

THE FLORIDA STATE UNIVERSITY
COLLEGE OF SOCIAL SCIENCES AND PUBLIC POLICY

EMOTIONAL EXPERIENCES DURING CHILDBIRTH:
THEIR ASSOCIATION WITH BIRTH PRACTICES AND BELIEFS

By

MIRIAM RACHEL SESSIONS

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The literature review is logically organized under headings.

CHAPTER 2

LITERATURE REVIEW

Feminists observe that childbirth serves as a site for the reproduction of gender inequality. Childbirth is an example of how biological differences between men and women can be used as a basis for gender inequality. Birth has the potential to be both a positive and negative experience for women, depending on the treatment they receive in the labor process. This treatment of laboring women and their resulting emotional experiences are a reflection of the status women hold in a society (Rich 1976; Ridgeway and Smith-Lovin 1999). In patriarchal societies, women's vulnerability during birth is exploited by men. Childbirth creates a power-differential between the sexes in which men can subject women to painful procedures or humiliating conditions that men will themselves never experience. In contrast, birth can be culturally celebrated as a miraculous and empowering event for women, in which mothers control and direct their labors, ensuring they have a desirable experience. While women's birth experiences are of interest to gender scholars, there is surprisingly limited sociological research on birth (Fox and Worts 1999; Martin 2003). Existing studies note that birth holds great importance in women's lives, observing that disappointing experiences can have long-lasting, detrimental effects on women's well-being (Davis-Floyd 1994; Oakley 1980). While the importance of exploring women's subjective experiences of birth is frequently mentioned in birth literature, there are few empirical studies that examine women's emotional experiences (Lyerly 2006; Patel and Sharma 2000).

Emotion scholars have produced numerous theoretical models for studying the social patterning of emotional experiences, suggesting that emotional experience is shaped by social structure and interactional processes (Kemper 1987, 1991). Applied to the topic of childbirth,

The introduction contextualizes the research to be presented in the literature review.

The introduction also provides a brief overview of existing research on this topic and the gaps in this research.

This paragraph and the next one explain the researcher's rationale for consulting the sources cited in the literature review.

emotion theory suggests women's emotional experiences are influenced by the power they are able to attain or maintain during birth, which is shaped by various birth practices. Emotion theory can be applied to some of the existing research on childbirth, specifically research examining the factors influencing women's general birth satisfaction or risk of post-partum depression. Research on emotional satisfaction and specific emotional experiences during birth is limited, suggesting that the application of emotion theory to reproduction research could expand understandings of how gender inequality is emotionally manifested and reproduced during childbirth.

This dissertation applies a sociology of emotions perspective to the study of childbirth, incorporating feminist research to consider how birth practices and beliefs impact women's birth experiences. This chapter reviews the power-status theory of emotion. This theory is outlined and integrated with the existing research on women's birth outcomes. This chapter concludes by detailing the research questions generated by an emotions perspective and prior reproduction research.

The Power-Status Theory of Emotion

The power-status theory is a prominent emotion theory proposed by sociologists, positing that people's emotional experiences are shaped by their power and status (Kemper 1987, 1991; Kemper and Collins 1990). Power is defined as individual's authority over others – their ability to force compliance. Status, in contrast, is obtained more congenially; individuals grant status to people they view as holding greater prestige than themselves. The ability to gain compliance from others – either coercively or consensually – enables individuals to get what they want from social interactions. This ability ensures that those with greater power and status experience more favorable emotions than those with less power and status (Kemper 1987, 1991).

Power and status are established at the structural and interactional levels (Kemper 1991). Individuals in social structural positions with greater power and status (e.g., whites, the wealthy, or men) have a greater probability of gaining compliance and feeling positive emotions. Compliance is also gained during social interaction; individuals can use social strategies to subordinate other people or persuade others that they are superior. Figure 2.1 presents a visual representation of the power-status theory of emotion.

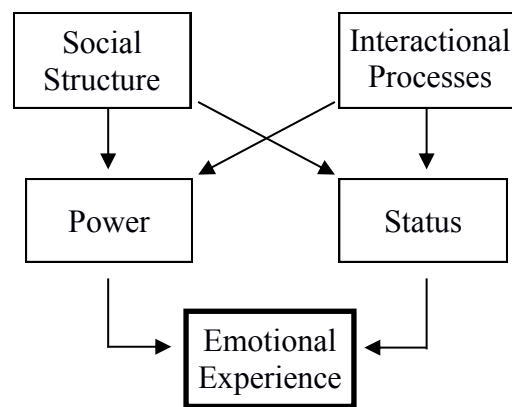


Figure 2.1. A Conceptual Model of the Power-Status Theory of Emotion

Emotional experiences are shaped by the loss or gain of power and status. Power gains, for example, elicit positive feelings of self-confidence and pride, while status gains promote positive feelings of satisfaction or joy. Power loss produces negative feelings of fear and anxiety, while a loss of status results in negative feelings of shame, embarrassment, and depression (Kemper 1987). An individual's emotional experiences also can be influenced by another person's gain and loss of power and status. If two people have an amicable relationship, a person feels positive emotions when a comrade gains power or status and negative emotions following a loss. If the relationship is inimical, the inverse occurs – individuals feel negative emotions when another gains power or status and positive feelings following a loss (Kemper 1991).

Power-status theory also proposes that the strength of emotion is influenced by power-status expectations (Turner and Stets 2006). When people expect to be granted power or status by others and their power and status is acknowledged, they experience more powerful positive feelings than those who did not hold similar expectations. Similarly, if a person expects to receive an acknowledgement of their power or status and does not, the strength of their negative emotions is greater than if they had not held these expectations.

Applications of Power-Status Theory to Childbirth Research

Reproduction research from a “radial” feminist perspective posits that women’s birth experiences are, in large part, shaped by social institutions and maternity care practices (Rothman 1991; Oakley 1980; Rich 1976; Weirtz and Weirtz 1989). Radical feminists argue that it is women’s limited power within medical institutions that leads to birth dissatisfaction and postpartum depression (Oakley 1980; Rubersson and Walderstrom 2003). The “medical” birth model – meaning hospitalized, medicated, obstetrician-attended births – controls women with institutional policies, drugs, and technology (Ladd 1989; Rothman 1991; Oakley 1980). Informed consent policy, for example, requires women to sign a general waiver upon admittance to the hospital. This waiver requires women to approve the administration of any medical procedure based on their doctors’ discretion, given that the doctor determines the circumstance to be “urgent” or the woman “incapable” of making judgments (Ladd 1989). This institutionalized practice erodes women’s power in the birth process, surrendering all decision-making control to physicians who frequently abuse this authority (Goer 2010). Similarly, drugs and medical technologies restrict women’s physical movement and capabilities, numbing them with epidural analgesia or confining them to a bed with wires from monitoring devices or intravenous fluid lines (Rothman 1991, 2006; Oakley 1980).

When applicable, the researcher groups studies with similar findings together.

The researcher points out trends or patterns they found in their research.

The feminist literature examining the medical birth model frequently takes a “gendered organizations” approach, highlighting the ways that medical institutions reproduce gender inequalities via their “processes, practices, images and ideologies”(Acker 1990: 567; Britton 2000; Martin 2006). Medical processes and practices (e.g., admittance waivers, physically restrictive technology) not only erode women's power during birth but also empower physicians who have historically tended to be male (Rothman 2006). Through their actions of performing objectifying practices and demanding patient compliance, physicians have promoted an institutionalized culture that presents physicians’ knowledge as authoritative, women's pregnancies as pathological or dangerous, and medical practices as necessary. This institutional culture is disseminated through broader culture in the shape of media depictions of birth and childbirth education (Kennedy, Nardini, McLeod-Waldo, and Ennis 2009; Morris and McInerney 2010). Feminists critiquing the hospital-based birth education note that women enter the birth preparation classroom with a personal history of subordination and are further socialized to provide a “docile response to a series of medical interventions and instructions” (Bartky 1990; Wolf 2001: 94).

Summary and paraphrase are used to contextualize direct quotations.

In their arguments opposing the medical model, feminist reproduction scholars advocate for the “new midwifery,” often referred to as the “natural” birth model (Campbell and Porter 1997; Rothman 1991, 2006). This model seeks to provide women with more satisfying birthing experiences by granting them more power and control over the birth process. The “woman-centered” approach to childbirth advocates non-hospitalized and (preferably) home birth. Feminists argue that removing women from the hospital enables them to escape the subordinate patient role, allowing them to labor in a familiar and comforting environment (Rothman 1991;

Weirtz and Weirtz 1989). Further, the natural model of birth promotes moving during labor and avoiding medical treatments (e.g., pain medication, epidurals, continuous fetal monitoring).

Birth locations are “gendered spaces,” physically separating men and women and consequently limiting women's access to the knowledge that enables men to reproduce their power (Spain 1992). Birth historically took place in the home and was attended by women, leading to a view of the experience and knowledge surrounding birth as feminine (Rothman 1991, 2006). Birth was later moved to the hospital, a male-dominated space, to be overseen and directed by male physicians. Feminists argue that in moving birth from the home into the hospital, women's knowledge and experience with birth have been silenced. The medical model devalues women’s experience and familiarity with their bodies, claiming that physician knowledge is more accurate or scientifically-informed (Wagner 2001). Classic feminist research on birth notes the ways that physicians ignore and patronize women’s birth preferences, for example, by trivializing women’s views with sexist, condescending remarks (Shaw 1974; Oakley 1980). Natural birth advocates suggest that the solution to women’s negative birth experiences lies in childbirth education (Dick-Read 1942). “Prepared birth” is championed as the key to having a desirable birth. Knowledge of the availability, risks, benefits, and alternatives to birth practices can provide women with power and status necessary to navigate birth, both in hospitalized and non-hospitalized settings (Willmuth, Weaver, and Borenstein 1978).

Birth scholars have observed that birth location also can influence women's ability to openly express their emotions during labor. Karin Martin (2003) conducted a secondary data analysis of 26 interviews with women who were three months postpartum in 1997 and 1998. Martin found that women birthing in hospitals frequently suppressed their expressions of pain or discomfort, in fear of appearing rude or impolite. Martin concludes that women birthing in

Verbs
introducing
other
researchers'
ideas are
varied and
nuanced.

hospitals were less able to express negative feelings due to a gendered institutional ideology depicting such behaviors as rude and unfeminine. Shannon Carter (2009) expands Martin's work by contrasting the behaviors of women laboring in hospitals with those laboring at home. Carter conducted in-depth interviews with 18 women who were six to eighteen months post-partum. Eleven women gave birth in the hospital while the remaining seven gave birth at home or in a birth center. Carter finds that home-birthing women were openly expressive, concluding that women who labor at home hold more non-traditional gender ideologies which promote authentic emotional expression. Both Martin and Carter's findings offer an emotions perspective to the concept of homes and hospitals being "gendered spaces;" laboring women are more apt to express themselves openly in a familiar space in which they feel comfortable and empowered. Some feminists caution this interpretation of birthing locations, however, noting that the home is not always a positive environment for women (Annandale and Clark 1996). Many women, for example, view the home as a site of oppression where they are subordinated and experience domestic violence. Thus, in their search for an ideal birth location, natural birth advocates and midwives must be cognizant of women's experience in the home, hospital, and other spaces.

Feminists' justifications for championing the new midwifery can be applied to the power-status theory of emotion to posit that greater power in the delivery room ensures more positive emotional experiences. However, there is limited empirical research testing the claims linking birth practices and emotional outcomes. The majority of reproduction research focuses on objective birth outcomes (i.e., morbidity and mortality), with a limited focus on women's subjective experiences (Oakley 1980). When women's subjective experiences are taken into account, the focus tends to be on objective conditions in the laboring environment (e.g., birth location, medical interventions, and birth practitioners) and general satisfaction, which is

The researcher makes connections among the various areas of research represented in their literature review. They also point out gaps in the research.

assumed to encompass emotional satisfaction (Hodnett 2002). However, studies exploring the associations between these laboring conditions and general satisfaction yield inconsistent findings. For example, a systematic review of 137 studies examining birth satisfaction finds that birthing environment and type of caregiver have weaker associations with satisfaction than do the behaviors of caregivers. In other words, it is the practices rather than the credential of caregivers that contributes to women's subjective birth experiences. While feminists continuously debate which birth model or types of practitioners produce the best outcomes, critiques suggest that such research is ideologically driven and does not consider how birth practices or women's views contribute to their birth experiences (Annandale and Clark 1996, 1997; Brubaker and Dillaway 2008, 2009; Campbell and Porter 1997; Lyerly 2006).

A key concept related to the power-status theory of emotion – control – is consistently associated with women's general birth satisfaction (Goodman, Mackey, and Tavakoli 2004; Green and Baston 2003; Humenick and Bugen 1981; Hodnett 2002; Namey and Lyerly 2010). Research indicates that women who feel in control of themselves and their laboring environment are more likely than women with less control to have positive birth experiences and less likely to have negative birth experiences (Green and Baston 2003; Waldenström, Hildingsson, Rubertsson and Rådestad 2004). This finding has been demonstrated by multiple international quantitative studies. For example, one English study collected surveys from 1,146 women six weeks post-partum. Findings indicated that women who felt in control of themselves, the attending hospital staff, and their contractions were more likely to report a general satisfaction with their labor experience (Green and Baston 2003). Further, a longitudinal cohort study of 2,541 Swedish women found that women with unexpected medical problems who felt a lack of control during labor were more likely to report their birth was a negative experience (Waldenström,

The researcher interprets the findings of a study.

Information from different sources is synthesized.

Hildingsson, Rubertsson and Rádestad 2004). Combined, these studies lend support to the power-status theory of emotion, as women with limited power during childbirth are more likely to experience negative emotions. Although these studies have explored satisfaction more generally, few have linked control with specific emotions. Further, natural birth advocates often claim that their practices grant women more control – and thus a more emotionally satisfying experience – in the birth process, but this claim has not been tested in a U.S. context. The majority of studies examining women’s subjective views and experiences with birth are conducted in other countries, which differ in their use of medical interventions during childbirth or the popularity of homebirth (Christiaens and Bracke 2008).

Research also suggests that women's expectations play a key role in birth satisfaction; women who expect to feel positive emotions during birth are more likely to feel satisfied than those with negative expectations (Ayers and Pickering 2005; Gibbins and Thomson 2001; Green, Coupland, and Kitzinger 1990). Opponents of the natural birth model assert that “natural” birth views unrealistically raise women's expectations, claiming that high birth expectations are doomed to lead to disappointment and dissatisfaction (Crossley 2007). Research suggests otherwise, finding patterns of a self-fulfilling prophecy. Women with positive expectations are more likely to have positive experiences, while women with negative expectations are more likely to have negative experiences (Green, Coupland, and Kitzinger 1990). For example, Green, Coupland, and Kitzinger surveyed 825 English women 4 weeks before their due date and 6 weeks after. They found that women’s prenatal birth expectations were predictive of their emotional appraisals of birth; women who expected birth to be painful or traumatic were more likely to report these kinds of experiences. Research on birth expectations has been expanded to encompass women’s birth views. Van Brussel and colleagues (2010) conducted a cohort study of

298 Belgian women who completed a survey at 30-36 weeks pre-partum and 8-12 weeks post-partum. Study findings indicated that “natural” birth views were associated with positive expectations and experiences (e.g., feelings of fulfillment, enthusiasm, relaxation) while “medical” views were associated with negative emotional experiences and expectations (e.g., feelings of distress, disappointment, pain). Feminists critique this form of research for superimposing a polarized “natural” versus “medical” dichotomy present in academic, cultural, and practitioner discourse, rather than exploring how women interpret these discourses (Annandale and Clark 1996, 1997; Brubaker and Dillaway 2008, 2009).

The power-status theory of emotion can expand the existing literature on emotional outcomes of childbirth several ways. First, power-status theory can help determine which birth practices significantly influence women's emotional experiences during labor. Radical feminists frequently claim that all medical practices subordinate women and lead to feelings of fear or disempowerment. However, these associations have not been fully tested (Campbell and Porter 1997; Davis-Floyd 1994). None of the data used in studies examining the influence of medical interventions on subjective outcomes is nationally representative of the United States. They either lack the sample size required to explore how multiple birth practices shape emotional experiences or use data from countries with birth models and practices that differ from those in the U.S. In the absence of a comprehensive study exploring a wide breadth of birth practices, reproduction literature that denounces the “medical” model at large is “not only inaccurate but also threatens to disenfranchise women for whom sensitively applied medical practices can enhance both the safety and agency so important to a good birth” (Lyerly 2006: 116-117). A suggested solution to the shortcomings of the politicized birth research is to explore a wide range of birth practices, discerning which are associated with positive or negative emotional outcomes.

Research typically limits analyses to birth location, attendants, and some select treatments (i.e., mode of delivery and pain medication). Exploring natural birth practices in addition to these factors would provide a more comprehensive understanding of the practices influencing women's emotional experiences of birth.

Transition words and phrases provide logical connections between ideas and emphasize key points.

Another way the power-status theory of emotion can build upon prior reproduction research is by drawing attention to how power influences emotional experiences. Prior research finds that women who maintain control of their birth environment are more satisfied with birth.

For example, in their classic work Humenick and Bugen (1981) propose a Mastery Model of childbirth, positing that independent women with more self-reliance, greater self-control, and an internal locus of control are more likely to have satisfying birth experiences. While research has explored the aspects of women's personality that may contribute to a sense of control, less attention is given to how birth practices may increase control and specific positive emotions, such as empowerment, pride, or confidence. Applying the power aspect of power-status theory to birth research – specifically, theoretical arguments positing that power exchanges in social interactions impact emotional experiences – could provide insight as to which types of birth practices empower or disempower women during birth and how these interactions shape emotional experiences.

Conclusions and Research Questions

Feminists have emphasized the importance of exploring women's experiences during childbirth as a means for studying gender inequality. However, research on women's subjective and emotional experiences of birth remains limited (Lyerly 2006; Oakley 1980). While birth is inherently painful, many claim it has the potential to be a positive, empowering, and self-fulfilling experience (Campbell and Porter 1997; Green, Coupland, and Kitzinger 1990; Rich

The conclusion reviews important trends in relevant research from a more informed perspective. Gaps in the research are emphasized to help the researcher justify the need for their study.

1976). Scholars suggest that women's emotional experiences are shaped by their power and control during birth, claiming that medical practices subvert control, thus promoting negative emotions (Davis-Floyd 1994; Rothman 1991; Oakley 1980). Further, feminists claim that the medical birth model promotes low birth expectations, depicting women's role in labor as passive and deferent. When women internalize this view, researchers argue, they have lower expectations for birth and are more likely to have negative experiences. While the linkages between emotional experiences and birth practices and views are often referenced in birth literature, few empirical studies have tested these associations. Research questions one and two address these gaps.

1. How are birth practices and views associated with women's positive emotional experiences during birth?

2. How are birth practices and views associated with women's negative emotional experiences during birth?

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