MELANIE BAYLY AND PAMELA DOWNE

"Most Often People Would Tell Me I Was Crazy": Defending against Deviance Ascribed to Alternative Birth Choices

Childbirth-related discourses and practices have fluctuated over time in Canada. A medicalized model currently dominates, but there is increasing plurality in how birth is conceptualized and enacted. From a sample of twenty-one first-time mothers who were interviewed about their childbirth-related experiences, we explored how women described and defended their alternative birth choices within the broader social context of medicalized birth. Data were thematically analyzed and explored in relation to theoretical work on stigma and deviance, since these concepts emerged as salient to women's narrated experiences. Findings illustrate that mothers who make alternative childbirth choices are often marked as deviant and may elicit moralizing judgments from others, which largely stem from perceptions of risk and/or safety. To counter or avoid feared and experienced deviance, women managed information about the birth of their child through passing, covering, normalizing through reframing, and condemning the condemners. This information management allowed women to present themselves as responsible, competent mothers in the face of deviance. Although previous research has demonstrated birth-related stigma in relation to the choice to birth at home or unassisted, our findings suggest that ascriptions of deviance may also extend to women's choice of midwifery and doula care despite their increasing prevalence as part of maternity care in Canada. Since these birth options are progressively available and used, and have some empirically documented benefits for mothers, further exploration of how they and other alternative childbirth options are perceived, experienced, and morally valued by women and the general public is warranted.

The landscape of Canadian maternity care has undergone significant flux over the past century. There has been a shift toward an increasingly medicalized[1] system characterized by high rates of in-hospital, obstetrician-attended birth and medical interventions (Delclerq et al.; Ye et al.). Most Canadian births occur in hospital; only approximately 2 percent of births in 2014 occurred outside of this setting (Statistics Canada). Moreover, women giving birth in hospital tend to undergo high rates of medical and technological intervention. In a recent pan-Canadian survey of childbirth intervention rates, almost half of the women sampled (44.8 percent) had their labour induced, 57.3 percent had epidural analgesia, and 90.8 percent were strapped to an electronic fetal monitor (Chalmers et al. 205). High Caesarean-section rates are also a significant indicator of the extent to which childbirth has become medicalized, accounting for 27.9 percent of all Canadian births in 2015 (Canadian Institute for Health Information). Evidence suggests that medically justified Caesarean section rates should fall between 10 and 15 percent, and that rates higher than this are neither medically justified nor beneficial (Ye et al. 243).

Interventionist practices and medicalized birth are strongly rooted in the prevailing belief that birth is risky, which elicits close monitoring of the birth process, a lack of distinction between risk factors and actual pathology, and expert intervention (Cartwright and Thomas 222; Lothian 45-46; Rooks 371). Risk discourse dominates the medical model of childbirth, and is propagated within obstetrics and by other medical officials (Craven 199; Reiger and Dempsey 369), hospitals (Rutherford and Gallo-Cruz), the media (Luce et al. 7-8), and the general public (DeJoy; Stoll et al. 223). Medicalized conceptions of birth risk also inform birth-related decisions such as the choice of Caesarean section, hospital birth, and obstetrical or physician-led maternity care (Chadwick and Thomas 73-76; Coxon et al. 57-61).

Partially in response to the medicalization of birth, the midwifery movement advances an alternative model in which birth is redefined as a normal physiological process. This model does not presuppose the need for technological intervention; it positions women and their bodies as capable, and prioritizes informed choice and woman-centred care (Macdonald 237; Rooks 370). By 1994, midwifery achieved the status of a publicly funded, self-regulating health profession in Ontario (Bourgeault and Fynes 1059). It has since expanded and is currently available in all but three Canadian provinces and territories[2]; the proportion of births attended by midwives has been increasing in Canada despite little or no access in some locations. From 2015 to 16, midwives were the primary care providers for approximately 10 percent of all Canadian births (Canadian Association of Midwives). The midwifery model propagates a public discourse that centres on birth as a natural but momentous event, includes the family in the birth process, and avoids interventions. The ascendance of this discourse influences maternity care and

how women think about birth (Rutherford and Gallo-Cruz; T. Miller 343), but researchers have argued that birth practices in North America remain highly medicalized, as childbirth is culturally positioned as a medical event best experienced in hospital (Coxon et al. 65).

In this article, we explore how first-time mothers in Saskatchewan describe and defend their choices for nonmedicalized births in the broader social context of medicalized birth. Our focus is on how the research participants position their decisions in contrast and response to the ascription of deviance that they routinely encountered.

Moral Valuation of Birth-Related Choices and Experiences

Within a context of multiple cultural discourses and practices around birth, there is the potential for greater choice in perinatal care and labour. Markella Rutherford and Selina Gallo-Cruz suggest that choice and ability to "shop around" in the pursuit of one's ideal birth is an important feature of contemporary childbirth (87). An increased emphasis on freedom of choice, however, heightens women's individualized responsibility to make the right choice (Lupton 331). As Claudia Malacrida and Tiffany Boulton state, "The combination of an increasingly technocratic medical approach to birthing, an individualized and blaming model of patient/consumer risk evaluation and the contested discourses concerning the 'ideal' way of giving birth can make patient 'choice' and risk evaluation more difficult" ("The Best Laid Plans" 46).

Notions of individualized responsibility and need to produce a so-called good birth and child align with another feature of contemporary culture which comes to bear upon women's experiences of childbirth: intensive mothering. As Sharon Hays (8) points out in her landmark work, intensive mothering defines good mothering as "child centred, expert-guided, emotionally absorbing, labour intensive, and financially expensive." A "good" mother must, therefore, focus on the needs of her child above her own, and is responsible for maximizing the outcome of the pregnancy (i.e., as close to a perfect delivery and baby as possible). This cultural logic is visible in the ways in which women negotiate risk through their (non)consumption practices (Gram et al. 446), choices about birth setting (Miller and Shriver), and understandings of birth options and experiences (Malacrida and Boulton, "Women's Perceptions"). In a context where women are responsible for assessing risk and making the best choices for their babies, these choices are both morally valued and tied to mothering identity.

In line with this, women appear to experience negative judgments from others for some childbirth-related decisions. Women choosing homebirth may receive negative feedback from family, friends, and health professionals, who perceive their decision as irresponsible (DiFilippo 59; Viisainen 806).

Similarly, women choosing to have a deliberately unassisted homebirth may fear and experience a significant degree of negative judgment (O'Boyle 184; A. Miller 411), and may be called an "unfit mother," which could elicit involvement from authorities (Feeley and Thomson 19). Amy Chasteen Miller describes how women who choose unassisted birth face "layered stigma"—stigma from within their own network of homebirth advocates in addition to broader societal stigma (421). Although these examples are not specifically within a Canadian setting (with the exception of Shawna Healey DiFilippo's work), they illustrate the degree to which childbirth-related options may be morally charged and viewed in relation to culturally widespread ideas around birth, motherhood, responsibility, and risk.

The Current Research: Deviance and Alternative Childbirth Decisions

The purpose of this article is to explore childbirth-related deviance (a concept closely related to stigma) within the birth narratives of a sample of Canadian first-time mothers who birthed their children within a medicalized context, which increasingly incorporates alternative discourses and care practices. This research is part of a broader study investigating the ways that women understand and morally position their childbirth-related decisions and experiences in relation to dominant discourses. Although exploring stigma and deviance was not explicitly the focus, these concepts were salient to the experiences of women who made alternative decisions deviating from medicalized birth.

Erving Goffman describes "stigma" as a deeply discrediting attribute, which through processes of social interactions marks an individual as both different from, and inferior to, others (3). Stigma can be understood as a moral issue; it threatens the loss or diminution of what is at stake or valued within an experience or encounter (Yang et al. 1530). As such, individuals work to manage their stigmatized identity and to protect it from the dangers posed by stigma (Goffman). Although many stigmas are "tribal" (of race, nation, and religion) or of the body (e.g., HIV/AIDS or other chronic conditions), Goffman also describes stigmas of individual character—a failing to live up to the values, norms, and standards upheld by a community. In this case, the norms are around childbirth practices and ideals of what constitute responsible mothering. More recently, however, Graham Scambler and Frederique Paoli differentiate between "stigma," which they argue refers to an "ontological deficit" beyond the control of the individual that engenders shame, and "deviance," which refers to an "achieved or moral deficit" based on an individual's behaviours that engenders blame (1850). Although the theoretical concepts of stigma and deviance are strongly related, and both may threaten identity and require information management, the latter term more precisely

pertains to non-normative and morally judged behaviours. The focus of the current analysis is therefore two-fold: (1) to illustrate the presence of deviance as described by women who chose alternative childbirth options; and (2) to delineate the ways in which these women managed information to preserve their identity as good mothers.

Methodology and Data Analysis

This qualitative research was positioned within a social constructionist framework, which locates meaning in people's interpretations and understandings (Crotty 43). We operated from the assumption that childbirth is grounded in meanings that are culturally, socially, and individually negotiated and that these meanings inform experiences and identity. Narratives were chosen as a method of inquiry, since they are a tool people employ to understand, reflect upon, and order life events and the emotions associated with them (Riessman 10).

Data were derived from the narratives of a smaller subset of the broader study sample. This sample consisted of twenty-one mothers (M_{age} = 29.48) currently living in the Canadian prairies who had given birth to their first child within the past eighteen months. Participants were recruited through pamphlets distributed through midwifery care and postpartum public health nurse visits, posters at leisure centres, Kijiji, and snowball sampling. From the broader sample, eleven of the twenty-one women interviewed had deviated from the dominant model of an obstetrician or physician-attended, in-hospital birth, either in choice of care provider (midwife-led birth) or type of birth (home or unattended). Four women from this subset also employed doulas, as did two women who chose hospital births with a physician or obstetrician. Data from these women who made alternative birth choices informed the present analyses.

Prior to participant recruitment, ethical approval was obtained for this research from a University Behavioural Research Ethics Board. Data were generated through audio-recorded narrative interviews, which lasted approximately an hour, conducted by the first author (MB). Interviews consisted of seven broad, open-ended questions about women's experiences with pregnancy, birth, and the transition to motherhood; four of these questions focused on birth-related options and experiences. One of the questions most pertinent to the current data, for example, asked women to describe any plans they had made regarding their labour and birth. Since most participants responded to these questions at length and in detail, the interviewer adopted a relatively passive approach so that interviews were shaped primarily by participants.

All interviews were transcribed verbatim, and initial analytic notes were

compiled. A general thematic analysis (Braun and Clarke) was then conducted, in which data were coded inductively using NVivo software and organized into themes. During this process, deviance emerged as a salient concept for the subset of women who made choices diverging from medicalized norms. Despite the theoretical distinctions between stigma and deviance drawn by Scambler and Paoli, scholars have largely retained the language of stigma in examinations of reproduction-related moral judgments and discrimination; the processes by which stigma is managed also appear to apply equally to deviance. Therefore, although the concept of deviance was chosen to discuss the social processes observed, both deviance and stigma theory were used to explore the techniques women used to manage information and identity.

Findings

Eight of the thirteen women who made alternative birth choices (working with doulas or midwives and/or having a homebirth or an unassisted one) described negative judgments about these choices, which threatened their status as normative and responsible mothers. The deviance they described was both enacted (episodes of moral judgments, blame, and discrimination by others) and felt (a sense of blame and fear of enacted deviance) (Scambler and Paoli 1850). Homebirth and unassisted birth[3] commonly elicited negative moral judgments from others. Brenda, for example, made a last-minute decision during labour to remain at home and deliver the baby with the assistance of her doula. Brenda described the pervasiveness of negative judgments from others about her choice, which called her maternal fitness into question: "So many people that I had talked to along the way or even now if they hear about our birth story are like, that is so dangerous. Or, you know, 'How irresponsible of you to do that, like I would never do that' and stuff…. Yeah, people who are genuinely like 'That's neglectful almost, like you should—it's scary that you would do that.'"

Women who chose homebirth or unassisted birth in this study felt passionately and positively about their choice. However, they also indicated that their decision was viewed negatively by at least some of the people with whom they interacted. These moral judgments mainly centred on difference (i.e., deviations from the norm of physician or obstetrician-attended, in-hospital birth) and on people's beliefs about childbirth-related risk. Although the feedback that women described tended to be quite moralizing, Carmen described a more subtle ascription of deviance in which her positive outcome with an unassisted homebirth was held up as an exception: "People are very quick to either dismiss it, as an anomaly and not obtainable for the general population, which I disagree with, or they are quick to tell me how lucky I am that everything worked out because birth is so dangerous." Overall, however,

Carmen belonged to a strong homebirth- and midwifery-aligned community, and had like-minded peers she could freely talk with.

Stigmatizing judgments of deviance (both enacted and feared) were more problematic when they came from healthcare providers who hold considerable power. Like Carmen, Melinda was part of an alternative peer group whose members were generally supportive of homebirth, but she described her frustration during a consult with an obstetrician during her pregnancy:

> She was supportive of me having a midwife. I don't know, her words were something like "I have no problem with midwives, but no one should have a homebirth" … When we asked questions and asked for evidence and gave our concerns, she disregarded them and told us that we needed to think of our baby. [She] used scare tactics, [and] gave us information that actually is incorrect.

Women were unappreciative of healthcare providers who disparaged midwives or homebirth, particularly when they experienced this as enacted deviance. Elizabeth felt both she and her midwives were viewed as incapable and irresponsible when she had to endure a hospital transfer upon failure to progress: "I felt as though my homebirth transfer made me almost a leper to them…. My midwives got treated like shit. Yeah, it was bad. And my doulas. They were asked to leave, and they didn't, because I said no." Although not all maternity care providers practicing in the hospital made moralizing judgments regarding alternative birth practices, enacted deviance had a negative impact on the care relationship when it did occur.

Although women often described deviance related to homebirth and/or unassisted birth, several women described negative judgments arising from their choice of a midwife or a doula as their primary care provider. Kella had planned a hospital birth, but the inclusion of a doula in her labour invoked judgments, which marked her as deviant: "Lots of people don't know what a doula is either. So then they thought I was doing something uh, way out there. Birth in the woods or something." Christina also described both felt and enacted deviance over her choice of midwives as primary caregivers and a doula:

> I was definitely cautious about, um, who to … tell that we were working with midwives, and that we were thinking about a homebirth…. And we did actually have quite a bit of confrontation with [partner's] mom over that … she found out we hired a doula and like … completely lost it. Yeah, she was like highly against me consulting anyone other than a doctor, about the birth—the birthing process.

The influence of medical hegemony is clear in this passage; healthcare providers working within the traditional medical model are often perceived as

the only safe and acceptable practitioners. The experiences described by these participants illustrate how even working with midwives and/or a doula may elicit negative judgments from others.

The processes of deviance women described in relation to alternative birth choices were rooted in their failure to make decisions that aligned with the dominant model. Negative judgments primarily resulted from evaluations of the deviations being risky and irresponsible. In a context of individualized responsibility and intensive mothering, this deviation threatened women's moral status and good mother identity. As such, felt and enacted deviance associated with women's alternative birth choices necessitated identity work in their interactions with others to preserve a positive identity.

The "Projects" of Women Who Chose Alternative Birth: Managing Deviance

In relation to both stigma and deviance, norm violation threatens the ability of individuals to present a positive identity, and stigmatized individuals often engage in various information management techniques to preserve or foster a positive and moral self (e.g., Ashforth and Kreiner 414; Clair et al. 79; Goffman 41-104; Hylton 625; Miller 421; Sykes and Matza, 667; Toyoki and Brown 729). Scrambler and Paoli refer to the employment of such techniques as the "projects" of individuals: the use of strategies to avoid or combat enacted stigma and deviance while minimizing the psychosocial impact of felt deviance (1851). The women in this research engaged in these projects as they described, enacted, perceived, and feared judgments from others about their birth-related decisions.

Passing

Although women's pregnancies were highly visible, their actual choice of alternative birth was not. They therefore had maximum control in most contexts over how they managed discreditable information. As such, they had the option to pass (Goffman 42, 74): to conceal, fabricate, or not disclose details of their intended or actual birth. Five women described passing in particular contexts or with specific people to avoid negative and moralizing judgments. Passing could entail both discretion, in which women did not offer information about their birth or plans, and concealment, in which women lied or hid information (Zerubavel 105).

Karen explained the nondisclosure of her planned homebirth in the face of felt and enacted deviance:

> I definitely wasn't a homebirth type person and we had to keep that, you know, keep that decision from different people because it worries people…. I shouldn't say we kept it from people; the only people we were purposefully trying to keep it from were my husband's parents

because we didn't want them to panic and say that we were risking the baby's life and to forbid us from having a homebirth or anything like that. So they were the only people that we didn't actually tell. Other people that we would chat with, we would say you know, we're thinking about having the baby at home, and a look of terror would cross their face, and they would say "Oh my God you cannot do that, oh my God, you can't do that, you have to go to the hospital." And we would say "Well, why," and they'd be like, "Well you just have to go to the hospital, and it's so dangerous, and you're risking the baby's life."… So we just sort of selectively learned to stop talking with people about it.

Since Karen and her husband expected his parents to react negatively to her planned homebirth, they did not disclose it and passed as normal expectant parents who would birth in hospital. Participants would use discretion (i.e., not bring it up) or lie when they encountered people whom they perceived as particularly judgmental regarding alternative birth choices. To pass more consistently and, thereby, mitigate enacted deviance, Karen explained that she ultimately stopped disclosing her birth plans altogether.

Covering

As a middle ground between passing and disclosure, deviant and stigmatized individuals may choose to cover: to reveal some discrediting information but in ways that minimize its deviance and obscure the real stigma or its most damaging aspects (Goffman 102). Covering by framing plans as tentative allowed women to be more honest about their impending birth while they could minimize its significance and impact on a moral identity. As Christina, for example, explained: "But most other people, I was really cautious about being like, 'Yeah, we're thinking about maybe doing a homebirth, I don't know'. And you know, I was pretty nonchalant about it, because I didn't want any confrontation." By presenting her plan to birth at home with a midwife as an option rather than a decision, Christina minimized association with the deviant identity of homebirther. Similar to other participants, Christina used different strategies of information control depending on the audience and used covering or passing when social cues were negative or unclear.

Annabel also covered by framing her birth plans as tentative to manage discrediting information. Additionally, because her birthing experience—a homebirth with a birth attendant rather than a maternity care provider licensed to deliver babies—was considered particularly deviant[4] (A. Miller 421), she concealed the most negatively perceived detail of her birth from most people:

> So mostly only the people who knew our situation were close friends and family, and afterward, the majority of the time [her partner] and I would just tell people that it was just us two to protect our birth attendant's anonymity. So that way, it's not coming down on her for anything if people are like "What, it was just you and your husband", the grief is only coming on to us.… And so it's almost a little more given in a good light than even saying we had a birth attendant. They're like, "a birth attendant, what's that?" So just learning the ways to be discreet enough but only give enough information that you solidify that it was a very safe positive environment.

Since Annabel perceived fewer moralized judgments about giving birth at home than she did saying she had an unregistered birth attendant, she only revealed some aspects of her son's birth. As such, she accepted deviance ascribed to a homebirther identity, but covering allowed her to edit out the information she felt would engender further moralizing judgment without having to fabricate her birth experience entirely.

Normalizing through Reframing

Although passing appears to be the most common strategy for managing stigma or deviance (A. Miller 407), individuals may choose to disclose—that is, communicate information about themselves that is otherwise not directly observable or known (Herek 198). All of the participants who described managing information through covering or passing also disclosed to some people in particular contexts. If the audience was not already receptive to, or supportive of, their birth choices upon disclosure, the women worked to manage deviance and promote a positive identity by reframing their choices and experiences as positive, safe, and normal. Reframing involves the transformation of meaning attached to a stigmatized attribute or deviant behaviour, either through infusing (imbuing the stigma with positive value) or neutralizing (negating the negative value of the stigma) (Ashforth and Kreiner 421-22).

One of the ways childbearing women normalized deviance through reframing was to play an educative role. They explained their alternative birth decisions to others, emphasizing that they were not strange, irresponsible, or unsafe. As Brenda described:

> We tried to explain that she's [doula] there emotionally, and you know, for some physical relief, whether it's hip compressions or whatever it was, she was there to help with that. She wouldn't be doing any of the fetal heart monitoring or anything like that. I had to explain to a lot of people what a doula was, and what a midwife did, and that they could deliver babies without a doctor there, as long as there were no complications.

Since most of the deviance attached to alternative birth decisions related to perceptions of risk and safety, education generally meant trying to reframe the decisions as equally safe or even safer than medicalized options. As Elizabeth stated, "I would just spout off some statistics about homebirth and how it's safe, and the infant mortality rate is the same either way, and birth outcomes are better at home anyway." Education was, therefore, a way of neutralizing negative meanings of alternative birth options. Because of the discourse of risk underpinning the ascription of deviance to alternative birth, reframing through neutralization often involved "denial of injury" (Sykes and Matza 667): the women often explained that no harm would come or had come to pass.

Women also reframed deviance through infusing their decisions with positive value (Ashworth and Kreiner 421). They did so by drawing on shared understandings of good mothering: they prioritised the safety and health of their baby just like other mothers. As Annabel explained, "They just want to be reassured that yeah absolutely I was concerned about emergency. As a parent, I did lots of research, I'm not high risk, we're very close to a hospital—kind of tell them the things that they want to hear." By aligning herself with other parents and emphasizing the health of the baby, Annabel presented herself as a responsible mother and normalized her birth-related decisions. Similarly, Brenda made it clear that the health and safety of her baby were her priority, and they were maximised through her decision to birth at home: "So I don't even really take it personally, like that they think it's irresponsible. It's like no, it's not actually. It's the best thing we could have done for our baby." Drawing on valued social roles and morality is one way to combat deviance and bolster a positive identity (Toyoki and Brown 731). By explicitly invoking their maternal status and drawing upon shared understandings of mothering wherein the baby's needs and safety are prioritized, women countered accusations of irresponsibility communicated by others.

Condemning the Condemners

Finally, women managed a positive maternal identity in the face of deviance by criticizing the character, knowledge, and authority of outsiders who judged their birth-related decisions. Gresham Sykes and David Matza label this the "condemnation of the condemners" and suggest that it redirects the concern onto the motives, behaviours, and flaws of those who are enacting deviance (668). Elizabeth defended her desired midwife-attended homebirth by both focusing on the positives of her experience and by criticizing the people who had suggested it was unsafe and inappropriate: "My labour at home was lots of fun. Like it was painful and long, whatever, but it was everything I wanted it to be. And I've had a few people say things like, 'don't you wish you would have just scheduled a C-section.' Like people are so stupid and insensitive." By

criticizing the character of people who criticized her birth choices, Elizabeth reaffirmed her own authority and capacity to make good maternal decisions.

Since many of the people involved in enacted deviance were friends and family, women often condemned the condemners specifically in relation to their lack of knowledge about birth (as opposed to broader aspersions on their character). Brenda, for example, said the following:

> Most of the negative reactions we get are from people who either are expecting a baby of their own or are kind of around that age who are going to do it, and basically just think that it's totally old school and crazy. And that it's not safe. "[What] if something went wrong", that's what everyone says…. But I mean when they say that stuff I just say no, you have to educate yourself. Because I know you don't know. You need to learn more, like I've studied the whole birth thing. I was crazy about it. I just wanted to know more and more, I couldn't know enough. And it's like ignorance; they just don't know.

By situating others' moralizing judgments as a function of their lack of knowledge, women protected themselves against internalizing blame and threats to their maternal identity. Moreover, women juxtaposed the ignorance of others against their own birth-related research, planning, and knowledge, and presented themselves as experts in the context of their decisions.

Discussion

Even in a context where midwifery and doula services are becoming increasingly common, women who make childbirth choices deviating from a medicalized model are often marked as deviant, and they elicit moralizing judgments from others. These negative judgments largely stem from the dominance of the medical model of birth (so that alternative decisions are markers of alterity) and centre on perceptions of risk and/or safety. Researchers have previously described birth-related stigma related to the choice of homebirth and, especially, unassisted birth (O'Boyle; A. Miller; Viisainen). Our study illustrates similar social processes in a contemporary Canadian context, but it suggests that stigma and deviance may also extend to the choice of midwifery and doula care. This is consistent with research in Canada and the United States, which finds that midwifery continues to be seen as a risky, if personally gratifying, choice (Dejoy 119; Sangster and Bayly 44).

Although scholars have used the concept of stigma to describe such social processes, we suggest that Scambler and Paoli's concept of "deviance"—as an achieved or moral deficit based on behaviours deviating from cultural norms— best reflects the processes described by childbearing women (1850). Rather than shame (as experienced with stigma), deviance engenders blame, which

was evident in the moral judgments and accusations of risky behaviour and baby endangerment. In addition to enacted deviance, women also described felt deviance; they feared the negative moral judgments and blame expressed by others (Scambler and Paoli 1850). However, participants did not appear to internalize any sense of blame, and as with women in other studies, they had confidence in and were proud of their choices (Jouhki e60; A. Miller 417).

It is unclear whether blame would have been internalized in the advent of negative birth outcomes; this is a question for future research. Most participants even in the broader study had clearly been exposed to alternative birth discourses, which may have increased self-confidence in choosing alternative options. These women had also researched birth options and were likely familiar with informal or peer-reviewed evidence suggesting positive outcomes and low risks of homebirth, midwifery, and doula care (see, e.g., de Jonge et al. 726; Elder et al.306; Fortier and Godwin e292; Hutton et al. el86; Sandell et al. 23; Snowden et al. 2645[5]). DiFilippo (56-57) describes a "relearning" that takes place as women seek information about alternative options through peers, alternative childbirth advice literature and other media, and empirical research. This relearning may involve a reconfiguration of which practices are normal and acceptable.

Despite the apparent lack of internalized blame in women's birth narratives, the presence of felt or enacted deviance necessitated information management in the form of passing, covering, normalizing through reframing, and condemning the condemners (Ashforth and Kreiner 421-22; Goffman 41-104; Sykes and Matza 667-68). The information management allowed participants to present themselves as responsible, competent mothers in the face of deviance. As Malacrida and Boulton argue, childbirth is understood in relation to cultural proscriptions around femininity and motherhood ("Women's Perceptions" 749). A positive and moral mothering identity could be implicitly and explicitly threatened by disclosure of alternative birth choices. The connection between identity work and mothering ideals was particularly salient when participants normalized their decisions by aligning themselves with other mothers, denying harm, and explaining how their baby came first. Women who actively reframe alternative birth options may not directly challenge child-centred mothering ideology, but they contribute to positive constructions of alternative childbirth. In doing so, they challenge the dominant medical model and the discourses it engenders. Hearing positive alternative birth experiences is an important part of learning about different options and unlearning the dominant narrative of birth as risky (DiFilippo 53), even though it may take a long time to demarginalize and culturally position alternative birth settings as normal given the dominance of risk discourse (Coxon et al. 65). Although the experiences of women in the current study suggest that these options may still engender ascriptions of deviance,

positive constructions through reframing counter negative moralizing judgments reinforcing the status quo.

Ultimately, it is important to critically examine the social processes of deviance surrounding women's alternate childbirth decisions in Canada. The current work was not without limitations; many of the participants were located in one province (Saskatchewan), and it is unclear how representative their experiences of deviance were of Canadians more broadly. Since evidence suggests that alternative models of childbirth may benefit women and are an increasingly viable option within the healthcare system, further exploration of how women's alternative childbirth decisions are experienced, perceived, and morally valued remains a top priority for scholars of motherhood, mothering, and mothers.

Endnotes

[1] A concept that is frequently invoked to describe modern childbirth, medicalization can be defined as a social process wherein a problem, behaviour, or condition (including natural bodily processes) become defined and treated within a medical framework (Conrad 196).

[2] Regulated midwifery care is not currently available in Newfoundland and Labrador, the Yukon, and Prince Edward Island (Canadian Association of Midwives).

[3] Refers here to a birth where a doula or birth attendant was in the residence, but no healthcare provider who is legally mandated to perform deliveries. Real names of participants have been replaced with pseudonyms.

[4] Although skilled birth attendants and lay midwives delivered many babies prior to the legalization and regulation of midwifery in 2008, all individuals working as midwives in Saskatchewan must now be registered with the Saskatchewan College of Midwives.

[5] Although Snowden et al.'s work indicates slightly higher risks for several outcomes in planned out-of-hospital birth, serious adverse outcomes are low in all settings and absolute differences in risk are small, as noted by the authors (2650).

Works Cited

Ashforth, Blake E., and, Glen E. Kreiner. "'How Can You Do It?': Dirty Work and the Challenge of Constructing a Positive Identity." *The Academy of Management Review,* vol. 24, no. 3, July 1999, pp. 413-34. *JSTOR*, www.jstor.org/stable/259134. Accessed 21 Aug. 2018.

Braun, Virginia, and Victoria Clarke. "Using Thematic Analysis in Psychology." *Qualitative Research in Psychology*, vol. 3, no. 2, 21 July 2008, pp. 77-101. *Taylor & Francis Online*, doi:10.1191/1478088706qp063oa.

Canadian Association of Midwives. "Midwifery across Canada." *Canadian Association of Midwives,* 2017, canadianmidwives.org/midwifery-across-canada/. Accessed 21 Aug. 2018.

Canadian Institute for Health Information. "Caesarean Section Rate." Health System Performance, 2015. *Health Indicators Interactive Tool*, 2017, indicatorlibrary.cihi.ca/display/HSPIL/Caesarean+Section+Rate. Accessed 29 Nov. 2017.

Cartwright, Elizabeth, and Jan Thomas. "Constructing Risk: Maternity Care, Law, and Malpractice." *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*, edited by Raymond DeVries et al., Routledge, 2001, pp. 218-28.

Chadwick, Rachelle Joy, and Don Foster. "Negotiating Risky Bodies: Childbirth and Constructions of Risk." *Health, Risk, & Society*, vol. 16, no. 1, 5 Dec. 2013, pp. 68-83. *Taylor & Francis Online*, doi:10.1080/13698575.2013.863852.

Chalmers, Beverly, et al. "Rates of Interventions in Labor and Birth across Canada: Findings of the Canadian Maternity Experiences Survey." *Birth,* vol. 39, no. 3, June 2012, pp. 203-210. *Wiley Online Library*, doi:10.1111/j.1523-536X.2012.00549.x.

Clair, Judith A., et al. "Out of Sight but Not Out of Mind: Managing Invisible Social Identities in the Workplace." *The Academy of Management Review*, vol. 30, no. 1, Jan. 2005, pp. 78-95. *JSTOR*, doi:10.5465/AMR.2005.15281431.

Conrad, Peter. "Medicalization: Changing Contours, Characteristics, and Contexts." *Medical Sociology on the Move: New Directions in Theory*, edited by William C. Cockerham, Springer, 2013, pp. 195-214.

Coxon, Kirstie, et al. "To What Extent Are Women Free to Choose Where to Give Birth? How Discourses of Risk, Blame and Responsibility Influence Birth Place Decisions." *Health, Risk, & Society*, vol. 16, no. 1, 28 Nov. 2013, pp. 51-67. *Taylor & Francis Online*, doi:10.1080/13698575.2013.859231.

Craven, Christa. "Claiming Respectable American Motherhood: Homebirth Mothers, Medical Officials, and the State." *Medical Anthropology Quarterly*, vol. 19, no. 2, June 2005, pp. 194-215. *Wiley Online Library*, doi:10.1525/maq.2005.19.2.194

Crotty, Michael. *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage Publications, 1998.

de Jonge, A., et al. "Perinatal Mortality and Morbidity Up to 28 Days After Birth Among 743, 070 Low-Risk Planned Home and Hospital Births: A Cohort Study Based on Three Merged National Databases." *BJOG: An International Journal of Obstetrics & Gynacology*, vol. 122, no. 5, Sept. 2014,

pp. 720-28. *Wiley Online Library*, doi:10.1111/1471-0528.13084.

Dejoy, Sharon Bernecki. "'Midwives are Nice, But…': Perceptions of Midwifery and Childbirth in an Undergraduate Class." *Journal of Midwifery & Women's Health*, vol. 55, no. 2, Mar./April 2010, pp. 117-23. *Wiley Online Library*, doi:10.1016/j.jmwh.2009.05.009.

DiFilippo, Shawna Healey. "Resistance and Relearning: Women's Experiences Choosing Midwifery and Homebirth in Ontario, Canada." *The Canadian Journal for the Study of Adult Education*, vol. 27, no. 3, June 2015, pp. 43-63.

Elder, Heather R., et al. "Investigating the Debate of Homebirth Safety: A Critical Review of Cohort Studies Focusing on Selected Infant Outcomes." *Japan Journal of Nursing Science*, vol. 13, no. 3, Jan. 2016, pp. 297-308. *Wiley Online Library*, doi:10.1111/jjns.12116.

Feeley, Claire, and Gill Thomson. "Tensions and Conflicts in 'Choice': Women's Experiences of Freebirthing in the UK." *Midwifery*, vol. 41, Oct. 2016, pp. 16-21. *Elsevier ScienceDirect*, doi:10.1016/j.midw.2016.07.014.

Fortier, Jacqueline H., and Marshall Godwin. "Doula Support Compared with Standard Care: Meta-Analysis of the Effects on the Rate of Medical Interventions During Labour for Low-Risk Women Delivering at Term." *Canadian Family Physician*, vol. 61, no. 6, June 2015, pp. e284-e92.

Goffman, Erving. *Stigma: Notes on the Management of Spoiled Identity*. Simon & Schuster, 1963.

Gram, Malene, et al. "'You Can't Use This, and You Mustn't Do That': A Qualitative Study of Non-Consumption Practices among Danish Pregnant Women and New Mothers." *Journal of Consumer Culture*, vol. 17, no. 2, Apr. 2016, pp. 433-51. *SAGE Journals*, doi:10.1177/1469540516646244.

Hays, Sharon. *The Cultural Contradictions of Motherhood*. Yale University Press, 1996.

Herek, Gregory M. "Why Tell If You're Not Asked? Self-disclosure, Intergroup Contact, and Heterosexuals' Attitudes Toward Lesbians and Gay Men." *Out in Force: Sexual Orientation and the Military*, edited by Gregory M. Herek et al., University of Chicago Press, 1996, pp. 197-225.

Hutton, Eileen K., et al. "Outcomes Associated with Planned Place of Birth Among Women with Low-Risk Pregnancies." *Canadian Medical Association Journal*, vol. 188, no. 5, 2016, pp. E80-E90.

Hylton, Mary. E. "Queer in Southern MSW Programs: Lesbian and Bisexual Women Discuss Stigma Management." *The Journal of Social Psychology*, vol. 146, no. 5, Oct. 2006, pp. 611-29. *Taylor & Francis Online*, doi:10.3200/SOCP.146.5.611-628.

Jouhki, Maija-Riitta. "Choosing Homebirth—The Women's Perspective." *Women and Birth*, vol. 25, no. 4, Dec. 2012, e56-e61. *Elsevier ScienceDirect*, doi:10.1016/j.wombi.2011.10.002.

Lothian, Judith A. "Risk, Safety, and Choice in Childbirth." *The Journal of Perinatal Education*, vol. 21, no. 1, Jan. 2012, pp. 45-47. *Proquest*, doi:10.1891/1058-1243.21.1.45.

Luce, Ann, et al. "'Is it Realistic?' The Portrayal of Pregnancy and Childbirth in the Media." *BMC Pregnancy and Childbirth*, vol. 16, no. 40, Feb. 2016, pp. 1-10. *Springer Link*, doi:10.1186/s12884-016-0827-x.

Lupton, Deborah. "'Precious Cargo': Foetal Subjects, Risk and Reproductive Citizenship." *Critical Public Health*, vol. 22, no. 3, Feb. 2012, pp. 329-40. *Taylor & Francis Online*, doi:10.1080/09581596.2012.657612.

Malacrida, Claudia, and Tiffany Boulton. "Women's Perceptions of Childbirth 'Choices': Competing Discourses of Motherhood, Sexuality, and Selflessness." *Gender and Society*, vol. 26, no. 5, Oct. 2012, pp. 748-772. *JSTOR*, doi:10.1177/0891243212452630.

Malacrida, Claudia, and Tiffany Boulton. "The Best Laid Plans? Women's Choices, Expectations and Experiences in Childbirth." *Health*, vol. 18, no. 1, Jan. 2014, pp. 41-59. *SAGE Journals*, doi:10.1177/1363459313476964.

Macdonald, Margaret. "Gender Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada." *Medical Anthropology Quarterly*, vol. 20, no. 2, June 2006, pp. 235-56. *Wiley Online Library*, doi:10.1525/maq.2006.20.2.235.

Miller, Amy Chasteen. "On the Margins of the Periphery: Unassisted Childbirth and the Management of Layered Stigma." *Sociological Spectrum*, vol. 32, no. 5, Jul 2012, pp. 406-23. *Taylor & Francis Online*, doi:10.1080/02732173.2012.694795.

Miller, Amy Chasteen, and Thomas E. Shriver. "Women's Childbirth Preferences and Practices in the United States." *Social Science & Medicine*, vol. 75, no. 4, 5 May 2012, pp. 709-716. *Elsevier ScienceDirect*, doi:10.1016/j.socscimed.2012.03.051

Miller, Tina. "'Is This What Motherhood Is All About?' Weaving Experiences and Discourse through Transition to First-Time Motherhood." *Gender & Society*, vol. 21, no. 3, June 2007, pp. 337-58. *JSTOR*, doi:10.1177/0891243207300561.

O'Boyle, Colm. "Deliberately Unassisted Birth in Ireland: Understanding Choice in Irish Maternity Services." *British Journal of Midwifery*, vol. 24, no. 3, 2016, pp. 181-87.

Reiger, Kerreen, and Rhea Dempsey. "Performing Birth in a Culture of Fear: An Embodied Crisis of Late Modernity." *Health Sociology*, vol. 15, no. 4, Oct. 2006, pp. 364-73.*Taylor & Francis Online*, doi:10.5172/hesr.2006.15.4.364.

Riessman, Catherine Kohler. *Narrative Methods for the Human Sciences*. Sage Publications, 2008.

Rooks, Judith P. "The Midwifery Model of Care." *Journal of Midwifery & Women's Health*, vol. 44, no. 4, July-Aug. 1999, pp. 370-74. *Wiley Online Library*, doi:10.1016/S0091-2182(99)00060-9.

Rutherford, Markella, and Selina Gallo-Cruz. "Selling the Ideal Birth: Rationalization and Re-Enchantment in the Marketing of Maternity Care." *Advances in Medical Sociology, Volume 10: Patients, Consumers and Civil Society*, edited by Susan M. Chambré and Melinda Goldner, Emerald Group Publishing, 2008, pp. 75-98.

Sangster, Sarah, and Melanie Bayly. "Anarchists, Naturalists, Hippies, and Artists: Beliefs about Midwifery Care and Those Who Choose It." *Canadian Journal of Midwifery Research and Practice*, vol. 15, no. 2, 2016, pp. 38-46.

Scambler, Graham, and Frederique Paoli. "Health Work, Female Sex Workers and HIV/AIDS: Global and Local Dimensions of Stigma and Deviance as Barriers to Effective Interventions." *Social Science & Medicine*, vol. 66, no. 8, Apr. 2008, pp. 1848-862. *Elsevier ScienceDirect*, doi:10.1016/j.socscimed .2008.01.002.

Snowden, Jonathan M., et al. "Planned Out-Of-Hospital Birth and Birth Outcomes." *The New England Journal of Medicine*, vol. 373, no. 27, Dec. 2015, pp. 2642-653. *New England Journal of Medicine Current*, doi:10.1056/ NEJMsa1501738.

Statistics Canada. "Live Births and Fetal Deaths (Stillbirths), by Place of Birth (Hospital and Non-Hospital), Canada, Provinces and Territories, Annual." *Statistics Canada*, www5.statcan.gc.ca/cansim/a26?id=1024516& retrLang=eng&lang=eng. Accessed 21 Aug. 2018.

Stoll, Kathrin, et al. "Why Are Young Canadians Afraid of Birth? A Survey Study of Childbirth Fear and Birth Preferences among Canadian University Students." *Midwifery*, vol. 30, no. 2, Feb. 2014, pp. 220-26. *Elsevier ScienceDirect*, doi:10.1016/j.midw.2013.07.017.

Sykes, Gresham M., and David Matza. "Techniques of Neutralization: A Theory of Delinquency." *American Sociological Review*, vol. 22, no. 6, Dec 1957, pp. 664-70. *JSTOR*, www.jstor.org/stable/2089195. Accessed 21 Aug. 21 2018.

Toyoki, Sammy, and Andrew D. Brown. "Stigma, Identity and Power: Managing Stigmatized Identities Through Discourse." *Human Relations*, vol. 67, no. 6, 2014, pp. 715-37. *SAGE Journals*, doi:10.1177/0018726713503024.

Viisainen, Kirsi. "The Moral Dangers of Home Birth: Parents' Perceptions of Risks in Home Birth in Finland. *Sociology of Health and Illness*, vol. 22, no. 6, Dec 2001, pp. 792-814. *Wiley Online Library,* doi:10.1111/1467-9566.00231

Yang, Lawrence Hsin, et al. "Culture and Stigma: Adding Moral Experience to Stigma Theory." *Social Science & Medicine*, vol. 64, no. 7, April 2007, pp. 1524-535. *Elsevier ScienceDirect*, doi:10.1016/j.socscimed.2006.11.013

Ye, Jiangfeng, et al. "Searching for the Optimal Rate of Medically Necessary Cesarean Delivery." *Birth*, vol. 41, no. 3, Sept. 2014, pp. 237-44. *Wiley Online Library*, doi:10.1111/birt.12104.

Zerubavel, Eviatar. "Personal Information and Social Life." *Symbolic Interaction*, vol. 5, no. 1, Spring 1982, pp. 97-109. *JSTOR*, doi:10.1525/si.1982.5.1.97.