UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

BODY STORIES OF POSTPARTUM WOMEN: EXAMINING SOCIAL INFLUENCES ON FIRST-TIME MOTHERS' BODY IMAGE

A THESIS

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

Degree of

MASTER OF ARTS

By

ISABELLA A. CHIARELI

Norman, Oklahoma

2020

BODY STORIES OF POSTPARTUM WOMEN: EXAMINING SOCIAL INFLUENCES ON FIRST-TIME MOTHERS' BODY IMAGE

A THESIS APPROVED FOR THE

DEPARTMENT OF SOCIOLOGY

BY THE COMMITTEE CONSISTING OF

Dr. Ann Beutel, Chair

Dr. Stephanie Burge

Dr. B. Mitchell Peck

~ Dedicated to my father ~

Dad, thank you for giving me a love for sociology and qualitative research. I could not have gotten this far without your encouragement and support to push for my dreams.

Acknowledgements

First and foremost, I would like to thank my thesis advisor, Dr. Ann Beutel, for the countless hours she committed to advising all aspects of the research and writing of this thesis. My success in this process is in no small way due to the support and feedback she has provided me over the past year. I am truly grateful for the dedicated care she put into helping me develop and polish this research, which has been incredibly meaningful to me. Her continued mentorship has given me a passion for gender studies within the field of Sociology and a desire to continue growing as a scholar.

I would also like to thank my other thesis committee members, Dr. Stephanie Burge and Dr. B. Mitchell Peck, both of whom were so gracious in their time, feedback, and support of my qualitative research. With expertise in the life course and medical sociology, their knowledge and guidance has added greatly to the depth and quality of my research. I also wish to recognize the support and friendship I have received from my cohort and esteemed members of our department.

Finally, I would like to thank my parents, Teresa and Dr. Antonio Chiareli, my grandparents, Helena and Wilson Chiareli, my aunt, Dr. Alessandra Chiareli, and my amazing partner, Hugo Preciado, for their incredible love and support of my education and academic career. Each of them has had a hand in my success over the years, which has allowed me to reach this milestone. I am especially grateful to my dad, Dr. Antonio Chiareli, a fellow sociologist, who introduced me to sociology at a young age and gave me the tools to pursue my passion for social justice.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

Pregnancy and childbirth remain a mystery to many. This research sheds light on these life-altering experiences and provides insights into how women view the changes their bodies undergo due to pregnancy and childbirth, a topic that has yet to be adequately studied from a sociological perspective. Through the use of in-depth, qualitative interviews, I delve into the birth narratives of twelve women who are adjusting to their postpartum bodies. The goal of this research is to better understand how the sense of body image that manifests itself during the early postpartum months develops. I focus on answering the question: what is body image like among postpartum women and what influences it? I also delve into questions of how beauty standards and support systems shape one's postpartum body satisfaction and/or body regret. My findings suggest that support systems, body function, and preparation are paramount to the level of satisfaction women feel in their postpartum bodies that can be understood using the lenses of Doing Gender, Symbolic Interactionism, and Role Theory.

Keywords: body image, body satisfaction, childbirth, gender expectations.

INTRODUCTION

Childbirth is a topic of interest among social scientists and laypersons alike. The lived experiences of pregnancy and childbirth and the postpartum period can fundamentally shape how women view themselves and their lives. This thesis approaches the issue of body image among postpartum women who are processing changes that happened to their bodies during pregnancy and childbirth. I ask the question: what is body image like among postpartum women and what influences it? In answering this question, I explore issues that will help sociologists better understand postpartum body image in a society with pervasive messages about the physical ideals that women *should* maintain in order to be considered beautiful. I am particularly interested in how these self-perceptions of the body might vary by birth experiences, support systems, and childbirth education. As a birth doula,[1] women often approach me with narratives about their pregnancy, childbirth, and motherhood experiences. This study explores the meanings that body changes carry and how they play into feelings of body satisfaction or regret among first-time postpartum mothers**.**

I begin by reviewing literature on the presence and influence of medicalization on childbirth, how women's body image is shaped in society, and how support systems and a sense of control lend themselves to more positive childbirth experiences and postpartum body image outcomes. I then discuss viewing postpartum body image through the lenses of Doing Gender (West and Zimmerman 1987) and Symbolic Interactionism (Blumer 1969). Next, I describe how I conducted in-depth interviews with twelve women who varied by type of birth experience (hospital versus midwife-assisted, non-hospital birth), each of whom were processing the changes to their bodies that were a result of pregnancy and childbirth, the life-

[1]A birth doula serves as a member of a woman's birth team by providing informational, physical, and emotional support to women and their partners; they help educate women about their bodies and the childbirth experience, help them in creating a comprehensive birth plan for their labor, connect them with additional resources, and support them in their birth preferences and decisions by helping them to advocate for themselves and establish an active role and voice in their childbirth experience.

altering experiences that gave them entrée to motherhood. In brief, my findings illustrate the impact of support systems and childbirth education (what I refer to as "preparation" for childbirth) on labor and delivery experiences and postpartum body image, as well as the relationship between *form* and *function* of a woman's body as she resists or internalizes social pressures to "fix" a body that has been altered by pregnancy and childbirth. I also uncover a number of unexpected associations, including the relationship between the mothering identity and the female athlete identity. I then discuss my findings and how Doing Gender emerged as the most prominent theoretical framework through which to position this research, aided by Symbolic Interactionism and Role Theory.

BACKGROUND

Medicalization of Pregnancy and Childbirth

Childbirth has been dramatically transformed since its medicalization within the last 100 years. This has not only altered the experience of childbirth itself, but also the way that women view themselves in the process. One significant change is that childbirth is much less celebrated as a female experience than it once was (Gaskin 2011); this may, in part, be a reason that some new mothers feel dissatisfaction with their postpartum bodies. Before the institutionalization of western medicine, childbirth was a field dominated almost entirely by women (Rothman 2016; Gaskin 2011; Ehrenreich and English 2010). However, childbirth in the modern era has become increasingly medicalized (e.g., births in hospitals attended by physicians with the use of labor-inducing drugs and other interventions), giving women much less control over their labor experiences. In 1970, 5.5% of U.S. births culminated in cesareans (Placek and Taffel 1980). As of 2017, the national average was 32%, according to the Centers for Disease Control (Hamilton et al. 2018); this considerable spike is not an indication of a large decline in women's health during pregnancy and labor, but rather a change in the way

society views the role of medicine within childbirth (i.e., western medicine must be present to protect a woman and her baby from possible risks throughout pregnancy, labor, and thereafter). We now know that the medicalization of childbirth throughout the United States, clearly illustrated by the stark rise in medically unnecessary[2] cesarean sections, has been found to increase health and mortality risks in laboring women (Lee and Kirkman 2008; London 2008; London 2004). Since the 1980s, the World Health Organization (WHO) has recommended that cesarean interventions remain between 10% and 15% of births (Lindmeier 2015). As compared to the rest of the country, the south-central U.S.,[3] where this research was conducted, has some of the highest rates of cesarean procedures, which remain consistently around 35% (NCHS 2018). Some states in this part of the country have even exceeded 40% in recent years (OSDH 2017). While data on the use of non-cesarean interventions (e.g., Pitocin, epidurals, pain reducing drugs, and episiotomies) in vaginal deliveries is limited, Declerq et al. (2013) note that these are implemented far more regularly than is recommended "best practice" by the American College of Obstetricians and Gynecologists (ACOG) (2018).

Considerable movement toward the medicalization of childbirth has fundamentally altered both labor and delivery, as well as the way women think about themselves in relation to this experience. This is accomplished by categorizing the pregnant/laboring woman as a "patient" (i.e., something is wrong with her body that must be made normal). Because our society has established that the "fixing" must be done by a physician, it is not difficult to impart a normalization of institutionalized medicine onto women's pregnancy and childbirth experiences as most effective for the woman and her "condition" (Rimke 2018; Cooper et al. 2012; Miller and Shriver 2012). Feminist scholars argue that the medicalization of childbirth

[2] Cesareans that are deemed medically unnecessary are those done for the sake of predictability; the mother may make this decision to avoid having to experience labor pains or unplanned events during labor, and possibly so she can choose her baby's birthday. However, these cesareans are specifically not due to medical crisis where the mother or baby's health is at risk (e.g., because of maternal hemorrhage, low fetal heartrate) (Curtin et al. 2015).
[3] South-eastern U.S. cesarean rates tend to slightly exceed those in south-central U.S., although numbers vary some from year to year (NCHS 2018).

stems from a tendency by social institutions to minimize minority (socially disadvantaged) groups, including women, racial-ethnic minorities, and LGBTQIA+ groups (Kattari 2015; Miller and Grollman 2015; DeVault 1996).

The modern hospital system's habit of treating laboring women like patients who have something wrong with them has taken the control away from women, and we can see this even in the language we use to talk about childbirth (Rimke 2018; Davis and Loughran 2017); in the medical world, it is the obstetrician who "delivers" a baby rather than the laboring woman herself. This differs greatly from natural birth professionals[4] who "help" a woman give birth. In today's society, many movements and organizations advocate for greater body autonomy for women, especially where reproductive issues are concerned, so why does this not also apply to childbirth? One answer is that historical changes in medicine have influenced the relationship between physician and patient that guides many of the decisions women are able to make about their childbirth experiences and their bodies (Hesse and Rauscher 2018; Conrad 2007; Guillemin and Holstrom 1986; Parsons 1939).

These developments have changed the way U.S. society views childbirth, as well as the labor and delivery experience (Rothman 2016; Gaskin 2011). In the western context, it could be argued that childbirth is not treated any differently in the medical world than any other case brought to a physician's attention, such as a disease or a broken arm. In addition, Shilling (2012:41, quoting Martin 1989 [1987]:94) discusses the ways in which:

> … bureaucratic regimes frequently subject women's bodies to more control than men's bodies. This is because women are expected to manage and conceal menstruation, pregnancy, and menopause 'in institutions whose organization of time and space takes little cognizance of them.'

[4] A natural birth professional as defined in this thesis could include, but is not limited to, a birth doula, midwife, prenatal/postpartum chiropractor, hypnotherapist, massage therapist, or an aromatherapy expert.

Recent decades have seen not only medicalization but also demedicalization of labor and delivery. Indeed, these processes can "operate simultaneously" (Torres 2014:160), which is paramount to understanding current birth culture in the United States. Efforts to demedicalize hospital births date back to the 1960s and 70s (Zwier 2019), and there has been an increasing number of women choosing more natural options for their labors and deliveries in hospital settings. Where once women were often sedated and/or had no family members present for the birth of their babies, now it is typical to have family members (e.g., partners, mothers, sisters) and friends present to give support (Harte et al. 2016; Caton, Frölich, and Euliano 2002). Increasingly, women have complimentary birth workers (i.e., birth professionals other than doctors and nurses, such as doulas) present as well. Instead of full anesthesia during delivery, childbirth techniques such as Lamaze or hypnobirthing often are used to improve the birth experience and to try to reduce or avoid the use of pain medication (Klaus, Kennell, and Klaus 2012; Lothian 2011). Some medical providers have changed parts of their procedures, such as allowing women to choose delayed cord clamping, and fewer push for cesareans as a first resort. Some hospitals have enacted policy changes as well, such as allowing women to keep babies in their room with them rather than taking babies to a nursery (CDC 2020).

Yet, even these less medicalized births still differ from those in communal cultures in which women dominate childbirth and find great celebration over their body's accomplishments; this kind of multigenerational celebration is harder to find in U.S. society (Gaskin 2011). Also illustrating the importance of a woman's control in birthing, a qualitative study of Canadian women with different care providers found that a sense of well-being and control was pivotal for a woman to have positive feelings toward her birth experience (Cook and Loomis 2012). Efforts by natural birth professionals to reorient perceptions about childbirth are gaining traction in the U.S., however. More and more, we see expectant mothers

choosing midwives and doulas to help facilitate positive and empowering birth experiences, also providing them greater control and a sense of agency over their labor and delivery, which still can be difficult to come by in hospital environments (Hesse and Rauscher 2018; Carter et al. 2017; Davis and Loughran 2017; Namey and Drapkin 2010).[5] This is done especially well through the help of birth doulas, many of whom help clients create birth plans that dictate the choices and preferences for their birth experiences.[6] Doulas and other birth educators also provide an avenue for women and their partners to thoroughly understand what to expect during labor by suggesting resources, including hands-on classes, books, and other self-educating tools.[7] Having knowledge and a sense of control over a woman's labor can significantly improve her experience overall, even in a medicalized environment (Davis and Loughran 2017); not only is a woman aware of her options, but she is better able to decide which interventions are best for her and her baby, even despite pressures by care providers to receive interventions. An overall sense of control during labor and delivery through self-educating and support systems could help create a foundation for more positive feelings about body changes after giving birth.

Body Image

From a sociological perspective, the definition of body image encompasses both a personal and a social element (Kelly and Field 1997); it is comprised of what an individual feels about how her body looks and functions, but it also embodies her sense of external social forces that influence her perception of self, such as her feelings of beauty and self-worth,

[5] In 2017, 9.1% of all U.S. births were attended by certified nurse-midwives or certified midwives (American College of Nurse Midwives 2019).
[6] In a 2012 U.S. survey of mothers, 6% of women reported using a doula during childbirth (Declerq et al. 2013).
[7] Some doulas will create a detailed birth plan with their clients that dictates what the clients desire for every possible outcome, including the best-case scenario that they have planned for. The birth plan may include what the client desires in the case that medical intervention becomes necessary. She may outline what interventions she would like to try before transitioning to a cesarean, and she may also indicate what kind of approach to a cesarean she would prefer ("family-centered" cesareans incorporate a much gentler approach). The birth plan may also include how the family would like to proceed if the baby does not survive.

which are socially constructed (Lovejoy 2001). The social standards that guide one's body image can vary greatly by culture, gender, race-ethnicity, belief system, and so forth (Winter 2019; Ciciurkaite and Perry 2017; Lovejoy 2001; Kelly and Field 1997). Beauty standards can be so deeply ingrained in society, that a woman can be seen as deviant if she does not conform her body to these norms. Reischer and Koo (2004:302) explain that, "If maintaining a 'beautiful' body – carefully monitored and controlled in its size and appearance – is a symbol of cultural and social cooperation, then striving for a body in direct opposition to that ideal is tantamount to civil disobedience." Fahs (2011:451) recounts the staunch "hostility" that female body norm breakers are met with, even for acts as inconsequential as choosing not to shave legs or armpits. As Martin (2017:91) points out, "Deciding whether, when, and how to have a child is an embodied process involving calculations about one's ability and desire to conceive, gestate, birth, and raise a child." Thus, social pressures about how the body should look can fundamentally influence the gendered experience of not only being a woman, but also being a mother in our society (Malacrida 2008). In other words, the female body bears a symbolic role in reinforcing femininity and gendered norms, and postpartum women are not excluded from these expectations.

Body image goes beyond self-perceptions of physical appearance of a woman's body (Clay, Vignoles, and Dittmar 2005); it also permeates her very sense of self-worth, which can be problematic if her social reality constantly reinforces the expectation of certain physical ideals. "What her body tells her, what she knows (and displays) by virtue of her bodily experience" (Jordan and Davis-Floyd 1993:152), or what Martin (2017:91) calls "embodied knowledge," is often in conflict with the outside world. Over 80% of U.S. women find their bodies distasteful in some way (Henderson and Ellison 2015); negative feelings about the body, and efforts to fix what they are not pleased with, can be highly associated with psychological disorders and self-esteem issues (Rimke 2018).

Unrealistic ideals mislead women into believing not only that they must reach and maintain a certain body type, but that this is attainable and indeed required for all women. Such expectations arise, according to Shilling (2012:39) as "the body in consumer culture… [which] has helped promote the 'performing self,' which treats the body as a machine to be finely tuned, cared for, reconstructed, and carefully presented…" The media has long been a rousing factor in convincing women to try to achieve unrealistic physical ideals, even if that means going to dangerous lengths to reach them (Luce et al. 2016; Brewis 1999). Shilling (2012:39) notes that social structures such as the media:

> …promote among people the experience of both becoming their bodies, in the sense of identifying themselves either negatively or positively with the 'exterior' of the body, and of being regularly anxious about the possibility that their body will let them down or 'fall apart' if they withdraw from its constant work and scrutiny.

This, no doubt, breeds "distorted perceptions" about what a woman's body should look like. In fact, Shilling notes that "body anxiety is central" to the maintenance of socially constructed expectations for the body (2012:39). These expectations[8] are pervasive in their influence over a woman's self-worth (Luce et al. 2016; Fox and Neiterman 2015; Chae 2014; Jordan, Capdevila, and Johnson 2005). At the interactional level, research (e.g., Hutchinson and Rappe 2007) also points to the influence of peers on young women's body image concerns.

And what of the postpartum woman who must now come to grips with many physical changes from pregnancy and childbirth? Many body changes are difficult to accept when, at every turn, she is reminded of her social responsibility to "get your body back!" How many magazines praise celebrities for how quickly they returned to their pre-baby bodies? How many films depict mothers with unrealistically perfect figures? Women may deal with

[8] It is worth noting the differences in body image that exist across races and ethnicities (e.g., Lovejoy 2001). Henriques, Calhoun, and Cann (1996:695) note the lower rates of eating disorders and higher rates of body satisfaction for black women, when compared with white women in the U.S. However, they also note that higher satisfaction extends to "situational social factors," meaning that for black women, gaining social feedback, be it positive or negative, does not significantly influence body image, while it does to a much greater extent for white women.

feelings of failure over an inability to meet unachievable standards of "beauty" that can be much harder to reach after childbirth (Adomaitis and Johnson 2019; Reischer and Koo 2004).

It is important to note that factors other than pregnancy, labor, and delivery experiences and societal beauty standards may affect how women feel about their bodies after childbirth. Fowles and Walker (2006:192) report that many postpartum women practice unhealthy nutrition (having much to do with weight retention), which they believe may be linked to "less self-care and a riskier lifestyle after childbirth," and that this situation is, not surprisingly, even more precarious for women of a lower socioeconomic standing (see also: Roosevelt and Low 2020; Guglielminotti et al. 2019). Poor self-care may also be associated with cultural values surrounding motherhood in which a woman sets her own needs aside in order to focus on mothering her child (Hays 1996). Because many postpartum women are occupied with the care of their infant, making it difficult for them to put forth effort toward their own bodies, it stands to reason that self-esteem issues may only grow – "My body has changed, and now I have less time to get it back."

This qualitative study tackles the issue of body image among postpartum women in order to bring greater awareness to their lived experiences and the societal expectations put on them. Interviews with new mothers were aimed at gauging the feelings that these women have about the changes their bodies have undergone, and how these play into body satisfaction or regret, or a mix of the two. Internalizing a sense of satisfaction or regret means that a woman feels that her self-worth (be that physical, social, or other) is impacted by the way her body looked (looks) or performed (performs) during pregnancy, labor, and after childbirth. For postpartum women, changes caused by pregnancy, such as weight gain, stretch marks, breast and nipple growth, vaginal changes, belly overhang, more visible veins on the breast or legs (varicose veins), and hair loss could contribute significantly to her body image. Possible negative connotations and gendered social expectations associated with these changes could

shape a woman's self-perceptions, leading her to think there is now something *wrong* with her body. Literature (e.g., Hallam et al. 2019) suggests postpartum women often struggle to feel confident about their bodies when they are not yet physically capable of even attempting to achieve the high (and difficult to attain) physical standards required by society, such as getting their pre-pregnancy bodies back.

In my research, I was interested in investigating whether type of birth experience was associated with how women felt about the changes in their bodies. Natural birth and feminist movements aim to empower women and place a higher value on the female body and its reproductive abilities by regaining control of childbirth through acquiring deeper personal knowledge of one's own body, pregnancy, labor and delivery, and the postpartum phase (Lee and Kirkman 2008). This, in turn, should promote a more positive perception of the postpartum body. One tangible way of accomplishing this, is through the use of a birth doula; by meeting with clients regularly during their pregnancies, doulas are able to answer their questions and provide them the resources they need to make informed decisions for themselves and their babies. Having the support of a doula also helps women feel more confident in their choices, even when they are not necessarily supported by their care provider as per hospital policy[9] or a physician's personal preference.[10]

Along with doulas, midwives and other natural birth professionals provide similar support to their clients; they may even meet with skeptical family members or friends who will be present during labor, providing them with the information they need to feel confident that their loved one is in good hands, and to reassure them that the midwifery team is

[9] Many hospitals have certain dated policies in place that contradict "best practice" procedures; physicians may be constrained within these policies for the sake of avoiding lawsuits, and to comply with different malpractice insurance stipulations (ACOG 2018).

[10] It is beyond a doula's scope of practice to make decisions for her client. She may suggest a number of options to help the laboring woman avoid medical interventions, giving her as much information about each of her choices so that she can feel confident going forward. Doulas may also provide the emotional support that a client needs to remain resolute in her decisions, and she may advocate for her client by helping her to communicate to her care provider by making use of correct medical terminology as well as her knowledge of medical procedures, equipment, etc. In this way, a doula often serves as a mediator between client and care provider.

equipped to safely support and empower a woman in labor. As opposed to obstetricians, midwives remain with their clients throughout labor, observing their progress, and rarely checking for cervical dilation, unless specifically asked for by the laboring woman. It is even more rare for midwives to perform episiotomies or break a woman's bag of waters. However, they often make use of dopplers (non-continuous fetal heart rate monitors), which are non-invasive. These measures allow midwives to help women through their labors without interrupting the natural birth process. They also encourage the use of a number of natural relaxation measures to promote the woman's optimal comfort, reduce fear and anxiety, and they provide lots of verbal encouragement and feedback. Instead of narratives such as, "Look what awful things are happening to my body!" birth doulas and other natural birth professionals encourage more affirmative narratives like "Look what my body can do (i.e., create, house, birth, and sustain this small human)!" These small modifications to childbirth language fundamentally impact the mindset of many women as they approach their childbirth experience.

This is not to say that a medical model for childbirth is inherently bad. Indeed, many women use advanced medical technology to give their bodies a chance at carrying a baby to term, or even getting pregnant in the first place. Some women need cesareans to safely give birth, and medical technologies can assist women in achieving what their bodies may have otherwise been incapable of doing. Nonetheless, it is important to recognize possible connections between over-medicalization and poor infant and maternal outcomes as I discussed above. Most women do not need medical interventions to safely give birth; providing women with strong support and knowledge can empower them to birth naturally and to feel confident in their laboring bodies and their postpartum body changes.

Support Systems

A thriving support system could mitigate negative social influences on a woman and possible negative feelings she may have about her post-baby body. Indeed, after childbirth, many women feel discomfort exposing their altered bodies to their partners. Even in supportive relationships, women may feel anxious or self-conscious around their partners when resuming sexual activity (Olsson et al. 2005) or when their partners see how their bodies have changed. This research considers how a support system can impact concerns over a postpartum woman's "new look," and the possible interplay between a support system and social mechanisms, such as the media, other relationships, or social identities, that could pressure women to meet a particular physical standard in order to feel beautiful (Clay et al. 2005).

This research delves into women's childbirth narratives in order to answer the question: what is body image like among postpartum women and what influences it? I was particularly interested in the possible dichotomy between hospital/medicalized births and that of births with natural birth professionals in terms of regret or celebration of a woman's body changes related to pregnancy and childbirth. Existing literature, as well as my work as a birth doula, suggest that women who have knowledge of their bodies and of pregnancy and childbirth, have positive support systems, and have access to educational resources, may have higher postpartum body satisfaction than women who do not (Stoll et al. 2014; Namey and Drapkin 2010; Manning 1983).

Embodied Mothering

In contrast to the possible association between broad cultural beauty standards and postpartum body-image describe earlier, a strong connection can also exist between the female body and a number of social expectations that revolve around mothering specifically.

Waggoner (2017) demonstrates this by discussing what she calls "anticipatory motherhood," which promotes long-established gender ideals about what women should and should not do with their bodies, not only during pregnancy, but before (what she refers to as the "zero trimester") and after. She emphasizes the socially valued act of motherly self-sacrifice for the sake of one's child, which some feminists believe reduces a woman and her body to no more than a reproductive vessel. This is essentially a part of what Hays (1996) refers to as "intensive mothering," a common cultural practice, at least among white, middle-class mothers. Waggoner admits to the complexities of this discourse. For instance, one might argue that greater emphasis given to women's reproduction could be an avenue for more research and better maternal and infant care. On the other hand, this treads a fine line between what might empower a woman, and what might hinder her due to firmly established gender norms and values.

Waggoner also acknowledges the conflicting relationship between the identity of mother and the identity of woman. Most women subscribe to multiple identities, and due to social and gendered expectations, these may not necessarily complement each other. Some women may be mothers and may work outside the home; others may be married and do not desire children, and so forth. In these cases, it can be difficult to respond to social expectations as women navigate conflicting roles or identities.

In terms of postpartum body image, these two embodied "identities" symbolize two very different ideals. One identity, that of woman, can lead to the pursuit of physical perfection and the downplay of self-sacrificing roles (e.g., mother). The other identity, that of mother, seemingly rejects beauty norms for a "higher cause" (e.g., self-sacrifice found in mothering). Nevertheless, society generally expects women to return to their pre-baby bodies as soon as possible. Of course, there can be body image variation among postpartum women and a number of reasons for this variation. As discussed below, unexpected connections may

exist between pre-pregnancy fitness and belief systems that may influence women's body image narratives.

THEORETICAL CONSIDERATIONS

Doing Gender and Symbolic Interactionism can help us to understand the body image of new mothers in order to gain new insights about the postpartum experience. "Doing Gender" is useful because of its focus on the interactional establishment of social norms by which gender functions to differentiate women and men in order to maintain a hegemonic social structure that controls women by controlling their bodies. West and Zimmerman (1987:126) explain it thusly:

> Doing gender involves a complex of socially guided perceptual, interactional, and micropolitical activities that cast particular pursuits as expressions of masculine and feminine "natures." When we view gender as an accomplishment, an achieved property of situated conduct, our attention shifts from matters internal to the individual and focuses on interactional and, ultimately, institutional arenas. In one sense, of course, it is the individuals who "do" gender.

It is notable that both the *group* as well as the *individual* are responsible for the doing of gender, as West and Zimmerman describe it, and this applies well to the issue of body regret and/or body satisfaction. Were it not for external social forces that are imparted to the individual through interactions (Henderson-King 1997), there would be little basis for women to internalize so deeply the pressures that could create negative feelings about the postpartum female body. On the other hand, there is an individual decision to allow these pressures to affect one's self-view. Some women have an easier time combatting these expectations. Thus, my emphasis is primarily on whether and how women internalize these social pressures that can bring about symbolic meaning to their body changes.

Symbolic Interactionist Theory is also relevant because of its emphasis on social interactions which give meaning to one's conceptualization of the world (Blumer 1969). These interactions perpetuate the doing of gender over and over by creating narratives

between subgroups within society (e.g., pregnant women, new mothers); these groups bond over their similar experiences and are informed by the social expectations around them, which are often fed through the media, celebrity and pop culture, and so forth (Chae 2014; Hundley et al. 2014; Sears and Godderis 2011; Martin 2003). Research has also shown that women regularly feel they must embody "feminine" characteristics, even during labor, which reinforces gender stereotypes in many facets of their social lives, but especially within the context of childbirth (Martin 2003). The body is fundamental to the understanding of society; indeed, there exists a reciprocal relationship in which the symbolic meaning given to the body necessarily guides one's perceptions of the society, and society in turn influences the sense of self, expressed through one's body image (Waskul and Vannini 2016). My research considers how support systems and postpartum body image can bring about symbolic meanings to women's body changes, be they positive or negative.

DATA AND METHODS

Using qualitative in-depth interviews, I examine the body image of women who had given birth within the past eight months to their first child (live birth and surviving) and how it is linked to their pregnancy and childbirth narratives. I connected with these women through flyers and social media platforms, my already existing network of birth workers (through my work as a birth doula), and snowball sampling. These women were emerging from their first pregnancy and childbirth experiences and were navigating the changes their bodies underwent during these natural processes.

The women I interviewed ranged from twenty-one to thirty-seven years of age and identified largely with a Christian denomination (except for two women who identified as "spiritual"). My sample was predominantly white, middle- and lower middle-class women, two of whom also identified as Asian-American/Pacific Islander. My sample was relatively

well-educated, with two respondents reporting graduate degrees, eight respondents having college degrees, and two respondents with only high school diplomas. Eleven of my respondents were married, heterosexual women, and one woman described herself as single and queer.

Respondents varied by location of birth and care provider, with some having had medicalized birth experiences (i.e., laboring and delivering with the use of medical interventions) and others having more natural births (i.e., fewer to no medical interventions). All of the women had vaginal births. Four of my respondents reported having home births with a midwife or a team of midwives, birth doulas, and/or their partners present. Some women also had mothers, sisters, and friends with them as well. Another six had hospital births accompanied by their partners, and some of them with friends and relatives present. Three of these women had doulas, while the other three did not. Finally, another two delivered in birth centers described as being associated with, but separated from, a hospital. These were assisted by nurse-midwives and nurse teams, as well as birth doulas. These women described having their birth partners (in one case, her mother, and in another, her husband) and other relatives present.

A questionnaire and in-depth interviews were utilized to gather data from my respondents. Interviews occurred once and lasted between forty minutes and three hours. Though I did not find it necessary to interview my respondents more than once, they all remained open to further questions or subsequent interviews. I met with some respondents in a local coffee shop where they felt comfortable and where conversation was possible. One respondent allowed me to interview her in her home, and still others preferred to talk via video conferencing (i.e., Skype or FaceTime). I initially wondered how public locations might affect women's openness to discuss their childbirth experiences, but they were all very open and honest, and they had no problems describing even very personal and emotional details

with me in these places. In fact, all of the women I interviewed felt comfortable sharing comprehensive narratives of their labor and delivery experiences, especially after I reassured them that I had "heard it all before" as a birth doula.

Before the interviews began, participants were asked to complete a questionnaire[11] that included a body image scale, a number of demographic measures, and a number of questions regarding the woman's pregnancy and labor experiences. Respondents were also asked on the questionnaire to list five adjectives to describe their bodies before, during and after pregnancy. These served as a helpful tool for framing each woman's body image history. The questionnaire provided a useful and necessary segue into the interviews, as it helped women to recall many details and feelings about each time phase before being interviewed. Questionnaires also further contextualized each woman's narrative and allowed me to orient my interview questions accordingly.

In-depth interviews were semi-structured, leaving room for each woman's unique narrative. The interview schedule[12] covered issues related to body changes and perceptions, body satisfaction and/or regret and comparison with others, type of care, complications, sense of support, and the childbirth experience itself. All participants were fully informed of the research goals and agreed to having their interviews recorded,[13] and each woman was given a pseudonym to establish complete anonymity.

Interviews were transcribed. Transcripts were coded and analyzed, informed by a Grounded Theory approach (Glaser and Strauss 1967). Coding began with a simple read-through to search for major themes. Then, by searching for keywords and phrases, subthemes were identified, which provided some interesting nuances to my findings. Finally, a third run

[11] The questionnaire can be found in Appendix A.
[12] The interview schedule can be found in Appendix B.
[13] Participants were given an informed consent and confidentiality form before the questionnaire administration and interview were conducted.

through the data revealed anything that may have been overlooked.[14] Selective coding was used in order to pinpoint significant patterns pertaining to my emerging evidence and theory. Indeed, after coding the data, there were a great number of remaining insights that were beyond the scope of this particular study but may prove useful for future research.[15] It should be noted that I previously conducted a pilot study for this research in my graduate research methods course, which inspired and informed important themes discussed here, such as the relevance of body image and support systems, and aided in the development of this project. This study investigates these themes and identifies some unexpected ones as well.

RESULTS

My findings indicate a number of interesting insights about the nature of postpartum body image in connection with pregnancy and childbirth, which were linked to support systems. I found, however, that thematic elements diverged into three categories pertaining to each woman's experience through pregnancy, childbirth, and postpartum. First, support systems, in terms of interpersonal, sensory, and spiritual support during childbirth and postpartum, were found to influence body image. Interpersonal support refers to support from a partner, friend, relative, doula, or another birth professional. Women also described sensory and spiritual support in terms of prayer and meditation, music, aromatherapy, and other relaxation methods as a part of their support during labor and delivery. Secondly, postpartum body image was related to body function, seen through breastfeeding and the "get my pre-baby body back" mentality, especially among women who identified themselves as athletes and fitness enthusiasts. That is, body stories were deeply connected to the bodily abilities of each postpartum woman as she navigated her newly entered role of motherhood. Finally,

[14] I only hand-coded my interviews. I did not incorporate a computer program to assist with coding since my background in qualitative research entirely made use of hand-coding.
[15] Participants were made aware of this possibility.

childbirth narratives suggested the importance of "preparation" for childbirth (i.e., self-education through reading, hands-on childbirth classes, and clearly communicating birth preferences, usually through the use of a birth plan) and the feeling of control that women reported during labor and delivery.

Body Image, Pregnancy, and Childbearing

Before discussing results for social support, postpartum body image, and control, I will provide an overview of body image over time using Table 1 (shown below), which displays descriptive adjectives given by my respondents about their bodies. One item on the questionnaire asked women to provide five adjectives to describe their pre-baby (pre-pregnancy) bodies; another asked for five more adjectives referring to their pregnant bodies; still another asked for five adjectives describing their postpartum bodies. While most women found it easy enough to come up with their adjectives on the questionnaire, some had difficulty doing so. From these words I was able to construct a timeline for each woman's body image. For each body phase of the participant, I coded the adjectives provided as overall indicating high satisfaction, moderate satisfaction, moderate dissatisfaction, and low satisfaction (i.e., dissatisfaction or regret), based solely on the words themselves. I then compared each woman's adjectives with how she used them during the interviews. This process helped me to contextualize the deeper meanings behind these words. Finally, I counted the number of positive, negative, and neutral adjectives on the questionnaire. If a time phase included only positive adjectives, it was coded as green (high satisfaction); for two or more neutral adjectives the box was coded as orange (moderate satisfaction). For time phases that had one negative adjective, it was also coded as orange (moderate dissatisfaction). Finally, if two or more negative adjectives were present, that time phase was coded red (dissatisfaction). In effect, this tables provided a visualization of each woman's body image

history, which I then contextualize through the richer data women provided during their interviews.

Table 1. Body Image Adjectives

Pseud. (age)	Before Pregnancy	During Pregnancy	Postpartum
Vivian (37)	Average, healthy, normal, fit-for-my-age, diligent	Glowing, adaptive, strong, healthy, bloated	Recovering, adaptative, strong, changed, proud.
Constance (22)	Active, thin, confident, fit, happy	Round, large, self-conscious, heavy, front-heavy	Determined, bloated looking, stretch mark-covered, flabby, semi-thin
Melena (28)	Obsessive, insecure, strong	Healthy	Healthy, strong, confident, different
Rhena (24)	Plump, confident, fit, stylish, gorgeous	Beautiful, evolving, sexy, glowing, enchanting	Exhausted, sore, strong, powerful, fit
Evelyn (22)	Slim, fit, not pregnant, young, beautiful	Round, hungry, tired, stressed, beautiful	Beautiful, slim, changed, tired, still hungry
Marin (23)	Curvy, fit, healthy, hourglass, athletic	Round, swollen, tired-eyed, cute	Athletic, curvy, overweight, tired
Kenna (23)	Small, self-conscious, beautiful, funny, happy	Big, sick, tired, beautiful, happy	Small, self-conscious, beautiful, funny, happy, tired, healthy
Julie (28)	Average, athletic, confident, content, desirable	Growing, life-giving, amazing, complex, beautiful, hurting	Skinny, stretchy, squishy, incredible, purposeful
Gabby (26)	Flat-chested, weight gain, broken, lacking confidence	Growing, matronly, alive, inflexible	Strong, comfortable, beautiful, foreign, capable
Bexley (26)	Athletic, confident, lean, strong, woman	Powerful, beautiful, confident, content, complete	Proud, uneasy, awkward, capable, pained
Terryn (36)	Tall, lean, strong, sexy	Curvy, sexy, proud	Curvy, fat, soft, flabby
Kirstin (32)	Negative, detached, discontent, sad, apathetic	Insecure, frustrated, content, strong, present	Sad, confident, content, strong, secure

**Green = High Satisfaction; Orange = Moderate Satisfaction; Red = Low Satisfaction*

It is important to note that some adjectives meant different things at different times and varied across respondents. For instance, many women used "curvy" to describe themselves. Interviews revealed the use of this word as being predominantly negative or

moderately negative before childbirth but had a very positive connotation in the postpartum stage. Nuances in word meaning were taken into account as I coded adjectives for each phase.

This table tells a thought-provoking story: 25% (3 respondents) of my sample had very high body satisfaction across the three-time phases (pre-pregnancy, pregnancy, and postpartum), 33% (4 respondents) decreased in body satisfaction over time, and about 33% (4 respondents) improved their body satisfaction over time. Only one woman remained neutral throughout. Some women repeated certain adjectives, such as Rhena, who described herself as being "fit" both before and after her pregnancy. Evelyn felt "beautiful" throughout all three stages. However, most women used different words at each phase. Interviews gave insight into word changes and indicated that, while some women's satisfaction in their bodies did not change, they realized their bodies had changed or evolved over time. Women who had lower pre-pregnancy body satisfaction tended to describe their bodies with more neutral or negative adjectives; they also used a number of different words at each time phase, indicating a sense of body change over time. Kenna was the only respondent who was coded as moderate/neutral at all time phases. She noted her feelings of "self-consciousness" both before and after her pregnancy, but not during. Her interview revealed only a slight increase in satisfaction during pregnancy compared to the more substantial increases seen among most other respondents.

An unexpected theme came to light regarding body image standards among female athletes. Constance, Marin, Bexley, and Tarryn were all athletes and/or fitness enthusiasts.[16] They each discussed frustrations they felt about being unable to maintain their pre-baby fitness and were anxious to regain their body's athletic abilities. Despite their efforts to rationalize their postpartum body shape, they felt a strong desire to get their pre-baby body fitness back. When asked to describe their postpartum bodies, these women referred to

[16] Other respondents, such as Melena, Julie, and Evelyn, talked about desiring to return to their normal fitness routines, but these comments were muted by their strong sense of embodied mothering.

themselves as “flabby,” “curvy,” “overweight,” “fat,” and, “awkward,” none of which were used to describe their pre-pregnancy bodies. Time was a concern for these and other women who desired to get their “pre-baby bodies” back. During their interviews, several of them expressed some half-hearted efforts to feel contentedness with their bodies as they were, but they ultimately concluded that the goal was to get back to the bodies they had before pregnancy, and it was just a matter of playing the waiting game.

While the athletes and fitness enthusiasts in my sample enjoyed being new mothers, their body image was oriented more around fitness and looking like their pre-baby selves than it was around their new mother status. This group of women had decidedly different body images than those who were less concerned with their fitness and athletic abilities. To further illustrate this point, some women, such as Terryn and Julie, also used adjectives like “curvy” and “flabby” in their interviews to describe their postpartum bodies. Among non-athletes, however, these words were used in a more positive context, noting the delight they felt in their partners pointing out their curvier hips, or showing off their flabby bellies to their friends because they enjoyed still “looking pregnant.”

Support Systems

For all the women I interviewed, the presence of a support system (or lack thereof) came through as a major theme, which I found to affect their pregnancy, childbirth, and postpartum experiences. Table 2 (shown below) summarizes the women’s birth provider and location, interpersonal support, and sensory and spiritual support. Originally, I desired to examine support during labor and delivery and their possible links to body image outcomes across home, birth center, and hospital births (both with and without a doula present). However, due to sample size and time constraints, my analyses were oriented more around experiences of support with less consideration of the location of the birth. Interestingly, I

found that the actual act of childbirth had less to do with a woman's body image than I had originally surmised. For a number of women, descriptions of labor and delivery were oriented around the physical pain or tiredness they felt, their emotional states, and their sense of support during labor. While women did describe feeling like their bodies did something incredible by birthing a baby, this seemed separate from overall feelings about their bodies.

Table 2. Respondents' Labor and Delivery Experiences

Pseud. (age)	**Provider/Location**	**Interpersonal Support**	**Other Support***
Vivian (37)	Obstetrician/Hospital	Partner	Prayer
Constance (22)	Obstetrician/Hospital	Partner, mother, grandmother	Prayer, worship music, aromatherapy diffuser
Melena (28)	Midwife/Home birth	Partner, mother	Water
Rhena (24)	Midwife/Home birth (midwife not present)	Partner	Prayer, water
Evelyn (22)	Midwife/Home birth	Partner, mother	None
Marin (23)	Obstetrician/Hospital	Partner	None
Kenna (23)	Obstetrician/Hospital	Partner, mother	Prayer
Julie (28)	Midwife/Home birth	Partner, doula	Water
Gabby (26)	Obstetrician/Hospital	Partner, doula	Prayer, aromatherapy diffuser
Bexley (26)	Nurse Midwife/birth center (hospital-affiliated)	Mother, doula, sister	Water, music
Terryn (36)	Nurse Midwife/birth center (hospital-affiliated)	Partner, doula, sister	Water
Kirstin (32)	Obstetrician/Hospital (intended home birth)	Partner, doula, friend	None

**"Other Support" refers to support systems such as sensory and spiritual support.*

Body image was attached far more to body change over time, as well as respondents' postpartum experiences, than to the body while giving birth. However, I discovered a number of associations between women who did and did not desire to return to their pre-baby bodies and the level of support during childbirth and postpartum. For instance, Vivian had a strong desire to regain her pre-baby body. She spent considerable interview time lamenting her lack of support throughout pregnancy, labor and delivery, and postpartum, especially her labor and postpartum phase:

> So my husband and my younger sister hate each other. A lot. And so that was a huge point of concern for me, because I really wanted a woman present… my husband felt very territorial and me needing more support than him was his failure… I DID NOT want my mom there… She just would have not been helpful. So the point is that I was really worried because my husband is not known for his compassion skills, but the nurses were amazing.

Besides lacking support from family members during labor (the only family member present was her husband), Vivian went on to discuss her early postpartum days:

> I asked my mom, will you help? She said, "I'm so glad you asked!" So I didn't meal prep or anything because I wanted to give her that space to be helpful… I gave her that, and she dropped it. I would literally cry and eat cheese sticks and peanut butter sandwiches, because not only had I not cooked, but I couldn't cook. I didn't have groceries. The first two weeks, I didn't take [my baby] to the grocery store. I don't know what happened to my husband. I don't even remember him at all! I think he was more taking care of our son maybe, but I don't remember where he was. So, I felt completely isolated… This was the first three weeks. So, I had no support.

Vivian shared that her early postpartum days of isolation caused her so much anxiety that she very nearly fell into postpartum depression, making time with her baby more tedious than precious. She said:

> It would have been a more precious time with my baby… instead of being worried I would fall asleep and smother her. And honestly, I just felt really sorry for myself, instead of feeling grateful or whatever. I just felt really alone. Now I have vowed, whether my friends like it or not, I will bring them casseroles after they have babies…Just learning lessons.

Vivian's postpartum experience was perhaps the most difficult of all the women I spoke with. While the adjectives she used on the questionnaire imply heightened body

satisfaction during pregnancy and afterwards, compared to before pregnancy, she shared that these descriptions were more about her journey of fertility. After struggling with infertility for most of her adult life, she was in awe of what her body was finally able to accomplish. Nonetheless, she shared her desire to get her pre-baby body back during her interview. What Vivian lacked was a strong support system. She noted her mother and half-sister had been influencers of poor body image throughout her life. After childbirth, having virtually no support from her partner, friends, or family, she did not receive the positive feedback that some of my other respondents benefitted from. She could not recall anyone praising her body's efforts during childbirth except for a nurse who was encouraging after her delivery.

From her partner she received very little positive affirmation about her postpartum body. In fact, the day following her delivery, she and her husband had this exchange:

> The next morning, I wake up at like 6 am and I get up to go take a shower. I still have a gown on, and my husband says, "Uhh, is there something wrong with your tummy?" (He was referring to her still pregnant-looking tummy). And I was like, "I don't think so. There was a baby in there."

This remark stayed with her and added to a plethora of small insensitive comments she described receiving. Lacking positive reinforcement from her partner or close friends and relatives, she said most comments about her body came from her clients at work:

> People would be like, "Oh my gosh you look so good! You're so skinny!" … So I put it (getting thin and fit) at the top of my priority list. "I want to get back into my old scrubs! I want to fit in my old clothes!"…These comments fed an unhealthy beast… That affirmation of something that wasn't particularly mentally healthy, over-worrying… Affirmation that three to four pounds people notice, which is not a healthy place to be.

Vivian went on to say that she had gotten very obsessed with thinness and became worried that she had become "skinny-fat." At only four months postpartum, she said she had joined an exercise class to try and get her body back, but recognizing this as somewhat unhealthy, she was trying to change her mindset to a more positive one. Throughout Vivian's entire interview, she spoke as if she was alone in many of her experiences. Vivian expressed some

of her body changes as being rites of passage into motherhood, which she had yearned for throughout her adult life. Nevertheless, with only her partner present at the birth, and very little support or positive affirmations from friends and relatives about her body during childbirth and postpartum, Vivian struggled to be at peace with her body changes.

Quite in contrast to Vivian's experience, Julie noted considerable support that she received during pregnancy, labor, and postpartum. Her husband's support was paramount to reinforcing a positive image of herself throughout pregnancy and thereafter:

> He was just really encouraging and affirming of my body during pregnancy. And that does a lot in helping a woman have confidence. He's the only person I'm trying to impress, and you know, he's always told me, "You could get super fat and I would still love you and think that you were really beautiful," you know? He's just always been really encouraging and affirming of my body. And so that's been true during pregnancy and during the postpartum period.

She noted the dynamic between her and her husband during labor as well, saying:

> He was really my rock, he was right there the whole time throughout labor… letting me hang on him, timing my contractions and encouraging me and just doing whatever I needed him to do. You know, he actually really wanted to catch [the baby] and when I was pushing, he was holding me from behind, and I was like, "I'm sorry you're not going anywhere. I need you right here." He was so supportive and held me and let me break his hands while I had contractions. I didn't break his hands, but it probably felt like it at some points.

This high level of interpersonal support was very meaningful to Julie's self-confidence, and she went on to share a number of conversations she and her husband had had about her body, especially during her pregnancy and postpartum:

> Another thing that my husband has been really crazy about was, he really, really, really cared about my body, so he's made every effort throughout pregnancy and throughout postpartum to make sure, if there's something going on with my body, that we're doing everything we can to take care of it. So that would be chiropractic care, paying for that. He's been really supportive, and like, "Hey, if you need this, we're gonna get it. We're gonna take care of it." He was really confident in my body's ability to give birth naturally, and really, really, really, supportive of doing a home birth.
>
> … He's made sure that I'm taking all the supplements that I need. Like fish oil, calcium, magnesium, vitamin stuff, probiotics, you know… after giving birth, he was, like I said, bringing me supplements all the time to help my body heal. He was making

> sure that I was taking this nasty iron supplement and chlorophyll to help replenish my blood supply (Julie hemorrhaged during delivery).

Throughout our conversation, Julie was equipped with countless examples of support from her husband that gave her the space and the confidence to listen to her body and have the birth experience she desired. This confidence carried into her postpartum phase as she developed a very positive post-baby body image, despite a number body changes. All of my respondents who had higher postpartum body satisfaction described this being driven, in part, by a strong sense of interpersonal support through positive comments made by partners, friends, and relatives.

Other relationships impacted my respondents' sense of support as well. Throughout her home birth, Melena had her partner and mother present. When intense contractions hit, a strong connection with her mother helped her to "ride the wave":

> You kind of feel like you're riding this wave and you have to stay on top of it, because if you start to feel yourself sink…You just have to pick yourself back up and get back on top of the wave... My mom was there, and she didn't say much… You know, there were times we would just look at each other and it was comforting to have that smile, or she would just look at me and I would have a feeling of, "You're doing it, you can do it!" Just a lot of support in the room.

Both her mother's presence, as well as a knowledge of her mother's history of positive midwife-assisted births, gave Melena great confidence during her labor experience. Constance also had her mother as well as her grandmother present at her hospital birth. She shared:

> I think having the two most important women in my life there was just an extra step. My mom, she's amazing. She sat in the room. She controlled the [aromatherapy] diffuser. She was praying. And then my grandma. She was more of the tough… She was my track coach in high school too, so she's more of the "You can do it! We're not gonna back out on what you want." She kept me like … "We're gonna do this. It's gonna be okay." … There are confident women in my family, so if anyone disagrees, they'll let you know. But I've been raised up like "Look, this is how I feel and you're just gonna have to get over it." So they were really, no one really pushed back.

These strong women helped Constance push through her hospital labor without any unwanted interventions, which she said were constantly being offered to her by hospital staff. Kirstin

also described having a lot of emotional support from her husband, as well a good deal of physical support from her doula at her hospital birth:

> The doula, when she got there, was very good with physically helping me relax, shifting positions, making sure I was continuing with breathing that would help. [My doula] was really good at helping us stay hydrated, especially support staff for my husband.

In these and other instances, respondents described strong feelings of support that gave them greater confidence in their bodies' abilities. These instances could be contrasted with those of Vivian and Kenna, especially, who did not have the same kind of support during or after labor. Understanding the importance of support at all time phases of each woman's experience is important to understanding their postpartum body image. In other words, having good support systems in place at all time phases seemed to positively affect postpartum body image. However, my findings indicate that unexpected issues that arise, such as an inability to breastfeed for those who really want to, can also affect one's body image trajectory.

Support: More Than Just Who Is in the Room

A number of women described other supportive measures in place, including sensory and spiritual support, that added to their comfort during pregnancy and labor. The vast majority of my respondents described some form of spiritual empowerment in childbirth as an element of support. However, only Bexley and Terryn recalled their childbirth experiences as deeply spiritual and described entering a "zen-like state," as Terryn described it, and felt a heightened awareness and connection to their bodies during labor and delivery. Both of these women identified as spiritual, but not Christian, and both were primarily supported by women during labor. The vast majority of my respondents who identified somewhere within the realm of Christianity described their births differently from the way Bexley and Terryn did, as I discuss further.

Constance recalled playing a number of her favorite praise and worship songs throughout labor, which had given her comfort during her pregnancy. Both she and Vivian discussed prayer as a very important part of their support experiences, guided by a book entitled *Supernatural Childbirth* (Mize 1995) which gave them a number of biblical promises to pray throughout pregnancy and spiritual goals or mantras to set their minds on during labor. Vivian also described a deeply meaningful experience during a prayer (at the very beginning of her pregnancy) when she said, "I heard a voice say, 'You will have a daughter'… I believe and I know for a fact she is a gift/promise that God gave me." Just a few days later, she learned she was pregnant after years of being infertile. Faith, for many of my respondents, was an important part of their support systems. However, this spiritual support differed from what Bexley and Terryn described, because it came from outside of themselves, rather than from within.

The varying kinds of spiritual support described by my respondents may have both positive and negative ramifications. For some women, like Gabby and Constance, prayer or worship music provided other elements of support as they labored. But, again, this was an external, God-centered source, while only Bexley and Terryn described their spiritual experiences as coming from within. This speaks to how traditional values and beliefs may reinforce narratives about women needing help, despite the way that the female body uniquely functions in its ability to birth a child.

Rhena was interesting because she had both a strong connection to her faith as well as a trust in the ancestry of female biological abilities; they fueled a profound confidence in her own body that allowed her to labor and deliver without any fear:

> I feel like I've read a lot about labor, just kinds of different methods of birth customs throughout the world… I think the biggest thing for me was also knowing, women have been doing this for hundreds of thousands of years, without doctors, without hospitals, with just midwives. In the strangest of places. Labor is normal. It's going to be fine. And it was.

Rhena's childbirth narrative stood out from all the others because her two-hour home birth occurred in her shower before her midwife arrived, and only her husband present. Despite this, she felt no fear or worry during labor, which she attributed, in part, to a strong connection with an ancestry of female reproductivity, giving her confidence in her own body's abilities. Rhena also noted support from her husband, and she also may have been influenced by the Catholic Theology of the Body, which emphasizes the abilities of the female body far more than most other Christian denominations. Indeed, to the majority of my respondents, sensory and spiritual support, in addition to interpersonal support, was paramount to confidence felt about their bodies during pregnancy and labor.

Postpartum Body Image

Those with higher postpartum body satisfaction felt their bodies were deeply connected to their new mothering roles. They saw their bodies as sources of life, care, and comfort for their babies. These women used their bodies to "mother" in a number of ways (e.g., skin-to-skin contact, cuddling, and comforting their babies by holding them), but breastfeeding was the most prominent aspect of embodied mothering described by my respondents. Rhena, for instance, shared her delight in "complaining" to her friends about all the milk she produced:

> … [I enjoy] complaining about all the milk that I have. And really, those are the things that I talk most about my body to other people. That milk just pours from my breasts!... If I'm around other women who are mothers, I try to avoid saying that. But when I'm around women who aren't mothers, then I end up telling them.

Julie emphasized that breastfeeding was hugely important in giving her body purpose:

> I think that breastfeeding has been a huge part of just helping me feel like, you know, I don't care if people see my breasts because they're not there for beauty and pleasure, they're there to feed and nourish and grow a baby, and comfort baby, so that's been amazing to learn all the different functions of breastfeeding and so I feel like they're purposeful more than I felt that way in my entire life. I feel like they're there for a purpose and not for like… I mean, my husband enjoys them, but they're there for a purpose and not primarily to make me look attractive in any way. They're there to help

> with babies. So that's been kind of interesting that I just am so used to using my breasts for anything that my baby needs, whether it's comfort, or pain relief, or immunity, or nourishment, or closeness, or whatever, you know?…I produced plenty of milk for my baby, which has been another huge, empowering thing… my body's doing what it needs to!

Marin described herself as "very self-conscious right when [she] got home." She described her hormones as taking her on a roller coaster ride of emotions, which did not bode well for her body image. However, she explained:

> I think that [my insecurities] pretty much went away after like a week, and I think really nursing really helped with that. You're bonding with your baby and your world basically revolves around this pure little ball of joy, and it was just… I think not having any issues with breastfeeding really helped in terms of body image.

Evelyn, too, made similar comments about breastfeeding:

> My breasts just pour out milk. She really doesn't need to suck much. There'll just be one suck and then there'll be a waterfall. Yeah, it's crazy. Same with my sister too. I think it just runs in our family. I have a saying that, if we ever have twins, we'll be very well supplied. Like we won't have to worry at all.

When I asked Evelyn if she would like to get her pre-baby body back, she said:

> I had a baby, so there's supposed to be some changes. It's not like everything it goes back the way it used to be. They're not bad changes either… I mean it's just proof that I went through pregnancy and labor. And now I have a baby and I'm still breastfeeding. It's pretty significant that I went through all of that… They [body changes] mean that I'm pretty cool! Not everybody can give birth naturally. Not everybody can breastfeed, so yeah, I feel pretty lucky to have these kinds of changes. I don't think people quite realize that cuz it's like "Let me get my body… my pre-baby body back!" It's like, "Uhh, its gonna take a while!" I wouldn't necessarily say get back to what it used to be, but I want to start running again.

These women focused on their body's ability to breastfeed, which gave them considerable confidence in their body changes. This was contrasted with other women who struggled with breastfeeding and quickly stopped altogether. Constance shared:

> …that was tough… She was born three weeks early, so she did not have the best latch. And she was really lethargic when she was born. So just had a hard time latching on… So I was having to pump a lot, by her not wanting to latch. My milk supply never like came in and was sufficient enough. So we had to start formula… those three weeks of trying to nurse her were so frustrating. I felt like this is where my… the only doubt I had about my own body was breastfeeding. Because I felt like, man I'm not doing enough. I can't support my kid. I cried. It was horrible because it would be like 2 in the morning and she would fall asleep… she lost almost a pound after she was born

> and… it was so frustrating! Yeah I cried … So I mean, it taught me to not be as hard on myself because I was super confident in my ability to have her and I didn't even know breastfeeding was that hard.

Constance and others, such as Vivian and Kenna, felt at a considerable loss when they were not able to breastfeed as they had hoped. Experiencing pain in breastfeeding or failing to produce enough milk amounted to more than just a difficult circumstance. These women felt that giving up meant that their bodies were failing at their motherly duty to provide for their babies and contributed to negative body connotations. Those with successful breastfeeding narratives found the experience deeply meaningful, and reinforced higher satisfaction in their postpartum bodies Thus, body function, specifically in breastfeeding, was closely tied to the feelings these women had about their bodies.

Embodied Mothering

The symbolic meaning given to body changes was significant for the new mothers I interviewed. For those who had positive postpartum body image (50% of my sample), the body changes they observed as a result of pregnancy and childbirth were more than just physical marks, but represented a host of (gendered) symbolic meanings associated with the new role of mother. Whether they, for example, had curvier hips, a baby "pooch," or bore significant stretch marks, these served to portray pride in their body's accomplishments and abilities. They were a "rite of passage" into their motherhood roles, which they thoroughly took delight in discussing and showing both partners and friends. Rhena spelled this out by saying:

> Something one of my friends put on Instagram, she posted her own before and after… picture of her scar marks. And she had the caption, something along the lines of, "The marks of being a mother" … I was like, yes, they are the scars of a mother… the scars of motherhood.

While they acknowledged difficulties associated with the healing process after giving birth, these were overwhelmingly focused on the new purpose of their motherly bodies.

Six of my respondents (50% of my sample) experienced regret over their postpartum body changes and wished to get their pre-baby bodies back. While they were also proud of their bodies' abilities in childbirth, they did not revel in their body changes like Rhena, Julie, and Evelyn, but rather wished to see them disappear with time. These changes, instead, caused women to feel pressure to attain socially ascribed body ideals. For instance, Constance's decrease in body satisfaction over time was partially due to her unsuccessful breastfeeding, reinforcing negative ideas about her body and its capabilities. Constance was quick to rationalize her body changes, saying it was all for the sake of her baby, but she did not retain the strong sense of positivity in her body changes that other women described.

Two key factors appeared to be at play for those who were happy with their postpartum body changes. The first is that they consistently described high levels of support from partners, friends, and family, who encouraged positive thinking about their body changes. These supports in effect gave them permission to feel good about their bodies. The second is that these women were doing gender by successfully using their bodies to enact a number of behaviors associated with motherhood. They were particularly successful with breastfeeding, which put on display their bodies' fertility, even after childbirth. For women who were less satisfied with their postpartum bodies, their identities, as they described them, were far less oriented around their body's abilities to provide for their growing infants (i.e., breastfeeding). Without this key factor, cultural expectations for women's bodies (e.g., as smooth and slim) took over. For women who did breastfeed but had lower body image, I found interesting ties between their body image and their identities as athletes and fitness enthusiasts, which I discuss below.

Constance's body story is particularly interesting because she exemplified many of the same characteristics as those women with higher body satisfaction, especially in terms of her support systems and proactive preparation for childbirth. The difference for her was that

she felt her breasts failed her and her baby. This points to the complexity of postpartum body image as Constance's narrative shows the importance not only of a positive pregnancy and birth experience but what comes after as well. Support played an important role in her decision to stop forcing the breastfeeding option as she recalled discussing the issue at length with her husband, mother, and friends, who encouraged her to try formula and donor milk:

> My family and my husband were so supportive of it and telling me, "Look, things happen… Every kid, especially, is gonna be different so you just roll with the punches" … It kind of hurts because I feel like I didn't do enough. Like I wasn't able to provide for her. I'm on both sides. I'm on that side [wishing she was able to breastfeed], but then I'm like, she's thriving on formula feeding, which was not in my plan at all. But I'd rather my kid be healthy and happy than suffering and us both being angry.

Body function appeared to play a role in Constance's sense of self. Despite her loved ones' efforts to reassure her that she was doing a great job as a new mom with a healthy baby, she felt defeated, and her body image reflected this strongly. In her struggle to breastfeed, a desire to work back to the body she knew before pregnancy was the symbolic "purpose" that was at the forefront of her mind. When I asked if she intended to get her pre-baby body back, she said:

> Yes… What do I want to look like? I want to see my arms not be as saggy, I want my stomach not to have extra flab that rolls over in that lower abdomen part. I don't want to look like I'm a month or two pregnant… two or three months pregnant again. Because I'm still a little bloated with the mama bulge. So that's what I'm trying to do. I'm trying to get back to looking as close to [my pre-baby body]… I want to fit in my old pants again. I want to be able to wear my old clothes.

While her labor and delivery experience was a positive one, Constance did not have good breastfeeding support from the lactation consultant provided by the hospital. She eventually found another woman to help her, but by then she said it was too late to help her establish a successful breastfeeding-only routine. Ultimately, she chose to use donor milk from a friend which she supplemented with formula.

Kenna, who already had a lower body image before pregnancy compared to most of the other women, might have experienced an increase in postpartum body satisfaction, had her

breastfeeding experience been more positive, as was the case for Melena and Gabby, who were able to sustain breastfeeding despite a number of obstacles. Instead, Kenna described her frustration in her postpartum phase, wishing she had stuck to her breastfeeding regimen. When asked what they would do differently with subsequent children, both Kenna and Constance said that they would endeavor to stick with breastfeeding for more than a few weeks, which they both felt would have been more possible with their first babies had they had the lactation support they both lacked.

There was a far greater emphasis on embodied mothering in Rhena's and Julie's postpartum body stories. These women did considerable preparation with their husbands, had a strong sense of support at all time phases, and were far more in control of their labor and delivery experiences. To add to this, their success in breastfeeding fed a growing positivity about their body changes which were centered around their identity as new mothers. They did not express a desire to get their pre-baby bodies back because their bodies held an important new meaning to them. In contrast, for women with lower postpartum body satisfaction, the focus was less on an embodiment of motherhood and more on the aspects of their postpartum bodies they wished to improve. This was evidenced by Bexley, who felt out of touch with her postpartum body. During pregnancy, she would touch her belly during her daily meditative body scans and felt a deep connection to it as "the center point of everything" for both her body and her baby. "Now it's just kind of a stomach," she said.

> I was like, "Wow, this little bump looks so good!"… and now afterwards, not that there's no pride, but it just feels awkward. It's a strange transition to getting back to the way it was.

When I asked Bexley to describe some of her body changes and her hopes for her body going forward, she replied:

> My belly has not gone back to its original size. It's definitely bigger. My hips are… slightly flabbier. And then the sad thing is that my butt got flatter. That wasn't supposed to happen. So, I'm hoping that once I get back to exercising maybe that will go away… my breasts are kind of droopy… you can see the veins in them… I would

> like for my stomach to get a little flatter. I would like my butt to go back to its normal size. I don't mind the stretch marks. I think they're kind of cool… I kind of thought that by three months it would have gotten a little [closer] to how it was.

She went on to describe some of the frustrations she had experienced, now being less active then she had been before having baby:

> I went to the park and tried to mess around with a soccer ball. Prior to that I had tried going for a run. And both of those were really painful towards the end… My whole pelvis was just super painful in a way it never had been before… it was obvious that I can't open and close my legs that way right now…It's disappointing. I thought at three months I would be able to do more athletic things that I want to get back to…. I'm just needing to wait longer. We go for a long walk every day… but just being a person who, for most of my life, I've exercised every single day… my job was exercise [she had a very physical job in the gardening and agriculture industry]… now I go on walks, but that's pretty much my only exercise… I want to get back to the things I love doing. So, in my free time I could go play a soccer game…. So that's what I'm trying to get back to, a more active lifestyle… I would like to feel the strength that I did then.

In describing these goals for her body, Bexley expressed the mental conflict she has felt in her efforts to get her body back while still being an involved mom. She shared:

> Oh, I can get my body back to the way it was if I kind of neglect my baby… and take more time for myself… like with my free time should I take a bath? Or should I go try to get my body back to the way it was?

Bexley was anxious to get back to her active lifestyle but felt the frustrations of what seemed to her to be conflicting priorities. Overall, she described feeling "out of touch" with her "awkward" postpartum body. Terryn, too, had some similar remarks about desiring to get back to her active lifestyle:

> During pregnancy, I really enjoyed being curvy. I liked my belly a lot, I kind of stuck it out…. Which was a surprise to me, as someone who has always needed to feel trim and athletic… Postpartum has been a little bit of a mental struggle 'cause everyone kept saying, "Oh, with breastfeeding you're gonna lose it all!" which initially I lost weight… but I haven't really been doing much at all, and I have definitely gained weight.

Terryn said she appreciated her body's ability to provide for her baby, but she said:

> It's mixed. I'd like to say, "I appreciate my body." But then I still crave a certain body type. And it took nine months to change one way, so I'm trying to give myself time to change another way. I'm trying not to be impatient… I'm trying not to compare. I feel

> like I met a lot of women that are so tiny and skinny, and as soon as they have their baby, they look like they didn't have a baby. And I'm like, oh my gosh! How is that?

When I asked Terryn what her goal was for her postpartum body, she answered:

> I think my initial goal is to focus on the feeling rather than the look of it. I want to feel strong. I want to feel healthy. I'm trying not to focus on a number… A part of me wants to lose weight… I'm trying to [use] other forms of exercise. If I could I would definitely [work out] every day.

Terryn also explained that she was "trying to allow [her] body to do what it needs to as a breastfeeding mom." This, to her, meant giving her body time. Yet, she described feeling uncomfortable when she heard people refer to her as "big" during pregnancy, and equally so when a close friend told her, "The weight looks good on you!" not long after giving birth.

These women's body stories were linked more to their fitness, having spent years living athletic lives. So, both Bexley and Terryn described loving pregnancy and feeling fertile, but as they became aware of their body changes, feeling incapable of achieving those goals was very frustrating for them. Other respondents described having a desire to get back into their workout regimens, but this did not carry the same significance for them as for the athletes and fitness enthusiasts in my sample, as their body narratives were oriented more around using their bodies for mothering.

Marin was an interesting case because she had a strong sense of embodied mothering as well as a fitness mentality. She was unique in that she found a way to intertwine these two identities into her postpartum body image. During her interview, she said:

> I think that, like I said, my husband and I are wanting to have more kids sooner rather than later, so I think for me, that is motivation in getting back to where I was (referring to her pre-baby body) quicker. But you know, not necessarily training my body, but stuff my body's familiar with, where it's supposed to be whenever you're not pregnant or after having kids and things like that. So I think that keeping that in mind has really helped motivate me as far as like diet and things like that because whenever I was pregnant… I think as far as body image goes, I feel like knowing that I want more kids and we want them sooner rather than later, I think that really helps you feel like, ok I need to get my body back to as close to as it was before we have more kids.

Marin was equally as determined to get her pre-baby level of fitness back, but not for the sake of fitness itself. Instead, Marin wanted to prepare her body to be able to support more children (i.e., to be pregnant again) as soon as possible. She found the challenge to get her body back an "empowering and motivating" one. Coupled with her positive experience with breastfeeding, Marin's embodied mothering gave purpose to her fitness and body image goals.

Preparing Begets Control

Not only was support important for both body image and the childbirth experience, each woman's preparation for childbirth played a role as well. Taking measures to self-educate and "prepare" for childbirth, such as writing up a birth plan, taking birth classes, and reading books, made women feel more in control during labor and delivery. This was seen either by the decision to have a midwife-assisted birth at home or a birth center or by adamantly preparing not to accept interventions (i.e., Pitocin, epidurals, pain medication) for those women (Gabby, Constance, and Kirstin) who had hospital births. However, while all of the women in my sample were determined to give birth vaginally, the remainder of my respondents who gave birth in a hospital varied in their amenability to interventions. For instance, Marin chose to be induced, Kenna's goal was to go natural as long as she could until she felt that her pain was unmanageable, and Vivian was open to medically necessary interventions. Women who felt in control of their experiences generally were equipped with knowledge about their bodies and the process of childbirth, so that they did not feel the need to accept medical interventions unnecessarily, even when pressured to do so by their care provider. Thus, preparation was a partial predictor of fewer interventions during labor and delivery for these women. In other words, women who prepared for their childbirth experiences by reading, taking classes, preparing a birth plan, and so forth felt more confident

in labor and were more determined to avoid interventions. Melena, who had a midwife-assisted home birth said about her birth plan:

> I think it's nice to know that someone else knows your plan and they're gonna go along with what you've wanted, as opposed to, at that time, when all of that's going on, you also feel like you have to be instructing people for it to happen the way you want it to happen…

Preparation ahead of time helped Melena feel "calm" and "confident" throughout her labor. This, along with support from her midwives, gave her a strong sense of control during labor and delivery:

> I did feel very in control. The midwives would tell me, they would give me options, like, "Do you think this would be good or do you want to get in the birth pool? Would you rather be on the bed right now? It was never anything like, "We're gonna move you right now. And you need to be in this position"... I was very in control of where I wanted to be.
>
> (Quoting her midwives), "We are educated in this field, and just as long as you know we are gonna try as hard as we can to give you what you want unless this is harmful to you… then we're gonna say we need to do something else." And knowing that at all costs, they were going to give me what I needed if it wasn't harmful to us did make a huge difference. It was a big confidence boost, just made you feel like a huge relief, made you feel that it was yours, you know, that it was *your* birth. And you can have it your way. And I'm kind of a controlling person anyway (laughs) and that's great because I get kind of anxious when I don't have control.

This control that Melena described came from the confidence she and her support systems had been nurturing throughout her pregnancy as she prepared for childbirth.

Of all the women, Vivian, who gave birth in the hospital, was the least "prepared" for her birth experience because she purposefully chose not to create a birth plan. She also did not describe participating in other self-educating measures such as reading or hands-on birthing classes. She shared that her goal was to keep herself open to whatever interventions might be necessary. This was an interesting difference from many of the other women, who desired to do as much planning as possible to *ensure* they were prepared for any scenario. Vivian's only family support at the hospital was her husband, who she described as quiet and hands-off. She found it easier to trust what the nurses and doctor recommended, having no birth plan or

previous preparation to follow. This came somewhat easily to her; as a veterinarian, she felt more comfortable with medical interventions and trusting medically trained staff than some of my other respondents:

> This is their skill set; this is what they do. This is their area of expertise. I just had to trust them. I knew you could choose epidural or not, IV fluids or not. But I would say things like, "I really don't want to get IV fluids," and they would say, "I know and I understand that, but when we change this part of the plan, the reason we feel this is safer for you or your baby, we feel like we need to go this way, if you're comfortable with that." And I'm like "You're a medical professional, I'm a medical professional." So I know what it's like to have someone going against what's medically not in your best interest. And this is their skill set, this is what they do. This is their area of expertise. I just had to trust them.

Although Vivian did not have a birth plan, her intention was to have a totally unmedicated, vaginal birth. Her lack of preparation did not set her up well to achieve this, however, and when her labor became very painful, she quickly agreed to a number of interventions. Coupled with very little active support from her husband, it is not surprising that Vivian did not succeed in her goal to avoid interventions. Her experience is well contrasted with that of Constance, who had a hospital birth but with preferences that were spelled out in her birth plan:

> It wasn't like a step-by-step what I wanted things to happen. It was more I didn't want them immediately taking her away. I wanted to do skin-to-skin [contact]. I didn't want to do a ton of medical interventions for her. We waited for the bath and everything… You can offer me pain meds, but please don't. Don't expect me to use them. I wanted my music going. I had praise and worship music going the whole time. I had my diffuser…

While Constance noted that her birth plan was not a "step-by-step" list of her desires and intentions, she had a clear, pre-conceived picture of what she wanted, using her birth plan to give her care provider clear communication of the interventions she wanted to avoid. When asked how a birth plan affected her childbirth experience, she said:

> It kind of kept me accountable. 'Cause there were some instances it was like, "Man, I'm getting really tired, what if I just went with it?" [referring to the options of pain medication or an epidural] … my husband was a big, big supporter of what I didn't want to happen. So I would get super tired, and he was like, "You can do it!" He

> would rub my back and everything. So it was more of an accountability for me… It helped support my mindset more than anything.

In addition to interpersonal support from her mother and grandmother, who were active motivators for her and buffered her against unwanted interventions, Constance noted that having a birth plan helped her to maintain some control over her experience:

> Everyone who told me they had hospital births, [the hospital staff] kind of pushed them to do stuff. I had a friend. They kind of pushed her into getting induced. And then they pushed her more and she got an epidural. She went into labor for 18 hours. So I like feeling more in control of things, especially when I'm in pain… since like they know they're accountable to what I want. They're not just gonna come in and be like, okay, "We're gonna put this in your back."

Constance said that having had previous candid conversations with her obstetrician during prenatal visits helped to solidify some of these desires for her experience, noting her doctor's surprise that she asked so many questions due to her extensive preparation.

> I think I kind of shocked my care provider because I knew what was supposed to be going on. I think it made him feel more confident. 'Cause when I got checked into the hospital, he came in and started telling me about the epidural. I said, "Look, I'm not gonna use it! I'm not!" and he's like "Well, if you need it…" and I was like "That's fine, I don't need it…" and he just kind of looked at me like "What? You're 21, having a baby..."

Being as young as she was, Constance surprised her care provider with her birth knowledge and tenacity to avoid interventions. With all the pressure to receive them, she felt that her preparation and support systems played important roles in helping her achieve her desired birth experience. This was the case for Gabby too, who on several occasions during labor was visited by her obstetrician. Due to a few hours of stalled labor, he insisted several times that she should accept Pitocin to move her labor along. Well into her labor, she became discouraged and nearly gave in. With the help of her doula and husband, she was able to walk the halls for several minutes to help her labor progress, and she ultimately was able to avoid receiving Pitocin. Women like Marin and Kenna, however, did not achieve this in their hospital births. While they both had birth plans, they were much more open to intervention, and had very little preparation (i.e., self-educating through reading and classes) beforehand.

They both eventually received epidurals, Pitocin, and had their water broken during their labors.

While the contrast between prepared and unprepared hospital births is suggestive of a woman's propensity to accept interventions, the decision to have a midwife-assisted birth may also play into this. A strong desire to maintain control over their birth experiences persuaded Julie, Rhena, and others to birth at home. Bexley and Terryn also desired more controlled experiences and opted for a birth center with a nurse midwife assisting. The home birth respondents, especially, had taken more than a few self-education measures to increase their knowledge and confidence in birth. But they also became aware that having a midwife present instead of an obstetrician would greatly diminish their chances of having unwanted interventions. These women had thoroughly thought through their birth plans and knew exactly what they wanted out of their labor and delivery experiences, unlike Kenna, Marin, and Vivian, who kept their hospital birth plans open to interventions, or had no plan at all.

It should be noted that all of the women in my study who had lower body satisfaction throughout (before, during, and after pregnancy), or who had decreased body satisfaction over the three time phases had hospital births. While not all respondents with hospital births had low postpartum body satisfaction, when compared with those who had midwife-assisted births, these women generally did far less preparation for childbirth during their pregnancies. For many of the women who did less, the extent of their preparation was a hospital's birth class, which they described as consisting of an hour or two of a few hands-off videos[17], a brief presentation by a labor and delivery nurse, and a tour of the labor and delivery unit. In other words, for those whose preparation for childbirth extended no further than the hospital class

[17] Hospital birth classes were described by the women who attended them as being "hands-off," meaning that they consisted of a few videos and a brief message from a labor and delivery nurse, as opposed to the more "hands-on" birth classes offered by natural birth professionals who invite women and their partners to participate in a number of activities and exercises on several different occasions to help them prepare for labor and delivery.

(e.g., no classes such as Lamaze or Bradley), and little self-education through reading or other resources, more medical interventions occurred, and greater body regret was expressed.

Constance and Kirstin were exceptions among the hospital birth group of women. Similar to Constance, Kirstin noted considerable preparation with her partner ahead of time. She had planned for a home birth but had to transfer to a hospital due to complications. This transition was difficult, but having much preparation under her belt, and support from her partner, doula, and midwife, all of whom were present with her at the hospital, she was able to avoid the majority of the interventions offered her. She described having read books, attended hypnobirthing and prenatal yoga classes, and a host of other self-educating measures to help her be prepared for childbirth. About her abrupt transition to the hospital, she said:

> Yeah, so that not being the plan, I was really… I was nervous. But I was also accepting of the process. Through hypnobirthing, one of the constant things we reiterate is to accept whatever turn my birth takes. So, realizing that I could prepare as much as possible, but literally anything could happen.

She went on to describe how her mentality was still very fixed on her ideal home birth, and she was determined to have as close to that kind of experience as possible. But her preparation through hypnobirthing classes also gave her peace of mind when her circumstances changed.

Finally, Gabby had a birth experience very similar to Constance's but with a birth doula present. Gabby also did more preparation than other hospital-birth women, thanks in large part to support and resources that her doula provided. Preparation and active informational support from her doula during labor helped her to deter constant pressure from her obstetrician to receive Pitocin. Close to her delivery, however, she allowed her doctor to break her water, but this was the only intervention she described receiving during labor and delivery. Thus, for these women, preparing for childbirth through self-educating measures helped them to enter their childbirth experiences with confidence and a sense of control.

DISCUSSION

By combining a background in sociology and qualitative research with my knowledge and experience as a birth doula, I was able to examine women's perceptions of themselves and their postpartum bodies. Despite many messages today about the strength and beauty of the female body, many women go into pregnancy, childbirth and postpartum with great trepidation. Many U.S. women, including some of my respondents, are convinced they need to be in a hospital in case of emergency (i.e., their bodies might not function as they should and/or they or their baby becomes at risk of harm) (Slade 2019; Stoll et al. 2019; Nilsson 2018). Thus, women may enter new motherhood with a host of fears about themselves and about their bodies. My findings suggest that support systems, body function, and preparation are paramount to postpartum body image. In addition, for women who have dealt with body dissatisfaction and regret during their lives prior to pregnancy, my findings indicate that they may struggle even more with their body image throughout their entrée into motherhood. As I illustrate below, my findings can be understood through the lenses of Doing Gender, Symbolic Interactionism, and Role Theory.

Support and Embodied Mothering

As Allison (1979:97) points out, "Pregnancy is probably the most dramatic, strictly female biological event—one that has meaning not only biologically, but culturally, interpersonally, and intrapsychically as well. Fertility is closely tied to woman's identity and roles." My research suggests that gendered body expectations are linked to mothering, which points toward a continued focus on traditional roles that women are expected play. In my sample, women who did not succeed at breastfeeding felt betrayed by their bodies, which they

felt were not functioning as they were "supposed" to in order to care for their babies.[18] This experience can be contrasted with "new fatherhood" narratives about men's ability to provide for their families while also showing themselves to be nurturing and supportive and closely engaged with their children (e.g., Parke 1996). Meanwhile, women face a host of body changes throughout pregnancy and childbirth that are devalued by society at large because they do not meet the conventional standards of female beauty. They are, however, praised for their fertility, which I argue is visible through the increase or maintenance of body satisfaction that nine of my respondents described during pregnancy (the remaining three did not have an increase in body satisfaction during pregnancy).

Nonetheless, women are expected to return to these same beauty standards as soon as possible after birth and, in fact, all of the women I spoke to acknowledge these pressures, whether they subscribed to them or not. Not only are these unrealistic standards for most women, but they also may cause women to feel that their bodies are no longer "valuable" once their fertility is no longer clearly visible to others (i.e., they no longer have a baby bump). Interactions with partners, family, friends, and the media further add to a complicated list of expectations that new mothers must navigate, within hours or days of giving birth. Many of my respondents who saw their friends lose weight quickly or who were able to be physically active not long after childbirth felt pressure to get "back on track" and felt deeply frustrated while playing the waiting game with their bodies, especially the women who were athletes (discussed further below). These women had a strong desire to reacquire their pre-baby bodies despite numerous body changes. Women in my study who were able to resist interpersonal and societal messages about beauty norms described having very strong support

[18] While the women in my sample were all planning to breastfeed, many women choose not to do so, and plan to use formula instead. Future research will ideally bring in other women who purposefully chose not to breastfeed, as I can then compare the way that such women interpret gendered expectations about embodied mothering to those who felt strongly that they wanted to breastfeed.

systems and felt especially encouraged by positive messages they received from their partners about their body changes. These women also had the strongest identities as mothers.

From a Symbolic Interactionist perspective, these findings suggest that women ascribe symbolic meaning to their postpartum bodies, based on their interactions with other postpartum women, family and friends, and especially partners, with whom they may engage in conversations about their bodies. Women who are praised for their bodies' accomplishments find symbolic value in their own bodies based on that positive feedback. Indeed, higher body satisfaction among my respondents seemed to be girded in a strong mothering identity that gave meaning to their changed bodies. The mindset of these women concerning their postpartum bodies was deeply imbedded in their ability to care for their babies with their bodies, pointing to a belief system that defines what it means to be a "good mother" in our society. This may stem, in part, from the cultural practice (mostly by white, middle-class women) of "intensive mothering" (Hays 1996). The opposite can also be true, where women who are belittled, or as some of my respondents described, do not have adequate interpersonal support in place, may not have the social reinforcement needed to ascribe value to their own bodies. Women who struggled with postpartum body changes were not any less excited about motherhood and nurturing their babies, but their body stories did not reflect the same "embodied mothering" identities that others expressed.

From a Doing Gender perspective, I find that body image hinges on the ways that postpartum women do gender by fulfilling gender stereotypes that are prescribed for them, either by enacting a "mothering" identity through breastfeeding, which has positive social repercussions, and therefore higher body image, or through endeavoring to get one's pre-baby body back, which overshadows the embodied "mothering" role in an effort to regain socially prescribed value in their bodies. Indeed, women in my sample who struggled to achieve pre-baby body standards for their bodies had lower body image overall.

Medical vs. Natural Childbirth, Preparation and Control

There is an important distinction that should be made between the model of care in hospitals versus midwife care. Interactions such as the ones Constance had with her doctor indicate a persistent gender dynamic that fundamentally shapes a woman's childbirth experience. In my study, the women who had hospital births with interventions also had male doctors. Literature indicates strong gender dynamics directly affect the kind of control a woman has during labor (e.g., Fee 2018; Pringle 1998; Fee 1975). Not only did the women in my study with natural birth outcomes (i.e., received few to no medical interventions) both in and out of hospitals indicate more preparation through birth plans, classes, books, and other resources, but they indicated higher levels of control in their labor and delivery than those who were more open to interventions. The institution of medicine is girded deeply in a tradition of patriarchy, and gender dynamics in childbirth play an important part in reinforcing a hierarchical power structure (Fee 2018; Han et al. 2018; Pringle 1998; Rothman 1982; Fee 1975). Even the language used by the women in my study who had hospital births, regardless of intervention use, differed from those who had midwife-assisted births, specifically in the ways they described their care providers. Women with hospital births discussed their obstetricians as taking good care of them, doing a great job of delivering their babies, and they were grateful when their doctors listened to them and respected their birth preferences. Vivian went as far as to say, "Did *I* do a good job of birthing my baby? I feel more like a spectator..." instead of owning her childbirth experience.

When negotiating interventions, women who did not have a strong support figure present, such as a doula or a mother, were quick to give in to their obstetricians' preferences for intervention. Partners were not usually described by these women as playing the "advocate" role. While many women said their husbands were very supportive, held their hands, supported them physically, and gave them reassurance that they were doing a good job,

they were not described as acting as verbal buffers like birth doulas and some mothers were. This is perhaps due, in part, to a history of fathers (or men in general, with the exception of physicians) culturally not being expected to be well-versed in women's reproductive health. Thus, men may feel less confident to be a strong voice of advocacy for their partners due at least partly to a lack of information (Etheridge and Slade 2017). This may be compounded by a long history of western gynecological care that does not prioritize sharing information with women and their partners (Williams and Dhillon 2019; Carter 2017; Rance 2013; Ehrenreich and English 2010).

It is possible that women who forgo the hospital route may have strong support systems already in place, giving them more confidence in their bodies' abilities to birth at home. Hospital staff support looks far different from that of midwives and doulas, especially in the amount of time physicians spend with a woman during her labor. Both midwives and doulas remain at the woman's side from the time they arrive (usually early in her labor) until well after she has given birth. Beforehand, they have typically established a relationship with the woman as well, which gives an added interpersonal element to the support they provide her with during labor. In contrast, hospital support rarely encompasses this sort of interpersonal element. While women meet several times with their obstetrician during prenatal visits, they often give birth with another care provider. This is because many hospitals have their doctors work on rotation, so it is anyone's guess who may actually be present when a woman goes into labor (a woman having a scheduled induction is a possible exception). Whether a woman gets her own obstetrician or not, the care provider spends relatively little time with her, coming in for a minute or two at a time to check her progress, and coming back to stay only when she is ready to push her baby out. Obstetricians, then, spend far less time observing the laboring woman and providing anything other than medical support. Nurses spend more time with a laboring woman, but theses nurses also work shifts, leaving it mostly

up to chance which nurses will be working at the time of any given labor and delivery; a woman is likely to have had little to no contact with any of the nurses prior to her arrival at the hospital.

Women in my study who had midwife-assisted births spoke about how "hands-off" their midwives were in the sense that they were present less for the sake of giving directions, and more to keep a watchful eye in case any problems arose. Midwives were reluctant even to check cervix dilation so as not to disrupt the natural birth process, while this is routinely performed throughout hospital labors (Downe 2013), all of which were attended by obstetricians among my respondents. To add to this, there is a far greater emphasis on preparation and self-education as a means of increasing confidence and control in labor among natural birth professionals, and this was evident among women who had midwives and/or doulas. Confidence in female reproductivity usually was felt more strongly by those who used midwives, which may be due to a culture of woman empowerment during pregnancy and labor among midwives and other natural birth professionals. It is also possible, however, that these women may have been more likely to seek out a midwife *because* they were confident in their bodies. Either way, this can be contrasted with hospital births which are oriented far more around everything that *might* go wrong. At the first sign of delay in labor, my hospital-birth respondents described being prompted by their obstetrician or nurses to accept interventions (especially Pitocin), so it is no wonder that their childbirth narratives were less oriented around empowerment, control, and confidence.

Whether to increase their sense of control or perhaps their comfort level, many women may prefer a female care provider for labor and delivery (perhaps more than for any other medicalized experience) because of the intimate nature of these events. However, because many obstetricians often work on rotation, and a woman in labor ends up with whichever one is on call, preferring a female care provider may be irrelevant. In my study, all midwives and

nurse midwives described were women, and all obstetricians present during labor and delivery were men. (A few hospital-birth women had had a preference for a female obstetrician, but one was not on call when they were in labor.) Thus, it is not possible to say from my study how female obstetricians would compare with male obstetricians in regard to the kind of control a woman has during labor and delivery. As of 2015, women made up roughly 55% of active OB/GYNs in the U.S. (AAMC 2015), and this number continues to climb as women make up over 80% of OB/GYN graduate residents in the U.S. (Vassar 2015). However, a few women described having seen a female obstetrician during prenatal visits and had encounters similar to those with male care. Nevertheless, obstetric care still follows the same patriarchal organization as all other branches of modern medicine (Shahvisi 2019; Fee 2018; Rimke 2018). This suggests that obstetricians, regardless of their sex and gender, may conform to structures that reinforce gendered dynamics through the authoritative role they have as a medical doctor over their patients. In other words, medicalization may trump sex and gender, even when the medical care provider is female.

Doing Gender, Even Outside of the Hospital

While gender reinforcement is certainly present in hospital births, there is an important caveat to what many feminist scholars consider woman-centered or empowered childbirth (i.e., natural and/or out of a hospital) (Lee and Kirkman 2008; Davis-Floyd 1992; Rothman 1982). That is, while natural birth professionals practice much more woman-centered childbirth methods, many of their laboring clients do not fully embrace them and still conform to gendered other-dominated behaviors during labor and delivery. For example, while many midwives are reluctant to direct pushing, many women expect it. That is to say, they rely on instruction from another, rather than focusing inward and listening to the body. One example of this, mentioned by a few of my respondents, was the Bradley Method, which has a

woman's birth partner, usually her husband, direct or coach her through labor. This method can be used in or out of a hospital but is predominantly associated with the natural (vaginal) birth process. Rather than relying on her body to guide her need to push (i.e., spontaneously bearing down), the laboring woman's birth partner counts her contractions and tells her how to breathe and when to push, calling into question how very (laboring) woman-centered this method actually is. Reliance on this kind of support also may be a function of our gender structure which seeks to undermine and control women by convincing them they are not capable in and of themselves. I point this out because, while many feminists describe natural (non-medical) childbirth as a woman-centered alternative, hegemonic gender norms may still dominate these labor and delivery experiences, whether women realize it or not (Shahvisi 2019). Some women may feel they need more direction than others, but women who feel confident in their bodies, according to my findings, rarely need direction at all. Such methods tread a fine line between (birthing) women-centered and hegemonic-reinforcing behaviors; feminist scholars must be willing to question alternative reproductive care just as they do medicalized childbirth.

The Athlete Identity and the Body

The influence of female athlete culture was an unexpected subtheme that presented itself in my findings. For women who identified as athletes and fitness enthusiasts, the goal of getting one's body back appeared to undercut that of embodied mothering. That is not to say that they were any less invested in the care of their infants, but that care was less a part of their body image than it was for those whose bodies were a central part of their new motherhood. Gendered body expectations that many women athletes struggle to attain (Kantanista et al. 2018) may play a role in these women's growing frustrations with their postpartum bodies. Research indicates that female athletes often struggle with body image as

they endeavor to portray both masculine and feminine body traits (Steinfeldt et al. 2011). As these women in my study were all accustomed to high levels of fitness before becoming pregnant, their less-active pregnant and postpartum bodies caused them to regret their bodies' postpartum delicateness. This was especially the case later in pregnancy when activities like running, weightlifting, and swimming became much more difficult and even painful, and then again, in the weeks and months after giving birth. This unexpected finding points to gendered body standards that many women face, including women who are fitness-oriented, who, when function prohibits, can cause feel discontent with their bodies.

Through the lens of Symbolic Interactionism, it would seem that the body mindset of a female athlete is constantly struggling to achieve the high standards prescribed by the gender structure, telling women that an athlete should be able to attain heightened physical fitness, while maintaining feminine traits such as slimness. Women may feel these pressures reinforced by interactions with peers and others who commented on their "recovering" post-baby bodies. I found postpartum mothers who have a background of fitness and athleticism do not simply lose the athlete mentality because they have given birth. My findings indicate a strong sense of frustration among postpartum athletes and fitness enthusiasts who feel that their bodies are not meeting the standards to which they have been held, and indeed, to which they have held themselves.

Role Theory can further inform this discussion. Research (Gowda and Rao 2018; Carnes 2017; Allison 1979; Russo 1976) shows that role conflict[19] can present itself when an individual carries multiple diverging identities that cause her to feel inner conflict because she cannot simultaneously fulfill the duties associated with both identities. For the women in my sample, there were two strongly held ideals about the female body. One was the "get your body back" mentality, informed by gendered beauty expectations of what a woman's body

[19] George Herbert Mead's *Mind, Self, and Society* (1934) also informs Role Theory.

should look like. The other was the valuing of a female body used for mothering (i.e., breastfeeding). These two ideals for the female body lie within the same society yet are at odds with one another. According to Role Theory (Merton 1968, 1957) women may feel disenchantment with their changed bodies when they feel these two ideals in conflict with each other. My findings suggest that, in order to settle these inner qualms, one of these identities has to become the primary one to which she subscribes. For women who had a strong connection to their bodies through breastfeeding their babies, they felt good about their bodies' changes because of the embodied mothering identity, which is highly valued in society. However, for those who did not succeed at breastfeeding, or who felt very attached to their identities as athletes, the "get your body back" mentality was at the forefront of their minds because the connection to embodied mothering was overtaken by socially valued beauty expectations.

Overall, embodied mothering identities seemed to be less sturdy among women who described themselves as athletes. It is possible that the social pressures that exist especially in female athlete culture to maintain high standards of fitness as well as femininity may attach themselves to the body images of women who did not identify as strongly with embodied mothering. Berry and Howe (2000) describe the disproportionate risks that female athletes face, especially at the collegiate level, of eating disorders and self-esteem issues surrounding body image due to social expectations to be thin. Regarding conflicting identities, Krane et al. (2004) point out that many female athletes battle the confusing realm of sports, which is dominated by masculinity, while still striving to maintain feminine ideals.

Gilchrist et al. (2018:78) studied Canadian athletes' "body pride," which they found to be associated with the function rather than the appearance of the body. They acknowledge a need for body image "investigations to move beyond the study of appearance and to consider body functionality" (2018:81) and find strong connections between the positive body image

and fitness. My findings indicate similar patterns related to body function, where women who were able to breastfeed and had unmedicated labors over which they had control had higher body satisfaction or "body pride" than women who could not successfully breastfeed or who felt frustrated by their bodies' postpartum delicacy, after having been accustomed to high levels of fitness. Thus, postpartum women athletes "do" gender as they work toward high standards for body appearance and function after "doing" gender in giving birth (Martin 2003); they also "do" gender through embodied mothering, and their postpartum bodies carry all of these socially valued, highly gendered identities. When these "feminine" beliefs and identities collide, role conflict may be experienced. Thus, it is no wonder women athletes' body satisfaction and sense of self may be especially affected by the changes their bodies undergo during pregnancy and childbirth.

Belief Systems

Martin (2003:69) argues that considering only institutional or interactional mechanisms of patriarchy is not enough because doing so "ignores other forms of power that shape women's everyday experiences of birth. Women's birth experiences are regulated by other social mechanisms, namely, internalized identities and especially, in this case, gendered identities." We might add to this list internalized faith systems, which were very meaningful to many of the women I spoke with. In fact, the women in my sample who tried the Bradley Method or had their partners use similar coaching styles all identified with some Christian denomination. I therefore pressed my spiritual/non-Christian respondents about their exposure to any such methods, of which they stated having no knowledge. This is a curious finding, leaving a number of questions regarding traditional Christian beliefs which may inadvertently cause women to do gender by following their birth partner's coaching during labor, rather than listening to their own bodies. Devaluing and belittling women's bodies, their sexuality,

and their independence is not far off from a number of conservative Christian beliefs, which may be at play even in childbirth. My sample was made up primarily of middle and lower middle-class white women; belief systems may be found to differ among working- or upper-class women or poor women. Adding to this possible racial-ethnic variation in the use of birthing methods, much more could be revealed by studying childbirth from an intersectional perspective (e.g., Collins 1990).

Limitations

While my study sample provided numerous insights into body image, I did encounter some limitations. For one, my sample size was small, and my demographic scope limited, especially in regard to race-ethnicity. However, I intend to further this research in the future by adding more interviewees to my sample, which will help me account for racial-ethnic differences regarding how bodies are viewed (e.g., minority groups possibly valuing larger women's bodies to a greater extent than the dominant white culture does). My research also relied on women's own narratives of their recent pregnancies (i.e., my data were retrospective), rather than gathering data during pregnancy.

I found it difficult to weigh in the possible presence and effects of postpartum depression (PPD) on women's body image in this analysis, mostly due to the fact that the women in my sample were reluctant to discuss any experiences with PPD. Only two women in my sample gave any mention of the condition, and while both described having many of its symptoms, they spoke about PPD as something they might have slipped into if they had not been careful, but certainly not something they had or were currently experiencing. This reluctance to admit to having postpartum depression, especially to a birth doula who is very comfortable dealing with these issues, reveals that stigma may still be attached to the condition, so much so that women do not want to be associated with it. Nonetheless,

postpartum depression is a serious matter, and steps should be undertaken to maximize the effectiveness of care and support for women who may find themselves battling symptoms of PPD, without having to hide from negative social stigmas such as being viewed as an unfit or neglectful mother.

Despite the obstetric field increasingly being filled by women, the obstetricians present during my respondents' hospital deliveries were all males. This may have been a function of place, with these births occurring in a predominantly conservative state in the south-central U.S.; my use of snowball sampling, as several of my respondents were acquaintances and gave birth at the same hospital, with the same obstetrician; and chance, if the only obstetrician available at the time of a woman's labor and delivery was a man. Thus, the women in my study reported having had either a female (nurse) midwife or a male obstetrician. Therefore, care provider-to-woman gender dynamics were likely different between those who birthed outside of hospitals with female (nurse) midwives and those who birthed in hospitals with male obstetricians. Because obstetricians and midwives operate under very different philosophies of care, this also must be considered when comparing care across my sample members. Finding respondents who had female obstetricians would have added further to my findings because gender dynamics could have been compared between women and men obstetricians and between women obstetricians and midwives. Additional sampling may allow for this and will give greater insight into the gender dynamics that may be present in obstetrician-assisted births.

It was also challenging to find women who had doula-assisted hospital births. This was originally meant to be a factor in sampling and would have allowed me to juxtapose hospital births with and without doulas and home or birth center births. While my research did find that the presence of a doula (or doula-like figure, such as a highly involved mother) did reduce medical interventions, and women with women-centered home births had the highest

body image overall, my sample size was relatively small. Research with a larger sample may uncover that these distinctions exist.

Conclusion and Suggestions for Future Research

Pregnancy and childbirth are not easy tasks, not only because the act of carrying and birthing a baby can be physically and emotionally taxing but also because gendered social pressures oriented around the female body make for a complicated experience. Most women in the U.S. bear children at some point in their lives, and there is a clear need for extensive research that can improve the overall care and well-being of women as they experience childbirth and highlight the hard physical and emotional labor that women endure throughout this profoundly meaningful experience. Body image is one important aspect of this experience and can be a deeply defining aspect of women's sense of self as they engage with the world around them. As I illustrated in this research, postpartum body image can encompass a host of gendered identities and values that shape a women's perception of herself. As pregnancy and childbirth are formative elements in the development of postpartum body image, measures for improved support and (birthing) women-centered care throughout pregnancy, labor, and postpartum are needed, especially in hospitals, so that childbirth can be an empowering experience, not an alienating one. With this in mind, social researchers should further analyze the relationship between care provider and patient and how patriarchy and gender dynamics play into the kind of care and support experienced by women, which may influence postpartum body image.

Support was a resounding theme in this study, with a focus on interpersonal support, but my research uncovered a number of other elements, such as the presence of sensory and spiritual support. A number of women described their faith or spirituality as being a help to them through labor, and future research could expand across a number of faith expressions in

order to determine what elements of religion and spirituality enhance childbirth experiences. Questions also remain regarding adherence to patriarchal gender norms that are encouraged in a number of organized religions. Whether or not such beliefs deteriorate a women's sense of control or empowerment during labor could be extremely insightful. To add to this, many organized religions look down on the sexuality of a woman's body, to which childbirth is inherently tied. These considerations could profoundly impact our social understanding of women's body image as they navigate the social world as expectant and new mothers.

My narrative data were very thick even with a sample size of twelve. While small, my sample still provided space to reveal some enlightening findings regarding gender dynamics in different childbirth scenarios, the effects of support, body function, and more. Before submitting this thesis as a manuscript to a journal, I intend to double my sample and thereby solidify the themes I have uncovered here as well as possibly uncover new themes or sub-themes. Ideally, I will develop my sample into one that is more racially/ethnically diverse. It would be equally fascinating to revisit women who express high body satisfaction to determine how their body image has developed a few years down the road when their children no longer directly depend on their bodies (i.e., are no longer breastfeeding). Will these women still find purpose and delight in their saggy bellies or their stretch marks? How far beyond the postpartum phase do women carry these symbolic meanings of their bodies? As my study suggests, postpartum body image is an important contributor to a woman's sense of self. As such, these considerations could have important implications in the health and wellbeing of women throughout the country and, indeed, throughout the world.

REFERENCES

ACOG Committee Opinion. 2018. "Approaches to Limit Intervention During Labor and Birth." *The American College of Obstetricians and Gynecologists*. No. 766. https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Approaches-to-Limit-Intervention-During-Labor-and-Birth?IsMobileSet=false

Adomaitis, Alyssa Dana, and Kim K. P. Johnson. 2019. "Post-Partum Celebrity Images: Influence on Self-Thoughts and Appearance Management Behaviours of Post-Partum Women." *Fashion, Style, and Popular Culture* 6(1):69-84.

Ajeet, Saoji, and Kasturwar Nandkishore. 2013. "The Boom in Unnecessary Caesarean Surgeries Is Jeopardizing Women's Health." *Health Care for Women International* 34:513-521.

Allison, Janet R. 1979. "Roles and Conflict of Women in Infertile Couples." *Psychology of Women Quarterly* 4(1):97-113.

American College of Nurse Midwives. 2019. "Essential Facts About Midwives." https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007531/EssentialFactsAboutMidwives-UPDATED.pdf

Association of American Medical Colleges (AAMC). 2015. "Active Physicians by Sex and Specialty, 2015." Retrieved on July 5, 2020 at https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-sex-and-specialty-2015.

Berry, Tanya R., and Bruce L. Howe. 2000. "Risk Factors for Disordered Eating in Female University Athletes." *Journal of Sport Behavior* 23(3):207-218.

Blumer, Herbert. 1969. *Symbolic Interactionism: Perspective and Method,* 1st Ed. Upper Saddle River, NJ: Prentice-Hall.

Brewis, Alexandra A. 1999. "The Accuracy of Attractive-Body-Size Judgement." *Current*

Anthropology. 40(4):548-552.

Carnes, Andrew M. 2017. "Bringing Work Stress Home: The Impact of Role Conflict and Role Overload on Spousal Marital Satisfaction." *Journal of Occupational and Organizational Psychology* 90:153-176.

Carter, Wendy, Debra Bick, Nicola Mackintosh, and Jane Sandall. 2017. "A Narrative Synthesis of Factors That Affect Women Speaking Up About Early Warning Signs and Symptoms of Pre-Eclampsia and Responses of Healthcare Staff." *BMC Pregnancy and Childbirth* 17:63-78.

Caton, Donald, Michael A. Frölich, and Tammy Y. Euliano. 2002. "Anesthesia for Childbirth: Controversy and Change." *American Journal of Obstetrics and Gynecology* 186(5):25-30.

Center for Disease Control and Prevention (CDC). 2020. "Infant Safety in Maternity Care Practices that Support Breastfeeding in US Birth Facilities." Retrieved July 28, 2020 at https://www.cdc.gov/breastfeeding/recommendations/safety-in-maternity-care.html

Chae, Jiyoung. 2014. "Interest in Celebrities' Post-Baby Bodies and Korean Women's Body Image Disturbance After Childbirth." *Sex Roles* 71(11–12):419-435.

Ciciurkaite, Gabriele, and Brea L. Perry. 2018. "Body Weight, Perceived Weight Stigma and Mental Health Among Women at the Intersection of Race/ Ethnicity and Socioeconomic Status: Insights from The Modified Labelling Approach." *Sociology of Health and Illness* 40(1):18-37.

Clay, Daniel, Vivian L. Vignoles, and Helga Dittmar. 2005. "Body Image and Self-Esteem Among Adolescent Girls: Testing the Influence of Sociocultural Factors." *Journal of Research on Adolescence* 15(4):451-447.

Collins, Patricia Hill. 1990. *Black Feminist Thought: Knowledge, Consciousness, and the Politics Of Empowerment*. Boston, MA: Unwin Hyman.

Conrad, Peter. 2007. *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, MD: Johns Hopkins University Press.

Cooper, Lisa A., Debra L. Roter, Kathryn A. Carson, Mary Catherine Beach, Janice A. Sabin, Anthony G. Greenwald, and Thomas S. Inui. 2012. "The Associations of Clinicians' Implicit Attitudes About Race With Medical Visit Communication and Patient Ratings of Interpersonal Care." *American Journal of Public Health* 102(5):979-987.

Curtin, Sally C., Kimberly D. Gregory, Lisa M. Korst, and Sayeedha F. Uddin. 2015. "National Vital Statistics Reports: Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data From the Birth Certificate, 2013." *DHHS Publication*, Vol. 64:4. No. 2015-1120: CS255967. https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf

Davis, Gayle, and Tracey Loughran. 2017. "Introduction: Situating Infertility in Medicine." Pp. 265-271 in *The Palgrave Handbook of Infertility in History*. London, England: Palgrave Macmillan.

Declerq, Eugene R., Carol Sakala, Maureen P. Cory, Sandra Applebaum, and Ariel Herrlich. 2013. *Listening to Mothers III: Pregnancy and Birth*. New York: Childbirth Connection. http://transform.childbirthconnection.org/wp-content/uploads/2013/06/LTM III_Pregnancy-and-Birth.pdf

DeVault, Marjorie L. 1996. "Talking Back to Sociology: Distinctive Contributions of Feminist Methodology." *Annual Review of Sociology* 22:29-50.

Downe, Soo, Gillian M.L. Gyte, Hannah G. Dahlen, and Mandisa Singata. 2013. "Routine Vaginal Examinations for Assessing Progress of Labour to Improve Outcomes for Women and Babies at Term." *Cochrane Database of Systematic Reviews* 7:1-3.

Ehrenreich, Barbara, and Deirdre English. 2010. *Witches, Midwives, and Nurses: A History of*

Women Healers. New York, NY: The Feminist Press

Etheridge, Jody, and Pauline Slade. 2017. "'Nothing's Actually Happening to Me.': The Experiences of Fathers Who Found Childbirth Traumatic." *BMC Pregnancy and Childbirth* 17(80):1-15.

Fahs, Breanne. 2011. "'Dreaded Otherness': Heteronormative Patrolling in Women's Body Hair Rebellions." *Gender & Society* 25(4):451-472.

Fee, Elizabeth. 1975. "Women and Healthcare: A Comparison of Theories." *International Journal of Health Services* 5(3):397-415.

Fee, Elizabeth. 2018. *Women and Health: The Politics of Sex in Medicine*. New York, NY: Routledge.

Fowles, Eileen R., and Lorraine O. Walker. 2006. "Correlates of Dietary Quality and Weight Retention in Postpartum Women." *Journal of Community Health Nursing* 23(3):183-197.

Fox, Bonnie, and Elena Neiterman. 2015. "Embodied Motherhood: Women's Feelings about Their Postpartum Bodies." *Gender & Society* 29(5):670-693.

Gaskin, Ina May. 2011. *Birth Matters: A Midwife's Manifesta*. New York, NY: Seven Stories Press.

Gilchrist, Jenna D. Eva Pila, Andree Castonguay, Catherine M. Sabiston, and Diane E. Mack. 2018. "Body Pride and Physical Activity: Differential Associations Between Fitness- and Appearance-Related Pride in Young Adult Canadians." *Body Image* 27:77-85.

Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York, NY: Aldine de Gruyter.

Gowda, Krishne, and Padmini Rao. 2018. "Managing Role Conflict: New Challenges Before Working Women." *PEOPLE: International Journal of Social Sciences* 4(2):229-248.

Guglielminotti, Jean, Ruth Landau, Cynthia A. Wong, and Guohua Li. 2019. "Patient-,

Hospital-, and Neighborhood-Level Factors Associated with Severe Maternal Morbidity During Childbirth: A Cross-Sectional Study in New York State 2013–2014." *Maternal and Child Health Journal* 23:82-91.

Guillemin, Jeanne Harley, and Lynda Lytle Holmstrom. 1986. "The Business of Childbirth." *Society* 23(5):48-54.

Hallam, Jenny, Chris Howard, Melissa Thomas, and Abigail Locke. 2019. "Empowering Women through the Positive Birth Movement." *Journal of Gender Studies* 28(3):330-341.

Hamilton, E. Brady, Joyce A. Martin, Michelle J.K. Osterman, Anne K. Driscoll, and Lauren M. Rossen. 2018. "Births: Provisional Data for 2017." *National Center for Health Statistics: Vital Statistics Rapid Release*. No. 004. https://www.cdc.gov/nchs/data/vsrr/report004.pdf

Harte, Davis J., Athena Sheehan, Susan C. Stewart, and Maralyn Foureur. 2016. "Childbirth Supporters' Experiences in a Built Hospital Birth Environment: Exploring Inhibiting and Facilitating Factors in Negotiating the Supporter Role." *Health Environments Research & Design Journal* 9(3):135-161.

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood*. New Haven, CT: Yale University Press.

Henderson, Andrea K., and Christopher G. Ellison. 2015. "My Body is a Temple: Eating Disturbances, Religious Involvement, and Mental Health Among Young Adult Women." *Journal of Religion and Health* 54(3):954-976.

Henderson-King, Eaaron, and Donner Henderson-King. 1997. Media Effects on Women's Body Esteem: Social and Individual Difference Factors." *Journal of Applied Social Psychology* 27(5):399-417.

Henriques, Gregg R., Lawrence G. Calhoun, and Arnie Cann. 1996. "Ethnic Differences in

Women's Body Satisfaction: An Experimental Investigation." *The Journal of Social Psychology* 136(6):689-697.

Hundley, V., E. Duff, J. Dewberry, A. Luce, and E. Van Teijlingen. 2014. "Fear in Childbirth: Are the Media Responsible?" *MIDIRS Midwifery Digest* 24(4):444-447.

Hutchinson, Delyse M. and Ronald M. Rapee.2007. "Do Friends Share Similar Body Image and Eating Problems? the Role of Social Networks and Peer Influences in Early Adolescence." *Behaviour Research and Therapy* 45(7):1557-1577.

Jordan, Brigitte, and Davis-Floyd, Robbie. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Long Grove, IL: Waveland Press.

Jordan, Kelly, Rose Capdevila, and Sally Johnson. 2005."Baby or Beauty: A Q Study into Post Pregnancy Body Image." *Journal of Reproductive & Infant Psychology* 23(1):19-31.

Kanstanista, Adam, Agata Glapa, Adrianna Banio, Wieslaw Firek, Anna Ingarden, Ewa Malchrowicz-Mośko, Pawel Markiewicz, Katarzyna Ploszaj, Mateusz Ingarden, and Zuzanna Maćkowiak. 2018. "Body Image of Highly Trained Female Athletes Engaged in Different Types of Sport." *BioMed Research International* 2018(6835751):1-8.

Kattari, Shanna K. 2015. "Racial and Ethnic Differences in Experiences of Discrimination in Accessing Health Services Among Transgender People in the United States." *International Journal of Transgenderism* 16:68-79.

Kelly, Michael P., and David Field. 1997. "Body Image and Sociology: A Reply to Simon Williams." *Sociology of Health and Illness* 19(3):359-366.

Klaus, Marshall H., John H. Kennell, and Phyllis H. Klaus. 2012. *The Doula Book: How a Trained Labor Companion Can Help You Have a Shorter, Easier, and Healthier Birth*. Philadelphia, PA: Da Capo Press.

Krane, Vikki, Precilla Y. L. Choi, Shannon M. Baird, Christine, M. Aimar, and Kerrie J. Kauer. 2004. "Living the Paradox: Female Athletes Negotiate Femininity and Muscularity." *Sex Roles* 50:315-329.

Lee, Amy Su May, and Maggie Kirkman. 2008. "Disciplinary Discourses: Rates of Cesarean Section Explained by Medicine, Midwifery, and Feminism." *Health Care for Women International* 29:448-467.

Lindmeier, Christian. 2015. "Caesarean Sections Should Only be Performed When Medically Necessary." *World Health Organization*. https://www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/

London, Susan 2004. "Hospitals with Second Opinion Policy Perform Fewer Cesarean Sections." *International Family Planning Perspectives* 30:150.

London, Susan. 2008. "Cesarean Section Is Safer Than Vaginal Delivery For Breech Births but Not Normal Presentations." *International Family Planning Perspectives* 34(2):97-98.

Lothian, Judith A. 2011. "Lamaze Breathing: What Every Pregnant Woman Needs to Know." *The Journal of Perinatal Education* 20(2):118-120.

Lovejoy, Meg. 2001. "Disturbances in the Social Body: Differences in Body Image and Eating Problems Among African American and White Women." *Gender & Society* 15(2):239-261.

Luce, Ann, Marilyn Cash, Vanora Hundley, Helen Cheyne, Edwin van Teijlingen, and Catherine Angell. 2016. "'Is it Realistic?' The Portrayal of Pregnancy and Childbirth in the Media." *BMC Pregnancy and Childbirth* 16:40-49.

Lundberg, Shelly, Robert A. Pollak, and Jenna Stearns. 2016. "Family Inequality: Diverging Patterns in Marriage, Cohabitation, and Childbearing." *Journal of Economic Perspectives* 30(2):79-102.

Malacrida, Claudia. 2008. *Sociology of the Body: A Reader*. Ontario, Canada: Oxford University Press.

Manning, Martha M., and Thomas L. Wright. 1983. "Self-Efficacy Expectancies, Outcome Expectancies, and the Persistence of Pain Control in Childbirth". *Journal of Personality and Social Psychology* 45(2):421-431.

Martin, Emily. 1989 [1987]. *The Woman and the Body*. Milton Keynes, England: Open University Press.

Martin, Karin A. 2003. "Giving Birth like a Girl." *Gender & Society* 17(1):54-72.

Martin, Lauren Jade. 2017. "Pushing for the Perfect Time: Social and Biological Fertility." *Women's Studies International Forum* 62:91-98.

Mead, George H. 1934. *Mind, Self & Society from the Standpoint of a Social Behaviorist*. Chicago, IL: University of Chicago Press.

Merton, Robert. 1957. "The Role-Set: Problems in Sociological Theory." *British Journal of Sociology* 8:106-120.

Merton, Robert. 1968. *Social Theory and Social Structure*, revised and enlarged ed. New York, NY: Free Press.

Miller, Amy, and Thomas Shriver. 2012. "Women's Childbirth Preferences and Practices in the United States." *Social Science & Medicine* 75(4):709-716.

Miller, Lisa R., and Eric Anthony Grollman. 2015. "The Social Costs of Gender Nonconformity for Transgender Adults: Implications for Discrimination and Health." *Sociological Forum* 30(3):809-831.

Mize, Jackie. 1995. *Supernatural Childbirth: Experiencing the Promises of God Concerning Conception and Delivery*. Tulsa, OK: Harrison House, Inc.

Namey, E. Emily, and Anne Drapkin Lyerly. 2010. "The Meaning of 'Control' for Childbearing Women in the US." *Social Science & Medicine* 71:769-776.

National Center for Health Statistics (NCHS). 2018. "Cesarean Delivery Rate by State." Center for Disease Control and Prevention. Retrieved July 8, 2020 at https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm.

Oklahoma State Department of Health (OSDH). 2017. "Cesarean Section Deliveries In Oklahoma." www.ok.gov/health2/documents/17040MCHS%20-%20Cesarean%20Section%20Deliveries%20in%20Oklahoma%20Booklet%208.5x11_HR5.pdf.

Olsson, Ann, Martina Lundqvist, and Elisabeth Faxelid, Eva Nissen. 2005. "Women's Thoughts About Sexual Life After Childbirth: Focus Group Discussions with Women after childbirth." *Nordic College of Caring Sciences* 19:381-387.

Parke, Ross. D. 1996. *Fatherhood*. Cambridge, MA: Harvard University Press.

Parsons, Talcott. [1939]. 2007. "The Social Structure of Medicine." *Seeing Ourselves,* 7th ed., edited by J. J. Macionis and N. V. Benokraitis. Upper Saddle River, NJ: Prentice Hall. 375-378.

Placek, Paul J., and Selma M. Taffel. 1980. "Trends in Cesarean Section Rates for the United States, 1970-78." *Public Health Reports*. 95(6):540-548.

Pringle, Rosemary. 1998. *Sex and Medicine: Gender, Power, and Authority in the Medical Profession*. Cambridge, UK: Cambridge University Press.

Rance, Susanna, Christine McCourt, Juliet Rayment, Nicola Mackintosh, Wendy Carter, Kylie Watson, and Jane Sandal. 2013. "Women's Safety Alerts in Maternity Care: Is Speaking Up Enough?" *BMJ Quality and Safety* 22:348-355.

Reischer, Erica, and Kathryn S. Koo. 2004. "The Body Beautiful: Symbolism and Agency in the Social World." *Annual Review of Anthropology 33*:297-317.

Rimke, Heidi. 2018. "Sickening Institutions: A Feminist Sociological Analysis and Critique

of Religion, Medicine, and Psychiatry." Pp. 15-39 in *Containing Madness*, edited by J. M. Kilty and E. Dej. London, England: Palgrave Macmillan.

Roosevelt, Lee K, and Lista Krane Low. 2020. "Understanding Fear of Childbirth Among Underrepresented Populations in The United States." *Journal of Psychology* doi:10.1177/1359105320922306.

Rothman, Barbara Katz. 1982. *In Labor*: *Women and Power in the Birthplace*. Manhattan, NY: W.W. Norton & Company.

Rothman, Barbara Katz. 2016. *A Bun in the Oven: How the Food and Birth Movements Resist Industrialization*. New York, NY: New York University Press.

Russo, Nancy Felipe. 1976. "The Motherhood Mandate." *Journal of Social Issues* 32:143-153.

Sears, Camilla A., and Rebecca Godderis. 2011. "Roar Like a Tiger on TV." *Feminist Media Studies* 11(2):181-195.

Shahvisi, Arianne. 2019. "Medicine is Patriarchal, But Alternative Medicine is Not the Answer." *Bioethical Inquiry* 16:99-112.

Shilling, Chris. 2012. *The Body and Social Theory*. London, England: SAGE Publications.

Slade, P., K. Balling, K. Sheen, and G. Houghton. 2019. "Establishing a Valid Construct of Fear of Childbirth: Findings from In-Depth Interviews with Women and Midwives." *BMC Pregnancy and Childbirth* 19:96-107.

Steinfeldt, Jesse A., Rebecca Zakrajsek, Hailee Carter, and Matthew Clint Steinfeldt. 2011. "Conformity to Gender Norms Among Female Student-Athletes: Implications For Body Image." *Psychology of Men & Masculinity* 12(4):401-416.

Stoll, Kathrin, Wendy Hall, Patricia Janssen, and Elaine Carty. 2014. "Why are Young Canadians Afraid of Birth? A Survey Study of Childbirth fear and Birth Preferences Among Canadian University Students." *Midwifery* 30:220-226.

Torres, Jennifer M.C. 2014. “Medicalizing to Demedicalize: Lactation Consultants and the (De)medicalization of Breastfeeding.” *Social Science & Medicine* 100:159-166.

Vassar, Lyndra. 2015. “How Medical Specialties Vary by Gender.” *American Medical Association*. Retrieved on July 5, 2020 at https://www.ama-assn.org/residents-students/specialty-profiles/how-medical-specialties-vary-gender

Vedam, Saraswathi, Kathrin Stoll, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney, Nan Strauss, Monica McLemore, Micaela Cadena, Elizabeth Nethery, Eleanor Rushton, Laura Schummers, Eugene Declercq, and the GVtM-US Steering Council. 2019. “The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States.” *Reproductive Health*. 16(77):1-18.

Waskul, Dennis, and Phillip Vannini. 2016. *Body/Embodiment: Symbolic Interaction and the Sociology of the Body*. New York, NY: Routledge Publishing.

West, Candace, and Don H. Zimmerman. 1987. “Doing Gender.” *Gender & Society* 1(2):125-151.

Williams, Serena A. P., and Soneet Dhillon. 2019. “Women’s Obstetric and Reproductive Health Care Discourse in Online Forums: Perceived Access and Quality Pre- and Post-Affordable Care Act.” *Preventive Medicine* 124:50-54.

Winter, Virginia Ramseyer, Laura King Danforth, Antoinette Landor, and Danielle Pevehouse-Pfeiffer. 2019. “Toward an Understanding of Racial and Ethnic Diversity in Body Image among Women” *Social Work Research* 43(2):69–80.

Zwier, Robin Kanak. 2019. “Taking Back Birth: De/Medicalization and Rhetoric of the Santa Cruz Birth Center.” *Western Journal of Communication* 84(1):1-18.

APPENDICES

Appendix A: Questionnaire

Please take a few minutes to complete this survey. Your responses are valuable to this research project, and your information will be kept completely confidential. By taking this survey, you affirm that you are both 18 years of age or older and that you are providing your information voluntarily. You may skip any questions you prefer not to answer.

Pregnancy, Childbirth, and Postpartum Questions:

Body Image Scales

I'd like to begin by asking you a few questions about your body image. First, think about your body image before you became pregnant and list 5 words to describe yourself at that time:

_____

_____

Please circle the number that best represents your feelings about the following statements:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Before becoming pregnant, I liked how my body looked.	1	2	3	4	5
Before becoming pregnant, I felt confident in my body's ability to give birth.	1	2	3	4	5
Before becoming pregnant, I felt self-conscious about my body.	1	2	3	4	5
Before becoming pregnant, I felt confident about how my body functioned.	1	2	3	4	5
Before becoming pregnant, I felt frustrated about the way my body functioned.	1	2	3	4	5

Now, think about your body image during your pregnancy and list 5 words to describe yourself at that time:

_____

_____

Please circle the number that best represents your feelings about the following statements:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
After becoming pregnant, I felt confident in my body's ability to give birth.	1	2	3	4	5
During my pregnancy, I felt good about how my body looked.	1	2	3	4	5
During pregnancy, I felt frustrated by the way my body functioned.	1	2	3	4	5
During labor, I felt confident in my body's ability to give birth.	1	2	3	4	5

Continue to next page…

Finally, think about your body image since you've given birth and list 5 words to describe yourself at that time:

_____

_____

Please circle the number that best represents your feelings about the following statements:	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
After giving birth, I feel good about how my body looks.	1	2	3	4	5
I feel empowered by the physical changes I've noticed in my body since pregnancy and childbirth.	1	2	3	4	5
I feel self-conscious about the physical changes to my body due to pregnancy and childbirth.	1	2	3	4	5
I feel empowered by how my body functions since pregnancy and childbirth.	1	2	3	4	5
I feel frustrated by the way my body functions since pregnancy and childbirth.	1	2	3	4	5
In time, I hope to regain my pre-baby body.	1	2	3	4	5

Now, please continue to the following questions about your pregnancy, childbirth, and postpartum experience:

1) How many day, weeks, or months postpartum are you? _____

2) How much did your baby(ies) weigh at birth?
   a) Weight of child 1: _____lbs _____oz

   b) Weight of child 2: _____lbs _____oz (if twins)

   c) Weight of child 3: _____lbs _____oz (if triplets)

3) Please fill in the table with your weights (in pounds). The weights you list may differ if you gained or lost during any of these phases:

Weight 1 month before pregnancy	Weight at end of 3rd trimester of pregnancy	Current weight

4) How tall are you in feet and inches? _____feet _____inches

5) What type of care did you use during pregnancy and labor? (Circle all that apply)
   a) Prenatal visits with Obstetrician
   b) Prenatal visits with a Midwife
   c) Birth Doula
   d) Prenatal fitness activities (e.g. yoga, Barre, Zumba, aerobics)
   e) Prenatal/postnatal chiropractor
   f) Massage therapy
   g) Water therapy
   h) Prayer or meditation
   i) Childbirth classes at hospital with a nurse
   j) Childbirth classes with natural birth professional (doula, midwife, other)
   k) Prenatal Lactation classes
   l) Spinning Babies
   m) Bradley Birthing Method
   n) Hypnotherapy
   o) Delivery with Obstetrician
   p) Delivery with Midwife
   q) Postpartum doula
   r) Postnatal lactation classes
   s) None of the above
   t) Other (please specify):

   _____

6) Do you know what a birth plan is?
   a) Yes
   b) No
   c) Not sure

7) If you answered yes to #6, did you have a birth plan for your labor?
   a) Yes
   b) No
   c) Not sure

8) Where did you give birth?
   a) At a hospital
   b) At a birth center
   c) At home
   d) Other (please specify): _____

9) Please list any complications you experienced during pregnancy, labor, or childbirth (i.e., preeclampsia, gestational diabetes, labor stalled, etc.):

   _____

   _____

   _____

   _____

10) Did you have any medical interventions during labor and childbirth? (Choose all that apply.)
   a) Induction
   b) Pitocin
   c) Epidural
   d) Episiotomy
   e) Cesarean
   f) None of the above
   g) Other (please describe):

      _____

      _____

      _____

      _____

11) Do you plan to have more biological children?
   a) Yes
   b) No
   c) Not sure

Continue to next page…

Almost done! The final set of questions are a list of demographic indicators:

12) What is your current age? _____

13) Which of the following races/ethnicities describe you? (Choose all that apply.)
   a) American Indian, Native American, or Alaskan Native
   b) Asian, Asian American, or Pacific Islander
   c) Black or African American
   d) Hispanic or Latino/Latina/Latinx
   e) Middle Eastern
   f) White or Caucasian
   g) Other (please specify): _____

14) What was your religion while growing up (if any)?
   a) Non-religious (e.g., atheist or agnostic)
   b) Evangelical Protestant (e.g., Baptist, Presbyterian (PCA), Pentecostal, Church of Christ)
   c) Mainline Protestant (e.g., Methodist, Lutheran, Presbyterian (USA), Episcopal, Anglican)
   d) Non-denominational Christian
   e) Catholic
   f) Jewish
   g) Muslim
   h) Hindu
   i) Buddhist
   j) Other (please specify): _____

15) What is your current religion (if any)?
   a) Non-religious (e.g., atheist or agnostic)
   b) Evangelical Protestant (e.g., Baptist, Presbyterian (PCA), Pentecostal , Church of Christ)
   c) Mainline Protestant (e.g., Methodist, Lutheran, Presbyterian (USA), Episcopal, Anglican)
   d) Non-denominational Christian
   e) Catholic
   f) Jewish
   g) Muslim
   h) Hindu
   i) Buddhist
   j) Other (please specify): _____

16) What is the highest level of education you have completed?
   a) Less than high school
   b) High school or GED
   c) Skilled trade, vocational program
   d) Some college (no degree)
   e) Associate's degree (2-year)
   f) Bachelor's degree (4-year)
   g) Some graduate school or professional school (but no graduate or professional degree)
   h) Graduate or professional degree

17) What is the highest level of education of that your baby's father has completed?
    a) Don't know
    b) Less than high school
    c) High school or GED
    d) Skilled trade, vocational program
    e) Some college (no degree)
    f) Associate's degree (2-year)
    g) Bachelor's degree (4-year)
    h) Some graduate school or professional school (but no graduate or professional degree)
    i) Graduate or professional degree

18) What is the highest level of education that your mother completed?
    a) Less than high school
    b) High school or GED
    c) Skilled trade, vocational program
    d) Some college (no degree)
    e) Associate's degree (2-year)
    f) Bachelor's degree (4-year)
    g) Some graduate school or professional school (but no graduate or professional degree)
    h) Graduate or professional degree

19) What is the highest level of education that your father completed?
    a) Less than high school
    b) High school or GED
    c) Skilled trade, vocational program
    d) Some college (no degree)
    e) Associate's degree (2-year)
    f) Bachelor's degree (4-year)
    g) Some graduate school or professional school (but no graduate or professional degree)
    h) Graduate or professional degree

20) What is your relationship status?
    a) Single, not dating
    b) Dating
    c) Cohabiting
    d) Married

21) What is your marital status?
    a) Never married
    b) Engaged to be married
    c) Married
    d) Separated/divorced
    e) Widowed

22) Which of the following best described you before becoming pregnant? (Choose all that apply.)
   a) In school
   b) Working for pay
   c) Other (please specify):

   _____

23) Which of the following best described you during your pregnancy? (Choose all that apply.)
   a) In school
   b) Working for pay throughout my pregnancy
   c) Quit my job
   d) Other (please specify):

   _____

24) Which of the following best describes you now? (Choose all that apply.)
   a) In school
   b) Working for pay
   c) Stay-at-home mom
   d) Other (please specify):

   _____

25) What was your occupation, if any, before pregnancy? Please specify.

   _____

26) What is your current (or most recent) occupation? Please specify.

   _____

27) Did health insurance cover all or part of your delivery?
   a) Yes
   b) No
   c) Not sure

28) If you answered yes to #25, was your health insurance SoonerCare?
   a) Yes
   b) No
   c) Not sure

29) What is your individual annual income?
   a) $0 - $19,999
   b) $20,000 - $39,999
   c) $40,000 - $59,999
   d) $60,000 - $79,999
   e) $80,000 or above

30) What is your household annual income?
   a) $0 - $19,999
   b) $20,000 - $39,999
   c) $40,000 - $59,999
   d) $60,000 - $79,999
   e) $80,000 - $99,999
   f) $100,000 or above

Thank you for taking this survey!

Your time and efforts are greatly appreciated! Your information will be completely confidential and will be used to guide our interview. Please contact me if you have any questions, and I look forward to our speaking with you in person!

Appendix B: Interview Schedule

1. Tell me a little about your body image throughout your life.
    a. What did you think about your body growing up (pre-pubescent child, teen, young adult)? Were you ever concerned about the appearance of your body or how it well it worked?
    b. Have you ever done anything that you thought would "fix" or "improve" your body (e.g. eating disorder, cosmetic procedures either surgical or non-surgical, etc.)?
    c. Do you/have you ever notice(d) yourself comparing your body to someone else's (friends, celebrities, etc.)? (Prompt for when during life they made comparisons and to whom.)
2. What, if anything, did you do to prepare your body for pregnancy? Childbirth? (Prompts: how prepared, resources used.)
3. Describe your labor and delivery experience. How did your body feel and how did you feel about your body while you were in labor and delivery? (Prompt: physical/health complications, support, knowledge/confidence/in control, scared/not in control.)
    a. What expectations, if any, did you have for yourself during labor? Did you meet any expectations you had?
    b. Did you have a birth plan? If yes, to what extent did having one influence your birth? Did you feel you more control over your experience? How did your care provider respond to your birth plan?
    c. Overall, how do you feel about your childbirth experience? Looking back, would you have done anything differently?
4. After childbirth, what do you think of your body's capabilities?

a. What do you think of your body's accomplishments? Do you think it did a good job of birthing your baby? (Probe for why or why not.)
b. Have others said anything to you about what you accomplished during pregnancy, labor, and delivery (e.g., care providers, partner, friends, etc.)? (Probe if necessary.)
c. Are you breastfeeding? (If yes, prompt: How do you feel about it? Also prompt: Do you like breastfeeding?)

5. Describe your post-baby body:
    a. How has it changed since before pregnancy? For example, do you have stretch marks or scars, changes to your weight, hair, breasts (e.g., shape, mastitis), or varicose veins?
    b. How do you feel about these changes?
    c. What significance do these changes mean to you, if anything? What adjectives could you use to describe what these changes mean to you?
    d. What perceptions and expectations do you have about your body (both what it can do and what it looks like) as you further navigate the "4th trimester" (i.e., postpartum)?
    e. Have others said anything to you about your post-baby body? (Probe if necessary.) Does this influence your own postpartum body perceptions and expectations?
    f. Do you talk with other people about your body? (Prompt: talking with other women about their bodies.) Does this influence your own postpartum body perceptions and expectations?
    g. What, if anything, would you like to change about your body as it is now (post-birth)? (If yes, probe for explanation and ask how. Prompt: fitness/exercise.)

Also ask: how achievable are these changes seem to you? (Prompt: fitness/exercise)

6. Any final thoughts that come to mind as you think about yourself as a postpartum mother? (Keep very open.)