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For the women who shared their journeys to motherhood.

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"Smooth waters never made a skilled sailor." –Anon.

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Abstract

Public health initiatives are spurred from three dominant political ideologies—neoliberalism, social justice, and pluralism—that influence the policy goals and methods. Neoliberalism, in particular, is the dominant socio-political framework that argues the free market is the best purveyor of individual freedoms. Neoliberal constructs have influenced much of the political environment, and contributed to the consumer model of health. Situated in neoliberalism, modern public health initiatives increasingly place onus on the individual as the solution for collective public health initiatives. However, the structural and interpretive influences of broader political philosophies and individual meaning making on the understanding of public health issues as these issues become more personal, is largely unknown. Thus, a case study of the public health initiative to reduce the number of Cesarean births was selected to investigate the ways in which interpretive structural resources shape women's meaning making about their birth plans. 36 pregnant and recently pregnant women were given journal prompts over a seven-week period, and a constant comparative analysis was employed to explore the ways in which meaning was constructed. Findings included support for neoliberal Discourse that guides understanding, and support for increasing political distrust of institutions, interests, and officials. Findings also presented a wealth of social conflict, including mommy wars over birth plans and horror stories used to socialize women into motherhood. Due to the number of choices afforded to women, public health issues such as childbirth presented more opportunities for fragmented meaning than for shared meaning. Without social consensus, collective public health goals suffer from lack of coordinated and situated meaning.

Chapter 1: Rationale and Literature Review

During the past thirty years, the commonly accepted role of public health policy has shifted from primarily infectious disease reduction to health promotion, chronic disease prevention, and early detection, as well as preparation and response to natural disasters and catastrophic events. Historically, the role of the United States Public Health Service (PHS) was to reduce the transmission of infectious disease by setting standards for hygienic practices and living conditions and setting environmental health standards with regards to waste disposal and water purification (Shi & Singh, 2011). Consistent nationwide effort by the PHS resulted in the eradication of many diseases such as small pox and polio (Tarantola & Foster, 2011). The threat of infectious diseases, however, was soon surpassed by the threat of chronic illness from various lifestyle causes such as smoking, poor diet, and lack of exercise (United States., 2010). Simultaneously, natural disasters and human-created threats also became a focus of public health (e.g., Khan, 2011; Tekeli-yesil, 2006). For example, Hurricane Katrina and biological threats from terrorist activities required action plans on behalf of public health professionals.

Despite the ever increasing shift to focus on contemporary public health concerns, critics are concerned about whether or not the United States' complex public health system is capable of attending to such a diverse agenda as eradication, prevention, and response to events (Shi & Singh, 2011). The public health system in the United States is a fragmented system consisting of federal, state, county, private, and local agencies (Baker et al., 2005). For example, the United States' system consists of federal programs such as the Affordable Care Act (ACA or Obamacare), Medicare,

the Veterans Administration, and the Indian Health Service, all of which extend federal public health initiatives. Combination state/federal programs include Medicaid and the State Children's Health Insurance Program. *Healthy People,* a National Institutes of Health publication produced every decade, outlines federal initiatives that require the assistance of federal, state, and private programs in order to be successful. Most private programs, such as employer-sponsored healthcare, also include voluntary and mandatory wellness initiatives that fulfill the federal initiative to reduce strains of chronic and preventative illnesses on the health care system (as well as assist in managing their own costs). Organizational control between these agencies is often decentralized, but also can be mixed, or centralized (Hyde & Shortell, 2012). Moreover, policy-making and regulation power differs from state to state, and organization to organization. Salinsky and Gursky (2006) report that state boards and their leaders are comprised of elected or governor-appointed officials, depending on the respective state. Inconsistencies in the infrastructure of the public health system result in confusion about agency responsibility and funding of public health initiatives.

Public health is unique in that it is a broad social enterprise, "more akin to a movement," that is interdisciplinary in approach and methods, and that it requires government and political decision making to address its dynamic agenda (Turnock, 2012, p. 3). An amalgamation of political orientations, or public health orientations, influences the trajectory of this complicated, and often contradictory, public health system. Neoliberal, social justice, and pluralist political perspectives each adopted by various political and public health stakeholders led to a patchwork of policies—not representative of a singular, coherent ideology — that make up the healthcare and

public health systems (Grob, 2008). Each perspective had a unique/separate influence on issues in our health care system.

Neoliberalism is a political philosophy that purports the free market is the best purveyor of individual freedoms. This philosophy, noted by critics as a pursuit of economic policies that prioritize profit above all, even at the expense of individuals, dominated the framework with which the United States' public policy has been pursued and built since the early 1970s (Harvey, 2005). In healthcare, neoliberalism dominates the discourse of initiatives and public messages, as well as the philosophy behind these policies—constructing what other scholars may call "cultural hegemony." Hinnant (2009), for example, found the dominant discourse in women's magazines emphasizes health as a decontextualized individual issue offering a "semblance of autonomy," which shapes popular representations of health and gender (p. 318). Popular magazine discourse that is representative of a consumer-driven healthcare model, constituted by neoliberal policies, is only one small example of meaning that is shaped by these policies. Fairclough (2000) proposes,

> this discourse projects and contributes to actualizing new forms of productive activity, new social relations, new forms of identity, new values, etc. It appears in specific forms and transformations in different spheres of life… economic discourse, political discourse, educational discourse, and the representations of everyday life in advertising and popular culture (p. 148).

Neoliberal policies push public health in the direction of privatization, commoditization, globalization, and individual freedom and control (Bourdieu, 1998; Navarro, 2007). Recent policies promote prevention and early detection, as well as the patient-as-consumer model (e.g., Hall & Jost, 2005), and emphasize the individual's role in public health problems and solutions. Herein lies a crucial problem with public health policy

in a neoliberal lens: conflict exists between public health goals which require government mandates and collective acceptance to improve population health, and individual rights to self-manage health care decisions and practices. However, as critics of neoliberalism note, neoliberal public health policies actually exist at the expense of individuals and the promotion of corporation and profit.

Social justice policies in public health, however, emphasize assisting disadvantaged populations in order to reduce health disparities, which advocates argue were created by neoliberal policies (Koh et al., 2010). Public policy, outside of health-specific policies, influence disadvantaged populations' health. Viruell-Fuentes, Miranda, and Abdulrahim (2012), for example, argue that anti-immigration policies foster racism and discrimination, which lead to social and economic inequities—conditions that are associated with chronic disease. They assert, "perceived discrimination is associated with lower levels of physical and environmental health; poor access to quality health care; and certain deleterious health behaviors across several immigrant groups" (p. 2101). Social justice policies and programs assist populations that are socioeconomically disadvantaged, racial and ethnic minorities, women, and people with disabilities, to name a few. Social justice policies are often in direct response to, and in conflict with, neoliberal financial policies—they focus on correcting health inequities caused by globalization. Thus, social justice and economic policies are synonymous with health policies, resulting in a patchwork of philosophies that governs the public health system.

Pluralist health policies, also known as mainstream health policies, acknowledge the environmental factors and social structures that may influence an individual or

population's health. Mainstream public health policy makers are not proactive in seeking social justice agendas, or in completely individualizing social ills like neoliberal policy. Yet, pluralist perspectives assume that policy-shifts needed in order to assist certain populations will occur naturally as interest groups enter the political sphere (Dahl, 1960).

Situated within the larger political framework of neoliberalism and responsive public health policies intended to thwart the impacts of neoliberalism is the social action theory of public health. Social Action Theory (SAT) offers an integrative approach social-motivational, cognitive, and environmental processes to define public health goals and policy responses from an interdisciplinary lens (Ewart, 1991). SAT highlights the social context in maintaining health habits, links self-change processes to the social world, and identifies larger structural and environmental influences that encourage or limit personal change. SAT seeks to describe health behavior change and self-regulation, or lack of change, in a broader context than solely cognitive or social explanations.

The shifting view of public health's mission in the U.S, the complexity of the public health system, and often-contradictory public health policy objectives, contribute to a convoluted arrangement. Specifically, the implementation of increasingly-neoliberal reforms since the 1970's, and now recently with the implementation of the Patient Protection and Affordable Care Act's (ACA or Obamacare) National Prevention, Health Promotion and Public Health Council, preventive care programs are at the heart of modern public health (Senzon, 2010). In particular, the focus of public health has shifted from fixing social problems to promoting health. That is, modern

public health, via a variety of interventions, requires individuals to change their "*life's* style" and behaviors, effectively limiting personal choice. For example, public health advocates cite sugary drinks, the leading source of dietary calories in the US, as a culprit to be targeted in order to combat obesity at the population level (Stanbrook, 2013). Hence, in 2013, a New York City law went into effect that prohibits the sale of sweetened drinks over 16 ounces. Stanbrook (2013) argues that intrusive actions such as these are necessary and reasonable "when weighed against the threat posed to the population" in order to not limit personal freedom, but to normalize a serving (p. 9). Akin to the popular phrases of "keep politics out of my [bedroom, wallet, uterus, video games, etc.]" public health's individualized focus, however warranted or reasonable, yields a venue ripe for social conflict, or conflicting meanings.

Herein lies the problems: 1) modern public health policy is constructed of multiple, often competing political views, resulting in a hodgepodge of programs and ideologies that even trained professionals have difficulty understanding and navigating, and 2) modern public health policy increasingly focuses on individual-level solutions to population-level problems, creating an area ripe for social conflict as government mandates seemingly impact personal choice.

A wide variety of health issues/initiatives demonstrate the conflict between policy and individual choice/rights. Some public health concerns receive significant media attention, such as obesity, and tobacco use. Others receive less media attention. One such modern public health initiative that represents a complex and contradictory system with an increasingly individual focus is that of the National Institutes of Health's initiative to reduce Cesarean sections (The following variants are documented

in medical research: Caesarean section, caesarean, cesarean, C section, and C-section. For consistency, in this study they will be referred to as Cesarean sections or C-sections, except in the case of direct quotations) (United States., 2010).

Since the 1980s, rates of Cesarean births have risen steadily. In 1998, *Healthy People 2010* set the goal to reduce Cesarean births among low-risk women giving birth for the first time by 3%, and those who had prior Cesarean births by 9% (United States., 2002). C-sections can be medically advised due to risks or complications, or elected by the mother, called a Cesarean Delivery on Maternal Request (or CDMR) or elective C-section. Proponents of the reduction initiative argue that elective C-sections interfere with the natural childbirth process, impose risk without benefit, and squander precious medical resources (Sakala, 1993). The federal objective, currently, is to reduce first-time Cesarean births, as well as subsequent Cesarean births (after previous Cesarean delivery), each by 10% (United States., 2010). In order to do so, professional standards of Obstetricians and Gynecologists shifted, states created initiatives to improve perinatal care, hospitals changed policies to prohibit elective delivery prior to 39 weeks, and state-wide public education initiatives were implemented.

Specifically, the initiative to reduce Cesarean sections includes recommendations from the American College of Obstetricians and Gynecologists who recognize that clinical practice patterns affect the number of Cesarean births. Often, Cesarean sections are performed when certain labor indicators show that the labor is difficult or risky. Caughey, Cahill, Guise, and Rouse (2014) of the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine propose the following: allow prolonged early phase labor, consider cervical dilation of

six centimeters instead of four centimeters as the start of active phase labor, allow more time for labor to progress in the active phase, allow women to push for at least two hours if they have delivered before, three if it's their first delivery, and even longer if they've had an epidural, use techniques to assist with vaginal delivery, such as forceps or a vacuum, and encouraging patients to avoid excessive weight gain during pregnancy. With regards to CDMR, obstetricians are not obligated to comply a patient's request, though ethicists and professional groups believe they should do so (Ecker, 2013).

Local and state implementation of this initiative varies, demonstrating how institutions shape meaning and structures. In Oklahoma, for example, a quality initiative (QI) was begun to reduce the 2011 34.2% C-section rate (Centers for Disease Control, 2013). The QI requires contracted providers with Oklahoma Medicaid to receive a letter each month with their C-section rates (Oklahoma Health Care Authority, 2011). After review of C-section claims, those that are deemed not medically necessary are subject to reduced reimbursement rates. However, Oklahoma Medicaid (Soonercare) C-sections represent only a portion of the C-section rates in the state, and specifically, only those who qualify for Medicaid (i.e., those who are poor). Also, for example, in South Carolina in 2013, Blue Cross Blue Shield, a major insurance provider, as well as the state's Medicaid program, enacted a Birth Outcomes Initiative, which denies reimbursement for any elective Cesarean sections prior to 39 weeks, thereby limiting the Cesarean sections to a term where rates of successful deliveries are higher (Perelman, Delbanco, & Vargas-Johnson, 2013). In Texas, a Healthy Texas Babies awareness media campaign, called "Some Day Starts Now" and website were

developed to encourage mothers to wait the full 39 weeks before giving birth, and to create a birth plan (with the assistance of a check list) with C-section listed as an option, but only if it is medically required.

The Cesarean section reduction initiative is a public health intervention that impacts personal liberties for the sake of the public's health. The purpose of this study is to gain a better understanding of the public's response to modern public health's role as it specifically relates to this initiative. First, the review of literature will explore connection between public health policy and meaning-making, the process of meaning construction, the implications of misaligned meaning structures with policy responses, the discourses of maternity, and medical ethics surrounding birth plans. Next, a research question to guide the study is developed and posed. Finally, a study is proposed to inquire into a communication phenomenon situated in a niche area of the communication discipline.

Literature Review

Public health policy and meaning. The public health system's agenda, structure, and policy construction and implementation, as demonstrated, is byzantine and contradictory. As a result, the public and even practitioners know little about public health—its goals, strategies, or campaigns. However, where knowledge about the system and its policies may be limited, meanings of health, healthcare (the system), health care (services received), and disease still exist. Exploring the ways in which these meanings (or representations) are socially constructed is imperative to understanding how public health is experienced in the United States.

Social constructions of meaning. In order to understand how meaning of modern health policy is created and sustained, the general distinctions between social construction as a philosophy and method must first be made. Hibberd (2005) distinguishes between social construction as an epistemology and social construction as a practice or methodology. Social constructionism as an epistemology examines metatheoretical assumptions (such as its relation to positivist philosophy) that undergird the practice of social constructionism. Social constructionism as a practice or methodology reveals a wide range of accounts of social facts, and these facts are localized to a specific cultural understanding (social theories of emotion and the self, among others).

Social construction (as epistemology) developed as a response to post-positivist claims of Truth that can be studied, explained, and predicted (Polkinghorne, 1983). Human beings cannot stand outside of their own language, experiences, cultures, and structures. Thus, physical science methodologies cannot be applied to social science phenomenon unproblematically. Knowledge, from this perspective, is social, conditional, and bound in time and space. Social construction is often identified with the scholars: Wittgenstein (1968), Mead (1934), Durkheim (1964), Giddens (1984), and Goffman (1974) whose work embodies the relativism of knowledge, or truth. Most social construction scholars, however, are not complete relativists, but "situational realists" (Hibberd, 2005). Many respect reasonable boundaries of context and perspective, without venturing into complete relativism. Social construction scholars are concerned with how this knowledge is created.

The terms constructivism and social constructionism are often used interchangeably, which makes it difficult to distinguish the difference between the two approaches (Andrews, 2012; e.g. Charmaz, 2000). Constructivism has psychological roots and proposes a cognitive process through which individuals experience the world (Andrews, 2012), whereas social constructionism focuses on the social actions whereby meaning is created, negotiated, sustained, and modified (Schwandt, 2003). Social construction suggests a process by which our experiences shape our perspectives, and our perspectives shape our experiences (Johnson & Weigert, 1980). Social processes "*produce* the facts of the social sciences, and these facts are (it is alleged) sometimes revealed to be facts *about* social processes and the social milieu" (Hibberd, 2005, p. viii).

Social construction as a method that reveals specific realities has many practices. Lippmann (1922) argued that the environment in which we live is so diverse, that individuals must simplify it by selecting simpler images, or pictures. Goffman (1974) suggests that we do this with socially constructed frames that guide our decisions in a way that allows for public acceptance. More specifically, Spector and Kitsuse (2001) examine the social construction of social problems, which they argue are "the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions" (p. 75). Social problems then are defined, understood, and acted upon. These actions, mainly talk, are the focus of social construction scholars.

Contextual constructionism, in particular, examines subjective claims making, but recognizes the social and cultural context requires some shared assumptions of

reality (Best, 1995). Public policy, illness, disease, and health all have some shared assumptions of reality and objective existence, but the ways in which individuals experience these is the product of how they socially construct meaning. Contextual constructionists agree that a public policy, written and decreed, exists in an objective sense. Public policy (health and otherwise) is often implemented through organizational structures via administrative actors. So, although a larger reality is shared (the policy exists), how people make sense of such a policy and act on such a policy is often unique. The policy as it was intended to exist may be different than the policy as it is understood and used. For example, Kirby and Krone (2002) discuss paternity leave policies in which the policies exist to allow men to balance their work-family life, yet highlight that these policies are not used because they are seen as illegitimate or as socially unacceptable by their peers in the workplace. The authors argue in this example that organizational policies are "produced and reproduced through processes of interpretation and interaction," and "discourse surrounding organizational policies impact the structuring of the policies, and, ultimately, policy implementation in that written policies may differ from policies 'in-use'" (p. 51). Thus, the policy, however objective in its construction and implementation, is socially constructed in ways that can impede, or possibly improve, its success.

Other examples highlight the rhetorical and social structures that limit agency or influence meaning about an issue. A series of studies reflect on feminist analyses of workplace maternity policies and women's experiences. For example, Buzzanell et al. (2017) explores maternity leave policies from standpoint theory of women in "pink-collar" jobs, i.e. professional jobs that are traditionally viewed as jobs for women as

they are support/service occupations. The authors argue that meaning making about these policies cannot be divorced of the power and organizational-political structures. The authors identified the temporal structures equated with economic realities as structuring women's need to return to work after maternity leave; meaning, the structures in place within the organization limited the agency afforded to women. They also found that discourse of ability, and disability, requires them to negotiate their meaning of the policy and the value of their role to the organization.

Similarly, Buzzanell and Liu (2005) studied the workplace experience of pregnant women, on maternity leave, and on returning to paid work. The authors found that pregnant or recently pregnant women's experience in the workplace expressed conflicting discourses about their experiences, wishes, and desires. Women expressed excitement about becoming mothers, but conflict with regard to others' positioning of their leave as detrimental to the organization or abusive of policy. Women's experience in the workplace structure their experiences of pregnancy and early motherhood, and vice versa, as it shifts their interpersonal roles, requires identity work governed by participation in the masculine sphere of the workplace, and more social negotiations within the spaces.

Also, Liu and Buzzanell (2004) highlight negative representations of women's experience with maternal leave policies, identifying a disconnect in the intent of the policy to strengthen the economic impact of women in the workplace, and the application of such policies in the workplace that result in women's negative experiences and ultimately, women not returning to the workplace. The lack of shared meaning in the policy between women and their employers with regard to expectations

of justice and care, they argue, should be revisited to allow for shared understanding and negotiated meaning. These studies identify the social, political, and organizational structures that influence meaning of policy and the resulting negotiations, both in identify and in the social sphere, in this case within the workplace, that are required to make sense of the experience.

Process of meaning construction. Now that distinctions between social construction as philosophy and method have been made, social construction theories can be explored. Quality social construction theories assist in understanding of the processes by which reality is socially constructed, rather than simply describing an instance of social construction. Meaning, as explored in this dissertation, is deciphered from discourse. Alvesson and Karreman (2000) distinguish between discourses and Discourses: the former being the talk or language that people use in conversation, and the latter being the talk or language that constitutes world views and systems. "Lower case d" discourse is the empirical material that indicates a linguistic happening. "Uppercase D" discourse is less observable: the "other levels of social reality are more or less shaped or even subordinated by the power-knowledge relations in established discourse (p. 1122). In other words, lowercase discourses are the mode of talking which exhibits meaning of a phenomenon, and uppercase Discourse prescribes the structure in which meaning can be understood and acted upon.

Meaning must be examined in the local context as well as with its cultural dimensions. Repetition of discourse indicates popularity of meaning. However, "incoherence, variation, and fragmentation" also yield meaning (Alvesson & Sveningsson, 2003 p. 378). Multiple, often-competing meanings construct an

ecosystem of discourses surrounding any topic, but particularly, public health. That is, people are exposed to an environment of messages, and a normalized way of how it can be talked about.

In addition to potentially competing meanings among identity, self, and stigma, other messages from policy-makers, the media, family, and friends assist in the production of, and shifting of meaning. High quality social construction theories do more than just describe the varying representations of a topic, they describe the ways in which meanings compete, and win.

Social Representations Theory, or SRT, as proposed by Serge Moscovici (2008) is one quality theory that explores the social constructions, or representations, of new or revived phenomena. Similar to the concept of an ecosystem of messages, social representations are socially constructed meanings that help individuals of a community to not only understand a phenomenon, but garner the socially acceptable language to participate in talk about the phenomenon with other members of their community. In his seminal study, Moscovici explores a scientific phenomenon among three different social groups and discovered two types of "knowledge" about an issue: a type of scientific knowledge and a type of lay knowledge, which are constructed through individual attitudes and cognitions, media messages (which he called propaganda), and interpersonal communication. He illuminates the process by which meaning is socially, or culturally, constructed. Different segments of society, he argued, create different meanings, each with its own consequences, of the same phenomenon.

For example, Moscovici was concerned with why Freud's psychoanalysis was assimilated into French society. As part of his study, he compared representations of

psychoanalysis in the French press among Catholic, Communist, and liberal publications. He discovered the different ways in which psychoanalysis was represented to each community, yielding different, competing attitudes toward the therapy.

Moscovici's theory offers a solid perspective from which to examine social constructions. By examining individual perceptions (rather than cognitions), media messages, and interpersonal discourse, one might have a better picture of a "happening." Social construction scholars often have explored the role of perceptions in social construction, media messages in social construction, and interpersonal communication in social construction. For example, social construction scholars in health communication have explored in-depth how health and disease is constructed via identity (Epstein, 1996; Powers, 2008). Political communication scholars note the role of policymakers and officials in shaping a public problem for the media (Baumgartner & Jones, 1993), the media's representation of an issue in order to construct a problem to elicit a particular policy response (Lawrence, 2000; Stone, 1989), and how the public understands a particular issue the media selected (Nicholson-Crotty & Nicholson-Crotty, 2004; Spector & Kitsuse, 2001).

In public health research, the perspective is largely similar. Researchers examine how various stakeholders socially construct a health care problem and thus, propose a policy solution (Malone, 1995); also, they study how a health care problem is structured, and thus, policy is implemented (Patterson & Keefe, 2008). For example, Malone identifies the social problem, as highlighted in health care reform debates, of a particular subset of the population who use emergency room visits at a higher rate. In

her study, she explores the social constructions of the problem of those that overuse emergency room visits and critiques stakeholders' proposed solutions. Rarely, however, have social constructions/representations been examined to understand the process by which multiple messages surrounding a singular phenomenon shape meaning. In other words, often social construction research focuses on representations and not the processes of how they come to be. To address this omission, this study will not only highlight representations of a particular case, but also explore the processes by which representations are constructed.

Social construction of public health policy. Public health policy is an area in which government mandates uniquely intersect with individual choice. Thus, a researcher must cast a large net to explore meaning-making structures, or the social construction of competing realities. One cannot only study the intended meaning or the message created by government institutions, but must also study the meaning created individually and collectively though public d/Discourses. Thus, a person's meaning of public health policy is 1) shaped by individual meanings of identity, health, and disease created through discourse, 2) shaped by one's culture, and 3) influenced by public Discourses of policymakers and actors who implement policies.

Seminal research in the realms of health communication, public health, and political communication yield insight into the meaning making of public health: a personal, social, *and* political process. Initially, though a disease or illness is objective and material, just as public health policy is, the way in which individuals experience and understand it is the product of how we socially construct meaning, in the same way the meaning of the above-mentioned paternity policy is socially constructed. The

meaning of illness, Fife (1994) argues, is comprised of self-meaning and contextual meaning, influences future behavior, and changes over time as more events (both self and contextual) occur. She argues that although illness may be relatively universal, the way in which it is experienced is personal and specific to the experience. Social construction in health communication research often discusses the concepts of illness, self, identity, and even stigma, and their role in seeking and adhering to medical treatments.

Next, the social construction of the meaning of illness or disease can also be culturally specific. The threat of social stigma may impact an individual's treatment seeking and adherence, or larger cultural groups' responsiveness to public health campaigns. Often, the labeling of a disease or illness can trigger negative mental models. Rintamaki et al. (2006) for example, exposes the relationship between high HIV stigma concerns and likeliness to be nonadherent to medication. Also, for example, the response from various public health centers to the H1N1 epidemic, or swine flu, revealed that the early nicknaming of the infection as swine flu resulted in resistance to testing for the illness due to stigma perceived by multiple cultural groups, such as those of Muslim or Jewish faiths (Powers, 2008). Resistance to testing yielded increased transmission, contributing to an even deadlier public health threat.

Finally, just as individuals and cultural groups may have powerful meanings for illness and disease, language used by public health campaigns and policymakers may also trigger disadvantageous mental models in the public. Puhl and Heuer (2010) discuss how public health officials have recently recognized the detrimental implications of HIV/AIDS stigma, and now explicitly identify it as a barrier to

addressing the epidemic. By contrast, they acknowledge that the stigmatization of obese individuals has not been a concern for officials, and in fact, is even used as a tool for obesity control, resulting in negative implications for individual and population health. Competition exists among meanings of obesity by those whom individually experience it, how policymakers construct the problem in order to place the problem on the public health agenda, how campaigns target the disease, and the public's meaning of obesity. This study will examine the ways in which meanings of identity, health, and disease, a person's culture, and public sensegivers combine to give meaning to public health policy, in addition to the larger socio-political constructs that shape such meaning.

Misaligned meaning structure and policy response. Exploring new public health initiatives that require government intervention in matters of personal choice, such as the reduction in C-sections, requires inquiry into socially constructed processes using an ecological perspective of which Moscovici's theory offers a good model. This type of inquiry is justified for two reasons: 1) most health policies are designed and implemented from a top-down perspective, and 2) ineffectiveness of and resistance to public health programs persists, suggesting that there may be disconnects among policymakers and their policy and the meaning or understanding created by those whom they are trying to reach. This compels us to explore instances in which policy fails to connect with the populations it intends to serve.

Health policies, health communication research, and political science research, tend to adopt the top-down, one-way model of communication where expert knowledge from stakeholders, policymakers, practitioners, and other healthcare professionals is

disseminated to the ignorant masses (Lupton, 1994). However, this top down approach is often ineffective. A first reason for this is that rarely are those who are the targets of public policy consulted as to their understandings and representations. Dutta (2010) argues from a global perspective that public policy is West-centric, and devalues and removes agency from minority perspectives.

Second, top-down policy may be the culprit as to why many public health programs are ineffective because they often fail to account for how understandings, or social constructions, of health and disease may influence these policy approaches and their successes. Ott, Rosenberger, McBride, and Woodcox (2011) for example, suggest that mental health policy is at odds with adolescent understandings of mental health. The authors discovered that unlike policy makers who view depression and anxiety as an individual phenomenon remedied by increasing access to mental health treatment, teenagers view mental health as an environmental phenomenon. The authors suggest, based on this discovery, that interventions should focus on healthier environments (teen relationships, such as social support systems, and context, such as the physical environment, safety, and financial resources), rather than treatment access in order to align resources with needs. The social construction of policy by the public, or those targeted by the policy, is rarely examined, despite scholars' argument that certain segments of the population are particularly affected by public opinion and public policy (Donovan, 1993; Schneider & Ingram, 1993).

For example, the fact that the cesarean section reduction initiative is ineffective is no surprise, considering the above research. The cesarean section reduction initiative began as a *Healthy People 2010* goal. The data from which the goal was derived was

population data from the National Vital Statistics System-Natality from the Centers for Disease Control and Prevention, National Center for Health Statistics health (United States., 2010). Without personalized data as to why women choose cesarean sections, the initiative cannot be effective. Indeed, the original objective for 2010 was not met, so it was retained as a 2020 objective. Top-down initiatives that do not account for individual or cultural perspectives will likely meet failure because they create a misalignment between policy goals, the problems the solutions are meant to fix, and the people who have to be open and willing to such changes.

Also, top-down public health policies may be unsuccessful because they often fail to reach populations because they elicit resistance: individual and social. Individual-level resistance to health initiatives, as well as medical directives, is often referred to in the medical literature as a lack of patient adherence or medical noncompliance. Studies on medical noncompliance often focus on either strategies to ensure compliance (Klingle & Burgoon, 1995; Rochon et al., 2011) or barriers to compliance (Purc-Stephenson & Thrasher, 2012). For example, Klingle and Burgoon (1995) discovered that gender influences the type of compliance gaining strategies (positive or negative) that practitioners can successfully use in an attempt to gain influence. Although men can use positive or negative compliance gaining strategies and be successful, female physicians are limited to positive compliance-gaining strategies in order to achieve success. Also, Rochon et al. (2011) identified cultural beliefs/language, stigma, cues to action, self-efficacy, and mood state as barriers to compliance for HIV treatment.

Barriers that prevent individuals from adhering to medical directives are often studied from an individual-level, psychological perspective. The majority of research on compliance barriers finds that the complexity of the directions and difficulty in understanding and reading medical instructions influences patient adherence (Osterberg & Blaschke, 2005). For example, Williams et al. (1995) examined indigent and minority patients' ability to understand common captions used to prepare a patient for a gastrointestinal exam and a section from the informed consent waiver. Researchers found a large percentage of these patients were unable to read and understand basic written medical directives.

Noncompliance has also been linked to health beliefs and intentions (Helme & Harrington, 2004; Purc-Stephenson & Thrasher, 2012). For example, Helme and Harrington (2004) studied diabetics' narratives for noncompliance, and discovered that when asked about their noncompliance, patients would either 1) admit to the noncompliance and indicate guilt or an apology, 2) admit to the noncompliance and offer an excuse or reason for the noncompliance, thus denying responsibility, 3) admit responsibility for the noncompliance, but minimize the harm, or 4) refuse to admit that they did not comply with the practitioner's directives.

Similarly, Purc-Stephenson and Thrasher (2012) argue in their study of compliance with triage recommendations that compliance is positively influenced by patient perceptions of perceived threat of illness and trust in provider, and the quality of the provider's communication using active listening and advising, but mediated by access. The Health Belief Model suggests that patients are more likely to comply based on perceived severity and susceptibility, as well as perceived benefits and barriers (Janz

& Becker, 1984). Research on compliance gaining and compliance barriers offers insight into psychological resistance to health messages, and the importance of communication.

What is important to note with regards to the vast literature on the varying forms and intensity of individual level resistance to health directives is that the literature is vast. Top down policies put onus on the individual. By emphasizing the individual as "hold[ing] the key to explaining health behavior," these theories ignore the structural and environmental constraints placed on individuals that influence, or even require, their resistance (individually and collectively) (Dutta-Bergman, 2005, p. 108).

Social resistance to health initiatives often takes form in health social movements, or HSMs. Historically, social movements dealing with health began with organizing around occupational health during the Industrial Revolution (P. Brown et al., 2004). Occupational health activists focused on reducing and developing protocols for workplace hazards (chemicals, work hours, noises, electricity, machinery), such as guidelines for handling chemical and toxic materials to ensure safety of workers. More recently, HSMs included AIDS activism to establish increased funding, research, and alternative treatments (Epstein, 1996). Among the many HIV/AIDs social movements, Gamson (1989) discusses the social movement ACT UP (the AIDs Coalition To Unleash Power) which seeks to use and target cultural resources, such as local gay and lesbian groups, in order to combat the AIDS epidemic by getting grassroots support in order to demand government action (such as successfully increasing access to experimental drugs). Also, women's health activists and their movements focus on a variety of women's health issues. Kolker (2004) identifies the funding activism of

breast cancer social movements. Kolker argues that breast cancer activists used culturally resonant frames to put funding for breast cancer on the public health agenda, and successfully increased breast cancer specific federal funding from 1990-1993. King (2006) argues that the breast cancer movement increased reproductive rights, established shifts in treatment practices, and established funding (King, 2006). For example, the breast cancer movement through grassroots organization and corporate alliances increased funding and changed breast cancer screening guidelines to improve detection rates. Brown and Fee (2013) argue that health social movements, both historical and current, improved population health in the United States.

Similarly, Zoller (2005) describes health activists as those who attempt to influence social change in public norms, policies, and social structures (and understands HSMs as a form of activism via grassroots communication efforts and/or public service campaigns). However, often resistance occurs collectively *in opposition* to public health campaigns seeking to improve the nation's health. For example, communities that resist vaccination requirements because of the belief that vaccinations cause autism act in direct opposition to national and state public health goals. These "anti-vaxer" communities, however, are not necessarily organized as a traditional social movement or interest group, but instead are loosely connected communities, connected only by internet discussion board commentary on vaccination news articles and blogs, who perpetuate and defend the rumor that vaccinations cause autism (Edy & Baird, 2014). Edy and Baird (2014) highlight the need to examine this community without preconceived notions of Truth in order to understand their discursive strategies.

Based on the intersections among the literatures listed previously, a critical approach that recognizes health communication as a political process that involves power relations is necessary to public health research (Lupton, 1994). To do this, Dutta-Bergman (2005), advocates structure-centered and culture-centered approaches to health communication research. Structure-centered approaches highlight the need to address basic life resources (food, water, shelter, clothing) in underserved populations (already marked by socioeconomic inequalities that are associated with poorer health outcomes) through community-based programs. A structure-centered approach both acknowledges this socioeconomic fact, and attempts to study ways in which programs can be implemented for maximum effectiveness. A culture-centered approach, however, focuses on co-constructing meaning that allows for participatory framing of the solution, rather than traditional top-down public health model that fails to reach populations at the local level (Dutta, 2012, Dutta-Bergman, 2006; Jamil & Dutta, 2012). Meaning of the problem and prescribed solutions are sought from the communities themselves, participating in what social theorist Rawls (1979) would call redistributive justice. That is, health disparities are social injustices and must be righted. One solution is the redistribution of resources, in this case, allowing those who have been marginalized and/or oppressed to speak for themselves.

To recap, public health policies are often developed and implemented in a top-down fashion: from powerful officials to individuals. Rarely do the people these policies target participate in the framing of the problem and implementation of the solution, resulting in ineffective policies. The reduction of Cesarean births is such an

initiative. Those to whom the policy is targeted must be consulted to determine construction of the problem, if one exists, and participation in the solution.

The modern childbirth context. Despite the evolutionary requirement of childbirth, the experience has evolved over centuries due to advancements in maternal, prenatal, and perinatal care and medicine. Modern childbirth poses a spectrum of options for delivery—from highly medicalized, elective surgeries, to non-medical births inside and outside of a hospital. Similarly, with the increase in choice and the movement toward more medicalized births, the modern childbirth context also includes medical and professional ethics of care providers, and patient-as-consumer and women's and patient's rights. Other modern influences on the context of childbirth and birth plan decisions include provider influence on birth plans and other stakeholders, including fathers and families.

The spectrum of birth options. Having discussed the unique position of public health in its political and health contexts, as well as communication theories that impact the creation of and reception of public health initiatives, the focus of the remainder of this dissertation is the particular area of public health concerning women's birth plans, and the federal initiative to reduce elective Cesarean section rates. On the spectrum of childbirth options available to women, choices range from highly medicalized births, such as Cesarean sections, to completely natural, medication-free vaginal births occurring outside of a hospital (see Figure 1). Overwhelmingly, childbirth in the United States is highly medicalized. In 2012, 98.6% of women gave birth in a hospital, of which, 85.8% were attended to by a doctor of medicine and 6% by a doctor of osteopathy. Cesarean sections, the most highly medicalized birth option, represent

32.8% of US births in 2012. Despite childbirth being a natural phenomenon, less-

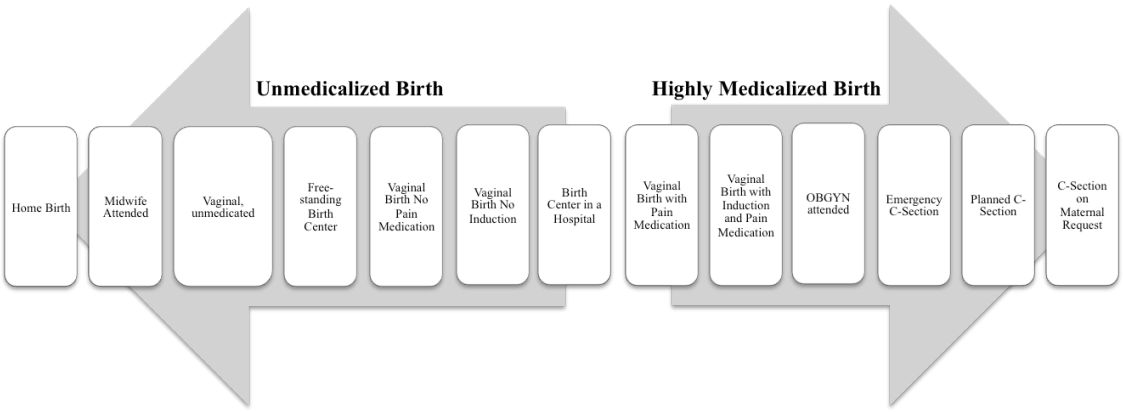


Figure 1. Birth Spectrum

medicalized births are rare in the United States, despite their comparable safety for mother and child. Only 7.6% of hospital births are attended to by a certified nurse midwife (CNM). Of the only 1.4% of out-of-hospital births, 65.6% occur at home (the highest rate since 1989), and 29% at a free-standing birthing center. In many developing countries, women have no choice but to deliver their child at home with few resources (FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 2013). Currently, some women in developed countries express dissatisfaction with hospital care and seek to give birth at home. Home birth in the United States, however, remains controversial due to lack of consistent evidence as to its comparative safety to hospitalized births (Cheng, Snowden, King, & Caughey, 2013; FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, 2013). Therefore, normative birth is not necessarily natural birth, especially in the United States.

Elective Cesarean characteristics. Many studies articulate characteristics of women who choose to have elective Cesarean sections. In studies based in Chile and Australia, women who receive private care, had prior Cesarean sections, and who have

limited access to midwives are more likely to have Cesarean sections (Laws, Abeywardana, Walker, & Sullivan, 2007; Murray & Elston, 2005). According to a study of Taiwanese women, Cesarean delivery propensity increases with maternal age (Lin & Xirasagar, 2005). Also, women who previously had a Cesarean birth are more likely to prefer a Cesarean section (Metz et al., 2013). Women choose to have elective Cesarean sections for a variety of reasons. International studies (Taiwan, Finland, Australia, Sweden, Norway) and professional opinions cite the following reasons for women to elect a Cesarean section delivery: previous negative birth experience, fear of childbirth, traumatic childhood experiences, fear of perineal damage, physical stamina, the ability to schedule a delivery in advance, late childbearing, protection from pelvic floor damage, refusal or reluctance to undergo labor pain, information from the doctor, and social convenience (Al-Mufti, McCarthy, & Fisk, 1997; Amu, Rejendran, & Bolaji, 1998; Chong & Mongelli, 2003; Fuglenes, Aas, Botten, Øian, & Kristiansen, 2011; Gamble & Creedy, 2000; Karlström, Nystedt, Johansson, & Hildingsson, 2011; Nzewi & Penna, 2011; Sahlin, Carlander-Klint, Hildingsson, & Wiklund, 2013). In addition to the popular reasons for elective Cesarean sections, there are less-cited reasons for the delivery choice. For example, in a case study of Taiwanese women, 45.1% requested a Cesarean section because of astrology (Huang, Yang, & Chen, 1997).

Interestingly, studies of Australian women and Swedish women determined that some women who chose elective Cesarean sections made uninformed choices. Karlstrom et al., (2011) described women as having difficulty choosing and lacking knowledge and experience, and thus, were characterized as ambivalent. Fenwick, Staff, Gamble, Creedy, and Baynes (Camann, n.d.) discovered that women "struggled to

articulate any personal meaning" about child birth, using the discourse of "getting" a baby, rather than "having" a baby (p. 397). In their study, the majority of women who chose elective Cesarean sections were unaware of long-term risks to themselves associated with Cesarean sections, and risks to the baby (Fenwick et al., 2010). Thus, the authors concluded that women minimized the likelihood and severity of risks about which they were informed because they perceived that medical professional Discourses designated their choice as safe and responsible.

Many studies that are critical of elective Cesarean sections on maternal request cite increased cost, and comparative safety as the primary reason to not promote Cesarean section on request as a standard of care for maternity patients (Druzin & El-Sayed, 2006; Latham & Norwitz, 2009). In an economic study using a cost-effectiveness analysis comparing elective Cesarean section and vaginal delivery reports, a researcher found that Cesarean section without labor appears to be more expensive than uncomplicated vaginal delivery (Zupancic, 2008). However, the author is cautious in his findings, asserting most studies that attempt to compare these costs use analyses that are methodologically flawed. He argues, these studies lack consistency in reporting direct and overhead costs, fail to report costs and effects in tandem; represent too few randomized trials; and have inadequate power to make predictions. Assumptions as to the economic implications of these medical interventions cannot be made without adjusting for these methodological flaws.

Non-medical birth characteristics. Non-medical births in the United States include midwife-attended births in a maternity center, or midwife attended births at home. Home births in the United States are relatively unpopular, accounting for only

1% of births ("Home birth—proceed with caution," 2010). While some studies argue for the safely of homebirths, others articulate the methodological flaws in the studies that advocate the safety of home births. In their groundbreaking meta-analysis, Wax et al. (2010) found that although planned home births are associated with fewer maternal interventions, fewer negative side effects for the mother, and fewer negative neonatal outcomes, they were also associated with significantly higher (tripled) neonatal mortality rates. However, critics of the study cite methodological issues such as neonatal mortality assumptions based on fewer than 50,000 women ("Editorials about home birth—proceed with caution," 2010).

Women choose home births for a variety of reasons. In a Swedish study of risk perception of women who chose home birth, women cited the risk of loss of autonomy (being "in the hands of strangers," being "in the hands of routines and unnecessary interventions," and being "in the hands of structural conditions") when choosing a hospital birth, and the risk of "being beyond help" (women considered the worst-case scenarios and distance to the hospital, yet identified that there are not guarantees) when choosing a home birth (Lindgren, Rådestad, Christensson, Wally-Bystrom, & Hildingsson, 2010). In terms of managing risk in choosing a birth plan, women articulated using their own intuition when weighing the risks of birth plans, relying on "extrovert activities" in which mothers would communicate risk with professionals, and avoiding talking about risk altogether. The majority of women articulated using their intuition to manage risk, followed by avoiding communication about risk with traditional health care providers (although they did consult partners and Internet

resources). Only a small percentage of women talked with pregnancy and childbirth professionals.

In Australia in 2009, submissions were solicited in response to a discussion paper on improving maternity services (Dahlen, Jackson, Schmied, Tracy, & Priddis, 2011). After submissions were received, the resulting report recognized the demand for more birthing centers and home births. The study found, however, despite the demand for hospital alternatives, there was less support for birth centers than for home births. Dahlen et al. (2011) argue that the home birth option requested by mothers was denied by government authorities who "feel they know best in terms of safety and recommend birth centre as compromise" (p. 170). Despite the need and desire for a home birth option, those with the power to make policy decisions overruled mothers and their needs.

A midwife-attended birth in a maternity center is another non-medical birth option, yet is also unpopular. Lawton, Koch, Stanley, and Geller (2013) studied the midwifery-led maternity service in New Zealand over a 15-year period to determine if a shift from medicalized birth (midwife-attended births in a maternity center, rather than doctor attended births in a hospital) would yield fewer Cesarean sections. Surprisingly, their study showed that not only did Cesarean rates not decrease as they anticipated, but rates actually increased similarly to that of other medically advanced countries. Access, an often-cited reason for lack of compliance, cannot be the only culprit. Social forces that influence perception of birth options must also be examined.

Rhetorically, home births are fraught with strikingly similar arguments elective Cesareans face. Ironically, medical professionals question the risk and safety of home

births for mother and child, as they do with elective Cesarean sections. Under this paradigm, Western medicine is prioritized as the answer to reduce risk and ensure safety, as long as it is not taken to the elective Cesarean extreme. Also, women who chose home births cite similar reasons to women who chose elective Cesareans: they want the autonomy to determine their own birth experience and to personally weigh risk, rather than have it weighed for them. Again, physicians' and policy makers' medical construction of birth, trumps a mother's personal construction of birth. Thus, acceptable birth plans are those that are medicalized, but not too much.

Medical and professional ethics. Practitioners—physicians and midwives— and scholars position themselves on many sides of the contentious topic of the medicalization of childbirth. Clinical, ethical, and legal discussions on childbirth typically center on the performing of elective and premature C-sections, as well as on the risk and choice surrounding at-home births.

Two tenets of medical ethics are central to childbirth discussions in the biomedical sphere (the dominant rhetorical sphere on childbirth): 1) the requirement to obtain informed patient consent, and 2) the requirement to do no harm, potentially two conflicting tenets. With respect to a patient's autonomy, doctors are required to obtain informed consent before treatment, except in the case of life-saving treatment in emergency situations. The right to refuse medical treatment, the autonomy to make decisions about one's body, is considered to be a principle of liberty ("The right to refuse treatment: a model act.," 1983). For example, Jehovah's Witnesses are unwilling to accept blood transfusions, even when their lives are at stake (Weinberger, Tierney, Greene, & Studdard, 1982). Legally, doctors are bound to respect refusal wishes.

Ethically, however, the general consensus among practitioners is that the decision is up to the doctor due to their oath to "do no harm."

Some doctors highlight concern that patients requesting Cesarean sections are not offered adequate information by their doctors to make an informed choice, and thus are not able to give informed consent (Gass, 2006). From this perspective, Gass advocates in an opinion paper that anesthesiologists may refuse to participate in an elective C-section due to the fact that it may not be medically necessary and also, put the patient in undue harm. Alternatively, Camann (2006) offers opposition to this in a response opinion paper and argues an elective Cesarean section is a reasonable choice that is protected under the norms of medical ethics, and thus, refusal is unjustifiable. Refusal to participate in a medical procedure deemed harmful to the patient or fetus, or care for a patient who chooses not to comply with the recommended treatment is one of three ethical provider options (The American Congress of Obstetricians and Gynecologists Committee, 1999). Providers may also choose to respect the patient's autonomy and proceed or not proceed with the unauthorized treatment, or completely disregard the patient's autonomy and request involvement of the court (discussed in the following section) (The American Congress of Obstetricians and Gynecologists Committee, 1999).

Practitioners also debate the "do no harm" oath with regards to conducting n unwarranted medical procedures. Critics of elective Cesarean sections cite the following risk arguments against CDMR (Cesarean delivery on maternal request): the increased risk of maternal mortality, morbidity, social inconvenience (from increased hospital stays), long term implications (increased propensity of risk on future

deliveries), and fetal and neonatal risks (e.g. increased risk of respiratory distress syndrome) (Lee & D'Alton, 2008; Penna & Arulkumaran, 2003). From this perspective, the risk of performing a surgery that is not medically justified does more harm than doing nothing. However, proponents of elective Cesarean sections cite tokophobia (fear of childbirth), avoiding maternal risk (e.g., avoids the pain of labor, reduces pelvic floor disorders that occur after natural birth), and convenience (C-sections take less time that natural birth and therefore frees practitioners to attend to other patients) (Penna & Arulkumaran, 2003).

Patient-as-consumer and women/patient rights. A patient's autonomy to choose his or her medical treatment has ethical, legal, and cultural implications. Ethically, obstetricians and gynecologists are obligated to protect both patients (the pregnant woman and the fetus), making the maternal-fetal relationship an ethical (and political) challenge. Often, mothers are willing to assume greater risk for the sake of their fetus, but when the mother and the doctor value risks and benefits differently, incongruity in decision-making may occur (The American Congress of Obstetricians and Gynecologists Committee, 1999). For example, if a pregnant patient's fetus is in danger, a doctor must weigh the risks and benefits to both mother and child. A doctor may recommend an emergency Cesarean section, despite the risks to the mother, in order to ensure successful delivery of the baby (who may be in greater risk than the risks that surgery imposes). The pregnant patient, however, may elect to not undergo a serious surgery because of her own risk or fears. The practitioner, then, has his or her own options as to if he or she will elect to respect the wishes, recuse him or herself, or get the court involved.

Next, federal and state laws are still unclear as to if patient requests or demands for medical intervention are protected under the same right to refuse medical treatment. Thus, the legal and political implications of pregnancy are abundant. First, and surprisingly, doctors and other medical professionals often debate if women even have the "right" to choose their birth place and method, e.g. a home birth without access to potentially lifesaving equipment and medical professionals, or an elective C-section without medical indication. Often, medical practitioners view home births as dangerous, unnecessarily risky choices. Midwives, on the other hand, often view elective or hasty Cesarean sections as dangerous, unnecessarily risky choices. Professionals in both camps articulate the "rights" of women in the context of how much *risk* they can *reasonably* assume on behalf of themselves or their child. In their study on Swedish mothers, Sahlin et al. (2013), highlighted mothers defending their choice in the face of critics (extended family and friends), which echoes the women's right to choose discourse. One mother stated:

> And I think that in today's society in advocating individualism, as it were, it is obvious that it will spread in maternity care that people will demand that I want it like this or like this. It is my body and if I want you to cut into me even though I am perfectly healthy, then you should do it I think.

Similarly, physicians and midwives often debate the role of "reasonable choice" in determining birthplace and method. The midwifery model emphasizes autonomy, whereas the medical model emphasizes Western medical intervention. In an integrative review of international literature about women's experiences in choosing where to give birth, researchers found that "women worldwide wish to be able to exercise their rights and make informed choices about where to give birth" (Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos, & Mårtensson, 2012, p. 380). The authors found the

following themes: choice of birth place and medicalization of childbirth, midwifery model and the rhetoric of birthplace choices, perceptions of safety shaped women's preferences, and informed choices and women's autonomy. They argue, however, that a woman's choice is governed, or structured, by the "normal progress of the pregnancy, the country's health system, and the geographical location of their home" (p. 389).

Under the midwife model, midwives often recognize their role in advocating for women's rights during the childbirth process (Floyd, 1995). In a 2013 discussion reported in the *American Journal of Obstetrics and Gynecology*, professionals present a slew of nuanced arguments as to patients' and women's rights with regards to the ethical acceptability of planned home birth (Charalampos & Charalampos, 2013; Chervenak, McCullough, Brent, Levene, Grünebaum, et al., 2013; Chervenak, McCullough, Grünebaum, et al., 2013; Chervenak & McCullough, 2013; Chervenak, McCullough, Brent, Levene, & Arabin, 2013; Dixon, 2013). They argue over patient safety, women's rights and autonomy to make decisions, among other issues. In an editorial presented in *The Lancet,* a British medical journal, the author states, "Women have the right to choose how and where to give birth, but they do not have the right to put their baby at risk" ("Home birth—proceed with caution," 2010). Arguments and counterarguments under both medical and midwifery models are evident.

Politically and culturally, the maternal-fetal relationship is a highly contentious debate. Since before the landmark decision of Roe v. Wade, the timing at which a fetus is protected as a person was under debate. Roe v. Wade, the Supreme Court case on abortion, declared that laws banning abortion in the first or second trimesters were unconstitutional due to a woman's right to privacy. Yet, despite the Supreme Court

ruling, a political and cultural war still exists. Many state laws exist to further the pro-choice agenda despite Roe v. Wade. For example, Texas law states that life-sustaining treatment must be sustained on pregnant patients. In early 2014, that case was put to the test when a 33-year-old pregnant woman was found unconscious by her husband (Morin, 2014). Doctors declared her brain-dead, but felt compelled to keep her on life-support to be consistent with Texas law. As previously mentioned, doctors can choose to use the courts to authorize medical intervention when they disagree with the patient's choice. After a month of being on life support, the local court ruled that the woman be removed from life-support because the law did not apply to someone who was legally dead.

Additionally, more legal interventions between mother and fetus criminalize behavior deemed harmful to the fetus. In August 2014, the first woman was arrested under Tennessee's new pregnancy criminalization law. Mallory Loyola, a 26-year-old, was arrested for illegal use of a narcotic drug (smoking meth) while pregnant, despite no evidence of harm to the child (Fitzpatrick, 2014).

Recently, political debates further confound the rights of women, the rights of a patient, and the rights of the unborn. Public discussions and court rulings on contraception cannot be left out of the discussion of whose "rights" are to be protected. Particularly, recent conversations on women's right to access contraceptives, particularly those known as "abortifacients" are of interest. "Pro-choicers" continue to maintain that a woman's right to privacy is protected under Roe v. Wade. "Pro-lifers," however, still advocate for the rights of the fetus as person. The Supreme Court's decision in Burwell v. Hobby Lobby Stores, Inc. (2014) was a win for pro-lifers in that

closely-held corporations could exercise religious rights, previously only afforded to persons, in exempting themselves from federal laws. In this case, Hobby Lobby now has religious rights, exempting itself from the Affordable Care Act's requirement to provide birth control for its employees by refusing to provide abortifacients. Regardless of one's position on the Supreme Court ruling, the case further exacerbated rhetorical struggles over the meaning of personhood and pregnancy.

As mentioned earlier, the medicalization of childbirth is the predominant framework for childbirth Discourse. Within that framework is also the predominant patient-as-consumer health care model. This model governs health care in the United States and is characterized by patient aims for choice, personalized care, and attention, in an electronic world where influence is sought using channels outside of the traditional doctor-patient relationship (Moses et al., 2013). The patient-as-consumer health care model also adds nuance to childbirth arguments. Penna and Arulkumaran (2003) present both sides of the maternal choice debate:

> The issue of the right of a woman to choose how she gives birth, as opposed to having this decided for her paternalistically by her obstetrician, is often given as a reason for performing non-medically indicated Cesarean sections. It is remarkable how an ethos that advocated greater involvement of women in decision-making regarding normal childbirth has been manipulated by interventionists to support their arguments. Analysis has led some to conclude that the increasing use of non-medically indicated Cesarean section actually represents an erosion of maternal choice by an increase in medical control (p. 402).

The *right* of a woman to have *privacy* to make a *reasonable choice* for a birth plan is increasingly becoming more and more rocky.

Although activists often cite a woman's right to control of her body, and thus, the right to choose her birth plan, public attitudes may not support this rhetoric. In a study on urban patient attitudes related to Cesarean delivery, Pevzner et al. (2008)

discovered that only 1% of the 95% of women who disagreed with CDMR felt the decision should be left to the individual, where as of the only 5% who supported CDMR, 75% felt the decision should be left to the individual. In other words, the overwhelming majority of women disagreed with Cesarean delivery on maternal request. When asked their justifications, very few (less than 1%) indicated it was a choice that should be left to the individual. Of those who support CDMR, the majority felt it should be an individual decision. Those who advocate against CDMR fail to frame it as an individual choice, where as those who support it, often articulate it is a "choice." Women do not always discuss their birth plans as a "right."

Provider influence on birth plans. Although patient choice is paramount in the modern health care model, providers influence birth plan decisions. First and foremost, the guidelines set forth for medical practice are often created post-research symposiums for large health organizations. An expert panel commissioned by the United States' National Institutes of Health in 2006 recommended prior to meeting in the panel and despite insufficient evidence, that until more research surfaces, doctors should carefully consider the risks and benefits before conducting a Cesarean section on maternal request (McCandlish, 2006). McCandlish argues that it is incredibly problematic to propose recommendations without addressing commentary of other experts in attendance. This consensus statement of recommendations, although not NIH policy, is influential in creating NIH policy, which guides providers' and hospitals' protocols (p. 205).

In addition to doctors' creating policy for which to guide practice, they also influence birth plans within the doctor-patient relationship. For example, Metz et al.

(2013) studied good candidates for trial of labor after Cesarean (TOLAC) and compared those who chose TOLAC with those who did not. They postulate that the differences in decision-making between the two groups is linked to personal experience. That is, women were more likely to choose TOLAC if they had also had a previous vaginal delivery, and patients counseled by an OBGYN were less likely to choose TOLAC, where as patients counseled by a midwife were more likely to choose TOLAC. Similarly, in a study of Norwegian women, authors found that counselors' use of a coping attitude (advocating the ability to overcome), rather than an autonomous attitude (advocating the choice of the woman), was strongly associated with a request to change their birth plan from a Cesarean section to a natural birth (Halvorsen, Nerum, Sørlie, & Øian, 2010.) LoCicero (1993) identifies mothers and obstetricians have conflicting "stories" as to their experiences with the birth processes (we would call these representations or social constructions). Mothers, she argues, largely speak of a disturbing process where they feel their bodies or babies "failed," and the obstetricians are the ones now responsible for the health of their babies. Some mothers identify that obstetricians dominated the birth process and had they not forcefully intervened, their "labor and birth would have gone fine" (p. 1262). Obstetricians, she argues, construct birth as dangerous, and themselves as necessary to ensure a safe process for mother and baby.

The research on physician influence on elective Cesarean births is contradictory and demonstrates a cultural component. Lin and Xirasagar (2005) argue that Taiwanese physicians may recommend Cesarean delivery for older women by citing safety reasons, whereas the decisions for Cesarean deliveries in the United Kingdom are

mainly patient-led. Al-Mufti, McCarthy, and Fisk (1997) found in their study of female obstetricians that 31% would prefer to give birth by elective Cesarean section rather than vaginal delivery; 80% cited perineal damage as their main reason. If a considerable percentage of female obstetricians would choose a Cesarean section over vaginal delivery, many citing a concern that mothers choosing elective Cesarean often indicate, doctors may not be actively working to reduce elective Cesarean rates, despite the federal initiative.

In their qualitative study using both ethnography and interviews of English women and their practitioners (at Maternity Service Providers who are committed to decreasing the Cesarean rate) in order to understand social relations' impact on birth plans, Powell, Kennedy, Grant, and Sandall (2013) discovered four themes encompassing elective Cesarean birth (ECB) and vaginal birth after Cesarean (VBAC): the culture of Cesarean, Cesarean counseling, perceptions of choice, and negotiating the rules. "The culture of Cesarean" reflects the medical team's orientation to Cesarean birth; they primarily support a vaginal delivery, but would eventually support the mother's choice for a Cesarean section. "Cesarean counseling" reflects the clinicians' interpretation of evidence and guidelines and how they communicate that to the mother. "Perceptions of choice" encompasses the provider's perceptions that the choices were complex, but the provider would attempt to manage the mother's needs as well as practicing clinical judgment. The mothers' perceptions of choice centered on their "personal desires and interactions with clinicians and the health system rules" (p. e141). Mothers requesting services not allowed by hospital policy or medical

recommendations, and clinicians trying to respect wishes within the constraint of systemic guidelines characterize the "negotiating the rules" theme.

Research on midwife influence on home births is also contradictory. Floyd (1995) highlighted that not all midwives are completely comfortable with performing home births. However, they feel political pressure as a professional midwife to support all home births, even though the mother may be an unsuitable candidate (i.e. high risk maternity client). However, "despite their [midwives] wish to give women freedom of choice, they only felt able to do so while they retained ultimate control over the situation" (p. 7).

With increasingly medicalized childbirths, midwives often feel as though they are outcasts among mothers and the medical community. Floyd (1995) demonstrates that hospitals and general practitioners view midwives as the problem. Mothers, also, generally seek advice from practitioners at the onset of their pregnancy, rather than a midwife. Without institutional support, midwives feel that hospital births are directed, and subsequently, they cannot broach the subject with expecting mothers. LoCicero (1993) asserts the current male-dominated obstetric system, as situated in the Western medical model that emphasizes rationality and technology, is incompatible with women's needs. Until the system is radically changed, she argues, midwives must be the primary care providers. Over the last decade, women are increasingly entering the OBGYN specialty (American Congress of Obstetricians and Gynecologists, 2011). As of 2007, women comprised 46% of all OBGYNs. Though women are progressively entering the field, the system may still lag.

Matthias (2010) compares uncertainty and decision-making by midwives and physicians in prenatal conversations. Counter to Brashers (2001; 2007) uncertainty management theory which characterizes uncertainty as negative, Matthias utilizes Problem Integration theory to evaluate uncertainty as positive, negative, or neutral. Under this perspective, using observations and interviews, Matthias found that physicians espoused the paradigm of shared decision making with mothers, but ultimately placed final decision making in providers rather than mothers, and that mothers are *allowed* choices, "within reason." Midwives indicated mothers have decision-making authority, and their role is to assist, support, and inform women to make the best decisions for themselves and their family. Not surprisingly, providers' models of interaction differ based on the dominant paradigms within their education and training. Uncertainty, from this perspective, is understood from the role of the provider, rather than the pregnant woman.

Other stakeholders: Fathers and families. Fathers and family members also influence the birth decisions of mothers. In a British study of expectant fathers, Bedwell, Houghton, Richens, and Lavender (2011) found that fathers unanimously asserted that the hospital was the safest birth place, most birth decisions were made silently with little to no challenging of views, and that if their partner wanted a home birth, fathers would chose to verbally persuade them against it in order to protect their own vulnerability and their partner's safety. For fathers and family members, normative birth (i.e., a hospital birth) is perceived to be the only reasonably option, so much so, that decision-making conversations are rare.

Proposed Contributions to Communication

Social construction is both a philosophy and a method. Often, social construction research examines particular representations in time, but fails to explore the processes by which representations are created and sustained. Public health policy representations are particularly complicated because many constructions influence representations: individual constructions of the person, health, and illness; cultural expectations for health and illness experiences co-created by communities and the media; and legislators' and health officials' presentation of problems and solutions. The ecology of messages creates a Rubik's cube in which the colors and patterns of messages rarely align. Misalignment occurs when those who are targeted by health policy are not participants in the problem construction and solution implementation.

The case of Cesarean births provides a venue through which to explore the ecology of messages surrounding birth plans. Birth plan options include non-medicalized births, medicalized births, and highly medicalized births. Medicalized births are seen as normalized, and women choosing this mode of delivery are rarely resisted and quested by authorities, family, friends, and the public. However, research demonstrates that women choosing non-medicalized births or highly medicalized births are met with skepticism and resistance. Even though the federal initiative only focuses on reducing highly medicalized Cesarean births, the home birth alternative is not considered an option. Thus, resistance and aversion to either alternative plan is of interest.

This dissertation seeks to contribute theoretically to social construction research in health and political communication as it is frequently used to understand social

phenomena, but rarely explicated. Social Representations Theory, a mid-century social-psychological theory rarely used outside of Europe due to its only recent translation, offers methodological insight into how to approach a multi-faceted phenomenon, like that of birth plans. Blending these two areas of research will further elucidate processes of social construction and representation.

Furthermore, despite the respective strengths of research in political communication and health communication, public health communication is rarely explored. Public health communication requires understandings of both areas of research, and this dissertation, as well as future work in the area, can serve to bridge related concepts in different topical divisions.

Research Question

Public health policy in the United States has shifted from a focus on communicable diseases to a focus on individual behavior as a means of prevention of illness. This shift puts onus on the individual to uphold the nation's public health. Simultaneously, the United States' health care model has shifted from a patriarchal model of health care to a consumer model of health care, also shifting focus to the individual, imposing responsibility on the individual, and giving them the "power" to make their own health care decisions, in an extremely complex industry. This structural shift of public health's focus toward individual responsibility and the additional power shift toward the patient-as-consumer, reconstitute the "public" in public health.

Public policy as Discourse is simply a reinforcement of discourse. Policy is created and sustained through ways of talking, i.e., social construction. In this case, maternal health policy is *developed* through discourse about pregnancy, health, illness,

the body, and motherhood, among others. Maternal health policy is also, *sustained* and *enforced* through discourse about pregnancy, health, illness, the body, and motherhood, among others. Maternal health policy is then, *resisted* through discourse about pregnancy, health, illness, the body, and motherhood, among others. Agents of Discourse include those voices heard who develop, sustain, enforce, and resist the policy. For example, physicians are agents of the policy because based on their own meanings of the policy, they can decide their level of enforcement. Discursive representations of the policy, then, can be studied through the interpretive lens of mothers' making decisions about their birth plans, and the ways in which they make meaning about the choices available to them. In order to gain a greater understanding of how the discourses surrounding maternity influence women's understanding of their situation, this dissertation addresses the following general question.

RQ: In what ways do interpretive structural resources shape women's meaning making about their birth plans?

By addressing this question, I seek to better understand how citizens interpret and act upon representations of modern public health initiatives. Representations constructed about policy occur in a multitude of contexts and about a multitude of constructs. Exploring how these resources are interpreted assists understanding of the messages of support or resistance in which the policy is situated. Consequently, the understanding gained helps create better policy.

The theoretical foundations for this study allow pursuit of this goal in a variety of cases. For example, the case study chosen could easily be the federal initiative to increase MMR vaccination rates and representations by the public as to their support of

and resistance to vaccination mandates. Or even timelier, the case could be public representations of the proposed 21-day quarantine period for travelers and health care workers returning from West Africa in order to prevent a large-scale Ebola outbreak in the United States. Both of these cases are relevant and timely, and would make excellent cases to explore the theoretical underpinnings articulated in the literature review. The focus on maternity policy is particularly valuable because it is an enduring issue. Women will continue to face birthing decisions regardless of the eventual outcomes of these more temporary issues. Women will continue to make either one-time decisions about their birth plans, or they will make the decision multiple times in their lifetime. Any previous decisions on birth plans may influence future decisions, but do not predetermine a future plan.

Chapter 2: Research Method

Case Study

Case study research has numerous strengths, among them being 1) theory generalizability, and 2) the ability to support contextualized and acontextualized knowledge claims. First, case study research's strength lies not in its generalizability to a population, but in the method's orientation to theory. Unlike most post-positivist research, case study research allows for the researcher to generalize from data directly to theory rather than generalizing from data to a population to theory. Thus, case study research allows for the researcher to remove the distance between the data and theoretical conclusions.

Second, case study method is broad in that inductive, deductive, and abductive logic claims can be made from the method, depending on the study design. Inductive reasoning is the process by which researchers develop propositions and logical conclusions moving from the particular to the general (Polkinghorne, 1983). Inductive reasoning from case study allows for phronesis, or contextual knowledge to be transferred to other contexts (Ruddin, 2006; Thomas, 2011). Deductive reasoning is the process by which researchers develop conclusions moving from general knowledge claims to particular claims (Polkinghorne, 1983). Case studies (called critical or crucial cases) used for the purpose of theory falsification, theory verification, and theory boundary setting offer acontextualized knowledge (Popper, 1980). Abductive reasoning is the process by which researchers move back and forth from the particular to the particular (Polkinghorne, 1983). Abductive logic, through constant comparison to other cases, allows for the discovery of sensitizing concepts (Christians & Carey, 1989) and

transferability to other cases. Hence, case studies many strengths lend it as a solid and desirable method with which to explore modern public health initiatives.

The case I will explore is the modern federal public health initiative of reducing the number of Cesarean sections, as well as the often unspoken federal initiative that advocates hospitalized births over home births. This case was chosen for the following reasons: 1) it is a modern health initiative that focuses on the individual, 2) it is a current health initiative whose goals of reducing the Cesarean rate have not yet been met, 3) it lacks a large amount of publicity that might heighten mass public Discourse, and make it more difficult to discern non-dominant voices, 4) it includes an easily accessible population, 5) women are an underrepresented population in public health research, and 6) the topic of birth plans for women who are currently pregnant or were recently pregnant is salient.

First, the initiative to reduce the number of Cesarean section births is a modern health initiative in that it is not about a communicable disease, which is the focus of historical public health initiatives. The initiative focuses less on the public, and more on the individual as the solution to public health concerns. Second, the federal initiative was first listed in *Healthy People 2010*, and was also listed in *Healthy People 2020*. Both indicate the goal to reduce the number of Cesarean sections among low-risk women. The previous decade's goal of reducing Cesarean sections by 3% was not met, hence the renewed focus on the reduction of Cesarean rates by 10%. Third, unlike other highly publicized public health concerns (e.g., the Ebola epidemic), Cesarean sections are less sensationalized, making them less ego-involved for participants involved in research. Fourth, pregnant women are a fairly easily accessible population, as pregnant

women and recently pregnant women are in ample supply. Fifth, women are underrepresented in medical and public health research (see below). And sixth, birth plans are a current and important topic for pregnant women and recently pregnant women. Thus, the women studied will likely have developed positions on birth plans, or will be in the process of developing their positions.

Participant Diaries Method

Solicited participant diaries or journals as a method for obtaining data was chosen for the proposed case study for a number of reasons. First, childbirth is an intimate experience involving physiological dysmorphia and pain, and complex emotions produced from the significance of the experience and the metamorphosis of hormonal composition in the body. The mode by which data were gathered required sensitivity from the researcher to research participants' experience.

Second, utilizing methods that collect data with less researcher presence reduces the chance for the simple presence of the researcher to influence the behavior of participants with inadvertent verbal and nonverbal cues. As an example, during the preliminary phone interview, women were asked their mode of birth. As a researcher, I detected hesitation and discomfort from women to identify if they gave birth vaginally or via C-section when I first contacted them. To reduce instances of researcher influence on the vulnerability of participants, journaling was the method collection of choice because journaling allowed for reflection without judgment.

Third, the research study proposed is consistent with the philosophy of and process of social construction of meaning, whereas situational realism (on the relativism continuum) recognizes meaning is relative to context, yet some realities are shared

creating general truths. In the case of the modern childbirth experience, using a method, such as that of solicited participant journals, can allow for inquiry of participant-led meaning-making processes over time, which was critical to examining the posed research question.

Thus, the researcher employed a modified version of Zimmerman and Wieder's (1977) diary-interview method in ethnographical research. To reduce observer influence, Zimmerman and Wieder utilized chronological diaries for participants to record facts and observations in their day-to-day setting. The researchers, then, reviewed the diaries to develop intensive interview questions to parse out meaning and further explore theoretical concepts.

Recently, Bartlett (2012) modified the diary-interview method for the purposes of dementia-related research because of its emphasis on participatory research in which the writer has the "time and space to think about what they want to express and how they want to express it" resulting in rich data "on personal motives, feelings, and beliefs" (p. 1718). Her modification, following suit of other researchers' modifications, included allowing participants to diary in unconventional ways, including with photos and in audio format, along with using other digital technologies. Similarly, Jacelon and Imperio (2005) utilized solicited participant diaries, but also modified the method. In their research on older adults' management strategies for chronic health conditions, the researchers elected to guide the diaries with open-ended questions, and allowed for written, audiotaped, or telephone conversation formats.

Zimmerman and Wieder (1977) and Bartlett (2012) utilized versions of the diary-interview method to explore "day-in-the-life" phenomena in which general,

chronological diaries exploring personal experiences over a period of time were useful in gathering ethnographical data. For the purposes of this case, the context of pregnancy or recent pregnancy, was not suited to an open-ended diary. Thus, modifications were made to utilize an approach similar to Jacelon and Imperio (2005). A journal prompt method was utilized, in which the weeks-long journaling process was gently led with prompts on policy stances for thoughtful discourse, along with more open-ended prompts to allow for the participant to discuss issues, events, thoughts, or concerns of their daily life, of which they are keenly aware in the moment of journaling.

This modified version of the diary-interview method allowed for more focused responses, as akin to a follow-up interview, but provided a focus for the diary entries to naturally reduce data on pregnancy and childbirth. The modified version is superior to open-ended survey questions because it allows for participants to revisit previous entries, and expound upon their feelings and thoughts over a significant period of time. Diaries were also modernized in format, similar to that of Bartlett, and offered digitally as well as in hard-copy.

Participant Recruitment

Using a variety of convenience sampling procedures, women who were pregnant at the time of the study and women who had given birth within the previous calendar year were recruited to participate. Women were not screened for participation based on their intended or resulting birth plans. Women were also recruited for participation through convenience sampling via word of mouth and social media platforms. Social networks of the researcher's contacts were leveraged via word of mouth, and through posting the study announcement on their own social media pages, and by posting to

"mommy" and "birthing" groups of which they were members. Participants were also recruited through additional "mommy" and "birthing" groups on Facebook, after permissions from the groups' administrators were received. Incentives for participation were offered to the participants in the form of a $25 Visa gift card. This was provided to the women who completed the full study.

During the first phase of recruitment, 28 women were recruited to participate in the study. After receiving informed consent consistent with policies and procedures set forth by the Institutional Review Board, each woman participated in Phase I of the study, an initial telephone survey where demographic information was collected and eligibility (pregnant or recently pregnant status) was determined, of which all were determined eligible. At the time of the study, five women reported being pregnant and 23 reported being pregnant in the last calendar year. Participants were then offered participation in Phase II of the study, a seven-week journaling process. All 28 women expressed interest in Phase II and were offered the choice of a hard copy journal or online journal. All participants preferred online journaling. During the second phase of recruitment, 10 additional women were recruited to participate in the study. After also receiving informed consent, each woman participated in Phase I of the study and all were determined eligible. At the time of the study, four women reported being pregnant and six reported being recently pregnant. Again, journaling preferences were offered and all participants chose to online journal.

The seven-week journaling process was begun by 35 of the 38 participants. Two women from the first phase of recruitment and one woman from the second phase

of recruitment did not complete any of the journaling prompts and were removed from the study.

Five women from the first phase of recruitment did not finish the entire study. One woman ceased journaling in week four, two women ceased journaling in week five, one women did not complete week seven, and another woman did not journal during weeks five and six, but returned to journaling in week seven. Another woman from the second phase of recruitment participated throughout the study, but misunderstood the directions and completed one-to-two prompts each week, rather than all the prompts. Since all of these women completed at least half of the study, they are included in the analysis. In all, a total of 35 women, eight pregnant and 27 recently pregnant are the basis for the resulting analysis.

Data Collection

Data were collected through the online journaling platform, Penzu. Participants were assigned a log in and randomly generated password for weekly participation. The online journals were set up with strict privacy settings so that only the participant and the researcher had viewing capabilities. Each week throughout the seven-week data collection process, journal prompts specific to the woman's pregnancy status (see Appendices B and C) were added and email reminders were sent.

Journal prompts (again, see Appendices B and C) were used to collect data using the following framework: progression of thoughts about pregnancy and child birth throughout the seven-week process, if respondents were pregnant, and in beginning, middle, and end stages of pregnancy, if respondents were recently pregnant; free word association of ideal and actual child birth (aligned with social representations

methodology using word associations); reflection on the progression or instances of conversations about childbirth with trusted confidants (family member, friend, and/or significant other) and with the birthing practitioner; comparison prompts on participants' birth plans and birth realities; reflection on types of childbirth including benefits of a midwife assisted childbirth at home or in a hospital or birthing center, benefits of elective C-sections births, personal and public drawbacks to home births and birthing center (non-hospital) births, and personal and public drawbacks to elective C-section births.

After the initial weeks of the study progressed, breaking news announcements were made about an outbreak in infant deformities now known as microcephaly. Initial causes of the deformities were unknown, but as time progressed, the cause was identified as Zika virus transmitted by mosquitos directly to pregnant women, or transmitted to men by mosquitos and then sexually transmitted to women, pregnant and soon-to-become pregnant. Global public health efforts shifted strategies and messaging in the early weeks of the outbreak as advancements in understanding were made, ranging from general sexual abstinence directed only to women, and to those women located in South and Central American countries, to recommendations for the utilization of DEET products to prevent mosquito bites for men and women.

Considering the currency of the public health threat to pregnant women and the heavy news coverage, along with public health recommendations to abstain from sex, use birth control, wear DEET products, to avoid traveling to countries where a Zika outbreak was identified, and others, a prompt regarding the public health

recommendations at the time was added for data collection. Only eight women completed the prompt on the Zika virus.

Participant Characteristics

Although a wide representation of women from a variety of social, regional, socio-economic, and racial/ethnic groups was sought, the resulting participants were relatively homogenous. When asked for the best option that described themselves, 30 women indicated they were white/Caucasian, three indicated Hispanic or Latino, one indicated Hawaiian or Other Pacific Islander and one indicated Asian or Asian American. One woman in particular, who ultimately indicated white, was expressly dissatisfied with the traditional categories offered in the survey.

The age of women ranged from 19 to 39, with an average age of 32. When asked for their marital status, 31 indicated they were married, two indicated they were a member of an unmarried couple, one indicated she was divorced, and one indicated she was separated.

Women indicated a range of yearly household income. The largest group of women, sixteen, indicated the highest yearly household income bracket offered: 100,001 and above. Six women indicated 60,001-80,000, six women indicated 40,001-60,000, four women indicated 80,001-100,000, and the fewest women, three, indicated 20,001-40,000.

When asked for health insurance status, the majority of women, 27, reported obtaining insurance through their employer or significant other's employer, five reported being privately insured, two reported being uninsured, and one reported being

on Medicaid or another state-sponsored health insurance. Thus, all women who participated in the study had health insurance.

Of the eight pregnant women, four were pregnant with their first child, three had one child, and one had two children. Of the 27 women who were pregnant within the last calendar year, 12 had only one child, 11 had two children, and four had three children. Importantly, when recently pregnant women were asked about their experiences, they were often asked about their most recent birth experience for saliency purposes. Therefore, some of these women were reflecting on their most recent birth, which was also their first childbirth experience. Since the study was conducted over a seven-week period, four pregnant women gave birth during the study timeframe: one in week three, two in week six, and one in week seven of journaling. Women were instructed to continue to answer the assigned prompts based on their status when entering the study, and indicate within the prompts that they gave birth—and to answer the prompts to the best of their ability.

During Phase I of the study, the women identified their place of birth (see Figure

Figure 2. Participants' Place of Birth

2). The majority of participants were born in the central United States with 12 hailing from Texas. One participant (not shown in Figure 2) was a US citizen born in the Soviet Union, Ukraine. Women participants represented a wide range of geography in the United States.

Figure 3. Participants' Current Location

During Phase I, participants also indicated their current location (see Figure 3). The majority of participants are centralized in the south central part of the United States. Women participants demonstrate not only geographical diversity, but also migration of location from their birthplace.

Pregnant women were asked to consider their current pregnancy and indicate their birth plan. Of the eight pregnant women, seven indicated they intended to have a vaginal birth in a hospital, and one woman intended an elective C-section. Three of those women wished to use medical intervention (Pitocin, the drug used to induce birth, and/or an epidural, the procedure used to minimize pain during birth), two of those women wished to not use any medical intervention, and two were undecided about

medical intervention. One of the women who was undecided about medical interventions desired a midwife to deliver the baby, and one of the women who was against medical intervention desired a doula to assist with delivery.

Out of the four of the pregnant women who gave birth during the study timeframe, two gave birth in a different manner than planned. One woman intended to have a vaginal birth but the birth resulted in an emergency C-section. The other intended to have an unmedicated birth but it resulted in medical intervention (see Table 1). Four women gave birth after the conclusion of the study. After following up with all four, only one responded. This woman indicated wanting a vaginal birth, but had an emergency C-section.

Women who were pregnant within the last calendar year were asked to consider their most recent pregnancy and their initial birth plan, as well as their birth reality. Eight indicated their plan was to have a vaginal birth with medical intervention in a hospital with a physician.

Table 1. Pregnant Journal Writers' Birth Plans and Birth Realities

Name	Number of Children	Most Recent Child Birth Plan	Most Recent Child Actual Birth
Ruby	1	vaginal, medication, hospital	vaginal, medication, hospital
Kelly	0	vaginal, medication, hospital	emergency C-section
Andrea	0	vaginal, medication, hospital	emergency C-section
Veronica	1	elective C-section, hospital	elective C-section, hospital
Christi	2	vaginal, unsure about epidural, OBGYN, hospital	Unknown
Bailey	0	vaginal, no epidural, doula, OBGYN, hospital	Unknown
Allison	1	vaginal, no medication, no Pitocin, OBGYN, hospital	Unknown
Emma	0	vaginal, undecided on epidural, midwife, hospital, undecided on doula	Unknown

Six indicated their plan was to have a vaginal birth with no medical intervention in the hospital with a physician. Two indicated their plan was to have a vaginal birth with no medical intervention in a hospital with a midwife. Three indicated their plan was to have a vaginal birth with no medical intervention in a birthing center with a midwife. One indicated they intended to have a vaginal birth with no medical intervention within a birthing center within their hospital, by a midwife. Two wished to have their baby in a hospital with a physician, but were unsure about medical intervention.

Three women indicated they wished to have a vaginal birth at home with no medical intervention. One of those women planned on giving birth in a swimming pool. One woman intended to have an elective C-section, and one woman had no birth plan.

15 of the 24 women indicated a birth reality different from their birth plan, including eight of these women whose childbirth resulted in an emergency C-section. Three planned on an unmedicated birth, but used medical intervention. One planned on a medicated birth, but was not allowed medical intervention. One intended a homebirth but gave birth in a hospital. Another intended a pool birth at home, but gave birth on land at home. A woman who intended on giving birth in a birthing center with a midwife, did so, but gave birth in water, which was unplanned (see Table 2).

Table 2. Recently Pregnant Journal Writers' Birth Plans and Birth Realities

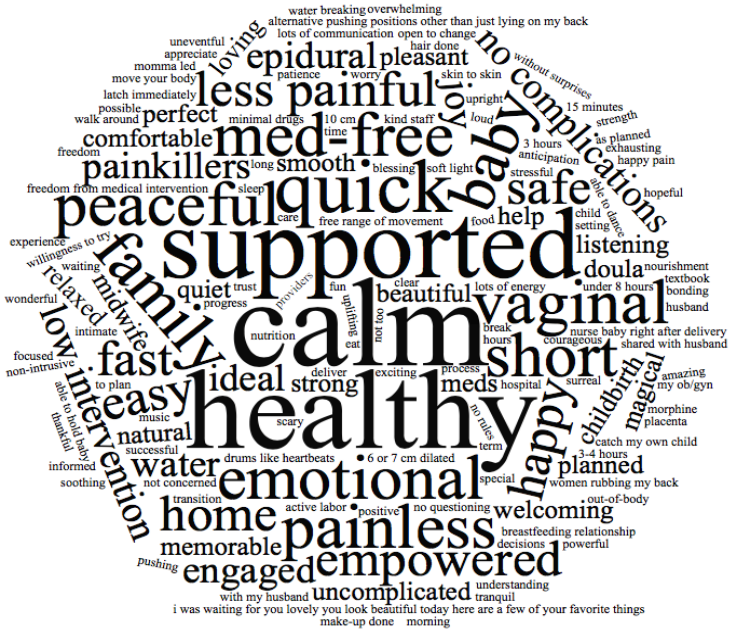
Name	Number of Children	Most Recent Child Birth Plan	Most Recent Child Actual Birth
Krystal	1	vaginal, no medication, hospital	C-section, hospital
Zia	2	no plan	C-section, hospital
Wendy	1	vaginal, no medication, hospital	C-section, hospital

Kandi	1	vaginal, no medication, hospital	C-section, hospital
Ouisie	3	vaginal, medication, hospital	C-section, hospital
Quinn	1	vaginal, no medication, birthing center	vaginal, medication, birthing center
Maggie	3	vaginal, no medication, hospital	vaginal, medication, hospital
Akeli	1	vaginal, medication, hospital	C-section, hospital
Copper	3	C-section, hospital	C-section, hospital
Katie	1	vaginal, no medication, hospital	vaginal, no medication, hospital
Sandra	1	vaginal, medication, hospital	C-section, hospital
Ryan	2	vaginal, medication, hospital	vaginal, no medication, hospital
Tatiana	1	vaginal, no medication, birthing center	vaginal, no medication, midwife, birthing center
Cheyenne	2	vaginal, medication, hospital	C-section, hospital
Melissa	2	vaginal, no medication, hospital	vaginal, medication, hospital
Lauren	3	vaginal, medication, hospital	vaginal, medication, hospital
Tina	1	vaginal, no medication, homebirth	vaginal, no medication, homebirth
Liz	1	vaginal, no medication, homebirth, pool	vaginal, no medication, homebirth, land
Meg	1	vaginal, undecided on medication, hospital	vaginal, medication, hospital
Taylor	1	vaginal, undecided on medication, hospital	vaginal, medication, hospital
Alexis	2	vaginal, no medication, homebirth	vaginal, medication, hospital
Jill	2	vaginal, medication, hospital	vaginal, medication, induced, hospital
Jessica	2	vaginal, birth center, no medication, midwife	vaginal, birth center, water birth, midwife and doula

Patty	2	vaginal, no medication, midwife, hospital	vaginal, no medication, midwife, hospital
April	2	vaginal, no medication, hospital, midwife	vaginal, no medication, hospital, midwife
Jade	2	vaginal, epidural, no Pitocin, OBGYN, hospital	vaginal, epidural, no Pitocin, OBGYN, hospital
Gloria	2	vaginal, no medication, midwife in a birthing center within a hospital	vaginal, no medication, midwife in a birthing center within a hospital

In accordance with social representations theory, women were asked to list all the words they could think of about their ideal childbirth. A word cloud of women's responses about their ideal birth was created (see Figure 4). Ideal birth was characterized by managed pain, speed, and tranquility. Women were also asked to

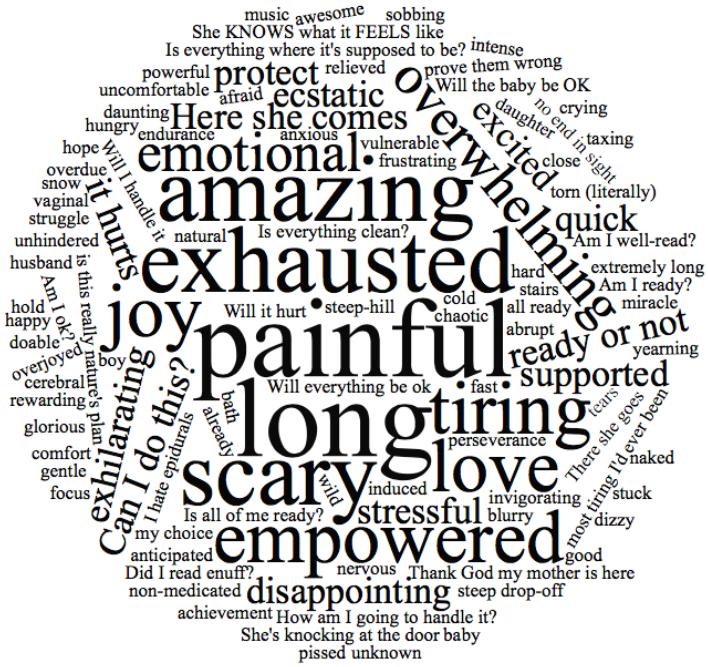
Figure 4. Ideal Childbirth Free Word Association



list all the words they could think of about their actual childbirth. As a comparison, a word cloud of women's responses about their actual childbirth was created (see Figure

5). Actual birth was characterized by lengthy time, pain, and words that indicate a highly emotional experience.

Figure 5. Actual Childbirth Free Word Association



Data Analysis

Overall, an inductive process (Charmaz, 2000) was used in that codes were not identified a priori (Glaser & Strauss, 1967). Initially, the entire dataset (872 total responses) underwent review for the purpose of data reduction (Lindlof & Taylor, 2011). Eleven questions were eliminated because they did not yield responses related to the research questions, or they collectively yielded incomplete responses. For example, responses that were left blank or an entry stated phrases such as, "I don't know," or "I think I already answered this," or "I don't really understand this one" were eliminated. A select few of the respondents, when asked about their birth, described their mother's

birth narrative, rather than their own. Those responses were eliminated. The 699 responses retained for analysis discussed the childbirth process, preparation, or policy. Responses that indicated social geography, or a lack thereof, in decision-making were selected, as well. Responses eliminated from analysis failed to reference the above, or discussed motherhood as separate from pregnancy and birth. Responses were also reviewed in light of the prompt given. Prompts were specifically posed to represent multiple sides of an issue, and were drawn from actual expert opinion. By iteratively contrasting and comparing responses from the same participant on opposing sides of a prompt, e.g. pro-home birth and anti-home birth, limitations associated with leading questions were minimized. Then, all remaining responses were iteratively examined using a constant comparative method (Glaser, 1992; Glaser & Strauss, 1967, Suddaby, 2006). During open coding, similar responses were identified and labeled. During focused coding, labeled responses were grouped based on similar categories, and continuously compared and contrasted and checked for consistency. Axial coding was determined through the process of comparing and contrasting categories to categories. Disconfirmations, alternative explanations, and negative cases for interrelationships were sought throughout to test researcher assumptions (Charmaz, 2000, 2002). Additionally, participants' own words were frequently revisited to ensure categories were appropriately represented. Finally, member checks were completed with follow up phone calls to a small subset of women to ensure analysis rang true to lived experience of the women studied. In total, five women provided feedback on areas of analysis when the researcher verbally presented axial codes developed from the analysis. Participants verified codes and example quotes from the journals. An initial

draft of the study was also distributed to a 32-year-old social worker with a Master's of Social Work who is currently pregnant. Her response to the research is included in chapter three.

To maintain anonymity and confidentiality, mothers' and their children were assigned pseudonyms. Whenever possible, quotes were provided in context without editing or other intervention to ensure rich description without undue influence from the researcher. At times, clarification, brevity edits, and copy edits to spelling and grammatical errors were warranted to prevent distorted meaning. Amendments are indicated in brackets. However, all efforts were made to leave the journal entries intact.

Chapter 3: The Modern Public Health Context

An Age of Neoliberalism

The concept of neoliberalism is well documented and demonstrated in modern research in the political landscape, and as Venugopal (2015) describes it, "neoliberalism is everywhere, but at the same time, nowhere" in that it is so dominant and pervasive, one no longer sees it. Thus, simply accepting its transcendence with no exploration in how it is reifying itself, even after its onset almost 40 years ago, is to take for granted how it is communicated. Neoliberalism, as dominant ideology (Navarro, 2007), is often characterized in literature by references to choice, individualism, globalization, and consumerism. Women discussing their childbirth plans and experiences also use similar language to that demonstrated in other research conducted in cultures where neoliberalism exists as the dominant socio-political context in the United States.

Consumer choice. A critical element of neoliberalism is the drive toward individualism and consumer choice. In the health care context, consumer choice is often referenced with regard to choice among multiple insurance plans in a global market and/or the medical provider to provide the health care. Although women in the study referenced these typical choices reflective of a larger neoliberal context, women also deliberated over a multitude of choices beyond insurance and providers. They discussed the way in which they seek information to make those choices, and ultimately, they described an illusion of choice, in which they had very little power or agency in executing choices afforded to the consumer choosing their health care.

Multitude of choices. Women's journaling about their childbirth preparation or experience emphasized the role of choice in modern pregnancy and childbirth. Women

described the wide range of choices they were making with regard to their impending births, including the method of delivery, whether they desired a natural birth or a C-section, and whether to deliver at home, in a birthing center, or in a hospital. Yet, the choices women were making multiplied in number and complexity beyond those basic choices. For example, women described the option of a medicated birth, but then offered even more specificity as to whether they wished to have an epidural. They discussed their preferences on inducting labor with the popular drug Pitocin, or the less popular Cervidil.

Women also described choices beyond the method of birth, focusing on the environment and experience, often focused on who would be present during the birth. For example, one women stated, **"**Still deciding who else will be present in the room at the time of birth." Yet another woman mentioned, "We aren't allowing anyone in the room (parents, friends, siblings, etc.); it will just be me and my husband." A third woman, provided even more detail about the decisions needed leading up to and at the time of the birth:

> The father moved out during the first month of pregnancy and due to recent behaviors, it's still up for a decision as to whether he will be present at the hospital at all, let alone in the room. I have yet to coordinate plans with my family regarding childcare for my two older children or even settled on who will drive me to the hospital.

In this quote, the mother discussed the decision of whom to have (or not have) in the delivery room. However, she also discusses the coordination involved beyond the delivery room, including arrangements for her children and transport to the hospital, to ensure she can execute her birth plan.

From there, the choices expand to other various options about the baby during and immediately after the birth. One mother stated:

> I think the only thing I want to discuss at my weekly appointment and reiterate to my husband is my desire to delay cutting the cord. I've read a [b]it about it and it's been on my mind a something to add to my plan. I didn't get the option with my first son as he was early and needed to be taken to NICU. This one I'd like to work to achieve this and a little skin-to-skin (another aspect I wasn't able to have).

Here, she discusses two choices related to birth: delayed clamping and skin-to-skin time. Many women discussed the choice of whether they would like immediate cord cutting, delayed cord clamping, and even cord saving. Delayed cord clamping is a practice of delaying the clamping of the umbilical cord until either after the cord ceases to pulsate, or until after the placenta is delivered. The benefits of delayed clamping for at least three minutes include increased blood flow to the child reducing the need for a blood transfusion, increased iron transmission to the baby reducing the likelihood of anemia, and possible neural development benefits, and is a recommended practice by the World Health Organization. Also, many women discussed the desire to have "skin-to-skin" time with the newborn, or holding the bare baby to the bare chest of the mother. For some, this is after yet another choice to make, delayed bathing of the child until after quality skin-to-skin time. In this instance, the mother also discussed regret of not having her choices realized in her previous birth experience, and thus, was clear about her desires for her impending childbirth experience.

Another mother described the choices she was faced with after gathering information in a child birth class:

> Many of our talks were after our birth class; it raised lots of topic[s] we hadn't thought to discuss. One being circumcision. We ended up not having circumcisions done on either of our boys. But we went into pregnancy thinking [there] was no question about it. You circumcise a boy if you have a boy.

Still another mother chose to discuss even finer details of decisions regarding the baby immediately after childbirth:

> In my most recent pregnancy, my husband and I discussed the use of eye ointment after the baby was born. I was declining it as there is no risk. Of course, it's recommended so my husband thought maybe we should "just do it to be safe."

The first woman described her matter-of-fact decision that she would circumcise both of her boys. However, she mentions despite her resoluteness, her plan was not realized. The next woman described having to decide if she should use eye ointment on her newborn. Both women articulate the recommendation or the norm on what decision is desired by others for their child, but neither resulted in the normative or recommended choice. Choices concerning circumcision and eye ointment such as the ones these women faced were similar to cord cutting, saving cord blood, and skin-to-skin contact. Beyond these birthing choices women also discussed breastfeeding and delayed bathing: To do or not to do. The amount of choices, consequential and those of lesser importance, afforded to women as they prepare, plan, and experience childbirth and early motherhood are abundant.

Informed choice. Another characteristic of neoliberalism is the concept of informed choice. Informed choice is a critical component of neoliberal ideology in that the free market depends upon a free exchange of information and ideas to allow for individual, consumer choice. The rhetoric of pregnancy and childbirth also demonstrate the role of information gathering and receiving in reference to choices and decision-making. Women discussed a range of information gathering and receiving, both intentional and unintentional. They discussed reading books, websites, and blogs, and watching birth movies, as well as talking with friends, loved ones and even strangers. For example, one woman stated,

> Ack. I read about something like [the pervasiveness of C-sections] when initially considering where to deliver and with whom. I read about the national averages

> of C-sections and how they're increasing. One reason given was that they generate more revenue for physicians and the hospitals. That threw me for a loop because I had always thought about C-sections as being for emergencies or being used for special health circumstances.

This woman discusses her information-seeking behavior in order to make her choice as a consumer on where to deliver and with whom. Without seeking out this specific information, she still stumbled upon it in her quest for other knowledge. Yet another woman also described her information gathering to make an informed choice for both herself and her husband:

> I remember one of the first times that I broached the discussion [of my birth plan] with my husband. I said that maybe I would like to have a home birth, in a birthing tub. He replied, "my family has a long tradition of being born on land. In a hospital." We laughed. I had shown him the movie "The Business of Being Born" and he knew that I wanted to have a midwife attended birth, but he didn't really understand my reasons enough for me to feel like he could be supportive. I knew that I would need his emotional support if I were going to be successful in having a natural birth, regardless of the setting. My main goal was to have a natural, intervention free birth–he was nervous about it being unsafe to attempt that anywhere but in a hospital. Thankfully, we have a hospital birth center and that was a great middle ground for us to agree to. The birth center required that we take a class on natural birth. My husband unknowingly agreed to the Bradley Course, which was 8 weeks long and 3 hours each week. In the end, the videos and materials there helped him and me get a better understanding of what I wanted in an ideal birth.

This woman utilized a popular Hollywood film, *The Business of Being Born*, in addition to a popular birthing course on the Bradley Method to not only gather information, but to utilize the selected information to persuade her partner to support her choice.

In contrast, a few women elected to reduce their information-intake, and at times, even purposefully avoided information about childbirth. One woman described her intake of research regarding pregnancy, but also her avoidance of research about childbirth:

> At this point in my pregnancy I'm really digging into all the books and materials I can read on pregnancy and childbirth. Previously my focus has been on the

> pregnancy process to ensure I doing everything right, but now I'm starting to move on to thinking about the childbirth process. Honestly, I haven't researched it much yet out of fear.

Other women also discussed avoiding information, but focused on information received from unsolicited anecdotes. For example, one woman wrote, "At this point, I am overall excited about pregnancy and am nervous for childbirth. I am trying not to think too far ahead about what will be happening during childbirth and once the baby is here. (Denial?)." Regardless of women exercising their choice to seek out and consume information, or to not seek out information, the neoliberal tenet of informed choice for effective consumerism in a globalized economy was evident.

Illusion of choice. Despite the plethora of choices afforded to women in childbirth within the broader neoliberal context, critics of neoliberalism often argue that neoliberalism does not allow choice, but the semblance of choice and agency in acting on those choices. Hinnant (2009) argued that neoliberal discourse creates a semblance of consumer choice, when in reality, the consumer is afforded their decision based on the illusion of choice. In other words, the power of personal choice is only as powerful as the degree to which an individual has control to exercise their independence. Childbirth is no different. Despite the multitude of "choices" women painstakingly researched and stressed over making, the decisions were ultimately merited to women by authority, circumstance, or the structuration (Giddens, 1984) of modern childbirth. Frequently, mothers reported that their choices were ignored. Katie described how others' expertise impacted her "choices" with the birth of her son:

> My water broke at 6 am and I delivered my son at 10:02 am. I planned on a natural birth, and I was able to do that. However I was extremely disappointed in my hospital stay. The nurses did not care about my birth plan. They did not even take a minute to read it. I was not supported in my decision to have no drugs, I was actually told I was nuts. I was offered the epidural many times. I was forced

> to labor on my back, my doctor gave me an episiotomy when I asked to tear instead, the cord was cut [immediately] when I asked for delayed clamping, and I [didn't] get immediate skin to skin. My blood pressure dropped so low due to a clot that I lost my vision and could not hear. They slapped a nipple shield on me during that time and that's how I "learned" to breast feed.

Similarly, when asked how she gave birth, another woman answered,

> A forced c-section with much fear and uncertainty in a whirlwind moment. My baby wasn't even shown to me and my first glimpse of my child was a photo on my husband's phone. The first time I saw him and held him in person was an hour later in the recovery room.

Still another woman's "choice" to have a natural childbirth was decided by the need for emergency intervention. She wrote,

> My delivery of [Scarlett] was the scariest and most exciting experience ever. I was induced due to gestational hypertension at 37 weeks 3 days. I received cervadil to thin my cervix on a Saturday night. When I woke the next morning the doctor came in I was dilated to a 3; she broke my water to advance labor. Within an hour I was dilated to a 6 and received an epidural at that time. The doctor ordered Pitocin soon after because I was no longer progressing. The baby's heart rate began to decline. It is expected that the heart rate of the baby will decrease during a contraction and then return to normal following the contraction. My baby did not like the contractions; her heart rate would decrease during the contraction and then drop again after the contraction. My doctor came in about 2pm and deemed a cesarean necessary. The baby did not like the Pitocin, the contractions, or labor in general even after oxygen was administered. I was prepped and had an emergency cesarean. The whole process happened so quickly that much of it is a blur to me today, but I remember it being the most traumatic experience of my life. The urgency to deliver the baby was so great that I was not completely numb when they began to cut me open. In addition to the initial pain, the baby was not wanted to "come down" so the nurse was on the table with me pressing on my abdomen to push the baby out.

All three of the women above discussed how their plans or decisions were thwarted by an outside force. For one, her team of providers ignored and undermined her requests. For the second, she did not consent to the delivery. Both of these women indicated they were "forced" to give birth in methods against their will. The third mother elected to give birth vaginally with medication. However, due to a sequence of events outside her

control—gestational diabetes, lack of progressing labor, concerns about the baby's declining heart rate—her choices became increasingly constrained; each choice was more limited by the situation by which it was preceded.

Other women's "choice" to deliver on the birth plan that they desired was ultimately decided due to a lack of choice, or a limited number of structural resources available to them. Often times, the lack of choice was demonstrated by financial resources or insurance coverage. For example,

> My husband and I moved to Oklahoma from Florida, where midwifery services are covered by insurance. We rarely have more than a few hundred dollars to our name, so I was in tears when I found out I'd have to pay out-of-pocket for our midwife- about 2400, not including labs, supplements, and supplies for the birth.[…] On another note, I realize that while we were blessed enough to pay out of pocket, many families do not have the means, and therefore have no other choice beside the hospital, unless they choose to have an unassisted home birth, which, if uneducated, can be dangerous.

Despite wanting to exercise her choice to utilize a midwife, this mother was constrained due to uncomplimentary insurance coverage that differs from state to state. Another woman similarly expressed disappointment with the "choices" afforded to her with childbirth. She wrote,

> YES. I wish I was strong enuff/educated about this enough/cared to stay on the phone with my insurance company long enuff/was supported enuff to have a home birth. Home is more than enuff. Pregnant women are not sick. Pregnant women do not need to be rushed to the hospital when the baby is coming.

The capacity for a woman to carry out her wishes was influenced—or structured—by her lack of access to resources, and her inability to change the existing rules set by the insurance company.

These examples illustrate that despite the illusion of control in the childbirth process due to the number of options available (method of birth, place of birth, delayed cutting, etc.), ultimately the decisions are often not within the mother's agency to

deliver on her plans. For as one woman summarized it, “It is frustrating in a lot of ways that as women we are told we have a choice, and then not really given one.”\[;

Globalization. An essential tenant of neoliberalism is globalization. Globalization refers to open economic markets that proliferate beyond national borders. Along with individualism and consumerism, proponents of neoliberalism argue that globalization allows for a more competitive market and an increase in individual liberty across international borders. Critics argue globalization results in the increase of inequality in the United States and across the world. Regardless of the ethics of globalization, it is both a product of and integral to neoliberalism. Globalization emerges from neoliberal mechanisms of international economic transactions afforded by modern temporality, or “time sense” in which the present is privileged over the future (Hardin, 2014), and the modernization of communication and information technology advancing societies (McChesney, Wood, and Foster, 1998). Both of these are critical to neoliberal expansion and highlighted in women’s responses.

Temporality. The shift to neoliberalism dominating the socio-political landscape of American culture is marked, at least in the context of pregnancy and childbirth, by time. The concept of time in childbirth, prior to globalization under neoliberalism in the 1970s, was marked by spontaneity and unpredictability. Childbirth was seen to happen on its own schedule, in its own time, with very little predictability and precision. For example, Cheyenne wrote:

> I was totally unprepared for the delivery of my most recent child. Don't get me wrong, I was more than ready to have her already because I was always tired and felt as big as a house. However, she came 6 weeks early and without notice. So I wasn't prepared to do this without my family by my side. Heck, I didn't even have a bag packed yet. After the initial chaos in realizing I was

> having her within an hour or so of my water breaking (at work), it actually was pretty smooth.

By describing multiple instances of unpredictability—feelings of unpreparedness, early arrival, no bag packed, and being at work when going in labor—all future plans are abandoned and replaced with the urgency of the moment. Although much of this unpredictability is still seen in some women's stories of childbirth, many women discussed childbirth in terms of schedules and planning. For many women, the ability to schedule and appropriately time childbirth was a positive aspect of modern childbirth. For example, when asked about her feelings on elective C-sections, one woman wrote:

> This was so me before I got pregnant. I always joked that if I did get pregnant I was going to have a C-section mostly because it was easy. One of the most stressful things for me at the end was not knowing when the baby was going to come. The last few weeks become hard to plan and any time one person has to go anywhere else for an extended period of time it is stressful. I completely understand the desire to want to plan the birth and c-sections are the easiest way to do that.

This woman empathizes with women who elect to schedule a C-section. She recognizes that toward the end of a pregnancy, it was stressful "not knowing" and it was "hard to plan." She also references the difficulty in scheduling travel with an impending birth, indicating a tension between unpredictable birth and predictable travel times. Another woman, Melissa, similarly spoke about scheduling as a benefit to her comfort. It gave her control over an uncontrollable process. She described,

> Most recently I was induced to begin labor with Cytotec, my first delivery used Pitocin. I checked in around 9:00 pm to begin the induction - which meant little sleep. […] I tried to bear [my contractions] as long as possible, but having the first experience under my belt and remembering being so exhausted by the time my son was born, I decided to order an epidural earlier rather than later so that I might be able to rest before hitting complete dilation. […] Apparently my pattern is to move from 8 to 10 cm very quickly - in about a

> 30 minute window of time after my water breaks. My doctor came in to check on me around lunch time and offered to break my water then - I told him I wanted to wait at that point and he allowed me to do so. It was then that I ordered the epidural as my contractions were getting much stronger and I knew that the pain would be worse after my water broke. Thankfully my contractions picked up - my actual contractions as the medication cycle had ended - and my water broke on its own not long after I had the epidural. I then was ready to push shortly after but had to wait about 45 minutes until my doctor was able to attend following the birth of another child down the hall. My daughter was born just after 3:00 pm.

Melissa describes her delivery in temporal detail. Beginning at 9pm and lasting until 3pm the next day, she details her progressing until she orders an epidural. She details her temporal patterns from a previous birth experience, and based on this, her election to wait for her water to break naturally rather than provider intervention.

Technology and expertise. In addition to the ability to pause and speed up time to fit the schedules of mothers and providers, the rise of industrialization, technological advancements, and increased reliance on expertise awarded to those with access to technological and philosophical innovation are also hallmarks of the neoliberal context. Ryan told the story of the birth of her daughter:

> [Hannah] was induced. We arrived at the hospital around 5am and were admitted to our room. The[y] hooked me up to the monitors and started an IV to administer the drugs that would induce labor. A couple of hours later the anesthesiologist came in and asked if I was planning to receive an epidural and I said yes. She informed me that she had to go to a surgery and she didn't know how long it would take (it is a small hospital so she was it). She said she could do it then or we could wait but that if I was too far along by the time she came back that I would have to skip it. Given that I knew I wanted one we decided to just do it then. The doctor (my OB) arrived a couple of hours after that. As she was looking over the print out of my contractions she said they were slowing and that labor was not progressing as it should. She seemed mad that I had received the epidural so early and suggested it was stalling labor. She basically told me I had to stop the pain meds or she would send me home. So I stopped them in hopes that labor would pickup again. Thankfully it did and shortly after she placed an internal monitor on the baby and broke my water. I have heard that can be painful and was happy the meds were still in my system for that part. Around 11 the contractions started coming very fast and hard. Of course when

> the anesthesiologist came back she was annoyed that the meds had been stopped and tried to start them again but [Hannah] was coming. In fact at one point when the nurse checked I could hear her yell for the OB that the baby was coming [b]ut since the doctor wasn't there they made me close my legs and roll on my side. Needless to say I wanted to punch someone.

Ryan's description of how her body was not cooperating with the schedule of multiple members of the medical team highlights the adverse facets of time and scheduling on modern childbirth. She also illustrates how globalization and time dominate the experience of women and childbirth in a medical setting. As a result of the increased expansiveness of technology and advancements, expertise in childbirth is awarded to those with high levels of education and training. Obstetricians and anesthesiologists are treated as the experts, rather than the female body, and thus they are bestowed more time and flexibility in the process. Women, then, are at the mercy of the experts' itineraries. The conflict of time and expertise being consistently awarded to the doctor-as-expert plants a seed of resistance to public health initiatives where plans are encouraged and invested in, but then disregarded by those with more power.

Similary, Akeli describes the expansiveness of technology, especially in the highest form of medicalized birth, an elective C-section:

> […] It felt pretty routine there, like the biggest day of my life wasn't a big deal but babies are born every day so I guess it gets kind of boring. They had me change into a gown, hooked up the needle thingy so that I could get antibiotics, and strapped heart monitors to me and my belly. I was so excited to hear my baby's heartbeat again! We waited for two hours for my appointment time and they wanted to put a catheter in me but I was like OH HELL NO and they said they would put it in after I was numb. Finally, the time came and I walked to the OR, which was smaller than I thought. It was so intimidating because it was all white and silver and everyone was in masks. I thought I was entering a space ship. They had me sit down and they put the leg compressor balloon things on my legs and were JUST taping other things to my legs when someone said there was an emergency and the mother was bleeding. They had to stop everything, take everything off me, and re-sterilize the room. I was like, dangit! But the emergency was more important and I thought to myself, "As

> long as everyone walks out of here with their baby, that's what's most important." So back to triage we went, and I took a nap. Finally it was my turn! They put the balloon things on, finished taping whatever it was they were taping, and the anesthesiologist tried to give me an epidural but I was so tense and I couldn't relax or something so he couldn't get the needle in correctly, so I had a spinal. As long as I couldn't feel a thing, I was fine with it. And I couldn't feel anything! My husband came in and sat by me and he was tearing up. He cried and I didn't! Well, I was teary but not weepy. They couldn't do delayed cord clamping or anything like that. I had written on a sheet what I wanted to do, like delay the bath (didn't happen, didn't care), but none of it happened (because I forgot to tell the doctor). I heard them mention that she was difficult to get out because her head was jammed in my ribs or something (hence the big ball on my left side the last three months). They said "She's here!" then I heard a small "waah!" They held her up over the sheet when they got her out! She cried more and they cleaned her up and my husband watched. He followed the nurse and watched the bath. I thought to myself "Oh I should tell them to wait....ehhhhh whatever." The rest of it was pretty boring. I joked a bit and talked with the doctors and nurses but I kept looking at the clock because I was getting bored. Finally they were done and wheeling me out of the room. I turned my head to thank the nurses and saw them putting bloody sheets in the trash (funny, it didn't feel like I bled a lot haha!). They wheeled me into recovery and I got REALLY cold (normal I guess) and then they gave me heated blankets. I couldn't feel or move anything below my waist and I kept remembering the Kill Bill scene where Uma Thurman kept telling her toe to move.

Akeli describes childbirth akin to a description one might find in a sci-fi series: needles, masks, numbness, space ship, and blood. Other women also described similar experiences, including bright lights, sterile clothing, coldness, multiple spectators in the room, and metallic operating tables. However, instead of descriptions like these existing solely in fiction, it is now the experience of many women despite the biological history and determinism of childbirth. Technological innovation is ubiquitous even in the most prehistoric of contexts.

Conclusion. Neoliberalism as the dominant framework through which decisions of economy are made is ubiquitous. Discourse surrounding individualism, consumer choice and informed choice demonstrate how neoliberalism as an economic theory has bled into ideology on pregnancy and childbirth. Over the last decade, since the rise of

public health care debates became prominent in the Clinton, Bush, and Obama administrations (also in the Trump administration, but that followed the collection of this data set), healthcare conversations cannot be divorced from conversations of free market ideologies, such as that of neoliberalism.

Technology, innovation, and the proliferation of information and knowledge is a hallmark of globalization, as a result of neoliberal policies, and rule the discourse of women regarding healthcare, in particular, pregnancy and childbirth. The ability to stretch and hasten time at the beckon of expertise further demands that health care for pregnancy and childbirth continue to maintain pace. Often, without awareness or acknowledgement, women discuss their experiences in the terminology only afforded to them by decades of policy under this political ideology.

An Age of Political Distrust

In addition to the pervasiveness of neoliberal discourse since the 1970s, scholars such as Bennett and Iyengar (2008) have described a political shift toward minimal effects of media on behavior, due in part to a detachment from cultural and social institutions. They argue that current political communication models should increasingly take into account "growing distrust of official communication, declining confidence in the political leaders who rely on managed public performances, and the widening disconnect between citizens and government" (p. 712). The distrust of official (and public) communication by authorities and political leaders, referenced by Bennett and Iyengar, is in reference to the lack of faith an increasingly large portion of the public has with regard to the honesty and sincerity of public officials. Largely, public officials are seen to be unethical or immoral as the self-interests of themselves,

their political parties, and the special interests, with which they are associated, take priority over constituents and the others they are intended to serve. In particular, discussions of powerful interests limiting personal agency or corroborating against the average American are evident. Several women wrote journal entries about the "bigs"—medicine, government, business, and insurance—signaling a distrust of larger than life interests with great power.

Big medicine. Big medicine, or the proliferation of the medicalization of pregnancy and childbirth, creates a one-sized fits all paradigm to standardize and make more efficient the care given to mothers and babies. Women varied on their discussion of the medicalization of childbirth, ranging from non-questioning of just "how it is," to critiques of the medicalization and profit-oriented nature of big medicine and "big pharm," to regretful statements that this is what childbirth has become.

Many women who discussed medical intervention in their childbirth experience, discussed it matter-of-factly in specific brand names and procedures by the proper medical terminology, typically reserved for use by medical experts. For example, one woman stated, "Most recently I was induced to begin labor with Cytotec, my first delivery used Pitocin," whereas another also mentioned the brand, and off brand, names of drugs:

> As we got to the hospital for the induction I was a nervous wreck - my doctor mentioned that he would use cytotec (Misoprostol) for induction this time rather than Pitocin as the time before. I had not looked up the drug because I had not had time, until we were on the way to the hospital. As I began reading the potential side effects, the uses and contraindications, I nearly lost it.

The proliferation of direct to consumer (DTC) advertising of drugs in the 1980s and the common practice of identifying the generic, or off brand, medications more typically

covered by insurance companies, demonstrates the neoliberal rise to individualized medicine. Consumer choice, evident by the ability of women to identify which drugs exist and are preferred, allows for knowledge of such drugs through marketing. Corporate healthcare, where medical interventions to "treat" pregnancy as an illness, is so commonplace, even drug brand names are now common vernacular.

A critique of big medicine is that it pushes pregnancy and childbirth to the sphere of illness and treatment, with a focus on pain management and treatment out of convenience for the experts.

> My closest friend from high school is a professional singer in Las Vegas, the last person on earth who would want to have a baby. She has always been able to help me relax about stressful situations and she was very curious about what I was feeling and everything I was going through. She asked me if I was going to get all the drugs and pain medications and when I told her "YES, even though some studies say they can pass through to the baby, everyone does it and everyone is fine." She made me laugh when she replied, "Yeah, and it really isn't so bad coming into the world high as a kite."

This woman describes her internal struggle of choosing a medicated birth despite potential negative side effects on the newborn. Her friend, however, counsels her and offers support by indicating the normalcy of a medicated birth, and how often mom and baby are fine. Medication, she argues, is the standard action, the norm. Then, she offers a phrase often used to describe those under the influence of illegal or prescription drugs, "high as a kite." Normalizing the use of medication in childbirth, like this example, was common. Another woman also discussed the rise of big medicine, stating "I think that too many doctors (especially in my area), push c-sections out of convenience, and too make more money. Doctors have become lazy and money hungry." Larger interest pushes for convenience and efficiency takes a toll on the patient/provider relationship where the decisions become more impersonal.

Not surprisingly, some women discussed the medicalization of childbirth in regretful terms. They discussed the desire to not focus on the pain and instead focus on the strength of a woman to deliver a child as she has successfully done for thousands of years. For example, "When we moved birth out of the home and into the hospital with drs instead of midwives we made birth into something different. We removed the woman as the focus and started monitoring machines." Articulating regret for impersonal decisions or resistance to the push by larger interests to standardize care through advancements and medicine demonstrates the broader political context of a personal, and universal, experience.

Big government. The concept of big government is often synonymous with unnecessary regulations, the imposition of sanctions, and in today's political landscape, synonymous with older, white males as the predominant legislator of policy regarding women's health. When asked about doctors who perform too many C-sections in opposition to public health recommendations, some women elicited resistance to sanctions, describing them as unfair, ineffective, and as an imposition into the doctor/patient relationship. In true neoliberal fashion, a few women also countered this notion by offering incentives as a way to induce compliance with public health directives, rather than financial sanctions.

When asked about her reaction to the public health policies to limit the number of C-sections, one woman wrote about her opposition to public health recommendations of reducing C-sections. She stated,

> These experts sound like right-wing men. ;) It's hard not to get a little defensive about things like this, because I just feel like I spend so much time defending the decision to have a c-section. The idea that I've taken a shortcut to motherhood is

> just annoying and the idea that anyone but a patient and her doctor would make these decisions is just infuriating.

Another woman, who also had a C-section, wrote: "I wonder who these experts are - doctors? moms? lobbyists? And having had a c-section, I half-jokingly wonder who is requesting to have them?"

In suggesting that lobbyists are at the root of public health recommendations, her comment demonstrates the infiltration of interest groups into government. The larger distrust of government stems in part due to the perception of the role of interest groups, or the powerful and resource-laden collective, in shaping public policy. Thus, the resulting distrust in the federal government is documented in modern political scholarship (Hetherington, 2005).

Big business. Of all the "bigs" discussed, big business infiltrated all, with discussions of the corporatization of pregnancy and childbirth, and the profit-driven nature of hospitals and insurance companies. For example, one woman wrote,

> Healthcare has become so business-focused, no one cares about the actual patient. I think most women are looking to take back their bodies and have an opportunity to experience childbirth in a setting where the health of the baby and mother are the determining factors without the influence of business needs.

Another woman who wrote earlier about the cost of malpractice insurance, also discussed her experience from working in a hospital:

> I think that women need to be comfortable with whatever avenue by which they will birth a baby. The challenge is that physicians are motivated by schedules, convenience, and finances to lean towards C-sections. Those factors are in turn influenced by hospital management/space, personal lifestyles, personal finances and insurance reimbursement. From my days working in a hospital, I know that our Labor & Delivery department was a money-loser. We did not turn a profit on L&D.

Both of these women remarked on healthcare or hospitals as a business, where the entities and their employees are concerned about profits over people. Interests other than the woman or her newborn fosters distrust of modern healthcare because it is a business.

Several women mentioned the film, *The Business of Being Born*, as a catalyst for their desired birth plan outside of medicine. The documentary advocates for non-hospital births attended by a midwife for those women who are low-risk, and cites the rise in C-section deliveries as a negative implication of the medicalization of birth. Despite articulating that the film was persuasive, ultimately the women had hospital births because of a limitation of resources, or resistance by their significant other. For example, one woman wrote,

> We had talked about birth plans long before I was pregnant, in the context of friends giving birth. We'd watched Business of Being Born together sometime after we got married, and my husband knew that I wanted a natural birth... eventually. When I became pregnant the first time and we went to see Dr. Moritz (chosen solely for his participation in the Business of Being Born movie), we were excited that he quickly assured us that I was a candidate for a midwife attended birth and that he wouldn't see us again unless something went awry.

Another woman, a performance artist, went into further detail about the business of birth, by offering a snippet of a performance piece she had started prior to participating in the study, but picked up again after being prompted to discuss her feelings and experiences. She wrote:

> "The Business of Being Born"
> Reaping a cash crop
> Unesse-Cesareans
> New York City is the epicenter of the world, branding a hot statement in our molecular evolution, trendsetting how we arrive at this earthly destination.
> Lights, camera, aaaand action!
> WOMAN 1: Let's do lunch. How's Thursday?

> WOMAN 2: My induction is scheduled that day, followed by a tummy tuck. Check and check. Check please!
> Check yourself before you wreck yourself.
> Designer shoes.
> Designer shades.
> Designer birth.
> Designer genes.
> I've seen them on the Discovery health channel and them TLC shows. Screaming women strapped to their beds. Any woman be like, "Fuck that shit!!! That's why we have medicine and doctors!" But pregnant women are not sick and giving birth is not an illness.
> DOCTOR: (on the phone) I'll be there, save those seats. (to patient) Ok, give me a good push, puuush, ok, yeeeahhh, you know what, this isn't happening fast enough, I'm going to use the vacuum... It's for the good of the baby!!!
> MOTHER IN LABOR: Can I get an "everything" epidural?

The role of Hollywood (a big business) in shaping many women's perceptions of the big business of birth, is ironic, but represents the infiltration and resulting skepticism of the current political landscape.

Central to business is the communization of goods and services, by which goods have economic value and are purchased by consumers. As one woman put it so candidly,

> Honestly - my birth plan was a little out of my hands for both pregnancies due to my health conditions. I didn't allow myself to get tied to one idea of perfect, I gave it up to my doctor - who I trusted. It was a health transaction - and I am glad that I made out well after each of my pregnancies.

By describing her childbirth as a transaction, she is describing, in essence, a business deal.

Big insurance. Related to big business, big medicine, and big pharmacy is the specific interest of big insurance. Many women discussed the negative implications of insurance dictating the choices that should be afforded to women. For example, one woman stated, "Insurance sucks. I wish we had a system that didn't put these extra

constraints on the choices we make about our healthcare." Yet another wrote about the structural constraints imposed by insurance companies,

> I live in a state that does not recognize midwives as birthing professionals and I think it makes the situation that much harder to navigate. If a person has insurance and expects coverage of prenatal care and labor/delivery then there really isn't a choice about one's birth plan...it has to be done by an OB in a hospital […]

Women, like this one, often offered critiques of big insurance and the limitations of choice in terms of what is covered and what is not, and even the high cost associated with "covered" procedures. Yet another woman struggled with the meaning behind insurance coverage and the need for many women to conduct a cost benefit analysis along with their childbirth plans. She stated,

> One concern I still find myself avoiding is the cost of childbirth and insurance involvement. I would love to think I could labor without pain medication and save myself the costs on that, but I'm not certain I can achieve that. And I find it unfortunate that in our country our healthcare system is so fraught with uncertainty and corruption that women find themselves trying to shortchange their health and births in order to save potentially thousands of dollars they don't have available. More standardized rates for care would be such a benefit.

Here, she describes not just the financial analysis, but the distrust associated with big insurance, medicine, and business and the constraints caused by both. Another woman described her experiences working in a hospital where malpractice insurance is so costly, that an OB-GYN elected to drop part of her certification in order to manage the costs of her practice. She stated,

> Malpractice insurance is also significantly higher for OBs than for midwives, because OBs have priviledges [*sic*] to operate. One OB that I know dropped her OB-status (reducing herself to a GYN), because of these costs. Even if she wanted to only take low risk patients that would be transferred in the event of a C-Section need, she is unable to do that and maintain a lower level of malpractice insurance.

Where critiques of health insurance were not offered, women articulated maneuvering around the insurance companies to achieve their desires of certain hospitals, certain doctors, or certain procedures. For example, one woman stated,

> My doctor delivers at two hospitals. I had chose one based on where my sister in law had delivered. During my pregnancy the hospital I had picked had changed some policies related to the drs. It would not have affected me or my delivery but the [doctor made] us aware that he was starting to limit his services [at] that hospital based on these new policies. He reassured me that he would [deliver] me where I chose to. [Joseph and] I said that we wanted to deliver where he was most comfortable. He had an independent practice and we really liked how he operated so if he was more aligned with this other hospital we would deliver there."

Similarly, Alexis stated,

> My doctor also happened to be an old friend and patron of my husband. We were really lucky to have a doctor we knew and trusted. I could not imagine going to a stranger. We moved mountains to get the "right" insurance, really just to cover the hospital […] He is in NY and the Chair of Obstetrics. We live in NJ. Getting an insurance that crosses state lines was the concern.

Both women discussed skillfully navigating the system terrain to meet their needs, or at least not work against their agency, despite the presented hurdles. By describing the shift of insurance coverage required her to "move mountains," Alexis demonstrates the God-like miracle needed to do the impossible in today's health care market bound by state boundaries. Finally, another woman elicited frustration but chose to silence herself on the issue, by stating, "*I will withhold from detailing my complaints about the cost of childbirth and our healthcare system."

Conclusion. As pervasive as neoliberal policies are in dominating the rhetoric afforded to women to discuss their options and experiences in pregnancy and childbirth, so is the increasingly noticeable distrust in government, corporations, and other

institutions. The power identified in big medicine, insurance, government, and business demonstrates an atmosphere of cynicism surrounding powerful interests.

The context, itself, is powerful. The interests of these organized and sometimes disorganized groups shapes the meaning structures offered to women to understand their experiences and use agency to accomplish their wishes. Although women seem to be distrustful of the options presented to them and the interests at work, vying to exercise influence over women's experiences, few women are able to exercise resistance to what they see as undesired influence. Though some may be able to navigate the system to achieve their end desires, many are relegated to "submission by structuration" of the way policies exist and the few resources at their disposal.

Ripe for Social Conflict

Public health's individualized focus within the neoliberal context is ripe for social conflict. Due to the progressive shift toward the individual as the solution for public ills, and the push for preventive medicine as the dominant public health paradigm, the collective good is distanced from today's public health experience. Individuals are saddled with the semblance of agency to control health outcomes for the greater good and thus, individual meaning and experience is varied and relatively disconnected. Modern childbirth, in particular, with extensive "choices" and a public display of impending choice (i.e., the "baby bump"), elicits commentary and subsequent conflict. Thus, multiple meanings of a single phenomenon in the absence of official communication yield a modern context that breeds social conflict. Conflict is evident in discussion of science versus nature, mommy wars, horror stories, and individuals' orientation to liberty and locus of control.

Absence of official communication. Despite the public health goal of reducing the number of C-sections, women were largely unaware of the initiative to lower the rate. Though some opposed the option of elective C-sections for a variety of reasons, none of them reported being counseled by their doctor about the need for a reduction or a resistance to performing C-sections unless absolutely medically necessary. In fact, most women reported very little interaction, if any, with their primary medical provider, let alone about their birth plan, if that provider was an OB/GYN (most interactions were with the nursing staff). Most could not remember talking with their doctor about their birth plan, whereas others mention it was brief. Despite the countless decisions and wishes expressed by mothers as their birth plan, only a few mentioned written plans delivered to their providers, and even fewer mentioned detailed discussions with their doctor about their wishes. For example, one woman recounted,

> My doctor was a little nonchalant about it. I asked him how we should align on the plan, and he said that I didn't have to write anything down, unless it was something "weird" or out of the ordinary. I guess he was fine with everything when I talked him through it. Nothing "weird" according to him.

Although many women reported having conversations with their providers about the progression of their pregnancy, and many had questions answered about their pregnancy, few had direct communications about childbirth, and their plans and wishes. Therefore, in the absence of official communication regarding public health initiatives, women's birth plans, whether communicated, followed, or not, became the course of action by which a mother created meaning about childbirth. Due to the multitude of choices afforded to women, this creates multiple touch points for conflict, not only with the provider, but in defense of and resistance to certain birth choices.

Science versus nature. A prominent social conflict noted in the women's journals is the science versus nature debate. Although this debate is evident in many contexts of public health, such as the impacts of climate change on human health and the role of and need for vaccinations and their impact on the public's health, the debate was widely evident in discourse on childbirth.

Trust in science. The role of science in childbirth is clear when women discussed highly medicalized births, such as elective C-sections. Yet, the role of science was also discussed in what many consider to be today's normative birth: birth in a hospital setting with medication for pain and other medical interventions. Women who demonstrated pro-science views discussed the use and promotion of medicine, as well as viewed medical professionals as experts on childbirth.

The use of and desire for medicine and medical intervention was described by many women. Some women described actively seeking medication, specifically epidurals for pain and induction medication for hastening labor. For example, one woman stated,

> My husband and I just talked about epidurals two nights ago. He asked, "Are you planning to get an epidural?" And I said, "You know, I've never really considered not getting one." I went on to explain that I don't know why I've always assumed I would ...Maybe because my mom didn't have one and wished she did, or perhaps because I fully appreciate modern medicine and think that if there's something to help me with extreme pain, sign me up.

Some women, such as this one, actively sought medication or other intervention to relieve the pain or prevent discomfort.

Other women described reliance on medicine and trust of scientific advancements as they detailed their ideal birth plans. Although little to no elective intervention was sought, the ultimate benefit of scientific knowledge with regard to

childbirth emergencies was emphasized as the "just in case" or "if necessary" scenarios. Women who avoided medical intervention in their birth plan wishes were still overwhelmingly honest about their desires for access to medical technology and expertise for themselves and their babies, if needed in emergency situations. For example, one woman stated, "I'd spoken to my husband often about how I wanted to try my best for an unmedicated, low-intervention birth, but always emphasized I was open to medication without being hard on myself, and open to interventions if medically necessary." Another women stated, "I told my husband early in my latest pregnancy (beginning of the 2nd trimester) that I didn't want to be induced unless it was necessary." Both of these women described the willingness to submit to medical intervention, if necessary for their pain level or for the safety of herself or her newborn, both putting their trust in science and constructing childbirth as subject to medical emergency, and requiring emergency planning.

Similarly, other women described their reliance on and trust in science by focusing on the scenarios in which the medical intervention may be deemed necessary. Women who elected to have hospital births often described the "what if scenarios," when defending their choice of a medical birth over a home or detached birth center birth, again preparing for emergency. One woman stated, "I worry about the unexpected things that can go wrong in a non-medical setting. I appreciate all of the machines and monitors on hand at the hospital, so I know the status of the baby through all stages." Another stated, "I'd rather be in a hospital in the event something happens. It might be my paranoia speaking, but I'm all about being safe than sorry." Overwhelmingly, women who elected to have a hospital birth, whether it be vaginally

or by C-section, discussed the importance of being near the best advancements in medical technology and expertise in case of emergencies. The need to plan for worst-case scenarios and have multiple technological options available were seen as the ultimate requirements for women who placed their trust in science, doctors, and medicine.

Women who placed their trust in science and medicine and the importance of a hospital birth did not solely emphasize the importance for in case of emergencies. They were more emphatic about their choice, a hospital birth, being the only viable choice. They were ardent that they "could never forgive themselves if something went wrong" and medical technologies were not accessible. For example, a woman who had a vaginal birth in the hospital to deliver her first son stated,

> What if something goes wrong... will those precious minutes/hours be the difference between life and death. I am not sure that my comfort of being home would trump the safety of the baby and the delivery. If something went wrong while delivering or the baby/me needed extra assistance and we had trouble getting admitted I would never forgive myself.

Utilizing language such as "I'll never forgive myself" demonstrates not only the deep personal responsibility felt with regard to the choices afforded to the family in childbirth, but also the strong reliance on science and medicine as the only rational (and emotional) option.

Trust in nature. Alternatively, as strongly as some women and their partners felt about the need for medical intervention, or at least access to medical intervention, others felt equally as strong that pregnancy is not an illness; childbirth should not be treated as an ailment to cure or alleviate. Women who put their trust in nature defended their position as biological and historical, and put their trust in the female body.

For example, one woman stated,

> […] Women have been having babies for millennia and only in the last few hundred years started giving birth in hospitals, and hospitals are at times unsafe for mother and baby (due to diseases they can catch or forced into unnecessary procedures), so if a hospital can be avoided then it should be.

Yet another stated, "Childbirth is a natural process. It is not a medical emergency. There is no reason to give birth in a hospital if you have a normal, healthy pregnancy." Women, they argue, have been giving birth naturally, at home, without intervention for centuries. Thus, nature and biological history should be trusted. After all, they argue, hospitals are a modern occurrence and are not an absolute for a problem-free birth.

Comparatively, other proponents of home births or non-hospital births described putting trust in the female body. For instance, a woman who advocated strongly for a natural birth but in the hospital illustrated,

> […] Having a child is NOT a medical emergency. This is a natural process. Animals give birth in the wild. Do they always survive? No. However, as humans we have access to options if something goes wrong. There is no reason to treat childbirth as a medical emergency. Take some time, do some research, and trust your body. As a female, you were born to have children. Your body knows what to do.

Not surprisingly, women, such as the one above, who were strong proponents for "as natural a birth as possible, in a hospital setting," often demonstrated trust in the female body, but also nodded to the desire for access to hospital equipment, in case of emergency. However, women who elected home births demonstrated they valued trust in their body over trust in science. The strength at which women who had or desired natural births whether it be at home, in a birthing center, or in a hospital, strongly advocated that the female body "knows what to do" and that women need to trust their bodies. The body, they argued, was intuitive and equipped with historical and biological wisdom to successfully navigate childbirth.

Same tune, different story. Women on opposing sides of the science versus nature conflict utilized similar rhetoric to defend their convictions and advocate against the alternative. Both pro-science and pro-nature advocates demonstrated moral superiority to their opposition, and articulated the opposition as trendy and based on convenience. For example, a pregnant woman who was yet undecided about her birth plan, but committed to it happening in a hospital, stated,

> I think what bothers me about the home-birth trend is that I think so many proponents get self-righteous about their choice. That they are doing it the "natural way" and women who choose to deliver in a hospital are doing a disservice to themselves and their baby. My cousin who delivered her second child at home was very matter-of-fact about her choice, but Facebook posts from acquaintances from high school have had holier-than-thou tones.

Similar to this perspective on home birth mothers as being "holier than thou" or self-righteous, other women also described moral superiority to mothers who chose C-sections. Even women who were pro-science, who wished to have a medicated birth in a hospital, felt strongly about women who elected the highly medicalized birth by C-section, and those who elected home births without any medical intervention. For example, one woman stated, "Honestly it seems to me, in my shallow knowledge of an elective C-sections, that it's a very selfish decision. Almost like choosing a water birth. Is this really in the baby's best interest or the mothers?" This woman exhibits moral superiority of two non-normative births: elective C-sections and water births, but characterizes women who elect to do so as selfish. Yet another wrote, "I absolutely do not agree with C-Sections period. To be honest, I think it is an uneducated persons decision. They are also being a bit selfish." And another wrote, "To be honest, I feel as though a mother who makes the decision to have a c-section is lazy and selfish." Thus, women who choose either a highly medicalized birth or a natural home birth, two non-

normative birth plans, were characterized as lazy, uneducated, and selfish by women who opposed those choices.

Crick (2004) posed a similar revelation in his rhetorical study of creationists' and evolutionists' use of logic and reason to push forward scientific discovery and the public acceptance of such arguments through thought experiments and enthymemes. In addition to new arguments of evolution and creationism using the same rhetorical structure as the original arguments, both sides of the scientific debate use similar rhetorical devices to persuasively move the debate forward within the scientific community.

As an alternative to condemning those who chose a non-normative birth plan, some women displayed opposition, but in a more subtle manner. Instead of outwardly condemning women for their non-normative choice, the women elected a "fine for you but not for me" narrative. However, the lack of outward condemnation demonstrated by these women was not without evaluation. For example, some women described the decision for a home birth as acceptable *if* the woman was close to a hospital, and *if* the woman was low risk, but personally, they would not make this decision for themselves. For example, one woman stated,

> Personally, not for me. Not a good idea. I know women have been delivering babies since the beginning of time without medical intervention, but I'm not comfortable with a home birth. Fine for someone else, but not for me. In case something terrible happened, I'd rather be at the hospital with medical professionals nearby. How could I forgive myself if something went terribly wrong and medical help didn't arrive fast enough to help my baby or even me?

Similar to the findings on the social construction of emergency preparedness (just in case themes predominant in women who elected a medicalized birth), these women discursively emphasized a disaster-preparedness stance focused on the emergencies that

may arise. Many women who commented the decision was fine for someone else, often ensconced the approval with the caveat that they would never make this choice because if something happened they "could never forgive [themselves]." For example, a woman who had a natural birth in a hospital birthing center as a compromise between her wish of having a home birth and her husband's wish of having a hospital birth stated,

> Despite professing an interest in natural birth, my SIL [sister-in-law] has effectively deferred to my uninformed brother's position on all decisions. She is not going to give birth in a birth center, even though there is one adjacent to the hospital. My brother responds to my inquiries in dramatic fashion - "If something happened to her or the baby, I could never forgive myself!" It is beyond irritating. He has refused all of our attempts to educate him on the topic, arguing that The Business of Being Born is biased and riddled with Hollywood drama. He puts full confidence in American doctors.

Here, the woman describes how her brother used this line of rhetorical positioning: that others can choose this path, but not his wife because if something happened to her or the baby he could never forgive himself. This expression of moral superiority was a common response in opposition--subtle or otherwise-- to all sides of the birthing spectrum. Initially, these women seem supportive of the alternative choice, but quickly added caveats of when the choice would be acceptable. Then, they turn the support and stipulations into an expression of moral superiority. To the opposition, it was unthinkable how a woman could retain her self-respect after prioritizing her needs, or her comfort, over her child's safety or well being. As one woman who disagreed with home births put it, "Having a baby isn't about you... it's about the baby." So, although the women did not outwardly oppose the alternative birth plan, they articulated so many caveats and moral superiority, that their judgment via proclamation was strongly noted.

Additionally, discursive tools used on both sides of the birth plan perspective was evident with both sides accusing the other of being trendy and obsessed with convenience. Some women explained their representation of home births and the increase of them as the generational trend driving toward a more natural, organic lifestyle. They described the home birth decision as similar to choosing cloth diapers and organic food. For example, one woman wrote, "More and more our society is telling women they have to be "all natural" and encourage "organic" lifestyles including all natural labors." Another wrote, "I think it goes along with the increase in everything going more "natural" and "organic." Both of these women, who did not elect a natural birth, describe home births as a trend toward all natural living.

Yet another wrote,

> Again, I believe that it is the mother's choice to have a home birth and to use a midwife. I think that certain things are "trendy", homebirths, midwifes, and breastfeeding being a few of those trends. Having a homebirth and a midwife were not my personal plan of birth, nor will they ever be, but I respect mothers that do decide to take this route.

Although this woman is generally supportive of the choice for a home birth, she exhibits the rhetorical turn of moral superiority. Interestingly, a return to traditional methods for childbirth and child rearing, such as breastfeeding, is seen as a trend or a fad that will pass with time. In alignment with the trendy argument, one woman referenced the rise of a popular reality television show, and said, "People are becoming progressive in many areas. I think certain religions also contribute to the rise of home-births (and the popularity of the Duggars)."

Women on the other side of the birth spectrum, those who advocated for a natural birth, also had similar rhetoric describing women who elected to have C-

sections. They indicated that C-sections may be considered more convenient, but convenience should not be valued over other aspects of childbirth. One woman wrote, "Convenience is killing us slowly. It is detrimental to our health, and our children's health. Look at fast-food restaurants. Look at electromagnetic fields. Convenience isn't always healthier, and it's certainly not better." Yet another wrote, "A c-section is more convenient, maybe even less painful. However, so is fast food. The long-term effect of convenient and easier things should always be taken into account." Convenience, a trend, these women argue, is not the same as healthy. These women communicate that the health of the baby should be valued over convenience in childbirth.

Other divisive communication experiences. Beyond the obvious conflict of science versus nature and moms-to-be advocating for and against positions, axial presentations of these issue conflicts are representative of more than just opposing viewpoints. The journal entries demonstrated broader social conflicts evident in early motherhood. Mommy wars and the use of horror stories evident in the journal entries demonstrated broader social incongruity among beliefs and between women.

Mommy wars. **"**Mommy wars" refers to the social and cultural conflict that women engage in or are subject to once they have children. Typically discussed with regard to stay-at-home versus career moms and the conflict that ensues based on differing values of what constitutes motherhood and differentiates "good moms" from "bad moms," mommy wars were also evident in communication about childbirth prior to motherhood. Some women specifically articulated birth plans as a "mommy war" topic. For example, one woman wrote,

> For women who want a home birth with a midwife, I think it's great for them. These women feel empowered to make this type of birthing experience choice. I

> can't say I'm for or against it. [It's] truly their choice. I do feel that the increase in homebirths might correlate with the level of news and mother wars on which is best birth is best.

Yet another woman also described birth plans as a mother/mommy war subject. She stated,

> Birth plans are one of those "mommy war" subjects that everyone has an opinion on--and make me apprehensive about being pregnant and becoming a mother. I will to do what's best for me and my baby based on consultations with my nurse-midwife, understanding my and my baby's medical needs, and research.

Both of these women are specifically highlighting a social and political issue, birth plans—whether women elect to have a highly medicalized or natural birth—that elicit conflict among women. By characterizing the conflict, nature or science, medicalized or natural, home or hospital, midwife or doctor, as a "war," mothers are emphasizing the degree to which these decisions polarize and divide women.

Horror stories. Other women were less blatant with their characterization of "mommy wars," but also described the conflict that results from the visible state of pregnancy that invites unwanted advice, opinions, and conflict. Many women specifically noted how other women, acquaintances, medical providers, and educators share "horror stories" (their words) about childbirth when they speak with a pregnant woman, whether or not the woman is receptive to the stories. For example, one woman wrote, "People start sharing all their pregnancy, birthing horror stories with you. Everyone assumes you want to know the details and that you should be prepared […] it all stressed me out." Another woman also described the unsolicited stories shared with her during pregnancy, and indicated hearing "horror stories" about childbirth from her doctor. She wrote,

> After leaving my obgyn and doing some research I wanted to try a birth center birth, but after listening to my obgyn talk about all the horror story births she's had my husband was scared that something would happen, that I wouldn't be able to handle a non medicated birth, that midwives wouldn't be able to handle the birth; so I compromised and went with the midwives at the hospital.

Both women specifically reference the term "horror stories" others shared about childbirth. One indicated narratives from acquaintances that elicited anxiety, the other indicated stories from her doctor that led her to believe she would not be strong enough to endure an unmedicated birth, and thus, compromised her birth plan. Women who specifically articulated these stories as "horror stories" often discussed these in the context of the stories being unsolicited, and leaving the pregnant woman with feelings of fear or anxiety. In addition to "horror stories" shared by family, friends, and acquaintances, fear narratives were also shared in birthing classes along with other medical information about pregnancy and birth. One woman wrote,

> I also stressed that I would be in labor for hour and hours and hours. The class told stories of women being in labor for 24 hrs and having to be induced and the issues that came along with it. It all was unpleasant. I don't feel like anyone shared the positive stories.

By describing stories shared in preparation for childbirth in a classroom setting, this woman highlights how prevalent and entrenched the sharing of horror stories is in American pregnancy culture. She also discusses the prevalence by which women shared these negative, fear-enduing stories over pleasant or empowering stories of childbirth. Overwhelmingly, like the woman above, women who discussed the prevalence of horror stories also discussed the equitable absence of positive stories.

In addition to the number and range of individuals—acquaintances, doctors, educators, friends, and family members—women also perpetuated their own terrifying stories and retold others' stories they heard. For example, Veronica wrote,

> The other conversation we've been having is that one of our friends went in for a routine 2nd c-section a couple of months ago, after having a completely normal pregnancy, only to find out that her uterus (according to her doctor) "looked like saran wrap." Basically, if her baby had kicked or elbowed the wrong way, it could've ruptured her uterus, so the doctor told her that it wouldn't be safe for her to get pregnant a third time and she recommended that she have her tubes tied that day.

This woman retells her friend's birth experience in descriptive terms suitable for a horror film: a uterus resembling saran wrap, and the warning of the baby's normal movement as causing potentially life-threatening rupture of an internal organ. Similarly, another woman describes her own horror story, along with the retelling of an acquaintance's story. She wrote,

> I know several people who have successfully had home births. So I think in theory its a great idea. I also know a little boy who is paralyzed because his brain was deprived of oxygen during a home birth preformed by a midwife. The mother later found out that had she had him in a hospital he would not have had the same complications. This last baby I had a healthy pregnancy (although considered high risk because I am a cancer survivor) and my delivery started off normal but then the baby dropped very quickly. He came out so fast that he did not have the natural labor process to get the fluid out of his lungs. He was struggling to breath. Had we not been in the hospital my baby probably would have died.

Although hearing successful stories of home birth experiences, this woman descriptively centers on the oral history of an acquaintance's unsuccessful home birth, followed by the horrors of her own delivery, in which her son's safety was in jeopardy.

Horror stories shared in the journals, or documented as the predominant discourse pregnant women revealed from their social interactions, revealed a ritualized quality in the narratives about childbirth. The narratives were not only apparent in descriptions of interactions with medical professionals and pregnancy and childbirth educators, but also were discovered in women's self-narratives and the repeating of others' narratives. Peterson (1987) also noted the ritualized quality of this transition

into motherhood, and stated that once a pregnancy is announced, women are initiated into the "secret club" with stories of their birth, others' birth, and impending parenthood, but also the ritualized silence of pregnancy and motherhood when around non-mothers.

The journals described horror stories about every mode of birth, elective and emergency C-sections, natural births, and medicated births. Additionally, the stories recounted an array of unsettling experiences more conducive to horror films and fiction novels: intense pain, blood and gore, disfigurement, paralysis, and suffering. For example, a pregnant woman awaiting the birth of her first child wrote,

> At this point, I am overall excited about pregnancy and am nervous for childbirth. I am trying not to think too far ahead about what will be happening during childbirth and once the baby is here. (Denial?) I'm currently experiencing an overwhelming panic; I'd like time to freeze. […] In addition, some other moms who mention childbirth talk about the birth in (what seems to me) to be insensitive ways, perhaps because they're so far removed from it. So, when I hear about people going into childbirth not wanting an epidural, but the pain being so bad they ended up wanting one and it was too late...I am influenced. Or, hearing stories about people who actually had an epidural and then experienced short-term paralysis. Eeps! Also, when people callously but jokingly say a truth like, "Be ready to tear from your vagina to your asshole. Just one big hole." ... Well, that doesn't help my anxiety.

The horrors chronicled by this first-time pregnant woman—intense pain, paralysis, and graphic disfigurement—further exacerbated her anxiety and provided an overwhelming sense of panic. For some, horror stories influenced women to doubt or change their plan. For example, a horror story of an epidural causing an acquaintance's temporary paralysis persuaded one woman to pursue a medicine-free delivery. For others, it influenced them to be more steadfast in their plans or more indecisive about what path to take should they have agency over their birth experience.

Avoidance of horror stories and stifling of positive birth experiences.

Interestingly, horror stories also divided women by having some avoid conversations about pregnancy and birth altogether in order to prevent unsolicited narratives and the social or internal conflict that may ensue. For example, Gloria who desired a natural birth in a hospital wrote,

> Again, I didn't really talk to people about my birth plan [because of the crazy stories people share], other than to say to some of them that I was using a midwife and using a birth center. I was at a party with family friends one night, when I was about 37 weeks pregnant. My mom was excitedly telling (bragging?) to several of her friends that I was planning on using a midwife and having a natural birth ("that means no drugs!"). I was usually somewhat embarrassed to discuss this with anyone, because I hadn't' actually DONE anything other than say "I want to have a natural birth." I hadn't been successful yet - and here were women who HAD given birth, listening to my mom tell them in such a way that made me sound like I was an expert. I was used to having people nod and smile or tell me some horror story about birth. Instead, two of her friends said that they both gave birth naturally and I would be fine. I had met so few people in real life that had done this, so it was really cool to hear their reassurances, particularly since I'd known them my whole life and they weren't hippies on Ina May Gaskin's farm :)

Gloria describes censoring herself from discussing her birth plan and avoiding conversations about childbirth because of the horror stories others shared with her. However, in this instance, a negative case, this mom-to-be found unexpected support in her desire, which was a shocking and refreshing departure from the norm. Notably, many women who discussed horror stories described the normative way in which the stories were shared, and with that, also described the narratives as unsolicited and avoided. Positive experiences of childbirth were rarely shared in social contexts.

Few women described positive stories about the joy and beauty of childbirth, or positive stories about births proceeding smoothly, as planned, when they discussed their social interactions when pregnant. In fact, some women were actually discouraged

from sharing their positive stories. For example, one woman wrote, "I was in labor for less then 4 hours. Actually, my nurse told me that I should lie when people ask me about the delivery because she said that it went so well other women would be jealous." She was discouraged from sharing her drama-free birth experience because the nurse felt it would make other women jealous. By pitting her experience against other women's experiences, the nurse fostered a woman against woman narrative where envy and other strong emotions create a chasm between women despite their shared experience of childbirth. Broderick (2016) also noted the absence of birth narratives in his auto-ethnographic exploration of his wife's home birth experience. In his inquiry, he noted the lack of birth narrative shared between the couple. Unfortunately, Broderick does not offer insight into if the experience was positive or negative, but does reference the notable absence of births in the family narrative.

Notably, women did share positive stories of childbirth in their journal entries. However, positive stories were relegated to journal entries about personal experiences, whereas horror stories dominated the social sphere. Also, the stories were generally positive from those who had the most agency in their childbirth, or whose birth reality did not vary far from their birth plan. For example, women, especially those who elected home births and were successful in their wishes, described their personal childbirth experiences as "empowering," "awesome," and "emotional." Consequently, horror stories recounted by women and those they encounter in the social world serve as a sort of ritual expression of those who experienced childbirth, and a rite of passage for those who are pregnant to bear witness to these stories and create those of their own. However, the social and internal conflict perpetuated by these stories results in some

women persuaded to an alternative position or strengthened in their existing position, and others even more confused about what the future entails. Yet, stories that fortify women in their decisions, or provide encouragement for their impending experience, are not only rare, but also discouraged. For as one woman put it, "the majority of other women aren't as supportive as you'd think they would be."

Liberty and control. Less overt than the conflict among women regarding science versus nature and mommy wars, but still apparent in some women's narratives was their social construction of childbirth demonstrated in their orientations to liberty and loci of control. Berlin (2002) philosophized about differences in liberty, characterizing liberty as positive or negative. Negative liberty is often referred as "freedom from," whereas an individual is free from external intervention. Positive liberty is often referred as "freedom to," whereas an individual holds capacity to exercise free will. Although the two types of liberty are generally seen as philosophical differences about democratic liberty and political structures, study participants demonstrated *orientations* to liberty that shed light on their birth plan desires.

For example, when asked to list all the words they could think of about their ideal birth plan, some women listed words such as "medication free," "freedom from intervention," "no induction," etc. These women created representations of their ideal birth that demonstrated orientations to negative liberty, in that they wished to have freedom from interference from their providers and their provider's team. Women who indicated negative liberty orientation tended to be those who wished a hospital birth, but wished to delay pain medication or advocated a desire to have as "natural" a birth as possible, within a hospital setting.

Other women indicated orientations to positive liberty in their representations of their ideal birth plan. For example, some women listed words such as "freedom to roam," "freedom to move," "move around," "walk," "eat," and "able to dance." The words to describe their ideal birth centered on agency to accomplish their childbirth desires. Overwhelmingly, the women who demonstrated positive liberty desired a home birth. However, some desired a hospital birth with as little intervention as possible. Although many women demonstrated an orientation to liberty in their responses, the clarity by which their orientation to liberty may impact their desired birth plan was muddled.

Similar to orientations to liberty was women's demonstrations of their loci of control. Badura (1997) described internal locus of control as the individual belief that she has power over the events in her life, and external locus of control as the individual belief that external situations and forces determine her outcome. Women who demonstrated an internal locus of control used language that demonstrated a high trust in their body to accomplish their desired birth plan outcome. These women described birth as "empowering," "engaged," and "strong." Women who demonstrated an external locus of control used language that demonstrated a high focus on the external environment as influential in their desired childbirth experience. These women described birth as "unknown," were concerned with "complications," and worried about "the stars aligning" to get their ideal childbirth.

A nuance between an individuals' orientation to liberty and their locus of control exists in the context of childbirth. To the extent some women feel free to act on their own will, they also feel they have the capacity and power to have an empowering,

transformative childbirth experience. Women who expressed positive liberty and an internal locus of control were women who both desired and accomplished a home birth with no medical intervention. Some women who demonstrated positive orientations to freedom with the capacity to deliver on their wishes, but who also felt childbirth was unpredictable with much outside of their control (external), elected a C-section, the most predictable type of childbirth.

However, because childbirth is largely unpredictable and because many women had previous births from which to compare experiences and desires, the relationship between loci of control and orientations to liberty were unclear with the narratives provided by many women. For the women who elected either a home birth or a planned C-section for the delivery of their first child, and for the delivery of subsequent children, largely the relationship between freedom and control were much more clear. The clarity of liberty and control is due in part to the first-time plan and first-time experience. Yet, the type of childbirth may also aid in the clarity of the relationship because both home births and C-sections have a high plan to reality ratio. Those women who intended a planned C-section rarely gave birth any other way because these were planned prior to the natural labor forces beginning. Similarly, women who elected to have a natural home birth prepared and planned for their birth at home with the arrival of a midwife and doula to assist them in their birth desires. Thus, because midwives and doulas do not have prescription privileges, only in rare instances would a mother's desired intervention-free birth be out of reach.

Instances where the relationship between liberty and control were far less clear were also grounds for increased conflict at the time of the childbirth experience.

Women who chose non-normative birth plans of highly medicalized C-section births and those who chose mainstream-resistant home births focused much of their narratives on defending their choice in the face of social criticism. Also, women who elected hospital births with or without medication, and who had their plans unrealized by being medicated against their will or unable to have medication despite their wishes, also expressed social conflict, but internal conflict as well. Even women who wanted a vaginal birth, but ultimately had emergency C-sections due to complications arising from delivery, expressed either social conflict with their birthing professional, or internal conflict post-delivery as they resolved their dissonance, demonstrating a tension between liberty and control due to a shift in agency.

For example, women who elected a C-section or a home birth discussed advocating for their method or defending against criticism of their method in the face of others' opinions and criticisms. One woman wrote,

> When [my family and my husband's family] heard we were going to have an unmedicated, home birth, they thought we were crazy, and thought we wouldn't be able to do it. They said they were worried about something going wrong, so I gave them a few statistics about how home births are actually not dangerous, and can actually be the safest thing for Mama and baby.

Yet another wrote, "My sister in law wasn't necessarily supportive of a birth plan.. She loved her hospital births and looked at my desire to stay out of the hospital as an affront to her experiences." A mother who had an elective C-section wrote, "With both my pregnancies there has been increased pressure to pursue a vaginal delivery and do things as naturally as possible. (Not necessarily pressure from my doctor, but pressure from mom groups that I participate in and society, in general.)" Yet another described her

struggle in making the choice for an elective C-section and the conflict she encountered as others attempted to influence her choice. She stated,

> My mother had 2 c sections 1978 and 1987 - the first one because she was told her pelvis was too small. The second because she knew what to expect from the first one. She seemed so flippant about my stress about making this choice. She would comment -- that's what I did, no problem, just do that. And I didn't want to JUST have a C Section [if] I didn't need it. I ended up needing it both times and really grateful I just did the planning. But it was interesting. My cousin had 3 C sections. Many people I spoke to about their experiences had C Sections - or wished they had due to complications. My one girl friend had a c section after 50 hours of labor, a 10.5 pound boy. She was like: "JUST PLAN THE C SECTION!!! Don't go through what I went through. And then you wear lip gloss." She told me about looking cuter both times - which I thought was hilarious. She told me she wouldn't hesitate the next time. Another friend - SUPER HIPPY AND PRO HOME BIRTH - told me she got an OB for her second baby because she was just a little nervous. Still planning a home birth but wanted an OB on her team. So....my conversations with many women simply led me in the direction of C Section. And I was grateful for that in the end. SO WORRIED ABOUT WHAT OTHERS WOULD THINK!!!! Really caught up in that and I think it is a problem. There is so much judgement [sic] and I really think that needs to leave the head space of an expectant mother so she can just make the decision that feels best for her.

Since these women elected births that are the least normative (highly natural at home, and highly medicalized through surgery) they seemed to express more social conflict in terms of their birth plan wishes and their orientation to liberty and control.

Women who resisted medicine in a hospital also expressed a certain degree of social conflict regarding their choices. One woman wrote, “Every one of my friends called me a "hippie" for wanting a natural childbirth.” This same woman was not supported at the hospital either and was often offered an epidural despite advocating for an unmedicated, intervention-free birth. Another woman wrote,

> After feeling in some ways like I was duped by my OB with my first pregnancy/labor/birth I was adamant that I would be able to do it the second time around exactly as I wanted[...] I told everyone I came into contact with that I would NOT be induced, that I would go past my "due date" if I needed to, and that my baby would come when she and my body were ready.

Both of these women indicate how they were not supported in their plans for an unmedicated, intervention-free birth by either their providers or their social support network. They described relentlessly advocating for their plan and defending the plan in the face of criticism, in order to achieve their ideal birth.

Finally, other women who elected for birth with or without medication, but ultimately "required" a C-section or other medical intervention because of a medical emergency described less defensiveness about their desires, likely due in part to the fact that birth at a hospital with medication is a typical, normative birth in the United States. However, women who desired the normative birth but instead had an emergency C-section expressed conflict, but mostly in the form of internal conflict that their plans were not realized due to medical emergency. For example, women who had unexpected C-sections (the majority of women who participated in the study) described, "This has been cathartic in some ways to go back through and rethink/process the decisions that were made. It was stressful to feel like my birth plan was chosen for me." Another woman wrote, "I never would have guessed that my delivery and birthing experience would be such an upsetting, emotionally taxing one nor did I ever imagine that I would have a sense of mourning because of the c section." Yet another stated, "I wished I was able to do a "normal" delivery without the need for such significant medical intervention (C-section) but it just didn't happen." These women describe the internal struggle and coping associated with a birth reality different from their plans. Their management of dissonance to come to terms with their delivery also demonstrates internal conflict requiring resolution.

The desired mode of birth combined with a woman's orientation to liberty and control, yield an interesting intersection at which women experience conflict (social and internal) with their friends, family, providers, and/or selves. Then, the extent to which they are required to advocate on their behalf in opposition to another seems to center on where the women are oriented in this intersection.

Conclusion. Due to the wide array of choices to be made during pregnancy for childbirth, and to the lack of agency to often deliver on one's childbirth plans, political opposition to others' goals occurs at multiple points both at the place of childbirth and as one comes to the end of her pregnancy and displays her ever-growing baby bump. In the absence of official communication of what birth plan is "right" or the "safest" even in the context of public health initiatives to reduce C-sections, thus identifying them as less desirable and a menace to public health, women are engaged in almost constant conflict both leading up to their birth and at the time of birth. Interactions that demonstrated conflict were evident in debates over science versus nature, and other divisive communication experiences including mommy wars, horror stories, the avoidance of and horror stories and the stifling of positive stories, and conflicting orientations to liberty and loci of control. Ultimately, pregnancy and resulting childbirth is a breeding ground for diverging meanings and human conflict.

Chapter 4: Discussion, Limitations, and Agenda for Future Research

Childbirth, specifically the rise in elective C-sections, is a considered a public health issue due to the increased risk of mortality and the over-utilization of surgical medical resources. With the goal of improving the health and well-being of women, infants, children, and families, *Healthy People 2020*, a publication of the National Institutes of Health, outlines the objectives of reducing Cesarean births among low-risk women and to reduce cesarean births among low-risk women giving birth with a prior Cesarean birth. Along with other objectives relating to positive and successful maternal and birth outcomes, these objectives focus on one specific mode of childbirth. Within today's modern childbirth larger sociopolitical context of neoliberalism, health care consumerism, and the general political environment of distrust of large institutions and special interests both public and private, the constructions of meanings of childbirth and policies governing childbirth were critical to examine in order to understand the processes by which meaning is created.

Summary

To explore the ways in which women understand and experience their birth plans and policies affecting birth plans, a case study was employed to inquire into the national goal to reduce the number of Cesarean sections among low-risk, first time mothers and low-risk women who previously had a Cesarean section. Pregnant and recently pregnant women were given weekly prompts to spur thoughts about their plans, relevant policies, and their social experiences. In total, 36 women kept journals for a seven-week period. A constant comparative analysis was employed to analyze their

responses. Journals were open, focused, and axial coded for similar themes and relationships among concepts.

The analysis of the women's journals of their childbirth experiences, decision-making, and interpersonal communications to answer the research question of in what ways do interpretive structural resources shape women's meaning making about their birth plans, resulted in three key tenets: modern childbirth occurs in an age of neoliberalism, modern childbirth occurs in an age of political distrust, and representations of childbirth are ripe for social conflict. Structural resources, then, utilized by women making meaning of their birth plans are drawn from 1) broader discursive structures in place by the larger socio-political context, including neoliberal concepts such as individualism, freedom of choice, and globalization through the proliferation of technology and expertise, as well as the current political environment marked by distrust of large interest groups and officials; 2) the creation of their birth plan becomes the most salient policy for which to ascribe, because the created policy holds precedence over other policies and governs expectations of the birthing experience; and 3) the fractured meaning occurring from individualized birth plans (policies) and the social conflict that it inspires isolates women and further distances them from a collective public health goal with which to align. Thus, women both draw on larger socio-political structures to create their birth plans, but they also draw on their birth plans to create structures by which to understand the impending experience.

First, women's journals demonstrated evidence of larger political constructs governing the discourse about childbirth. Neoliberalism, the political philosophy that has dominated the public policy framework since the 1970's and purports that

individual freedoms are best supported and created by a free market, as a dominant discourse in women's rhetoric was identified. Consumer choice, the free market concept that refers to consumer decision-making for products and services, was documented in the multitude of choices available to women as they planned their birth. Women were given the authority to make decisions in a birth plan about their mode of birth, the types of drugs available to request, and numerous other decisions afforded to women as they prepare for birth. They also demonstrated consumer choice by articulating the processes by which they were informed on those choices, via information gathering through the media, preparation classes, and other means. However, the choices afforded to women were merely apparitions, as despite the multitude of decisions to make, they lacked the agency to succeed in consummate their choices. Largely, their choices were made for them by their providers, the situation, and the series of situations, in which each decision was further limited by the decision that preceded it.

Globalization, another axiom of neoliberalism was evident in discourse on temporality, and technology and expertise. 21st century childbirth is governed by temporality, in that present time is privileged over future time. The unpredictability of childbirth prior to the 21st century is now scheduled or delayed to accommodate new moms' and/or medical providers' schedules. Likewise, technology and expertise has also transformed childbirth where medical experts are afforded power over the female body. Childbirth, under neoliberalism, has increasingly become more medicalized as technological innovation in equipment and pharmaceuticals has infiltrated the birthing experience, and in some cases, has replaced it.

Second, journals about childbirth and birth plans revealed evidence of the larger context of growing socio-political distrust permeating the experience. Women signaled a larger systemic distrust by concentrating much of their representations of birth plans and childbirth on the influence of larger interest groups, including big medicine, big government, big business, and in particular, big insurance. The proliferation of the medicalization of pregnancy and childbirth was noticeable in the use of brand names for multiple pharmaceuticals. The infiltration of direct to consumer (DTC) advertising, with women articulating brand names, and even their generic counterparts, highlighted the normative influence of big medicine on pregnancy and childbirth, as well as the skepticism of such pushes of childbirth to the sphere of illness and treatment. Overbearing bureaucracy and regulations was synonymous with older, white male figure-heads and powerful legislators dictating the ways in which the female body should be governed with regard to childbirth. Discussions of policy were often equated with overt influence of politicians meddling in the affairs and bodies of females. Big business and big insurance were also articulated as larger-than-life special interests penetrating the decisions of women and their relationships with their providers. The corporatization—Hollywoodization—of birth were both examined as women discussed the challenges of weighing finances to afford birth, and their overwhelming discontent with the *Business of Being Born.*

Finally, modern childbirth in the larger socio-political context is ripe for social conflict due to the absence of official communication, and the already documented distrust of the system. Women rarely discussed conversations with their primary providers, let alone conversations about public health initiatives and the drive to reduce

the number of Cesarean section births. For the majority of women who have a normative birth in a hospital with an OB-GYN, the women rarely discuss the actual birth, but even more notable, they have few interactions with the primary provider as most of their consult is with their nurses. With this lack of official communication, women turn to their social interactions, which are laden with conflict due to the number of choices that can fragment shared meaning. Social conflict is evident in a science pitted against nature debate, in which women demonstrate either 1) trust in the medical system and doctors to provide life-saving care in case of emergency, or 2) trust in nature and the female body, allowing for predetermined biological destiny to occur without intervention. Women who articulate trust in and advocate trust of science or nature use similar rhetoric in their opposition of the other camp. Others, they describe with moral superiority, are subject to trend and convenience.

Other divisive communication experiences expressed by women include mommy wars, horror stories, the avoidance of horror stories and stifling of positive birth experiences, and liberty and control. Mommy wars were described in vivo as the female battles encountered by women as they become mothers, when they suffer scrutiny and judgment in the face of parenting decisions. Birth plans, it seems, become the first rite of passage into mom wars, making new and seasoned moms vulnerable to criticism if and when they air their desires. In particular, birthing horror stories filled with narratives of pain and gore are shared freely by seasoned mothers whether it is their story or that of an acquaintance, and are solicited grudgingly by pregnant women simply because of the visible display of a baby bump. Pregnant women resort to censoring themselves or avoiding social encounters to avoid the conversations, isolating

them from the community. The positive stories about birth, typically shared by women who had the most agency over their birth, are relegated to private journal thoughts and rarely shared in social settings. In some cases, the positive stories are even discouraged from being shared.

Liberty and control were also evident in descriptions of child birth preparation and experience. Women varied in their social constructs of birth as a negative or positive freedom. Negative freedom was indicated by a philosophy that ideal childbirth should be free from obstruction, interference, or edict. A positive freedom orientation was indicated by personal agency to do as they wish in delivering their child.

Representations of childbirth within the constructs of neoliberalism, increasing distrust of special interests and those in power, and the social conflict that results from the shifting meaning of childbirth in a modern environment demonstrate not only instances of competing meanings and the varying representations of a problem or issue. The processes by which the meanings of phenomena—varying childbirth constructs and policy initiatives regarding childbirth— also compete, are negotiated, sustained, and modified are influenced by the broader public sphere.

Discussion

The internal and social conflict that resulted from the multitude of individualized meanings as represented in the findings, highlighted division between women of differing birth camps, which provided few opportunities for meaning to converge to create a broader shared experience of childbirth. Despite very few women participants who intended on and resulted in an elective Cesarean section, the range of respondents provided far more meaningful understandings of how policy is created,

sustained, and acted upon within an influential political and social context. The answer to the posed research question, in what ways do interpretive structural resources shape women's meaning making about their birth plans, is explored in four parts. The discussion centers first, on the way in which broader discursive structures shape meaning, second, how birth plan policy exists as a dynamic, lived experience created by women to shape meaning of their birth plans, third, how the public is increasingly distanced from public health, and finally, practical implications of competing meanings are explored in response to the *Healthy People 2020* objective to reduce the number of Cesarean births by low-risk women and reduce C-sections in low-risk women with prior Cesarean births.

Broader contextual discursive structures shape meaning. Findings largely supported the influence of the broader socio-political context of neoliberalism and health care consumerism in the modern childbirth context of multiple modes of birth in a medicalized setting. Although instances of hegemonic Discourses governing language and social rules is less theoretically interesting than the processes by which this context influences meaning, this research must demonstrate the larger political constructs that regulate the discourse.

Recently, popular culture and news articles pontificate the assumed influence of neoliberalism, without any evidence that the philosophy truly guides policy-making, let alone understandings of problems and the policies constructed to resolve them. Altman (2005, July 16), Monbiot (2016, April 15), Metcalf (2017, August 18) all discuss neoliberalism as a broader philosophy in which the establishment concedes its authority to the market. They differ, however, in their beliefs if the philosophy survives and

actually governs the way in which we exist in the world. The neoliberal myth, as its critics call it, does not operate as a philosophical platform, nor is it practical as an calculated agenda. Those who are critical of neoliberalism yet acknowledge its existence, speak to it less as a philosophical platform, but more as a way of being and living in the modern world. Ultimately, the criticism is that we assume the existence of neoliberalism as the dominant socio-political discursive framework, but we rarely articulate and defend its existence.

In this case, key tenants of neoliberalism in public health, rather than pluralism and social justice, were evident in women's journals of their birth plan decision-making and general experience of pregnancy and childbirth. The sheer number of choices afforded to consumers in the free market economy, and the demonstrated importance of making those choices as an informed consumer, indicate a likely shift in what preparation for childbirth means in a neoliberal world, as the magnitude of choices, the onus on the mother to make those choices, and the seeming importance of making the "right" choice did not exist pre-neoliberalism.

For example, the 32-year-old social worker who reviewed an initial draft of the research wrote,

> More globally, this particular study paints a pretty bleak picture for the experience of women in pregnancy and the many ways that we continue to find ways to divide ourselves or be divided (feels sort of chicken/egg-ish). Something around us makes us feel "otherized" and then we perpetuate that by trying to bring others to our position, or surround ourselves with those who are on our same side. It causes me to reflect... I will be "choosing" a hospital birth based on my limited options (reiterating her assertions about the myths of neoliberism about our "choices"), versus my co-worker who didn't really want a home birth, but "chose" it due to our limited options regionally

This woman resonated with the choices afforded to women in their birth plans, articulating "choice as myth," and emphasizing the socio-economic structures in place

limiting the amount of choices afforded to pregnant women. Structural resources, then, that shape women's meaning making about their birth plans range from broader political philosophies that shape the political context, to the dominant policy framework that governs health care and women's health, to interpersonal environments that shape the ways in which women formulate their plans to which they ascribe (see Figure 6).

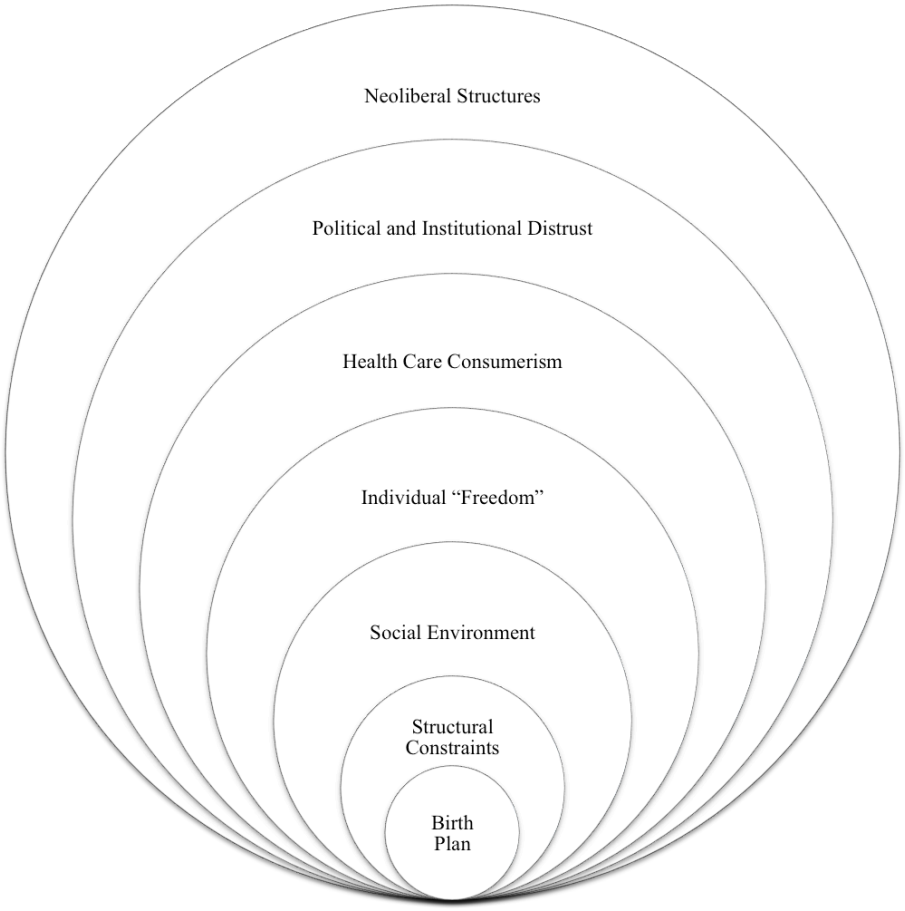


Figure 6. Structural Resources for Childbirth Meaning-Making

The socio-political context provides the Discourse for which meaning is negotiated, creating an ecology of messages in which meaning of birth plans and childbirth is situated. For example, without understanding the larger political context of birth plans, scholars may be inclined to focus solely on the standard health communication lens of reviewing the phenomenon through the lens of social support,

and illness and treatment. However, the relationship of the phenomenon's meaning to the larger environment and context, yields far richer data to support observation of neoliberal influences, of which one may not be aware they are producing and reproducing. Therefore, the dominant Discourse offers implications to policy creation and policy response in the form of measurable outcomes for instances of social construction. This notion supports Hadjigeorgiou, Kouta, Papastavrou, Papadopoulos, and Mårtensson's (2012) finding that a woman's choice is often structured by the country's health system, but goes further to demonstrate a larger public policy philosophy at play.

Notably, when examining the broader interplay of hegemonic Discourse that structures the way in which individual and social phenomena are created and sustained, identifying the discourses that are missing from the broader context is also critical. Despite the recent shift to social justice theories in public health, which focuses policies and initiatives on social determinants of health in order to remove or address cultural and economic barriers as a way to balance historical inequalities brought on by neoliberal policies, social justice rhetoric was largely absent from this context. Although social justice theories do focus on women as a target population worthy of focus due to historic focus on men in public health, and the reduction of C-sections initiative is focused on increasing the health of women, very few women reproduced social justice rhetoric.

For example, one woman lamented on the cost of a midwife-assisted birth, which was more expensive in the state she currently resided. Along with lamenting the increase in costs from one state to another, she also acknowledged the plight that other

women, not as financially fortunate, would face in the same situation. The advantage afforded to her because of economic resources was acknowledged, but it was rare. More common, was the notion that if you had insurance, you should be able to choose whatever birth you wish. The unspoken warrant was those who cannot afford it, should not have the luxury of choice.

Again, the pregnant social worker highlighted the influence of cost on birth plans as a structural barrier. She wrote,

> I'm sure cost very much impacts birthing decisions. Health care is so strange these days. My co-worker who had a home-birth with a mid-wife mistakenly thought it would be cheaper than the hospital. However, due to our "out-of-pocket max" I believe the 2 end up being essentially the same. Depending on how many of the optional labs in addition to recommended labs you do pre-natal, the cost varies quite a bit. We are fortunate to be insured and in pretty good shape financially. We did realize there will suddenly be a new human without insurance who could have medical problems (not that we're expecting that.. simply he will need his own care while at the hospital), but I am told (and will soon verify) that the little guy will be on my insurance automatically for the first 30 days, during which we will be able and expected to enroll him in his own insurance.

Lately, debates regarding social justice issues in childbirth have made their way to the public sphere. National Public Radio (NPR) recently began a series on maternal death in childbirth following the well-reported death of 33-year-old neonatal intensive care nurse, Lauren Bloomstein. Lauren died in the hospital where she worked only 20 hours after giving birth. The NPR series, which began with news of Lauren's death (Martin, 2017, May 12) and continued with further analysis on the American model and ways women might protect themselves (Gallardo, 2017, August 3; Martin, 2017, August 17), criticized the American maternal health model that prioritizes the baby's needs over the mother's care, when both are vulnerable.

This predominant neonatal care model in the U.S. that prioritizes the baby over the mother, putting new mothers at risk, was not specifically explored in the analysis, but is generally supported. For example, women who were opposed to home births or elective C-sections described mothers as selfish and as putting their needs over the safety of their baby. The moral superiority demonstrated highlighted a shared value that baby's needs must trump mother's, or the mother's ethical and moral peripheries are in question. Hence, the absence of social justice language, but preliminary evidence of a public health need to re-situate power-dynamics to ensure quality care for both mother and child, is equally telling than evidence of neoliberal discourse.

Correspondingly, pluralism as political philosophy is also missing from the findings. Although political philosophies are most often discussed in the context of policy creation, one would anticipate finding evidence of a predominant philosophy that recognizes that no one entity should have power over another, and that all entities should be able to enter the public sphere to negotiate conflict to a mutually beneficial solution.

Although many women articulated generally a "to each their own" philosophy when presented with birth plans other than their own, women also signaled distrust in large interest groups influencing policy and the larger socio-political context in which childbirth occurs. Themes of big medicine, government, business, and insurance dominated rhetoric regarding the choices available, and those unavailable, to women.

If democratic pluralism is to be successful, it requires a level playing field. Interest groups under this philosophical perspective all are able to access the debate, and via civil discourse, are suited to influence the debate. Although a lofty ideal, women's

journals echo a larger, national pattern of increasing distrust of our political institutions and public officials within the narrow context of childbirth. For public health contexts, distrust of the influence of special interests is particularly problematic, as theoretical shifts continue to put onus on the individual in the name of the collective good.

Policy as lived experience. Modern childbirth and birth plans exist within the larger context of neoliberalism with a focus on inane amounts of choices afforded to the consumer in the modern health care environment. Under the patient as consumer health care model, pregnant women operate from a mode of informed choice, educating themselves on the wide array of decisions they will face when they ultimately give birth. Will they give birth in a hospital, birth center, or at home? Will they use medication to alleviate pain or will they choose to deliver naturally as women have for centuries? What type of medication should they use? When faced with induction, will they choose to have labor induced to ensure the safety of their child or solely out of comfort for themselves knowing that without induction, they may not have their planned doctor deliver the child? Should they go ahead and just choose a C-section to prevent the anguish of attempting a vaginal delivery, only to have the ultimate result be a delivery by emergency Cesarean section? Though few women elect to not consider the options available, and truly elect to have no plan, reserving the difficult decisions to be made by their medical provider, most women make specific decisions as to their plan and document their desires.

Many women expressed stress and anxiety in the amount of decisions afforded to pregnant women as they prepared for delivery. The number of choices available, as well as the need to prepare with research and investigation as to what the correct

decision should be, saddled women with decision fatigue and at times, choice-paralysis. Women described "just being ready" for the baby to come out so that would not have to think about "it" any more, or they described as just wanting someone, their provider, to tell them "what to do." Schwartz (2004) offers a sociological and psychological perspective on the number of choices afforded to consumers in modern America. He documents how the sheer magnitude of choices catapult individuals into cognitive-overload, filling them with distress and anxiety, and paralyzing them of action. Schwartz counter argues that by limiting our choices, we actually expand our freedom by relinquishing ourselves from the psychological shackles of intrapersonal parley.

Also, the stress and anxiety exhibited by women about their choices may also be attributed to uncertainty, with birth planning as means by which to manage uncertainty. For example, Vos, Anthony, and O'Hair (2014) argued that pregnancy is enshrined in uncertainty, specifically with regard to the due date of the baby. In their study of women's uncertainty management of due dates in response to other public health initiatives to reduce the number of babies born preterm, they propose axiological uncertainty, in addition to other forms of uncertainty, that is characterized by the evaluation of the orientation as ethical or good or bad. Although this study did not specifically focus on due dates and the initiative to delay birth until the full 40 weeks, the evidence found herein supports the assertion of the moral or ethical implications of an evaluative orientation; the woman does not know if the decision is good or bad. However, similar findings were supported with regard to high levels of uncertainty, early information seeking, and the provider as gatekeeper who, in addition to gatekeeping women's requests, at times activate labor for their own benefit.

Neoliberalism and a consumerist healthcare culture created an environment where choices equate freedom. For example, Americans have the ability to choose from dozens of toothpaste brands and types, affording them more flexibility to choose the product best for them, and to conduct a cost-benefit analysis, which ultimately rewards the companies who manufacture the best products (a true free market economy). Similarly, women who make choices about their birth plans are afforded a wide range of options from which to conduct a cost-benefit, or risk-benefit, analysis to make the "best" choice for themselves, their families, and their newest additions.

However, with informed choice comes implication, as evidenced by Schwartz (2004). The more choices afforded to women in their birth plans, the more opportunities for social conflict, the more opportunities for the plans to be disrupted or unrealized, expectations to be violated, and the more opportunities for guilt, shame, anxiety, disappointment, and dissatisfaction. For example, a mother who planned for a vaginal birth but had a Cesarean wrote,

> My childbirth was not what I had 'planned;' after all, I spent nine months telling my doctor that I did not want to be induced and I did not want to have a cesarean. I had no clue what I was in for. Although the moments leading up to the cesarean were scary and the procedure was traumatic, the birth of my baby was smooth and really trouble free.

For every decision in which a mother indicated a position, there was more opportunity for disappointment, and more opportunities to lay the groundwork for resistance to public health initiatives with conflict over policy, and whose expertise is prioritized. Unsurprisingly, in her quantitative analysis of 551 online birth stories, Bylund (2005) found that less than 4% of birth decisions were made solely by the patient, and only 6% had equal participation between patient and doctor. However, Bylund expands her definition of *shared* decision-making to *some involvement* in

decision making, expanding her findings to 57% of women who were involved in the decision-making. With this loose definition, Bylund found that the decision mostly involved the use of medication in the delivery. This finding is in alignment with the findings discussed within this study, whereas the choice for medication is the most agency-laden decision in the childbirth process, as compared to the other "choices" afforded to women.

Pregnancy, a birth plan, and childbirth—process and action—are inherently political. They require action, and are value-laden like any other political action. However, they are represented differently than the way in which other political issues and political behavior are studied. Whereas political behavior is typically viewed with the result of voting for one party, which represents a single identity for a collection of platform positions and political views, pregnancy and childbirth are acted on in a series of decisions and actions with no true group identity, other than motherhood. Thus, when a plan composed of multiple intentions veers off course by one or more choices, there is more opportunity for disappointment and dissatisfaction. As Goffman (1974) noted, socially constructed frames guide our decisions in a way that allows for public acceptance. These "pictures in our heads" simplify our social reality to make sense of a complex world. However, what happens when these frames are used to define our experience before it occurs, only to be abruptly faced with an alternative reality? Women are then saddled with guilt and shame from making the wrong decision or being unable to exert their agency in the situation, despite months of planning. For example, women who made choices that were ultimately upended often described feelings of

remorse. “If only I had advocated for myself more, I wouldn’t have so much sadness and regret to process now,” lamented a woman who felt she was forced into a C-section.

The previously cited Bylund (2005) study on patient decision-making identified a similar notion where women’s involvement with decision-making was positively correlated with their use of positive language about their birth experience, as well as negatively correlated with negative emotions. Applied to the findings identified in the study herin, choices in which women were able to articulate and have agency in their realization (decision-making), yielded positive feelings about the birth, and vice versa.

Interestingly, despite the number of choices afforded to women and the painstaking research involved in making each and every one of these choices, women receive very little guidance from their providers. Some women indicated asking providers about a specific option and providers being open and knowledgeable about their options, but with only a few exceptions, very few women indicated providers who advocated for a position. Despite public health recommendations, few women were counseled about their birth plans and had providers advocate for certain options over others. Therefore, the public policy that women experience with regard to childbirth was often not that of federal or state regulations or guidelines, but that of their own plan, researched and developed, and their lived experience, in alignment with or contradictory to the plan. Childbirth policy does not exist in childbirth meaning, except for that of larger political constructs; the birth plan that is researched, agonized over, and created becomes the only policy that matters.

Women create the only policy they come to know in childbirth, their birth plan. These plans are negotiated, often publicly as other women pull them into debates on the

merits of their decisions (social impacts are discussed in the following section). However, women have little to no agency in the modern health care context to demonstrate fidelity to the plan. Adherence to the birth plan is decided by the broader context and women often relegate power to the providers who have the technology and expertise. Therefore, women's meaning constructed over nine months for what childbirth is and will look like is often reconstructed and supplanted by another actor in an instant. Mothers, then, are resigned to reconcile the meaning they created with the meaning that was chosen for them.

Additionally, within the larger context of the commodization of health care under neoliberalism is the debate of whether healthcare should or should not be treated as a commodity. For pro-capitalist thinkers, health care as a commodity results in more choice and more consumer freedoms to consume the health care you desire. This perspective articulates the idea that health care is and should be a good because ultimately, it is a service provided by another individual who must be rewarded or paid for their expertise and service. An alternate view is that health care is a right to be afforded to all just as freedom is a right afforded to all. Adequate and affordable universal health care is a prerequisite for life, liberty, and the pursuit of happiness. Regardless of which value provides the foundation for one's political views on health care, the healthcare as commodity perspective dominates the discourse on childbirth choices. This perspective leaves the consumer with an unexpected consequence: the inability to be faithful to salient policy (birth plans), and the inability to have recourse for a bad or undesirable experience. Birth plans, unlike other commodities, cannot be

returned for cash or credit. Consumers are then left with a residual mix of bad feelings, disappointment, and/or inadequacy.

Removing the public from public health. Despite the migration of childbirth from personal experience to the realm of public health due to the rising C-section rates in the United States, this study supports the assertion that childbirth is largely a personal experience. Moving childbirth to the public sphere is in line with current trends in public health to shift public health issues to the realm of individual responsibility. However, despite the theoretical shift and trends, the shift in meaning has not paralleled the policy shift.

In large part, this is due to the multitude of choices resulting in plans comprised of fractured decisions, leaving few opportunities for coordinated and shared meaning with others. If two women are unified in their birth experience as having a vaginal birth, the shared-meaning may end there when one confides that she had a medicated birth, whereas the other had a "natural" (see Turner's (2002) definition of 'a natural' birth rather that 'the natural' birth), unmedicated birth (see Figure 7). Natural, in this case, meaning a vaginal birth without medication, regardless of environment. The two experiences, despite being similar, diverge in meaning as each choice is made, or each result is actualized despite the choice. Instead of childbirth or motherhood unifying women, the "choices" are fracturing the shared experience.

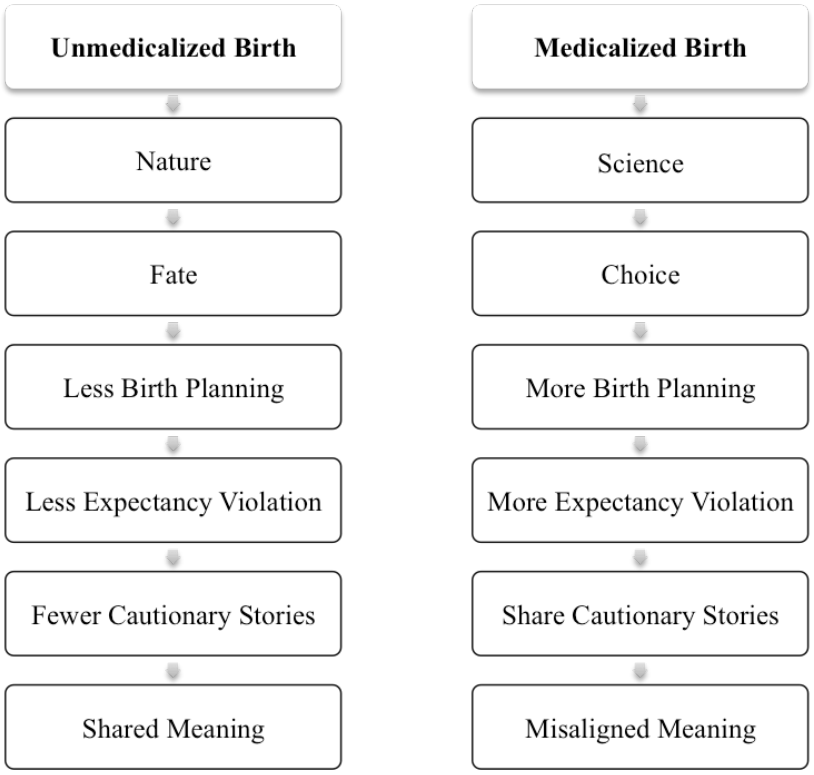


Figure 7. Childbirth Meaning-Making Process

For example, the pregnant woman who reviewed an initial draft of the research wrote after describing her choice for a hospital birth in relation to her co-worker's choice for a home birth,

> I then already feel less close to her and less interested in her experiences. I don't particularly feel judged, but I'm certain she has adopted a similar "right for her, not right for me" attitude, just as I have with her. Since I have that same chorus of "what if something bad happen to the baby or me during childbirth - self righteousness" the judgement (sic) is still there (mommy-war phenomenon). And I'm sure she has her own "birth is a normal thing and not a medical emergency" judgment going through her head about me. I then have a few friends who have had their babies at our local hospital and I feel closer to them and aligning with them (to a limited degree) on other choices - where to day care? cloth or disposable diaper? breast feed or not? I find myself wondering... if the outcome of my pregnancy is natural, medication-assisted, or c-section, will that ultimately impact my decisions/actions related to who I connect most with post-birth? Thus allowing me to reinforce my own decisions/experiences to myself. I feel lucky to be in the camp of women who know women who have had successful natural births, because it doesn't make that option feel impossible…

She reflects on how those choices pre-determine her "camps" of women with whom she feels close to due to similar experiences. Tajfel and Turner (1979) articulated this as social identity, in which a person's sense of who they are is based on the groups with which people belonged. As women prepare for their birth plans, they are projecting a future group identity. However, as many of these choices are beyond their agency, women are then required to reconcile their intended group identity with their resulting group identity, in addition to offering social implications on divisions between women due to the maternal groups with which they are aligned.

Ironically, despite the painstaking choices made and the commitment to such choices in childbirth, women have very little agency over their experiences. Yet, despite the lack of agency, choices are evaluated by others as lesser than or more than the "choices" they made or were given. For example, women who elected or were required to have C-sections describe the heartbreaking criticism that they hear or embody that somehow they "took a shortcut" to motherhood. Despite the unifying experience of pregnancy and the growth of a living human in their female body, they did not give birth; they had surgery. The multitude of choices, or even semblance of choice, leaves women subject to a wide range of potential conflict. Yet, despite one woman having no more agency over the experience than another, the choices are viewed as political and subject to criticism, evaluation, and judgment.

The splintering of meaning of childbirth removes the public in public health, at least with regard to childbirth. Women have few opportunities to converge on meaning, and when they do, another "choice" appears which may splinter the brief shared experience.

Additionally, multiple opportunities for social conflict exist with debates over science versus nature as the strongest value in childbirth, mommy wars over multiple side issues related to or a product of childbirth, and conflicting orientations to liberty and loci of control varying from women to woman. Some social conflict can be productive when processes are created in which social change and progress can occur through civil discourse and open minds. Other social conflict can be destructive, lending to social division and creating castes within the social relationships.

Largely, women within this study reported conflict leading to fragmentation, a lack of support, and feelings of isolation. Horror stories shared with pregnant women describing fear-inducing narratives of unplanned emergencies, horrible outcomes, and warnings for women to take heed of others' experiences created feelings of anxiety, ostracizing women from each other. Similarly, mommy wars where women criticized others' "choices" as being trendy or out of convenience created a culture of isolation where women felt increasingly lonely despite an experience that historically has unified women. Ideology regarding childbirth factions, like other recent trends in political ideology, has created more separation than social cohesion, removing the public from public health.

Before succumbing to the sole realization that a historically shared experience can increasingly become fragmented due in part to dominant political ideology, overarching economic policies, and the modern political environment of special interest and big government distrust, the reasons women feel the need to share horror stories and convey frightening experiences, often without solicitation, with other women must be explored.

In this study, women shared horror narratives to describe their own experiences as to why they were making particular choices, they shared others' narratives to describe why they were making particular choices, and they shared how others' shared these stories, with or without solicitation.

Horror narratives provided catharsis to relieve the anxiety felt about the number of choices, and to lessen stress over the deliberation over such choices in anticipation of an event largely outside of one's control. These narratives also seemed to function as catharsis for dealing with trauma and to express actual fears of an unknown experience in order to cope.

For example, one woman described her need desire for a C-section as a need, after the fact, documenting that her baby girl had the umbilical cord wrapped around her neck which would have been increasingly dangerous with a vaginal delivery. Here, she is describing a traumatic story that likely aids in processing the event, but also in defending her choice for an elective C-section that would have been necessary anyway. Another woman described a harrowing tale of her emergency surgery occurring before the numbing agent could take effect. Yet another woman described doctors whisking away her child to perform life-saving CPR and a lack of oxygen resulting in multiple extra hospital days in the Neonatal Intensive Care Unit (NICU). Both of these women indicate a need to describe their experiences to deal with the trauma of their childbirth experience. Yet another described a friend's story of a paralyzed baby after home birth complications, demonstrating why she would not be comfortable with a home birth experience as it delays access to life-saving and complication-preventing treatment. Finally, other women described being faced with horror stories filled with unwanted

descriptions of tearing and bleeding that may have served as catharsis for trauma for them.

The sharing of horror stories seemed to serve the main purpose of a psychological need to process a traumatic event and relieve anxiety, distress, and remorse over cognitive dissonance in reconciling meaning with experience. Yet, the sharing of horror stories may also have served the social purpose of persuasion to sway pregnant women in making a choice similar to the one they made. In an effort to achieve connection in motherhood, women use these stories as a way to recruit others to their way of understanding. In the increasingly disconnected modern childbirth context where when feel isolated and self-censor to avoid conflict, women who have already experienced birth may be seeking to reestablish the connection with others, now that the experience has passed.

The urge for mothers to convey traumatic stories to women who are currently pregnant, even on behalf of others' experience, has ultimately become a pregnancy and motherhood rite of passage. The horror stories of what new moms should expect are shared as way to socialize expecting mothers, an apprenticeship into motherhood. While these stories are described by expecting women as unwanted and unsupportive, driving them further away from conversations about the event to come, cynical seasoned mothers, survivors, may be attempting prepare these pregnant women for the more difficult task ahead, motherhood.

In a sense, these stories are used to drive more division between women. The more horrifying the story, the more righteous the rite of passage and justification in the experience. However, women may also share these traumatic experiences because they

do feel so isolated in their experiences, and are seeking to find social support after the event. Despite the justification, the culture of storytelling traumatic events may have lasting impacts on the isolation of pregnant women in their childbirth experience.

Again, women primarily discussed the terrible stories other women shared with them about childbirth. In their conversations with others, negative stories about birth plans dominated the social setting, so much so, that women commented concerning keeping silent about their plans in social situations so as to avoid the inevitable sharing of horror stories. Other women, who were outed in their birth plans by others, at times were surprised by support, again demonstrating the dominance of horror stories in public conversations about birth. However, some women did share positive stories about childbirth, but typically only when sharing their personal experience in the privacy of their journal. The women who shared positive experiences tended to be those who had the most agency in their childbirth experience: where their plan and their reality were similar (again, see Figure 7). For example, women who elected having a home birth often discussed the experience as transformative, empowering, and beautiful. One woman who had a medicated delivery, as desired, for her second child described it as being full of laughter. Still another second-time mom who elected to have a repeat C-section also described the experience in positive terms—as full of excitement and hopeful anticipation about completing her family. Notably, these women did not describe social situations in which they shared their stories with others. First time moms, then, are especially vulnerable to negative stories about birth.

Implications for Healthy People 2020 objectives. The interpretive structural resources available to women as they create, negotiate, sustain, and modify their

meaning about childbirth and their birth plans has practical implications for the federal health objectives to reduce the Cesarean births among low-risk women with no prior Cesarean births, and to reduce Cesarean births among low-risk women giving birth with a prior Cesarean birth.

Initially, public health's shift to individual, preventative solutions for public, collective problems may pose problems when the problem-construction misidentifies the cause. The majority of women in this study intended a vaginal birth. However, many of their births resulted in an "emergency" C-section. That is, despite their intentions and best planning for a vaginal delivery, interventions by providers supplanted their policy. Matthias (2004) provided insight into the paradigms of midwives in comparison to physicians in prenatal consultations by highlighting midwives comfort in uncertainty and the natural processes of pregnancy and childbirth, whereas physicians view childbirth and pregnancy as "an accident waiting to happen." The objectives then, may best be articulated as "to reduce unnecessary Cesarean interventions among low-risk women." By rephrasing the objective to put the onus on those who have the agency to make the ultimate birth decisions, the policy constructs and related initiatives now target the appropriate audience. Women give birth; physicians perform medical interventions. The policy is misaligned with the situational agency. The somewhat small rhetorical shift relieves the burden on mothers, who are already saddled with making burdensome plans that have little chance of reaching fruition. Of the 31 women whose birth reality was revealed, 55% indicated a reality different from what they planned for or desired. Of those women who were giving birth for the first time, 50% resulted in an "emergency" C-section (the national average is

33.9%). By making a rhetorical shift in the objective, responsibility is shifted from the mother back to the medical practitioner. Since the objective was articulated for 2010, and again for 2020, perhaps shifting rhetoric to the one accountable for the solution will situate agency.

Once responsibility is shifted to the appropriate party, attention must then be placed on how emergencies are social constructed in childbirth both by the mother and by the practitioners. Women clearly articulated the need to be near medical technology and advancements, in case of emergency, if they put their faith in science. They constructed childbirth as the potential for disaster and the need for emergency-preparedness. Access to emergency medical intervention takes priority in the majority of births, which occur in hospitals or in birthing centers attached to hospitals. All other decisions are secondary to emergency access. Women who construct birth plans as a disaster-preparedness response may be more susceptible to practitioner's recommendations that either the baby or mom are in danger, despite their initial desires to have an intervention-free birth.

As the objective for reducing C-sections was instituted for 2010 and repeated for 2020, the number of women who construct their plans and their meaning of childbirth, but who ultimately have births inconsistent with their plans is considerable. Practitioners, then, must take into account the psychological distress women experience after giving birth in an unexpected fashion. Though women are typically relieved with the delivery of a healthy baby boy or girl, many demonstrated a sense of remorse or regret that needs resolution. Postpartum care must include methods to assist new moms in processing their experience so that their methods for catharsis are not to perpetuate

fear in others. Instead, these mothers are supported in their experience, providing a future support network for new mothers who will experience the phenomenon for the first time.

For example, in the member check conducted by the 32-year-old social worker, she wrote,

> I also like the idea of processing birth experiences as part of post-pardum care as a way of stopping the horror-story perpetuation. While I certainly haven't had too many people force horror stories on me now that I'm pregnant, I was well-aware of many of them before I even got pregnant. AND my stupid pregnancy app sent me a story once about a terrible birth that ruined a gal's vagina... I was kinda like.. who is this supposed to help? Is this supposed to help me mentally prepare for that outcome? 1. It's probably not going to happen and 2. No amount of thinking about it ahead of time is going to make that not suck. Anyway, that poor woman obviously needed an outlet for telling her story... and in general, when people are telling me their stories, I am often successful at viewing it as that.. more for them than for me. But perhaps that's because I'm a counselor and I am pretty good these days at hearing other people's stories without thinking they need to apply to me.

Although she was not subjected to many horror stories from other women, she indicates she was well-aware of them before becoming pregnant. Perhaps, horror stories are more culturally entwined with womanhood than solely with pregnancy. Yet, she does indicate the perpetuation of such horror stories through a website application.

In addition to discussing the perpetuation of horror stories, the social worker describes seeking advice from trusted sources, both in alignment with her desires and with other choices she is exploring. She mentions being vulnerable with trusted sources as she is in information-seeking mode. Women's vulnerability for information may heighten their social in-group/out-group meaning constructions, and possibly more open to the support networks referenced above. Clearly, supporting the social aspects of pregnancy care and post-partum care may assist women, particularly first-time mothers, as they prepare for and make sense of their birth experience. For the social worker

indicated after providing feedback on the research, "I must say, I had a lovely conversation with my OB yesterday about this very topic, inspired by some of the things I read. Best appointment yet." Thus, this study supports the development of opportunities for women to explore information and process their experiences in safe spaces with their providers or other women.

However, as demonstrated, physicians have the most agency in determining when a delivery is normal and when a delivery becomes an emergency. Agency is also critical in women's perceptions of the birth experience as positive or negative. Unfortunately, one's agency in childbirth is a power dynamic only possessed by women who have the resources to choose modes of birth that give them the most control. As mentioned in the review of literature, in many states, C-sections are reimbursed at a lower rate, especially those funded by Medicaid; thus elective C-sections are often not a course of action. Similarly, Medicaid and many private insurers do not fund midwife services, especially those performed in a home. Thus, positive birth experiences are reserved for those with the most agency to exert control over their birth experience, which means positive birth experiences are reserved for the wealthy or well-insured. C-sections are a social justice issue in public health, despite the lack of discourse situating it that public policy space.

Finally, public health relies on a unification of health actions for the collective good. If public health continues to move in a trajectory that emphasizes individuals' actions as the cure for public ailments, issues such as childbirth, which offer multiple areas for conflict and few areas for shared meaning, provide barriers that must be considered by public health campaign officials. Adherence to an individualized plan as

policy crafts multiple meanings for a single issue. Contradictory meanings, beliefs, and attitudes about public health issues requires public health policy and public health behavior campaigns to prioritize a culture-centered approach to health communication and craft messaging for a more diverse audience. Public health officials must seek participatory solutions to ensure policy and related campaign messaging is crafted to the audience it intends to reach. For example, Dutta (2008) argues that a culture-centered approach in health communication allows community members to co-create problem construction of health issues that impact communities. Though typically applied in non-Western cultures, this advice holds true for public health situations in which meaning may be more fractured, than shared. Participatory policy making and review that takes into account instances in which meaning diverges may increasing positive outcomes associated with public health campaigns.

Limitations

Limitations in the data and analysis can be attributed to the subsets of populations who participated in the study, as well as challenges with data reduction and exhaustion. Although a sufficient sample size participated for quality qualitative analysis, the study did not have equitable representation from women who gave birth by different methods. For example, although this study intended to seek out women who had elective C-sections, few women who chose this birth plan participated. Thus, comparisons between the modes by which individuals gave birth are preliminary, and are subject to further exploration with a more equitable subset of women who elected typical modes of delivery: vaginally with medication, vaginally with no medication in a hospital, vaginally with no medication at home, elective C-section, and emergency C-

section. Similarly, due to the limited number of women who elected Cesarean sections, findings related to doctor consults to convey the public health initiative of Cesarean reduction are at most, preliminary. As women who elected C-sections admitted little doctor guidance, further exploration of this subset of women is necessary to understand the dynamic between them and their doctor regarding medical directives.

Without a more comparable subset of women, differences in subpopulations' discourse and the processes by which they develop situated meaning are noted, but subject to further analysis. For example, preliminary evidence suggests home birth mothers situated birth as a natural experience and use discourse to convey that pregnant women are not sick, and thus hospital births are not required. Interestingly, women who elected a hospital birth did not describe themselves as sick or ill, but they did socially construct birth as a potential disaster. Seemingly, women who are part of a home birth community use common language to counter the normative birth plan, and thus, defend their own choice.

Likewise, the study sought women who were either currently pregnant or recently pregnant within the past calendar year. The justification for soliciting women from both populations is that childbirth would be salient for women about to give birth and women who recently gave birth, resulting in similar populations. However, the resulting analysis demonstrated that there are likely differences in meaning of childbirth for pregnant first-time mothers, as compared to first-time mothers reflecting on birth, or mothers of multiple children reflecting and comparing birth experiences, currently or recently pregnant.

Finally, although the method of soliciting journals presented extensive and rich data from which to construct a constant comparative analysis, it did have challenges. Women who participated varied in the length and depth of their responses. The biggest challenge associated with solicited journals with prompts was the amount of data. Data reduction was a particularly difficult step in the constant comparative method, lending limitations to data exhaustion.

Agenda for Future Research

Areas deserving of further exploration include orientations to liberty and loci of control, comparisons of subpopulations, quantitative exploration of variables, and the ways in which policy is co-created and managed and how the meaning construction of childbirth and other individualistic public health issues distance the public from public health. Further inquiry is also warranted in the journaling method of qualitative inquiry.

First, an area deserving of further exploration is the concept of one's orientation to liberty and locus of control in childbirth within the political and health contexts. Many women expressed clear orientations to liberty within their narrative responses, whereas others were more unclear. Similarly, many women expressed having a high-need for control over their situation; whereas others expressed a much more laid back philosophy on childbirth. Still others demonstrated loci of control by expressing an internal locus of control, describing one's belief that they can overpower a broad range of factors, whereas others expressed an external locus of control, describing one's belief that they are subject to the external environment and have very little agency over their situation.

Although evidence of liberty and control were clear in the data, especially with regard to women who planned and delivered on their ideal childbirth, the relationships among the concepts and their connection to a woman's desired birth plan when plans were not realized were more unclear. Childbirth is complicated. Detailed plans outlining the number of "choices" afforded to women leave many avenues for the plans to not be realized. Elective C-sections and home births allow for the most agency and thus, were clearer in their relationship to liberty and control. Other birth plans and lack of agency with regard to medicated or unmedicated births, requires more consideration to determine the relationship between liberty and control and an individual's birth plan.

Further study can yield more understanding into the nuance among various birth plans and individuals' orientations to liberty and control. For example, Judge, Locke, and Durham's (1997) theory of core self-evaluations may yield insight into the constructs preliminarily demonstrated in this study. According to Judge and Bono (2001), core self-evaluations traits of self-esteem, generalized self-efficacy, locus of control, and emotional stability have correlations with job satisfaction and job performance. Further exploration in the nuance of control is warranted.

Additionally, further exploration into the subgroups of women based on birth plan and pregnancy status is necessary to parse differences in meaning among the different subgroups. For example, the study found that women in opposition to home births and those in opposition to elective C-sections used similar rhetoric to advocate against the other position. Additional research involving larger subsets of women in these groups representing the most extreme ends on the birth continuum will illuminate

further understanding of community meaning, but also of how hegemonic language is accessed to participate in the public debate.

Furthermore, in addition to the qualitative explorations warranted above, quantitative research exploring the variables preliminarily evidenced in this study, and the correlations to childbirth plans within the health and political contexts are also worthy of exploration. Quantitative analysis of qualitative inquiry assists with theory testing of concepts evidenced within the case study.

From a broader perspective, much qualitative research in the field of health communication focuses on social support and experiences in sudden or chronic life-threatening illnesses. By focusing research on social constructions of the illness experience and the relation to social support, representations of health and other physiological phenomena occurring outside of the illness sphere may be overlooked and misdirected. Health communication topics outside of illness may be better studied form an interpersonal lens to address theoretical questions of politics and public policy. For example, research on public health foci, such as vaccinations and diabetes prevention, among other topics, may result in additional contributions to theoretical knowledge, if explored from a wider, interdisciplinary theoretical lens.

Policy as lived experience and removing the public from public health suggest a need for theory building not of policy as written and interpreted, but policy as experienced, communicated (or not), and lived. Despite the best intentions of policy makers in public health and other fields, written policies are created and reviewed, often from the perspective of clarity, policy outcomes, and initiative purpose. Rarely are policies reviewed to analyze converging and diverging of meaning, especially from the

perspective of broader contexts that may influence meaning making. How policy is co-created and negotiated among social actors is equally important when seeking to understand reception to public policy. Only then, can such policies and initiatives be investigated to determine successful outcomes of particular platforms.

Moreover, removing the public from public health must be further explored not only in the context of childbirth, but other socio-political contexts as well. For example, one could argue the social conflict surrounding vaccinations and the increase in once-obliterated diseases due to the decrease in vaccination rates may also have a component of diverging meanings creating an isolated public. Similarly, the polarization of political beliefs described by numerous media scholars (e.g. Stroud (2011)) may contribute to or be impacted by a cultural shift, shifts that can be better understood with qualitative inquiry into long-standing issues with a modern contextual lens.

The extent to which recently pregnant women offered thanks for the opportunity to reflect and journal about their experience highlighted a willing participant pool. For many, childbirth and motherhood is a life-changing experience, and the degree to which they researched and deliberated on decisions, and for many, the extent to which their decisions were unrealized, provided a pool of participants willing and eager to describe their experiences. Perhaps, the isolation of modern childbirth outlined in this research, yields a need for women to have opportunities to therapeutically narrate their experiences for resolution or catharsis, as well as a need for health care providers to provide a space for such reflection. Regardless, as researchers consistently seek willing

participants to further theoretical understanding, pregnant and recently pregnant women offer promise.

Finally, this case study has methodological implications that are worthy of future study. Soliciting journals as a data gathering method for qualitative inquiry shows immense promise for the study of complex meaning-making concepts. As previously mentioned, the data was extraordinarily rich, lending to methodological challenges. However, the richness of the data provided more insight into the female experience of childbirth, as well as the broader context of how theoretical concepts must not be studied in a tight methodological vacuum.

Although the data in the study was reduced to focus on the posed research question, the data revealed much more about the women's lives than interview or observation would have allowed. For example, the women were much more forthcoming and descriptive in their journals than they were in their preliminary telephone survey. When asking women their mode of birth, they were reluctant to describe how they gave birth, and hesitated on how to describe to a third party, a vaginal birth. The simple act of removing myself, the researcher, from the data collection experience, allowed women to communicate their experiences with ease, and limited researcher-imposed hesitation.

Moreover, the data elicited extremely rich information about the women and their lives that would likely not have been revealed in an interview setting. Through the course of the journals, women expressed personal issues in their life that influenced the meaning-making structures limited to the phenomenon. For example, one woman was a cancer survivor whose birth of her third child was constructed by her doctor's concern

for her health. Another woman, business owner and mom-to-be, revealed she procrastinated thinking about the upcoming birth of her child because she was busy readying for the opening of her own coffee shop. Yet another shared the heartbreaking story that her husband moved out immediately after finding out she was pregnant again. Thus, she was making the decisions alone. Many women referenced or described their struggles with infertility prior to their pregnancy. Some of these women insinuated guilt having any preference on their birth plans because in the end, they will be grateful for a health baby to hold in their arms. The method encouraged women to share insight in their identities and the life forces with which they were situating meaning of their experience.

Further exploration into solicited journals as a data collection method is warranted to ensure sound methodological principles of data reduction and exhaustion, without losing the benefits of the rich data experience, and the deep examination into participants' lives.

Conclusion

Modern public health shifts responsibility onto the individual as the solution for public ailments. In doing so, meaning making of public policy problems becomes increasingly complex, resulting in fragmented meaning and social isolation. Without in depth analysis of the social construction of public health problems and the larger contexts in which they are situated, public health officials will continue to create policy disconnected from the human experience. Meaning making in the public health context is a personal, social, and political process that requires a multidisciplinary approach to further aid understanding.

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Appendix A: Pregnant Women Journal Prompts

Directions: Each week, you will be emailed a new set of prompts to guide your journaling for the week. Please answer the prompts each week, but feel free to write about anything related to your pregnancy that is on your mind. If any prompt provides you anxiety or distress, you are free to stop participation in the study at any point. If you have any questions or concerns about the information contained within the prompts, please notify the researcher and contact your birthing professional or doctor.

Week One
Title: Your Birth Plan
Prompts:
1. Tell me your feelings about childbirth at this point in your pregnancy.

2. Take no more than one minute to write all the words you can think of about your childbirth in an ideal world.

3. Describe your childbirth plan.

4. Which statement best describes your birth plan? "My birth plan is my right," "My birth plan is my choice," or "My birth plan is a private decision." Explain your chosen statement.

5. Tell me about a recent talk you had with your partner, a friend, or family member about your ideal birth plan.

Week Two
Title: Proponents of Home Births attended by a Midwife
Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Some experts think women who are low risk for complications should be able to have home births with a midwife instead of going to a hospital because it's just as safe. They say it is less expensive, more comfortable, and does not expose the baby to germs and diseases. Tell me what you think about this idea.

3. The number of women having babies at home with a midwife has increased since 2004. Tell me what you think about this increase.

4. Sometimes insurance companies do not reimburse mothers for midwives' services because they do not consider midwives as birthing professionals. Do you agree with this? How do you feel about this?

Week Three
Title: Proponents of C-section Births

Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Some experts think that C-sections at the mother's request help moms who are scared of childbirth. They also say that C-sections are less painful and are more convenient than natural childbirth. Tell me your thoughts on this.

3. Tell me about a recent talk you had with your partner, a friend, or family member about your birth plan.

Week Four
Title: Home Births and Birthing Centers
Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Some experts say that home births are dangerous because the mom and baby do not have access to doctors and medical equipment. They say that only childbirth in a hospital is safe. Tell me your thoughts.

3. Your city wants to build more birthing centers so that women can give birth with help from a midwife, but have access to doctors and equipment in case of emergency. They think this will help control the high costs associated with childbirth. Tell me your thoughts.

4. Tell me about a recent talk you had with your partner, a friend, or family member about your birth plan.

Week Five
Title: Public Health's Aim at Reducing C-section Births
Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Some experts are trying to limit C-sections requested by women who are at a low risk for complications. They say that childbirth is a natural process and should not be messed with. They also say that C-sections are too risky for mom and baby, are expensive, and use up too much equipment and doctors that could be used for emergencies. Tell me your thoughts.

3. Some experts are also trying to limit C-sections requested by women who have had a C-section before. They say that even though a woman had a C-section, she still has a good chance of delivering a baby naturally. Tell me your thoughts.

4. Some hospitals punish doctors who do too many C-sections at the woman's request by not paying them as much, hoping that they'll do fewer of them in the future. Do you agree with this? How do you feel about this?

Week Six
Title: Your Birth Plan and Your Practitioner
Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Tell me about the first time you talked about your birth plan with your provider (midwife, doctor, and/or doula, etc.).

3. Tell me about later talks you've had about childbirth with your provider.

4. Suppose your provider doesn't agree with your birth plan and tells you that you should choose another plan or find another provider. How do you react?

Week Seven
Title: Your Birth Plan, Your Partner, Family, & Friends
Prompts:
1. Tell me your feelings about childbirth after another week of pregnancy.

2. Tell me about a recent talk you had with your partner about your birth plan.

3. Tell me about a recent talk you had with a family member about your birth plan.

4. Tell me about a recent talk you had with a friend about your birth plan.

5. As your last prompt, please feel free to add what's on your mind—or talk about anything I haven't asked.

Follow Up:
As your childbirth occurred outside the seven-week study, please describe your birth experience. How did it differ from your ideal birth plan?

Appendix B: Recently Pregnant Women Journal Prompts

Directions: Each week, you will be emailed a new set of prompts to guide your journaling for the week. Please answer the prompts each week, but feel free to write about anything related to your pregnancy that is on your mind.

Week One
Title: Your Birth Plan
Prompts:
1. Take no more than one minute to write all the words you can think of about the delivery of your first child.

2. Describe the delivery of your most recent child.

3. Take no more than one minute to write all the words you can think of about your ideal childbirth.

4. Describe your childbirth.

5. Which statement best describes your birth plan? "My birth plan is my right," "My birth plan is my choice," or "My birth plan is a private decision." Explain your chosen statement.

6. Tell me about a talk you had with your partner, a friend, or family member about your ideal birth plan.

Week Two
Title: Proponents of Home Births attended by a Midwife
Prompts:
1. Tell me your feelings about childbirth toward the beginning of your most recent pregnancy.

2. Some experts think women who are low risk for complications should be able to have home births with a midwife instead of going to a hospital because it's just as safe. They say it is less expensive, more comfortable, and does not expose the baby to germs and diseases. Tell me what you think about this idea.

3. The number of women having babies at home with a midwife has increased since 2004. Tell me what you think about this increase.

4. Sometimes insurance companies do not reimburse mothers for midwives' services because they do not consider midwives as birthing professionals. Do you agree with this? How do you feel about this?

Week Three
Title: Proponents of C-section Births
Prompts:

1. Tell me your feelings about childbirth toward the middle of your first pregnancy.

2. Some experts think that C-sections at the mother's request help moms who are scared of childbirth. They also say that C-sections are less painful and are more convenient than natural childbirth. Tell me your thoughts.

3. Tell me about a talk you had with your partner, a friend, or family member about your birth plan.

Week Four
Title: Home Births and Birthing Centers
Prompts:
1. Some experts say that home births are dangerous because the mom and baby do not have access to doctors and medical equipment. They say that only childbirth in a hospital is safe.
Tell me your thoughts.

2. Your city wants to build more birthing centers so that women can give birth with help from a midwife, but have access to doctors and equipment in case of emergency. They think this will help control the high costs associated with childbirth. Tell me your thoughts.

3. Tell me about a talk you had with your partner, a friend, or family member about your birth plan.

Week Five
Title: Public Health's Aim at Reducing C-section Births
Prompts:
1. Some experts are trying to limit C-sections requested by women who are at a low risk for complications. They say that childbirth is a natural process and should not be messed with. They also say that C-sections are too risky for mom and baby, are expensive, and use up too much equipment and doctors that could be used for emergencies. Tell me your thoughts.

2. Some experts are also trying to limit C-sections requested by women who have had a C-section before. They say that even though a woman had a C-section, she still has a good chance of delivering a baby naturally. Tell me your thoughts.

3. Some hospitals punish doctors who do too many C-sections at the woman's request by not paying them as much, hoping that they'll do fewer of them in the future. How do you feel about this?

Week Six
Title: Your Birth Plan and Your Practitioner
Prompts:

1. Tell me about what you remember about the first time you talked about your birth plan with your provider (midwife, doctor, and/or doula, etc.) about your most recent pregnancy.

2. Tell me about what you remember about other talks you've had about childbirth with your provider.

3. Suppose your provider doesn't agree with your birth plan and tells you that you should choose another plan or find another provider. How do you react?

Week Seven
Title: Your Birth Plan, Your Partner, Family, & Friends
Prompts:
1. Tell me your feelings about childbirth toward the end of your most recent pregnancy.

2. Tell me about what you remember about a talk you had with your partner about your birth plan.

3. Tell me about what you remember about a talk you had with a family member about your birth plan.

4. Tell me about what you remember about a talk you had with a friend about your birth plan.

5. As your last prompt, please feel free to add what's on your mind—or talk about anything I haven't asked.

Appendix C: Interview Schedule for Pregnant Women

How old are you?

Please tell me the one option that best describes you:
- American Indian or Alaska Native
- Hawaiian or Other Pacific Islander
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Non-Hispanic White

Please tell me the one option that best describes you:
- Married
- Divorced
- Widowed
- Separated
- Never been married
- A member of an unmarried couple

Please tell me the one option that best describes your yearly household income:
- Under 20,000
- $20,001-$40,000
- $40,001-$60,000
- $60,001-$80,000
- $80,001-$100,000
- $100,001 and above

In what city and state were you born? In what city and state do you reside?

Which best describes your health insurance:
- Uninsured
- Medicaid or State Subsidized HealthCare
- Employee-sponsored insurance
- Private Insurance

Do you have children?
- If yes:
- Are they biological?
- How did you plan to give birth?
- How did you actually give birth?
- How many children do you have?
- What age(s) are your children?

How do you plan on giving birth in this pregnancy?

Appendix D: Interview Schedule for Recently Pregnant Women

How old are you?

Please tell me the one option that best describes you:
- American Indian or Alaska Native
- Hawaiian or Other Pacific Islander
- Asian or Asian American
- Black or African American
- Hispanic or Latino
- Non-Hispanic White

Please tell me the one option that best describes you:
- Married
- Divorced
- Widowed
- Separated
- Never been married
- A member of an unmarried couple

Please tell me the one option that best describes your yearly household income:
- Under 20,000
- $20,001-$40,000
- $40,001-$60,000
- $60,001-$80,000
- $80,001-$100,000
- $100,001 and above

In what city and state were you born? In what city and state do you reside?

Which best describes your health insurance:
- Uninsured
- Medicaid or State Subsidized HealthCare
- Employee-sponsored insurance
- Private Insurance

How many children do you have?

What age(s) are your children?

How many are biological?

How did you plan to give birth?

How did you actually give birth?