## **ABSTRACT**

This thesis examines narratives of C-section experiences to understand the personal perspective of a national conversation on medicalized birth. Birth statistics, child health, and reproductive rights, are often the focus of C-section studies. However, these approaches often exclude the perspectives of those experiencing the C-section. By centering narratives, we regain an understanding of what it means to experience a C-section in a system of medicalized birth. The analysis includes authoritative knowledge, self-education, and becoming a mother. Using narrative as an anthropological tool allows us to enlighten a topic that is so heavily studied through lenses of observation and data collection.

# CENTERING C-SECTION NARRATIVES IN BIRTH DISCOURSE

Emma Dolan Honors Thesis Department of Sociology and Anthropology

> Mount Holyoke College South Hadley, MA 2017-2018

# TABLE OF CONTENTS

Acknowledgements	3
Introduction	4
Existing C-section Discourse	12
Understanding Narrative.	<b>2</b> 3
Authoritative Knowledge in Narratives	33
Self-Education in Narratives.	52
Becoming a Mother	60
Conclusion	78
References	82

## **ACKNOWLEDGEMENTS**

I would like to thank Lynn Morgan for advising me throughout this process.

Thank you for all the meetings, advice, and answering my endless questions. I am so grateful for all the support and help making this project possible.

Thank you to Elif Babül and Jacquelyne Luce for being on my committee. I am so honored to have two brilliant minds engaging with my work in these last steps.

Lastly, thank you to Emily Jetmore and Rumi Handen for being my anthropology thesis companions. I am too social to have done this alone, so thank you for listening to all my thoughts and hesitations and supporting me throughout this process.

### **INTRODUCTION**

Rachael's story

Rachael and her husband arrived at the hospital around 10:00pm on a cold February night. It was five days after her due date, and Rachael was excited to finally have her first baby in her arms. She felt prepared, she had read many books and taken a few classes to get her ready to give birth. Soon her doula would meet her here. She had hired a doula because she thought that is what you did if you did not want medication for birth.

With the support of her husband and doula, Rachael labored all night. She was in and out of the tub, walking the floors, standing, squatting, doing everything her doula suggested to advance her labor. Her goal was to give birth un-medicated, and without intervention. This was her first pregnancy, but she felt well prepared. Rachael was not one to back down from a challenge, so even in the early hours of the morning she followed her doula's instructions and kept walking the hospital hallways. Eventually it became clear that her baby was not descending into the birth canal. The doctors told her that the baby was stuck on her pubic bone; they thought the baby's head was tilted to the side prohibiting her advancement. The doula suggested that she stomp one foot and then the other, to jog the baby from its position. She had Rachael get back into the tub to relax her muscles. Rachael was confident in her ability to have this baby without intervention, and though the pain increased she kept laboring.

Finally, as the sun began to rise Rachael felt the urge to push. With the support of her husband, doula, and doctor Rachael put everything she had into pushing. She pushed and pushed, breathing as instructed, and imagined meeting her daughter for the first time. As Rachael continued to push the pain grew; she was having back-labor. (Back-labor is when the baby is stuck in a way that contractions push it back into the

sacrum area instead of down into the birth canal. It is exponentially more painful than regular labor. The feel has been described as a jet flying into the lower back, and Rachael herself said it felt like someone was hammering hot nails into her sacrum.)

Rachael back-labored for three hours. During these hours, the doctor kept telling her she could have a Cesarean-section because the baby was not coming. The anesthesiologist was waiting outside the door, ready to begin the C-section process as soon as Rachael consented. However, Rachael continued to labor through her extreme pain. She described regular labor as painful but in between contractions she could find relief. With back-labor it blinded her, and she could not see out of the pain. By midmorning Rachael knew that she was not going to have this baby vaginally. She did everything she could to make it happen, but it was not going to work. The next time the doctor offered a C-section, Rachael agreed. She had tried her hardest, and felt that there was nothing left to do, she just wanted this baby out of her.

Rachael asked to be kept awake for the surgery, so she could meet her little girl as soon as she was born. The surgery was uncomplicated, and her daughter was brought into the world. She was placed on Rachael's chest, and Rachael kissed her and sucked on her little toes. She was exhausted from laboring for hours on end, but suddenly she could not keep her eyes open. She looked at her doula and asked if anyone else was tired. The doula looked at the doctor and realized that he had given Rachael a sedative. Though she had requested to stay awake throughout the operation, the doctor believed Rachael should sleep while he stitched her up. Rachael's first hours as a mother were spent sleeping, while her little girl was bathed, examined, and held by her father. Rachael's recovery went smoothly, and she was healed within a few weeks. She did not regret her experience, and was grateful to finally have her baby.

According to the Centers for Disease Control and Prevention website, 31.9% of US births are Cesarean-sections (2017). The number is double the World Health Organization recommended percentage. The C-section rate has steadily increased throughout the past fifty years, and has become the subject of many studies. Studies aim to pin point the cause of rising rates, and propose solutions for lowering them. Csections are a medical procedure as well as a form of birth, so they have been studied by the medical community as well as the feminist studies and anthropology communities. Some believe the C-section rate is high because women choose them over vaginal births. Others argue that doctors prefer C-sections because they are convenient and predictable. A third argument states that the rate reflects societal and structural beliefs in medicalized birth. One feminist perspective of C-section focuses on a woman's ability to choose a C-section or vaginal birth. These studies conclude that women cannot choose because they are under societal pressure to have a C-section (Malacrida and Boulton 2012). Other feminist studies focus on the medicalization of birth and the ways women are left out of their birth experiences. Doctors create bonds with the fetus via technology throughout the pregnancy, so during the birth they continue this connection often pushing the mother to the periphery. These studies argue that women must be included in birth because it is their experience (Wendland 2007). One of the most prominent pieces written on C-sections in the US is Theresa Morris's 2006 book, Cut It *Out.* She writes that C-section rates are high due to the fear of malpractice lawsuits. Hospitals pressure doctors not to take any unnecessary risks, which leads them to practice more C-sections than they otherwise might. In this case, it is not about the women or the doctors, but the structural systems of insurance and lawsuits. She argues the ultimate way to lower C-section rates is a structural shift to understand vaginal birth as a safe form of birth, and therefore reducing medical interventions (Morris 2006).

These studies help us understand the C-section rate and why it is rising. We need to think about the reasons behind this rate, and how to reduce it. What is missing is the personal perspective of the women having the C-sections. Some scholars incorporate individuals' perspective in the form of interviews or survey data. For example, Morris incorporates women's narratives into her work to show how they felt when they had a C-section. These perspectives enlighten her overall argument, but are not the focus of her study (Morris 2006). Robbie Davis-Floyd also uses interview excerpts in her book *Birth as an American Rite of Passage* (2003) to show how women work through their birth experiences. The use of interviews in Morris's and Davis-Floyd's respective works is important because it adds a personal perspective to their larger body of research, creating a more complete understanding of the C-section rates and experience.

In this thesis, I show what we can learn by focusing on women's narratives of their C-section experiences. By analyzing interviews as narratives on the C-section experience, we can see how C-sections are both a medical and a personal experience. I aim to connect the literature on C-sections to the literature on medical narratives by analyzing my own set of interviews as C-section narratives. Through this analysis, I show how women create their narratives and the role that plays in being a mother. Narratives are more than just stories, they are part of the process of becoming a mother via C-section.

Before I continue I want to clarify that in this thesis, I will be referring to the people who experienced the C-sections as women. I recognize that not all people who give birth identify as women, and that not all people who identify as women give birth. I have made this decision for two reasons. One, it keeps my writing concise and in line with the literature I review. Second, all the people I interviewed in my research identify as women.

### Methods

My research is based on seventeen interviews I conducted during August and September of 2017. I chose to use interviews because I wanted to see how women frame their experiences given the range of narrative options available to them. I also wanted to understand how women constructed narratives of their experiences. I began my research by applying for and receiving Internal Review Board (IRB) approval through Mount Holyoke College. The process required that I define my research question and purpose, provide details of how many people I intended to interview, list the questions I would ask, and explain how I would obtain consent. A description of the possible harm that could come to the participants was included, which for this study was minimal. All my participants were required to sign a consent form before being interviewed. All participants agreed to being audio recorded. They also understood the voluntary nature of the study, which meant they could end the interview at any point for any reason. The consent form also informed the participant that they would have complete anonymity in the study. I offered them the opportunity to receive a copy of the study when it is finished. All participants signed the form without question and either sent me a photo of a physical signed copy, or scanned and sent it back to me.

I chose to use Facebook to ask people to participate in my study because word spreads quickly, and people would be able to reach out to me without feeling pressured. I thought that if I had called and asked specific people they would have felt pressure to participate and that could be uncomfortable. My post was shared by friends and was posted in several C-section support groups. Within approximately forty-eight hours around twenty people has messaged me saying they would be willing to participate. We communicated through Facebook messenger and I sent them the consent form and scheduled a time to talk. Two participants did not contact me via

Facebook, one was a close family member who I asked in person, and the other was a family member of a friend who wanted to participate but was not on Facebook.

\*Interview process\*\*

I downloaded an app on my phone that recorded the interview as it happened. At the arranged interview time, I called the participant, made sure the recorder was working and began the interview. I first briefly went through the consent form, reminding them that the recorder was on and that they could end the interview at any point. I asked if they had any questions before we proceeded.

The first question I asked was, how many C-sections have you had, and what was the given reason. I asked this question because it is an easy question to answer, and not explicitly personal. It allowed the participants to divulge as many details as they wanted to. After answering this question, many participants continued to tell me the story and subsequently answered the following questions. This was the best-case scenario because I wanted their uninterrupted narratives. However, because not all participants continued to tell their story, I was prepared with more questions.

The second question asked about their opinions on C-sections before they knew they would have one, or even before they were pregnant. I asked this question because I wanted to see how their thoughts on C-sections changed when they experienced one. I should mention that by asking my participants about the past I was facing the possibility of "recall bias," when a memory is different from the events that happened. I thought if I asked this question I could see how societal opinions about C-sections affected the individual. This question advanced the interview similarly to a regular conversation and helped propel the narrative.

Third, I asked what it was like for the participant to learn that she was going to have a C-section. This question is at the core of my research. This question was halfway

through the interview so the participants were already warmed up and comfortable talking about this potentially traumatic moment.

Following this question, I asked about the healing process, both physically and mentally. I am interested in how the healing process was different for different participants. This question was at the end of the interview because some participants were still healing, and it brought their narrative up to the present day.

The interviews ended with the participants adding any details not previously covered. At the end, I thanked them and said they would hear from me when they received a final copy of the project. This concluded the data gathering process.

Once the interviews were complete, I transferred the audio files to my computer from my phone. I decided to transcribe the entirety of the interviews manually, instead of using a computer program. Since my research is focused on narratives and how people tell their stories, I wanted to make sure every word of each interview was transcribed. Manually transcribing the interviews allowed me to identify repeating and overlapping themes between interviews. During transcription I removed all names, and replaced them with pronouns, or ID numbers in the case of my participants. I assigned each participant a pseudonym that I will use in the following chapters. I saved the interview recordings and the transcriptions on my computer. At the end of my study I will delete the recordings as stated in my consent form, although I will save the anonymous transcriptions.

I coded the interview transcriptions to identify the themes I cover in the following chapters. When reading my literature, I found themes that also correlated to my narratives. These themes included authoritative knowledge, self-education, becoming a mother, and breastfeeding. I also identified poignant quotes in my transcriptions that I use as entries for each chapter.

Following this introduction is a literature review that synthesizes the existing literature on C-section studies in anthropology. I follow that chapter with an explanation of narrative as an anthropological topic. My first analytical chapter examines authoritative knowledge and how my narratives show the ways women interacted with and understood their position within an authoritative knowledge framework. The second chapter describes how women are expected to educate themselves to reduce the likelihood of having a C-section, and how my participants did just that. In the final chapter I argue that creating a narrative is part of the recovery process for women who had C-sections. Anthropologists often examine "sensemaking," the ways people understand their position in life and culture. My analysis in this chapter fits into this mold of anthropology, though I do not directly use "sensemaking" as an analytic tool.

I conclude this project with an explanation of my findings from this research. I have two major findings. The first is how we can understand the theme of ambivalence in narratives, specifically C-section narratives. Though ambivalence is prevalent in my narratives, it is not discussed in other literature on analyzing narratives. This suggests that understanding C-section narratives presents the opportunity to grow narrative analytic tools. My second finding is on breastfeeding and how women experience it as part of the birth experience. I argue that women who experience C-sections have a specific relationship with breastfeeding as a second chance at "natural" motherhood. I conclude that women perceive initiating breastfeeding is part of birth, instead of postpartum. This concept is something we can learn from narrative analysis that was not researched previously.

## **EXISTING C-SECTION DISCOURSE**

C-sections have been studied from many angles, including feminist ideas of choice, statistics and rising rates, medicalization and technology, and the implications of authoritative knowledge. In this literature review, I will summarize the anthropological literature on C-sections, and identify the specific themes I will be exploring with my own research. The first theme is the idea of choice; can women choose? Do they have equal ability to choose across race and socioeconomic status? Should they have to choose? I examine these questions and propose my own ideas about moving the focus from women's choices to larger structural forces. Some argue that women's education is the way to reduce the C-section rate. However, this also puts the pressure and focus on women to have a successful birth experience. I argue that we must look at larger structures before we place blame for C-section rates and unwanted birth outcomes. These structures promote "authoritative knowledge" to control what happens during labor and birth. The literature describes authoritative knowledge as the power behind "objective knowledge" and "facts." A product of authoritative knowledge is the use of technology in birth. The literature shows the connection between doctor and fetus via technology, in these cases the mother is left out of the conversation. For example, continual fetal heartrate monitoring could influence a doctor's decision to perform a Csection leaving the mother of out of the decision-making process. The themes I examine in this chapter create the background for my analysis.

### Choice

I will begin with the conversation surrounding women's ability to choose a C-section of a vaginal birth. "Women's perceptions of childbirth 'choices'" is a study that was conducted to understand how women think about their choice-making ability during birth (Malacrida and Boulton 2012). The authors interviewed woman who had

never experienced birth and women who had. Their participants consisted of 43 American women ages 18-40. The analysis focuses heavily on feminist theory considering the societal and cultural pressures on women to make certain decisions. Some of their participants believed C-section births were better due to cleanliness, vaginal tightness, and stretching; while others thought vaginal births were better because they are natural. Sexuality was also a point of discussion for Malacrida and Boulton's participants, because some women felt that C-sections allowed for birth to stay separate from their sexuality if their vaginas were not involved. Malacrida and Boulton analyze the women's focus on their appearance, and specifically their sexuality. Overall this study put the emphasis on the ability of women to make a choice. In conclusion, the authors state that women do not truly have freedom of choice because societal expectations and cultural raisings influence any choice.

The idea of women choosing a C-section is a common focus for birth research. "Trial of labor versus repeat cesarean: are patients making an informed decision?" uses a questionnaire to understand if women are choosing repeat C-sections, or trial of labor (VBAC) (Bernstein et al. 2012). The questionnaire was designed to determine not just if women had the choice, but how much knowledge they had about their options. The authors conclude that women would choose trial of labor if they were better educated about their options. The study suggests that practitioners could spend more time with patients and educate them about the trial of labor process.

Why do these studies focus on choice? What are the hidden implications of assuming women have a choice? Should women have to make a choice? If we expect women to make the choices surrounding their birth, then we can blame them if it does not go right. When research suggests that women be better educated before they give birth, it implies that women will be able to choose what they want. Barbara Katz

Rothman argues that the choices women make are constrained by what happens inside hospitals (1987). Women may choose to have Pitocin, or an epidural, but these options are presented to them by the hospital. If women choose from the options provided them by the hospitals, and something goes wrong it is the hospital's fault. However, women are usually blamed for making the wrong decision when something goes unplanned. I think we should not focus on women's choice in birth, but rather the doctors and hospitals that influence their experience and outcomes. In this project, I do not specifically write about C-section narratives and choice. Though my participants did talk about being able to choose a C-section, I decided to not focus on this aspect of their narratives. I made this decision because existing studies on choice are based on interviews. Instead I will be focusing on aspects of birth that are not often research with interviews and narratives.

In her book *Cut It Out* (2013) Theresa Morris writes about the "C-section epidemic" happening in the US. She examines the reasons why rates are so high, and shows it is due to the hospitals' fear of malpractice lawsuits. Morris explains that if doctors have concerns about how a labor is progressing, they will call for a C-section. They do this because if a there is a birth complication they hospital is less likely to be sued, Because C-section births are believed to be a last resort. Rising C-section rates mean that doctors are more comfortable performing C-sections than they are delivering vaginal births. This feeds back into the cycle of doctors performing C-sections when they are unsure about labor. Morris proposes three levels of solutions. The first is advocating for women, educating them and offering support through doulas and partners (Morris 2013, 156). She cites several studies that suggest continual support for the laboring woman will reduce the chance of intervention including C-section. This will help lower rates in the immediate future. The second level is educating doctors to

be more comfortable delivering babies via vaginal births. This can happen in school, and continuous training, and will eventually help lower rates. The third and ideal level of change happens at a structural and cultural level. She suggests that we reform the malpractice system, and encourage out-of-hospital birth. This can be accomplished by changing insurance so it covers homebirths. She also suggests hiring more midwives and nurses to provide care to women in hospitals. Her last point supports the argument I was making earlier about looking at the structural reasons for C-sections, and not blaming women. By showing what causes the high C-section rates (malpractice lawsuits), Morris enlightens a debate that often blames individuals such as doctors or women.

If we are going to study choice and the idea of choice, we must do it well, and consider the various other factors that can influence the ability to choose. In this case, women are presented with an array of options, but they might not be aware of these options, or they might not fully understand them. In "What do women want?: Issues of choice, control, and class in pregnancy and childbirth," Ellen Lazarus argues that childbirth experiences are dependent on one's social economic status (SES) (Lazarus 1994). Her research takes place in three hospitals between urban and suburban populations. She shows that women's abilities and opportunities to make choices are heavily influenced by their SES. She describes the different hospital environments, and their access to technology. At some hospitals, natural childbirth is now defined as a vaginal birth when the mother is awake. This means that medication, and assistance such a forceps or suction is considered natural. When women choose a natural birth, they are immediately consenting to many medical interventions (Lazarus 1994). I would like to note that Lazarus was writing over two decades ago, and these views are now seen as outdated.

Lazarus critiques the focus on choice when studying birth and C-sections. She writes that studies focus on choice because it is an important feminist approach to understanding and advocating for reproductive health. Reproductive health is built on the idea of choice, and the freedom of people to make choices about their health. However, Lazarus argues that the idea of choice usually focuses on a class of women who are expected to make choices. Lower class women are not expected to make the same choices as upper class women when considering vaginal birth and C-section. When women are presented with the opportunity to decide, their approach will vary based on their level or angle of understanding. Lazarus argues that women's experiences differ based on their experiences often related to class. Women have different knowledge attained in various ways, such as childbirth education classes, family, books, or internet searches. This connects back to "Women's Perceptions of Childbirth Choices" (Malacrida and Boulton 2012) and the argument that women cannot make choices free from culture.

Lazarus argues that not only are women's choices situated in culture, they are situated in the specific culture of that woman. When studying women's ability to choose, we must study women in different cultures, to gain a broader perspective on choosing (Lazarus 1994). In "Women's Perceptions of Childbirth Choices" (2012) Malacrida and Boulton wrote about how women had various perceptions and experiences, but did not attribute this to class. The trial of labor study by Bernstein et al. also neglects to collect data on class, and does not examine the complexities that class would add to their analysis. Bernstein et al. suggest that women spend time with their obstetricians to learn about their birth options (2012). I think Lazarus would argue that lower class women do not have the ability to spend time with their doctors and have these conversations in the same capacity as upper class women. I think it is important to

study C-sections across classes, however my research was not able to accomplish this. Due to the size of my study and my resources, most of my women are in the same white middle to upper-class demographic. I will use this in my analysis of their experiences. In their conclusion, Malacrida and Boulton propose that doctors should be educated so they can make the right decisions for individual woman's health. I think this is an important step, but as I wrote about earlier with Morris's work, ultimately the doctors' decisions are influenced by hospital protocols, malpractice insurance regulations, and larger structures. The idea of doctors' knowledge and their autonomy to make decisions will be discussed in the following study.

# Technology

In "The Ideological and Technological Shaping of Motherhood" (1992), Charles King examines the influence of technology on birth. In western culture, birth is medicalized, meaning that technology is at the forefront of the birth experience. According to western medical beliefs, technology-assisted birth is the safest and simplest form of birth. King quotes Barbara Katz Rothman's description of medical staff interacting with the fetus without encountering the woman: "Instead of having to approach the woman, rest one's head near her belly, smell her skin one could now read the information on the fetus from across the room, or from down the hall. While woman and fetus were still one being on the bed, medical personnel came to see them as two separate and different patients" (Rothman 1989, in King 1992, 7). From the beginning of the pregnancy, the doctor builds a relationship with the fetus. They use the ultrasound to show the mother a picture of her fetus, but they also explain to her what she is looking at. Only the medical professionals such as doctors and technicians can tell the sex of the baby from the ultrasound image. Throughout the pregnancy, the doctors measure the baby, listen to the baby, and watch the baby, constantly decoding the

technology for the expecting family. In a setting where technology is the key to safety, the doctor is the gatekeeper to that knowledge. This idea comes from the idea of "medical gaze," written about by Michel Foucault in his chapter "Docile Bodies" (1977), to describe the way women function in medical spaces. In this setting, the doctor is essential for the woman to know about her birth. When it comes time for her to deliver, it has already been established that she needs the doctor to feel safe.

King concludes that this is problematic, and doctors must learn to listen to women. He also suggests that women need to be more assertive and advocate for what they want during their labor and birth. Unwanted outcomes are blamed on women when they are expected to stand up for what they want. This is his solution for reducing the C-section rates and evening out the technological playing field. If doctors just remember to listen to these empowered women, then everyone will be better off.

Claire Wendland would argue in "Vanishing Mothers" (2007), that doctors cannot simply "listen to women" because they operate in an era of evidence based medicine. She writes about the concept of "evidence based obstetrics," and how it fails to consider what the woman in labor is experiencing. Evidence-based obstetrics is the idea that by collecting enough data on past births, doctors can predict what to do with a current labor. This leads to the doctors referring to data instead of talking to the women in front of them. But Wendland argues that because birth is not inherently a medical procedure, it does not unfold the same way every time (to the chagrin of biomedicine). Therefore, it cannot be "solved" by evidence-based research. This idea echoes King's observations: technology and medicalization are in the way of including women in decisions about labor and birth.

Wendland writes that "evidence based obstetrics" is problematic because what is considered "evidence" and "knowledge" is situated in culture. She writes "'Objective'

and 'neutral' knowledge is dominant knowledge in disguise" (Wendland 2007, 226).

The idea that truth is just the dominant knowledge and not objective is called "authoritative knowledge."

The idea of "authoritative knowledge" is described in "Knowledge, practice, and power: court-ordained cesarean sections" (1987), a study of court ordained C-sections in the US. Authors Susan Irwin and Brigitte Jordan present cases in which women were ordered by the state to have a C-section. They develop the framework of "authoritative" knowledge" to describe the ways different types of knowledge are given power. They show how medical knowledge is authoritative knowledge because when women refused to have a C-section, lawyers were called to the hospitals to order them legally to comply with the doctors' orders. Lawyers were physically in the rooms with the women, or called to wherever they were to explain why they needed to have a Csection. It is clear to see in this example that when the law and the state sides with medical knowledge, that is the authoritative knowledge. The law is a direct product of western culture, and is the definition of authority. Theorist Foucault writes describes how the state punishes people who do not submit to its power (1977). He also describes how the state creates "docile bodies," people who will comply with the rules because it is for their own good. Laboring women are a type of docile body, and when they do not comply with what the doctor wants, they are punished. His theory can help us make sense of how the law works with the hospitals to perform C-sections. Medicalized birth is also a product of western culture, so the law supports these beliefs and gives them the power of authority. The way medical knowledge is used in this article is clearly authoritative, but this is not always the case.

Authoritative knowledge is not always enacted with lawyers and court orders, and at times it can be subtle and challenging to identify. In her book, *Birth in Four* 

Cultures (1993), Bridgette Jordan expands on the idea of "authoritative knowledge," by describing how it is enacted in what would appear to be a normal birth story. In chapter 6, "The achievement of Authoritative Knowledge" Jordan analyzes a videotape of a woman giving birth. She observes the ways the woman is treated by the nurses and doctor, the power dynamics between the doctor and nurses, and the use of technology. The nurses talk to the woman but never answer her questions; they stick to telling her what to do to follow the procedures. Eventually, the woman needs to push and deliver the baby, but the nurses tell her not to until the doctor can come and clear her to push. The doctor is late, and the woman's urge grows stronger. When the doctor finally arrives, he tells the nurse that the woman can push, the nurse tells the woman, and the baby is delivered. Jordan notes that the woman knew all along that she could push; the policy to be cleared by the doctor is a sign of "authoritative knowledge." "To legitimize one way of knowing as authoritative devalues, often totally dismisses, all other ways of knowing" (Jordan 1993, 152). In this example, the woman's knowledge is being dismissed and the medical knowledge is given the authority.

Knowledge is not simply given the power to be authoritative, and Jordan writes, "The constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships with in a community of practice. It does this in such a way that all participants come to see the current social order as a natural order, i.e., as the way things (obviously) are" (Jordan 1993, 152). Authoritative knowledge is so ingrained within our culture, that it is difficult to separate it from "facts." Other sources I use for this project (such as the one below) do not use the framework of authoritative knowledge, however it is present in their field, and is important to keep in mind.

*Birth as an American Rite of Passage* (2003) applies the anthropological idea of ritual to birth in the US to provide a woman-centric analysis. Robbie Davis-Floyd aims

to make the familiar strange by examining and questioning what US culture assumes to be normal birth practices. In classic anthropology, the ideas of rites and rituals have been used to understand other cultures' practices. However, in her book Davis-Floyd uses these methods to decode her own culture's behavior. Though she does not specifically use the language of "authoritative knowledge," she does write about how dominant cultural knowledge is forced upon women as part of their cultural transformation.

Rites of passage occur during times of vulnerability and transition from one social status to another. Examples include puberty (neither a child nor an adult) and pregnancy (neither childless nor a parent). Rites of passage are used to create a sense of control over the uncontrollable. During a rite of passage, messages are repeated to inform the new beliefs and reality of the participant. This is a form of creating authoritative knowledge. When birth is examined as a rite of passage, messages are used to show the women how they should behave in the hospital. Davis-Floyd provides a list of the symbols used in the messages, they are not usually questioned and are often taken for granted. Examples of symbols are wheelchairs, the "prep," wearing a hospital gown, lying in a bed, fasting, cervical checks, sterility, Pitocin, separation form the baby, and so on. By identifying these symbols and messages, we can see how deeply encoded they are in our understanding of birth. The timing of these culturally affirming practices is not arbitrary. Davis-Floyd notes that women enter a liminal state when they are in labor, and are susceptible to suggestions and consenting to procedures.

Towards the end of *Birth as an American Rite of Passage*, there is a chapter titled "Scars into Stars" that explores how women reflect on their birth experiences. Her chapter is like what I am doing in this thesis, because she focused on interviews and narratives. Davis-Floyd used the narratives of women to show how they made sense of

what they experienced. She did not specifically interview women who had C-sections, but what she wrote resonates with my own findings. She wanted to know how women reflected on their experiences. Some women never wanted to think about their birth again, some women realize that though their birth didn't go as planned it was still valid, and some women go into birth professions as a way of further understanding. These ideas are strongly reflected in my narratives, and so I will be using her concepts and theories to guide my analysis. She explains how important it is for women to share their stories, because it empowers other women to know they are not alone. She describes women realizing they don't have to obey doctors, and can refuse certain authoritative rituals such as wearing a gown or staying in bed. She found that women were more likely to take control of their subsequent births, because they realized how much power they have.

King and others suggest that women assert themselves more, but they don't suggest that women share their stories to do so. I agree with Davis-Floyd and believe that narratives have the power to change peoples' experiences of their births. I will situate my narrative analysis in Davis-Floyd's ideas of ritual and rite to show how we can understand the power of narratives. Her writing on the experience of becoming a mother is reflected in the narratives I gathered. I will also engage with the theories of "authoritative knowledge" to show how women did or did not conceive of greater systemic pressures surrounding their experiences. My narratives show that women who had C-sections were grappling with the validity of their motherhood. In the following chapter I explain the importance of narratives, and how to use and understand narratives to provide evidence of the theories discussed in this chapter.

### **UNDERSTANDING NARRATIVE**

### Introduction

Knowing how to think about narratives is important to understanding how personal experience can add to our conversation around birth. The goal of this chapter is to show why narratives are important to consider, and how they are analyzed. I focus on Arthur Frank's work on illness narratives, Perri Klass's article on the importance of patient narratives, Robbie Davis-Floyd's work on birth narratives, and an argument against narrative by Angela Woods. None of these sources specifically focus on C-section narratives, so I am using them as building blocks for my own analysis. In this chapter, it is important to clarify how I write about the relationships among illness, medicine, and birth. Frank's work focuses on illness, and while I use his framework I do not mean to imply that birth is an illness.

### How to Understand a Narrative

Arthur Frank's book *The Wounded Storyteller* (2013) shows how people suffering illness tell their stories, and how society expects to hear those stories told. Frank argues that stories can play two roles: they can heal bad memories, and/or they can inform others of what is happening in the present. To Frank, storytelling or narrative is not a simple recitation of events, it is a portrayal of the experience a person had that makes sense to them. A story is a retelling of events that happened, whereas a narrative is a construction of how the individual experienced the event. Narratives must make sense to the narrator before they can be told to an audience. This process is not arbitrary nor is it easy for the sick person. Often, people have created a narrative of their experience before they have it: it could be influenced by the media, a friend's experience, or a previous diagnosis. For example, someone might know they have cancer and they conceive of their recovery process, yet their recovery goes very differently than they

imagined. This is challenging for the sick person because they must change their narrative and make a new one. Figuring out a new narrative is complex, but it must happen to reflect the experience of that person. For example, if someone is diagnosed with stage two cancer, and is told that after some simple chemo and therapy they will be better, they create a narrative that suits this expectation. However, if the healing process takes longer than was planned, or the cancer comes back, their narrative will change. This changing process is difficult because the narrator must make sense of it, and then make sense of it to others. Frank writes that people must tell their stories, not just to remember them, but because memory is made in the storytelling. The details in stories often change, and these changes can influence the memory. For example, if a woman's C-section narrative always omitted how frustrated she was with herself when she consented to the surgery, the memory of her birth might forget that she was frustrated in that moment.

Frank makes it clear that narratives are not objective, nor are they static.

Narratives are created, morphed, and solidified to fit their social purpose. Narratives are told in ways that make sense to the narrator and a specific audience. Frank identifies three types of narratives people tell about their illness experience. The restitution narrative focuses on how things will return to the way they were after the illness. This narrative fits stories about the flu, or a broken wrist, as an episodic experience from which the person will heal. The chaos narrative is characterized by lack of focus or timeline. This narrative is used by people who have experienced trauma, and is familiar to holocaust survivor stories. Chaos narratives often take the form of "and then...and then...and then" as the details are told as they are remembered, sometimes in no comprehensible order. The final narrative style is the quest narrative, which is the most familiar type. The person leads a normal life, they become ill, and thus begins their

journey through which they are enlightened and return a changed person. Quest narratives are used in fairytales and news stories. They are easy to listen to and inspire the listener. Often narratives of cancer or other chronic illness are quest narratives. Society accepts quest narratives because they provide a hero who inspires. The audience is relieved of guilt when listening to a quest narrative because in the end the sick person overcame their illness and gained something from the experience. Quest narratives do not always end with a healthy protagonist. The ill person can learn and change through their illness, and could still die. Quest narratives describe change and understanding for the ill person rather than victory.

The three types of narrative Frank defines (restitution, chaos, and quest) are useful analytical tools. He offers a way to categorize and understand illness narratives that goes beyond listening to stories. Frank's work is widely read and used to analyze narratives because he has developed theories and examples. I will use Frank's analysis as a tool, to understand how my participants' narratives are constructed and presented.

Unlike an illness diagnosis, birth is not usually a surprise to women. However, when and how the labor and birth happen can be quite unexpected. In this way, birth can be equated to an illness experience. Frank writes that people create narratives in their heads before the diagnosis happens, and pregnant women do this too. They imagine and dream about their birth, and create a narrative that rarely corresponds to the reality. For example, women are encouraged to make birth plans outlining their desires for their birth experience. Birth plans include information about what type of medication they would like, interventions they want to avoid, and early postpartum procedures such as cord clamping and placenta management. Birth plans embody the expectations of the mother, and the narrative she has designed in her head. It is commonly understood that births do not to go exactly as planned. When C-sections are

not planned, they often interrupt the designed narrative (and birth plan); this can be a painful and challenging process. In Frank's illness narratives, there are moments when the patient learns something unexpected about their health or condition. In birth narratives, a similar moment is when women learn they are having a C-section.

Frank found that people have a "good illness story" as well as the other narratives they carry (2013, 63). A good illness story neglects details such as disappointment, resentment, and hardship. This makes storytellers appear as though they are accepting their illness and making the best of it. They must convey that they are grateful to be alive, and humbled by the love and support received from friends and family. They do not talk about how this was not how they wanted their life to turn out. In the narratives I gathered, the "good illness story" was characterized by, "I was grateful to have my baby in my arms." A good illness story is directed by following social norms and expectations, highly influenced by the audience.

The audience is a key detail of analyzing a narrative. Frank writes that women always have an audience either in other people, or in themselves. Regardless of the presence of a third-party audience, an ill person will create a narrative to tell themselves. This narrative will be different than the one they tell other people. He argues that sick people must reclaim themselves through their narratives. One person might have multiple selves, and each self might have its own narrative. For example, one woman who experiences a C-section might have a professional self, a mother self, and a family self. The professional self's narrative might be that the C-section happened because the heart rate was falling, she had been in labor for 36 hours, and it was necessary. The mother's self-narrative might be that she really wanted a natural birth, and she is frustrated, disappointed, and resentful towards her C-section and she will mourn. The family self's narrative might be that her sister and mother also had C-

sections and therefore she is like them. From this example, we can see how creating a narrative is not about telling a story to a friend or doctor. Rather, it adds to our understanding of the complexities and multi-dimensionality of narratives in relation to the self that proceeds sharing with the outside world.

Perri Klass (2010) and Davis-Floyd (2003) also write about the idea of the audience. Who is listening to these narratives, and how does that affect the narrative being told? Frank argues that narratives constantly change to fit the audience, be it self, friend, or group. For him, the audience influences the narrative as much as the illness. Klass argues that doctors must make themselves an audience, to allow for narratives to be told. Davis-Floyd argues that women must tell each other their narratives; therefore, the narratives of audience members are informed by other narratives. How do my narratives fit into this discussion?

I am the audience for my interviewees' narratives. I asked them questions, I listened, and I affirmed what they said. Sometimes I could hear them deciding what to tell me or how to tell it, in the form of a stutter or pause before explaining their thoughts. My status as a researcher and young childless woman influenced the way they constructed the narrative they shared with me. Through this sharing they validated me as a peer, though I had not given birth. As I continue to analyze and work through the narratives I recorded, I must remember that these narratives were framed for me. Certain details were included or omitted; these are not complete narratives (if there even is such a thing). They will add to the conversation of C-section and birth, but they cannot stand in for one-on-one conversation between postpartum women.

It has been argued that doctors must listen to their patients' medical narratives to allow them to understand them. If a patient has an insight into their condition that is not clear to the doctor, their narrative can enlighten the situation and allow for more competent care. Perri Klass's article "Patient Narrative" (2010) describes how she trains first year medical students to value patient narratives. Before they begin attending appointments and learning to make diagnoses, Klass has her students listen to a patient tell their story. She believes that in this moment the students hear the patient for who they are, and feel the true weight of their condition. She believes that practitioners must value and connect to a patient's story to provide competent and humane care, and this must begin in the first year in medical school. Although she does not specifically write about obstetricians or maternity ward staff, her point is still applicable. Often clinicians treat people as nothing more than their diagnosis or an assemblage of body parts. Klass is trying to combat this by incorporating the voice of the patient into the experience of treatment.

If the patient narrative is crucial for general practitioners, what would Klass say about obstetricians? Surely narratives of patients in the maternity ward are equally important for providers to hear. Though birth is not inherently a medical process, laboring women are often treated as medical patients. Birth is often treated as a physical function of body parts, at the risk of ignoring women's emotions and mental states. Applying Klass's argument to obstetrics shows that if obstetricians listened to the stories of their patients, they would be better equipped to understand the whole woman and provide the care she needs. For example, if a woman was not progressing in labor, the obstetrician might assume that the baby was stuck and order a C-section. An obstetrician who listened to the woman tell her story might learn that she is terrified of giving birth and unable to relax. Understanding her perspective could lead the

obstetrician to reassure her and talk her through the process, instead of ordering a C-section. My research and analysis in the following chapters shows examples of this type of narrative, and how the obstetricians listening could have changed the woman's experience.

In Birth as an American Rite of Passage Robbie Davis-Floyd specifically addresses the importance of understanding birth narratives. In the chapter titled "Scars into Stars" she writes about how women tell their stories and how they remember their births (2003). Davis-Floyd found several themes throughout the birth narratives. Some women compartmentalize their experience and choose never to think about it again. These women often suffer from birth-related trauma, or a birth outcome they did not want. I would hypothesize that compartmentalization could happen with women who have unplanned C-sections. Because my research relied on volunteers who were willing to talk, I did not interview women that fall into this category. Other women who had an unplanned birth experience (specifically C-section) chose to move pass their disappointment, and learned to rethink their experience. For example, some women who had C-sections originally felt they had not truly given birth. However, they explained their process of understanding C-section as a valid form of birth, and it did not negate from their motherhood. These women often worked to help others work through their birth to realize their validity and strength. This is a form of acceptance, but on the woman's own terms. Many of the women I interviewed had this outlook and told me about their journey to acceptance. Note here the clear quest narrative as outlined by Frank.

The third theme Davis-Floyd found in her interviews is "further epistemic exploration" (Davis-Floyd 2003, 245). This is when a woman had an unwanted experience, and decided to educate herself and learn more about what happened and

how to change it for the future. Some women became doulas, midwives, or nurses to change birth outcomes for other women. Another form of exploration was through a subsequent childbirth experience, where the women could demand other procedures or supports during labor and birth. Many of the women I interviewed engaged in both types of exploration, including homebirth after C-section, doula training, lactation consulting, and vaginal birth after Caesarean (VBAC).

The final form of exploration Davis-Floyd discusses is narrative. She observed that women engaged in storytelling to empower each other to experience birth the way they wanted to. When women share their narratives, and listen to others, they begin to situate their experiences in a larger discourse. She noticed that sometimes women talking about their experiences changed the way they would tell their own stories because they would remember forgotten details. Davis-Floyd specifically writes that childbirth narratives should be studied in greater depth as a speech genre, which is a category of communication alongside small talk, bragging, and so on. However, she acknowledges her narratives do not suffice for this type of research. A project like mine is a step closer to focusing on the narrative aspect of birth. Though I only focus on Csection narratives, I hope that my work can continue the conversation on narrative that Davis-Floyd begins. What she observes from the few interviews she does analyze, applicable to my interviews and narratives. She finds that women are grateful, regretful, disappointed, and I find this in my narratives as well. This will allow me to build from what she started, and add to this conversation. In this way, I try to pull together the pieces of narrative, C-section, and process, which are all rooted in Davis-Floyd's work.

Before I conclude this chapter, I want to summarize an argument against using narratives. Angela Woods argues in "The Limits of Narrative" (2011) that while

narratives are useful tools in the humanities, there must be limits. She is specifically responding to "Against Narrativity" (2004), a blunt article by Galen Strawson that rejects narratives in any form due to their individuality. Strawson argues that not everyone experiences life as a story, and some people (himself included) only experience independent episodes. For example, some people would describe their life as a story, where one event would lead to another. Strawson for example would tell you about individual events in his lifetime, but would not connect them to each other. Woods acknowledges Strawson's view, but argues for several precautions before using narratives. She wants us to consider whether the truth matters in the context of the narrative, what counts as a narrative, and not to forget to ground narrative within a culture (it is not free floating). Her last precaution aligns with Strawson, who says that we should not promote storytelling as the only/best way to understand a personal perspective and individuality. This neglects people who do not tell stories to express their lives. Her biggest concern is that people use a few narratives to represent an entire group of people.

Woods's caution surrounding narrative provokes another question: why do we study narratives at all? Recently narratives are becoming more popular. Anthropology in general is incorporating self-reflexive ethnographies and auto-ethnographies, studies of one's own "culture." Our neoliberal society focuses on individuals and the control they supposedly have over their own livelihoods. In some cases, listening to narratives has the potential to blame individuals for their conditions, and avoids implicating a larger system. For example, we can listen to a birth narrative and point out all the places the woman could have done something differently, and then maybe she would not have had a C-section. This micro-focus on individuals deliberately ignores the systemic forces. In other cases, listening to narratives allows for structural issues to be

humanized and embodied. This aligns with the goal of my project, where I argue that C-sections are often studied through data and observation, and women's perspectives are left out. Narratives are powerful because they are relatable, and we must use them carefully as to humanize medicalized birth, without ignoring the strength of larger structures (hospitals).

### Conclusion

The goal of this chapter was to give an overview of the ways narratives have been studied and how I will use them in my own analysis. I tried to show how various authors (Frank, Klass, and Davis-Floyd) used the concept of narrative to understand people interacting with medicine. These frameworks and usages of narratives show me what already exists, this allows me to build from them and situate my own narratives. Many aspects of Frank's and Davis-Floyd's narratives are reflected in my participant's narratives. My C-section narratives are enough like illness and medical narratives to find similarities, but they are also their own entity. I will also show the ways my narratives move outside of these molds, and hopefully can add to the existing analytic tools for understanding narrative.

34

### **AUTHORITATIVE KNOWLEDGE IN NARRATIVES**

"But you know, I told myself 'I am just going to trust that everything is just going to turn out the way it needs to be.'" - Gretchen

"I was a tiny bit scared, because, as I said to the anesthesiologist, 'I've watched just enough Grey's Anatomy to make me panic, and enough Grey's Anatomy to make me know I don't know very much about what is going to happen to me now.' He started laughing and said, 'good thing I am in charge.'" – Rachael

"I will say at the same time that I never considered having a homebirth, I never took my children or my health in my own hands, because at the time I truly believed that doctors and medical institutions were only going to do what's best for you. And that experience for me was the experience that opened my eyes to the fact that I, and only I, am responsible for my health." - Jackie

"As soon as someone talks about the safety of your baby, you know, you're kind of 'ok, then just do what you have to do' you know, whereas, you know, at a second situation or third situation, you're like 'well, you know, let me think about this.'" – Caroline

### Introduction

Authoritative knowledge is the idea that in specific settings certain knowledge is given power over other types of knowledge. Brigitte Jordan defines authoritative knowledge as,

The constitution of authoritative knowledge is an ongoing social process that builds and reflects power relationships within a community of practice. It does this in such a way that all participants come to see the current social order as a natural order, i.e., as the way things (obviously are). (Jordan 1993, 152)

Authoritative knowledge is not created by a higher power and enforced on people, rather it is existing knowledge that is granted authority by a community. It is often viewed as facts, or objective knowledge, because it is the knowledge accepted by the community. In birth settings such as a hospital, authoritative knowledge is embodied as medicalized birth and the use of technology. Processes such as routine exams, fetal heartrate monitoring, and Pitocin to increase contractions are just a few examples of symbols of authoritative knowledge in birth. Symbols of authoritative knowledge are

rarely questioned because they seem to be a given part of the birth experience, or in Jordan's words "Authoritative knowledge is persuasive because it seems natural, reasonable and consensually constructed" (Jordan 1993, 153). Jordan's ideas on authoritative knowledge are shown throughout my narratives, and we can see how they are participants in its creation and legitimacy.

I decided to include a chapter on authoritative knowledge because it is an aspect of the literature that my participants also experienced. Authoritative knowledge is characterized by technocratic birth including Cesarean-sections, therefore narratives of C-sections can specifically contribute a personal perspective of authoritative knowledge. Jordan emphasizes how authoritative knowledge is created and agreed upon by all parties, and my participants show the patients' perspectives. My participant's narratives also show the negatives and positives of authoritative knowledge. Often the positive aspects of authoritative knowledge are not discussed in a critique, however I will try to find some balance in my analysis. For example, authoritative knowledge gives us C-sections that are sometime life-saving surgeries.

A clarification about accuracy and authenticity before I begin. Some of the experiences my participants describe happened decades ago, and their memories may not be exact. Other's narratives might not be exactly true to what happened due to their state of mind and awareness during birth. I am not concerned by the accuracy of these narratives. Authoritative knowledge is as real as how it is perceived and understood. If my participant felt persuaded one way, then that is what happened. To quote Jordan, "The point of authoritative knowledge is not that it is correct but that it counts" (Jordan 1993, 154). It counts for the people in the community that has established that type of authoritative knowledge. This means that authoritative knowledge of birth counts for participants because they are members of the community where it was agreed upon.

I hope to show how narratives are not just stories but also valuable sources for understanding birth and the maternal experience. Narratives are not just a telling of an experience, they are a qualitative piece of research. They are an asset of anthropology, because they show the researcher how participants feel about their experiences. We can find similarities or dissimilarities between narratives, this allows us to study the complexity of a scenario we might have overlooked through observation. Narratives should be used when conducting research on a broad and personal topic such as birth to gain a greater understanding of what happens.

I will look at the ways authoritative knowledge was discussed by my interviewees. In the existing literature, authoritative knowledge has been observed or calculated, but not examined through a narrative lens. By looking at authoritative knowledge in narratives, we can understand it from a personal perspective. When looked at objectively, it is easy to point out the ways it could be combatted in hospitals. From a personal perspective, we can see how complicated and impossible this feels, and even how hard it is to identify this authoritative knowledge. An outside perspective could state that authoritative knowledge forces women to do things they do not want. However, I will show one case where the woman giving birth was grateful for the doctors taking charge and allowing her to not be pressured into a decision. *Suzanne* (age 51)

The first interview I will use is reproduced here in its entirety, because the layers of the story make it such a clear example of authoritative knowledge in birth. Suzanne had her first birth at age 19, her second birth was eleven years later, and her third two years after that. After her first C-section, she was not allowed to try for a VBAC. I chose to include her story in this chapter because as she spoke I could hear how her perceptions of the authoritative knowledge that dictated her birth changed from the

time of her experience. The transcription of our conversation has been slightly edited for comprehension.

I should say back when I had a C-section, being of that age, I felt that there was not a lot of information that was shared with me. Yes, I know it was an emergency but it was...I was really going into it very blindly. I ended up having some really bad hemorrhaging after the C-section, and had seven blood transfusions. That was scary, because when you look back on the timeline, it was 1985 and there was a lot of talk about AIDS and people contracting AIDS through blood transfusions. That was on my mind for many, many, many years, and I was tested many times because of that, but it [C-section] was something I would've never thought about. That was my first C-section. Years later, 11 years later, my daughter came along and that time I had a very progressive doctor in Portsmouth NH. When she read my chart, she was not interested in even attempting a natural birth, there was no encouragement at that time from this particular doctor. She just didn't, she wouldn't want to be involved in any type of lawsuit. If I was to have her as my surgeon, or her as my OB/GYN, I was going to have to give up any thought of having a natural birth the second time around. So, we had a scheduled C-section for that too, I picked the date seven days before my due date, and scheduled a C-section .... I felt from this doctor, who I think I had an admiration for, that I wouldn't question that. She said, 'you know it's very risky looking at your paperwork, you could fight if it you want to, but I wouldn't be the doctor, I wouldn't take you on as a patient, because I will only do a C-section on you.' So, the third time came around, and I had the same doctor. She was an excellent physician, I kind of trusted her. The C-sections went I felt very smoothly and I certainly didn't question it the third time around, I knew that I would have a C-section, and so that was my son, two years after my daughter.

The OB stating that she would recommend a C-section and in fact would not deliver a vaginal birth after C-section (VBAC) is a clear example of authoritative knowledge. Suzanne had all her trust in the doctor and did not push back against the doctor's opinion. Through Jordan's statement that "Authoritative knowledge is persuasive because it seems natural, reasonable and consensually constructed" (Jordan 1993, 153), we can understand Suzanne's passivity not as submissive, but rather as agreement about knowledge they share. One detail of Suzanne's narrative I am unsure about is her statement that her doctor was "progressive," even though she refused to deliver a VBAC. If I were to interview her again, I would ask what she meant by "progressive."

I continued our conversation by asking her about her experience learning she would have a C-section.

Well there is a lot of, at that stage, I was in my 30's, and I had heard from a lot of women that they did not want C-sections and that they did not want to be pushed into them, and they would go from doctor to doctor just to find one that would encourage them and be supportive of their decision to do a VBAC. I carried large children, you know my son was nine pounds, three ounces, I am five-foot-two, I am a small person it didn't take me long for a doctor to convince me that if I wanted to go through with it that it was going to be a long labor. I think actually that there is some sort of relief that I didn't have to think or worry about that piece of it. I knew I could handle the surgery, for me it was a relief. I look back at it differently now, I'd probably encourage any mom to have a vaginal birth, but for me successful was a means to an end, and I didn't get emotionally caught up in how the baby came into the world. I wanted a healthy child, and I was familiar with the surgery, I was a pretty easy patient when it came to trusting the doctors on that.

The size of the pregnant woman is a recurrent theme in authoritative knowledge surrounding birth. Size and stature of a woman is often given as a reason to not attempt a vaginal birth at all. I would argue that this idea is a symbol of authoritative knowledge because in alternative knowledge systems, the woman's physical size is not considered an indicator of her ability to birth vaginally. For example, I have heard homebirth midwives say that you cannot know what the inside of the pelvis looks like from the outside of a woman. Furthermore, Claire Wendland argues that production of birth statistics allows for OB's to make decisions without considering the woman in front of them (Wendland 2007). In the instance of measuring the size of a woman to determine her ability to have a vaginal birth, the data can be collected and used later for an OB to determine if a woman is suited to attempt a vaginal birth.

Suzanne mentions that in retrospect she would encourage other women to have a vaginal birth. She reasons that she did not push for one because that was not the way things were back then (she was specifically referring to the mid 1990s). Another interpretation is that she did not push for one because she had a doctor who was

threatening to leave her if she did not cooperate. Throughout our interview, Suzanne mentions how she was different back then from how she is now. This might be because she perceived women as more empowered today to have a vaginal birth. Perhaps she is referring to this new birth dynamic and imagining herself in today's birthing world. This next excerpt shows her further explaining her ideas.

Exactly, I think that I'm not an argumentative person, or just confrontational, I would take a doctor's advice and trust that. I just think that...even though I had a lot of influences from my friends that I should try to find a different kind of physician that was more open to it, I think I just took their advice first. I honestly don't regret it at all. My children were all born healthy, and I bounced back from surgery. When you step that far away (I am 18 years after my C-sections) I look at it a little differently. I think I would stand up for myself more or go to a midwife, or be part of a support group that was, you know, more supportive of a vaginal birth. But back then? That was not the way I looked at things, I just wanted to be taken care of, and I wanted to trust my doctor, and I did and I followed whatever she said.

Though Suzanne repeatedly told me how she would act differently now than she did "back then," she never regrets her experience. I wonder if her experience would be different now than it was then. At the time of her C-section all the doctor had to tell her was that she would not deliver vaginally. This reasoning put the blame on Suzanne's body, declaring it simply incapable of delivering vaginally. However, by understanding Suzanne's C-section as the result structural systems, we can place the blame on authoritative knowledge and not Suzanne. Using this reasoning, would Suzanne have a C-section today? If she wanted to have a vaginal birth today, and went into the hospital fully prepared to fight for it, she might still have a C-section although for different reasons. Today the doctor might say the fetal heartrate was not right, or her cervix was not dilating fast enough. When the C-sections are the result of authoritative knowledge, then the women's behavior is not likely to change the outcome.

We continued the conversation by talking about her recovery process. The next chapter focuses on the C-section postpartum experience, so I include the excerpt below only because it is a significant piece of her story. It is interesting to note how she clearly states that she is not like other women and did not regret her decision. This theme will come up in the next chapter as well.

Well I think after the C-sections I really didn't give it much thought as to how our babies came into the world. I was immediately focused on taking care of the baby, recovering from the incision. I honestly never felt bad or guilty, that I went for the C-sections, I definitely do feel honestly feel like it is a means to an end of the pregnancy. The pregnancy was hard, I gained a lot of weight in all my pregnancies. I was looking forward to the end, if that was surgery, if that's what the doctors wanted, I was not second guessing that. As I was recovering from the surgery, my energy went towards the new baby and their needs. Nursing and trying to nurse, and not being too successful on that. I never looked back, let's put it that way. I never felt I was less of a mother, that I didn't try it that way. I know that is a big issue with women, but I did not feel that way, I moved forward in to the next phase of being a mother with babies.

I asked if she had anything to add, and she said something I was not expecting to hear. This piece of the interview shows how important support is in birth, an idea I return to in my analysis at the end of this interview.

I would have to say, I felt a strong connection with the anesthesiologist. I think of all the C-sections that they come in, and they are in the life or death position. They make it very clear that they are giving you this, you know whatever type of medication you're opting for your particular. There are different ways, you can make it spinal block, or you can be fully asleep. They let you know right there the seriousness of what you are going to undergo. I would say that that always came as a surprise, but that anesthesiologist is in a powerful position, and they stay and you have all the trust in them in the whole world. They stay right there next to you, and they hold your hand after they give you the medication, and they are looking at the vitals the entire time and they are asking you questions 'how do you feel?' or 'do you feel a little pain in your shoulder?' or 'do you have a cramp here?' I just felt so much deeper of a connection with my anesthesiologist than I did with my doctor. As I looked down at her [the doctor], she was clearly working behind the sheet, and she was clearly working to delivery my baby. I talked to other moms too about their connection with that anesthesiologist and there is a lot of agreement there, that yes, they felt that there was a stronger bond there with the person guiding medication than with the doctor. I don't know how

relevant that is but I do think about it often as that position and that bedside manner of the anesthesiologist and it is just everything I felt. And it's just a little moment.

Suzanne's feelings about the anesthesiologist surprised me, this was not like anything I had heard before. The anesthesiologist was not a key figure in any of the articles or books I read. The writings on authoritative knowledge described the women giving birth, the nurses, and the doctors, and sometimes a doula or support person. Suzanne's story suggests that when there is not a specific person there for support, but support is needed, the anesthesiologist can fill that role. The anesthesiologist, I would argue, is an important purveyor of authoritative knowledge. I will explore and analyze the ways the anesthesiologist supported Suzanne at the end of her interview. During our conversation, I asked her to expand on the ways she felt supported during her birth.

There is a lot of support in that room, it seems like your doctor, it's so interesting, she is very pretty I remember, she had two children I remember, she was all dressed up very nicely. She was not in scrubs at all, she had pretty earrings and necklace, and I was very focused on that, a silk blouse I remember just thinking. For the small amount of time my doctor was in there that in the OR, you have the nurses, you already have this connection with the anesthesiologist and you've already decided what kind of medication he is going to give you. She [the doctor] is just the superwoman, she walks in and everyone just does all the prep ahead of time, she comes in and she is there for such a short amount of time, that is what it really comes down to. Her job as the surgeon is to make the incision, guide the baby out and walk away. She says "good luck! It's going to go great," she holds the baby up and then she quickly leaves the room. That was true for both of my C-sections, she was here for almost an instant. Maybe that's why I felt removed from my relationship with her was not what you hear of a midwife, or anything like that. It is a surgical procedure to her, and she did her job.

From Suzanne's description of her interactions with the obstetrician, it is clear to see the power dynamics between the two. The doctor is the authority who seemingly conducted the birth. Because these were planned C-sections, Suzanne presumably arrived at the hospital prepped and the obstetrician came in and delivered. This is different from an experience someone would have if they had been laboring, and we

will see that later. I wonder what made the anesthesiologist stay and support Suzanne. That is not the anesthesiologist's job, but I guess in Suzanne's case that position had to be filled.

Here Suzanne switched from describing her relationship to the doctor to telling me her thoughts on her children's experience of the C-section.

It was quick, you know it's a rush of emotions when you go through that, but I felt that honestly it was a beautiful way for my children to be born. They had no stress, both of them were fast asleep, and they came into the world asleep until they got awakened by that pinch or whatever the doctor does to make them cry. It was a very gentle way to come into the world compared to friends I had heard about who had been in labor for 48 hours, and the babies were under an incredible amount of stress. But again, I hear that that's one of the most important struggles that any of us will have in life is getting through the birth canal, and how important that is. So, I kind of thought about how my children missed that. My children also -- and this is interesting, Emma, all three of my children were diagnosed with severe colic. I couldn't imagine how that could be, because they all came from beautiful births, especially the last two who were asleep. All three of them had colic, and I had read that it might have been related to C-sections. But I don't know, I was so busy caring for them that I didn't even have time to think 'how could that be?' But I wonder what they say about that now, and how it relates to how, and if it has anything to do with the surgery. They were very very difficult babies for the first babies. More than any of my friends that had vaginal births. And it just always surprised me, but it was a challenge, people say it might be related to the surgery, and I never delved back into that. I just felt too overwhelmed, but I am kind of curious about that, and how that works.

In this part of Suzanne's interview her views and others do not align, and she recognizes this. She says she is happy about her C-sections and glad that her children were born that way, but there is something deeper. She reflects on what she has heard other people say, and is maybe interested in learning more. Maybe if she had another child now she would do the research, we know she believes she would do it differently now. In the next chapter I write about when women do research and educate themselves to have a "better" birth experience.

Suzanne continued to tell me about her experiences talking to other parents and school teachers about her birth experience. Though she knew she made the right decision having a C-section, she always felt a little judged by others.

To be honest, I never apologized. I was questioned, "why didn't you question a VBAC, why didn't you question that? Didn't you want that for yourself? Why did you go through another major surgery?" I guess I was swayed very easily, I trusted the medical profession and I didn't question that. At this age, I definitely look back at that. Hmmm, when my daughter has a baby, I want her to get as much information as humanly possible. I want her to make a birth plan and to stick to it, and I want her to find someone who will support her decision. Whether it's in the kitchen or the bathtub, in a pool or upside down, I think it is really important for women to [decide]; but for me back then, it really wasn't. To be honest I really wasn't, I did stand up for myself for a lot of things back then, but I got my two-cents. When my kids have babies hopefully, but that is their beginning and that is their story. I think now women are a lot more clear on what they want for their bodies, but back then, not so much.

She makes it clear in this passage that she is not sorry for the way her births went, yet she continues her narrative that things are different now. She brings up her daughter, and how she would want her daughter to have a different experience than she did. This helps her prove the point that she has changed.

I continued our conversation by asking about criticism from other parents, and she continued explained how she was not greatly affected by other's comments.

Yeah, I think when you get through nine months of pregnancy, I mean even the miracle of even conceiving a child, even getting through the pregnancy. I mean my doctor always said, 'it was a means to an end, it really is, don't give too much thought into how this child is brought into the world.' Once again, they put the fear of god into me, 'you are under a fair amount of risk if you want to have this child any other way than a Csection. We have medical reports to prove that. If you want to fight that, then I will not be the doctor to deliver the baby.' That's not what I did, it was a good bit of pressure, and good bit of fear I guess. Back then I didn't stand up to things, I just I wanted to do the right thing, and I certainly didn't want any risks to my children. I would've felt awful if I had said 'No, I really want to try it this way, and for something to go wrong' ugh! So, I definitely took the safe way, you know your personality afterwards, and that's sort of my personality and I kind of like to do the things that make sense at the time. I am not going to make a big fuss out of things. I am a little bit like that to be honest.

We continued to talk about how each person's experience is different and valid. Suzanne explained to me how when she gave birth she didn't realize how that story would follow her and her child for the rest of their lives. We talked about why I chose this topic for my project before she continued to tell me her thoughts. She told me about a couple she knows whose birth did not go as planned and their child is disabled as a result. She used their story to show me how by having a C-section she had made the right decision. This story had clearly affected the way she thought about her birth experience and how she and her doctor had made the right decision.

I've got all these healthy children, and I am very glad that I went with the doctor's decisions. I think it was a beautiful birth, and I am glad that it is my story. As I get older and meet people who have stories about birth vaginal or C-section, I think 'boy, there is something to be said about going with a strong doctor's advice saying, 'from experience here is where I am guiding you to give birth to this child.' She [the doctor] made it really clear that just because you are having a C-section and having a surgery is not that you are not giving birth. That made a lot of sense, and I needed to hear that from another woman. [For her] just to say, 'oh no, you are giving birth too, but you're giving birth in a way that makes sense for your body, a vaginal birth is not going to be your story, you could bring harm to you or your child.' I needed to hear that, and the sense of relief. It's a big decision, boy, more for some women than for others, but I am glad at the outcome of my situation. I have three scars on top of each other, I wouldn't wear a bikini anyway, but I do have that scar, but that's all I have to remind me really of the choice I made for my children to come into the world. And that's it, no regrets.

I wrapped up our conversation with details about how she could receive a copy of my work and thanking her for participating.

Several significant themes that arise throughout Suzanne's interviews show the different ways authoritative knowledge played into her C-section experience. I am going to break down this analysis into four pieces: finding support, being an ideal patient, the role of the audience, and gratitude. Suzanne speaks about how supportive the anesthesiologist was for her during the surgery. This was something I had never

considered. Often the support role is fulfilled by a partner, parent, doula, or even nurse. Birth is challenging and often scary, and having a support person eases the experience. However, Suzanne never mentioned a support person, and instead told me about the anesthesiologist. While the anesthesiologist comforted her during the surgery, he did not (because it is not his job) support her for the rest of her birth experience. I think this is relevant because support people often help the woman advocate for herself and make decisions when necessary. Because Suzanne presumably did not have this type of support person, she did not have the backing to stand up to the doctors even if she had wanted to. The anesthesiologist was a comfort, but was himself a key person in the production of authoritative knowledge in the room. Because anesthesia is necessary for a C-section, the anesthesiologist has the power to provide a good experience for the patient. In Suzanne's case, she felt lucky to have a good anesthesiologist because it made her experience comfortable.

Suzanne did not question the decisions the doctors made, and she let them take care of her. In many ways, she was the ideal patient for a medical hospital birth. Not because she had any risk factors that made a VBAC impossible, but because she believed in and went along with everything the doctors said. She did not question the doctors' decisions, and seemed relieved by their guidance. She was openly grateful for how well they treated her. Even when her babies were struggling with colic, she stayed grateful that she had had C-sections. The next interview shows what it looks like when the laboring woman brings a strong alternative knowledge, and how she engages with authoritative knowledge. We might imagine that Suzanne would be the ideal patient from the way she describes her experience.

Suzanne repeatedly mentioned that she would advocate for herself now more than she did "back then." Back then she did not stand up for herself, nor did she know

what she wanted from her birth experience. However, she assured me that if she gave birth today she would ask more questions and attempt a VBAC. What interests me is how it felt like she was assuring me of this fact, like I would want her to say that. This led me to think about my role as her audience for this rendition of her narrative. As I mentioned in a previous chapter, Arthur Frank writes about how people adjust their narratives for different audiences. In Suzanne's case I wondered if she would have repeated how she has changed to other audiences. One of the reasons I included her entire interview was so the reader could experience her repetition of this comment. There are several possible ways to interpret Suzanne's comments that she has changed. One, she was convincing herself that she had changed while she talked to me. Maybe she had not thought about it that deeply before, and as we talked she realized how she had changed. Two, she realized how she could come across as passive to me, a young passionate birth advocate, and tried to gain my respect by assuring me it would be different now. Three, Suzanne mentioned that some parents she has talked to ask her why she did not stand up for a VBAC. I think she might have been expecting me to ask this question as well, because it felt like she was continuously answering it. I began to understand how she was accustomed to telling her narrative. Finally, maybe her apologetic tone had become part of her narrative, and so that was how she told me her story.

The final aspect of Suzanne's narrative I want to analyze is her gratitude. She makes it clear in her narrative that she was very grateful for her C-section experience. Having a C-section birth meant safety, familiarity, ease, and predictability. Her gratitude is a prime example of how doctors are the gatekeepers of authoritative knowledge. Charles King writes that "Physicians are 'the keeper[s] of the keys,' they release the power born from the application of reproductive technology" (King 1992, 5).

Methods include blood tests, ultrasound images, heartbeat readings, and the vital signs during labor. Though these are symbols of authoritative knowledge in a hospital, they are not forced on women by doctors. Jordan explains "the constitution of AK [is] an ongoing social process that builds and reflects power relationships within a community of practice" (Jordan 1993, 153). Doctors' positions as gatekeepers are not enforced by a higher power, but rather constructed as necessary by all those operating in a system of authoritative knowledge. In Suzanne's experience, she cannot understand the machines outputting information about her baby, so she needs the doctor to tell her how she is doing. Suzanne's gratitude for the doctor is not simply because she is happy to have a baby, she is grateful because in the authoritative knowledge framework the doctor was the key to her and her baby's safety. Her gratitude is a direct result of her reliance on authoritative knowledge. The power of authoritative knowledge relies on this dynamic, or else it is questioned. In my next interview, I show how this dynamic slightly changes when the laboring woman can read the machines and is part gatekeeper to authoritative knowledge.

# *Katherine* (age 30's)

The next interview highlights varying interactions with authoritative knowledge. The first excerpt is from my interview with Katherine, a homebirth midwife by training, and the mom of two babies both born via C-section a couple years apart. To summarize her narrative, Katherine believed C-sections happened too often and not for the right reasons. She was glad they existed in emergency situations, but most of the time with the right care she believed women's bodies were made to give birth without surgery. She was pregnant with her first child for 42 weeks and six days, the maximum length legal in her state. After 42 weeks of pregnancy the chance of risk increases for the mother and fetus, so hospitals want women induced if they are pregnant past this point.

Katherine went to the hospital to be induced, but labor never started, and she ended up with a C-section. The piece of her narrative I share here shows how her knowledge of birth interacted with the authoritative knowledge of the hospital.

There are two things to notice in Katherine's narrative. The first is that her birth could be easily categorized as an emergency, where the C-section saved her and the baby. This makes it easy to dismiss her experience of authoritative knowledge, because it "saved her life." However, I have argued that the definition of an obstetric emergency is constructed within the framework of authoritative knowledge. The second is when she acknowledges her training and knowledge around birth, but she is only willing to push it so far. This includes the idea of going into "good girl mode," and her fear of the doctor's treatment.

I was like 'I don't want to be here, but there is a reason I am.' I found with my first they put the monitor on me and the decelerations were pretty low. They were quick to recover but they were down into the 70's and she had two of them. I know what that heartrate means, so as a provider I was like 'I can hear that heartrate and that is not okay.' So that was very scary, and it was very like 'Ok we are doing a C-section, ok! That's what we're are doing!' At the same time, I was really afraid to speak up for the things I wanted out of the C-section. At that point I was like, 'alright, I've done some cowboy things that are outside your comfort levels already care providers, I now need you to be on my side.' I went into super good girl mode, and like I need to not make waves at this point. I have seen hospital staff treat homebirth transfers badly, and I just wanted everyone to nice to me in this tense situation, and not make my life harder. I was really lucky both of my...so my midwife and her assistant and one of my best friends who I met in midwifery school were all there with me, along with my husband.

Katherine used her training to find other ways to have her baby without a C-section, what she refers to as "cowboy things." Her C-section seemed to be an emergency, because she was not having natural contractions. The declaration of an emergency C-section is itself a product of an authoritative knowledge framework, especially in this scenario. Katherine was 42 weeks pregnant, and while that is longer than the average

gestation it is not unprecedented. The protocol that made her go to the hospital to have her baby at that date is mandated by authoritative knowledge. Simply put, authoritative knowledge deemed she was in danger, and then swooped in with a C-section to save her.

A piece of authoritative knowledge that Katherine does interrupt is the idea that doctors are gatekeepers of knowledge because they can read the machines that monitor the baby. Katherine was trained as a homebirth midwife, and therefore could understand what the fetal heartbeats meant during her labor. She mentions this to show that she knew the baby was under stress and a C-section was needed. When she realized she was going to have a C-section her behavior changed, she "went into good girl mode." She knew how the doctors might treat her and she wanted to be on their good side. This suggests that there is a certain point where women should no longer advocate for what they want, and should give in to authoritative knowledge to avoid the possible repercussions of "behaving badly." She mentions above how she was afraid to ask for what she wanted out the C-section, but she was not afraid to demand everything during her labor. This marks her change in behavior, and shows how C-sections are completely within the authoritative knowledge domain. However, with her second birth (also a C-section), she did demand and receive all the specific care she wanted post-operation.

In the next chapter I write about how women are expected to educate themselves and stand up against doctors for what they want. Katherine's narrative shows that even when the person giving birth is a trained birth professional, there is a point where it becomes dangerous to stand up and ask for what you want or need in the maternity ward or operating room.

# Diane (age 34)

The last narrative I examine in this chapter is from Diane, the mother of two children (one vaginal birth and one C-section born about two and a half years apart). In Diane's case, her C-section was due to the size of her baby, and her weakened pelvis from her previous birth. Her narrative complicates the previous ones by showing an instance when a C-section seems necessary. Though Diane is grateful for the option to have a C-section, she butts heads with the doctors and the ways they treat her. Through this moment, I want to clarify that doctors do not own the realm of authoritative knowledge. Jordan makes it clear that authoritative knowledge is produced by the community, and it a mutual space. Here Diane describes the moments after her first child was born, and a conversation she had with her doctor as he stitched up a tear.

When they were stitching me back together with my fourth-degree tear with my daughter, he said 'you might need a C-section next time' and I'm like 'literally I pushed a baby out of my vagina like 10 minutes ago, so you should go ahead and stop the discussion of another child now, because, no. You are literally stitching me back together from having a baby 10 minutes ago, and you're talking about me reproducing again? I don't think so!' I kind of blew him off, because he is not a doctor I personally mesh well with. So, I'm going ok, you're an arrogant asshole, I'm not going, no, I'm not acknowledging what you said. I never really liked him, he wasn't super friendly during my OB visits because I tried to see all the doctors in the practice so that whole spiel. So, I just blew him off, and as we get into the second one, I started seeing my doctor more regularly you know she's measuring pubic bone up to the fundus of the uterus, and she's like 'he's a pretty solid size, he's measuring pretty good, you know.' And so, we started that conversation of if he gets too big, you may be in for a C-section, or if you try to deliver you might be into that reconstructive pelvic floor surgery. And that to me just seems like the worst plan ever, for pelvic floor reconstructive surgery, like no thank you. Like that sounds horrible. And so, in talking more with her and keeping in contact the whole time, and trying to make sure we are all on the same page, and that medically we are going to make the right choice for my health and my body and my forever.

To clarify, when he was born at 39 weeks' gestation, Diane's baby was 11 lbs. She was very enthusiastic to tell me about how he could have been 13 or 14 pounds if he had

been born at 40 weeks. Babies of this size are often born via C-section due to their size, and the belief that they cannot be born vaginally.

I had to have a C-section, and I would've loved to have a vaginal delivery but now looking at him, there is no way I could've done that. It was predetermined, there was no way I could have done that. I had to come to grips with it before hand, but when he came out I was like 'thank the good freakin' lord that they made a C-section possible.' And it was kind of done, like the emotional part of it at that point, cuz like holy crap! There was no needing to emotionally recover after that. Like I am so glad they have C-sections right now. He came out that big, and the OB, the fulltime OB goes 'glad we did C-section!' and I was like 'me too!' My OB came in the next day and she goes 'well that was a good choice' and I go 'absolutely!' And so, it was the mental prep beforehand, the anxiety of a surgery, that was really the problem. Mentally and emotionally after has really been fine. Physically, obviously, nothing really before, just knowing that you are going in for a surgery. But the recovery from a C-section and carrying an 11-pound baby, were probably less painful than the fourthdegree tear, and that probably without a doubt the C-section recovery was easier than the recovery from that fourth-degree tear.

Diane was grateful for her C-section, and the option to avoid a painful vaginal birth. This narrative reminds us that in some cases C-section are desirable for a healthy birth. I easily take the side of C-sections happen for unnecessary reasons, and the rates must be lower. A result of listening to C-sections is hearing the stories of when C-sections are necessary. In this chapter I have heavily focused on how authoritative knowledge in birth results in C-sections. Diane's narrative reminds us of the life-saving benefits of C-sections. These cases are the benefits of technology and medicalization of birth, and are important to remember.

#### Conclusion

The goal of this chapter was to complicate the existing literature on authoritative knowledge by sharing some experiences of my participants. To summarize, Suzanne showed how authoritative knowledge is mutually constructed, and therefore unquestioned during birth. She also described how she would act differently now than she had then, suggesting that through talking with other women she had gained insight

on the power of authoritative knowledge. Katherine's narrative offered a way to consider various knowledges in a hospital, and how they must be balanced by the woman. Her insight will lead us into the next chapter on women educating themselves to prepare for birth and avoid C-sections. Finally, Diane's narrative reminded us that C-sections can be necessary, and while authoritative knowledge can be frustrating, ultimately allowed her to have a safe birth. In the cases of these three women authoritative knowledge is recognized in some form, whether frustrating or comforting.

How can we read these stories as narratives and not just commentary on authoritative knowledge? These women include the role of authoritative knowledge in their narratives of C-section. Arthur Frank writes that people construct narratives that people want to hear, and more specifically they construct narratives that fit their audience. Perhaps my participants include narrative on authoritative knowledge because that is what people want to hear, and because it constructs them as responsible women who want the best for their children. They want to hear that the doctors were present, competent, and professional, the best guides for the woman's birth. Or maybe, they include these details because they think I want to hear them. I have discussed my role as audience member, and in this instance maybe that affected their inclusion of authoritative knowledge. The most likely reason I think authoritative knowledge was included is that my participants experience C-sections, the ultimate technological birth. Telling a story of technological birth without describing authoritative knowledge might not be possible. In this case, I think it is important to notice the different ways women talk about authoritative knowledge as I have done here.

# **SELF-EDUCATION IN NARRATIVES**

"I was walking the floors, I was drinking all the water, I was peeing all the time, I was bouncing on the ball, I was doing everything I knew how to do to make this happen for myself." - Jackie

#### Introduction

The idea that women should educate themselves to advocate for what they want in labor and birth is widespread. Researchers suggest that women should educate themselves to reduce the national C-section rate. In Cut It Out (2013), Theresa Morris suggests three ways to reduce C-section rates. The first way is for women to prepare for birth and be ready to advocate (Morris 2013, 155-158). The second way is for hospitals to change their policies to allow for doulas, one-on-one care, and legalizing VBAC's (Morris 2013, 158-164). The third is long term, a cultural shift, to normalize birth center and homebirth methods, and to reduce reliance on technologies. (Morris 2013, 165-172). Her first suggestion is her plan for quick and immediate change that happens on an individual basis. She writes that ultimately it will not be up to women to reduce the rate, however, if people want to reduce their own likelihood this is what needs to happen. Charles King (whom I quote in the previous chapter on this topic) writes that to reduce rates must be a combination of women being educated and doctors listening to them (1992). King does not write about structural or societal change to reduce the rates. From an objective viewpoint, it is easy enough to put the responsibility on the women. However, women internalize this perspective and take on that responsibility when they feel the need to advocate for themselves during birth. Through the narratives, I show how much women do to try to avoid C-sections, especially for subsequent birth experiences. I argue that while women's education can reduce their individual chance of having a C-section, it should ultimately not be their responsibility. Doctors should be responsible for offering care and support of vaginal births, and our

society should remember C-section are meant as emergency procedures. Through excerpts of my participants' narratives, I show how women do feel the pressure to educate themselves, while I argue it is not their responsibility.

Caroline (age 30's)

Caroline has three children (a couple years apart), the first was a C-section and the following two were vaginal births after cesarean (VBAC) at her home. When she learned that her first baby was breech, she tried to avoid a C-section.

I found out probably around 35 weeks and they told me he was breech and told me that there were some things that I could do to try to flip him. I did literally everything they told me. I went to a chiropractor, I spent a lot of time on my hands and knees, I put ice on my upper abdomen and played music down low, hoping he would [flip]. I literally did everything I could find on Google or any kind of pregnancy forum to try and flip him. So that was the main focus for the last few weeks of my pregnancy was trying to get him to go head down.

This excerpt shows how when the doctor's recommendations do not work, the Internet becomes a useful resource. Caroline was determined enough to move past what the doctor offered her, and found her own information.

After the birth of her first baby via C-section, Caroline was told that she was mostly likely going to have C-sections for the rest of her births. She was not keen on this idea, and decided to explore how to make sure this did not happen.

After that I really dived in doing more research because I really, I didn't see any reason why I should have to commit to C-sections only for the rest of my life, or for the rest of my pregnancies. I got really frustrated, you know I did the doula workshop because of that. I mean I made peace with it now I did the best I could with the information I had at the time, but I am much more satisfied with my two subsequent births.

After doing more research on her own and learning that VBAC homebirths are an option for "low risk" pregnancies, she had her next two babies at home. In this case, education allowed Caroline to have the births she wanted. Her doctors would have told her this was not safe or possible, so it was up to her to figure it out and take the risk.

Through her narrative, Caroline told stories that happened in the past. She could tell me how her first birth and C-section influenced the way she educated herself and had the two home births. The next interview excerpt I examine is a narrative that is set partly in the past and partly in the future.

Claire (age 30's)

Claire had one C-section birth around four years ago, and was pregnant with her second child during our interview. She had been induced for a while, had an anterior lip (when the front of the cervix is stuck under the baby's head and unable to efface), and the fetal heart rate was getting erratic, so the doctor ordered a C-section. Claire was disappointed because she did not want a C-section, but she agreed to one. Talking with friends postpartum, Claire learned there were a few things the doctors could have done to reduce the anterior lip, giving her a better chance at a vaginal birth. When she became pregnant with her second baby, Claire decided the best idea was to educate herself to prevent something like the anterior lip phenomenon from happening again.

One of the first things I did was delve into a lot of research in the beginning to figure out what would be best to increase my odds of having a successful VBAC. Doing a lot of the research one of the first things to come up was a doula. You are like 40% less likely to have a C-section if you have a doula, so I've hired a doula for this pregnancy.

As someone who has trained as a birth doula, I offered my endorsement of this idea.

Doulas are a great way for women to have support and advocacy without having to do it for themselves, and I will write more about this later.

I've been much more active this pregnancy (in my first pregnancy I didn't do anything) I was running up until 31 weeks, and doing yoga twice a week. I still do the yoga, but I'm not able to do the running anymore. I go to acupuncture, I go to the chiropractor, so literally everything humanly possible, everything to have a successful VBAC. I'm doing exercises, and the stability ball at night. Because my baby was posterior and anterior lip, I had a lot of things that weren't going for me, haha. We are going to try our best for this baby to try and be in the best position.

Claire listed off almost every conceivable thing people do to support themselves during birth. By her perception she tried everything, and did her best to have a VBAC with her second baby. If she did have a VBAC, she is probably thrilled that all this education paid off. If she had a repeat C-section maybe she would say to herself "well, I gave it my all, and it just was not meant to be." Regardless of outcome, further education has the potential to make women feel better about their experience.

Later in our conversation, Claire reflected on her first birth experience, and why she was not her best advocate.

One thing I think that I failed myself, is not doing, not having enough education on labor and delivery. I didn't take any classes, or anything like that. I did a ton of research on breastfeeding, and I was very successful on breastfeeding for 18 months, regardless of some of the bumps we did hit especially right after delivery. She wouldn't latch, and my milk came in a week later instead of a few days later, so there were a few bumps. I felt because I had all of this education and support from other mothers, I was just ready to plow through that situation. Like if I had done more research on actual labor and delivery and both birthing processes I would have been able to advocate for myself better.

This reflection supports her current preparation for a VBAC. If she successfully has a VBAC, then she will be an example of why women should educate themselves to reduce the likelihood of having a C-section. This example could be used to argue against me, that if women's education can lower the rate, then why should we not rely on it? I would like to reiterate my argument; I argue that the women should not have the responsibility of lowering the rates. Ideally, Claire would be able to talk to her doctor about her desire to have a VBAC and have the support to make that decision. Claire's narrative illustrates how women internalize their roles as educators and advocates. When a birth experience does not go as planned, it is clear to the woman that if she wants a different experience next time she must educate herself.

Rachael (age 58)

This next interview narrative is an example of how self-education often prepares for the dream and not the reality. Rachael had a C-section with her first birth after a long labor and enduring painful back-labor for several hours.

Everything had been straight forward, I was very healthy, so I read the childbirth book up until the chapter on Caesarean births, and I remember thinking, well I am not going to need to know very much about that. So, I didn't really have a relationship with the concept.

Rachael knew she wanted to be educated on the process of birth, and so she read the birth books. Her decision to not read the chapter on C-sections is not an uncommon decision. Several of the women I interviewed planned for their best-case scenario birth, and often it did not include preparing for a C-section.

I was very clear that if I didn't have medication, I understood a doula to be what you do if you weren't medicating yourself for birth. Like you have to do something, you can't just go in there and have a baby. I feel like I brought all that I could've brought to the table.

Rachael and her doula had advocated for a vaginal birth throughout the labor. She walked the halls, stamped her feet, used the tub and shower, and the birthing ball. When she did consent to having a C-section, it was a few hours after it had first been suggested. She had tried to have a vaginal birth, but she ended up with a C-section because her baby's head was turned in the wrong direction.

I was thinking not medicating would help that, and having a doula would help that, and being in shape and eating well would all help that. But it wasn't about me achieving some physical goal, it was about me bringing a lot of help to my baby, so when the answer was "well it will be a caesarean" It felt like, "okay! If that what it means to have a healthy baby, let's do it" It didn't feel like, I didn't feel upset by that. I was a tiny bit scared, because I, as I said to the anesthesiologist "I've watched just enough Grey's Anatomy to make me panic, and enough Grey's Anatomy to make me know I don't know very much about what is going to happen to me now" He started laughing and said, "good thing I am in charge" But um, I remember thinking that this is not...I do not know anything about what is going to happen now. You know, I really didn't have a clue. I went through that...I mean they were nice about it and told me, but I didn't know what I was walking into. And so...it's a medical procedure, so you know, they treat you...a little bit differently.

Rachael educated herself before her birth; she had a doula, made a birth plan, and was ready for a vaginal birth. However, she did not educate herself on C-sections and medical procedures, which left her feeling uncertain during the C-section. Rachael's C-section was deemed an emergency because the baby was not going to come out vaginally. Due to the education she did have, she was able to labor for much longer than the doctors wanted her to. Perhaps if Rachael had been more educated on the C-section procedure she would have felt more empowered, even if she was unable to avoid a C-section all together.

Doulas are the embodiment of education and advocacy. They are trained to support women physically, emotionally, and mentally through childbirth. Doulas can educate pregnant women about medications, procedures, and simplify medical jargon. They also have knowledge and tips/tricks to try and reduce pain, increase contractions, and dilate the cervix. A doula's presence is commonly believed reduce the likelihood of an unwanted C-section. They fit into my argument because they allow women to be relieved of the responsibility to be educated, while also not requiring the doctor to change. However, doulas are not usually covered by insurance policies, and so women must pay out of pocket. Some doulas offer pro-bono care, but this is not available everywhere. Theresa Morris suggests that one way for hospitals to reduce C-section rates is by hiring doulas to work for the hospitals (2013). Portsmouth Regional Hospital has a team of four birth doulas, they lead childbirth education classes, and attend births in the hospital if requested. I do not know how this has changed their C-section rate, but it is something they are trying.

I also want to add that women educating themselves does not lead to a vaginal birth or a VBAC. Even women like Rachael who read and study labor and birth

throughout their pregnancy can end up with a C-section. For women who have a C-section, and then decide to educate themselves to avoid a second one, I think part of the education is the C-section in the first place. Once a woman has experienced a C-section, she knows more about that process. Maybe she knows what failure to progress is like, or feeling exhausted, she knows about being prepped for the surgery, and the recovery process. She has gained insight on the steps that lead to a C-section. The next time she is preparing for birth, she knows the things she is trying to avoid. Even when women are educated before their first birth, and still have C-sections, so I think that having an initial C-section is part of the reason they know how to avoid a second one. Another reason doulas or doctors could be key in preventing C-sections is they have already experienced them before. They could bring the knowledge of the C-section to a woman's first birth, and share this insight with her.

#### Conclusion

In this chapter, I argued that women should not have the responsibility of educating themselves to reduce the likelihood of having a C-section. I showed examples of women educating themselves to avoid C-section, sometimes it worked and sometimes it did not. To conclude this chapter I want to examine my argument through the lens of understanding narrative. Why and how do women incorporate the details of their education into their birth narratives? Arthur Frank writes about different types of narratives, the most popular being the quest narrative. The quest narrative situates the protagonist as one who confronts adversity and returns victorious and morally enlightened based on their experience (think fairy tale, or heroic journey). Frank applies this to illness narratives, where the ill person faces their diagnosis, goes through treatment, and returns to health with a new appreciation for life. I wonder if women including their education in their narratives is a type of quest narrative. If vaginal birth

was the goal, then a C-section birth implies failure. If a woman was fully educated and prepared to fight for a vaginal birth and ended up with a C-section, she can frame it as she tried everything. To make a crude analogy, it is like a sports team that though they lost, they left it "all on the field." By telling her audience about her education process, she still creates a quest narrative that is acceptable for the audience. This frames their experience as absolute, and leave little room to question if they could have done something differently.

## **BECOMING A MOTHER**

## Introduction

In *Birth as an American Rite of Passage* (2003), Robbie Davis-Floyd writes about the experience of pregnancy, labor, and birth as a transformative life experience, one that happens through the involved ritual of medical care. She argues "... that these obstetrical procedures are in fact rational ritual responses to our technocratic society's extreme fear of the natural processes on which it still depends for its continued existence" (Davis-Floyd 2003, 2). She argues that pregnancy and birth in the US are opportunities for society to convince women there is a right and a wrong way to act and experience birth. Through media, childbirth classes, and doctors, women learn they should experience labor, and vaginal birth because that is "natural" and good. When women do not have this experience, and instead have a C-section they might be upset, devastated, or regretful about their experience. The narratives Davis-Floyd shares in her chapter "Scars into Stars" are not meant to analyze her greater point of birth as a ritual, rather she is trying to show how women remember their experiences in the ritual of medicalized birth.

In this chapter, I argue that in the case of C-section birth experiences, creating a narrative can be an important part of postpartum processing. Women who have absorbed messages that labor, contractions, and vaginal birth are expected parts of birth can suffer postpartum if they did not experience these things, or if they felt they were denied these important experiences. Furthermore, these expected experiences are tied to motherhood identity, so if a woman does not experience contractions, labor, or vaginal birth, then she might feel that she is less of a mother. In constructing a narrative on their C-section experience, women may include feelings of distress, frustration, or devastation that they did not experience the "normal." Some women might portray

feelings of ambivalence in their narratives, showing gratitude for their healthy baby, but also frustration that they had a C-section. These are themes I will follow throughout this chapter, and will guide my analysis of the narratives.

I begin with a few excerpts from one interview. This narrative shows how one woman conceptualized and articulated her transition into motherhood. Then I examine the ways women processed their C-section experience, and how that is part of becoming a mother. I finish this chapter with a discussion of breastfeeding, and what role it plays in processing a C-section.

Gretchen (age 46) was living abroad during her pregnancy and birth. She worked hard to understand the maternal care system where she was living. She had a C-section because her son's heartbeat stopped, and before she knew what was happening they began performing an emergency C-section. Postpartum she was not upset that she had had a C-section, because she understood it to be what was necessary at that time. Her experience beautifully illustrates how she became a mother through her pregnancy and birth. I should note that Gretchen had worked as a celebrant (someone who professionally guides a celebration) for part of her life, and was keenly aware of the various times of change throughout one's life.

Gretchen explained how her relationship changed with her mother-in-law once she had given birth.

I mentioned to you that my mother wasn't present for the birth, but my mother-in-law was. My mother-in-law and I, our relationship is better now, but before my son was born, we had a very contentious relationship. I will never forget that week when I was in the hospital and even though we were in a very contentious relationship, she was very present. She would come and bring me food and sit with me and make sure I had what I needed. I will never forget the momentous change in our relationship just because I was now a mother. It brought with it a kind of indescribable knowing and peace and power. She's an unpleasant person, and she was saying the same unpleasant things to me that she always said without

thinking. I just remember sitting there in my bed and thinking 'I am calling the shots' I just felt like a mama bear.

The experience of becoming a mother empowered Gretchen, and gave her the ability to be comfortable around her mother-in-law. This next quote is an example of how this power supported her in challenging moments.

One of the things she said to me, and I don't remember if she said it that first week, but definitely that first year as sort of the details of the birth came out. She said, 'so you don't even really know what it's like to have a baby, do you?' Because I hadn't had a vaginal birth. I don't remember exactly what I said but, I remember replying to her in a way that it didn't matter if she understood or not. It didn't matter at all. Before having the experience and having a baby, it really mattered to me that she didn't understand me or she accused me of things, or she misunderstood me. So that was just a tectonic shift.

Davis-Floyd writes about how a woman's relationship with the world changes when she is pregnant, suddenly her body is a public space for opinion and conversation (2003, 58). Davis-Floyd argues that pregnancy changes a woman's position for herself, in public, among friends, and in the medical sphere. Gretchen's narrative builds on that idea and shows how relationships within her family changed when she became a mother. Though she was now a mother and more of an equal with her mother-in-law, her mother-in-law still questioned her motherhood because she had a C-section birth. The idea that a C-section birth is a lesser birth than a vaginal birth is a theme that was mentioned by several of my participants. I included Gretchen's narrative here because she shows how her experience shaped her familial relationships. I could make the argument that her C-section was central to transforming the relationship with her mother-in-law, without it their relationship would not have changed. These excerpts support my argument because they show that recognizing shifting family dynamics and including them in her narrative was key to the processing of her C-section experience.

Creating a Narrative as Part of Processing

My argument in this chapter is that for women who have experienced C-section birth creating a narrative can be part of processing their birth. This part of the chapter will show how creating a narrative goes further than processing birth, sometimes it creates an understanding of motherhood. Davis-Floyd describes how women become mothers through the ritual of birth. Some women compartmentalize their experience and choose not to think about it. They might compartmentalize if they had a traumatic birth, or if the birth went according to plan and they did not need to think about it further. If women do not compartmentalize, they process their birth in various ways. Some women talk to each other, sharing stories and experiences to make sense of what they experienced. Others might read and educate themselves about what they experienced. I have already written about this in terms of authoritative knowledge, and self-education. Here I argue that C-section births sometimes require processing for the woman to see herself as a mother. The world may perceive her as a mother because she has a baby, but how does she perceive herself? I want to show that when a woman has a C-section, processing – in the form of creating intelligible narratives -- can be integral to their understanding of their own motherhood.

Women can become mothers through vaginal birth, C-section birth, assisted reproductive technologies (e.g. IVF), surrogacy, or adoption. Although these are all valid ways to become a mother, they carry different cultural implications. The difference between motherhood via vaginal birth and motherhood via C-section birth is specifically relevant here, and some of my participants felt that their motherhood was in question because they did not give birth vaginally. One might argue that the child is still biological, as compared to surrogacy or adoption, but for my participants this was no consolation. Perhaps this is because they were expecting a vaginal birth, and so it stems from disappointment. Maybe it is because they have absorbed messages of

vaginal birth as the truest form of birth, and their different experience puts the authenticity of their motherhood into question. This chapter examines a few instances in which women questioned their claim to motherhood. I will begin my narrative analysis by looking at a few excerpts that show mixed emotions from C-section experiences and how women processed them. One of my interview questions was about physical and mental recovery from C-section. The excerpts that follow are mostly from the answers to that question.

The doctor told Monica (age 30's) that her placenta was growing over her cervix, and if it did not relocate she would be unable to have a vaginal birth. He said that she was early enough in the pregnancy that there was a good chance the placenta would move. However, it did not, and Monica ended up having a scheduled C-section.

My processing started before the baby was born. I started talking to friends who had had C-sections to ask them what it was like, and how the recovery was. I remember being very upset, and not being able to talk about the C-section. Then my friend who had had a C-section prior to that was like 'come with me to this ICAN [International Cesarean Awareness Network] meeting.' ICAN was really the way I got through it, like talking to these women who had these C-sections. Talking through, that you're not alone. That you feel devastated over the surgery, even though I didn't have you know an "unnecessarean" [unnecessary cesarean] as they like to call them. I didn't feel like I was pushed into or scared into [it], I had no choice. I just processed through by talking to other women who had gone through similar situations.

Monica processed her C-section experience with a group of women who had similar experiences. She began processing before she gave birth, because she knew she would have a C-section. Due to this, she was hyper aware of how she would become a mother. Monica says she was "very upset" and "devastated" that she had a C-section. As I wrote at the beginning of this chapter, these feelings can come from social messages about the values associated with "normal" birth. In Monica's case, she had already had a vaginal birth (about two years earlier) and was anticipating that experience again, so

her devastation stemmed from disappointment. The narrative she created includes mentioning these feelings, so perhaps they are part of the way she processed her experience. From the excerpt of her narrative, it seems that she is used to telling her story to other women who have had C-sections. Perhaps she includes these sentiments (distress and devastation) because they often connect her to other women. This idea connects to Frank's work and his idea that people create multiple narratives to express their feelings. Maybe for Monica her expression of disappointment and devastation is included in this specific narrative because it brings her closer to others.

Whitney (age late 20's) had been in labor for many hours, and was eventually convinced to have a C-section. It was her first birth and she was scared by what the doctor was telling her. She cried before the operation, because this was not how she had imagined her birth. After the baby was born she was feeling upset and confused, and wanted to talk about her experience.

I don't remember who it was, but one of them [midwives] came by and she was just on rotation in the hospital at that point. We were still there, I started to try to explain it to her, and I started to break down. I was still very upset about it, and it just wasn't what I thought it would be. I have done some journaling about it and written about it for myself, which was helpful. To put it down on paper, and to be able to look at it that way, a little more objectively, was very helpful. It would not be what I would plan or hope for if we have more children, but if that's the safest way for me to deliver the baby, then that's what it is... Though it was interesting to think back, I mean it wasn't that long ago, she is only 16 months old. I don't know if it's like, if you just stop thinking about it after a while, or it doesn't take up as much room in your consciousness. In the beginning, I thought about it and obsessed over it for maybe a couple of months, and thought over every detail, and what I could've done differently. You just kind of try to process it like that which was interesting. Then when I went to refresh or to think about it before speaking with you, there are some details that are difficult to remember, which is interesting how our brains try and protect us, how we process it.

Whitney was only sixteen months postpartum when we talked, and she was still getting used to talking about her birth experience. She told me more about how

the midwife supported her and made her feel heard. Whitney began her processing with that midwife, and continued through journaling. When we were talking, it sounded like she was still processing. However, finding time to journal with a newborn baby is not easy. It often takes some time to process such complicated emotions.

The following narrative shows that processing is not necessarily a straight or easy path. Jackie (age 34) had a healthy pregnancy, and was planning on a vaginal delivery. She went to the hospital with contractions, and was put on Pitocin after laboring without progress for about twelve hours. The Pitocin did not help the way the doctors were hoping, so by the end of the day they called for a C-section. Jackie was healthy, the baby was healthy, there was no emergency, but she was not progressing. This was her first birth, and she was so excited to meet her baby. She told me that when she had her first baby it felt like her life had begun, and this was who she was meant to be.

I was completely fulfilled, so I didn't care what I had to do. Part of that obsession and that intense emotion I felt for her protected me from having severe postpartum depression, or even how hard the recovery. Once she was here it was just about me and her... Emotionally, at the time of the Csection I believed what the doctor said, I believed we were at risk, and that it was the best thing. I wasn't like 'oh he saved our lives' or anything like that. I believed that he had made the decision he had to make because we were at risk, and something was wrong with my body. Something was wrong with the process that I had tried to do. Something was different, and I was definitely upset. The hardest thing was, people, nurses, family, definitely made me feel that my disappointment was selfish and invalid because I had a healthy baby, so like 'isn't that all that matters?' Like 'move past this now, she's healthy.' That was very confusing, because I was obviously elated, I have never been so happy in my life as when I had my first child. I had this conflicting feeling of being disappointed and feeling like I had missed out on something. There was this commercial running around the time she was born, and it was a Gerber commercial, and it cut to these clips of women laboring, working so hard to have their babies. I could not watch it without sobbing, because it made me feel that I had not worked to have my baby. I had missed something that all women are supposed to go through, I had missed that work, like almost as if I was

not as much of a mother. Like I didn't deserve it as much as other women deserved it. I had a really hard time with that. I definitely talked about it and tried to process it, but I didn't have a very understanding audience. My husband would listen to me, but you know when you don't know what the words are, it's hard to have someone sit there and listen to you try to think of the words. I didn't know exactly what was wrong. About the time, I started trying to have my second child which was about a year later, that's when I started looking into VBAC. What I found in those Google searches were women who were hurt by their C-sections, and women who had already been processing it. Reading other women's stories and having that interaction with some of them, and having those group chats online. That was what kind of helped propel me into understanding what kind of language I needed to use, to then have my friends and family listen to me. In that process of having the people that I am closest to, one by one be able to finally come to an understanding of what I was feeling, has taken years, it has been an incredibly long process. My husband being the first one to listen and understand, my mother being a close second. It wasn't that long ago that I was re-hashing my first birth with one of my brothers, who finally, because of the point he reached in his life where he was finally able to understand more of why this was such a devastating thing to me really. How hard that was because it brought me the greatest thing in my life, to have me say that that experience was so devastating. That alone is so conflicting and confusing, it is hard to process yourself, forget about the other people.

Jackie's narrative is another example, like Gretchen's, of how having a C-section can seem an illegitimate form of birth. In Gretchen's case, her mother-in-law did not consider her C-section a birth. In Jackie's story, she felt less than a mother because she had not experienced the intensity of labor. Earlier I have mentioned social influences telling women that vaginal birth is more real than C-sections. Jackie acknowledges a concrete example of the Gerber baby food advertisement. Advertisements like these are ways for cultural messages of "normal" to be spread and accepted by society. Like Monica, Jackie also described feeling upset and devastated that she had not had a vaginal birth. Jackie felt that she did not deserve to be a mother because she had not worked for it. This echoes capitalist associations of production and value, and reproductions with value, a subject Foucault writes about extensively. Other women I interviewed told me that they were not upset by their C-sections because they were just

grateful to have a healthy baby. While Jackie was grateful to have a healthy baby, she was also upset by her experience. She did not know how to communicate her experience to her family to help them understand her until she read about other people's experiences. Reading others' narratives led Jackie to create a narrative that was authentic and true to the way she felt. This advances my argument because it shows that not only do woman create narratives to process their birth experiences, they create narratives that reflect their emotional experiences. Jackie believes that processing not only can, but should, take longer than just immediately postpartum.

I think it is also a little bit of your own mind. You are in such a vulnerable place after you have a baby, you need to protect your own mind. I did that, I subconsciously protected my own mind from going down this dark path. By the time, I was really able to go down the path and have an understanding, I was in a better place, I was more stable. I didn't have all the postpartum hormones, and all of the pressure of learning how to have a baby, you know be with a newborn and all that stuff. It was a little bit of a safer environment for me, where immediately postpartum was just too unstable.

The three narrative excerpts I have shared are examples of women whose understanding of their motherhood is connected to the processing of their C-section experience. They actively processed their experiences through creating a narrative to gain an understanding of their motherhood. However, some of the women I interviewed had negative experiences of C-section and their processing experience looked different, because it was traumatic. Postpartum recovery included haunting memories (such as seeing the bright operating lights and white lab coats when they closed their eyes) of the surgery and doctors. These narratives demonstrate how C-sections can negatively influence motherhood. In these cases, processing includes creating a narrative that makes sense of the experience and manages the emotion still attached to the experience.

I wrote about Monica's experience earlier, she had a C-section because her placenta grew over her cervical opening. Earlier I quote her on processing her planned C-section, and how she was at peace with it. However, later in our interview I learned how she was traumatized by the experience. This is an example of narrative ambivalence that appears throughout the rest of this chapter.

I have started almost every night, having these C-section dreams, nightmares, and so I mean, I have processed through, like it still does invade the subconscious many years after. Yeah, those are not fun. My brain doesn't really like me, and so I suffered a lot earlier this year. My dreams right now, every night are a choice, I either get a dream where I go to the doctor and the baby has died, or I go to the doctor and I am having a C-section. These are the dreams my pregnant brain gives me.

She blames these dreams and thoughts on her subconscious, and passes them off as symptoms of her current pregnancy. I am aware here of her audience (myself) and how that influences the way she is not emphasizing these dreams. I think these dreams show how traumatic her experience truly was, and incorporating these anecdotes in her narrative is a key part of her processing.

This next narrative is from Olivia (age 34), a naturopathic doctor who had planned a home birth but after laboring for three days ended up in the hospital. Because of her training and background in natural medicine, Olivia was very determined not to have a C-section. She believed that with the right care and the right mindset almost anyone could have a vaginal birth. The emotional recovery and processing of her birth has been challenging.

After all the drugs and everything wore off after about a week, it would come back to me when I was really tired, or I was sitting and looking at her. I would think about her birth, and I would just remember being in the OR [operating room] and the lights and being prepped and the epidural and they ended up doing a spinal. It was invasive, it was just coming back without me wanting to think about it. That was really difficult, but it just sort of faded over time. Sometimes I will look at a picture of somebody in the tub and they are holding their baby on their chest, and it really gets me because that's what I really wanted, and that's not what I got. That's really

hard, but it doesn't bother me every day. Maybe up until my six-week appointment I remember going to my doctor and looking at the wall of all of her homebirths because we used midwives up north and so they do a lot of homebirths and birth center births. I couldn't even look at that because it was too painful. Because that now that I've had a C-section, I have to be in the hospital for my next birth even if it's vaginal because its riskier, and if I had a successful VBAC I could have a homebirth...I think the biggest thing was just realizing that she still was born, but she just wasn't born the way I was expecting her to be born. We are definitely having our own issues now, because she has tummy issues, could've been avoided if we had had a natural birth, because of the gut flora, but ultimately all the problems are fixable, and she is doing very well I think. My judgment about the whole process has dissipated and I don't feel judgmental when I read about C-section births. I think that was a big huge learning piece for me, and why I had to go through that whole process, you know cosmically.

Olivia seems ambivalent about her experience. On one hand, she and her baby are healthy, and on the other she did not have the birth experience she wanted. Part of Olivia's narrative is this ambivalence, and it has supported her processing. Her narrative is a compelling example of the reasons women give themselves to rationalize their experience with C-section. For Olivia, the reasons the doctors gave did not suffice, she needed to do her own processing and rationalizing. She also reflects that maybe her C-section was a lesson to her about judging other people. None of my participants talked about God or a higher being influencing their experience. But I think Olivia's narrative has a hint of a justification for her C-section.

Katherine trained as a homebirth midwife, and planned to have a peaceful home birth like the many she attended. She believed that women's bodies are designed to give birth, and C-sections were unnecessary. However, at forty-two weeks and six days (the legal limit to be pregnant) she still had not started labor. She went to the hospital and after being on Pitocin for many hours, she consented to a C-section.

I really, really, struggled with the idea that my body didn't do the thing it was supposed to do. I trained as a midwife, man, I know this is what bodies are supposed to do. I am very much like 'Oh yeah, your body was made for this, you can, people have babies, they come out, just give it the

space, and babies will come out.' The fact that I never even had a contraction with my first, that I could feel, I was like 'am I even a mom?' A C-section mom is a mom, of course a C-section is like a [mom]. I still felt like my baby had a birth, and I didn't necessarily give birth. That was how I felt, of course C-section births are a birth, she was born. I didn't labor and birth her. I struggled with [that], also because I was struggling with a low milk supply, so I was like 'so my body just can't do any of it right.' People's bodies do this and mine just doesn't.

Katherine clearly struggled with the idea that her body did not work the way she had expected it to. She knows that she had to have a C-section, and without one she could have been in danger. For example, one risk of a too-long pregnancy is the baby will grow too big to be born vaginally without causing harm to the woman's body. She also struggled with the idea of being a "real mom" if she gave birth via C-section. This was an issue for Gretchen and her family, who I wrote about at the beginning of this chapter. In Gretchen's case, this tension was between her and her mother-in-law. However, for Katherine, this is her own battle, she is trying to recognize her experience as a birth. Because she trained as a homebirth midwife, Katherine has other philosophies and expectations of vaginal birth on top of the ones from society. She had been trained to think about birth as a natural process. These ideals made her postpartum process challenging. She includes these details in her narrative that I would argue is part of her processing experience, and are important in terms of how she sees herself as a mother.

In this section I tried to show how creating or crafting a narrative is a way to process a birth experience and understand motherhood. Following the themes of upset, devastation, and ambivalence in women's narratives showed how women process birth experiences they did not want to have. Women cannot create any narrative, rather they must create a narrative that is authentic, intelligible to others, true to their emotional experience, and reflects the "self" they want to project. When women create narratives

to process their experience, the details they include can show the reader what mattered in their experience and who they are. The details included in narratives are not meaningless, rather they are keys to understanding how women experience C-sections and the postpartum process.

## Breastfeeding's Role in Processing

I will examine breastfeeding as an important part of some C-section recoveries. My argument is that women who have unexpected C-sections may feel they missed out on the "natural" experience of a vaginal birth, and breastfeeding is a second chance to take part in a "natural" experience of early motherhood. Malacrida and Boulton complicate the idea of natural birth. They explain how different women define naturalness as some combination of no drugs, no interventions, no C-sections, or no hospital (Malacrida and Boulton 2012). What is natural? This is a much larger debate than my goal in this chapter. I am not focused what birth is or is not natural; rather I am interested in how women consider their experiences and motherhood. To continue with what I have built off Robbie Davis-Floyd's work, women who had a C-section sometimes use breastfeeding to legitimize their motherhood. I will use excerpts from narratives to show the importance of breastfeeding to some of my participants.

Katherine's experience of recovery from the C-section and her thoughts on breastfeeding are closely tied together.

It's a little hard to parse out C-section recovery with breastfeeding struggles for me, because I had pretty major breastfeeding struggles with both of them. With my first, my milk didn't come in. She was 10 pounds 5 ounces when she was born, and lost a ton of weight in that 24 hours.

Katherine had depression previously to her birth, and she knew this could be problematic postpartum. She did experience postpartum depression and considered stopping breastfeeding. She realized that breastfeeding was the one

thing keeping her up. Though she had to supplement milk because she did not produce enough, this helped her feel like she was participating in motherhood.

One of the keys was to keep breastfeeding. A lot of people feel a huge [relief] if they are able to set aside breastfeeding when they are having troubles. It takes a huge weight off of them. I knew if I stopped breastfeeding, I was going to spiral and it was going to be worse, and it would be another failure. I was like 'No, I am going to breastfeed forever. I don't care if I have to supplement forever, I am just going to breastfeed.' Which I did, we supplemented at the breast for eighteen months, which is nuts, that's not something I would recommend.

I asked how breastfeeding went with her second child, and it happened that she was currently still breastfeeding.

Once again, we are struggling with breastfeeding...I've been way more proactive. I am still right in the think of it, but I had a lactation consultant lined up prenatally. We did a prenatal visit and I said 'ok, I am going to have you come over on these days after I have the baby.' Both of my kids had tongue tie, and I was like 'I am going to have you assess for a tongue tie within 24 hours.'

From Katherine's narrative, we can see how important it was for her to breastfeed to accomplish the feeling of natural motherhood. Because Katherine did not feel like a true mother after her C-section, breastfeeding helped her accept her motherhood.

This next narrative is from Jackie, who I wrote about earlier in a discussion of processing C-section experience. Here I will use her narrative to show what breastfeeding meant to her.

Due to the C-section, I wasn't able to breastfeed...I had one nurse try to help me with a pump... My daughter wouldn't latch on and I ended up pumping for her for a long time. That was a whole other hurt that went along with the birth because I thought that I would breastfeed and have no problem doing that. I was determined for her to have breast milk, and so I ended up pumping every three hours. She was breastfed until she was fourteen months old, so I was attached to a pump for 14 months making sure she had all the milk she needed. That's crazy, that's crazy stuff, but you do what you have to do.

Jackie's struggles with breastfeeding were another disappointment like her C-section had been. In the case of breastfeeding, she was still able to participate and experience breastfeeding, which she found helpful to her processing.

I began this chapter with Gretchen's narrative about being empowered by motherhood and standing up to her mother-in-law who thought her C-section birth invalidated her motherhood. Now I would like to revisit Gretchen and look at how she discussed breastfeeding. Throughout her labor and birth, she decided and reminded herself that she would trust the doctors. It was easiest and safest if she trusted what the doctors told her.

I really came back over and over again, to that agreement I made with myself to just accept whatever comes, and that was with breastfeeding. The baby was bottle fed from the very beginning, and when he was introduced to my breast the next morning, he didn't know what to do. He screamed and screamed for, I mean we broke after two and a half days. He was never breastfed, he never latched on. I mean I am very happy with my team of midwives, but there was no one who was dedicated to teaching new mothers how to breastfeed when their child isn't teaching them how to do it. I don't know if I want to put the word regret on it, but it is a great conversation that my husband and I had. He said, 'I support you, whatever you want to do, if you want to keep trying I am here, if you want to give him a bottle I am here.' We tried pumping, but we couldn't really get our hands on a pump that would do the trick, so we ended up giving him formula. I still feel like there is a lot of stigma attached to that. I would say that is the big issue that stings about the whole experience, that I wasn't able to breastfeed my son.

After experiencing an unwanted C-section in a foreign country, the hardest piece for Gretchen was the fact she did not get to breastfeed. Breastfeeding is more than a debate about the health benefits of breastmilk vs. formula. It starts in the hours after birth, and is a possible connection between mother and infant. The nurses were not there to help facilitate this connection, and so it was lost for Gretchen. I will continue this discussion in the conclusion.

One positive story before I conclude this chapter. This is from my conversation with Claire, who had an unwanted C-section and found breastfeeding helped her process her experience. I wrote about her experiences with authoritative knowledge earlier, she is now preparing for her second child and has all the tools in her tool belt.

I did a ton of research on breastfeeding, and I was very successful on breastfeeding for 18 months, regardless of some of the bumps we did hit, especially right after delivery. She wouldn't latch, and my milk came in a week later instead of a few days later. There were a few bumps, because I had all of this education and support from other mothers I was just ready to plow through that situation.

Claire shows that with education and support breastfeeding is possible. Maybe breastfeeding was part of her birth processing, and having breastfeeding as part of her narrative allowed her to feel comfortable with her narrative.

## Conclusion

This chapter examined processing as an integral part of becoming a mother for women who had unwanted C-section births. I argued that creating a narrative is part of processing a C-section birth experience. In some cases, processing takes only a month or so, and for others it takes years to come to terms with their birth. One could argue that processing never stops because narratives are often recrafted and amended over time. Processing happens through conversation, reading, or writing. Through creating a narrative, women process their birth as part of their motherhood experience. If their C-section experience was unwanted or traumatic, women can feel like they are not truly mothers. I wrote about anguish and devastation, analyzing these feelings as the result of societal messages that vaginal birth is preferable to C-section. I mentioned and identified ambivalence in a few of my narratives, noting the role of ambivalence in C-section narratives. Ambivalence may represent a moment when women feel badly due to societal judgments, but it may also have reflected the fact that I was the audience. On

one hand, women may have been upset, but they also wanted to sound optimistic for my benefit. Lastly, their ambivalence could be a sign of the process they are going through. Maybe their narrative is under construction, and they are still deciding how to tell their story. Frank does not address ambivalence in his narrative analysis, which suggests my findings on ambivalence is specific to C-section narratives.

Breastfeeding can also play an important role in processing a C-section birth. Breastfeeding can function as a second chance for women who did not have their expected birth experience. Davis-Floyd does not write about breastfeeding in this way. I wonder if she did not consider it, or if it did not appear in her research. I think the importance of breastfeeding is understood through narratives. My research shows how breastfeeding is part of becoming a mother, especially for women who had C-section births. Breastfeeding begins in the hours after birth, therefore we must consider it in writings on birth and the implications of the birth experience. It starts in the hospital or place of birth, and women therefore associate it with the birth. This is the perspective and insight we gain by examining the narratives of women.

One thing I have not addressed, but was recurring throughout the narratives is the idea of birth as a catalyst for change in family structure. With birth, daughters become mothers, mothers become grandmothers, sisters are aunts, and so on. Some women are aware of these changes, for example if they are the first child to make their parents into grandparents, while some are not. Narratives that included this change in family dynamic suggest that it is part of the postpartum process. Women recognize how their experiences and narratives shape a larger family structure. I would argue that creating a birth narrative that includes a greater awareness moves beyond individual processing and facilitates familial processing. I would like to end this chapter with a quote that exemplifies this awareness that birth changes a family. Throughout my thesis, Gretchen

has offered a reflexive narrative, but this excerpt sums up her experience of what birth meant to her and her larger family dynamic.

If I were to have another baby, if that somehow happened, I would relish the experience, I would just see it as such a privilege and gift. I feel like some of the reason I feel that way is in the power of how I have changed in many ways as a human being. I do kind of feel like all of those shifts that I have experienced in the past 10 years, all started with the birth of my son. Here is another thing that I will share with you. When I was pregnant, I started having all these dreams about death. In that same period, I was talking to my therapist by phone, she was in NY, but I was living abroad. I was so just hormonal and crying every day, my whole pregnancy wasn't like that, but this chapter was. I said, 'I just feel like my life is over. She said, 'Well the part of your life where you are not a mother is over, and now the next part of your life is starting.' I don't know if these dreams are connected to what I am going to tell you. I became very aware of that fact that, because I had made the decision to get pregnant and have a child, which by definition is creating the next generation I was pushing my parents toward death. I haven't really thought about it since then, but at the time I was very conscious of what they wanted. I mean they were already grandparents because of my siblings, but I had never made them grandparents, and the fact that I was bringing children into the world was pushing them into the ends of their lives, and I was very aware of that.

## CONCLUSION

The goal of this thesis was to show what narratives of C-section experience can add to the conversation on C-sections and birth. This project was not designed to make recommendations for change in individuals, doctors, or society, but to show what we can learn from examining C-section narratives. In conclusion, I focus on two areas in which my research can contribute to the larger conversation on narratives and birth studies.

Arthur Frank writes that ill people are not only expected to have a narrative, but a certain type of narrative (2013). He creates a typology of three types of narratives told about illness experiences: the restitution narrative, the chaos narrative, and the question narrative. I found that most of my participant's narratives were quest narratives. Some of them showed how the women overcame their C-section experience and grew wiser for their next birth. Curiously, though, some of my participant's narratives did not fit into Frank's categories.

Women who have C-sections are expected to discuss how it made them feel, and choose from a spectrum that ranges from frustration to relief. Women who felt fully positive or negative fit well into Frank's framework. Still, their narratives were not static or fixed; their narratives and feelings shifted throughout their postpartum years. Some women were still figuring out how they felt, and women who had C-sections decades ago had different types of stories and feelings than early postpartum women. Frank writes that people create a narrative to explain their situation, and that their audience shapes the type of narrative they tell. I found that narratives change over time. I identified a trend of ambivalence in some of my participants' narratives. On one hand, a C-section allowed them to have a healthy baby, and on the other, they regretted it because it was not the experience they hoped to have. This ambivalence, I argue, is a

sign of a changing or unstable narrative. I would offer that this ambivalence continues to change as women to tell their stories and process their experience.

Is the theme of narratives changing over time specific to C-section narratives? Or can it expand Frank's frameworks? The ambivalence is particularly important to understand in C-section narratives, and birth narratives when there is an unexpected outcome. Narratives do not easily fit into one category or another. Here I am also thinking about how my method elicited such ambivalence. I can imagine a group of survey researchers asking women to rate their satisfaction with a C-section birth. If this woman felt ambivalent, then a number from one to ten on a survey would miss the nuance of her feelings. By using open-ended interviews to analyze narratives, we can understand how women's feelings about their birth experiences can be ambivalent, and that this ambivalence is noteworthy. It is noteworthy because it was not addressed in Frank's analysis of narratives, yet it was prevalent in my narratives. The presence of ambivalence could be specific to C-section narratives, and therefore not relevant for Frank's analysis. However, I would argue that Frank's frameworks are not conducive for analysis of themes like ambivalence that do not allow a narrative to fall only partially into one category or another. Further research on C-section narratives could lead to developing analytic tools for understanding ambivalence.

My chapter "Becoming a Mother" explains how breastfeeding was part of the C-section processing experience for some of my participants. I want to return to that analysis here, to conclude with what it can add to the larger conversation.

Several of my interviewees told me how important breastfeeding was to their birth experience, even though most of the literature did not address breastfeeding. I found that writings on breastfeeding were included in postpartum studies, not birth studies. Yet, when I was talking about birth with my participants, many of them

mentioned breastfeeding in their stories. They explained that breastfeeding gave them an opportunity to have part of their expected birth experience by mitigating the disappointment they felt after having a C-section. This dissonance is important because it makes an original contribution that I can add to the scholarship. If women talk about initiating breastfeeding as part of the birth experience, then it should be studied as such. This finding adds to the literature about birth discourse in the United States.

If this research yields any recommendations at all, one of them would be that practitioners incorporate the importance of breastfeeding into care during the immediate postpartum hours. Many women told me that clinical staff did not regard breastfeeding as a priority after a C-section birth. I know that some hospitals are starting to do skin-to-skin contact and delayed cord clamping after C-sections. My findings suggest that they could expand this to include breastfeeding support for C-section babies and new mothers. If this became common practice, some women might have a more positive postpartum C-section experience. For the women that expressed disappointment that they did not have breastfeeding support postpartum, this could change their experience of C-section recovery. More research on breastfeeding initiation as part of the birth experience could enlighten this topic and show the implications of shifting attitudes and practices.

I set out to use Frank's frameworks on illness narrative to understand C-section narratives. Even though C-section narratives are not illness narratives, both involve medicalization. Frank's frameworks were helpful for understanding the process of creating a narrative, however, I learned that C-section narratives are both medical and personal. C-section birth narratives are simultaneously stories-in-process, medical narratives (a version of illness narrative), and personal stories of what it takes to become a mother. Here I have demonstrated how C-section narratives are situated, and

how they can be analyzed anthropologically to add to the existing discourse on birth in the United States.

## **REFERENCES CITED**

- Bernstein, S. N., S. Matalon-Grazi, and B. M. Rosenn. 2012. Trial of labor versus repeat cesarean: Are patients making an informed decision? *American Journal of Obstetrics and Gynecology* (September 2012): 204.e1.
- Centers for Disease Control and Prevention. Birth- methods of delivery. [database online]. 2017 [cited 3/25 2018]. Available from https://www.cdc.gov/nchs/fastats/delivery.htm (accessed 3/25/2018).
- Davis-Floyd, R. 2003. *Birth as an american rite of passage*. 2nd ed. Vol. 1. London, England: University of California Press.
- Foucault, Michel. 1973. *The birth of the clinic*. Trans. A. M. Sheridan Smith. Vol. 1. New York: New York: Pantheon Books.
- Foucault, Michel. 1977. Docile bodies. In *Discipline and punishment: The birth of the prison*. 1st ed. Vol. 1, 135-169. New York: Pantheon Books.
- Frank, A. W. 2013. *The wounded storyteller*. 2nd ed. Vol. 1. Chicago; London: The University of Chicago Press.
- Irwin, S., and B. Jordan. 1987. Knowledge, practice, and power: Court ordered caesarean sections. *Medical Anthropology Quarterly* 1 (3): 319-34.
- Jordan, B. 1993. Birth in four cultures: A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States. 4th ed.Prospect Heights, Ill.: Waveland Press.

- King, Charles R. 1992. The ideological and technological shaping of motherhood. *Women and Health* 19 (2/3): 1-12.
- Klass, P. 2010. The patient narrative. In *Becoming a doctor.*, ed. L. Gutkind. 1st ed. Vol. 1, 39-50. New York. London: W. W. Norton and Company.
- Lazarus, E. S. 1994. What do women want?: Issues of choice, control, and class in childbirth and pregnancy. *Medical Anthropology Quarterly* 8 (1): 25-46.
- Malacrida, C., and T. Boulton. 2012. Women's perceptions of child birth choices. *Gender and Society* 26 (5): 748-772.
- Morris, T. 2013. Cut it out. 1st ed. Vol. 1. New York: New York University Press.
- Rothman, Barbara Katz. 1986. *Tentative pregnancy: Prenatal diagnosis and the future of motherhood*. Vol. 1. New York: Viking.
- Rothman, Barbara Katz. 1989. Recreating Motherhood: Ideology and Technology in a Patriarchal Society. New York: Norton.
- Strawson, G. 2004. Against narrativity. Ratio (17): 428-52.
- Wendland, Claire L. 2007. Vanishing mothers: Cesarean section and "evidence-based obstetrics". *Medical Anthropology Quarterly* 21 (2): 218-33.
- Woods A. 2011. The limits of narrative: Provocations for the medical humanities. *Medical Humanities* (37): 73-8.