dearth of research, theory, and practice in the area of childbirth contributes to the continued oppression and marginalization of those who experience distress in childbirth.

The practice implications outlined above are connected with social work theories, and social work practice and theory should be informed by social work research. Anti-oppressive, narrative, intersectional, critical trauma, and feminist theoretical approaches all work to deconstruct, contextualize, and depathologize the lived experiences of childbearing people and are relevant to understandings of childbirth experiences (Baines, 2011; Burstow, 2003, 2005; Crenshaw, 1991; H. Fraser, 2004, 2009, Ussher, 1992, 2006, 2011).

I also believe social work research into distress in childbirth should reflect a material, discursive, and intrapsychic (MDI) (Ussher, 2012b) theoretical position which considers the material effects of gender-based oppression, the discursive processes which contribute to the creation of this oppression, and the psychological effects these have on women. This MDI approach neither over-endorses nor minimizes the various contributors and consequences of women's distress. Although it allows for the theorizing of distress, it also is associated with the need for action to mitigate distress (Ussher, 2012b).

These theoretical frameworks are useful in practice to fight against discrimination and marginalization. However, in order to fight discrimination we must first be aware of

the discrimination, and social work researchers are in the position to raise awareness of the importance of childbirth distress as a topic of concern worthy of further study. Current and critical methodologies, such as feminist narrative methodology, are an ethical, conceptual, and pragmatic fit for social work research. Research centring the voices of participants regarding an under-recognized topic of concern, distress in childbirth, results in the topic being more approachable for researchers from the social work field and allows social work to join and support the growing movement fighting for the rights of women in childbirth (S. Kitzinger, 2006b; Schiller, 2015, 2016a, 2016b; White Ribbon Alliance, 2011).

This research contributes to the growing body of evidence pointing to a significant social problem. Rights violations, indignities, and abuses in childbirth, and the distress and trauma that are associated with these events and experiences are not simply something that happens "out there." Women, including privileged women in Canada, are experiencing these violations and are being left with emotional, psychological, and physical consequences. This study focused on childbirth distress as it was experienced by those at various intersections of privilege and marginalization, illuminating how social location affects distress in childbirth. In doing so, this study disrupts the view of distress as individual pathology, and instead demonstrated how structural factors and discursive constructions work to create and contribute to women's distress in childbirth. That is, this social work research sought to uncover how oppression and marginalization operate in childbirth in order to improve understanding of the effects of marginalization, privilege, and oppression on those giving birth. This study can act as fuel for future social work

theorizing and research about the experiences of those who experience distress in childbirth.

Limitations of the Study and Suggestions for Future Research

Given the dominance of medical knowledge and science in the field of childbirth, and with the value placed on quantitative and generalizable data, studies such as this one may not be considered credible for contributing to material changes in how childbirth is carried out in this a medical context. However, quantitative research in the area of childbirth distress cannot provide the depth of understanding of experiences that might allow for childbirth distress (even distress that does not meet criteria for diagnosis of PTSD) to be considered important.

This feminist narrative inquiry and analysis fulfilled all the criteria for trustworthiness outlined in Chapter 4. This research is a small study with a sample of 15 women, all of whom are White, most of whom are middleclass, and who all live within one broad geographic region. This is a particular snapshot of experiences and is not intended to be generalizable, to represent all women, nor all childbirth experiences. Participants in this study all identified as White women, and so gender non-conforming, gender queer, and trans voices are absent in this research. Thus, future social work research into this topic area would benefit from greater diversity in its participants. For example, having Indigenous and other racialized social work researchers carry out a similar project would strengthen research into this topic area. This would increase the likelihood of racialized and Indigenous participant involvement and would strengthen the intersectional analysis.

Furthermore, as social work is a profession of action, future research might take a more action-oriented approach. For example, a participatory action research project, partnering with midwives, doulas and those who have and will be giving birth, might be useful in advocating for changes in how childbearing people are treated by the systems that are supposed to help them.

Social work has a commitment to protecting the emotional wellbeing of all people, to supporting self-determination in general, to pay special attention to ensuring self-determination in childbirth, and to protect women from gender-specific discrimination which includes discrimination in childbirth (IFSW, 2012, 2016b). Thus, social work researchers might explore the current level of understanding about childbirth related distress among social work students and faculty so that gaps in social work education might be addressed.

Concluding Thoughts

This research has used a feminist narrative inquiry and analysis to explore distress in childbirth from a social work perspective. I have explained how oppressive and gendered discourses interact with mechanism of power, and gender-based violations of human rights to create the conditions for distressing childbirth experiences to occur. The violence, rights violations, and indignities experienced by women in childbirth are not necessarily reflective of individual bad actors. They reflect structural processes that construct women in problematic ways and result in various contributing factors to distressing childbirth experiences (Cohen Shabot, 2016). As such, distress in childbirth deserves the attention of social workers both to work to dismantle the structural forces

267

that create distress and to mitigate the distressing effects these structural forces have on childbearing people.

The lack of social work research regarding distressing childbirth experiences means that social workers cannot contribute to the dismantling of these structural forces and to improved life experiences for those giving birth, without relying on the scholarship of related professions. The literature reviewed for this research demonstrated that the scholarship coming from other professions, while in many ways helpful and applicable, also often ignores or pathologizes the lived experiences of those who express distress in childbirth. My hope in doing this research and asking the question: "What are individuals' experiences of distress in childbirth?" was that social workers will be better positioned through practice, theory, and research to contribute to improved care for those who give birth and to reduce emotional suffering during childbirth.

The feminist narrative methodology used in this research privileged subjugated knowledges and allowed for an exploration of how various factors (such as discourse, power/knowledge, agency, the body, gender and intersections of identity, distress and emotion, and childbirth narratives) shape understanding about distress in childbirth. The knowledge gained through this approach challenged dominant stories, and acted as a focus point for social change (Clandinin, 2013; Frank, 2005). Fifteen White women, from a variety of locations across Atlantic Canada, and ranging in age from 18 to 43 years old, participated in this research project. By focusing on experience, this feminist narrative approach rejected the idea of a single truth, and uncovered areas of similarity and difference among the participants' stories of their experiences.

Women's stories reflected the discursive constructions of "good mothering," the gendered discourses that construct women who display certain emotions and behaviours as "overly dramatic" and "divas," and the discursive construction of women as heterosexual. Their stories also reflected how the material reality of regimes of truth created conditions where their own knowledge was discredited and subjugated to medical knowledge. Exploring participants' narratives illustrated how disciplinary power orders the lives of women in pregnancy, childbirth, and the postpartum period, and also highlighted acts of resistance, where mechanisms of power were seen and women resisted their disciplining influences. The analysis of participants' narratives also exposed the emotional labour involved in childbirth, sharing numerous stories of women working hard to express empathy and appreciation of the medical staff involved in their care, even when the participants were concurrently feeling emotions of anger, frustration, and sadness. The women in this study additionally pointed to the problematically polarized discourses surrounding various aspects of childbirth: the mutually exclusive categorical construction of childbirth as either a natural or medical event; the polarized views among medical staff regarding the role women should have in making decisions about childbirth; polarized expectations about what knowledge women should possess about childbirth; and the frequently contradictory messages about the importance of breastfeeding. Participants gave voice to the ways in which these polarized views of childbirth created distress—they wanted their experience of giving birth to be seen; they wanted the experience of childbirth to be treated as special; and women wanted to be seen as central to the birth experience and in this as deserving of care and attention.

In this study I have argued that one way in which women can have their experiences and needs in childbirth privileged is to consider the benefits a humans rights approach might offer in understanding the various and intersecting facets of childbirth experiences. For example, the IFSW (using a human rights framework) outlines the social work value of self-determination, and yet, this study has demonstrated how women's self-determination in childbirth is undermined. The IFSW calls for freedom from coercion in its discussion of self-determination, and yet this research demonstrated how women are coerced in childbirth through (sometimes subtle and sometimes overt) regulating forces. This means women are discriminated against in childbirth due to their gender alone and risk further discrimination on the basis of class, age, and sexual orientation. When pregnant and labouring women are not seen as fully human, and instead are seen as vessels holding a more precious being, women face a barrier in having their needs and rights respected in childbirth. The IFSW calls upon social workers to identify and fight discrimination and women should not be excluded from this focus simply due to their reproductive status.

Social workers in hospitals and various government and community agencies are in frequent contact with women who given birth, which means that social workers have numerous opportunities to address childbirth distress and work towards improving the lives of those who have had problematic birth experiences. This work should be informed by social work specific theory and research that uses anti-oppressive, narrative, intersectional, critical trauma, and feminist theoretical approaches to advance our understanding of the lived experiences of childbearing people.

Social workers must begin to recognize that childbirth is an important life experience and event that is frequently experienced as distressing. As a profession we must align this recognition with our social work values of promoting human rights and ending discrimination. This means that social work as a profession of theory, research, and practice, must pay new attention to the multitude of factors that contribute to suffering in childbirth. We must do a better job of preventing and alleviating the suffering of those who have had problematic childbirth experiences.

REFERENCES

4 ways to be gender inclusive when discussing abortion. (2014). Retrieved from
http://everydayfeminism.com/2014/08/gender-inclusive-discussing-abortion/

Aanerud, R. (2007). The legacy of white supremacy and the challenge of white antiracist
mothering. *Hypatia*, *22*(2), 20–38. https://doi.org/10.1111/j.1527-
2001.2007.tb00980.x

Abortion Access for All: Two Nonprofits Embrace Gender Inclusive Language. (n.d.).
Retrieved August 6, 2015, from http://www.autostraddle.com/abortion-access-for-
all-two-nonprofits-embrace-gender-inclusive-language-251440/

Accreditation Canada. (2013, November 5). Tool for identifying harmful incidents in the
hospital setting to disclose. Retrieved from https://accreditation.ca/tool-
identifying-harmful-incidents-hospital-setting-disclose

Adams, E. (2010). If transmen can have babies, how will perinatal nursing adapt? *MCN:
The American Journal Of Maternal Child Nursing*, *35*(1), 26–32.
https://doi.org/10.1097/01.NMC.0000366807.67455.de

Adewuya, A. O., Ologun, Y. A., & Ibigbami, O. S. (2006). Post-traumatic stress disorder
after childbirth in Nigerian women: Prevalence and risk factors. *BJOG: An
International Journal of Obstetrics & Gynaecology*, *111*(3), 284–288.
https://doi.org/10.1111/j.1471-0528.2006.00861.x

Agger, B. (1991). Critical theory, poststructuralism, postmodernism: Their sociological
relevance. *Annual Review of Sociology*, 105–131.

Akom, A. A. (2008). Black metropolis and mental life: Beyond the "Burden of 'acting white'" toward a third wave of critical racial studies. *Anthropology & Education Quarterly*, *39*(3), 247–265. https://doi.org/10.1111/j.1548-1492.2008.00020.x

Alaimo, S., & Hekman, S. (2008). Introduction: Emerging models of materiality in feminist theory. In S. Alaimo (Ed.), *Material feminisms* (Kindle). Bloominton, IN: Indiana University Press.

Alcoff, L., & Potter, E. (1993). *Feminist epistemologies*. New York: Routledge.

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devily, G. J. (2010). A prospective longitudinal study of the prevalence of post-traumatic stress disorder resulting from childbirth events. *Psychological Medicine*, *40*(11), 1849–1859. https://doi.org/10.1017/S0033291709992224

Alder, J., Stadlmayr, W., Tschudin, S., & Bitzer, J. (2006). Post-traumatic symptoms after childbirth: What should we offer? *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 107–112.

Allen, K. R., & Baber, K. M. (1992). Ethical and epistemological tensions in applying a postmodern perspective to feminist research. *Psychology of Women Quarterly*, *16*(1), 1–15. https://doi.org/10.1111/j.1471-6402.1992.tb00236.x

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of traumatic childbirth. *Journal of Reproductive and Infant Psychology*, *16*(2–3), 107–131. https://doi.org/10.1080/02646839808404563

Allsop, J. (2013). Competing paradigms and health research: Design and process. In M. Saks & J. Allsop (Eds.), *Researching health: Qualitative, quantitative and mixed methods* (2nd ed., pp. 18–41). Los Angeles: Sage.

Alvesson, M., & Sköldberg, K. (2009). *Reflexive methodology: New vistas for qualitative research*. Thousand Oaks: Sage.

American Psychiatric Association, & American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders-text revision: DSM-IV-TR®*. American Psychiatric Association.

Amoros, Z., Callister, L., & Sarkisyan, K. (2010). Giving birth: The voices of Armenian women. *International Nursing Review*, *57*(1), 135–141. https://doi.org/10.1111/j.1466-7657.2009.00775.x

Andersen, L. B., Melvaer, L. B., Videbech, P., Lamont, R. F., & Joergensen, J. S. (2012). Risk factors for developing post-traumatic stress disorder following childbirth: A systematic review. *Acta Obstetricia et Gynecologica Scandinavica*, *91*(11), 1261–1272. https://doi.org/10.1111/j.1600-0412.2012.01476.x

Anderson, C. A. (2011). Construct validity of the childbirth trauma index for adolescents. *Journal of Perinatal Education*, *20*(2), 78–90. https://doi.org/10.1891/1058-1243.20.2.78

Anderson, C. A., & Gill, M. (2014). Childbirth related fears and psychological birth trauma in younger and older age adolescents. *Applied Nursing Research*, *27*(4), 242–248. https://doi.org/10.1016/j.apnr.2014.02.008

Anderson, K., Armitage, S., Jack, D., & Wittner, J. (2004). Beginning where we are: Feminist methodology in oral history. In S. N. Hesse-Biber & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp. 224–242). New York: Oxford University Press.

Andrews, M. (2013). Learning from stories, stories from learning. In I. F. Goodson, A. M. Loveless, & D. Stephens (Eds.), *Explorations in narrative research* (Vol. 6, pp. 33–41). Springer Science & Business Media.

Anton, R., & David, D. (2013). Response expectancy versus response hope in predicting birth-related emotional distress and pain. *International Journal of Psychology*, *48*(5), 954–963.

Archibald, J. (2008). *Indigenous storywork: Educating the heart, mind, body, and spirit*. UBC press.

Arvay, M. J. (2003). Doing reflexivity: A collaborative narrative approach. In L. Finlay & Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences* (pp. 163–175). Oxford: Blackwell Publishing.

Atlantic Canada Opportunities Agency. (2012, November 16). Retrieved from http://www.acoa-apeca.gc.ca/eng/publications/FactSheetsAndBrochures/Pages/FS_Educationandtraining.aspx

Atlantic Canada Opportunities Agency. (2015, September 9). Retrieved from http://www.acoa-apeca.gc.ca/eng/ImLookingFor/Pages/AboutAtlanticCanada.aspx

Aveling, N. (2004). Critical whiteness studies and the challenges of learning to be a" White Ally". *Borderlands: E-Journal*, *3*(2).

Averitt Taylor, J. (2014). Reproductive health policy affecting low-income women: Historical precedents and current need for social work action. *Social Work in Public Health*, *29*(2), 132–140. https://doi.org/10.1080/19371918.2013.775872

Ayers, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Posttraumatic stress disorder after childbirth: Analysis of symptom presentation and sampling. *Journal of Affective Disorders*, *119*(1–3), 200–204. https://doi.org/10.1016/j.jad.2009.02.029

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a result of childbirth? A prospective study of incidence. *Birth*, *28*(2), 111–118. https://doi.org/10.1046/j.1523-536X.2001.00111.x

Bacchi, C. (2005). Discourse, discourse everywhere: Subject "Agency" in feminist discourse methodology. *NORA - Nordic Journal of Feminist and Gender Research*, *13*(3), 198–209. https://doi.org/10.1080/08038740600600407

Bachman, D. H., & Lind, R. F. (1997). Perinatal social work and the high risk obstetrics patient. *Social Work in Health Care*, *24*(3–4), 3–19. https://doi.org/10.1300/J010v24n03_02

Bailham, D., & Joseph, S. (2003). Post-traumatic stress following childbirth: A review of the emerging literature and directions for research and practice. *Psychology, Health & Medicine*, *8*(2), 159–168. https://doi.org/10.1080/1354850031000087537

Baines, D. (2011). *Doing anti-oppressive practice: Social justice social work* (2nd ed..). Halifax, N.S.: Halifax, N.S. : Fernwood Pub.

Baker, S. R., Choi, P. Y. L., Henshaw, C. A., & Tree, J. (2005). 'I Felt as though I'd been in jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology*, *15*(3), 315–342. https://doi.org/10.1177/0959-353505054718

Banner, F. (2016). "She was just a Chechen": The female suicide bomber as a site of

collective suffering in wartime Chechen Republic. In M. J. Casper & E. H.

Wertheimer (Eds.), *Critical trauma studies: Understanding violence, conflict and*

memory in everyday life (Kindle Edition, p. loc. 708-1177). NYU Press.

Barbour, R. (2008). *Introducing qualitative research: A student guide to the craft of doing*

qualitative research. Los Angeles: Sage Publications ltd.

Barnhart, R. (1988). *The Barnhart dictionary of etymology*. New York: H. W. Wilson Co.

Baron, R. S., Cusumano, M. A., Evans, D. C., Hodne, C. J., & Logan, H. (2004). The

effect of desired control and anticipated control on the stress of childbirth. *Basic*

& Applied Social Psychology, *26*(4), 249–261.

https://doi.org/10.1207/s15324834basp2604_2

Beck, C. T. (2004a). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*(1),

28–35.

Beck, C. T. (2004b). Post-traumatic stress disorder due to childbirth: The aftermath.

Nursing Research, *53*(4), 216–224.

Beck, C. T. (2011). A metaethnography of traumatic childbirth and its aftermath:

Amplifying causal looping. *Qualitative Health Research*, *21*(3), 301–311.

https://doi.org/10.1177/1049732310390698

Beck, C. T., & Driscoll, J. (2006). *Postpartum mood and anxiety disorders: A clinician's*

guide. Jones & Bartlett Learning.

Beck, C. T., Driscoll, J. W., & Watson, S. (2013). *Traumatic childbirth*. Routledge.

Beck, C. T., Gable, R. K., Sakala, C., & Declercq, E. R. (2011). Posttraumatic stress disorder in new mothers: Results from a two-stage US National Survey. *Birth*, *38*(3), 216–227.

Benhabib, S. (1995). Feminism and postmoderism. In L. Nicholson (Ed.), *Feminist contentions: A philosophical exchange* (pp. 17–34). London: Routledge.

Berentson-Shaw, J., Scott, K. M., & Jose, P. E. (2009). Do self-efficacy beliefs predict the primiparous labour and birth experience? A longitudinal study. *Journal of Reproductive and Infant Psychology*, *27*(4), 357–373.

Beresford, P. (2005). Social work and a social model of madness and distress: Developing a viable role for the future. *Social Work and Social Sciences Review - An International Journal of Applied Re*, *12*(2), 59–73.

Berger, P. L., & Luckmann, T. (1967). *The social construction of reality: A treatise in the sociology of knowledge*. New York: Anchor Books.

Bernier, A., Jarry-Boileau, V., Tarabulsy, G. M., & Miljkovitch, R. (2010). Initiating a caregiving relationship: Pregnancy and childbirth factors as predictors of maternal sensitivity. *Infancy*, *15*(2), 197–208.

Best, A. L. (2003). Doing race in the context of feminist interviewing: Constructing whiteness through talk. *Qualitative Inquiry*, *9*(6), 895–914.

Bhaskar, R. (1998). General Introduction. In M. Archer, R. Bhaskar, A. Collier, T. Lawson, & A. Norrie (Eds.), *Critical realism: Essential readings* (pp. ix–xxiv). Routledge.

Bilge, S. (2013). Intersectionality undone. *Du Bois Review: Social Science Research on Race*, *10*(02), 405–424. https://doi.org/10.1017/S1742058X13000283

Birthsource. (2016, November 22). Amnioinfusion. Retrieved from http://www.birthsource.com/scripts/article.asp?articleid=42

Blix, B. H., Hamran, T., & Normann, H. K. (2013). Struggles of being and becoming: A dialogical narrative analysis of the life stories of Sami elderly. *Journal of Aging Studies*, *27*(3), 264–275. https://doi.org/10.1016/j.jaging.2013.05.002

BMI for Adults. (2016). Retrieved from http://www.dietitians.ca/Your-Health/Assess-Yourself/Assess-Your-BMI/BMI-Adult.aspx

Bogolub, E. (2010). The obligation to bring about good in social work research: A new perspective. *Qualitative Social Work*, *9*(1), 9–15.

Bold, C. (2012). *Using narrative in research*. London: Sage.

Boorman, R. J., Devilly, G. J., Gamble, J., Creedy, D. K., & Fenwick, J. (2014). Childbirth and criteria for traumatic events. *Midwifery*, *30*(2), 255–261. https://doi.org/10.1016/j.midw.2013.03.001

Borland, K. (2004). That's not what I said. In S. N. Hesse-Biber & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp. 522–534). New York: Oxford University Press.

Brant, J. (2014). From historical memories to contemporary visions: Honouring Indigenous maternal histories. *Journal of the Motherhood Initiative for Research and Community Involvement*, *5*(1).

Breggin, P. R. (1994). *Toxic psychiatry : Why therapy, empathy, and love must replace the drugs, electroshock, and biochemical theories of the "new psychiatry."* New York, NY : St. Martin's Press.

Bremness, A., & Polzin, W. (2014). Trauma-informed care. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *23*(2), 86.

Briddon, E., Slade, P., Isaac, C., & Wrench, I. (2011). How do memory processes relate to the development of posttraumatic stress symptoms following childbirth? *Journal of Anxiety Disorders*, *25*(8), 1001–1007. https://doi.org/10.1016/j.janxdis.2011.06.008

Brown, C. G. (2012). Anti-oppression through a postmodern lens: Dismantling the master's conceptual tools in discursive social work practice. *Critical Social Work*, *13*(1), 34–65.

Brown Wilson, C. (2009). Developing community in care homes through a relationship-centred approach. *Health & Social Care in the Community*, *17*(2), 177–186. https://doi.org/10.1111/j.1365-2524.2008.00815.x

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: The use of grounded theory, discourse analysis and narrative analysis. *Journal of Family Therapy*, *27*(3), 237–262.

Burns-Pieper, A. (2016, November 7). "Stop! Stop!": Canadian women share stories of alleged mistreatment in the delivery room. Retrieved from http://www.cbc.ca/news/health/child-birth-mistreatment-complaints-1.3834997

Burr, V. (2015). *Social constructionism* (3rd Edition, Kindle). London and New York: Routledge.

Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence Against Women*, *9*(11), 1293–1317.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the DSM. *Journal of Humanistic Psychology*, *45*(4), 429–445.

Burstow, B. (2006). Understanding and ending ECT: A feminist imperative. *Canadian Woman Studies*, *25*(1).

Burstow, B., & Weitz, D. (1988). *Shrink resistant: The struggle against psychiatry in Canada*. Vancouver: New Star Books.

Butler, J. (1995). Contingent foundations: Feminism and the question of "postmodernism." In L. Nicholson (Ed.), *Feminist contentions: A philosophical exchange* (pp. 35–58). London: Routledge.

Butler, J. (1999). *Gender trouble*. New York: Routledge.

Butler, J. (2004). *Undoing gender*. Boca Raton: Routledge.

Cacciatore, J. (2009). The silent birth: A feminist perspective. *Social Work*, *54*(1), 91–95.

Callahan, J. L., & Hynan, M. T. (2002). Identifying mothers at risk for postnatal emotional distress: Further evidence for the validity of the perinatal posttraumatic stress disorder questionnaire. *Journal of Perinatology*, *22*, 448–454. https://doi.org/10.1038/sj.jp.7210783

Callister, L. C. (2004). Making meaning: Women's birth narratives. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *33*(4), 508–518.

Campbell, R., & Wasco, S. M. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology*, *28*(6), 773–791.

Canadian Association of Social Workers – Association canadienne de travailleuses et

    travailleurs sociaux. (2005a). Code of ethics: Core social work values and

    principles. Retrieved from http://www.casw-acts.ca/en/what-social-work/casw-

    code-ethics

Canadian Association of Social Workers – Association canadienne de travailleuses et

    travailleurs sociaux. (2005b). Guidelines for ethical practice. Retrieved from

    http://www.casw-

    acts.ca/sites/default/files/attachements/CASW_Guidelines%20for%20Ethical%20

    Practice.pdf

Caplan, P. J. (1992). Gender issues in the diagnosis of mental disorder. *Women &*

    Therapy, *12*(4), 71–82.

Caplan, P. J. (2012). Sex bias in psychiatric diagnosis and the courts. In W. Chan, D. E.

    Chunn, & R. Menzies (Eds.), *Women, madness and the law: A feminist reader*

    (Kindle Edition). Routledge.

Carbado, D. (2013). Colorblind intersectionality. *Signs*, *38*(4), 811–845.

    https://doi.org/10.1086/669666

Carter, S. K., & Guittar, S. G. (2014). Emotion work among pregnant and birthing

    women. *Midwifery*, *30*(9), 1021–1028.

    https://doi.org/10.1016/j.midw.2014.05.003

Case, K. A. (2012). Discovering the privilege of whiteness: White women's reflections on

    anti-racist identity and ally behavior. *Journal of Social Issues*, *68*(1), 78–96.

    https://doi.org/10.1111/j.1540-4560.2011.01737.x

Casper, M. J., & Wertheimer, E. H. (2016). *Critical trauma studies: Understanding violence, conflict and memory in everyday life* (Kindle Edition). NYU Press.

Chadwick, R. J. (2009). Between bodies, cultural scripts and power: The reproduction of birthing subjectivities in home-birth narratives. *Subjectivity*, *27*(1), 109–133.

Chadwick, R. J. (2014). Bodies talk: On the challenges of hearing childbirth counter-stories. In S. McKenzie-Mohr & M. N. Lafrance (Eds.), *Women voicing resistance: Discursive and narrative explorations* (pp. 44–53). East Sussex: Routledge.

Chadwick, R. J. (2017). Embodied methodologies: challenges, reflections and strategies. *Qualitative Research*, *17*(1), 54–74.

Chadwick, R. J., Cooper, D., & Harries, J. (2014). Narratives of distress about birth in South African public maternity settings: A qualitative study. *Midwifery*, *30*(7), 862–868.

Chan, W. (2012). Gender, murder and madness. In W. Chan, D. E. Chunn, & R. Menzies (Eds.), *Women, madness and the law: A feminist reader* (Kindle Edition, pp. 147–168). Routledge.

Chase, S. (2005). Narrative inquiry: Multiple lenses, approaches, voices. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *The sage handbook of qualitative research* (3rd ed., pp. 651–680). London: Sage.

Chase, S. E. (2001). Pregnancy and childbirth. In M. F. Rogers & S. Chase (Eds.), *Mothers and children: Feminist analyses and personal narratives* (pp. 144–173). New Jersey: Rutgers University Press.

Chastine, C. (2015). Cisgender Women Aren't the Only People Who Seek Abortions, and

    Activists' Language Should Reflect That. Retrieved August 26, 2015, from

    http://rhrealitycheck.org/article/2015/03/18/cisgender-women-arent-people-seek-

    abortions-activists-language-reflect/

Chesler, P. (2005). *Women and madness.* Palgrave Macmillan.

Cho, S., Crenshaw, & McCall, L. (2013a). Toward a field of intersectionality studies:

    Theory, applications, and praxis. *Signs*, *38*(4), 785–810.

    https://doi.org/10.1086/669608

Cho, S., Crenshaw, & McCall, L. (2013b). Toward a Field of Intersectionality Studies:

    Theory, Applications, and Praxis. *Signs*, *38*(4), 785–810.

    https://doi.org/10.1086/669608

Clandinin, D. J. (2013). *Engaging in narrative inquiry*. Walnut Creek, CA: Left Coast

    Press.

Clandinin, D. J., & Caine, V. (2013). Narrative inquiry. In A. A. Trainor & E. Graue

    (Eds.), *Reviewing qualitative research in the social sciences* (pp. 166–179). New

    York: Routledge.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in

    qualitative research*. San Francisco: Jossey-Bass.

Clark, A. M. (2008). Critical realism. In *The Sage encyclopedia of qualitative research

    methods* (pp. 168–170). Los Angeles, [Calif.]: Los Angeles, Calif.

Clegg, S. (2006). The problem of agency in feminism: A critical realist approach. *Gender

    and Education*, *18*(3), 309–324.

Cohen, M. M., Ansara, D., Schei, B., Stuckless, N., & Stewart, D. E. (2004).

> Posttraumatic stress disorder after pregnancy, labor, and delivery. *Journal of*
>
> *Women's Health*, *13*(3), 315–324. https://doi.org/10.1089/154099904323016473

Cohen Shabot, S. (2016). Making Loud Bodies "Feminine": A Feminist-

> Phenomenological Analysis of Obstetric Violence. *Human Studies*, *39*(2), 231–
>
> 247. https://doi.org/10.1007/s10746-015-9369-x

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics*

> *of empowerment* (Rev. 10th anniversary edition). New York: Routledge.

Combs, G., & Freedman, J. (2012). Narrative, poststructuralism, and social justice:

> Current practices in narrative therapy. *The Counseling Psychologist*, *40*(7), 1033–
>
> 1060.

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry.

> *Educational Researcher*, *19*(5), 2–14.
>
> https://doi.org/10.3102/0013189X019005002

Cooper, N., & Burnett, S. (2006). Using discursive reflexivity to enhance the qualitative

> research process: An example from accounts of teenage conception. *Qualitative*
>
> *Social Work*, *5*(1), 111–129. https://doi.org/10.1177/1473325006061541

Cosgrove, L. (2000). Crying out loud: Understanding women's emotional distress as both

> lived experience and social construction. *Feminism & Psychology*, *10*(2), 247–
>
> 267.

Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of

> acute trauma symptoms: Incidence and contributing factors. *Birth*, *27*(2), 104–
>
> 111.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *U. Chi. Legal F.*, 139.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 1241–1299.

Creswell, J. W., Hanson, W. E., Plano, V. L. C., & Morales, A. (2007). Qualitative research designs selection and implementation. *The Counseling Psychologist*, *35*(2), 236–264.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, *39*(3), 124–130.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches* (Fourth Edition). Thousand Oaks, California: Sage publications.

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, *39*(1), 35–51.

Dale-Hewitt, V., Slade, P., Wright, I., Cree, M., & Tully, C. (2012). Patterns of attention and experiences of post-traumatic stress symptoms following childbirth: an experimental study. *Archives of Women's Mental Health*, *15*(4), 289–296.

Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Posttraumatic stress symptoms following childbirth and mothers' perceptions of their infants. *Infant Mental Health Journal*, *29*(6), 537–554.

Davis, J. E. (2002). Narrative and social movements: The power of stories. In J. E. Davis (Ed.), *Stories of change: Narrative and social movements* (Kindle Edition). SUNY Press.

DeMier, R. L., Hynan, M. T., Hatfield, R. F., Varner, M. W., Harris, H. B., & Manniello, R. L. (2000). A measurement model of perinatal stressors: Identifying risk for postnatal emotional distress in mothers of high-risk infants. *Journal of Clinical Psychology*, *56*(1), 89–100. https://doi.org/10.1002/(SICI)1097-4679(200001)56:1<89::AID-JCLP8>3.0.CO;2-6

Devault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. *Social Problems*, *37*(1), 96–116.

Devilly, G. J., Gullo, M. J., Alcorn, K. L., & O'Donovan, A. (2014). Subjective appraisal of threat (criterion A2) as a predictor of distress in childbearing women. *The Journal of Nervous and Mental Disease*, *202*(12), 877–882.

DTC. (n.d.). Retrieved from http://www.doulatraining.ca

Ehrenreich, B. (2010). *Witches, midwives, and nurses: A history of women healers* (2nd Ed. Kindle Edition). New York: Feminist Press.

Ehrenreich, B., & English, D. (2005). *For her own good: Two centuries of the experts' advice to women*. Anchor.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461–477.

Ellis, C., & Berger, L. (2002). Their story/my story/our story: Including the researcher's experience in interview research. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research: Context and method* (pp. 156–183). Sage.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced Nursing, 66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Fairbrother, N., & Woody, S. R. (2007). Fear of childbirth and obstetrical events as predictors of postnatal symptoms of depression and post-traumatic stress disorder. *Journal of Psychosomatic Obstetrics & Gynecology, 28*(4), 239–242. https://doi.org/10.1080/01674820701495065

Fegan, E. (2012). Reclaiming women's agency: Exposing the mental health effects of "post-abortion syndrome" propaganda. In W. Chan, D. E. Chunn, & R. Menzies (Eds.), *Women, madness and the law: A feminist reader* (Kindle Edition). Routledge.

Fenwick, J., Gamble, J., & Mawson, J. (2003). Women's experiences of Caesarean section and vaginal birth after Caesarian: A Birthrites initiative. *International Journal of Nursing Practice, 9*(1), 10–17. https://doi.org/10.1080/01674820701495065

Fleetwood, S. (2005). Ontology in organization and management studies: A critical realist perspective. *Organization, 12*(2), 197–222.

Fook, J. (2012). *Social work: A critical approach to practice* (2nd ed.). Los Angeles: SAGE Publications.

Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict post-traumatic stress symptoms following childbirth. *Journal of Anxiety Disorders*, *24*(3), 353–359. https://doi.org/10.1016/j.janxdis.2010.01.008

Forssén, A. S. (2012). Lifelong significance of disempowering experiences in prenatal and maternity care Interviews with elderly Swedish women. *Qualitative Health Research*, *22*(11), 1535–1546. https://doi.org/10.1177/1049732312449212

Fottrell, E., Kanhonou, L., Goufodji, S., Béhague, D. P., Marshall, T., Patel, V., & Filippi, V. (2010). Risk of psychological distress following severe obstetric complications in Benin: The role of economics, physical health and spousal abuse. *The British Journal of Psychiatry*, *196*(1), 18–25. https://doi.org/10.1192/bjp.bp.108.062489

Foucault, M. (1972). *The archaeology of knowledge (AM Sheridan Smith, trans.)*. Great Britain: Routledge.

Foucault, M. (1977a). Body/power. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 55–62). New York: Vintage Books, Random House.

Foucault, M. (1977b). *Discipline & punish*. New York: Vintage Books, Random House.

Foucault, M. (1977c). Power and strategies. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 134–145). New York: Vintage Books, Random House.

Foucault, M. (1977d). Prison talk. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 37–54). New York: Vintage Books, Random House.

Foucault, M. (1977e). The confession of the flesh. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 194–228). New York: Vintage Books, Random House.

Foucault, M. (1977f). The eye of power. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 134–145). New York: Vintage Books, Random House.

Foucault, M. (1977g). Truth and power. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 109–133). New York: Vintage Books, Random House.

Foucault, M. (1977h). Two lectures. In C. Gordon (Ed.), *Power/knowledge: Selected interviews & other writings 1972-1977 by Michel Foucault* (pp. 78–108). New York: Vintage Books, Random House.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, *8*(4), 777–795.

Foucault, M. (1988). *Technologies of the self: A seminar with Michel Foucault*. Amherst: University of Massachusetts Press.

Frank, A. W. (2005). What is dialogical research, and why should we do it? *Qualitative Health Research*, *15*(7), 964–974.

Frank, A. W. (2008). Why study people's stories? The dialogical ethics of narrative analysis. *International Journal of Qualitative Methods*, *1*(1), 109–117.

Frank, A. W. (2013). *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.

Frankenberg, R. (1993). *White women, race matters*. Minneapolis: University of Minnesota Press.

Franks, M. (2002). Feminisms and cross-ideological feminist social research: Standpoint,

situatedness and positionality–developing cross-ideological feminist research.

Journal of International Women's Studies, *3*(2), 38–50.

Franzosi, R. (1998). Narrative analysis-or why (and how) sociologists should be

interested in narrative. *Annual Review of Sociology*, 517–554.

Fraser, H. (2004). Doing narrative research analysing personal stories line by line.

Qualitative Social Work, *3*(2), 179–201.

https://doi.org/10.1177/1473325004043383

Fraser, H. (2009). Trying to complete socially just, politically sensitive social work

research. *Journal of Social Work*, *9*(1), 87–98.

Fraser, N. (1995). False antithesis. In L. Nicholson (Ed.), *Feminist contentions: A

philosophical exchange* (pp. 59–74). London: Routledge.

Gamble, J. A., & Creedy, D. K. (2000). Women's request for a Cesarean section: A

critique of the literature. *Birth*, *27*(4), 256–263. https://doi.org/10.1046/j.1523-

536X.2001.00101.x

Gannon, S., & Davies. (2007). Postmodern, poststructural, and critical theories. In S. N.

Hesse-Biber (Ed.), *Handbook of feminist research: Theory and praxis* (pp. 71–

106). Thousand Oaks: Sage.

Garthus-Niegel, S., von Soest, T., Knoph, C., Simonsen, T. B., Torgersen, L., &

Eberhard-Gran, M. (2014). The influence of women's preferences and actual

mode of delivery on post-traumatic stress symptoms following childbirth: A

population-based, longitudinal study. *BMC Pregnancy and Childbirth*, *14*(1), 191.

Georgakopoulou, A. (2006). Thinking big with small stories in narrative and identity analysis. *Narrative Inquiry*, *16*(1), 122–130.

Given, L. M., & Saumure, K. (2008). Trustworthiness. In L. M. Given (Ed.), *The Sage encyclopedia of qualitative research methods* (pp. 896–897). Thousand Oaks: Sage Publications.

Guba, E., & Lincoln, Y. S. (2004). Completing paradigms in qualitative research: Theories and issues. In S. N. Hesse-Biber & P. Leavy (Eds.), *Approaches to qualitative research: A reader on theory and practice* (pp. 17–38). New York: Oxford University Press.

Hair, H. J., & Fine, M. (2012). Social constructionism and supervision: Experiences of AAMFT supervisors and supervised therapists. *Journal of Marital and Family Therapy*, *38*(4), 604–620.

Hair, H. J., & O'Donoghue, K. (2009). Culturally relevant, socially just social work supervision: Becoming visible through a social constructionist lens. *Journal of Ethnic & Cultural Diversity in Social Work*, *18*(1–2), 70–88.

Hall, M. F. (2013). The psychological impact of medical trauma: One woman's childbirth story. *Nursing for Women's Health*, *17*(4), 271–274. https://doi.org/10.1111/1751-486X.12045

Halvorsen, L., Nerum, H., Øian, P., & Sørlie, T. (2013). Giving birth with rape in one's past: a qualitative study. *Birth*, *40*(3), 182–191.

Hankivsky, O. (2012). Women's health, men's health, and gender and health: Implications of intersectionality. *Social Science & Medicine*, *74*(11), 1712–1720.

Harding, S. G. (1991). *Whose science? Whose knowledge?: Thinking from women's lives*. Cornell University Press.

Harper, D. (2001). Online etymology dictionary [Electronic resource]/D.

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of intrapartum 'hotspots.' *Psychology & Health*, *27*(10), 1166–1177.

Harrison, J., MacGibbon, L., & Morton, M. (2001). Regimes of trustworthiness in qualitative research: The rigors of reciprocity. *Qualitative Inquiry*, *7*(3), 323–345.

Hartsock, N. (1990). Foucault on power: A theory for women? In L. Nicholson (Ed.), *Feminism/Postmoderism* (pp. 156–175). New York: Routledge.

Hayes-Klein, H. (2016, May 19). Human rights in childbirth. Retrieved May 27, 2016, from http://www.humanrightsinchildbirth.org/womendeliver2016/

Healy, L. M. (2008). Exploring the history of social work as a human rights profession. *International Social Work*, *51*(6), 735–748. https://doi.org/10.1177/0020872808095247

Herman, A., & Jackson, P. (2010). Empowering low-income parents with skills to reduce excess pediatric emergency room and clinic visits through a tailored low literacy training intervention. *Journal of Health Communication*, *15*(8), 895–910.

Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence: From domestic abuse to political terror (rev. ed.)*. New York: Basic Books.

Heron, B. (2005). Self-reflection in critical social work practice: Subjectivity and the possibilities of resistance. *Reflective Practice*, *6*(3), 341–351. https://doi.org/10.1080/14623940500220095

Hesse-Biber, S. N. (2007). Feminist research: Exploring the interconnections of

    epistemology, methodology, and method. In S. N. Hesse-Biber (Ed.), *Handbook*

    of feminist research: Theory and praxis (pp. 1–26). Thousand Oaks: Sage.

Hesse-Biber, S. N. (2008). Feminist research. In L. M. Given (Ed.), *The Sage*

    encyclopedia of qualitative research methods (pp. 336–339). Thousand Oaks:

    Sage Publications.

Heyes, C. J. (2003). Feminist solidarity after queer theory: The case of transgender. *Signs*,

    28(4), 1093–1120. https://doi.org/10.1086/343132

Hochschild, A. R. (2012). *The managed heart commercialization of human feeling*

    (Updated, with a new preface..). Berkeley: Berkeley : University of California

    Press.

Hole, R. (2004). *Narratives of identity: A poststructural analysis of three deaf women's*

    life stories (Doctoral dissertation).

Holmes, M. (2004). Feeling beyond rules: Politicizing the sociology of emotion and anger

    in feminist politics. *European Journal of Social Theory*, *7*(2), 209–227.

Holstein, J., & Gubrium, J. (2011). The constructionist analytics of interpretive practice.

    In N. K. Denzin & Y. S. Lincoln (Eds.), *The sage handbook of qualitative*

    research (4th ed., pp. 341–357). Los Angeles: Sage.

Horwitz, A. V. (2007). Transforming normality into pathology: the DSM and the

    outcomes of stressful social arrangements. *Journal of Health and Social Behavior*,

    48(3), 211–222.

Houston, S. (2001). Beyond social constructionism: Critical realism and social work.

    British Journal of Social Work, 31(6), 845–861.

Huisman, K. (2008). "Does this mean you're not going to come visit me anymore?": An inquiry into an ethics of reciprocity and positionality in feminist ethnographic research. *Sociological Inquiry*, *78*(3), 372–396.

Huynh, T., Alderson, M., & Thompson, M. (2008). Emotional labour underlying caring: an evolutionary concept analysis. *Journal of Advanced Nursing*, *64*(2), 195–208.

Hydén, M. (2013). Narrating sensitive topics. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research* (2nd edition Kindle edition, p. loc. 5145-5510). Sage.

Ife, J. (2008). *Human rights and social work towards rights-based practice* (Rev. ed..). Cambridge, UK: Cambridge, UK : Cambridge University Press.

International Federation of Social Workers. (2012, March 3). Statement of ethical principles. Retrieved from http://ifsw.org/policies/statement-of-ethical-principles/

International Federation of Social Workers. (2016a). What we do. Retrieved from http://ifsw.org/what-we-do/

International Federation of Social Workers. (2016b). Women. Retrieved from http://ifsw.org/policies/women/

Jaggar, A. M. (1989). Love and knowledge: Emotion in feminist epistemology. *Inquiry*, *32*(2), 151–176.

Johnson, N. (2007). *(Un)learning oppression through the body: Toward and embodied critical pedagogy*. Ontario Institute for Studies in Education of the University of Toronto.

Josselson, R. (2007). The ethical attitude in narrative research: Principles and

    practicalities. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry: Mapping a*

    methodology (pp. 537–567). Thousand Oaks: Sage Publications.

Keogh, E., Ayers, S., & Francis, H. (2002). Does anxiety sensitivity predict post-

    traumatic stress symptoms following childbirth? A preliminary report. *Cognitive*

    Behaviour Therapy, *31*(4), 145–155.

    https://doi.org/10.1080/165060702321138546

Kersting, A., Dorsch, M., Wesselmann, U., Lüdorff, K., Witthaut, J., Ohrmann, P., …

    Arolt, V. (2004). Maternal posttraumatic stress response after the birth of a very

    low-birth-weight infant. *Journal of Psychosomatic Research*, *57*(5), 473–476.

Kim, H. S. (2007). The politics of border crossings: Black, postcolonial, and transnational

    feminist perspectives. In S. N. Hesse-Biber (Ed.), *Handbook of feminist research:*

    Theory and praxis (pp. 107–122). Thousand Oaks: Sage.

Kimpson, S. A. (2005). Stepping off the road: A narrative (of) inquiry. In L. Brown & S.

    Strega (Eds.), *Research as resistance: Critical, indigenous, and anti-oppressive*

    approaches (pp. 73–96). Toronto: Canadian Scholars Press.

Kitzinger, C., & Kitzinger, S. (2007). Birth trauma: Talking with women and the value of

    conversation analysis. *British Journal of Midwifery*, *15*(5), 256–264.

    https://doi.org/10.12968/bjom.2007.15.5.23397

Kitzinger, S. (2006a). Birth as rape: There must be an end to `just in case' obstetrics. *Br J*

    Midwifery, *14*(9), 544–545. https://doi.org/10.12968/bjom.2006.14.9.21799

Kitzinger, S. (2006b). *Birth crisis [Kindle edition]*. New York: Routledge.

Kong, T. S., Mahoney, D., & Plummer, K. (2003). Queering the interview. *Inside Interviewing: New Lenses, New Concerns*, 91–110.

Kristeva, J. (1984). *Revolution in poetic language*. Columbia University Press.

Ladd-Taylor, M. (2014). Mother's right are human rights: Reflections on activism and history. *Journal of the Motherhood Initiative for Research and Community Involvement*, *5*(1), 21–34.

Lafrance, M. N., & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy. *Feminism & Psychology*, *23*(1), 119–140.

Leeds, L., & Hargreaves, I. (2008). The psychological consequences of childbirth. *Journal of Reproductive and Infant Psychology*, *26*(2), 108–122. https://doi.org/10.1080/02646830701688299

LeFrançois, B. A., Menzies, R., & Reaume, G. (2013). *Mad matters: A critical reader in Canadian mad studies*. Canadian Scholars' Press.

Lemola, S., Stadlmayr, W., & Grob, A. (2007). Maternal adjustment five months after birth: The impact of the subjective experience of childbirth and emotional support from the partner. *Journal of Reproductive and Infant Psychology*, *25*(3), 190–202.

Lev-Wiesel, R., Daphna-Tekoah, S., & Hallak, M. (2009). Childhood sexual abuse as a predictor of birth-related posttraumatic stress and postpartum posttraumatic stress. *Child Abuse & Neglect*, *33*(12), 877–887. https://doi.org/10.1080/02646830701467231

Liegghio, M. (2013). A denial of being. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 122–139). Toronto: Canadian Scholars' Press.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* (Vol. 75). Beverly Hills: Sage.

Lincoln, Y. S., Lynhan, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 99–128). Sage.

Lindemann, H. (2012). The woman question in medicine: An update. *The Hastings Center Report*, *42*(3), 38–45.

Lindemann, H. (2014). When stories go wrong. *Hastings Center Report*, *44*, S28-31. https://doi.org/10.1002/hast.266

Lindemann, H. (2015a). How to counter a counterstory (and keep those people in their place). *Narrative Works; Vol 5, No 2 (2015)*. Retrieved from https://journals.lib.unb.ca/index.php/NW/article/view/25017/28974

Lindemann, H. (2015b). Miscarriage and the stories we live by. *Journal of Social Philosophy*, *46*(1), 80–90.

Lloyd-Williams, M., Reeve, J., & Kissane, D. (2008). Distress in palliative care patients: Developing patient-centred approaches to clinical management. *European Journal of Cancer*, *44*(8), 1133–1138.

Long, C. R. (1997). *Grandmothers laughing: Intergenerational transmission of cultural beliefs about pregnancy and childbirth among Native American women*.

Longino, H. (2007). Reason, truth, and experience: Tyrannies or liberation? In S. N. Hesse-Biber (Ed.), *Handbook of feminist research: Theory and praxis* (pp. 547–552). Thousand Oaks: Sage.

Lundgren, L. (2011). The meaning of giving birth from long-term perspective for childbearing women. In G. Thomson & S. Downe (Eds.), *Qualitative research in*

midwifery and childbirth: Phenomenological approaches (pp. 115–132). Oxon: Routledge.

Lyons, S. (1998). A prospective study of post traumatic stress symptoms 1 month following childbirth in a group of 42 first-time mothers. *Journal of Reproductive and Infant Psychology*, *16*(2–3), 91–105. https://doi.org/10.1080/02646839808404562

Maclean, L., McDermott, M., & May, C. (2000). Method of delivery and subjective distress: Women's emotional responses to childbirth practices. *Journal of Reproductive and Infant Psychology*, *18*(2), 153–162. https://doi.org/10.1080/02646830050008396

Masson, J., & Dickens, J. (2015). Protecting Unborn and Newborn Babies. *Child Abuse Review*, *24*(2), 107–119.

Mayo Clinic. (2016a). Clomiphene. Retrieved from http://www.mayoclinic.org/drugs-supplements/clomiphene-oral-route/description/drg-20063072

Mayo Clinic. (2016b). Hypoxemia. Retrieved from http://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930

McCabe, K. (2016). Mothercraft: Birth work and the making of neoliberal mothers. *Social Science & Medicine*, *162*, 177–184. https://doi.org/10.1016/j.socscimed.2016.06.021

McCall, L. (2014). The complexity of intersectionality. *Signs*, *30*(3), 1771–1800.

McCance, T., McKenna, H., & Boore, J. (2001). Exploring caring using narrative methodology: An analysis of the approach. *Journal of Advanced Nursing*, *33*(3), 350–356. https://doi.org/10.1046/j.1365-2648.2001.01671.x

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, *25*(2), 82–89.

McKenzie-McHarg, K. (2004). Traumatic birth: Understanding predictors, triggers, and counseling process is essential to treatment. *Birth*, *31*(3), 219–221. https://doi.org/10.1111/j.0730-7659.2004.00308.x

McKenzie-McHarg, K., Crockett, M., Olander, E., & Ayers, S. (2014). Think pink! A pink sticker alert system for women with psychological distress or vulnerability during pregnancy. *British Journal of Midwifery*, *22*(8), 590–595.

McKenzie-Mohr, S. (2008). *Out from and beyond trauma: Women's experiences of the process from rape to living well (NR55394)*. Retrieved from http://search.proquest.com/docview/304403047?accountid=12378

McKenzie-Mohr, S., & Lafrance, M. N. (2014). Women's discursive resistance: Attuning to counter-stories and collectivizing for change. In S. McKenzie-Mohr & M. N. Lafrance (Eds.), *Women voicing resistance: Discursive and narrative explorations* (pp. 1991–205). East Sussex: Routledge.

McLaren, M. A. (2002). *Feminism, Foucault, and embodied subjectivity*. Albany: State University of New York Press.

Medscape. (2016). Ectopic Pregnancy Treatment & Management. Retrieved from http://emedicine.medscape.com/article/2041923-treatment

Mehrotra, G. (2014). Considering emotion and emotional labor in feminist social work research. In S. Wahab, B. Anderson-Nathe, & C. Gringeri (Eds.), *Feminisms in*

social work research: Promise and possibilities for justice-based knowledge (pp. 259–275). New York: Routledge.

Merriam-Webster. (2017). Medical Dictionary. Retrieved from https://www.merriam-webster.com/medical/peripartum

Michener, A. J. (1998). *Becoming Anna*. University of Chicago Press.

Miedema, B., Stoppard, J. M., & Anderson, V. (2000). Introduction. In B. Miedema, J. M. Stoppard, & V. Anderson (Eds.), *Women's bodies/women's lives: Health, well-being and body image* (pp. 13–25). Toronto: Canadian Scholars' Press.

Mishler, E. G. (1995). Models of narrative analysis: A typology. *Journal of Narrative & Life History*, *5*(2), 87–123.

Mohanty, C. T. (1988). Under Western eyes: Feminist scholarship and colonial discourses. *Feminist Review*, (30), 61–88.

Moreton-Robinson, A. (2000). *Talkin' up to the white woman: Aboriginal women and feminism*. St. Lucia: Univ. of Queensland Press.

Morris, T. (2005). *Social work research methods: Four alternative paradigms*. Thousand Oaks: Sage.

Morse, M. (2012). A war on whom? The importance of inclusive reproductive justice conversations. National Women's Health Network. Retrieved from https://nwhn.org/2012/06/27/war-whom-importance-inclusive-reproductive-justice-conversations

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery*, *2*, 8–14.

Murdach, A. D. (2011). Is social work a human rights profession? *Social Work*, *56*(3), 281–283. https://doi.org/10.1093/sw/56.3.281

Murphy, Y., Hunt, V., Zajicek, A. M., Norris, A. N., & Hamilton, L. (2009). *Incorporating intersectionality in social work practice, research, policy, and education*. Washington, D.C.: National Association of Social Workers.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51–59.

Nagoshi, J. L., & Brzuzy, S. (2010). Transgender theory: Embodying research and practice. *Affilia*, *25*(4), 431–443. https://doi.org/10.1177/0886109910384068

Native Women's Association of Canada. (2013). Understanding from within: Research findings and NWAC's contributions to Canada's national population health study on neurological conditions. Retrieved from http://www.nwac.ca/files/download/UFW%20Research%20Report%20FINAL%20June2013%20_wACmemberslist.pdf

Nilsson, C., Bondas, T., & Lundgren, I. (2010). Previous birth experience in women with intense fear of childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *39*(3), 298–309. https://doi.org/10.1111/j.1552-6909.2010.01139.x

Niner, S., Kokanovic, R., & Cuthbert, D. (2013). Displaced mothers: Birth and resettlement, gratitude and complaint. *Medical Anthropology*, *32*(6), 535–551. https://doi.org/10.1080/01459740.2013.769103

Nipperess, S. (2013). Human rights: a challenge to critical social work practice and education.

Noseworthy, D. A., Phibbs, S. R., & Benn, C. A. (2013). Towards a relational model of

decision-making in midwifery care. *Midwifery*, *29*(7), e42–e48.

Nussbaum, M. C. (2003). *Upheavals of thought: The intelligence of emotions* (Kindle).

Cambridge University Press.

O'Donovan, A., Alcorn, K. L., Patrick, J. C., Creedy, D. K., Dawe, S., & Devilly, G. J.

(2014). Predicting posttraumatic stress disorder after childbirth. *Midwifery*, *30*(8),

935–941. https://doi.org/10.1016/j.midw.2014.03.011

Olde, E., van der Hart, O., Kleber, R. J., van Son, M. J., Wijnen, H. A., & Pop, V. J.

(2005). Peritraumatic dissociation and emotions as predictors of PTSD symptoms

following childbirth. *Journal of Trauma & Dissociation*, *6*(3), 125–142.

https://doi.org/10.1300/J229v06n03_06

O'Reilly, A. (2004a). Introduction. In A. O'Reilly (Ed.), *Mother matters: Motherhood as*

discourse and practice: Essays from the Journal of the Association for Research

on Mothering (pp. 11–26). Association for Research on Mothering.

O'Reilly, A. (2004b). Labour signs. In A. O'Reilly (Ed.), *Mother matters: Motherhood as*

discourse and practice: Essays from the Journal of the Association for Research

on Mothering (pp. 29–36). Association for Research on Mothering.

Oxford English Dictionary. (2000). Oxford English dictionary online. *Memorial*

University. Retrieved from http://www.oed.com.qe2a-proxy.mun.ca

Padgett, D. K. (2008). *Qualitative methods in social work research* (2nd ed.). New York:

Sage.

Palladino, H. (2015). Motherhood's opening chapter: Birth stories as performance and

    counter performance across dueling media platforms. *Journal of the Motherhood*

    Initiative for Research and Community Involvement, *6*(1).

Palley, E. (2016). Pregnancy Discrimination and the Law: Implications for Social Work.

    Affilia. https://doi.org/10.1177/0886109916654733

Pamphilon, B. (1999). The zoom model: A dynamic framework for the analysis of life

    histories. *Qualitative Inquiry*, *5*(3), 393–410.

    https://doi.org/10.1177/107780049900500306

Parker, I. (2014). Madness and justice. *Journal of Theoretical and Philosophical*

    Psychology, *34*(1), 28.

Parpart, J. L. (2010). Choosing silence: Rethinking voice, agency and women's. In

    Secrecy and silence in the research process: Feminist reflections (pp. 15–29).

    Routledge.

Parton, N., & O'Byrne, P. (2000). *Constructive social work: Towards a new practice*.

    New York: St. Martin's Press.

Patterson, W. (2013). Narrative of events: Labovian narrative analysis and its limitations.

    In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research*

    (2nd edition Kindle edition, p. loc. 788-1246). Sage.

Pinnegar, S., & Daynes, J. (2007). Locating narrative inquiry historically: Thematics in

    the turn to narrative. In D. J. Clandinin (Ed.), *Handbook of narrative inquiry:*

    Mapping a methodology (pp. 3–35). Thousand Oaks: Sage Publications.

Plant, R. J. (2014). "The perfect painless labor": The natural childbirth movement in the mid-twentieth-century US. *Journal of the Motherhood Initiative for Research and Community Involvement*, *5*(1).

Polachek, I. S., Harari, L. H., Baum, M., & Strous, R. D. (2012). Postpartum post-traumatic stress disorder symptoms: The uninvited birth companion. *The Israel Medical Association Journal*, *14*(6), 347–353.

Polese, M. (2015, June 24). Regional Economics. Retrieved from http://www.thecanadianencyclopedia.ca/en/article/regional-economics/

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, *52*(2), 137–145. https://doi.org/10.1037/0022-0167.52.2.137

Polkinghorne, D. E. (2007). Validity Issues in Narrative Research. *Qualitative Inquiry*, *13*(4), 471–486. https://doi.org/10.1177/1077800406297670

Pollock, D. (1999). *Telling bodies performing birth: Everyday narratives of childbirth*. Columbia University Press.

Poole, J. M., & Ward, J. (2013). "Breaking open the bone": Storytelling, sanism, and mad grief. In B. A. LeFrançois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 94–104). Toronto: Canadian Scholars' Press.

Preeclampsia Foundation. (2016). HELLP Syndrome. Retrieved from http://www.preeclampsia.org/health-information/hellp-syndrome

Price, K. (2010). What is reproductive justice?: How women of color activists are

    redefining the pro-choice paradigm. *Meridians: Feminism, Race,*

    Transnationalism, 10(2), 42–65.

Priddis, H., Dahlen, H., & Schmied, V. (2013). Women's experiences following severe

    perineal trauma: a meta-ethnographic synthesis. *Journal of Advanced Nursing,*

    69(4), 748–759. https://doi.org/10.1111/jan.12005

Public Health Agency of Canada. (2011). The Sensible Guide to a Healthy Pregnancy.

    Retrieved from http://www.phac-aspc.gc.ca/hp-gs/pdf/hpguide-eng.pdf

Reynolds, J. L. (1997). Post-traumatic stress disorder after childbirth: the phenomenon of

    traumatic birth. *Canadian Medical Association Journal, 156*(6), 831–835.

Rich, A. (1995). *Of woman born: Motherhood as experience and institution.* New York:

    WW Norton & Company.

Riessman, C. (2002). Narrative analysis. In M. Huberman (Ed.), *The qualitative*

    researcher's companion (pp. 471–486). London: Sage.

Riessman, C. (2008). *Narrative methods for the human sciences.* Los Angeles: Sage.

Riessman, C. (2012). Analysis of personal narratives. In J. F. Gubrium, A. B. Marvasti, &

    K. D. McKinney (Eds.), *The Sage handbook of interview research: The*

    complexity of the craft (pp. 367–380). Thousand Oaks: Sage.

Riessman, C. (2013). Analysis of personal narratives. In A. E. Fortune, W. J. Reid, & R.

    Miller (Eds.), *Research in social work* (2nd ed., pp. 168–191). New York:

    Columbia University Press.

Riessman, C., & Quinney, L. (2005). Narrative in social work: A critical review. *Qualitative Social Work*, *4*(4), 391–412. https://doi.org/10.1177/1473325005058643

Robb, K. (2011). A qualitative study exploring women's' experiences of unplanned Cesarean surgery and their suggestions for improving care. *Canadian Journal Midwifery*, *10*(3), 17–28.

Ross, L., & Solinger, R. (2017). *Reproductive Justice: An Introduction* (Vol. 1). Univ of California Press.

Rubin, A., & Babbie, E. (2011). *Research methods for social work* (7th edition). Belmont, CA: Brooks/Cole.

Ryding, E., Wijma, K., & Wijma, B. (2000). Emergency Cesarean section: 25 women's experiences. *Journal of Reproductive and Infant Psychology*, *18*(1), 33–39. https://doi.org/10.1080/02646830050001663

Sago, S. (2016). Retrieved from http://www.babycenter.ca/what-is-a-membrane-sweep

Salem, S. (2013). Feminist critique and Islamic feminism: The question of intersectionality. *The Postcolonialist*, *1*(1).

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, *18*(2), 179–183. https://doi.org/10.1002/nur.4770180211

Sawyer, A., Ayers, S., Smith, H., Sidibeh, L., Nyan, O., & Dale, J. (2011). Women's experiences of pregnancy, childbirth, and the postnatal period in the Gambia: A qualitative study. *British Journal of Health Psychology*, *16*(3), 528–541. https://doi.org/10.1348/135910710X528710

Schiller, R. (2015). *All that matters: Women's rights in childbirth* (Kindle). Guardian

      Books.

Schiller, R. (2016a). Dignity in childbirth is a human right. *Journal Of Family Health*,

      26(2), 14–16.

Schiller, R. (2016b). *Why human rights in childbirth matter* (Kindle). Pinter & Martin.

Schneider, D. A. (2009). *Beyond the baby: Women's narratives of childbirth, change and*

      power (Order No. 3416170). Retrieved from

      http://search.proquest.com/docview/734794337?accountid=12378

Schneider, D. A. (2012). The miracle bearers: Narratives of birthing women and

      implications for spiritually informed social work practice. *Journal of Social*

      Service Research, *38*(2), 212–230.

Scott, J. W. (1991). The evidence of experience. *Critical Inquiry*, *17*(4), 773–797.

Sexual Assault Centre Hamilton Area. (n.d.). Statistics. Retrieved from

      http://sacha.ca/resources/statistics

Shuman, A. (2005). *Other people's stories*. Urbana and Chicago: University of Illinois

      Press.

Simkin, P. (1991). Just another day in a woman's life? Women's long-term perceptions of

      their first birth experience. Part I. *Birth*, *18*(4), 203–210.

Simkin, P. (1992). Just another day in a woman's life? Part II: Nature and consistency of

      women's long-term memories of their first birth experiences. *Birth*, *19*(2), 64–81.

Skari, H., Skreden, M., Malt, U. F., Dalholt, M., Ostensen, A. B., Egeland, T., &

      Emblem, R. (2002). Comparative levels of psychological distress, stress

symptoms, depression and anxiety after childbirth—a prospective population-based study of mothers and fathers. *BJOG: An International Journal of Obstetrics & Gynaecology*, *109*(10), 1154–1163. https://doi.org/10.1111/j.1471-0528.2002.00468.x

Smith, A. (2005). Beyond pro-choice versus pro-life: Women of color and reproductive justice. *NWSA Journal*, *17*(1), 119–140.

Smith, C. P. (2000). Content analysis and narrative analysis. *Handbook of Research Methods in Social and Personality Psychology*, 313–335.

Smith, D. E. (1975). Women and psychiatry. In D. E. Smith & S. J. David (Eds.), *Women look at psychiatry* (pp. 1–20). Vancouver: Press Gang Publishers.

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Boston: North Eastern University Press.

Smith, D. E. (1990). *Text, Facts, Femininity: Exploring the Relations of Ruling*. London and New York: Routledge.

Smith, J., & Morrow, M. (2012). Mothers, madness and the labour of feminist practice: Responding to women in the perinatal period. In G. Wong (Ed.), *Moms gone mad: Motherhood and madness oppression and resistance* (pp. 21–34). Ontario: Demeter Press.

Söderquist, J., Wijma, B., & Wijma, K. (2006). The longitudinal course of post-traumatic stress after childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 113–119. https://doi.org/10.1080/01674820600712172

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth*, *30*(1), 36–46. https://doi.org/10.1046/j.1523-536X.2003.00215.x

Solas, J. (2008). What kind of social justice does social work seek? *International Social Work*, *51*(6), 813–822. https://doi.org/10.1177/0020872808095252

Somera, M. J., Feeley, N., & Ciofani, L. (2010). Women's experience of an emergency caesarean birth. *Journal of Clinical Nursing*, *19*(19-20), 2824–2831. https://doi.org/10.1111/j.1365-2702.2010.03230.x

Spring, K. (2014). *Status Quo?: The Unfinished Business of Feminism in Canada*. National Film Board of Canada. Retrieved from https://www.nfb.ca/film/status_quo_the_unfinished_business_of_feminism/

Squire, C. (2013). From experience-centred to socioculturally-oriented approaches to narrative. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research* (2nd edition Kindle edition, p. loc. 1279-1823). Sage.

Squire, C., Andrews, M., & Tamboukou, M. (2013). What is narrative research? In M. Andrews, C. Squire, & M. Tamboukou (Eds.), *Doing narrative research* (2nd edition Kindle edition, p. loc. 147-764). Sage.

Stapleton, K., & Wilson, J. (2004). Gender, nationality and identity: A discursive study. *European Journal of Women's Studies*, *11*(1), 45–60. https://doi.org/10.1177/1350506804036962

Statistics Canada. (2009a, July 28). Population by selected ethnic origins, by province and

      territory (2006 Census) (New Brunswick). Retrieved from

      http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo26d-eng.htm

Statistics Canada. (2009b, July 28). Population by selected ethnic origins, by province

      and territory (2006 Census) (Nova Scotia). Retrieved from

      http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo26d-eng.htm

Statistics Canada. (2013, February 12). Trends in sexual offences. Retrieved from

      http://www.statcan.gc.ca/pub/85f0033m/2008019/findings-resultats/trends-

      tendances-eng.htm

Statistics Canada. (2015, November 27). Lone-parent families. Retrieved from

      http://www.statcan.gc.ca/pub/75-006-x/2015001/article/14202/parent-eng.htm

Stone-Mediatore, S. (2003). The power of stories. In S. Stone-Mediatore (Ed.), *Reading*

      across borders: Storytelling and knowledges of resistance (pp. 1–16). New York:

      Palgrave Macmillan.

Struthers, R., & Peden-McAlpine, C. (2005). Phenomenological research among

      Canadian and United States indigenous populations: Oral tradition and

      quintessence of time. *Qualitative Health Research*, *15*(9), 1264–1276.

Szasz, T. (1961). *Myth of mental illness* (Vol. 15). New York.

Taghizadeh, Z., Arbabi, M., Kazemnejad, A., Irajpour, A., & Lopez, V. (2014). Iranian

      mothers' perceptions of the impact of the environment on psychological birth

      trauma: A qualitative study. *International Journal of Nursing Practice*.

      https://doi.org/10.1111/ijn.12286

Taubman-Ben-Ari, O., Findler, L., Bendet, C., Stanger, V., Ben-Shlomo, S., & Kuint, J. (2008). Mothers' marital adaptation following the birth of twins or singletons: Empirical evidence and practical insights. *Health & Social Work*, *33*(3), 189–197.

Tester, F. J., & McNicoll, P. (2006). 'Why don't they get It?' Talk of medicine as science. St Luke's Hospital, Panniqtuuq, Baffin Island. *Social History of Medicine*, *19*(1), 87–106.

Tew, J. (2005). Core themes of social perspective. In *Social perspectives in mental health : Developing social models to understand and work with mental distress* (pp. 13–31). London: London.

Tew, J. (2008). Social perspectives on mental distress. In *Learning about mental health practice* (pp. 235–52). Chichester: Wiley.

The Canadian Medical Protective Association. (n.d.). Informed consent: More than a signature. Retrieved from https://www.cmpa-acpm.ca/serve/docs/ela/goodpracticesguide/pages/communication/Informed_Consent/three_key_elements-e.html

Thomas-MacLean, R., & Miedema, B. B. (2012). Feminist understandings of embodiment and disability: A "material-discursive" approach to beast cancer related lymphedema. *Atlantis: Critical Studies in Gender, Culture & Social Justice*, *30*(1), 92–103.

Thomson, G. (2011). "Abandonment of being" in childbirth. In G. Thomson & S. Downe (Eds.), *Qualitative research in midwifery and childbirth: Phenomenological approaches* (pp. 133–152). Oxon: Routledge.

312

Thomson, G., & Downe, S. (2008). Widening the trauma discourse: The link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(4), 268–273. https://doi.org/10.1080/01674820802545453

Truell, R. (2016, December 9). Towards a Social Work Rights Framework. Retrieved from http://ifsw.org/news/towards-a-social-work-rights-framework/

Tseris, E. J. (2013). Trauma theory without feminism? Evaluating contemporary understandings of traumatized women. *Affilia*, *28*(2), 153–164. https://doi.org/10.1177/0886109913485707

Tufford, L., & Newman, P. (2012). Bracketing in qualitative research. *Qualitative Social Work*, *11*(1), 80–96.

Turton, P., Hughes, P., Evans, C., & Fainman, D. (2001). Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *The British Journal of Psychiatry*, *178*(6), 556–560. https://doi.org/10.1192/bjp.178.6.556

Twine, F. W., & Gallagher, C. (2008). The future of whiteness: A map of the 'third wave.' *Ethnic and Racial Studies*, *31*(1), 4–24. https://doi.org/10.1080/01419870701538836

Ukpong, D., & Owolabi, A. (2006). Postpartum emotional distress: a controlled study of Nigerian women after caesarean childbirth. *Journal of Obstetrics & Gynecology*, *26*(2), 127–129. https://doi.org/10.1080/01443610500443386

U.S. Department of Commerce. (2015, November 6). Families and living arrangements. Retrieved from http://www.census.gov/hhes/families/data/cps2015FG.html

Ussher, J. (1992). *Women's madness: Misogyny or mental illness?* Boston: University of Massachusetts Press.

Ussher, J. (1997a). 'Body talk': What does this mean? In *Body talk: The material and discursive regulation of sexuality, madness, and reproduction [Kindle Edition]* (pp. 1–8). New York: Routledge.

Ussher, J. (1997b). *Fantasies of femininity*. London: Penguin.

Ussher, J. (2006). *Managing the monstrous feminine: Regulating the reproductive body*. New York: Routledge.

Ussher, J. (2010). Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism & Psychology*, *20*(1), 9–35.

Ussher, J. (2011). *The madness of women: Myth and experience*. London: Routledge.

Ussher, J. (2012a). Unravelling women's madness: Beyond positivism and constructionism and towards a material-discursive-intrapsychic approach. In W. Chan, D. E. Chunn, & R. Menzies (Eds.), *Women, Madness and the Law: A feminist reader* (Kindle Edition). Routledge.

Ussher, J. (2012b). Unravelling women's madness: Beyond positivism and constructivism and towards a material-discursive-intrapsychic approach. In W. Chan, D. E. Chunn, & R. Menzies (Eds.), *Women, madness and the law: A feminist reader* (Kindle Edition, pp. 19–40). Routledge.

Van Bussel, J., Spitz, B., & Demyttenaere, K. (2010). Childbirth expectations and experiences and associations with mothers' attitudes to pregnancy, the child and motherhood. *Journal of Reproductive and Infant Psychology*, *28*(2), 143–160. https://doi.org/10.1080/02646830903295026

Van Pampus, M., Wolf, H., Schultz, W. W., Neeleman, J., & Aarnoudse, J. (2004).
Posttraumatic stress disorder following preeclampsia and HELLP syndrome.
Journal of Psychosomatic Obstetrics & Gynecology, *25*(3–4), 183–187.
https://doi.org/10.1080/01674820400017863

van Son, M., Verkerk, G., van der Hart, O., Komproe, I., & Pop, V. (2005). Prenatal
depression, mode of delivery and perinatal dissociation as predictors of
postpartum posttraumatic stress: An empirical study. *Clinical Psychology &
Psychotherapy*, *12*(4), 297–312. https://doi.org/10.1002/cpp.446

Verreault, N., Da Costa, D., Marchand, A., Ireland, K., Banack, H., Dritsa, M., & Khalifé,
S. (2012). PTSD following childbirth: A prospective study of incidence and risk
factors in Canadian women. *Journal of Psychosomatic Research*, *73*(4), 257–263.
https://doi.org/10.1016/j.jpsychores.2012.07.010

Walks, M. (2014). Stratified reproduction: Making the case for butch lesbians',
transmen's, and genderqueer individuals' experiences in British Columbia. In F.
Scala, S. Paterson, & M. K. Sokolon (Eds.), *Fertile ground: Exploring
reproduction in Canada* (pp. 74–93). Montreal: McGill-Queen's Press-MQUP.

Walther, V. N. (1997). Postpartum depression: A review for perinatal social workers.
Social Work in Health Care, *24*(3–4), 99–111.

Warhol, R. (2012). A feminist approach to narrative. In D. Herman, J. Phelan, P. J.
Rabinowitz, B. Richardson, & R. Warhol (Eds.), *Narrative theory: Core concepts
and critical debates*. Columbus: The Ohio State University Press.

Weedon, C. (1997). *Feminist practice and poststructuralist theory*. Oxford, England:
Basil Blackwell.

Wertheimer, E. H., & Casper, M. J. (2016). Within trauma: An introduction. In M. J. Casper & E. H. Wertheimer (Eds.), *Critical trauma studies: Understanding violence, conflict and memory in everyday life* (Kindle Edition, p. loc. 108-377). NYU Press.

White, M. (1990). *Narrative means to therapeutic ends*. New York: New York : Norton.

White Ribbon Alliance. (2011, October). Respectful maternity care: The universal rights of childbearing women. Retrieved from http://whiteribbonalliance.org/wp-content/uploads/2013/10/Final_RMC_Charter.pdf

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology*, *24*(02), 107–120. https://doi.org/10.1016/j.jpsychores.2012.07.010

Widdowfield, R. (2000). The place of emotions in academic research. *Area*, *32*(2), 199–208. https://doi.org/10.1111/j.1475-4762.2000.tb00130.x

Wijma, K., Söderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: A cross sectional study. *Journal of Anxiety Disorders*, *11*(6), 587–597. https://doi.org/10.1016/S0887-6185(97)00041-8

Williams, J. (2005). Women's mental health: Taking inequality into account. In *Social perspectives in mental health : Developing social models to understand and work with mental distress* (pp. 151–167). London: London.

Zaers, S., Waschke, M., & Ehlert, U. (2008). Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. *Journal of Psychosomatic*

316

Obstetrics & Gynecology, *29*(1), 61–71.

https://doi.org/10.1080/01674820701804324

APPENDIX A : LITERATURE REGARDING TRAUMA AND DISTRESS IN CHILDBIRTH

Adewuya, A. O., Ologun, Y. A., & Ibigbami, O. S. (2006). Post-traumatic stress disorder
after childbirth in Nigerian women: Prevalence and risk factors. *BJOG: An
International Journal of Obstetrics & Gynaecology*, *111*(3), 284–288.
https://doi.org/10.1111/j.1471-0528.2006.00861.x

Alcorn, K. L., O'Donovan, A., Patrick, J. C., Creedy, D., & Devily, G. J. (2010). A
prospective longitudinal study of the prevalence of post-traumatic stress disorder
resulting from childbirth events. *Psychological Medicine*, *40*(11), 1849–1859.
https://doi.org/10.1017/S0033291709992224

Allen, S. (1998). A qualitative analysis of the process, mediating variables and impact of
traumatic childbirth. *Journal of Reproductive and Infant Psychology*, *16*(2–3),
107–131. https://doi.org/10.1080/02646839808404563

Amoros, Z., Callister, L., & Sarkisyan, K. (2010). Giving birth: The voices of Armenian
women. *International Nursing Review*, *57*(1), 135–141.
https://doi.org/10.1111/j.1466-7657.2009.00775.x

Andersen, L. B., Melvaer, L. B., Videbech, P., Lamont, R. F., & Joergensen, J. S. (2012).
Risk factors for developing post-traumatic stress disorder following childbirth: A
systematic review. *Acta Obstetricia et Gynecologica Scandinavica*, *91*(11), 1261–
1272. https://doi.org/10.1111/j.1600-0412.2012.01476.x

Anderson, C. A. (2011). Construct validity of the childbirth trauma index for adolescents.
Journal of Perinatal Education, *20*(2), 78–90. https://doi.org/10.1891/1058-
1243.20.2.78

Anderson, C. A., & Gill, M. (2014). Childbirth related fears and psychological birth
trauma in younger and older age adolescents. *Applied Nursing Research*, *27*(4),
242–248. https://doi.org/10.1016/j.apnr.2014.02.008

Anton, R., & David, D. (2013). Response expectancy versus response hope in predicting
birth-related emotional distress and pain. *International Journal of Psychology*,
48(5), 954–963.

Averitt Taylor, J. (2014). Reproductive health policy affecting low-income women:
Historical precedents and current need for social work action. *Social Work in
Public Health*, *29*(2), 132–140. https://doi.org/10.1080/19371918.2013.775872

Ayers, S., Harris, R., Sawyer, A., Parfitt, Y., & Ford, E. (2009). Posttraumatic stress
disorder after childbirth: Analysis of symptom presentation and sampling. *Journal
of Affective Disorders*, *119*(1–3), 200–204.
https://doi.org/10.1016/j.jad.2009.02.029

Ayers, S., & Pickering, A. D. (2001). Do women get posttraumatic stress disorder as a
result of childbirth? A prospective study of incidence. *Birth*, *28*(2), 111–118.
https://doi.org/10.1046/j.1523-536X.2001.00111.x

Bachman, D. H., & Lind, R. F. (1997). Perinatal social work and the high risk obstetrics
patient. *Social Work in Health Care*, *24*(3–4), 3–19.
https://doi.org/10.1300/J010v24n03_02

Baker, S. R., Choi, P. Y. L., Henshaw, C. A., & Tree, J. (2005). "I Felt as though I"d been in jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum. *Feminism & Psychology*, *15*(3), 315–342. https://doi.org/10.1177/0959-353505054718

Baron, R. S., Cusumano, M. A., Evans, D. C., Hodne, C. J., & Logan, H. (2004). The effect of desired control and anticipated control on the stress of childbirth. *Basic & Applied Social Psychology*, *26*(4), 249–261. https://doi.org/10.1207/s15324834basp2604_2

Beck, C. T. (2004a). Birth trauma: In the eye of the beholder. *Nursing Research*, *53*(1), 28–35.

Beck, C. T. (2004b). Post-traumatic stress disorder due to childbirth: The aftermath. *Nursing Research*, *53*(4), 216–224.

Beck, C. T. (2011). A metaethnography of traumatic childbirth and its aftermath: Amplifying causal looping. *Qualitative Health Research*, *21*(3), 301–311. https://doi.org/10.1177/1049732310390698

Beck, C. T., & Driscoll, J. (2006). *Postpartum mood and anxiety disorders: A clinician's guide*. Jones & Bartlett Learning.

Beck, C. T., Driscoll, J. W., & Watson, S. (2013). *Traumatic childbirth*. Routledge.

Beck, C. T., Gable, R. K., Sakala, C., & Declercq, E. R. (2011). Posttraumatic stress disorder in new mothers: Results from a two-stage US National Survey. *Birth*, *38*(3), 216–227.

Berentson-Shaw, J., Scott, K. M., & Jose, P. E. (2009). Do self-efficacy beliefs predict the primiparous labour and birth experience? A longitudinal study. *Journal of Reproductive and Infant Psychology*, *27*(4), 357–373.

Bernier, A., Jarry-Boileau, V., Tarabulsy, G. M., & Miljkovitch, R. (2010). Initiating a caregiving relationship: Pregnancy and childbirth factors as predictors of maternal sensitivity. *Infancy*, *15*(2), 197–208.

Boorman, R. J., Devilly, G. J., Gamble, J., Creedy, D. K., & Fenwick, J. (2014). Childbirth and criteria for traumatic events. *Midwifery*, *30*(2), 255–261. https://doi.org/10.1016/j.midw.2013.03.001

Briddon, E., Slade, P., Isaac, C., & Wrench, I. (2011). How do memory processes relate to the development of posttraumatic stress symptoms following childbirth? *Journal of Anxiety Disorders*, *25*(8), 1001–1007. https://doi.org/10.1016/j.janxdis.2011.06.008

Cacciatore, J. (2009). The silent birth: A feminist perspective. *Social Work*, *54*(1), 91–95.

Callahan, J. L., & Hynan, M. T. (2002). Identifying mothers at risk for postnatal emotional distress: Further evidence for the validity of the perinatal posttraumatic stress disorder questionnaire. *Journal of Perinatology*, *22*, 448–454. https://doi.org/10.1038/sj.jp.7210783

Chadwick, R. J. (2014). Bodies talk: On the challenges of hearing childbirth counter-stories. In S. McKenzie-Mohr & M. N. Lafrance (Eds.), *Women voicing resistance: Discursive and narrative explorations* (pp. 44–53). East Sussex: Routledge.

Cohen, M. M., Ansara, D., Schei, B., Stuckless, N., & Stewart, D. E. (2004).
Posttraumatic stress disorder after pregnancy, labor, and delivery. *Journal of Women's Health*, *13*(3), 315–324. https://doi.org/10.1089/154099904323016473

Creedy, D. K., Shochet, I. M., & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth*, *27*(2), 104–111.

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, *39*(1), 35–51.

Dale-Hewitt, V., Slade, P., Wright, I., Cree, M., & Tully, C. (2012). Patterns of attention and experiences of post-traumatic stress symptoms following childbirth: an experimental study. *Archives of Women's Mental Health*, *15*(4), 289–296.

Davies, J., Slade, P., Wright, I., & Stewart, P. (2008). Posttraumatic stress symptoms following childbirth and mothers' perceptions of their infants. *Infant Mental Health Journal*, *29*(6), 537–554.

DeMier, R. L., Hynan, M. T., Hatfield, R. F., Varner, M. W., Harris, H. B., & Manniello, R. L. (2000). A measurement model of perinatal stressors: Identifying risk for postnatal emotional distress in mothers of high-risk infants. *Journal of Clinical Psychology*, *56*(1), 89–100. https://doi.org/10.1002/(SICI)1097-4679(200001)56:1<89::AID-JCLP8>3.0.CO;2-6

Devilly, G. J., Gullo, M. J., Alcorn, K. L., & O'Donovan, A. (2014). Subjective appraisal of threat (criterion A2) as a predictor of distress in childbearing women. *The Journal of Nervous and Mental Disease*, *202*(12), 877–882.

Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and

    experiences of a traumatic birth: a meta-ethnography. *Journal of Advanced*

    Nursing, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x

Fairbrother, N., & Woody, S. R. (2007). Fear of childbirth and obstetrical events as

    predictors of postnatal symptoms of depression and post-traumatic stress disorder.

    Journal of Psychosomatic Obstetrics & Gynecology, *28*(4), 239–242.

    https://doi.org/10.1080/01674820701495065

Fenwick, J., Gamble, J., & Mawson, J. (2003). Women's experiences of Caesarean

    section and vaginal birth after Caesarian: A Birthrites initiative. *International*

    Journal of Nursing Practice, *9*(1), 10–17.

    https://doi.org/10.1080/01674820701495065

Ford, E., Ayers, S., & Bradley, R. (2010). Exploration of a cognitive model to predict

    post-traumatic stress symptoms following childbirth. *Journal of Anxiety*

    Disorders, *24*(3), 353–359. https://doi.org/10.1016/j.janxdis.2010.01.008

Forssén, A. S. (2012). Lifelong significance of disempowering experiences in prenatal

    and maternity care Interviews with elderly Swedish women. *Qualitative Health*

    Research, *22*(11), 1535–1546. https://doi.org/10.1177/1049732312449212

Fottrell, E., Kanhonou, L., Goufodji, S., Béhague, D. P., Marshall, T., Patel, V., & Filippi,

    V. (2010). Risk of psychological distress following severe obstetric complications

    in Benin: The role of economics, physical health and spousal abuse. *The British*

    Journal of Psychiatry, *196*(1), 18–25. https://doi.org/10.1192/bjp.bp.108.062489

Garthus-Niegel, S., von Soest, T., Knoph, C., Simonsen, T. B., Torgersen, L., &

    Eberhard-Gran, M. (2014). The influence of women's preferences and actual

mode of delivery on post-traumatic stress symptoms following childbirth: A
population-based, longitudinal study. *BMC Pregnancy and Childbirth*, *14*(1), 191.

Hall, M. F. (2013). The psychological impact of medical trauma: One woman's childbirth
story. *Nursing for Women's Health*, *17*(4), 271–274. https://doi.org/10.1111/1751-
486X.12045

Halvorsen, L., Nerum, H., Øian, P., & Sørlie, T. (2013). Giving birth with rape in one's
past: a qualitative study. *Birth*, *40*(3), 182–191.

Harris, R., & Ayers, S. (2012). What makes labour and birth traumatic? A survey of
intrapartum "hotspots." *Psychology & Health*, *27*(10), 1166–1177.

Keogh, E., Ayers, S., & Francis, H. (2002). Does anxiety sensitivity predict post-
traumatic stress symptoms following childbirth? A preliminary report. *Cognitive
Behaviour Therapy*, *31*(4), 145–155.
https://doi.org/10.1080/165060702321138546

Kersting, A., Dorsch, M., Wesselmann, U., Lüdorff, K., Witthaut, J., Ohrmann, P., …
Arolt, V. (2004). Maternal posttraumatic stress response after the birth of a very
low-birth-weight infant. *Journal of Psychosomatic Research*, *57*(5), 473–476.

Kitzinger, C., & Kitzinger, S. (2007). Birth trauma: Talking with women and the value of
conversation analysis. *British Journal of Midwifery*, *15*(5), 256–264.
https://doi.org/10.12968/bjom.2007.15.5.23397

Kitzinger, S. (2006a). Birth as rape: There must be an end to `just in case' obstetrics. *Br J
Midwifery*, *14*(9), 544–545. https://doi.org/10.12968/bjom.2006.14.9.21799

Kitzinger, S. (2006b). *Birth crisis [Kindle edition]*. New York: Routledge.

Lemola, S., Stadlmayr, W., & Grob, A. (2007). Maternal adjustment five months after

birth: The impact of the subjective experience of childbirth and emotional support

from the partner. *Journal of Reproductive and Infant Psychology*, *25*(3), 190–202.

Lev-Wiesel, R., Daphna-Tekoah, S., & Hallak, M. (2009). Childhood sexual abuse as a

predictor of birth-related posttraumatic stress and postpartum posttraumatic stress.

Child Abuse & Neglect, *33*(12), 877–887.

https://doi.org/10.1080/02646830701467231

Long, C. R. (1997). *Grandmothers laughing: Intergenerational transmission of cultural

beliefs about pregnancy and childbirth among Native American women*.

Lundgren, L. (2011). The meaning of giving birth from long-term perspective for

childbearing women. In G. Thomson & S. Downe (Eds.), *Qualitative research in

midwifery and childbirth: Phenomenological approaches* (pp. 115–132). Oxon:

Routledge.

Maclean, L., McDermott, M., & May, C. (2000). Method of delivery and subjective

distress: Women's emotional responses to childbirth practices. *Journal of

Reproductive and Infant Psychology*, *18*(2), 153–162.

https://doi.org/10.1080/02646830050008396

McKenzie-McHarg, K. (2004). Traumatic birth: Understanding predictors, triggers, and

counseling process is essential to treatment. *Birth*, *31*(3), 219–221.

https://doi.org/10.1111/j.0730-7659.2004.00308.x

McKenzie-McHarg, K., Crockett, M., Olander, E., & Ayers, S. (2014). Think pink! A

pink sticker alert system for women with psychological distress or vulnerability

during pregnancy. *British Journal of Midwifery*, *22*(8), 590–595.

Moyzakitis, W. (2004). Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. *Evidence Based Midwifery*, *2*, 8–14.

Nilsson, C., Bondas, T., & Lundgren, I. (2010). Previous birth experience in women with intense fear of childbirth. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *39*(3), 298–309. https://doi.org/10.1111/j.1552-6909.2010.01139.x

Niner, S., Kokanovic, R., & Cuthbert, D. (2013). Displaced mothers: Birth and resettlement, gratitude and complaint. *Medical Anthropology*, *32*(6), 535–551. https://doi.org/10.1080/01459740.2013.769103

O'Donovan, A., Alcorn, K. L., Patrick, J. C., Creedy, D. K., Dawe, S., & Devilly, G. J. (2014). Predicting posttraumatic stress disorder after childbirth. *Midwifery*, *30*(8), 935–941. https://doi.org/10.1016/j.midw.2014.03.011

Olde, E., van der Hart, O., Kleber, R. J., van Son, M. J., Wijnen, H. A., & Pop, V. J. (2005). Peritraumatic dissociation and emotions as predictors of PTSD symptoms following childbirth. *Journal of Trauma & Dissociation*, *6*(3), 125–142. https://doi.org/10.1300/J229v06n03_06

Priddis, H., Dahlen, H., & Schmied, V. (2013). Women's experiences following severe perineal trauma: a meta-ethnographic synthesis. *Journal of Advanced Nursing*, *69*(4), 748–759. https://doi.org/10.1111/jan.12005

Robb, K. (2011). A qualitative study exploring women's' experiences of unplanned Cesarean surgery and their suggestions for improving care. *Canadian Journal Midwifery*, *10*(3), 17–28.

Ryding, E., Wijma, K., & Wijma, B. (2000). Emergency Cesarean section: 25 women's experiences. *Journal of Reproductive and Infant Psychology*, *18*(1), 33–39. https://doi.org/10.1080/02646830050001663

Sawyer, A., Ayers, S., Smith, H., Sidibeh, L., Nyan, O., & Dale, J. (2011). Women's experiences of pregnancy, childbirth, and the postnatal period in the Gambia: A qualitative study. *British Journal of Health Psychology*, *16*(3), 528–541. https://doi.org/10.1348/135910710X528710

Schneider, D. A. (2009). *Beyond the baby: Women's narratives of childbirth, change and power (Order No. 3416170).* Retrieved from http://search.proquest.com/docview/734794337?accountid=12378

Schneider, D. A. (2012). The miracle bearers: Narratives of birthing women and implications for spiritually informed social work practice. *Journal of Social Service Research*, *38*(2), 212–230.

Skari, H., Skreden, M., Malt, U. F., Dalholt, M., Ostensen, A. B., Egeland, T., & Emblem, R. (2002). Comparative levels of psychological distress, stress symptoms, depression and anxiety after childbirth—a prospective population-based study of mothers and fathers. *BJOG: An International Journal of Obstetrics & Gynaecology*, *109*(10), 1154–1163. https://doi.org/10.1111/j.1471-0528.2002.00468.x

Smith, J., & Morrow, M. (2012). Mothers, madness and the labour of feminist practice: Responding to women in the perinatal period. In G. Wong (Ed.), *Moms gone mad: Motherhood and madness oppression and resistance* (pp. 21–34). Ontario: Demeter Press.

Söderquist, J., Wijma, B., & Wijma, K. (2006). The longitudinal course of post-traumatic stress after childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(2), 113–119. https://doi.org/10.1080/01674820600712172

Soet, J. E., Brack, G. A., & DiIorio, C. (2003). Prevalence and predictors of women's experience of psychological trauma during childbirth. *Birth*, *30*(1), 36–46. https://doi.org/10.1046/j.1523-536X.2003.00215.x

Somera, M. J., Feeley, N., & Ciofani, L. (2010). Women's experience of an emergency caesarean birth. *Journal of Clinical Nursing*, *19*(19-20), 2824–2831. https://doi.org/10.1111/j.1365-2702.2010.03230.x

Taghizadeh, Z., Arbabi, M., Kazemnejad, A., Irajpour, A., & Lopez, V. (2014). Iranian mothers' perceptions of the impact of the environment on psychological birth trauma: A qualitative study. *International Journal of Nursing Practice*. https://doi.org/10.1111/ijn.12286

Taubman-Ben-Ari, O., Findler, L., Bendet, C., Stanger, V., Ben-Shlomo, S., & Kuint, J. (2008). Mothers' marital adaptation following the birth of twins or singletons: Empirical evidence and practical insights. *Health & Social Work*, *33*(3), 189–197.

Tester, F. J., & McNicoll, P. (2006). "Why don"t they get It?' Talk of medicine as science. St Luke's Hospital, Panniqtuuq, Baffin Island. *Social History of Medicine*, *19*(1), 87–106.

Thomson, G. (2011). "Abandonment of being" in childbirth. In G. Thomson & S. Downe (Eds.), *Qualitative research in midwifery and childbirth: Phenomenological approaches* (pp. 133–152). Oxon: Routledge.

Thomson, G., & Downe, S. (2008). Widening the trauma discourse: The link between childbirth and experiences of abuse. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(4), 268–273. https://doi.org/10.1080/01674820802545453

Turton, P., Hughes, P., Evans, C., & Fainman, D. (2001). Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *The British Journal of Psychiatry*, *178*(6), 556–560. https://doi.org/10.1192/bjp.178.6.556

Ukpong, D., & Owolabi, A. (2006). Postpartum emotional distress: a controlled study of Nigerian women after caesarean childbirth. *Journal of Obstetrics & Gynecology*, *26*(2), 127–129. https://doi.org/10.1080/01443610500443386

Van Bussel, J., Spitz, B., & Demyttenaere, K. (2010). Childbirth expectations and experiences and associations with mothers' attitudes to pregnancy, the child and motherhood. *Journal of Reproductive and Infant Psychology*, *28*(2), 143–160. https://doi.org/10.1080/02646830903295026

Van Pampus, M., Wolf, H., Schultz, W. W., Neeleman, J., & Aarnoudse, J. (2004). Posttraumatic stress disorder following preeclampsia and HELLP syndrome. *Journal of Psychosomatic Obstetrics & Gynecology*, *25*(3–4), 183–187. https://doi.org/10.1080/01674820400017863

van Son, M., Verkerk, G., van der Hart, O., Komproe, I., & Pop, V. (2005). Prenatal depression, mode of delivery and perinatal dissociation as predictors of postpartum posttraumatic stress: An empirical study. *Clinical Psychology & Psychotherapy*, *12*(4), 297–312. https://doi.org/10.1002/cpp.446

Verreault, N., Da Costa, D., Marchand, A., Ireland, K., Banack, H., Dritsa, M., & Khalifé, S. (2012). PTSD following childbirth: A prospective study of incidence and risk factors in Canadian women. *Journal of Psychosomatic Research*, *73*(4), 257–263. https://doi.org/10.1016/j.jpsychores.2012.07.010

Walther, V. N. (1997). Postpartum depression: A review for perinatal social workers. *Social Work in Health Care*, *24*(3–4), 99–111.

White, T., Matthey, S., Boyd, K., & Barnett, B. (2006). Postnatal depression and post-traumatic stress after childbirth: Prevalence, course and co-occurrence. *Journal of Reproductive and Infant Psychology*, *24*(2), 107–120. https://doi.org/10.1016/j.jpsychores.2012.07.010

Wijma, K., Söderquist, J., & Wijma, B. (1997). Posttraumatic stress disorder after childbirth: A cross sectional study. *Journal of Anxiety Disorders*, *11*(6), 587–597. https://doi.org/10.1016/S0887-6185(97)00041-8

Zaers, S., Waschke, M., & Ehlert, U. (2008). Depressive symptoms and symptoms of post-traumatic stress disorder in women after childbirth. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(1), 61–71. https://doi.org/10.1080/01674820701804324

APPENDIX B: INVITATION TO PARTICIPATE LETTER

Social Work Exploration of Distress in Childbirth

Invitation to Participate

Hello,

I am a doctoral candidate with Memorial University's School of Social Work and I am affiliated with the Nova Scotia Health Authority. As part of my doctoral dissertation I am conducting research under the supervision of Dr. Heather Hair (Memorial University).

I am recruiting participants for my study about distressing childbirth experiences. Distress, in this case, is defined as emotional suffering and upset, and may or may not be defined as traumatic by the person giving birth. Knowledge and information generated from this study may help practicing social workers, social work researchers, and policy developers in their work with, and system responses to, those who experience distress in childbirth.

I am hoping to interview people who have experienced distress (however, they may define it) in childbirth within the last 12 months, who speak English, and who were at least 16 years old when they became pregnant. Interviews will take about 60 - 90 minutes. Interviews will be held at a time and place that is acceptable to the participants. It is important that our time together is private. Participation is completely voluntary. You will make your own decision as to whether or not you would like to be involved. If you choose to participate you can withdraw before the interview, or at any time in the study.

To respect your privacy and rights I will not be contacting individuals directly. If you think you might be interested in hearing more about this study or participating in this research please contact me, Christiana MacDougall Fleming, to discuss participation in this study in further detail. My contact information is included below.

I look forward to hearing from you.

Christiana MacDougall Fleming PhD (Candidate), RSW

Phone: (506) 540-0681, or (902) 667-3879
Email: ckmf45@mun.ca or christiana.macdougallfleming@nshealth.ca

Telephone Scripts

Answering machine message:

Hello. You've reached Christiana MacDougall Fleming. I am a PhD candidate with Memorial University of Newfoundland. I'm sorry I am not available to take your call at the moment. If you are interested in hearing more about possibly participating in my research project regarding childbirth experiences, please leave your name, your phone number, and a convenient time to call you and I will return your call as soon as I can.

Initial phone contact script:

P = Potential Participant; I = Interviewer

I - May I please speak to [name of potential participant]?

      P - Hello, [name of potential participant] speaking. How may I help you?

I - My name is Christiana MacDougall Fleming, and I am returning your call about your possible interest in participating in my PhD research project with Memorial University. Are you still interested in hearing more about this project?

      P – No I have changed my mind.
<div align="center">OR</div>

      P – Yes.

I – Is this a good time to talk more about the project?

      P – No. Can you call be back another time please? (agree on a more convenient time to call person back).
<div align="center">OR</div>

      P – Yes.

I – Can you please tell me where or how you heard about this project?

      P – (Provides information)

I – I am currently conducting research under the supervision of Dr. Heather Hair on distressing childbirth experiences. As part of my research, I am conducting interviews with people who have given birth within the last year to hear their birth stories. I'd like to tell you about the interviews I will be conducting.

- I will be interviewing participants starting in [insert date].
- The interview would last about one hour, and would be arranged for a time and place convenient for you. It is important that our time together and will be private.
- Involvement in this interview is entirely voluntary and the risks are considered minimal, such as potentially remembering things that might have been upsetting at the time.
- The questions are quite general (for example, "Tell me about your childbirth experience").
- You may decline to answer any of the interview questions you do not wish to answer and may end the interview at any time. With your permission, the interview will be digitally recorded to facilitate collection of information, and later transcribed for analysis.
- All information you provide will be considered confidential.
- The data collected will be kept in a secure location and disposed of 5 years after the project is completed.
- If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please feel free to contact Dr. Heather Hair at (709) 864-2562
- The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to comply with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or at (709) 864-2861. However, the final decision about participation is yours.

With your permission, I would like to email/mail/fax you an information letter which has all of these details along with contact names and numbers on it to help assist you in making a decision about your participation in this study.

P - No thank you.

OR

P – Sure. (get contact information from potential participant i.e., mailing address/fax number).

I - Thank you very much for your time. May I call you in 2 or 3 days to see if you are interested in being interviewed? Once again, if you have any questions or concerns please do not hesitate to contact me at (506) 540-0681

I - Good-bye.

P - Good-bye.

Follow-up phone contact script:

I – Hello – It's Christiana calling you back about the research project we discussed the other day. Have you had a chance to read the material I sent you?

     P – Yes
<div align="center">OR</div>
     P – No (arrange a time to call back later)

I – Do you have any questions about the information I sent you?

     P – Yes
I – (answer questions)
<div align="center">OR</div>
     P – No.

I – Do you think you would like to be involved with this research project?

     P – No

I – That's fine. Thank you for your interest and your time.

<div align="center">OR</div>
     P – Yes, I would.

I – Wonderful. Can we arrange a time to meet? At our meeting I will again go over the information and your decision about being involved with the research. Once you decided to be involved and sign the consent form, we will proceed with the interview, which will be private and last be about an hour or two. (Arrange time and place to meet). I'm looking forward to meeting with you. Thanks again for your interest in this research study.

A Social Work Exploration of Distress in Childbirth
Information Letter for Participants

You are invited to take part in a research project hoping to explore distressing childbirth experiences. The Principal Investigator (PI) of this research project is me, Christiana MacDougall Fleming. I am a PhD student at Memorial University completing this study for my dissertation. Dr. Heather J. Hair, professor from the Memorial University School of Social Work, is the supervisor of this project. If you would like more information, you are welcome to ask questions. Please take time to read this carefully.

It is entirely up to you to decide whether to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

PURPOSE OF STUDY: In this study I hope to explore how people understand and make meaning about distressing childbirth experiences. I am especially interested in how parts of peoples' lives like class, race, ethic background, disability, sexuality, and others shape these experiences.

WHAT YOU WILL BE DOING & FOR HOW LONG: You are invited to meet with me for a face-to-face interview, lasting between 60 and 90 minutes. We will be talking about your childbirth experience. It is important that this conversation is private and that we meet at a time and place agreed upon between both of us. The interview will be audio recorded and will be typed out (transcribed) after the interview. I will send you a copy of the transcript to give you a chance to add or clarify any points that you wish.
You will receive a $20 gift card to thank you for your time and energy that you can keep even if you withdraw from the study.

WITHDRAWAL FROM THE STUDY: If you do not want to be part of the study anymore you can let me know in person during our interview or later by telephone. If you choose to leave the study I will ask you what you would like done with any data collected. You will decide if you want all your data (i.e. interview transcripts) erased, or if you would like to have the data collected included even after you have withdrawn.

I plan to have the final written work prepared by approximately September 2017, and so you can leave the study any time up to that point. Once the written work is completed you will not be able to leave the study.

POSSIBLE BENEFITS and RISKS: You may find participating in this study to be helpful to you. You may appreciate the chance to tell your birth story to a researcher who has dedicated her time and attention to hearing about your experience. You might find that sharing your story gives you new understandings about your childbirth experience. It

is also possible that you may find talking about your childbirth experience upsetting. If you believe need additional counselling and support due to being upset from sharing your story, I will help you contact local agencies that can provide support, such as local mental health crisis lines, or other counselling services.

CONFIDENTIALITY and PRIVACY: Every reasonable effort will be made to keep the interview content confidential and to protect your identity. Your name or any identifying information will be removed from the interview notes. You should be aware that I am bound to report potential or actual abuse/harm/risk to a child or vulnerable person. Your consent form will be kept in a locked cabinet and the interview transcript will be entered into a computer that is password protected and stored in a locked filing cabinet, in my personal office, which is also locked. A transcriber will listen to your interview and write out what was said. This person will sign a confidentiality agreement. Other than this, Dr. Hair and I will be the only people who will have access to the interview content. After the study is completed, the data will be securely stored for a minimum of five years, as per the Memorial University policy on Integrity in Scholarly Research. No participant will be identified in any presentation, publication, or discussion of the research. You are welcome to contact me for a written copy of the aggregated research results.

REPORTING OF RESULTS: If any of your comments are used as sample quotations, all identifying information will be removed. You will not be identified in any presentation, publication, or discussion. This research will be published as my PhD dissertation and will be publically available at the QEII library of Memorial University.

If you have any questions about the study or the procedures, you may contact me at ckmf45@mun.ca or (506) 540-0681 or Dr. Hair at hhair@mun.ca or (709) 864-2562, or Darlene Gould at (902) 667-3879. The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to comply with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or at (709) 864-2861 or the NSHA REB at (902) 473-8426.

MEMORIAL UNIVERSITY ICEHR INFORMED CONSENT FORM

Social Work Exploration of Distress in Childbirth
Informed Consent Form

This research project has been developed to learn more about childbirth experiences. With your help social workers will learn more about how to be helpful to individuals who may have had distressing childbirth experiences.

Your signature means:
- You have read the Information Letter about the research and have had adequate time to think about what you learned.
- You have been able to ask questions about this study and are satisfied with the answers.
- You understand what the study is about and what you will be doing.
- You understand the risks and benefits of your participation.
- You agree to be audio-recorded.
- You agree to the use of direct quotations, using a false name in the written work.
- You understand that you are free to withdraw participation in the study without having to give a reason, and that doing so will not affect you now or in the future.
- You understand that if you choose to end participation during data collection, any data collected from you up to that point will be retained by the researcher, unless you indicate otherwise.
- You understand that if you choose to withdraw after data collection has ended, your data can be removed from the study up to the time your data is included in the final report (approximately September, 2016).
- You understand that after the research is completed, the data will be securely retained for a minimum of seven years, as per the Memorial University policy on Integrity in Scholarly Research and the Nova Scotia Research Ethics Board (NSHA REB)
- The interview recordings and the transcripts will be kept on my Nova Scotia Health Authority computer behind the NSHA file wall and will only available to me. If I leave employment with the NSHA before the data is destroyed (7 years) a copy of the data will be provided to the NSHA REB to meet their audit requirements. The data will be kept confidential.
- You understand that you can contact me directly to request a copy of the findings of this study.
- You understand that if you have questions regarding the procedures and goals of the study at any time, you can contact me at ckmf45@mun.ca or (506) 540-0681 or Dr. Hair at hhair@mun.ca
- You understand this project has received ethics approval through Memorial University of Newfoundland.
- You voluntarily agree to participate in this research project.
- You understand if any of your comments are used as sample quotations, all identifying information will be removed. You will not be identified in any presentation, publication, or discussion. This research will be published as my PhD dissertation and will be publically available at the QEII library of Memorial University.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities. The researcher will give you a copy of this form for you to keep.

_____   _____
Name   **Signature**

_____
Date

Researcher Statement:
I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____   _____
Signature of Researcher   **Date**

APPENDIX F: INTERVIEW GUIDE

Proposed Interview Questions

The initial interview question will be a broad opening for discussion; "I'd like to talk today about your childbirth experience and how it may have been similar to and different from what you had expected." The following prompts and questions will be used as needed to continue the interview:

- "What was giving birth like for you—consider physical, emotional, social, spiritual aspects of childbirth?"

- "In what ways was childbirth like you expected it to be?"

- "How was childbirth different than you expected it to be?"

- "Describe some of your family traditions, cultural traditions, and/or religious beliefs about birth and how they influenced your expectations."

- "In what ways, if any, did you feel good, positive, or satisfied about your birth experience?"

- "In what ways, if any, did you feel poorly, negatively, or distressed by your birth experience?"

- "Do you have any advice or messages you would give to those who are going to experience labour and delivery?"

APPENDIX G: ICEHR APPROVAL LETTER

MEMORIAL
UNIVERSITY

Interdisciplinary Committee on
Ethics in Human Research (ICEHR)

St. John's, NL Canada A1C 5S7
Tel: 709 864-2561 icehr@mun.ca
www.mun.ca/research/ethics/humans/icehr

ICEHR Number:	**20160538-SW**
Approval Period:	September 30, 2015 – September 30, 2016
Funding Source:	N/A
Responsible Faculty:	Dr. Heather Hair School of Social Work
Title of Project:	*A Social Work Exploration of Distress in Childbirth*

September 30, 2015

Ms. Christiana MacDougall Fleming
School of Social Work
Memorial University of Newfoundland

Dear Ms. MacDougall Fleming:

Thank you for your email correspondence of September 24, 2015 addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) concerning the above-named research project.

The ICEHR has re-examined the proposal with the clarification and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* to September 30, 2016. ICEHR approval applies to the ethical acceptability of the research, as per Article 6.3 of the *TCPS2*. Researchers are responsible for adherence to any other relevant University policies and/or funded or non-funded agreements that may be associated with the project. As obtained, provide ICEHR with a copy of FRC administrator/board approvals for this project, which must be obtained prior to the start of recruitment at each site.

If you need to make changes during the course of the project, which may raise ethical concerns, please forward an amendment request form with a description of these changes to icehr@mun.ca for the Committee's consideration.

The *TCPS2* requires that you submit an annual update form to the ICEHR before September 30, 2016. If you plan to continue the project, you need to request renewal of your ethics clearance, and include a brief summary on the progress of your research. When the project no longer requires contact with human participants, is completed and/or terminated, you need to provide the annual update form with a final brief summary, and your file will be closed.

The annual update form and amendment request form are on the ICEHR website at http://www.mun.ca/research/ethics/humans/icehr/applications/.

We wish you success with your research.

Yours sincerely,

Kelly Blidook, Ph.D.
Vice-Chair, Interdisciplinary Committee on
Ethics in Human Research

KB/lw

cc: Supervisor – Dr. Heather Hair, School of Social Work