The Social Dynamics of Childbirth:

A Women's Place is in the Home ?(1)

by Laura Climenko Johnson

and Constance A. Chapman

The reasons women and their mates choose a particular mode of childbirth and the relative advantages and disadvantages of home births versus hospital births has recently begun to attract the attention of a variety of researchers. The predominant North American pattern (the doctor-in-hospital system) is unique among industrial societies, and in recent years has been criticized from both the medical and feminist points of view. Critics have noted that rates of infant mortality are significantly lower in such countries as Great Britain and Holland, where a majority of mothers give birth at home assisted by midwives. (Haire; 1972)

Our own particular interest was in the effects of birth setting on the parents' experience of childbirth as well as their later adjustment to parenthood. In this context, Sheila Kitzinger, a British social anthropologist and childbirth educator, describes a home birth in the following terms:

> . . . the mother is in the security of an environment with which she is familiar and which she likes. The whole process seems more natural than it can in hospital and she is far less likely to be frightened. (Kitzinger; 1972:45)

The women we interviewed who had home births and the narrations we read of home births all described the event in

very powerful terms. As we read and talked, we came to suspect that power is a key variable in understanding home and hospital births. It is not the setting per se that affects a woman's experience of birth but rather the amount of power or control over the event that the woman and her mate can exert in each setting.

The most suggestive research on the subject of childbirth is a recent analysis of the social meaning of the North American doctor-in-hospital maternity health care system. (Shaw; 1974) This analysis of the institutional processing of maternity patients was based on field research in three different medical settings. Shaw observed that many of the standard hospital obstetrical procedures serve to ensure a powerless position for the maternity patients within the hospital system. Precisely at the time the woman is acquiring the new role of mother, a role in which she must assume active responsibility for the care of her child, she is assigned the passive, dependent role of patient. We are interested in the implications this dependency has for her relationships to her mate, her newborn and the society as a whole.

In the context of the present research, power has two relevant sociological dimensions. First, information is power. Expectant parents require information about the physiological processes of pregnancy and birth and about the effects of drugs on the mother and on the fetus. When a doctor inadvertently or purposely withholds this information from a pregnant woman, he is in a position of power and can more easily manipulate her. Furthermore, when a woman is not well informed about the birth process, childbirth often becomes a fearful, mystifying process. It has been documented elsewhere that women without information are more apt to neglect their own health care in general. (Morris and Sison; 1974) In fact, one thrust of the women's health movement has been to provide women with the information they need in order to remain or become healthy. (Boston Women's Health Book Collective; 1973, Reynard; 1972)

A second relevant sociological dimension of power is choice. During the course of a normal pregnancy and birth, doctors and other medical professionals make decisions about the correct procedure, medication and diet that a woman must follow. Most women, not having access to information about alternative courses of action, are in no position to question these decisions. And even if they do have the information, doctors' routines and hospital procedures are often not set up to allow women to choose between alternatives. In discussing the options a woman has in regard to choosing a doctor, Shaw (1974: 146) notes:

> Most women have no options about their accoucheur [birth attendant --midwife or obstetrician]. Those who begin with a private doctor have initial freedom, due to income, to pick among obstetricians . . . .[But] as long as there are no other options than other obstetricians, the woman is saddled with the obstetrical approach and the hospital. The knowledge of such practitioners that she has no choice decreases their incentive for pleasing her and providing the services that others, such as midwives and teachers of prepared childbirth, could provide.

Even in countries like Canada where a universal health insurance system exists to insure everyone of access to doctors and medical care, women are still denied a full range of options. In Toronto, for example, whilst some pre-natal classes are provided free through public health programmes other organizations charge $50.00 for a course, a fee which is not covered by health insurance. In addition, many doctors do charge above the provincial health insurance fee, thereby limiting women's initial choice of doctor. And, as Shaw points out, even when income does not limit choice, other psychological and sociological factors do.

When a woman is in a powerless position vis à vis her doctor and the hospital, there seem to be two main psychological consequences for her. First, her care becomes dehumanized and she undergoes what Goffman (1961) calls the "mortification of self." When a labouring woman enters hospital, she is stripped of all her personal effects, given a name tag and number, classified and finally subjected to the uncomfortable and impersonal ritual of enema and shaving. (Shaw; 1974: 65-67) During the birth itself, if she is allowed to remain conscious, her body is draped to such an extent that "the only more effective or more complete separation [of the person from the event] would be to have a wooden panel descend just below breasts, and prevent those on the delivery end from having to deal with her at all." (Shaw; 1974:84)*

A second consequence of the woman's powerless position is that her role in the birth process is minimized. All the forces which have been discussed so far combine to shift the emphasis for giving birth from the mother and child to the doctor. He becomes the star and director.

> As the director of the drama of birth, the obstetrician times the

*In one of Toronto's teaching hospitals, clinic gynecological patients are examined on tables which are divided in half by drapes. Thus the woman, from the waist up, does not exist for the examining doctor and medical students.

> scenes, directs the other actors in their places and roles, and modulates as best he can the emotional tone of the production. He can make a long or short delivery, depending on how much time he has, whether he wants to teach about doing a delivery, his interpretation of the patient's condition, etc. He directs the other actors in such a way that he can reserve a large or small role for himself. (Shaw 1974: 100)

Shaw also contends that the doctors' desire for a controlling role leads them to restrict fathers' participation in childbirth, even to excluding them completely from the delivery room. (Shaw 1974:100)

On the basis of her field experience, Shaw isolates a set of five characteristic features of the doctor-in-hospital maternity system--features which decrease patient control. These are: giving birth in the hospital setting; the medical monopoly on childbirth care; specialization and fragmentation of care; reliance on technology and anesthesia; and the use of power and status by predominantly male physicians. (Shaw 1974: 131-144)

In the years since Shaw completed her field research, there has been increased attention paid to alternative approaches to childbirth. For example, in both Canada and the United States there has recently developed interest in home birth and in alternatives to use of physicians as accoucheurs. (Haire 1972; Canadian Medical Association 1974:5-8; Levy 1974) Since 1966, 18 states in the United States have re-introduced nurse-midwives as birth attendants--partly to meet manpower shortages in obstetrics in certain geographical regions and partly to meet a growing need for more humane, family-centred maternity care. (American College of Nurse Midwifery: 1974) At the present time, Canada utilizes midwives only in the Northwest Territories; however, nurses' associations have begun work to legalize nurse-midwifery in Canada. (Canadian Nurses Association 1974)

In this paper we investigate some of the effects and some of the implications of alternatives to the doctor-in-hospital system. We contrast the birth experiences of groups of normal home and hospital births, in order to determine the relationship between birth setting and women's sense of power. We have investigated, first, the distinguishing characteristics of women who opt for the home setting and, second, the manner in which new mothers relate to their physical selves, their sense of themselves, their mate and their offspring. We have investigated the relationships between the following variables:

1. The socioeconomic status (SES) of home compared with hospital birth couples and the discrepancy between

SES of husbands and wives in the home and hospital birth groups.
2. The mothers' sense of power/powerlessness during childbirth in the home and hospital settings.
3. The mothers' sense of closeness to her newborn in the home and hospital settings.
4. The fathers' involvement in the experience of childbirth in the home and hospital settings.

Method

The subjects for the study were 54 women who, along with their mates, attended childbirth preparation classes at the Toronto Childbirth Education Association (CEA). One half of the women had elected to deliver at home. The other half delivered in hospital. The group of 27 home birth cases made up the entire population of home births fully recorded and documented in the files of the CEA. The 27 hospital cases were selected at random from the files of that organization.(2)

The main aim in selecting the two subgroups was to compare the characteristics of two groups of parents who experienced childbirth in different settings. This sample design was felt to be appropriate for exploratory investigation of some of the factors associated with childbirth setting. The lack of a systematic random sample design, combined with the small number of sample cases, precludes generalization of the findings to the larger population, as well as the use of statistical tests of significance of the results. Further, some of the measures used to assess the mothers' reactions and experiences have not as yet been used extensively in additional research and, consequently, must also be regarded with some caution.

The data on which this report is based come from the questionnaires sent out by CEA which the women are asked to complete shortly after giving birth. Information for the study included basic demographic background data for all couples as well as a set of open-ended questions about labour, delivery and early postpartum adjustment. The present study utilizes these available data and subjects the questionnaire responses to various types of content analysis. The births about which we are reporting took place over a five-year period from 1969-74.

In order to make meaningful comparisons between the home and hospital subgroups it was necessary to check that they were fairly similar on a number of factors. The parents who form the clientele of the Toronto CEA, and thus the parents who serve as subjects, tend to be upper-middle class, professional persons. The SES of the fathers(3)of the group as a whole, measured by Blishen's occupational scale of SES (Blishen 1971:499-507) is fairly high;(4)it is slightly higher

for the hospital subgroup than for the home subgroup. (See Table 1) Mean age and parity (number of children born to a mother) were also very close for the two subgroups. (See Table 1)

Almost all of the couples in the study group experienced "prepared childbirth," as selection for the study group was determined by participation in a series of natural childbirth classes. All of the birth experiences were normal: there were no Caesarian deliveries, no major complications and all of the babies were considered to be normal, healthy infants. With a single exception (unplanned), all of the births were attended by a physician. The hospital births took place at thirteen different hospitals. In all cases, both parents participated in the childbirth classes. In most of the cases, the fathers accompanied the mothers during labour. (See Table 2) With respect to the fathers' presence at the time of delivery, a considerably higher proportion of the fathers in the home birth subgroup witnessed delivery than did the fathers in the hospital subgroup. (See Table 3)

Results

1. Active/Passive Orientation to the Birth Experience: Previous research by Dianna Warshay on male/female speech differences has suggested that speech which includes a high proportion of verbs is indicative of an active orientation to the

TABLE 1

COMPARISON OF DEMOGRAPHIC CHARACTERISTICS OF HOME AND HOSPITAL SUBGROUPS

	Mean SES[a] (fathers)	Mean Age (mothers)	Mean Parity (mothers)
Home Birth Subgroup	58.7 (16)	26.1 years (17)	1.5 children (23)
Hospital Subgroup	63.3 (21)	26.3 (22)	1.2 children (18)

[a]Based on Blishen's Socioeconomic index for occupations (Blishen; 1971)

TABLE 2

PERCENTAGE OF FATHERS PRESENT DURING LABOUR IN HOME AND HOSPITAL SETTING

	Fathers Present	Fathers Absent
Home Birth Subgroup	92.6 (25)	7.4 (2)
Hospital Subgroup	88.9 (24)	11.1 (3)

TABLE 3

PERCENTAGES OF FATHERS IN HOME BIRTH AND HOSPITAL BIRTH SUBGROUPS ATTENDING THE BIRTH OF THEIR BABY

	Home Subgroup	Hospital Subgroup
Fathers Attending Birth	92.6 (25)	48.1 (13)

world, while speech which employs more nouns reflects passivity. (Warshay 1972:6) In the present study, an index of activity was devised, assuming that the verb form of reference to birth was indicative of an active orientation, while a noun form of reference indicated passive orientation. Thus, for example, the phrase, "I delivered at 7 o'clock" was coded active, while "the delivery was at 7 o'clock" was coded passive. The data for this comparison were obtained from women's written responses to the following two questions:

1. What, if anything, surprised you about your labour and delivery?
2. General comments about your labour and delivery.

Analysis of the data revealed that the home birth subgroup used a higher ratio of verbs to nouns to describe the birth than did the hospital subgroup. (See Table 4)

TABLE 4

MEAN ACTIVITY SCORES [a] OF WOMEN IN HOME BIRTH AND HOSPITAL BIRTH SUBGROUPS

	Home Subgroup	Hospital Subgroup
Mean Activity Score	2.2 (27)	0.6 (27)

[a] Ratio of verb to noun birth references

2. Fathers' Involvement in the Birth Experience: The number of times a woman refers to her mate in her description of her labour and delivery was assumed to indicate the relative degree to which he is involved in the experience of childbirth. Women who delivered in the home setting tended to mention their mates two and a half times more frequently than did women giving birth in hospital. (See Table 5) Kitzinger (1971) notes that having the husband present at the birth does not always mean that he will be a significant part of that experience. The hospital routine, the unfamiliarity of the hospital setting, along with the doctor's relationship to the woman, is often enough to make the husband an outsider to the birth experience. Also, in hospital, the husband is set home after the birth and the woman is left by herself. The following comment made by a new father

TABLE 5

MEAN NUMBER OF MATE REFERENCES OF WOMEN IN HOME BIRTH AND HOSPITAL BIRTH SUBGROUPS

	Home Subgroup	Hospital Subgroup
Mean Mate References	5.7 (27)	2.2 (27)

in the home birth subgroup supports this notion: "This joyous experience was too warm, too intimate to share with a hospital." In contrast, the following statement by a hospital subgroup mother whose husband did not attend the birth, suggests a sense of loss at his exclusion: "I did not experience the real joy of birth until I could share it with my husband in the recovery room."

3. Mothers' Perception of Closeness to/Distance from Baby: Mothers differ in the degree of closeness which they feel to their newborn infant. The term(s) used by mothers to refer to the infant was used as an index of this sentiment. A scale of closeness/distance was constructed in the following manner. All of the subjects' labour reports were surveyed and all baby reference words were recorded. These words were listed randomly and were presented to 10 judges who were instructed to rate them on a 5 point scale on which the poles were labelled "close" and "distant." Males and females, parents and non-parents were represented among the judges. There was a high level of agreement among judges. The resulting ten point scale, in order of decreasing closeness, appears in Figure 1. Lower numbers indicate greater closeness, high numbers indicate distance.

One difference between the home and hospital settings is that women in the home setting have more and sooner initial contact with their babies. From this we expected that home birth mothers would feel closer to their newborns than would hospital mothers. Statements from the labour reports support this pattern. For example, a 25-year-old mother, speaking of her first child born at home wrote: "I was absolutely amazed that I wasn't afraid of the baby when he was born." Another home birth mother whose first two children were born in hospital described her third birth experience as follows:

> Of my three births this has been the most wonderful for both my husband and myself. . . . The feeling of wonder and closeness to the baby came immediately and was much stronger than with the other two.

A hospital mother (first child, 25 years old) answered: "When the baby was born I expected to feel related to her but I didn't." We thus expected that the maternal closeness scores for the home birth subgroup would be lower than for the hospital subgroup. This, in fact, is the case, although the difference between the two groups is not as great as we had expected. (See Table 6)

4. Socioeconomic Status One of the most interesting and suggestive findings from this study is the relationship between mothers' and fathers' SES. On the Blishen scale, we found

FIGURE 1

MATERNAL DISTANCE/CLOSENESS TO NEWBORN AS REFLECTED IN BABY TERMINOLOGY

BABY TERMINOLOGY	RANKING
Given Name	1
My/Our baby	2
S/he/him/her	3
My/Our Son/Daughter	4
Her brother/sister	5
The new sister/brother	6
"Baby"	7
The Baby	8
The infant	9
It	10

TABLE 6

MEAN MATERNAL CLOSENESS SCORES OF WOMEN IN HOME BIRTH AND HOSPITAL BIRTH SUBGROUPS

	Home Subgroup	Hospital Subgroup
Mean Maternal Closeness Scores	5.8 (27)	6.55 (27)

that the SES rating of the women giving birth at home was nearly identical to that of their husbands. However, the rating of the woman giving birth at hospital was well below that of her mate. (See Table 7)

Our data suggest that in the work world, these home birth women are very much the equal of their mates. We hypothesize that this sense of equality carries over into the birth setting; these women choose to give birth to their babies in a place where they can also maintain some control vis à vis the medical system. As Shaw has suggested, this is most easily accomplished outside the hospital setting. (Shaw 1974:124-5)

Discussion

The results of this study suggest that, relative to women who give birth in hospital, women who give birth at home tend to see themselves as active, powerful individuals. The women who selected themselves into the home birth subgroup appear to have more egalitarian relationships with their mates than do the women in the hospital subgroup. We have speculated that women in the home birth subgroup generally perceive themselves as independent and powerful and thus are motivated to choose a birth setting which will enable them to maximize their own power. Our results do show that women who deliver at home tend to describe the birth experience in more active terms than do the women in the hospital subgroup. Consistent with these results, we would expect that the very experience of home birth tends to increase women's sense of their own power--however, a test of this notion would require data which are unavailable at present.

TABLE 7

MEAN SES RATING FOR WOMEN AND MEN IN HOME BIRTH AND HOSPITAL BIRTH SUBGROUPS

	Home Subgroups	Hospital Subgroup
Women's SES	58.3	56.6
	(12)	(16)
Men's SES	58.7	63.3
	(16)	(21)

The data in the present study also suggest that birth setting affects the mother's perception of her relationship to her newborn and her perception of the father's involvement in the birth experience. Mothers in the home birth subgroup appeared to feel slightly closer to their newborns than did hospital subgroup mothers. Home birth mothers attributed to their mates a larger role in the birth experience than did hospital mothers--despite the fact that all fathers in the study group had participated in childbirth preparation classes. From this, we would expect that postpartum adjustment to parenthood would be easier for home birthing parents; in order to test this prediction longitudinal data would be needed.

Given the exploratory nature of this study it is not possible to draw any major conclusions. Nevertheless, if we are concerned with the experiences of women giving birth, the results suggest interesting differences between the hospital and home birth groups which require further attention from both the medical profession and other researchers.

NOTES

1. Data for this study were collected in 1975 from records of the Toronto Childbirth Education Association, whose generosity in making them available is hereby gratefully acknowledged. The authors wish to express their appreciation to the teachers of the CEA for their interest and constructive criticism of this research.

2. Technically, the 27 home births subjects constitute a population, while the 27 hospital birth subjects are a sample. Since it was felt that this terminology might lead to confusion, the groups were labelled as follows: The total 54 subjects = the study group. This is comprised of a hospital birth subgroup of 27 cases and a home birth subgroup of 27.

3. The authors are loathe to perpetuate the pattern of using fathers' SES to locate families in the status structure--nevertheless, the data on fathers' occupations were more complete than the data on mothers' occupations.

4. Mean SES index scores for fathers in the study group and for home and hospital subgroups fall within the top 9% of the Ontario labour force according to 1961 statistics. (Blishen 1971:506)

REFERENCES

American College of Nurse-Midwifery 1974 "Legislative Review: Patterns of Legislation and the Practice of Nurse-Midwifery" Washington, D.C. 1000 Vermont Ave. N.W. (mimeographed)

Blishen, Bernard R. 1971 "A Socioeconomic Index for Occupations in Canada," Canadian Society, Sociological Perspectives. Edited by Bernard Blishen, et al. Toronto: Macmillan.

Boston Women's Health Collective 1973 Our Bodies, Ourselves. New York: Simon and Schuster.

Canadian Medical Association 1974 Mediscope Special Supplement on Midwifery in North America, Vol. 2, no. 4, pp. 5-8.

Canadian Nurses' Association 1974 "Statement on the Nurse-Midwife." Ottawa, Ontario.

Goffman, Erving 1961 Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, Garden City, New York: Doubleday.

Haire, Doris 1972 The Cultural Warping of Childbirth. Seattle, Washington: International Childbirth Education Association.

Kitzinger, Sheila 1971 Giving Birth: The Parents' Emotions in Childbirth. London: Victor Gollancz, Ltd.

1972 The Experience of Childbirth. Middlesex, England: Penguin Books.

Levy, Judith 1974 "Sexism in the Daily Practice and Teaching of Obstetrics." Paper presented at the Annual Conference on Psychosomatic Obstetrics and Gynecology, January 1974, Key Biscayne, Florida (mimeographed).

Mead, Margaret and Niles Newton 1967 "Cultural Patterning of Perinatal Behavior" in Stephen A. Richardson and Alan Guttmacher (eds.) Childbearing: Its Social and Psychological Aspects. Williams and Wilkins Co. pp. 142-244.

Morris, Naomi and Benjamin Sison 1974 "Correlates of Female Powerlessness: Parity, Methods of Birth Control. Pregnancy," Journal of Marriage and the Family, Vol. 36, no. 4, pp. 708-712.

Reynard, Murial Joyce 1972 Gynecological Self Help: An Analysis of its Impact on the Delivery and Use of Medical Care for Women. M.S. Thesis: School of Allied Health Professions State University of New York at Stonybrook (unpublished).

Shaw, Nancy Stoller 1974 Forced Labor: Maternity Care in the United States. New York: Pergamon Press.