Reclaiming A Sacred Domain: An Ethnographic Study of Mormon Women Overcoming the Media-Supported Message of Acceptable Birth Practice Through Giving Birth at Home

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RECLAIMING A SACRED DOMAIN: AN ETHNOGRAPHIC STUDY OF MORMON WOMEN OVERCOMING THE MEDIA-SUPPORTED MESSAGE OF ACCEPTABLE BIRTH PRACTICE THROUGH GIVING BIRTH AT HOME

Celeste Elain Witt

A thesis submitted to the faculty of Brigham Young University in partial fulfillment of the requirements for the degree of

Master of Arts

Department of Communications
Brigham Young University
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of a thesis submitted by

Celeste Elain Witt

This thesis has been read by each member of the following graduate committee and by a majority vote has been found to be satisfactory.

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ABSTRACT

RECLAIMING A SACRED DOMAIN: AN ETHNOGRAPHIC STUDY OF MORMON WOMEN OVERCOMING THE MEDIA-SUPPORTED MESSAGE OF ACCEPTABLE BIRTH PRACTICE THROUGH GIVING BIRTH AT HOME

Celeste Elain Witt
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This study ethnographically explores the experiences of 30 American Mormon women who chose to give birth at home, a practice which differs from the culturally expected birth practice supported by most media birth scenes. The dominant birth practice among American Mormon women aligns with the biomedical birth system nearly universally practiced in the United States.

Recent research indicates that the biomedical model is supported by most media portrayals of birth (Elson 1997b). Mormon women who had given birth at home with a midwife were located and invited to participate. A semi-structured interview guide was used to frame the research process. Verbatim transcriptions of the interviews provided the raw data for coding and analysis.

The responses of the women suggest limited but important media effects within the context of perceptions of birth and acceptable birth practices, consistent with both Cultivation Theory (Gerbner, Gross, Morgan & Signorelli, 1986, 1994; Gerbner & Gross,
1976) and Social Cognitive Theory of Mass Communication (Bandura, 1994). The effects seem to emerge on three levels: 1) The women indicated that some birth decisions may have been influenced by media messages; 2) the women explain the difficulty in overcoming media messages to shift to a different birth practice and reveal earlier attitudes that match the biomedical model of birth; 3) the women describe criticism from others consistent with the model communicated through media. These explanations are derived from qualitative analysis of interviews. The women were asked to describe recollections of media birth scenes, expectations of birth and their experience choosing a culturally divergent birth practice.

Also explored was the participants' introduction to homebirth, its appeal to them and how the decision to give birth at home was made. Their descriptions detail the challenge of choosing and carrying out a homebirth in a micro-culture (Mormon) and a macro-culture (American) that support a specific birth practice. Homebirth operates from a set of assumptions that differ substantially enough from the biomedical birth model to be considered paradigmatic in nature (Kitzinger, 1991, 2000).

The women in this study describe considering the best birth option available, rejecting an assumption of superiority of the media-supported biomedical birth model. To varying degrees, they researched birth information, sought spiritual confirmation of their decision, negotiated with their husbands, and responded to criticism.
ACKNOWLEDGMENTS

What began as a simple graduate thesis research project grew to be an all-consuming passion of immense magnitude. I am grateful to those who both fueled and cooled my passion.

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There would have been no thesis without the 30 homebirthing women of faith who opened up their hearts and homes as they told their homebirth stories—to them I give thanks. And to Suzanne Smith, a devoted Mormon midwife, many thanks for leading me to enough LDS homebirthing women to get this study started.

I stand in awe as I see the sweet children to which I gave birth contribute to my life and to this project. Heather, my firstborn, who now has a home-born baby of her own shows me every day what empowered and gentle womanhood can be. Blair, my second child, survived a hospital birth sufficiently unpleasant to motivate me to choose birth at home from that point forward. Lindsey, my first home-born baby sacrificed her adolescent social life to transcribe the interviews. Dallin, my larger-than-life home-born
baby, continues to amaze me. And Tessa, my youngest, massaged both my feet and my ego.

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Chapter 1: Introduction

A Homebirth Story

Hannah Lawson, a 23-year-old, married, college-educated Latter-day Saint, was expecting her first child. Her desire was to have a completely unmedicated, technology-free, natural birth. She felt confident she was equal to the task. Her challenge was to find a cooperative health care provider who shared her vision of birth. She imagined working with a gentle obstetrician, who, like her, stood in awe at the creation of a new life and would do nothing to interfere with a God-ordained process unless something went seriously awry. She dreamed of how she and Jeffrey would work together as a team to plan and carry out the peaceful arrival of their first baby. She imagined the loving care she would get from an attentive hospital staff as her personal miracle took place.

Although aware of homebirth as an option, Hannah planned to give birth at a hospital because she felt it was “cleaner, safer, and virtually risk-free.” She described television images of birth scenes that contributed to her imagining every potential crisis and “I just figured the hospital was the best place, just in case...I wanted things to be taken care of at the hospital.”

As this was Hannah’s first birth, the unfamiliar process made her understandably anxious. “Facing the unknowns of labor and delivery made me nervous and I thought they would just take care of everything just the way I wanted.” In order to be certain that the birth went according to her specific instructions, Hannah drafted a “birth plan.”
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For Hannah this was a turning point. "It never occurred to me that my doctor would want such control over my birth. I just wanted control over my body and my baby. No inducing labor. No epidural. No episiotomy. No I.V." Although the pregnancy continued to progress well, her relationship with her obstetrician collapsed. She suddenly realized that her image of being cared for by a compassionate and cooperative staff was giving way to the reality of a medical bureaucracy locked into procedures and policies she found unacceptable.

It was at this point, less than two months before her due date that Hannah contacted a midwife. After one meeting she saw birth in a whole new light. Hannah had found a health care provider who was willing to support her in having the natural, spiritually grounded birth experience she desired. "I felt like I had come home at last."

After emancipation from the media-supported view of a culturally acceptable hospital-based birth, Hannah had her homebirth. A difficult 22-hour labor generated a few moments of self-doubt, but the concluding moment when her daughter was born was so powerful and peaceful that she wonders why other Mormon women have yet to explore this empowering option. "I want to talk about it more with other women, because I feel like it's an experience that they want to have. They don't know what they're missing out on...Childbirth made me feel victorious."

Research Framework

Mormon women, due in part to religious beliefs that teach that childbearing is a sacred duty (Church of Jesus Christ of Latter-day Saints, 1995), have a higher birth rate than the national mean. In Utah County, Utah, where the Mormon population is almost 90 percent (Church of Jesus Christ of Latter-day Saints, 2000; Utah Department of
Workforce Services, 2000), the birthrate for 1998 was 27.1 (Utah Department of Health, 1998), nearly twice the national mean for the same year, when the combined rate for all fifty states was 14.6 (Ventura, et al., 2000).

Among Latter-day Saints, the counsel in the Old Testament to “multiply and replenish the earth” (Church of Jesus Christ of Latter-day Saints, 1979, p. 2)) is taken seriously and quoted frequently (Church of Jesus Christ of Latter-day Saints, 1995). There is a clear religious and spiritual framework that surrounds pregnancy, motherhood and birth in Mormon culture and beliefs. The overwhelming majority of American Mormon women embrace the standard American cultural birth practice of hospital-based birth as evidenced by current birth data in Utah County, which show that 99 percent of births in 1998 took place in a hospital (Utah Department of Health, 2000).

Hospital-based, obstetrician-attended birth is a specific cultural system that is not universally practiced throughout the world. Predominant in much of Western culture is a mechanistic view of the human body (Capra, 1982). Some of those who have studied birth practice in the United States see traditional birthing practice in the United States as emerging from that belief (Davis & Davis-Floyd, 1997; Davis-Floyd, 1992). Anthropologist and birth researcher Robbie Davis-Floyd has referred to the resultant pattern as the “technocratic” model of birth. Within this model the body is objectified and viewed as a machine, and in the case of the female body, a defective machine (Davis & Davis-Floyd, 1997; Davis-Floyd, 1992). It has also been referred to as the biomedical model referring to a dependence on the established medical system (Davis-Floyd, 1992). This model seems to be reinforced by the majority of birth-related scenes depicted in the media (Elson, 1997a, 1997b; Pincus, 1999, 2000).
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A small percentage of American Mormon women each year choose to give birth at home, in spite of being raised in a cultural environment that assumes a different birth practice. Research participants come from this group of women. All the women in this study, with the exception of two, report never having been present at a live birth prior to giving birth themselves. Most indicated that their perceptions of the birth process, including pregnancy, labor, delivery and recovery, were influenced in large measure by the images of media-created birth scenes accumulated over a lifetime.

Research Question

How did the American Mormon women in this study arrive at the decision to give birth at home when the media consistently portray obstetrician-attended birth in a hospital as the accepted and expected birthing practice in American culture? This study has been designed to discover, within an ethnographic framework, what factors emerge as the most powerful influences among these women who are willing to act in opposition to media-supported societal norms and intentionally select to give birth to their babies in a location outside of a hospital. Their impressions of media-created birth scenes, what they expected for their first birth experiences, and how giving birth at home relates to their personal beliefs is explored.

Relevance and Importance

This research is relevant to current communications issues, particularly mass media effects, and how the absence or presence of certain images and portrayals may create assumptions on the part of audience. Although there was no presupposition as to what would be found regarding media effects, the data collection was framed to explore this area of substantial divergence and debate.
Due to the important status of birth in this culture and the number of industries that rely on the revenue generated from birth, how pregnancy, labor and birth are portrayed and perceived is an important discussion. Women who respond in a divergent manner to the dominant cultural message on birth practices provide a fertile research platform for this issue. In a review of current research, no studies were found on LDS homebirth mothers, their media-connected perceptions of birth, or their motivations for choosing to give birth at home, thus leaving a gap to be filled.

Definitions of Terms

The specific population studied was Latter-day Saint women who have chosen and intentionally give birth at home attended by a midwife. Mormon, Latter-day Saint or LDS for the purposes of this research, are synonymous, each term equally referring to a self-described actively practicing member of The Church of Jesus Christ of Latter-day Saints. Research participants did not include those who do not regard themselves as actively practicing Mormons nor those who are members of religions considered disconnected from mainstream Mormonism.

Homebirth, within the context of this study, identifies those births where the expectant mother selects her place of residence as the location to give birth and is attended by a midwife. This generally means a birth that is supported by the midwife and directed by the birthing woman. Medication and technological intervention are normally not used, but may be available.

The term midwife refers specifically to those midwives who attend homebirths and have received their training through an apprenticeship system rather than through traditional medical and nursing schools. Midwives of this type are commonly referred to
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as direct-entry, traditional or lay midwives. By comparison, midwives who attend births in hospitals and birthing centers and have had extensive nursing training are generally known as Certified Nurse Midwives (CNM) and are not the focus of this study.

As used in the interview situations to discuss created images of birth, the term media, was left sufficiently undefined for participants so as to comprise all forms of mass communication including television, radio, newsprint, books, magazines, and movies. All genres within each medium that may have produced a message regarding birth practices are considered. Due to its saturation within American society, the focus is primarily on television and the embedded as well as evident messages regarding expected cultural birth practices.

The terms technocratic, traditional, hospital-based, biomedical and obstetrician-attended are used interchangeably to describe the most widely practiced method of birth in the United States. This model assumes the necessity of birth taking place in a hospital, attended by an obstetrician or physician and supported by an array of technologies and medications that may be used to manage the progress of birth. This does not reflect the full continuum of birth options available, but rather reflects the dominant model portrayed in the media.

The word hospital is generically applied to all medical centers, emergency rooms, clinics and birthing centers, which fall under the jurisdiction and control of doctors, obstetricians, anesthesiologists, and other medical practitioners related to traditional birth practice. The medical practitioners at these locations generally have access to and routinely utilize pharmacological and technological interventions to monitor and control the birth process.
Paradigm, as used in this study, refers to a specific conceptual orientation, the embracing of which requires the rejection of a different or competing orientation where assumptions are in opposition.

Delimitations

This study recognizes but does not fully discuss the diversity of birthing options available to women in America. The focus is on Mormon women who have chosen to give birth at home. When considering the full spectrum of birth choices, homebirth appears to be, philosophically and in practice, the most dissimilar from the biomedical birth model. This polarity provides an opportunity to discover the process and reasoning used by the women in this study for such a significant shift in belief structure as well as behavior.

There are other essential persons in the construction of a homebirth experience besides the birthing woman. This study does not fully address the midwives and other attendants. They are only discussed by the researcher in the context of their perceived roles as described by the birthing women. Their actual techniques and practice are mentioned superficially and no conclusions are made regarding their function.

The husbands, who also contribute much to a successful homebirth, are not the focus of this study, but are often included in comments by the birthing women. They are seen most prominently in the discussion of marital consensus.
Chapter 2: Background and Theoretical Framing

History of Midwifery and Homebirth In the United States

American women who choose to give birth at home act outside the norms of current cultural expectation when nearly all births take place in a hospital attended by an obstetrician or physician. Historically, this has not always been the case. A shift in the culturally-expected birth venue occurred over the past century (Donnison, 1988), concurrent with the rise of media influence and saturation. Although no known research has studied the relationship between the adoption of television and the decline of midwifery, it is interesting to note the parallel in time between the two.

A compilation of United States census data indicates that television, introduced nationwide in the early 1940s, reached 90 percent saturation by the early 1960s (Rogers, 1994). In 1940, birth outside of a hospital, most often the home, represented almost half of all American births; by the early 1960s hospitals claimed all but about three percent (Davis-Floyd & Sargent, 1997; DeVries & Barroso, 1997). Recent research shows that nearly every American home has at least one working television and 87 percent report having more than one (Stanger & Gridina, 1999). Currently, births in hospitals and birthing centers likewise represent almost complete saturation with nearly 99 percent of births annually in the United States (DeVries & Barroso, 1997).

Homebirth—midwife-attended and woman-centered—has been the norm in most societies and across the generations (Jordan, 1993). In some countries midwives attend
as much as 80 percent of the births (Hyder, 1998). Various factors, reflective of
significant social changes in American culture, intervened to move the accepted and
expected site for giving birth to an institutional setting. Those same factors, along with
others, altered who would be the expected birth attendant from midwife, most frequently
a woman with personal birthing experience, to a member of the medical establishment,
most often a male, for whom the birth experience on a personal level is not only foreign
but impossible. Undergoing a simultaneous transformation was perception of the birth
process within society. The accepted model incrementally shifted from a normal,
healthy, expected life experience for women to an increasingly pathological one which
required medical management and technological intervention to accomplish successfully
(Davis & Davis-Floyd, 1997).

A substantial amount of the research on homebirth and midwifery comes from
the late 1970s when it was a topic of substantial public interest running in tandem with
the women’s and civil rights movements (DeVries & Barroso, 1997; Pincus, 1999).
Numerous books reframing birth practices, some of which are still in print today, were
written and published (Klassen, 1997). Activists who hoped for the de-medicalization of
the birth process as well as increased acceptance and adoption of homebirth as a natural
outcome of the alternative birth movement of the era have conceded being disappointed
at the apparent derailment of the movement (DeVries, 1996). Although feminists report
some progress, the perception of the female body as pathological remains the dominant
cultural paradigm (see Appendix E; Davis & Davis-Floyd 1997; Davis-Floyd 1992;
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How women perceive their own bodies seems to contribute to women's culturally acquired tendency toward acquiescence to medical intervention. Mitchinson (1997) addresses what she calls the "medicalization" of the female body, where anything that is not distinctly male in nature or function is considered suspect and potentially problematic. Women's perceptions of their bodies and how they should be treated under various conditions seem to be related to socialization within a media-saturated androcentric culture. Reasons for seeking medical assistance and how women are expected to behave while in the hospital are modeled in great detail within media. The images display patterns of passivity, incapacity and compliance.

The near disappearance of midwifery in America needs to be addressed, as it is essential in most cases for a woman to have access to a supportive homebirth attendant in order to have the freedom to choose the site and circumstances for birth. The decline of midwifery may not have been the unavoidable result of medical progress. Rather it may have been, at least in part, the result of a successful attempt by the medical profession to extend the domain of their influence (Donnison, 1998). Midwifery endured decades of specifically targeted professional assaults declaring their apprentice-style training as non-scientific and their practice as risky, unsanitary and unprofessional (Davis-Floyd & Sargent, 1997; Donnison, 1998). DeVries & Barroso (1997), in their historical assessment of midwifery, noted physicians deliberately labeled midwives as dangerous and the cause of a high rate of infant and maternal mortality. There is evidence to show that obstetricians began "an organized campaign to systematically eliminate the competition from midwives" (Davis & Davis-Floyd, 1997, p. 9). Throughout the twentieth century hospital births were increasingly promoted as the safest and most
modern choice with an unspoken subtext that it was a status symbol for mother, baby and family to choose a hospital birth. Hospital births were actively promoted among new immigrants to the United States who were attempting to assimilate and become “real Americans” (DeVries & Barroso, 1997).

In spite of the lack of an upsurge of support in the past two decades, there seems to be a fairly constant demand for alternative birth experiences including homebirth. Midwives have had increased acceptance nationwide, although it is still difficult in some states for midwives to function in the best interest of the women they serve due to statutory limitations (DeVries, 1996).

Midwifery in Utah, though a common practice in earlier days, followed the pattern of the rest of the United States and virtually disappeared among the population considered mainstream LDS. In Salt Lake County a study of homebirth in the early 1970s indicated an increasing interest in homebirth as an option that was frustrated by a lack of supportive health care providers (Foster, Chase & O’Neal, 1979). Upon interviewing two practicing Mormon midwives it was learned that in the late 1970s, initiating with one midwife in St. George who had apprenticed with a naturopathic physician, midwifery began to see a resurgence in Utah (personal communication with Dianne Bjarnson, November 8, 2000). The availability of a trained lay midwife—particularly an LDS midwife—to attend Mormon homebirth mothers in Utah continues to increase according to the current academic dean at the Utah College of Midwifery (personal communication with Suzanne Smith, November 8, 2000).
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Cultural Framing

In consideration of the cultural norms that drive deeply personal issues such as the environment and conditions of a birth experience, it seems reasonable to question whether the actions of Mormon homebirth mothers are sufficient to consider them and their behavior a subculture of the Mormon community. Singer (1998) posits that behavior patterns linked with culture are based on acquired perceptions of the external world, that those shared perceptions create a sense of membership in a perceptual group. With media as the acculturating mechanism, the birth scenes portrayed could create a sense of maternal membership with shared symbols, behaviors, social hierarchies and language. This contributes to explaining the 99 percent of women who choose to give birth in a hospital environment; what it may not explain is the one percent who proactively choose to give birth at home. These women were raised in the same cultural environment as those who chose the more socially accepted birthing location. Homebirthing women have no separate, formal or organized social contact with each other where a unified counter-culture view of birth could be explored and solidified.

Theoretical Framing For Media Effects

Within ethnographic research it is expected that no theory or explanation will predate the data collection or drive the direction of the exploration (Lincoln & Guba, 1985). Since ethnography is designed to be a journey of discovery, open-ended questions and open-minded inquiry provide the model. That being said, it is also true that once the research begins, explanations begin to naturally evolve. Some of those explanations correlate with existing theories while others, unique to the phenomenon being analyzed, emerge independently.
Positivistic orientation assumes data collection for the purpose of hypothesis testing, while qualitative inquiry requires the researcher to assume a posture of innocence and openness (Agar, 1980; Lincoln & Guba, 1985). It is not assumed that a mirror reflection of reality will be created, but meanings that these women attribute to their birth choices and experiences will be uncovered (Miller & Glaser, 1997). During the course of the research and concurrent analysis certain existing explanations seemed to contribute to the overall understanding of certain elements of the phenomenon, but this did not interfere with continuing to explore better and more complete explanations of the phenomenon. Qualitative research always incorporates multi-causality and the natural interdependence of factors for interpretation (Lincoln & Guba, 1985).

Social Cognitive Theory of Mass Communication

It is not assumed that the media are responsible for current birth practices in the United States. The media must be recognized, however, as complicit in reinforcing a specific set of cultural patterns and expectations whether or not they are in the best interest of the woman, baby, family or community.

Bandura (1994) posits in his Social Cognitive Theory of Mass Communication that while a one-sided deterministic model of media effects has been universally discounted, a triadic reciprocal relationship may be more able to explain the apparent effects of media exposure. The three components that comprise the model are (B) behavior, (P) perceptions (affected by cognitive, biological and other internal events) and (E) external environment. Interaction of these factors, in Bandura’s view (1994), determines the influence a media exposure may have. He suggests that this model
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explains how people can process mediated information using it vicariously to draw conclusions about the non-mediated world in which they live.

As Bandura explains, the use of symbolic modeling expands the range of experiences upon which one can interpret the world and make decisions. Within that theoretical framework it is easy to see how women, immersed in images from media-created birth scenes with no competing reality, could make decisions based on misconceptions or misinformation. Bandura suggests that, “Heavy exposure to this symbolic world may eventually make the televised images appear to be the authentic state of human affairs” (1994, p. 76). This seems to coincide with the observation of birth researcher Ellen Lazarus, who states, “Birth models are...made up of beliefs and expectations that are part of a person’s cultural experience and cognitive being” (1997, p. 138).

The most widely accepted perceptions of birth practice in American culture were found to be neither universal nor unchangeable. This is evidenced by the fact that the women studied ultimately chose an unmedicated, midwife-attended homebirth experience in opposition to the most common images portrayed in the media. Bandura (1994) explains the limited nature of apparently ephemeral media effects as the result of the self-reflective capability of effective cognitive function. In other words, when a personal experience or a competing, more powerful media message does not match a specific received media image, most will actively consider how to deal with the apparent disparity and adjust accordingly. A media effect does not need to be permanent, however, to be an effect.
Bandura further notes that electronic media, still dominated by television, have become the sole agent for what he calls “electronic acculturation” (1994, p. 67), where people in American culture learn mores, meaning of symbols, social practices, and language. Although apparently efficient for the conveyance of certain social behaviors and shared cultural knowledge, individuals that become dependent upon the media to interpret the world, seem to be more likely to act upon the images of reality portrayed in the media and be exposed to a much greater cumulative social impact (Bandura, 1994).

One aspect of Bandura’s theory that is not validated by this research related to his observation that “People cannot be much influenced by observed events if they do not remember them” (1994, p. 68). The women in this study, both those individually interviewed and those who participated in focus groups, frequently struggled to bring to mind a specific birth scene from a particular television show or movie. Yet they were remarkably unified in their broad generalizations of what typically would take place and be conveyed as the normal expectations for a birth in American culture through mass media. This seems to be consistent with Gerbner’s Cultivation Theory (Gerbner & Gross, 1976; Gerbner, Gross, Morgan & Signorelli, 1986, 1994). Elson (1997b) observes that mass media have become the dominant source of information about childbirth in American society. Data in Elson’s (1997b) study seem to indicate that media memory can be nearly as potent as an actual lived experience. The recurring themes contribute to unrealistic fears about childbirth and reinforce roles in which doctors control the knowledge upon which decisions are made.

Congruent with Bandura’s theory is Peterson (1991) who, in An Easier Birth, suggests substantial effects for young women who view media birth scenes.
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Movies and television shows about birth may also teach us emotional attitudes and expectations. Where there is no other context in which to learn about childbirth, young girls, in particular, may be susceptible to media messages—whether of strength and joy or of helplessness and danger. These messages can become a script that is stored in the emotional center of the brain....most young girls look to movies or soap operas for the story of childbirth” (p. 67).

Cultivation Theory

Gerbner and Gross (1976) propose that television is the primary tool of socialization in America due to its control of symbols and its near complete penetration of American society and ubiquitous presence. Rather than being focused on the effect of a single exposure to a message, or even multiple exposures within a limited time frame, the Cultivation Hypothesis claims that the major effects of television can be seen as a result of incremental, long-term exposure to consistently similar messages and images (Gerbner & Gross, 1976).

Since the dominance of the biomedical model of birth has emerged concurrently with the nearly universal presence of television in the home, cultivation theory contributes to understanding the high degree of consistency among the women in describing media-created birth scenes as well as the equally consistent personal expectations of the birth experience. When it comes to something as sensitive, personal and infrequent as how and where to give birth, it is reasonable to expect that the combined influence of hundreds of messages about birth as well as years of accumulated images of birthing and pregnant women has had some effect, particularly in conjunction with other similarly oriented cultural messages regarding birth. It appears that the use of consistent symbolic representation, consistent framing of the stories, and consistent selection of language has combined over the years to narrow the cultural expectation of
an acceptable birth experience into one defined by those who benefit directly from the control of those services rather than those who will be giving birth.

Gerbner’s Cultural Indicators Project has explored the portrayal of a considerable number of themes beyond violence on television, where the research began in 1967 (Gerbner & Gross, 1976). Since then, using the same strategies, Gerbner has investigated the extent to which television viewing contributes to audience perceptions of gender, minorities, health, science, family, education, politics, religions and others. Gerbner stated that after a review of the Cultural Indicators Project database, which contains over thirty years of television programming, that media portrayals of birth and audience perception of those portrayals had ever been studied (personal communication, November 9, 2000). Cultivation research monitors a “commonality of outlooks and resistance to change” (Gerbner, Gross, Morgan & Signorelli, 1994, p. 25). Of particular concern is programming that consistently provides reifying images of the populations that maintain the greatest control and influence. The apparent pattern of media programming that supports the hegemony of traditional medicine should therefore be of interest.

Gerbner (Gerbner, Gross, Morgan & Signorelli, 1994) has gone on to refine cultivation theory to include “resonance,” a phenomenon that may amplify the messages of television. If the viewer directly experiences or learns of someone who has experienced something similar to what is viewed on television, then the image or message from the media receives double credibility and is potentially validated in the mind of the viewer. This strengthens the belief that the perception of the media message accurately reflects reality even if it does not.
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The women in this study were asked to what extent they viewed television during their adolescent years. Besides cultivation theory, which depends upon long-term exposure to consistently framed messages, there is evidence to suggest that during adolescent years there is a particular susceptibility to media messages contributing to the construction of their identity, their understanding of gender roles, and their development of values and beliefs (Arnett, 1995; Peterson, 1991).

Application of Theoretical Framing

As most women are not members of the medical profession, their exposure to acceptable and expected birth practices are likely to come from and be supported by media messages. Additionally, social contacts who have been similarly exposed to a lifetime of media-created birth scenes will likely communicate from the same media-based perspective. A recent study of birth practices shown on television or in movies reveals that almost all take place in the hospital and those that do not are the result of error, miscalculation or emergency (Elson 1997a, 1997b). Gerbner (1998; Gerbner & Gross, 1976; Gerbner, Gross, Morgan & Signorelli, 1986, 1994) asserts that television programming is designed to support and maintain conventional beliefs and behaviors, as well as existing power relationships, which may explain, in part, cultural resistance to re-embracing the tradition of midwifery and the practice of homebirth.

It seems unnecessary and ineffectual to attempt sorting out the various types of media, their unique form of message delivery and variations in the actual message and reception when considering the topic of birth and the accumulated effect. The unified message delivered in American culture in support of the technocratic birth model seems to be conveyed consistently in all media forms. As the other cultural forms communicate
a similar message it appears there is no competing message. Pincus, who has researched and written on women’s health issues for over 30 years, observes that “Media, including television, magazines, films, and even the Internet will always reflect the dominant attitude toward birth” (2000, p. 212). Elson (1997b) suggests, “Mass media is our culture and it can be indistinguishable from other cultural forms” (p.4, italics in original).

Cultural Birth Studies

In studying the women who choose homebirth, Klassen (1997) has explored the spiritual and religious meaning that women of various religious orientations bring to the homebirth experience. She discovered through her ethnographic study that nearly all women attribute some type of religious connection to the birth experience, sometimes directly related to their professed religion and other times more connected to a spiritual transcendence in conjunction with the birth itself. Although numerous religions were represented, there were no Mormon women included in the study.

The meaning Mormon women attach to childbirth has been recently explored by Callister, Seminic & Foster (1999) within the context of hospital and birthing center births which may contribute to the discussion of those who choose to birth outside the traditional practice yet hold similar beliefs. Callister (1994) raises additional related issues in her research on how women select a health care provider for pregnancy care; although homebirth is not specifically addressed, many of the issues are pertinent and parallel the process homebirthing women use.

In Kitzinger (2000; see Appendix E), a hospital-based, obstetrician-attended birth is compared to a home-based, midwife-attended birth experience. The differences are substantial enough across all elements of the experience, from prenatal care to birth, to be
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considered paradigmatic in nature. Although there are birth options that may reflect
selected characteristics of each paradigm, the distinct elements of the two philosophies
and practices are compared and contrasted by Kitzinger (1991, 2000). Research among
women in this study of LDS women giving birth at home reveals the presence of many of
these culturally distinct perceptions and beliefs connected with those who embrace the
paradigm of homebirth.

Cultural birth researcher, Brigitte Jordan, explains the importance of
understanding a culture's shared attitude toward birth and birth practice.

A society's way of conceptualizing birth constitutes the single most powerful
indicator of the general shape of its birthing system. In all settings, the definition
of the event is of fundamental importance in that it informs all participants
regarding the proper who, where and how of birth. (1993, p. 48).

Neo-Technological Determinism

Postman (1997) raises the issue of how our society views new technologies; he is
particularly concerned at how Americans embrace technologies without considering the
social and cultural ramifications of the use of the technology. Postman criticizes Western
culture as rarely questioning whether technological innovation is the same thing as
progress.

This ideology, when applied to birth practices, assumes that the use of any new
technology is in the best interest of the birthing mother and the infant when, in fact, some
highly technically-advanced equipment, designed for critical emergency situations, have
the potential of being dangerous, or encouraging life-threatening courses of action, when
utilized in a normal birthing situation (Davis-Floyd, 1992; Pincus, 1999). Those that are
not potentially dangerous may simply unnecessarily interrupt the normal progress of
labor and delivery, diminishing the compelling human core of the process. Preeminence of technology is a dominant cultural message imbedded in most media birth scenes (Elson, 1997a, 1997b; Pincus, 2000).
Chapter 3: Research Design

Research Plan

Ethnography, as a qualitative methodology, was selected for this study as it offers the best opportunity for exploration and discovery within a complex human cultural phenomenon. Hammersley (1992) compares the process of selecting methodologies for a particular research project to traveling through a complex maze, where at each intersection specific choices must be made with the information at hand and with the final research product in mind. The research question determined the paradigmatic orientation (see Appendix E; Hammersley, 1992; Strauss & Corbin, 1998). Descriptive statistics and demographic data from the sample are included as they inform the discussion, but the overall design is qualitative in nature and construction with an ethnographic product as the result (see Appendix D; Alasuutari, 1995).

The research was conceptualized and designed to explore the perceptions and beliefs of a select group of women with shared cultural and religious beliefs in an attempt to understand their ability and desire to act in opposition to the apparent hegemony of the dominant medical system and cultural birth practices. This exploration seeks to identify the process by which the women in this study overcame the culturally prescribed birth practices, with the specific intent of seeking commonalities and patterns to inform the ultimate explanation. Jordan, author of Birth in Four Cultures, has done extensive ethnographic research on birth practices (1993). In a recent telephone conversation with
Jordan on effective methodologies to employ for exploring childbirth issues, she commented that due to its complex human framework and cultural meaning “The experience of birth is best explored ethnographically” (personal communication, November 6, 2000).

Current societal norms point toward obstetrician-attended hospital birth as the safest and most culturally acceptable location and situation for the birth experience (DeVries & Barroso, 1997). But a substantial number of Mormon women in the state of Utah choose to give birth at home each year (Utah Department of Health, 1998). A qualitative research design is best suited to discover the process these women use to make this decision. The power of qualitative research in this instance is the opportunity to be prepared for the unexpected, unlikely, and unfolding. The process is more uncertain in the beginning, but more accurate, more detailed and more usable in its ultimate iteration.

In Utah, where most of the research was done, homebirths, as a percentage of all births, have varied from 0.9 percent to almost 1.5 percent of recorded births over the twenty years records have been kept (Utah Department of Health, 1998). These numbers include unintended as well as intentional homebirths, which may indicate a lower incidence of consciously selected homebirth. In Utah County, which provided the majority of the informants for this research, 1.0 percent of recorded births took place outside the hospital attended by a direct-entry midwife in 1998 (Utah Department of Health, 2000). Though rates have not varied significantly over the past fifteen years, it is worth noting that the Utah State Health Department no longer produces a booklet on homebirth, which they did in 1985 (Evans, 1985) when homebirths peaked (Utah Department of Health, 1998).
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Creating a cultural framework for this study that embraces the diverse motivations of Mormon women making the choice to give birth at home was not as exigent as expected. Although the individual women independently arrived at a similar decision, they often took divergent paths and were fueled by dissimilar rationale, especially initially. Seeking commonalities was the challenge and explicating them along a continuum was the strategy. Conceptualization emerged throughout the study from inception to final analysis.

There was no attempt to approach this study with an a priori theoretical construction of what would be found. Instead, a loosely structured, but clearly defined strategy for exploration was engaged. In a recent conversation with Kenneth Erickson, director of the Center for Ethnographic Research, University of Missouri—Kansas City, on research methodologies, he supported the strategy of approaching the participants in an open learning mode rather than a testing mode. Erickson gives credit for the concept to Agar (1980), a prominent ethnographic scholar, further explaining that the best practice in the field requires becoming personally connected to the data because “You are the instrument” (personal communication, November 7, 2000). Critical to the success of the research, which is so united to the researcher, is complete commitment to the project and belief in its importance and value (Hammersley, 1992). Prior to initiating the research, approval was obtained from the Institutional Review Board for Human Subjects.

Research Process

One of the most difficult, yet critical elements of qualitative research to manage is the serendipitous nature of the process (Lincoln & Guba, 1985). Even though the final
product was envisioned, the actual steps used to get there took some unforeseen twists and turns that allowed for uncovering unexpected and useful data. Discussed here is the history of data collection and analysis for this ethnography.

**Locating and Contacting Potential Participants**

Of concern, prior to the study, was accessing this nearly invisible segment of the female Mormon population. Inasmuch as there is no organization to which Mormon women choosing homebirth would naturally belong, a specific strategy for locating qualified respondents was undertaken. A practicing LDS midwife in Utah County agreed to assist in contacting LDS homebirthing women in the area. Since she needed to protect the confidentiality of her clientele, she offered to attach labels to letters of invitation, which would include a response card. It was intended that these interviews be substantial in depth and breadth, it was projected that ten to twelve respondents would be sufficient as appropriate for ethnographic inquiry. The midwife recommended that 50 letters be sent to her known LDS clients in Utah County who had delivered at home in the past two years.

The letter to prospective participants was drafted by the researcher (Appendix A), approved by the midwife, printed and mailed. Within ten days 46 positive responses were received—43 from those who had been sent the letter and three from others who had heard about the project via their social network. One letter was returned as undeliverable. Considering the likelihood that some of the recipients had moved outside the area, the 88 percent positive response rate from the original recipients of the letter was exceptionally high. Response rates for mail surveys are generally low, normally ranging from 30 to 60 percent (Fain, 1999; Ward & Hansen 1993; Wimmer & Dominick,
Enthusiasm for the project was also revealed in notes made in the margins of the response cards. The follow-up phone calls made it clear that these women wanted to share their story as no one refused once the project was further explained. Appointments were quickly and easily made. Not one appointment was forgotten or cancelled in the individual interviews. Additional participants were found through networking or discovered in the process of interviewing. The experiences described in the text reflect the birthing practices of at least seven different midwives, most of whom were LDS.

Attempts were made to reach all those who expressed interest in the project. When contact was successfully made each was invited to participate in either an individual interview or a focus group. A consent form was designed for each interview setting taking into consideration the specific privacy and confidentiality issues necessary for each venue. Each participant signed an approved consent form that is being kept on file. They also completed a demographic survey, which provided information on religious background, education, marital status, number of children born in a hospital and at home, and television viewing as an adolescent and as an adult (Appendix C).

**Individual Interviews**

There were a total of 13 in-depth interviews conducted, which lasted from 45 minutes to two hours in length. For the individual interviews, data were collected through the audiotaping of the interviews. In order to help informants feel at ease with such private and deeply spiritual issues, interviews took place in the homes of the women who agreed to participate. Open-ended questions were posed from an interview guide (Appendix B) which allowed for the respondents to freely explore their feelings about the specific issue at hand and where deemed appropriate a follow-up question could be asked.
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(Lofland & Lofland, 1995). The interview guide was modified as the interview process progressed so awkward wording could be eliminated and the questions asked would result in the greatest usable data.

After introducing the researcher as a homebirth mother to establish a relationship of openness and trust, neutrality and objectivity were maintained in order to elicit candid responses that would reveal the underlying process involved in the decision to give birth at home (Lincoln & Guba, 1985; Strauss & Corbin, 1998). The variety of answers given by the respondents attests to their comfort with sharing their experiences honestly and completely. Not unlike what was discovered in other research on childbirth, the women seemed to appreciate the opportunity to tell their birth story (Callister, 1995). Callister believes it is important for women to have opportunities to express their birth experiences (personal communication, November 17, 2000).

The audiotapes from the interviews were carefully transcribed, then reviewed for accuracy (Easton, McComish, & Greenberg, 2000). The transcribing resulted in about 150 pages of raw verbatim narrative text. As might be expected, some difficulties emerged in the taping and transcribing process that had to be worked around. At several homes, crying infants or restless children created frustrating noise levels, or what have been called “environmental distractions” (Easton, McComish & Greenberg, 2000, p. 705), that made it difficult to transcribe portions of the tape. At one home, local traffic noise interrupted segments. The final result, however, provided ample data from which to create codes and develop analysis.
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Focus Groups

Focus groups were held in the researcher's home. All who could not participate in an in-depth interview or focus group were offered the chance express their feelings by mail or phone so their voice would be part of the research. The three focus groups, designed to further validate the data collected in the individual interviews (Kidd & Parshall, 2000) took about 90 minutes each.

The conversations of the participants in the focus groups were recorded on videotape. There was no intent to create a full transcription of the data, which were collected primarily to validate the findings of the individual interviews. The questions asked were taken from the interview guide so that answers were framed similarly to the individual interviews, but were modified for the format of a focus group (Kreuger, 1994). Because of the insight and clarity reflected in answers by some of the respondents, the videotapes were carefully reviewed and various remarks from participants were selected and included in the text. In the biographical sketches of the LDS homebirth Mothers provided in Appendix D, those who participated in the individual interview in their own home is noted. A few homebirth mothers, who desired to participate but for various reasons could not attend a focus group, were given the opportunity to respond in writing to six questions. Their answers are treated as if they had participated in a focus group, but their biographical sketch reveals that their participation was in writing.

Transcription and Coding

Following the transcription, the text was thoroughly read to create codes and establish recurring themes. Coding was done for the purpose of creating understanding and discovering explanations (Strauss & Corbin, 1998). When possible, the words of the
participants were used, creating in vivo codes (Strauss & Corbin, 1998). The order and focus of the interview questions helped produce some of codes and themes, while others emerged as the data was further manipulated. Although a sequential process was expected as analysis moved conceptually from the specific to the general, the emergent codes and connecting themes or axial codes often took form simultaneously (Strauss & Corbin, 1998). Initially, sixty-six codes were identified within a framework of six recurring themes. Some codes, which originally seemed to represent separate issues, were later collapsed into a single code, while at the same time other codes were divided into multiple sub-codes for purposes of clarification. The coding sheet that was used for the majority of the coding is found in Appendix F. Interviewing and coding continued until theoretical saturation was achieved (Strauss & Corbin, 1998); in other words, research was terminated once no new information or insights seemed to be emerging from the data collected.

Objectivity and Credibility

Appropriate objectivity was sought by maintaining a certain degree of distance from the research and the respondents. This was done in order to represent the participants truthfully and give them a voice independent of the researcher (Strauss & Corbin, 1998). At the same time, due to the personal nature of the data and the natural bond existing between birthing women (Jordan, 1993), a warm relationship naturally evolved between the participants and the researcher. Joyce Foster, professor at the University of Utah College of Nursing, commented on her experiences with research among birthing women: “Creating an ethnography on women and childbirth that is
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credible requires establishing a bond of trust. As you do the research your experience becomes an integral part of the data” (personal communication, November 7, 2000).

Threads that connected these Mormon homebirth women across different situations (location, birthing experience, economic status, background, ethnicity, community, and education) were found as they told their homebirth stories. Each revealed a commitment to reclaim the right to control the sacred environment of their birth experience. The individual interviews and focus groups explored the behaviors and beliefs of these women as more than an anomaly. Their views of motherhood and the process of childbirth were investigated with anticipation that patterns, divergencies and commonalities among them would be revealed. Each story was unique and unpredictable. Patterns emerged that partially explicate the source of their strength to act in opposition to cultural expectation and prevalent media image.

In the process of telling their birth stories, deep feelings and beliefs regarding childbearing, motherhood and womanhood were discovered and illuminated. The emotion elicited by the telling of these stories was noteworthy; on several occasions both the homebirth mother and the researcher were moved to tears. The level of honesty and engagement in the topic indicated a high degree of interest and enriched the data significantly. Their willingness to reveal uncomfortable data such as family disagreement, financial instability, self-doubt and marital discord adds substantial credibility to the text of the interviews.

Trustworthiness

Consistent with accepted practice in qualitative research methods (Strauss & Corbin, 1998), analysis was concurrent and continuing with each interview or focus
group, as responses revealed categories and themes. Coding was handled as an ongoing process, assisted by others familiar with the project, to assure that accuracy was maintained and authenticity was enhanced. As needed, for both clarification and reliability purposes, some informants were re-contacted during the research and analysis processes.

To enhance the trustworthiness of the study, member checking (Lincoln & Guba, 1985; Belk, Sherry, & Wallendorf, 1988) was utilized; some respondents were given an opportunity to verify text passages or respond to the analysis. Trustworthiness of the data and the analysis were substantiated by a thorough review by Dr. Lynn Callister, of the College of Nursing, Brigham Young University, who has published extensively on the cultural meaning of childbirth. The researcher established the audit trail and trustworthiness was verified (Lincoln & Guba, 1985; Rogers & Cowles, 1993; see Appendix G). All informants have been assigned pseudonyms for final publication and no individually identifiable characteristics or details are revealed in the text, additionally protecting others who may be mentioned in responses. Attending midwives' names are removed from the text completely. The descriptions of research participants in Appendix D are authentic with the exception of the pseudonyms given to both the participant and her husband.

Suitability

Issues of suitability for a homebirth mother to do research on homebirth may be reasonably raised. This researcher's support of homebirth is understandable and longstanding. There was a commitment to recording what was heard and observed in the interviews both accurately and completely.
Conducting the interviews as a known homebirth mother created an immediate connection of trust with the respondents as well as the ability to describe situations with detail and veracity that come from personal experience. The insider-outsider debate, especially within feminist issues (Reinharz, 1992) is a continuing one within the social sciences. Both positions deserve recognition for inherent strengths and weaknesses. This is further supported by Sandelowski (2000) who noted, “Descriptions always depend on the perceptions, inclinations, sensitivities, and sensibilities of the describer” (p.335).

Agar (1980) observes that all ethnographic researchers are a blend of the insider-outsider designations, and that both attributes contribute to the data collection process. As a homebirth mother, and even more specifically an LDS homebirth mother, this researcher was an insider; but that was counterbalanced by the number of years since a homebirth, more than ten, making the researcher an outsider to current social and cultural influences on birth practices. There are those who argue that in order to make legitimate knowledge claims that researchers “must have lived or experienced their material in some fashion” (Collins, 1990, p. 232).

Jordan (1993), in her commonly cited ethnographic study of birthing women in four different cultures, observed that birth issues are best researched by women due to their personal connection to the process.

Anthropological field research on birth is most frequently, most easily, and maybe most appropriately done by women.... As far as the study of childbirth is concerned, one could argue, then, that there are biological as well as cultural reasons why women are uniquely suited not only to participate in birth but also for the documentation, analyzing, understanding, and teaching of the birth process (pp. 119-120).
Verstehen

It is not the objective of this research to formulate a generalizable conclusion that could be applied elsewhere. Lincoln and Guba (1985) observed, “The problem with generalizations is that they don’t apply to particulars” (p. 110). It is rather the intent, within the context of this ethnographic research, to systematically seek a deeper level of understanding of a human cultural phenomenon or verstehen (Hammersley, 1995). Verstehen, in as much as possible, involves direct contact or direct experience with the phenomenon to avoid explanation solely on the basis of observation.

In this case, the phenomenon being studied is the small percentage of Mormon women who choose to give birth at home while growing up in a society acculturated by a media that consistently portray a technologically dependent hospital environment as the culturally expected location for birth. The final ethnographic research product contributes to the understanding of long-term media effects and the strategies undertaken by one group to overcome those effects. There may be a degree of limited transferability when the data and findings are considered in other contexts by future researchers (Lincoln & Guba, 1985).
Chapter 4: Findings

Description of Sample

The data collected from women who self-selected to participate in this research provide a unique glimpse into a subset of Mormon culture. Thirty Mormon women who had given birth at home at least once, ranging in age from 20 to 43, volunteered to participate. Thirteen women participated in the in-depth interviews, 12 in the focus groups and five submitted comments in writing. The mean age of the women at the time of the interview was 28.0, while their mean age when giving birth at home for the first time was 25.5. Each of these women describes herself as an active Latter-day Saint. All are currently married, two of them for a second time.

Education ranged from just short of completing a high school diploma to over seven years of college. One third of the women have a bachelor's degree, with an additional six participants near completion. As a result the mean number of years of education is 15.0. The group was comprised primarily of stay-at-home mothers, with some working part time. Only one participant identified herself as employed full time outside of the home.

All of the participants watched television growing up; 60 percent of them viewed in excess of two hours per day between the ages of 12 and 18. As adults, television watching has become a less prevalent activity, with only 10 percent watching over two hours per day. Only two of the women, 6.6 percent, report having been present at the
birth of a child before giving birth themselves, thus the predominant exposure to the process of birth, prior to their own experience, was through the media.

Less than one third of the women surveyed were born in Utah. Of the thirty participants, all but two describe themselves as Caucasian. In the study there is one African-American and one Native-American. Three were born outside the United States, one each in Honduras, Germany and South Africa. All but two grew up in a home with two LDS parents; one is an adult convert to Mormonism and the other has an LDS mother and a Catholic father.

Even though these are women who chose to give birth at home, only 27 percent accomplished a homebirth with their first pregnancy, meaning 73 percent gave birth in a hospital for their first birth. Eight of the women in this study tried homebirth as a primipara (first-time birth mother). Nine had given birth at home more than once. None of the 30 homebirth mothers in the study chose to later give birth in a hospital with an obstetrician, although two had a subsequent birth with a certified nurse midwife in a birthing center. Among these women there have been 87 births, 45 of them in hospitals or birthing centers and 42 at home. The mean number of births for these women is 2.9. Four of the women stated that they are currently expecting another baby and each said they were planning a homebirth.

Economic status of the families varies widely with several couples still in school and living in student housing while others are firmly established in homes and careers. Additional information on each of the participants can be found in Appendix D.
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Birth As Portrayed In The Media

The distribution of social power in American culture is a function of social class, gender and race and television seems to mirror those patterns, both reflecting and reifying current social conditions. Although a causal link is not implied, the pursuit of social equality among various social strata is made more complex when unequally distributed relationships of power are reinforced by consistent television portrayals. Lemon (1978) studied the portrayal of dominance—the manipulation, persuasion, restriction or control of others' behavior—on prime-time television programming. Her results show that social class, as indicated by the occupation of the character, had greater importance to the portrayal of dominance than sex or race. This seems to explain, at least in part, the representation of acquiescence by pregnant/laboring women when dealing with their doctors upon entering the hospital environment.

From descriptions of birth scenes given by women in this study, a pattern of submitting to medical staff seemed to apply to almost all female characters, even those who, under other circumstances were considered especially independent and self-assured. Once admitted to the hospital, media-created birth stories tend show the locus of control in the hands of the medical practitioners rather than in the hands of the woman. Sullivan and Foster (1989) established the presence of this cultural phenomenon among women giving birth in various settings through research based on Rotter’s (1966) classic work dealing with locus of control.

The women in the study were asked about their recollections of how pregnancy, labor and birth were depicted in television, movies and other media. Micah Shafer, a 23-year-old mother of two, was able to capture many of the elements of the typical birth
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scene remembered by these women. "Most of the shows have a couple laying in bed. She says, 'It's time,' and so they make this mad rush to the hospital. She's screaming. They put her in a wheelchair. The husband has to stay out in the hall."

In analyzing the descriptions of birth scenes given by these women, six categories of underlying messages that may contribute to an overall perception of culturally acceptable birth-related behavior were revealed: 1) Birth is doctor centered; 2) Birth is hospital bound; 3) Women are weak, incapable and passive; 4) Birth is too scary and painful to manage; 5) Men are useless during birth and the source of women's pain; and 6) Birth is a medical event.

Media Message: Birth Is Doctor Centered

In their description of media depictions of doctors in birth scenes, the women in this study describe a consistent theme of ultimate authority resting with the doctor—giving the doctor almost god-like status. Amanda Franson, who had three hospital births before having a baby at home, claimed that while growing up she watched a lot of television. Regarding doctors in the delivery room, she observed, "He was the decision-maker. He was 'God.' He took control and he knew what to do. He was the most important person there at the birth." She further commented on the use of crisis to create a sense of drama, which would then place the woman in a position of dependence upon the doctor. "Thank goodness there's the doctor there. He usually knows everything...because these doctors are like God. They're there to save the day."

Joyce Bailey, a new mother of only five weeks when interviewed, was among the eight who had never experienced a hospital birth. Her newborn son lay sleeping on the sofa as she recalled from her experiences with the media that "[The doctor] was all
powerful. You only ever saw him right when it was the critical moment. So, he wasn’t there during any part of the labor, if you saw it. He was just there to save you.”

Melinda Rowley, a 27-year-old mother who has given birth at home twice, made these comments in a somewhat frosted voice:

The doctor was the god. If the doctor wasn’t there you were in trouble. They portray it as though, if the doctor weren’t there, the woman would just fall apart. The baby wouldn’t come out, the woman would fall apart, or the baby would die or get stuck. Everything depends upon the doctor.

Among these highly religious Mormon women it was surprising to hear religiously laden, sacred-sounding terminology employed. Lisandra Henderson, an African-American mother preparing to give birth at home for the second time saw doctors in television birth scenes as the central figure in the birth tableau. “He was the savior! He came and brought the baby and presented it to you. You kind of felt like he had the key role, basically.”

Also recalled consistently by these women was that the doctor was the source of all knowledge pertaining to the birth with the birthing woman rarely consulted on decisions that would affect both her and her baby. This coincides with the research of Brigitte Jordan (1993) on authoritative knowledge in birth. As a culture, Americans perceive that the knowledge for a successful birth rests in the hands of doctors and their technology. Other cultures hold the position that it remains with the birthing mother and her female midwife (Davis-Floyd & Sargent, 1997)). Television seems to fortify the American assumption of the superiority of the biomedical model and is therefore raising concerns, as American television programming is being exported and distributed worldwide (Davis-Floyd, 1992; Davis-Floyd & Sargent, 1997; Elson, 1997b; Jordan, 1993)
A mother of four children whom she homeschools, Stella Washburn seemed annoyed when she recalled the images she saw in the media.

[The doctor] was there to tell you what to do. He knows exactly how babies are born. Everything is exactly the same; he tells you when to push and when to stop and breathe. If he’s not there, you can’t have the baby. You have to wait for the doctor.

Likewise, Victoria Gerald, mother of two and expecting her third to be born at home soon after the interview, observed that

[The doctor] is the one who is responsible for everything. He was the one who decided when they needed medication. He was the one who decided when the baby was born. The doctor was a focal point of childbirth...whether a woman has natural birth, or gives birth via cesarean, or with a lot of medication, it’s the doctors choice. I was just thinking of Father of the Bride II, for example, and different sitcoms that have had births on them. It seems as though it’s still the doctor’s decision.

The message of the doctor’s power position was often conveyed subtly in the description of various interactions. Hannah Lawson, who claims that under other circumstances she displays independence, confidence and determination, lost it all at the doctor’s office. After having a particularly unpleasant experience with one obstetrician she could not find the strength to say she would not be returning when the receptionist attempted to schedule a second appointment. Many of the women admitted to acquiescing to choices, procedures, and interventions, including delivery in the hospital, based on recommendations from the powerful authority figure of the doctor.

In most media portrayals, the doctors and staff are portrayed as the ones with ultimate authority over the birth and the woman’s body (Elson, 1997b). Hope Richards, a three-time mother who has almost finished her college degree, expressed it this way:

A lot of women feel like the doctors know everything. They also feel like they need to be coached and told what to do when they’re having the baby. In My Life, Nicole Kidman is having a baby and someone is telling her to “Push! Push!” I
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have a real pet peeve about people telling you to “push.” Stuff like that makes it sound like such an emergency, as if there’s nothing natural about it. I think that the compound effect of...viewing birth that way is unnatural. It’s destructive.

Authoritative knowledge, in other words who retains the most influential pieces of knowledge in a given situation, according to Jordan (1993), is culturally defined. Authoritative knowledge as it pertains to birth-related issues in this culture belongs to the medical community and their technologies and seems to be reinforced by messages, images and characters within the mass media.

**Media Message: Birth Is Hospital Bound**

Televised images of authoritative medical personnel appeared to have at least some effect on the women being studied as they told of submitting to medical authority figures even when other plans were made prior to the birth. The doctor’s most powerful province, both in media and in the culture, is within the walls of a medical center. Media birth scenes, except in rare circumstances, always took place within the domain of power for those in authority. The goal of every early labor scene is to get to the hospital and the frantic transporting of the laboring woman may be the driving force for the entire plot.

Rather than in the home of the birthing mother where she would exercise some degree of control, most births take place in the hospital where the medical staff, particularly the doctor, has ultimate authority. Stella saw the message of the media as plain and unmistakable: “Go to the hospital, everyone goes to the hospital.”

A trained doula, or labor coach, Melinda, claims the message coming from television leads people to think that “something will go wrong at home and not at a hospital.”
Felicity Palmer, who was born in Honduras and has a degree in recreation, remarked, “The media made me feel if I didn’t have a hospital birth I couldn’t have a safe birth.”

Sarah Paulsen, one of ten children from a farm in the Northwest, tells the story of her mother which points out the feeling that the hospital is still the destination that legitimates the birth even if the birth has already taken place elsewhere.

She was pregnant with twins and we lived out on a farm 45 minutes from the hospital. She went in to use the bathroom, knowing it was getting close, but figured she still had time. Anyway, she had her first baby right there. She called the ambulance and they said she didn’t have time to have the next one in the hospital, so she was advised to just have it at home. She delivered the other one with my father and brother, while waiting for an ambulance, and then she went to the hospital.

This follows the observation of Karma Sylvester, who noticed that media communicate the idea, “You just need to get to the hospital as soon as you possibly can, otherwise you’re not going to make it [survive].”

A classic scene everyone was able to recall was the “mad dash” to the hospital. Somehow this has become an icon of dramatic retelling of birth stories, which would be interesting to have semioticians analyze (Elson, 1997b). Joyce, who has been married one year and recently had her first child at home, recalls media birth scenes in this way:

It was a traumatic experience. You see movies and it’s an emergency. You have to run around and rush. You saw it as rushing them into the hospital. It’s some major, traumatic thing that has to be taken care of right away. You can’t do it anywhere else but a hospital. It’s painful, screaming, horrible.

Embedded in the message that all births should take place in the hospital is the related message that birth outside of the hospital is an emergency and certainly the result of some mistake. Should mother and baby survive without injury or disability the event falls into the realm of the miraculous. Annica Brown, the mother of five, four of whom
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were born at home, observed that the way the stories are told, any birth outside of the hospital that turns out all right elicits the same response: “They were so lucky. There was no one [no doctor] there to take care of it. It was just really a blessing, a miracle.”

Amanda, who soured on hospital birth after a negative experience, said of television shows, “If it’s not in a hospital, they’re emergency births at home or in a car some place, like on Rescue 911. The conclusion is, ‘Wow, it’s so amazing that this woman was able to make it through and her child is okay. It was a miracle.’”

Bethany Walker, after having two births at home, recalled whenever a birth took place out of the hospital in the media it was portrayed as “One big trauma. Paramedics had to come because the mother couldn’t make it to the hospital.”

The one way a birth outside of the hospital was portrayed with a degree of normalcy was if the show had an historical setting. Victoria remembers from her experience with the media that outcomes were often unpleasant leading viewers to conclude that the negative outcome could have been avoided if a hospital-based birth had been available.

[It was] generally pioneer settings, or some sort of older setting, where the woman would lay down on her bed with lots of quilts. They would boil lots of water, and it seemed as though either she or the baby would die—not always, but often enough.

Hope mentioned that news reports also contribute to the belief that births outside the hospital are scary and dangerous as in one news story she remembered.

It was a couple years ago at [university married student housing]. [According to a news report, the pregnant woman] told her husband, “We have to get to the hospital!” And they got outside and she said, “He’s coming now!” And she ended up having the baby on the top of the car. This was before I was enlightened and I thought that was amazing. The whole entire thing was painted up to be a miracle.
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Melinda also recalls the news contributing to the discussion, “I do remember on the news, the only time birth was discussed was if a baby was had at home accidentally and it was a miracle that both [mother and baby] were alive.”

Lisandra, who has a college degree in human development, noticed that if birth takes place away from the hospital, “It’s always chaotic and everyone is really panicked. It’s usually in a car or something. Things seem to turn out right for the most part, but it seemed like it was really scary.”

Media Message: Woman Are Weak, Incapable and Passive

Of particular concern to all of the women interviewed was the way women’s behavior during pregnancy, labor and delivery was portrayed in the media. Each of the women described her labor in terms that indicated intensity, discomfort and surging biological forces that required energy to cope with. However the descriptions also rang with the satisfaction of rising to the challenge. They were surprised that female characters normally independent and self-reliant became weak, irrational and incapable when faced with labor and delivery.

Repeated messages of passivity, compliance, dependency, incapacity and victimization seemed surprisingly out of place in a contemporary media environment which is ordinarily supportive of more empowered images of women. Annica, whose oldest is now 14 years old, said that as a result of media images,

I saw pregnancy as a condition that was treated as fragile...women were confined and couldn’t come out. My first idea was you couldn’t do anything while you were pregnant; you had to be handled with care. You couldn’t do your normal everyday things... I thought women had to be handled carefully, treated differently when they were pregnant.
The images of dependency continued from pregnancy to labor. Amanda saw that “The woman is being told what to do. Her birth is directed.”

Passivity and incapacity are sometimes communicated without dialogue. Hannah, who has never had a hospital birth, commented on what she observed.

One thing I’ve noticed about birth in the media is that the woman doesn’t move at all. She is transported in a wheelchair to the room, or sometimes they just cut right to the part where she is laying in the bed having contractions or pushing, but she doesn’t move at all. She just sits there.
This is echoed in the thoughts of Lisandra, an African-American homebirth mother, who saw women in labor portrayed as passive. “It seems like she went through pain, and that was it.”

Melinda noted that when she saw birth scenes, “The moms and babies were always in the hospital, generally lying in bed. I never thought anything of it.” Now, she sees things differently.

[What’s] frustrating to me that the moms are always laying down. They’re always portrayed as very weak beings that need to be taken care of. I believe that a mom needs to be supported and nurtured, but not treated like a child during a journey like this.

Hope, who had two hospital births before choosing to give birth at home, said, “The biggest thing I see is that the woman is a victim and needs to be saved.”

Stella observes that it seems that the woman “hates what she’s going through. She does what she’s told to. She just listens to everyone else.”

Portraying the woman as out of control was described as another recurring theme. Hannah recalled of birth scenes, “the ones in the hospital were all the same. The lady was screaming and saying crazy things.”
Joyce, 20, who has not had a hospital birth, observed, “You watch ER; you have this woman screaming in horrible pain and you just want to go in there and tell her to calm down.”

Of some interest has been a state-sponsored series of public service announcements (PSAs) called Baby Your Baby. These began airing in 1985 and have been consistently broadcast since that time (Utah Department of Health, 1991). When asked about these announcements, which encourage taking advantage of various government funded prenatal and infant health care programs, the majority of the women

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1 Baby Your Baby, a public relations and advertising program under the jurisdiction of the Utah Department of Health, was designed to increase awareness of the availability of Medicaid-funded prenatal care for low-income pregnant women and the importance of prenatal care for all pregnant women (Utah Department of Health, 1991). It was developed in response to concern over a decrease in the rate of decline of Utah’s infant mortality rate. In 1985, KUTV with a consortium of health organizations, created a name, logo, public service announcements, pamphlets, and 30-minute television specials with the purpose of encouraging pregnant women, and especially low-income pregnant women, to seek prenatal care (Utah Department of Health, 1991). The public relations campaign has been effective in making the targeted low-income population aware of the program and increasing enrollment.

According to Karen Zinner of Maternal and Child Health, Utah Department of Health, in 1998, nearly 9 percent of the births statewide were to mothers who had received prenatal care through Medicaid presumptive eligibility, which was promoted through Baby Your Baby (personal communication, November 9, 2000). Because Medicaid clientele could not be singled out for any of the years following implementation of Baby Your Baby, no direct correlation has been made between the program and any decline in the infant mortality rate in the past fifteen years, though the program has increased awareness of the availability of governmentally subsidized prenatal care (Karen Zinner, personal communication, November 9, 2000).

At one point data seemed to indicate a correlation between the program and a decline in infant mortality. The 1991 analysis of the effect of Baby Your Baby (Utah Department of Health) has been subsequently reinterpreted due to a lack of accounting for multiple interventions during pregnancy and multi-causalities of birth-related choices. “Given the lack of solid data, it would be inappropriate to identify Baby Your Baby or any single intervention, as being responsible for a decline in infant mortality” (Karen Zinner, personal communication, November 9, 2000). Since its inception, the program has expanded to include promotional messages on other topics of concern for pregnant women and new mothers such as smoking cessation, nutrition and childhood immunizations (Karen Zinner, personal communication, November 9, 2000).
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expressed no knowledge of them. Of those who expressed some degree of recognition
the responses varied from indifference to irritation.

Victoria saw the overriding message to be somewhat condescending.

You’re not going to take care of yourself. The state is going to take care of
you...But it’s kind of funny to have these newswomen telling me that they need
to help me take care of my baby because I’m not smart enough to figure it out.

Media Message: Birth Is Too Scary and Painful To Manage

Lynn Callister, RN, PhD, a professor of nursing at Brigham Young University,
noted that “Women are socialized into being afraid of their own bodies” (personal
communication, May 3, 2000). This socialization process is accomplished through
multiple social interactions, but the one-way messages and images of the media leave a
specific imprint that if repeated often enough may be perceived as reality (Bandura, 1994;
Gerbner, Gross, Morgan & Signorelli, 1994). Recent research indicates “strong evidence
for a cultural element in the United States that influences women’s interpretations of
labor sensations as painful” (Lowe, 1996, p. 86). It has been observed that an emphasis
on potential dangers of childbirth justifies the locus of control remaining in the hands of
medical professionals (Lanier, 1995).

Almost all of the women mentioned words with strong negative connotation when
describing media-created birth scenes. Words that frequently appeared in the texts of
these interviews include: “agony,” “panic,” “fear,” “crisis,” “scary,” “emergency,”
“terrible,” “afraid,” and “screaming.” Several of the women went on to say, without
further questioning, that there seemed to be an assumption that the laboring woman could
not handle the birth process without pain medication. The media support the perception
that labor and birth are beyond the capacity of the average woman to bear (Elson, 1997b).
Katrina Bachman, who has worked in a natural food store, remembers that

On T.V., birth is always portrayed as this uncomfortable, unexpected, scary process women don’t really want to go through. There is always the mother grunting, screaming, out of control, always with an ill temper and bad attitude. The epidural is always demanded. It seems all the negative aspects are portrayed.

Rachel Satterfield, mother of six, noted that her recollection from media portrayals of birth scenes was “women screaming out of control.”

Deborah Clarke, a 32-year-old mother of four, two of whom were born at home, said this of the impact of media images on her: “I was scared to death… I signed up for a birth class so I could gear up, grit my teeth and get through this.”

Annica, an adult convert to the LDS Church with her husband, Stanfield, saw exaggeration in the way media played out birth scenes. “In the media it was always frantic and a lot of fear. When I was actually having birth, it wasn’t anything like that.”

Ashley Little, who had all three of her children at home, mentioned,

I think a lot of times, when it’s portrayed, it’s on shows like ER. They like to make it really dramatic. People come away from it with the idea that they could never possibly do that on their own, as though it’s some super-scary medical procedure.

Natalie Stover, a mother of five who had her last baby at home, acknowledged, “I didn’t want to have any kids. It made it look too scary.”

Birth scenes seem to have a collective impact over a number of years, supporting Gerbner’s cultivation hypothesis. Amanda observed, “Before this [her first homebirth], I had three babies at the hospital with epidurals and everything else. I wasn’t sure if I could cope with labor on my own.”

Not only do women have to deal with their own natural fear and anxieties, but they have to cope with the additional anxieties others pass on to them. Cornered for
choosing homebirth, which by design is normally completely unmedicated, Hannah remembers being asked,

“How are you going to handle the pain? How do you know if you can handle that?” Well, I didn’t know if I could handle that. I had never done it before. But there was no real reason for me to doubt that I could do that, except for that fact that they doubted that they could do it, and they passed on that fear to me.

Likewise, Annica had her mother challenging her ability to handle an unmedicated birth.

I told my mother, that I was going to try and not have any drugs with the birth. She asked, “Why would you do that? With every single one of you, they knocked me out and then I woke up and they told me I had a boy or a girl. Why would you want to go through all that pain?” Her attitude was “Why go through all that pain when they have drugs that can eliminate that? Why would you want to do that?” I told her that I wanted to experience it. I wanted to be coherent. I wanted to know what was going on. She just couldn’t relate.

Very little in the media seems to support women in pursuing an unmedicated birth experience.

A message of fearfulness in media-created birth scenes is described by Stella. She saw birth portrayed as a “terrible thing to have to go through. You watch women have their babies on TV. They’re just screaming and they’re in dire agony.”

Lisandra claimed she did not remember much from birth scenes in the media except “a woman screaming that she’s in pain and then being whisked to the hospital.”

With a consistent message of uncontrollable pain and women lacking the personal capacity to cope with it, it is no wonder that the use of anesthetic medication becomes the logical next step. Sarah points to messages in the mass media saying, “I think they set you up to think that it’s something you can’t really handle unless you’re drugged up, as if it’s an emergency type thing.”
Amanda recalls in detail one episode of a sitcom that she has watched several times that reinforces the expectation of medicated labor and birth.

One episode of *Designing Women*, Charlie has her baby and she asks another woman, “Well, you have natural childbirth, don’t you?” And she said, “Oh no, I’m from the old school—where your husband knocks you out. You don’t wake up until the child’s reading something.” She talks about a woman who was planning on having a natural birth at home and she had all her friends around and they were going to tie a quilt while she was in labor. They were going to sing songs and light candles and have this wonderful birth experience. She said that the lady ended up ordering out for morphine before the birth was over. That sounded weird to me.

What was once impossible, to numb the sensations of childbirth, is consistently portrayed as both normal and desirable. Dramatic images with assumptions built into them can be retained as if the experienced happened to the viewer. If the person then needs to make a decision, if they have no competing perception they may make the decision based on the media image (Bandura, 1994). Melinda, who teaches childbirth preparation classes, describes her first hospital birth with candor.

I remember thinking that I was going to get an epidural, because that’s just what you do when you have a baby. Then I remember reading something about some classes that were available and I started thinking that I should maybe take those classes, but without changing my view of having an epidural. Maybe...I would be better at the breathing thing...and then start screaming for the drugs when I needed them.

**Media Message: Men Are Useless During Birth and the Source of Women’s Pain**

One recurring media theme mentioned by a number of women was anger towards men, particularly the husband or boyfriend, as labor progressed. The presence of this theme was confirmed in the research of media birth scenes (Elson, 1997b). Stella, who grew up with seven siblings, remembered that the laboring mom on television often “starts yelling at the husband. [She’s] very vocal. Not nice words. It’s just not a happy situation.”
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Briana Waverly, a mother of three who was born and raised in South Africa, sees a pattern in American media where the woman is “really mad at her husband for putting her into that situation.”

The wife of a marriage and family therapist, Kristine Schultz, found it disturbing that women were often screaming “you did this to me” at the person with whom they would be sharing parenting responsibilities.

Paula Ellefsen, one of eight homebirth mothers who had her first child at home, seemed honestly perplexed that the female character would be “screaming at her husband. She’s really mad at him.”

Men are not only portrayed as the victim of a laboring woman’s wrath, they are further displayed as fearful, incapable and incompetent when faced with birth. Amanda, a Native American whose husband was both supportive and helpful during her two homebirths, sees media images inconsistent with her personal reality.

Husbands waiting out in the waiting room and smoking cigarettes and pacing back and forth and being really ditzy. Husbands always had a hard time trying to find their way to the hospital...The men are incapable of helping their women...The husbands are portrayed as not being able to handle things. They’re trying to comfort their wives, but still not quite sure what to do.

Likewise, Hannah, mother of a newborn daughter, mentions, “There was always the scene with the husband running around like crazy trying to prepare for the hospital and the wife was breathing funny while she was waddling to the car.”

Hope, who made it a point to call the shots in her homebirth, noticed that “The husband is there, not knowing what to do with himself and honestly doesn’t know what’s going on...a nervous wreck basically.”

Joyce, saw that fathers were “pacing and nervous, freaking out.”
Stella, a small but energetic mom, conveyed the feeling she felt insulted by the message that “Father is an idiot. They portray fathers as idiots. He doesn’t know what he’s doing. He’s just there.”

**Media Message: Birth Is a Medical Event**

The model of birth as a medical event that needs to be attended by a physician in a hospital is present in most dramatic birth stories in television and movies (Elson, 1997b; Pincus, 2000). It also has a presence in many other media platforms—from commercials touting “three out of four doctors recommend” to health insurance pamphlets to birth announcements in the newspaper. The assumption that birth is a medical event plays out in every venue, but most visibly within television. Assumptions become accepted when they go unchallenged. This can be problematic if the assumptions reinforce the social power of one class of people while placing another class of people at risk.

Pregnancy and birth is often presented in the media as an illness or potential illness. Illness is defined in traditional medicine as anytime the body is not functioning correctly according to a pre-existing standard that may or may not take into account individual differences (Lanier, 1996). Lanier (1996) has observed that midwives frame birth as a healthy function of the female body and do not attempt to apply a universal definition of normal.

By framing birth as a medical event, the doctor as practitioner and hospital as location of the procedure go unquestioned. For most women, homebirth is not even considered an option. For Ashley it was important to think it through each time she became pregnant. “Every time I had a pregnancy, I wasn’t set on homebirth, but we
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always prayed about it, and homebirth was always the right answer. It was nice to have options. I see that most people only have one option—it’s a medical procedure.”

With birth established as a medical event, the line between media image and stories communicated in other ways begins to blur. Hope wonders aloud how she and her childhood friends ever got started on this game.

“Cut her open”—we played that as children. Cut mommy open and take the baby out. That’s the way we played it...I don’t know where my sister and I got the idea, but we used to say, “I’m going to cut your tummy open” and then we’d have the doll there. I just assumed that’s where babies were born. I honestly have no idea where I got that.

As the women in this study went through the process of transformation prior to homebirth they had to reach a point where they changed how they saw the birth process, moving to a more holistic and healthy view of the body (Kitzinger, 1991; 2000). Ashley sees birth as “a natural process that our body was designed for. I don’t know if I’ve ever seen it portrayed really well on the mainstream movies or television...It’s usually not addressed in a peaceful, natural way.”

Media-Influenced Expectations

The women expressed varying degrees of perceived impact by the media. Many claimed an almost impervious nature toward the cultural messages on acceptable birth practices reinforced in the media. Teresa Mackay, a trained labor coach expecting her second child to be born at home, stated “My mom had a home birth...So the media didn’t overshadow my perceptions of birth.” The data seem to indicate a far greater initial acceptance of those messages as almost three quarters of those participating in the study had at least one hospital birth prior to choosing homebirth.
These women did not want to seem easily affected by the media as evidenced by the comment by Abbey Nelson, mother of six, who said, "I didn’t take what the media portrayed as accurate. I read a lot. The media didn’t influence me.” Yet she also explained, after four doctor-attended hospital births that matched the traditional pattern, the process of her point of view changing which allowed her to take control of her future birth experiences. “I became very critical of what happened to me in the hospital. I decided birth is a normal thing…a wonderful thing and I don’t need to be here in the hospital with sick people and lots of people I don’t know.”

When asked how they expected pregnancy and birth to progress prior to experiencing it for the first time, their comments reflected varying degrees of influence by media images. Lisandra, who was born and raised in the Northwest, explained, “I expected to get a little sick and then feel better. Basically, I knew I would be in a lot of pain right away and be whisked off to the hospital.”

Hope, who has nearly finished her bachelor’s degree in education, is teaching her preschoolers to speak Russian. When considering how she viewed birth based on years of media images, she conceded that prior to her first birth, which was in the hospital, “I felt that I didn’t know anything and I believed that. I really had always felt that doctors know best. They know our bodies better than we do. They know everything. They have more wisdom than we do.”

In the course of interviewing these women, there was natural introspection regarding the power of the media. Some of them acknowledged being influenced. Annica, who claims she did not watch that much television growing up and watches even less now, concedes her ideas about birth coincided with the typical media portrayal. “I
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never realized how much media does affect how you view pregnancy. I had never felt a baby, never felt a woman that was pregnant, until I was pregnant with my first child.”

Amanda, who claims she watched more than four hours per day during her adolescent years, acknowledges to surrendering some of her autonomy as she began prenatal care. “I did expect to go in and have the doctor tell me what to do. I was okay with that. I thought the doctor was well trained and all-knowing, so I thought you were supposed to let him take control of the situation.”

Stella was immersed in the cultural view of birth and never even saw homebirth as a possibility. “I remember hearing, occasionally, that someone had a baby at home. I thought that was so archaic. Why would you do that? I remember when I got married, one of my first comments was, ‘As soon as I get pregnant, just hook me up to that drip thing so you don’t feel it.’”

Ashley saw the inherent problem of seeing birth through the eyes of the media, when she observed,

I think it’s helpful sometimes not to be totally addicted to popular culture because whether we like it or not, what we take in is what comes out to some degree. So my impression of birth was always that it was painful and everybody screamed and they said, “Don’t ever do this to me again!”

There comes a point, when the mindset of these women has been sufficiently disengaged from the media images, that televised births begin to have a different effect on them. Melinda, after a number of years of labor coaching and two births described her reaction to media-created birth scenes this way:

When I see a birth portrayed on television, I’m usually screaming at the television, jumping up and down, saying, ‘That’s not the way it is! That’s not true!...Once or twice my husband watched [The Baby Story] with me and he said he couldn’t stand it because all I did was scream at the television.
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The Recentering of Birth: A Paradigmatic Repositioning

Melinda, whose first birth was in a military hospital in Hawaii, explains, “With my first baby, homebirth didn’t even enter my mind.” The process of selecting to give birth at home represents a substantial paradigmatic shift, as the conceptual beliefs supporting homebirth are not compatible, in most cases, with those that support a traditional hospital-based birth (see Appendix E; Kitzinger 1991, 2000; Pincus, 1999).

Kuhn observed “The decision to reject one paradigm is always simultaneously the decision to accept another” (1996, p. 77). There was little fence straddling among these women. Once they embraced the new birthing paradigm, they did so with a high degree of commitment as indicated by the infrequency of returning to giving birth in a hospital and the complete absence of using a male obstetrician or physician after once giving birth at home.²

² Two women, Rachel Satterfield and Amanda Franson, chose to use a Certified Nurse Midwife for a subsequent birth in a birthing center at a hospital. Both women mentioned that following their home birth experience, for subsequent births they did not want to have a traditional hospital birth with a male obstetrician or physician. What brought each to return to a hospital was slightly different, but both exhibited permanent changes in their paradigmatic orientation regarding birth practice even though they opted for an institutional venue.

Amanda, in describing the birth of her fifth child, told of a troubling dilemma she and her husband faced.

When faced with a pregnancy we couldn’t afford otherwise, we knew that Medicaid would pay for nurse-midwives but not for a homebirth. It wasn’t that I was dissatisfied with my homebirth, but I just needed to use the nurse-midwives that time. Even though I enjoyed the nurse-midwives, it was still like a hospital; it was not as nice as home. The staff kept coming in and out. I was much more proactive in my care at the hospital after having delivered at home. I knew what I wanted and I demanded it.

Rachel, having just moved, had a different reason for not delivering at home after having a positive homebirth experience. She remembers,

In California where I delivered at home they’re apparently more relaxed about who can deliver where. When I moved to Utah I didn’t know how to find a midwife. Nurse-midwives like I used in California aren’t allowed to deliver at
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Many of the attitudes required for homebirth are incompatible with the technocratic view of birth (see Appendix E). Kitzinger (1991; 2000) has described the polarities of the two paradigms and the inevitability of embracing one or the other. Her analysis based on years of anthropological research on birth issues shows that what she terms the “woman’s way of birth” differs substantially from the “obstetric way of birth,” both conceptually and pragmatically. She notes four major areas where the two paradigms diverge: 1) cultural definition of birth; 2) settings for birth; 3) caregivers, including support given and the way labor is handled; and 4) techniques used (see Appendix E).

Explored here is the process undertaken by these women to move from the media-endorsed perspective that supports current culturally accepted birth practice to one supportive of homebirth. This was made additionally complex by support for the prevailing birth model within both the macro-culture (American) and micro-culture (Mormon community) in which they live and interact socially. Individually, the women described their personal process of decision-making as well as the process of seeking a unified marital consensus. These women, like other LDS women who have been studied (Callister, Seminic, & Foster, 1999), took the issue of childbirth seriously. They also considered the impact of their decision on others, including their husband, immediate family and extended family.

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home here. So I had to use the hospital. I would have definitely delivered at home if the nurse-midwives could have done it. After having a birth at home it was totally different for me at the hospital. I knew what I could ask for and got it. I went in completely empowered. I knew in my head beforehand what my options were and made sure I got what I wanted. I definitely felt in control.
Since a positive portrayal of homebirth does not appear with any regularity on television (Elson 1997a, 1997b), the women in this study were introduced to the concept in a variety of ways. This study revealed that the vast majority of the participants became aware of homebirth through their social network of family, friends, neighbors and other social contacts. Several of the women also mentioned printed material such as books, pamphlets, advertisements, or newspapers as well as television, movies and newscasts.

Some of the mothers were introduced to homebirth early in their lives while others did not know it was even a possibility until adulthood, sometimes with a pregnancy underway. There seem to be two periods of exposure to the concept of homebirth, which the researcher has designated as initial and critical. Initial exposure is an early introduction, perhaps in childhood, while the personal reality of giving birth was still substantially remote. Critical exposure refers to contact with the idea when birth issues are being actively considered. Both types of exposure have a place in the decision-making process. The length of time between the two types of exposure may be years or no time at all. The length of time between the two types of exposure and actually selecting to give birth at home varied widely.

Introduction To Homebirth

When asked, not all the women could describe the situation in which they were first introduced to the concept of homebirth. Those who could often gave fascinating details. Both media-based exposure and introduction through their social network were important to the decision-making process. Within their remarks are insights that reveal their level of acceptance of the new paradigm of birth and whether it was an initial or critical exposure.
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Initial exposure.

Ashley, who had her first homebirth at age 20, remembers her introduction to the idea was when she was 16 and she came across a paperback in her parents' home entitled *Birth at Home*. That initial exposure left a lasting impression.

I read it and I don't even know why. At the time, I didn't know anyone who had had a homebirth... But I read that book and it said that 95 percent of women could give birth safely at home. It talked about some of the benefits and some of the dangers of medical procedures and it just made so much sense to me. From that time forward, I thought that was what I wanted to do.

Additionally, upon arriving at college, she sought out women who had given birth at home.

There was such a difference in the way they spoke about it. They liked birth. Nobody else did. They thought birth was hard, but neat. They wanted to tell you about their stories, because they thought they were wonderful. They were the only ones I knew that had a positive outlook on it. So to me it seemed like the obvious thing to do.

Some read brochures and pamphlets as in the case of Karma, mother of two, whose husband is a student. After having an unpleasant experience in the hospital with her first birth, she remembers receiving "a little thing in the mail before I was pregnant with my second. It just talked about midwives and I thought, 'This is a good chance to get some research done.' That was really my first exposure to homebirth."

Lisandra, an African-American homebirth mother, remembers her initial exposure, which left an impression that led to a homebirth decision with her second child.

It actually happened before I had my first child, which I had in a hospital. I was just through reading some books that had a homebirth section and I could feel of the control that it gave the mom and how much she had to do and was involved in bringing her baby to the world. It just sparked something inside of me [but] I was too scared to do it.
Although her first birth was in a hospital, Annica, recalls seeing a movie as a teenager, which caused her to view birth differently than she had previously.

I remember seeing a film where an Indian woman was giving birth and she was outside. It wasn’t very graphic, but I knew that she wasn’t in a hospital setting and it really intrigued me. I remember thinking, “Wow. They didn’t have hospitals then. This is how it must have been done.” I remember I was very interested. I wasn’t scared. It took away the fear.

An extended social network is the most common way women recall being introduced to the idea of homebirth, but the exposure was not always positive. Melinda, who was 24 at the time of her first homebirth, recalls that when she was in high school a woman down the road had a baby at home, “I remember saying, ‘Why doesn’t she believe in doctors? What if something went wrong? What if she died? What if the baby died?’ I remember thinking she was really weird.”

Hannah was introduced to the idea of homebirth at home, but the lasting impression was initially negative.

The first exposure was my mom having a homebirth, and that was with my sister. For me it wasn’t a really positive experience. I just didn’t like the blood or the noises that went with it and I felt uncomfortable about the whole thing. When my little brother was born at home, I felt just as sick. I just didn’t want to be there. Maybe it was too emotional for me...When my next sibling was born, [my little sister], it went a lot quicker and I think I was a lot more mature. I was glad that she was a girl. But when I got married I was still pretty against the idea of a homebirth. I wanted things to be taken care of at a hospital. After I got pregnant I still wanted to have a baby at the hospital.

The negative cultural opinion of midwifery and the predominant opinion of the rightness of a hospital birth often collide with these initial impressions of homebirth. Victoria, who had her first homebirth at 23 following a cesarean birth two years prior, remembers, “When I was 18, I came to Brigham Young University and someone had mentioned that she wanted to be a midwife and I thought, ‘They still have those?’”
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Similarly, Deborah, who teaches Bradley Method childbirth preparation classes and has had two homebirths, mentioned that when she first heard of homebirth her reaction was negative. "I thought how crazy. You have all that stuff in the hospital. You don’t have a 10 to 15 minute drive to the hospital in case there are complications."

Stella, who had three hospital births before she opted for homebirth, remembers her initial introduction to homebirth as a teenager. She got to know a woman in her neighborhood who had delivered eight children at home.

I met her and her babies. That was my first major exposure to homebirth...She told me that she had all her children at home and after she has them, she always wanted to mop the kitchen floor. She said it felt so good to get on her hands and knees with no baby inside and mop the kitchen floor with a rag...She was very happy and positive and I thought of her as I had my first homebirth...She was different than other mothers.

Melinda started to rethink her automatic acceptance of hospital birth as she went through training to become a childbirth educator.

I took classes and they talked a bit about homebirth. Then I started really thinking about it. I started actively reading and interviewing midwives and people who had had homebirths. I did a lot of research—probably more than most people who had homebirths would do—[because] I was so far on the other side beforehand.

Critical exposure.

At some point after initial exposure, these women recall a moment when they were more open to the idea of giving birth at home. In some cases they were pregnant and making important decisions, in others they were simply planning ahead. The great majority describes reintroduction to homebirth through their social network of family, friends and other associations.
Although not LDS at the time, Annica remembers,

I was pregnant with my first child and I was going to a prenatal exercise class and we went around and said who we were and where we were giving birth. This one young woman in the class said that she was going to have her baby at home with a midwife. That just piqued my interest. I remember coming home and telling my ex-husband that I would really like to try this homebirth thing.

Some of the relationships were close familial relationships, some were established friendships and others informal and spontaneous. Joyce, who had her first child at home, explained, "When I got married, my husband’s sister became a midwife. She introduced the idea to me."

Others responsible for introducing the idea of homebirth were within a close social circle such as Lisandra describes: "[a fellow church member’s] wife happened to have her child at home and so she started talking about it. She was really excited and I couldn’t understand why. I knew, though, that it must be something really neat."

Karen Sullivan, a 27-year-old mother of three who had her first birth at home in her university apartment, remembers,

I had a friend in our ward who was having a baby at home. My husband went and gave her a blessing while she was in labor. That was his first strong feeling that it was the right thing to do. We knew that with our next child we would have it at home.

Victoria started a discussion about birth with some neighbors where she learned of someone who had experienced a homebirth. "I had talked to a girl who lived next door to me, whose sister had her baby with a midwife. We had a night where we sat around and talked about childbirth. This was something new to me, but it was something that felt really good."

Sarah got both initial and critical exposure at just the moment when she was making important decisions regarding her upcoming birth.
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I had just gotten pregnant and I was working...as a teacher and I announced it to my work crew. One of my workmates there was actually studying to be a midwife. She said, “You know, you can just have your baby at home.” I had never really thought about it before.

In yet other cases, social contact was more casual, as in Hope’s experience with a store clerk.

[At a local natural foods store]...We were talking about having babies and she said, “Have you considered having a baby at home?” And I said, “No! Blake wouldn’t even consider that”...She told me about her “wonder midwife” that she really wanted me to check out....So I called her [the midwife] and immediately when I talked with her, I knew it was right.

It is worth mentioning that almost all of the cases of both initial and critical exposure that involved social network were with other women. Three of the women, however, mentioned that their introduction to homebirth was through men. Two pointed out that their husband had introduced them to the idea and one, Karma, mentioned that it was through her father-in-law.

My husband’s father was actually the first one who got me even thinking about midwives. I was talking with him once when he came out to visit, and I was saying that I didn’t know what to do with affording another baby. I asked, ‘What do you do if you just can’t afford it?’ He said, “Well, you have a midwife.”

Woman-Initiated Decision

The women’s movement is still struggling to figure out what to do with the homebirth movement as evidenced by no mention of midwives or homebirth at the National Organization for Women website (National Organization for Women, 2000). A certain concurrence with mainstream feminism is seen in the expression by these women that responsibility over reproduction is a woman’s unique domain. Women in this study believe that giving birth at home can be positive experience for the woman and for her marriage. When considering a shift from the pattern of traditional birth, women initiated
the move in 90 percent of the cases in this study. The husbands, for the most part, were supportive of homebirth with varying degrees of additional information needed to move them away from a dependence on technology and traditional health care providers in the technocratic birth model.

Ashley, committed to homebirth since before marriage, launched right into it with her fiancé. “I had always been interested [in homebirth], so I think we talked about it before we got married and then we talked about it in the beginning.”

Hope claims with certainty that “With my husband and I, the rule is, ‘Anything that Hope feels very strongly about, she can do.’”

Amanda, whose husband is fourteen years her senior, stated, “I always just decide and then tell my husband...I told my husband that that’s what I wanted to do. I asked him how he felt about it and he said, ‘It’s up to you.’ We prayed about it together, also.”

Melinda and her husband, who is a correction officer, typify the way the decision-making process proceeded for many of the couples. “It was definitely my journey, first of all, but my husband...was really open to the idea.”

Sarah, on the other hand, struggled a little because of the newness of the idea for her husband. “I came home and talked with him. He didn’t really understand what I meant, or where I was coming from.”

Similarly, Lisandra, initiated the discussion with great hope that her husband would agree that it was the right choice.

I was just praying, because I knew I couldn’t do it alone. It was scary. Nobody I knew personally had done it so that they could tell me all the ins and outs. I just felt a really peaceful feeling and I knew this was going to be all right. I felt really strongly about it, even though I didn’t feel like I had much support as far as my husband or family.
Joyce, although an outspoken advocate for homebirth with her five-week old son, said that her husband first introduced her to the idea of giving birth at home. “Probably the idea came from my husband. If he hadn’t mentioned it in the first place, I probably would have gone and done what everybody else does and stayed at the hospital.”

Likewise, Cecelia Stratton remembers “My husband wanted it before I did. When I finally decided OK, I’m going to do this, I was about six months along. I prayed about it. I said, ‘Heavenly Father, please help me to trust in the things that Thou hast given me that are natural.”

Prayer and Personal Revelation

Breaking free of a dominant cultural pattern, particularly one so endowed with symbolic importance, demands substantial effort and the capacity to defend the decision using commonly held symbolic language of the community. Almost every single woman specifically mentioned praying about her homebirth choice—either on her own or with her husband. Personal revelation, some form of divine manifestation of affirmation, was seen as the single most powerful reinforcement in the decision-making process—more powerful than comments from others and vastly more powerful than the media. There were also instances of the participants using intuitive language such as “felt good” or “seemed right” to describe positive feelings about their choice.

Compliance with the societal expectation, on the other hand, requires no explanation whatsoever. There were no instances where any of the women interviewed referred to praying about their hospital births, unless they were considering giving birth at home. Hannah describes that scenario plainly as she recounts her shift from a traditional birth to a homebirth.
We just assumed that it [a hospital birth] was the right thing to do. It never even occurred to us to pray about it. After a few less-than-ideal experiences with our doctor, we had an inkling that homebirth might be the right choice. So we prayed about it and it was clear what we needed to do...[Jeffrey] and I prayed about it for several days. We really wanted to make sure it was the right thing to do.

Prayer was also employed by a number of the women to feel secure about their selection of a birth attendant. Victoria recalls, “I prayed about who should be my midwife and I came up with [our midwife]. I felt really good about her.”

Briana, who was uncertain to begin with, describes how she sought spiritual reassurance. “We went to the temple and we prayed about it. We prayed about it really hard. We just had a real peaceful calm feeling about it. It was a lovely experience.”

Her confidence unmistakable, Hope stated that she relied on spiritual confirmation not on what other people said to make this important decision.

I felt that it was the right thing for us to do. If there were a problem with this, the Lord would let me know...We discussed this. I know, not just because I’m LDS, but because I’m a woman. I think if we put our trust too much in other people, whether it be a doctor or an expert of any kind, we could learn to mistrust that “still small voice.” And as far as I am concerned, I believe that the still small voice was enough peace that it didn’t matter to me what anyone said.

The empowerment of these women seems to begin with the decision to deliver at home, even though many described their new sense of strength and power as being a result of the birth. Ashley, only four months postpartum from her third homebirth, explained how she felt about relying on personal spiritual feelings to make a determination on something she deemed important.

It was nice to have inspiration be in charge. I liked praying about the decisions and then make up our minds...We felt like we were the basic stewards over our reproduction. Not that it didn’t mean that we might need help at times, but we felt like it was basically our duty to receive the inspiration.
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Lisandra, quiet spoken, yet confident, said, “I knew that prayers could be answered and Heavenly Father would let me know if that was the right path for me to be taking.”

Melinda, self-assured as she described her shift to homebirth: “When I first made my decision to have a homebirth, I prayed about it a lot. My belief is that if I’m supposed to have a baby at home I will know.”

Likewise, Stella, felt solid in her decision. “I felt confident about my choice. I felt that I had had an answer to a prayer.”

Brenda Bostwick, who has had both her children at home, expressed the peace that comes from “Having the assurance of the Spirit that Heavenly Father is OK with our decision—especially stepping away the way I did from my family and from tradition—having the assurance from the Spirit that everything is going to be all right.”

Marti Jacobs, who had three hospital births before trying to give birth at home, expressed the power she felt. “After we prayed and felt that everything was going to be OK, then why not? If you’ve gotten that spiritual confirmation that there’s not going to be anything dreadful, then it’s an act of faith.”

Studying Birth

A spiritual manifestation of the rightness of their choice was not the only factor. These women, to varying degrees, became students of the birth process, as they fortified themselves in reclaiming this sacred domain. The women in this study had an average of three years post-high school education. Eleven had completed a bachelor’s degree and six more were near completion. Education and learning is highly regarded in LDS culture; members are counseled to “seek ye out of the best books words of wisdom; seek
learning, even by *study* and also by *faith*” (Church of Jesus Christ of Latter-day Saints, 1981, p. 173, italics added). Each of these women explored the homebirth option through some level of independent study.

The issues of the availability, perceived credibility of pregnancy and birth information affected utilization. Although, not the preeminent factor in the decision-making process, almost all the women described accessing support materials of one type or another, both materials specific to homebirth and those which addressed pregnancy more generally. The women were selective in what they read or viewed and were thoughtful as to what degree of dependability they assigned the information. Their skepticism was validated by a recent assessment of childbirth advice books by Jane Pincus, longtime women’s health advocate. She observed that most books on childbirth, in spite of their attempt to encourage women to take control of their birth experience, “send their readers directly into the arms of the obstetric establishment” (2000, p. 210). Further Pincus (2000) makes the point that informing women should not automatically be equated to empowering women.

When asked, the homebirth mothers claimed to ignore or be only superficially aware of the state-produced public service announcements, *Baby Your Baby*, even though they were directed specifically to pregnant women. Sarah, who has a bachelor’s degree in finance, said, “As far as choosing my own birthing experience they didn’t really affect me.”

A mother of three, Bethany, in reflecting on her exposure to the frequently run public service announcements, said, “By the time I started paying attention to them [*Baby Your Baby*] I had already made my mind up. I didn’t believe what they said. Of course
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in my teen years, all the things like that [television images of birth], added up together, gave me a picture of what birth was.”

Karen, who has a degree in accounting, noted that she felt the overriding message was not helpful to women. “Turn yourself over to them [Baby Your Baby] and everything will be wonderful.”

Stella’s impression of the program [Baby Your Baby], both the public service announcements and the printed material they distribute, was that “They take away the idea of listening to your God-given intuition and knowledge of your body and your children.”

Much like the women in a recent study, they varied in degree of desire for additional knowledge about birth (Lazarus, 1997). Some consumed great amounts while others were satisfied with much less. Lazarus noted further that birth knowledge is more than just information about the physiological changes in the pregnant body or the growth of the fetus, it is also about how the health care system works and how to get the care you want. Framed in that way, the women in this study had great knowledge and also put it to use.

Some of the women used research to calm their anxieties. Karma, who had received substantial criticism for her decision had doubts along with her conviction

[The midwife] sent me all this information and I read it and I just ate it up. I couldn’t believe it. I kept looking into it and prayed about it. [I had thoughts like] How could I ever forgive myself if the baby died?...But with the more research I did, the more I realized homebirth was something I could handle.

Annica, prior to her first homebirth experience, remembers that she “went to the library and got as many books as I possibly could on the subject.”
After she started feeling that homebirth was the right choice but needed to deepen her knowledge, Amanda said, “I looked up so many things that I don’t even remember. I did need some validation that I wasn’t doing something completely nuts.”

Kristine, who has a degree in human development, indicated that study is a way for her to be fully independent. “I read a lot. I rely on what I can gain rather than what someone else is telling me. Studying it out for myself meant a lot to me.”

Hannah, whose mother gave birth at home, was like a number of the homebirth mothers when she said, “I think after I had made my choice I did a lot of reading to support my decision.”

Lisandra said she studied to fortify her decision. “Once I chose a midwife and visited with her, she had a library that I took books from... I read one called The Silent Knife, and there was one called Spiritual Midwifery that really helped me boost my choice. The way that they described the births was really neat. It got me excited.”

Joyce, who has nearly completed her bachelor’s degree, saw the study time as valuable for her marriage. “We did research together...then ultimately, we prayed about it.”

Many of the women could not remember the exact books they had read, but did recall feelings associated with them. They were quite measured in their responses and none mentioned being converted to the idea of homebirth by reading books alone.

One mother, Karma, remarked, “I read some old books and I can’t recall the names of them. Those didn’t do much to motivate me about homebirth. They were really hippie-like. All the pictures were women totally nude and their husbands were always bearded.”
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Amanda wanted to educate herself in order to make better maternal choices. "I feel like we have the responsibility to educate ourselves so that we can make responsible decisions. I feel like having my children at home was the way that I am able to have control over the birth."

The research reveals a varied combination of study and faith used by these women to inform their decision, with the spiritual component overriding the merely instructive, and the instructive being hierarchically arranged based on personally established criteria. Briana, who had her second homebirth just two weeks before being interviewed, points out the value of both. "Educating yourself is how you can feel confident. Then pray about it. You’ve got that resource that a lot of other people don’t know about."

Marital Consensus

With the unique Latter-day Saint doctrine of the family as an eternal unit (Church if Jesus Christ of Latter-day Saints, 1995), there is an essential component of marital consensus naturally embedded in a decision of this magnitude. Annica remembers being turned down flatly by her first husband when suggesting homebirth. "In my second marriage...I asked my husband, 'What about having this baby at home,' and he said, ‘Sure. Absolutely. Why not?’" She experienced the full continuum of the challenge of marital consensus, but found her marriage strengthened by being unified on this issue. "I am so grateful to be married to such a spiritual man who would be open to a homebirth."

Even though it was an appealing idea, Bethany explains how she almost changed her mind. "I came so close to saying that, ‘OK, I’ll do a homebirth next time.’ But she and her husband, Jesse, considered it carefully. "We kept reading and praying and
making little charts with the advantages and disadvantages....Through study and prayer, realizing they go together. By learning in our minds and also by what we were feeling in our hearts, we knew what to do.”

Hannah was aware of two LDS women who wanted to give birth at home, but because of a lack of marital consensus have not done so. “A friend of mine told me, ‘I wanted to do homebirth, but my husband was too scared, but I would have loved to do that.’ Another [friend] said, “I had a sister who delivered all her babies at home... and I would love to have all my babies at home, but my husband wants to have them in a hospital.’”

Some of the women needed to nudge their husbands along to a level of comfort and acceptance. Meredith Ellis, mother of three, had her first homebirth 12 weeks before being interviewed. She tells of the challenge of getting her husband to be open to the idea.

I found myself being more and more drawn to the idea of homebirth. I asked ladies at La Leche League about their homebirth experiences. I read more books and I became convinced that homebirth was what I wanted. My husband was another story. While he wasn’t violently opposed to homebirth, he just figured we had such a great birth experience in the hospital that why not do it again....Neither of us have ever regretted the decision to give birth at home. He glories in the knowledge that his hands were the first to touch our daughter.

Hope’s husband was anxious about the birth but had established a pattern of being generally cooperative with what she suggested in other areas.

Blake was worried about it a little, and then his brother gave him a blessing. In the blessing, he said, “Do not be afraid to accept the counsel of your wife.” And after that, he was totally at peace with that. There was not a worry for either one of us.
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Victoria, whose first birth was in the hospital because of her husband’s resistance, recalls the difference the second time she was pregnant. She sensed that he still was not totally committed to the idea of giving birth at home.

I said, “Look, I had a C-section. You think maybe I need to have a normal birth at the hospital to prove that I can give birth before having a homebirth?” And his response really surprised me. He said, “Victoria, you wanted a homebirth the first time and I told you ‘no.’ They gave you a C-section. I’m not going to do that again.”

Maintaining marital harmony was a serious concern for several of the women, producing a degree of anxiety over how to approach the issue. Lisandra expressed her apprehension over sharing her desire to deliver at home with her husband, even though she felt the decision was right. “It was the hardest for me to tell Don, because we usually make joint decisions, but that was a time when I knew this is what I needed to do. It was going to be just fine.”

Hannah had similar concerns since she was seven months pregnant and they had already made plans to give birth at the hospital.

When I finally made the decision I was kind of nervous and I took the phone into the other bedroom because I was a little afraid about what Jeffrey would think. He came in and gave me a hug and said, ‘Sounds like this is what you want to do. It sounds like the right thing to do.’ It made me feel really good, because I knew it was.

The easiest situations were those where the husband wanted what the wife saw as best for their situation or was already enthusiastic about homebirth. For Ashley, her husband’s attitude was always, “Whatever you want to do.’ I don’t think he had a really strong impression one way or another about birth.”

Karma knew that even though it was it was financial considerations that initially had them looking into homebirth, they both had to feel right about it. “My husband was
really open to the idea. He's a very open-minded person. With every idea I brought home, he would encourage me to research it. He was always there for me.”

Carla Crandall, a mother of two whose husband is an optician, was grateful when she brought the idea up and it went so well. “I proposed it to my husband. He commented that the idea sounded ‘cool’ because he remembered his grandfather talking about the home he was born in.”

Joyce, whose husband initiated their consideration of homebirth, knew they had to be unified in their decision.

He pretty much left it up to me. He didn’t want to pressure me into it and scare me off of the idea. He was really excited about the idea. If I asked him to look something up, then he would look it up. Otherwise, he would leave it up to me.

Dealing With Criticism of Homebirth

As described by these women, one of the most complex and frustrating aspects of choosing to deliver at home was facing criticism for their decision. Avoiding confrontation became one of the strategies undertaken by some during their pregnancy. Micah, a recent homebirth mother, said, “Some people I didn’t even tell because I knew what their opinion was.”

In some cases the criticism was merely insensitive, while in other cases it appeared deliberately unkind. More than three fourths of those in the study had delivered at least one child in the hospital before choosing to try homebirth, yet they made no mention of any criticism of their hospital births—even when things went badly. This seems to reinforce the position that the media-supported technocratic birth model is so entrenched in society that there is an automatic assumption of its selection. An option such as homebirth, widely available as recently as sixty years ago (DeVries & Barroso,
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1997), is no longer considered a rational or reasonable decision. Criticism ranged from mildly negative to strongly condemnatory with verbal comments to these women on their homebirth decision falling into seven categories of descriptors: 1) Brave; 2) Uninformed; 3) Archaic; 4) Indigent; 5) Misled; 6) Mentally unbalanced; and 7) Irresponsible.

Criticism: “You are brave.”

Many of the mothers interviewed were startled at the reactions to their decision from other women. It was common when they would reveal their plans to give birth at home that other women would comment on the homebirthing mother’s bravery or courage to do so. Although, it may not be considered particularly negative, the comment needs to be compared to what would normally be said to an expectant mother if she were describing the hospital where she planned to deliver. It is unlikely, based on the comments of these women that they would expect any reaction at all. Embedded in the comments regarding bravery is an unspoken assumption that the act of homebirth is highly unusual and represents adding a substantial degree of risk that would not be present if a hospital venue had been chosen.

Based on current research on homebirths in Great Britain, Holland and Switzerland (Remez, 1997), the data show that homebirth can be a safe option with outcomes as good or better than hospital births when dealing with healthy pregnancies (Remez, 1997). However, if acquaintances were making their judgment on potential danger to the mother and her unborn child based on out-of-hospital birth scenes portrayed in the media, then a perception of a high-risk situation would be understandable.

Hope remembers one response to her plans for having a completely unmedicated homebirth. “There was one guy that knew I was going to have the baby at home, and he
said, 'Oh, you’ll ask for something.' I said, 'I'm not even going to ask for a Tylenol.' And I didn’t. He was shocked that any woman could do that.”

Amanda, described reactions of her friends. “There were friends in the neighborhood that all thought I was brave....They were just glad it wasn’t them.”

Hannah, who had originally planned to give birth at the hospital, remembers some of the comments she received. ‘Are you sure you want to do this?’ or ‘You’re brave,’ or ‘Hospital birth is much better because if anything goes wrong there are doctors there and people to help out.”

Joyce recalled, “I’ve had a few simply describe that you can’t do it without the drugs, because it’s just way too hard. Others say I’m some kind of a pioneer, or courageous woman. I’d say most of them think it’s way too difficult to do it at home.”

Katrina, a homebirth mother of Norwegian heritage, “Because of giving birth at home, my husband’s family called me a ‘Viking woman.’”

Criticism: “You are uninformed.”

The women in this study had to sometimes endure the well-meaning but impolite attempts by some to provide them with the “facts” so that these mothers could make a truly “informed” choice.

Hope, in a casual conversation with a neighbor was told how important doctors are as if she were lacking sufficient information to make an informed decision.

The other day I went next door and I said, “I was thinking of having my baby underwater.” And he said, “I always wondered why you were going to have your baby at home. Why did you choose that?” I said, “Well, I didn’t want to be told what to do.” And he said, “Well, that’s what doctors are for. That’s why they go to school for years and years.”
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Hope went on further to recount an incident where friends tried to talk her out of her decision.

Once I’ve made up my mind, there’s nothing anybody can say. I was cornered by someone and they said, “Now, who’s your doctor? Where are you going to have the baby?” I was at a retreat, so I couldn’t get away that easily. One lady there was a nurse. I answered, “Well, I don’t have a doctor; I’m having the baby at home.” And they freaked out. They actively tried to get me to see it their way. They all told me how they would have died if they had not had the baby in the hospital.

Victoria shared the experience one of her homebirthing friends had when, in defense of homebirth, she reminded a member of her Mormon congregation, “Mary had her baby in a stable.” She was met with the response of, “Well, God gave us epidurals for a reason.”

Resistance from the medical community is understandable. Hope mentioned a dilemma she had with her physician who made it clear that he felt she was making the wrong choice. “He kept telling me it was my choice, but ‘don’t, don’t, don’t, don’t.’”

Criticism: “You are archaic.”

Much of the success of the biomedical model promoted through the media depends on the concept that progress is good and that current methods and practices are superior to what has been done in prior times. Behaviors such as homebirth seem anachronistic when compared to the media-supported model and often draw reactions from those who have not been exposed to the reality of other options.

Joyce faced criticism for making a choice that seemed out of step with modern American life. “People wanted to tell me it was unsafe and unsanitary. How could you possibly think of doing that any more? It’s archaic. No one does that any more.”
Hannah was confronted with a similar comment, just framed a little differently. “There was lady in my ward [LDS congregation] who said, “Oh, my aunt did a homebirth. She’s kind of a granola-type lady, though.’ And I thought, ‘I wonder what she thinks of me. Am I a granola?’”

Criticism: “You are indigent.”

The idea that a mother might be forced to do something to put her infant at risk due to economic circumstances conveys a poignant social dilemma in this society. It is a reality faced by women across America and across the world every day. However, to assume that these women who carefully selected homebirth after much study and prayer were putting their baby in harm’s way to save money is a tragic misinterpretation of their actions.

Lisandra cringed as she told the story of investigating homebirth due to financial considerations. She told how she had been drawn to the idea long before, but a lack of insurance nudged her into considering it more carefully. As a result of their situation, family members made some remarks. “Don’s sister said, ‘I hope he’s not making you do this because of money.’ I told her it was my choice….I think they were completely shocked.’

Stella, a 32 year-old homeschooling mother with four children, tells what happened at a family gathering. “A relative came up to me and said, ‘Those stupid people who think you can have babies at home! How dumb can you be? Only people without insurance do it!’ My husband walked up to me and said, ‘You’re having this baby at home, for sure.’”
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**Criticism: “You have been misled.”**

The critics in this case do not directly insult the homebirthing mother, except in questioning her ability to judge the character of those whom she trusts. They communicate to woman that the decision was made based on faulty information from other sources and that the information they had was more reliable. These comments often came from medical professionals in positions of authority.

Hope, when visiting with her obstetrician in order to have a back-up plan, recalls this interchange. “[My obstetrician] very much tried to dissuade me from going to [the midwife]....He very much said, “I don’t support [your midwife] here. I do not endorse her. I don’t think you should have your baby at home.”

Amanda remembers a specific confrontation with her obstetrician where she defended her decision. “I had a doctor tell me that he was not supportive of homebirths. He asked me why I felt like I should have the baby there. I told him that I prayed about it and the Lord told me this is where I could have my baby. It shut him right up.”

**Criticism: “You are mentally unbalanced.”**

The following comments communicate how deep the hegemony of traditional medicine is embedded in our society. It would be difficult to imagine the same tone of comments being levied at a woman for choosing to give birth in a hospital. These criticisms seem to communicate to the women in this study that their actions were perceived as outside normal parameters of behavior.

Victoria, preparing to give birth to another child at home, reflects on how the idea played out in her family. “My family, for the most part, has the standard hospital births with doctors making the decisions. I don’t really talk about childbirth with my sisters
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because I think that they think I'm really loopy.” Among her friends, she perceived about the same reaction. “People would ask me where I was having my baby…. ‘You’re not having your baby at [local hospital]?’ I would say, ‘No, in our apartment.’ Then they would say, ‘Oh, that’s interesting.’ That’s usually where it went. No one tried to talk me out of it; most people thought that was weird.”

When thinking about how the decision was received in her family, Amanda, reports, “My immediate family, they thought I was crazy, but they were supportive... We didn’t tell my husband’s mother. In fact, she still doesn’t know about our first homebirth. She would be very critical about it.”

Hope, a determined and confident woman, said, “Most people didn’t try to change our minds about it, they just thought we were nuts. And the doctor also tried to persuade me not to do it.”

Joyce said most of her friends reacted the same way. “They think I’m crazy for staying home for my birth. I’ve had a few that were intrigued with some of the research I have done on homebirth versus hospital births.”

Melinda is openly enthusiastic about homebirth and has additional credibility as a childbirth educator. Yet, she found, “my friend thinks I’m pretty crazy for having my babies at home. She may try a natural childbirth, but she’s for sure going to the hospital.”

Criticism: “You are irresponsible.”

Perhaps the most stinging of all, were the comments from friends and family that these women were somehow doing something particularly selfish or irresponsible. Many of these women reported facing condemnations that implied they were not considering what was in the best interest of their unborn child. Lazarus noted that in this culture “If a
woman does not do ‘everything’ (and that means availing herself of technological birth), the process is her individual responsibility and ultimately she must be blamed if she does not have the perfect birth” (1997, p. 135, parenthetical remark in original text).

The media image of the god-like doctor rescuing the mother and baby from some unforeseen life-threatening emergency belies the normalcy of most births. But those powerful images conveyed repeatedly to all members of society cast the midwife into the shadows of incompetency and homebirth into the realm of unacceptability. The decisions by these women, however well reasoned, were labeled as negligent, endangering and self-serving by those who made these comments.3

Joyce, faced the ultimate criticism. “One woman in particular was very critical, saying that I was going to kill myself and my baby and then I would have that guilt on my head.”

More subtly Melinda faced a similar message.

I was in the car with my two sisters-in-law and we were talking about me having my baby and I finally told them the news. It’s a good thing we didn’t get in a wreck, because both of their mouths practically dropped to the ground. They couldn’t believe I was having a baby at home. Both of their comments were, ‘I could never do that,’ [which] means ‘I couldn’t have a baby at home because I would never subject my baby to the possibility of dying.’ They thought that if you had a baby at a hospital everything was going to be fine.

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3 A recent tragic maternal death of a young homeschooling mother prompted a Brigham Young University faculty member to comment, “I’ll bet she was a homebirth mother. Check it out.” After several phone calls, it was discovered that the mother had delivered and died in a Salt Lake County hospital (Suzanne Smith, personal communication, April 2000). Her death was due to a rare but fatal conditional that cannot be pre-diagnosed. Her life would have likely ended regardless of the location of the birth. But the assumption by this professor was that a homeschooling mother was likely to be homebirthing mother and that somehow explained her tragic death.
Ashley had to deal with her husband’s mother who really questioned her decision. “We did have some [criticism]. My mother-in-law was sure my baby was going to die. That wasn’t enough to sway our confidence.”

Annica, trained as a massage therapist, said, “I had the most resistance from my mother... She was very upset. She thought I was being very selfish and being very ignorant and that I was willing to risk myself and my baby, to have this baby at home. In her mind, it was absolutely ridiculous and selfish on my part. At first I started rattling off statistics, like it was going to matter to her. And then ... a peace came over me that said to me ‘You need to do things that feel right in your heart.’

Even though she was trained to help other women labor well in the hospital or elsewhere, Melinda, faced opposition from her husband’s uncle who was an obstetrician. “He told people that he thought I was irresponsible and that I was doing a very bad thing. He was the type that practiced quite interventively and I remember him saying, ‘If your water breaks, you go immediately to the hospital.’”

The criticism came from all corners, both close family members, who had an interest in the well being of mother and child, as well as total strangers. Sarah describes her struggle.

Because of my upbringing, I knew that my family would be a little critical of my choice. It was kind of hard for me to go against what I had been trained to view... ‘Am I putting my child in danger by having the baby at home?’ ...It’s not an emergency-type of situation like it’s portrayed on TV and in the media. Actually, 95 percent of the people have births just fine. So that made me feel a lot better, but we prayed and fasted about it as a couple to make sure that we wouldn’t be putting out child at risk at all. We felt really secure in our decision.
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Amanda faced a particularly difficult situation giving birth to a congenitally deformed child who would not live. She remembers some of the responses following her experience.

There were people who gasped and looked at me thinking strange things. They didn’t know the circumstances though. But after they found out about everything, they were more understanding. I know there are people who thought my baby died because he was born at home. But I prayed about it, and I knew this was where I was supposed to have this child.

Precipitating Experiences

Since homebirth is not the culturally dominant pattern for expectant women, there generally needs to be some reason for shifting both birthing paradigm and practice. These women often cite a precipitating experience that pushed them into exploring the idea of giving birth at home. Some incidents were instantaneously life altering where others represented a more incremental shift. A unifying theme in these stories is the desire to regain control over the birth experience.

Being acknowledged as the expert on your own body as the birth processes surging within is empowering (Weaver, 1998). The converse is what Amanda experienced. She describes an incident in the hospital that moved her toward rethinking the traditional birth model.

It had a lot to do with my last experience at the hospital. Too many things happened to me. Specifically, I was in labor for hours and hours and they told me I wasn’t in labor. A nurse came in with a syringe full of morphine and injected me. Then after the fact told me that it was morphine, “You’re not in real labor. Come back in a few days when you are.” A couple of hours later I gave birth to my son. I was in real labor. He was asleep for a couple of days. I think the morphine had an effect on him. I decided that there was something about this that was not right. People can’t just do this stuff to me. I needed to have more control.
Hannah realized that she needed to reevaluate her decision to give birth in a hospital when her obstetrician discounted her birth plan.

The doctor told me that the birth plan I had so carefully written for him, was for my benefit only and that he might look at it, and the nurses might look at it, but it wasn’t something they were going to take seriously or even use; they were going to do whatever they wanted to. The birth plan, he said, was so that I could understand what I wanted. But if I wasn’t going to get what I wanted then why even write it out or give it to him?

Karma remembers her first hospital birth as a turning point in her life. The experience did not come close to what she had imagined and hoped for.

I had a horrible birth experience in the hospital with [our first baby]. The doctor came in to deliver me and he didn’t say a word to me. He didn’t even look at my face really. He just sat down and then the next morning, he came into me and said, “Did you get the license number of the truck that hit you last night?” And that was it.

I said, “Yeah, it was pretty rough.”
And he said, “Well, that’s really normal.” It wasn’t like I really wanted this great relationship with this doctor, but it was such a spiritual, neat experience, that I felt like he detracted from it.

And that wasn’t all. I really had wanted to go natural and granted I wasn’t that educated on the whole birth process as I am now. But when it started going and I had these cramps, there was no support whatsoever. It was like, “Well, why don’t you just go get an epidural?” After fourteen hours, the doctor came in and said, “I don’t see why you’re going through this. There’s no reason to have it naturally.” So I got an epidural and….I really wanted something else.

Stella, a mother of four, tells of an incident early in her marriage that influenced her birth choice years later.

My obstetrician...led me in that direction. My first pregnancy was a miscarriage at eleven weeks. I had gone in and I had seen him before. He told me that I’ll never have a vaginal birth. He said they would all be cesarean. So after I lost the baby, and got pregnant again, I read a book that said you can’t just judge a woman by the shape of her bones or hip size, fat or skinny. It has nothing to do with it. So I give him all the credit for steering me to homebirth.
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Before choosing to give birth at home, she had an experience where she felt that she had been under-informed by her medical provider when experiencing a pregnancy-related problem.

I went into pre-term labor. They had no reasons for it, but they shoved drugs down my throat. So I went ahead and did it...When they gave us the drugs, they didn’t tell us one of the [possible] complications of that drug is death for mother, baby or both. So when I found out about that, we prayed together and talked and researched more. All those together made us feel right about homebirth.

Appealing Aspects of Homebirth

Regaining Control of The Birth Experience

There seems to be a universal desire for a greater degree of control over the birth experience. Every one of the women in this study mentioned retaining control over some element of the birthing process as one of the most appealing aspects of homebirth. A recent study explored the satisfaction in childbirth experiences with women who felt they had control over what happened to them during a hospital birthing experience (McCrea & Wright, 1999). Another study addressed the difficulty that surrendering control to the laboring women represents to the health care provider as well as its importance to the laboring woman (Weaver, 1998). One study indicates that an important way that women exercise control over their birth experience is in their selection of a health care provider (Callister, 1994, 1995). Abbey, 43, who had her last two babies at home, said of her hospital experiences, “When I went to the hospital I felt I was putting myself in their hands and in their control.”

Both those who had previous hospital birth experiences, and those who had not, expressed the feeling that one attractive feature of homebirth was the ability to avoid the unpleasant and potentially dangerous aspects of a traditional birth. Part of this stems
from the fact that maternity care has been designed in large part for the ease and comfort of those who control the services, primarily men, rather than for the ease and comfort of those who will be most directly affected, exclusively women (Murphy-Black, 1995).

This underlying reality helps to explain this observation by Felicity: “In a hospital birth, I felt they would pressure me into what would be easiest for them, rather than what would be the best and healthiest for me or our baby....In a home birth, my husband I were in control.”

Many of the feelings expressed by the women seem to stem from the paradigmatic shift already mentioned (see Appendix E; Kitzinger, 1991, 2000). Once the model of homebirth is embraced, many of the policies and procedures of a traditional birth seem out of place and unacceptable. The loss of control upon entering the hospital domain was frequently cited as an unappealing aspect of traditional birthing practice. Those who had prior hospital experiences freely shared what they were seeking to avoid by giving birth at home.

Abbey, who gave birth at home for the first time at age 39, expressed her personal dissatisfaction with her four hospital births, as she described relinquishing control over the experience. “The way medicine has taken over and taken control of the whole thing—it becomes something we don’t want to participate in—we almost sit back and let them do what they need to do to get the baby out.”

Annica, in reflecting upon her first birth, said,

My hospital experience was one of feeling completely out of control. From the moment I stepped in, until I walked out of the door, I had no choice. It was my first baby. I was 20 years old. Yet, I had enough wherewithal to know in myself that what was taking place was not what should be happening to me and that this experience of bringing this baby into the world, could have been so much better,
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and I wanted control. We made our birth plan, gave it to the doctor, everything. That birth plan went out the door the minute I walked in there.

The homebirth mothers, when given a chance to be introspective, found the empowering climate of homebirth far more acceptable. Hope commented, “When I realized that I was in control, enormous doors of power opened up. It was wonderful....I realized that the husband’s not the coach. The doctor’s not the coach or the team owner either. I am the coach. I am the team captain.”

The areas over which these women wanted to have control were: 1) health decisions; 2) comfort measures; 3) physical environment; 4) access to baby; and 5) spiritual environment.

**Control of health decisions.**

Understanding exactly what is going on and being an active participant in the process was one of the key elements mentioned by several women. Ownership of the experience and their own body was crucial. Annica spoke for many when she said, “It was my body, my baby, my birth and I wanted it my way. So, when I had the opportunity to have a homebirth, I did.”

Ashley, who had delivered at home only four months prior, stated, “I’m in control. I decide how I want things to be and who I want to be there and what I want done to me. I really like the freedom of thought I had.”

So disturbed by the rejection of her birth plan by her obstetrician, Hannah went to a midwife and explained the situation to her. “I told her about the way [the doctor] had responded to my birth plan....Having her say, ‘There’s a better way,’ really calmed me down and made me feel a lot better.”
Lisandra expressed the feeling that she wanted more than her hospital experience provided. “Just being able to have control and feel like I’m doing something. I didn’t want to feel like the doctor comes and takes the baby away. I wanted to be involved in the whole experience.”

Rachel, who had two hospital births before her homebirth, compared her two types of experience and observed, “[Homebirth] felt more relaxed and normal...I recouped much faster, rested better, and felt more at ease because I was in my own home.”

Carla, who has a degree in English had her first birth at home this year. She looked back at her hospital birth and expressed a high degree of discontent by comparing the two experiences.

The attitude of conventional medicine is that birth is an illness that must be medicated and fixed so things will go correctly. My hospital birth was much more painful and frustrating. I felt in a whirlwind—and once they hooked up the I.V. for the inducement, I had no more control over my body or my baby.

Hope told her midwife, “Here’s the deal; you do what I say.” And she said, “Yes, ma’am.” And that was the whole deal. I told her I would listen to her advice and respect her counsel....but I would not do what she said. And she said, “Good. Good. That’s what I want. This is your baby.”

Control of comfort measures.

Since these women had already decided on unmedicated births, being able to control comfort measures was important. The rigidity of hospital procedures was sometimes mentioned as a contrast to the fluidity of the homebirth experience. Kristine said of one of her hospital births, “I didn’t feel like I was in control of the situation. I felt like everybody else—the hospital, the doctor—were in control. They were doing things to me that I agreed to but didn’t feel in control of.”
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Hope, explained the value of writing down some of her expectations. “On the birth plan, I wrote some things down that I wanted Blake to say to me. I told him there was a point where I feel shocked at how painful it is and that that is totally normal. I asked him to keep reminding me. He did. He kept reminding me.”

Ashley remembers,

For this birth, sitting on the edge of the couch with my knees wide apart seemed perfect. My second birth, I just marched through the house. All I wanted to do until I was ready to deliver was walk around the house. But this time I didn’t want to walk; I wanted to sit on the couch.

Being at home was one of the most important comfort measures of all. Stella remembers, “The comfort was appealing. You could be in your own bed. I don’t sleep well in hospitals.”

Lisandra also recalls the appeal of controlling comfort measures in her own way.

At home it was familiar and it’s different than being at a hospital in their little gown and strangers coming in to check on you. I felt so much better being at home. It helped me to deal with the pain a lot better. I felt like it was progress and not pain.

Control of physical environment.

Physical environment included everything that contributed to the overall atmosphere and setting for the birth. Some of the women went to great lengths to make the surroundings special by including candles, music, birthing tub, special friends and/or family members, while others were especially comfortable with their home in its normal and undisturbed state. Recent research has explored the process of how couples assume control through the construction of their home birth environment (Morrison, Hauck, Percival & McMurray, 1998; Lanier, 1995). Amanda, who is preparing to give birth at
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home again, mentioned, "I liked being able to choose where I had my baby. I liked being able to have who I wanted to have at the birth."

Felicity mirrored those feelings when she observed, "I could move around in a safe and comfortable environment with people I knew and trusted....I wanted a setting that was peaceful and calm, instead of loud and frightening."

Hannah, as she tried planning a hospital birth with a homelike feeling finally came to the realization that home was where she wanted to give birth.

I wanted it to be in my environment with surroundings that I chose and people that I chose. I wanted to do things whenever I wanted to do them. When I started thinking about the things I wanted to bring to the hospital....I thought, "Well, why don't I do this at home?"

Reflecting on her homebirth experience, Hannah observed,

When I had my baby at home, I wore whatever I wanted to, which was nothing! Another thing I have noticed about hospital births on TV is that they are talking a lot and when I was in labor, I didn't want anyone talking or any sound, and a laugh track would have been the last thing I wanted. Also, that chanting "Push! Push!" is something you hear a lot on television. That wasn't something I heard in homebirth. I was given instructions, rather than shouted at.

Sarah, a first-time mother, reported "They [the midwives] were all there for me. It was the kind of environment that I had always wanted. It wasn't cold and hard and rush, rush, rush. I was able to do it at my own speed and whatever was most comfortable."

Kristine, who had two previous hospital births, recalls her home birth experience in the warmest of terms. "It was so calm and the lights were dim. They whispered to each other and they talked to me. I appreciated the softness and tenderness they had. It was so nice."
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Control of access to baby.

Control over what happens to their babies once they are born is of high concern for the women in this study. The media has had an impact on all birthing women with the broadcast of numerous stories of babies being switched at birth or being kidnapped from the hospital. New hospital procedures, reported in the media (Lombardi, 1998), underscore the perception of risk. Additionally, the traditional model of the infant being taken from the mother and placed in the hospital nursery for the family to view through a large glass window is still present in the media but is incompatible with the homebirth model and is not an accurate reflection of current practice in many medical facilities.

These women express deep feelings about not being separated from their newborns. Some of them have had previous negative experiences, while others simply do not want to have to face the possibility. Amanda mentioned,

I loved the fact that they didn’t take my baby from me...to put it in the nursery. That’s the most unnatural thing in the world, to have your child taken from you. We were just watching, last night, the video of Murphy Brown having her baby. People came to visit her and then the nurse brought in the baby. My four-year-old said, “Why did they take that baby away?....That’s not right. That’s not nice of them to take that baby away.”....My oldest [her first child, who was born in a hospital] was gone for a few hours because they had to do tests....It was four hours before I got her back. It’s not nice and it’s not right. My daughter said, “That’s why you have babies at home.” Yes it is.

As she told this story, you could hear an edge in Melinda’s voice:

My first baby was taken away from me afterward....they wouldn’t bring him to me....I was really upset. I wanted my baby. They said, “Sorry, we don’t have any plans to bring him to you right now.” I was furious. I got out of bed and the nursery was, I swear, a mile away from where the moms were. It was this huge military hospital....The nurses were staring at me. They couldn’t believe that I was walking. I went down there and got my baby....The most horrible things of all was when I walked into the nursery and didn’t know which one was my baby. Someone had to tell me. That was the most horrible feeling.
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Brenda, born in Germany, echoed a similar sentiment when she said, “The image of rows of babies in a nursery seems to inhumane to me. I want to have my baby.”

Teresa, who gave birth to her first child at home and is expecting her second, just reveled in being able to be with her baby. “The thing I liked about home birth was having my baby right after she was delivered. In the hospital they take it away and they put it in a place where you can’t see the baby. I held her [daughter born at home] for two hours.”

Control of spiritual environment.

Having control over the spiritual environment of a hospital room is difficult at best, and impossible according to some of these women. It was mentioned by many that creating a spiritually supportive environment for the birthing mother is essential. These women also considered the spiritual well being of the father, siblings, newborn and midwife. Control over the spiritual elements of the birth included feeling free to pray, discuss birth within a spiritual framework, and receive priesthood blessings for strength, healing and encouragement. Planning ahead for the spiritual elements of the birth created a sense of control, manageability and support and most participants expressed that could best be accomplished in the home.

Annica observed,

In the church we are taught doctrines of family and how important it is and why not start those very first moments of life in your actually home with the people you love and care about the most? Your first experience as a human mortal being—the whole thing is so spiritual—why not have it at home?

Hannah was so pleased to find a midwife who, though not LDS, understood her spiritual longings. “[Our midwife] wanted to get to know Jeffrey and I and wanted our
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birth to be a spiritual experience for us. She wanted it to be the kind of experience that we wanted it to be and not what she wanted it to be.”

Ashley, sought out a birth attendant with compatible spirituality.

We’ve always had LDS midwives, who encouraged us in those ways [spiritually]. They encouraged us to be prayerful and to get a blessing. My first two children were breech for a time and the midwife always had my husband give me a blessing and try to kind of communicate with the baby. We let the baby know that we would strive to teach them the gospel and let them know that they were coming to a home that loved the Lord. It made such a difference. The first baby turned right away when we did the blessing.

Hannah described the freedom she felt at the birth to behave in spiritual ways and the importance of the spiritual focus she was able to maintain.

We prayed with her [midwife] when her assistant came over and she talked about that a few times during labor. She prayed after labor when we had one complication, and it really helped me to see that God was an important part. I trusted in my body.

Teresa likewise felt the freedom to respond spiritually without hesitation. “My husband was able to freely give me a priesthood blessing during the labor....You could feel the spirit. It’s not being hindered by other things. I never felt the spirit in the hospital. It’s possible, you can, but I haven’t yet.”

Ashley indicated a comfort from knowing the midwives had a respect for spiritual things:

The midwives themselves have generally asked their husbands for a blessing as they leave for each birth. On the first birth, the midwife was told in the blessing that angels would attend her and she knew right there that she was in trouble, because she had never been told that before. It was a long and difficult birth.

Annica, whose first child was born in a hospital, acknowledged the intrinsically spiritual experience of giving birth and mentioned that she felt that would be enhanced by
having the birth at home. “Giving birth to my son, I realized how spiritual of an experience this was. I wanted more of a spiritual experience.”

Amanda was faced with a remarkable dilemma late in her pregnancy, where the spiritual focus of her birth became the single most important issue.

I went in for an ultra-sound at 36 weeks, because my baby was breech. My midwife just wanted to know if there was a reason we couldn’t do a version [turning the baby in utero] on the baby so that he could be born head first instead. At the ultra-sound, we found out that my son had so many deformities, that he would probably not live.

It was a hard decision for me to make, as to where to have this child. At first I thought, “I don’t know if I want to have this baby at home. Why go through all that pain, when I know what the outcome is.” That was a pretty hard decision.

When I prayed about it, I realized that I wanted to be at home when it happened. I didn’t want my child to belong to the hospital. I didn’t want my only memories of this child to be at some other place. I wanted it to be with me and with my family….He had only two chambers of his heart developed. He was not going to live whether I had him at home or in the hospital… I went ahead with the homebirth. It was difficult, but I know that I was very blessed during the whole pregnancy.

I know that birth process itself was a great blessing to me, because my labor was…short, considering he was a double footling breech.

It was a good experience, though. When it came down to pushing, I had a very difficult time, because I knew as soon as he was born, that he was going to be dying. So I kind of had a hard time with that. I was struggling with that until we let physical things take over, and then I couldn’t help but push him out. I was so happy to have him at home.

He lived for one hour and two minutes. That whole time, he was at my home. He was with me. Nobody took him away from me to weigh him or measure him or check on him. They just left him with me and let me hold him until he passed away….It was a very spiritual experience to have him there and to have him pass away at home, too.

When he died, my husband was holding him. I thought that was very appropriate. He went from his father’s arms into his Heavenly Father’s arms. That was the way it needed to be.

**Woman-to-Woman Care**

Female midwives attended all the homebirths except one in this study. That birth was attended by a prominent Illinois family physician, Gregory White, who had
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established a homebirth practice. Many of the women describe the value of developing a relationship with a female care provider who was more inclined to establish a peer relationship than a hierarchical one (Davis-Floyd, 1992; Freedman, 1999; Kitzinger, 2000; 1991; Pincus, 1999). Sometimes the women framed the distinction between the two types of care by describing a negative incident they had experienced with a male doctor or obstetrician. Portrayals in the media focus on hierarchical power structure, even if the medical practitioner in the story is a female. Homebirth relies on a shared knowledge, cooperative behaviors and a common holistic view of birth developed during the prenatal period (Davis-Floyd, 1992).

Both those who had previous hospital birth experiences and those who had only homebirths, expressed the opinion that one benefit of homebirth was the ability to avoid what they perceived to be the unpleasant aspects of a traditional birth. Part of this stems from the fact that maternity care has been designed in large part for the ease and comfort of those who control the services, primarily men, rather than for the ease and comfort of those who will be most directly affected, exclusively women (Murphy-Black, 1995).

For these women, finding a health care provider that matched their orientation, philosophy and care needs led them to a midwife. Locating someone they felt comfortable with enhanced the positive experience of birth and increased their descriptions of contentment. This is similar to other research that discovered positive feelings about childbirth stemmed from using a health care provider with similar attitudes (Callister, 1994).

Many of the complex feelings originate with the paradigmatic shift already mentioned (see Appendix E; Kitzinger, 1991; 2000). Once the model of homebirth is
embraced, many of the policies and procedures seem out of place and unacceptable or if homebirth is being considered these issues can become precipitating events. Those who had prior hospital or doctor experiences freely share what they now were seeking to avoid.

Hannah, who had no intention to give birth at home initially, remembers a disagreeable contact with her obstetrician which gave her real doubts about the traditional medical system being able to provide the idealized birth she imagined. “He did an internal ultra-sound. They stick something up you, but they have to put a condom on it first, and the doctor said that was to keep me from getting a ‘computer virus.’”

Natalie complained, “When I went to my first appointment he [doctor] was basically asleep in the chair.”

Micah recalls an upsetting dialogue with her doctor in the hospital. “He said, ‘It’s a good thing you had your baby on time or we would have had to call another doctor. You’re a very efficient laborer.’ What’s that supposed to mean? Who cares?”

Melinda, in thinking back on her experience with a military hospital, compared her feelings about the two different types of care.

The prenatal care I got in the hospital frustrated me because I always saw a different person...I did not like that at all, because every single time I went in, I had somebody I was just meeting for the first time having their hands on my body....Homebirth sounded so appealing because I would have the same person that would sit there and speak with me and listen to my fears and concerns for more than five minutes. When she touched my body, her hands would be warm and I would know and trust her.

Lisandra thinks back rather sadly on the birth experiences her mother described

My mother talked a lot about the doctors putting her in a room and giving her a local or something, and she just sat there, while women around her were screaming. She said it helped a lot to not think about what she was going through. She seemed really alone. It kind of made me sad. I didn’t understand why no one
was there supporting her. I knew that I wanted to be supported and have people around me.

Some of these women had as many as four hospital births, before selecting to deliver at home. In looking back on the transitional period, they could immediately identify important differences. Victoria saw the issue as plain and simple. “I figured out that childbirth is something a woman is supposed to do. It makes so much more sense to have a woman working with you, than it does to have a [male] doctor.”

Ashley described feeling an immediate bond with her midwife.

She was willing to spend as much time as I needed. I felt so known, individually. Even though we were only together for a month and half, I felt like we just go to know each other so well. I felt like she was one of my best friends. She was so interested in me personally and in all my health issues and questions.

It was a series of frustrating situations that brought Hannah to finally choose homebirth. After her first visit with her midwife she claims her attitude changed immediately.

When I started seeing [the midwife] it was like finally someone cared about how I felt about the experience. She spent a lot of time with us. Every time she visited with us she would come in and sit down and we would all get comfortable and just talk and she would stay for sometimes two hours just talking with us...It was so nice not to feel rushed and to feel like Jeffery and I and the baby were the most important people in the world to her and that she really cared about what we wanted.

Joyce recalls when she went into active labor both the midwife and her assistant came over. It became a wonderful session for woman-to-woman connections and support.

Both of them stayed the entire time. They were there hanging out. I think we fed them dinner. It was pretty fun and very relaxed most of the time. It was very easy going....My mother and mother-in-law were both there. They all did their little tricks and pressure points. It was fun.
A feeling of abandonment sometimes accompanied these women’s descriptions of hospital experiences. Homebirth and midwifery care focus on touching and support. Victoria recalled, “If their hands were on me as the contraction began, it made me feel connected to the room and the earth. I felt taken care of.”

Continuity of care throughout pregnancy, labor and delivery was frequently mentioned as a benefit of midwifery care. Recent studies support the idea that the stability and individualized attention typically received through midwifery care leads to higher levels of satisfaction (Wagner, 1996) and increased ability to manage pain (McCrea & Wright, 1999). Hannah remembers realizing that that she knew “that [her midwife] would be there for the entire labor and delivery and that she wasn’t just going to come in ‘Wow, look what’s happening. Ooh look—the baby’s coming out, all right.’”

Melinda, who had experienced long labors, was looking forward to being “surrounded by people that can support me, that will stay awake, and not change shift.”

Normalcy of Birth

Once these women released themselves from viewing birth from a biomedical or pathological perspective, they tended to accept the view that pregnancy, labor and birth were perfectly normal, healthy states of being. Because they interfaced with many who did not hold this point-of-view it created interesting moments. Ashley, who has given birth to all three of her children at home, remembers that,

The whole neighborhood knew I was in labor. The Relief Society [LDS women’s organization] presidency came over and visited me. One of them said, “Wow, it’s so neat to see someone doing a real contraction. I’ve only had a C-section. I’ve never seen this before.” It wasn’t really that neat, I was just sitting there.

Joyce expressed confidence in her body and the process when she said, “I feel that God made our bodies to do things naturally. He gave us the power to do them. He would
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not make us faulty in any way. He would not create us in a way that we couldn’t do it on
our own if necessary.”

Karma observed that everyone seemed to have a horrible labor story because of
some hospital interference. “It seemed so wrong to me. It couldn’t be the ways that the
pioneers did it. How did they ever survive?”

Melinda stated, “I believe that God created our bodies to have babies and that a
lot of the complications that happen go wrong because of doctor-caused things.”

Victoria expressed her opinion on the rightness and naturalness of women giving
birth.

Woman knows how to do this. She knows how to give birth; her body is designed
to give birth. I wasn’t going to be encumbered by some authority figure telling
me how to do it, or treating me a certain way. It was a passive role and I didn’t
like that passive role. I didn’t like the idea of someone coming in to do
something to me when my body is supposed to do it anyway.

In contrast to the emergency-orientation of the media, Katrina explains, “I think
of birth as such a natural process. It’s an everyday experience, not a crisis.”

Lower Cost of Birth

With fees of the hospital, obstetrician, pediatrician and anesthesiologist edging
upwards and many insurance plans not covering maternity care completely, the reduced
cost of choosing midwifery care is appealing to many families. There did not seem to be
any couple that selected homebirth solely on that condition. There were those, however,
who felt uncomfortable with answering to critics who criticized them for endangering
their unborn child for financial reasons.

Karma revealed, “Money was a factor, because we had such a hard time paying
for [our first baby]...we didn’t want to go with welfare or on Medicaid.”
Hope was elated when she discovered that giving birth at home would cost about $6,000 dollars less than at a hospital.

So I came home and said, Blake, I’m thinking about having the baby at home.” And he just went white. But then I showed him the numbers and he said, “We can think about that.” So originally, it was the price that got me interested.

Many families found themselves expecting a child without having maternity coverage, which initiated an immediate reappraisal of their plans. Lisandra recalled what it was like to not be able to afford traditional obstetric care. “It happened because Don is self-employed and our insurance stopped carrying maternity. So I started looking into my options...My husband told me not to look at money, but I still wanted to see what my options were.”

Sarah became pregnant while she and her husband were both students. Her experience reflects the importance of the economic issue but also how it did not override her other feelings about having a desirable birth experience.

To be truthful, part of it that was attractive to me was the aspect of money. Because I am a college student, money is very tight and it is much cheaper to do a homebirth than at a hospital. That was an aspect. But I don’t think I would have considered it, unless I was already attracted to the idea of going natural.

Congruent With Religious Beliefs

These women all expressed deep commitment to their LDS religious beliefs. All but one grew up in a Latter-day Saint home where they actively participated in the church during their childhood and adolescent years. The one participant who was a convert, joined the LDS church as an adult after she had married for a second time. The women who were interviewed in their homes had numerous indications throughout their homes of their religious convictions. There were pictures of Jesus, temples, church leaders, biblical and other religious scenes as well as quotes of a sacred nature. Also, present and
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visible in many of the rooms were copies of sacred texts, hymnals, church publications, and workbooks and manuals for various church-related classes. Their devotion to Mormon principle and practice seemed evident and apparently gave them the strength to take a different path from the traditional birth.

Although these women describe freely how the act of homebirth fits neatly with their spiritual beliefs, homebirth at one point twenty years ago came under some criticism by respected members of the LDS Church, particularly in the health care field (Bates, et al., 1981). None of the women mentioned any conflict between homebirth and doctrine of the LDS Church; rather they referred to supportive teachings.

When asked how their personal religious feelings related to the choice to give birth at home, the answers were varied, showing what they considered sacred and

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4 Occasionally the arguments against homebirth mentioned to these women were reiterations of opinions gleaned from both broadcast and print media sources. In 1981, the official monthly publication to adult members of the LDS Church, the *Ensign*, published a statement on homebirth. The 300-word essay was part of a larger article on staying healthy. The article, written by leading LDS health care practitioners, led members to believe that the infant mortality rate for homebirth was twice that of hospital-born infants, that maternal risks during homebirth were high, and that pregnancy is a medical condition that should be managed by medical personnel in a hospital (Bates, et al., 1981). It is likely, because of the credibility of the publication that these comments were repeated as official statements of the church, which they were not; and because the answer was in harmony with other media messages regarding birth, it was probably not questioned by most readers.

Three months later, in the “Comment” section of the magazine, three letters responded to the material in the original article. One from a practicing midwife, one from a faculty member of the University of Utah certified nurse-midwifery program of the College of Nursing, and one from a researcher whose work had been cited in the article (Foster, 1981; Miller, 1981; Webster, 1981). Each took issue with the content of the article. As is the case with most publications, it is far more likely that people saw and read the original material then any response in subsequent issues. It is possible that the underlying positions that informed the article are still being quoted today although there was no specific evidence indicating that negative opinions among Church members regarding homebirth were connected to that original article.
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religiously significant. Joyce mentioned, “Eve didn’t have a doctor when she gave birth to her children. I felt that He taught her how to do things. I think you could call her the first midwife, as well as the first mother.”

Amanda, expecting her seventh child, declared,

I feel like the greatest responsibility I have is being a mother. I feel like part of being a good mother is to bring my children into the world in the best possible way and in the best possible atmosphere. The homebirths I have had have been such spiritual experiences, as opposed to what I had in the hospital....Motherhood is the most important calling I have. Nothing is as important as my children are.

Overcoming the images of birth in the media was easy for Hope once she gave it consideration. She was the only respondent who actually quoted an LDS Church leader or a passage of scripture, although all referenced religious beliefs.

Everything that I do with my health relates to my religious beliefs. I believe that the Lord gave us herbs. Brigham Young wrote, “If you are sick, live by faith and let the surgeon’s medicine alone if you want to live, using only such herbs and mild foods as are at your disposal.” And in the Doctrine and Covenants, it says, “Whosoever among you are sick and have not faith to be healed, but believe shall be nourished with all tenderness with herbs and mild food, and that not by the hand of an enemy.”

Hope states an activist position that seems to be the result of her change in paradigm in how she views herself and her reliance on health care providers.

God’s medicine was not designed to profit the powerful at the expense of the sick or weak. God is an unchangeable being, therefore, his medicine is like his gospel; it’s free. And as with the gospel, it costs no money, but rather dedicated personal study, sincere prayer and hard work. God’s medicine is grown in nature and in home gardens and is prepared in warm cheerful kitchens by moms who love their families. The earth itself and the Spirit of God bear witness of this beautiful and simple truth.

Ashley, said, “I felt like homebirth was the way we could make our decisions through prayer and blessings. They’ve always been such a part of our births.”
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Victoria used her religious beliefs to modify how she viewed the birth experience.

I see childbirth as an extremely spiritual event, and it’s very sacred to be bringing a child into the world. I feel as though our spirits were birthed. So it makes sense to me that the process of giving birth is there for a reason. You can be aware of that reason when you’re at the hospital—it’s just a lot harder.
Chapter 5: Discussion

Theoretical Explanation of Findings

This study documents ethnographically the complex process involved for Mormon women who choose and carry out a homebirth in a culture that supports a different specifically prescribed birth practice (Davis-Floyd & Sargent, 1997). The standard birthing practice in American culture—which is consistently portrayed in the media and clearly identified by the women in this study—relies upon technology, centralized birthing locations, trained medical specialists, interventionist strategies and includes a view of birthing women as incapable of successfully giving birth outside of the biomedical model.

The characteristics of the researcher provided both important insights and possible biases during the process of research and analysis. As both an active Latter-day Saint and a mother who chose to give birth to the last three of her five children at home, the researcher had experiences and beliefs in common with the participants. These were revealed to participants prior to the interview, which proved to assist in establishing an immediate rapport and may have enhanced the quality of the raw data.

The self-selecting LDS homebirth mothers interviewed expressed enthusiasm for the project and their comments evidenced support for homebirth as a birth choice. There were no participants who described a predominantly negative home birth experience. Of those who had given birth at home more than once they detailed the elements of each
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birth experience they found significant, difficult or enjoyable. Effort was made on the part of the researcher to gather sufficient data to create an honest picture of the experience these women had in the process of choosing and carrying out a homebirth.

Not included in this study is the Certified Nurse Midwife (CNM) whose training is within the paradigm of the traditional medical community but whose philosophical orientation may reflect some of the beliefs of the homebirth perspective and could represent an acceptable birth practice compromise under some conditions. Two of the women in the study used a CNM in a birthing center after having given birth at home. Questions were posed in a post-interview setting to determine reasoning for the choice, which may be seen as a reasonable one along a continuum of birth care options.

Through the narratives of the Mormon homebirthing women in this study, evidence is presented that suggests limited but significant media effects on three levels. First, to varying degrees these women express that they feel they have been affected by the media images of pregnancy, labor and birth and indicate that some birth decisions and some of their expectations of the birth experience may have been influenced by media messages. Second, the women, through telling their pregnancy and birth stories, reveal attitudes that match the biomedical model of birth, the prevalent model in the media, during the time prior to giving birth at home. They further express the challenge in overcoming media images and messages to shift individually and as a couple to a different birth paradigm and practice. Third, the women describe criticism from others who challenged their homebirth decision by citing reasoning consistent with the birth model communicated through mass media. These effects are consistent with the mass communications theories of both Gerbner and Bandura mentioned earlier.
Gerbner’s Cultivation Theory addresses the potential impact of accumulated images over many years of homogenized representation in television. Media-created birth scenes seem to have a number of elements repeatedly portrayed as described from the memories of these women and the research of Elson (1997b). The impact of those images may have been multiplied consistent with Gerbner’s concept of “resonance,” where personal experiences that mirror the media image seem to provide validation and confirmation, whether or not the images are accurate (Gerbner & Gross, 1976; Gerbner, Gross, Morgan, & Signorelli, 1994). The women spoke of being told birth “horror stories” by friends. These stories explained the dire outcomes a birth mother would have experienced had she not been in the hospital surrounded by technicians and technology. Resonance (Gerbner, Gross, Morgan & Signorelli, 1994) helps to explain some of the amplification of the original media effect, a multiplying of the media message through personal or near-personal experience. This may also point to a partial explanation of the difficulty in overcoming the accumulated images that have been validated through some degree of individual experience.

Bandura’s Social Cognitive Theory of Mass Communication (1994) explains the vicarious pre-experiencing of birth by women through using media images for symbolic modeling. This was supported by what many of the women reported about their personal expectations regarding birth prior to their first actual experience. For example, most of them had serious doubts about their ability to handle the pain associated with childbirth. Since all but two of the women in the study had never been present at the birth of a child prior to their own first birth, one of their primary exposures to the process would have been vicariously through media versions of birth. His theory also contributes
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understanding of the ability of these women to override the predominant message of acceptable birth practice through specific cognitive efforts (Bandura, 1994). These women expressed how they actively selected a birth choice that differed from what they had seen in the media.

The data from the women in this study present an opportunity to reassess the dichotomous framing of active and passive media audience (McQuail, 1994; Stout, 1996). The comments of these homebirthing women reveal characteristics of passive audience by both showing and expressing influence by media messages received over a lifetime. While at the same time they describe actions and attitudes that would place them squarely in the camp of active audience, such as talking back to the television or not attending to offensive messages. This may further the discussion of the division and whether the constructs of active and passive actually contribute to an understanding of media effects.

Birth As a Sacred Domain

In many cultures birth is viewed as an event or rite of passage, imbued with deeply spiritual and sacred overtones. These can be grounded in specific religious beliefs or the result of personal transcendent spiritual experiences (Callister, Seminic, & Foster, 1999; Callister, Vehvilainen-Julkunen, Lauri, in press; Klassen, 1997). In America in the 20th century, childbirth has experienced dramatic changes in authoritative knowledge, conceptual orientation, and cultural practice. Kitzinger, in an assessment of motherhood in Western culture lamented the status of birth.

In achieving the depersonalization of childbirth and at the same time solving the problem of pain, our society may have lost more than it has gained. We are left with the physical husk; the transcending significance has been drained away (1978, p. 133).
Movement from midwifery to obstetric care, increased dependence upon an array of technological and pharmacological interventions, and shifting from home to an institutional setting may have served to remove the birth experience from its spiritual context for many women. From a variety of perspectives and life experiences, the LDS women in this study intentionally repositioned themselves to embrace a birth practice which is culturally viewed as anachronistic and exceptionally risky to mother and baby.

These LDS homebirth mothers defy fitting into a single homogenous category. It would be incorrect to explain these women as a subculture anomaly as their reasoning and motivation for choosing homebirth are definitely mainstream within the LDS culture, even though their conclusion is not.

In their own voices, these women describe their experience with media-created birth scenes, their subsequent expectations of the birth experience, and their journey toward giving birth at home with a midwife. They explain the challenges of making a decision that runs counter to both the norms of the ambient culture and the images they and their social network have been exposed to regarding birth. Although it is estimated that homebirth represents only about one percent of Latter-day Saint birth in the United States, it is reasonable to imagine that homebirth and other alternative birth choices could increase in both availability and usage if the media treated diverse birth options in a more positive fashion, depicting empowered healthy women giving birth in a variety of settings.

The concept of reclaiming a sacred domain may appear to assume that birth practice is a domain the women in this study had once dominated and controlled. The perspective here is not individualistic but historical in nature, in other words reclaiming
that which was incrementally lost over the course of several generations (Davis-Floyd, 1992; Davis-Floyd & Sargent, 1997; Donnison, 1988). The concept as it applies to birth has been defined to some degree by a prominent midwife, Ina Mae Gaskin, when she wrote, “Sacred space isn’t so much physical space, although it may be, it’s the emotional and spiritual space” (Chester, 1997, p. 133). The women in this study, the majority of whom had given birth in both an institutional and a home setting, described most successfully finding this sacred space by delivering at home.

Reclaiming this sacred domain, reclaiming the control of the birthing experience, necessitates taking several steps, all of which are out of rhythm with current societal expectations and media portrayals. As described by the participants in the study, the paradigmatic reorientation regarding birth practice is sometimes awkward, uncomfortable and uncertain. When marital consensus is not accomplished easily, the shift for the woman has to be solid in order to persuade the husband to come to the conclusion that birth at home is more than acceptable, it is optimum for their circumstances, needs and desires.

**Implications For Media**

Elson (1997b) found that there is consistency and similarities among media portrayals of birth across various genres and over a two-decade time span of scenes studied. The great majority of those depictions are supportive of the traditional biomedical model. By marginalizing alternative birth choices or eliminating them completely, media have contributed to strengthening the hegemony of the medical establishment and their technocratic, biomedical model of birth. Media reinforcement of the dominant birth practice appears to be innocent and lacking in any intent to
deliberately lead women to a specific birth choice. The result, however, has been to remove the perception there are reasonable options beyond a traditional hospital-based birth.

Although the media may not be intentionally broadcasting messages that support the biomedical model over the woman-centered midwifery model, it still seems that within most media-based birth stories there is an unspoken assumption that a hospital-based birth is the best and most desirable choice. This assumption, as innocuous as it may seem, framed a recent university television news story on student health insurance. After agreeing to be interviewed as a new homebirth mother, Karma was startled and disappointed at how the story was broadcast.

After I had the baby NEWSNET [KBYU News] came and interviewed me about having my baby at home. I went on about how great it was. The program was focused on the problem with health care and people affording maternity care. So they interviewed me and I spoke so highly about how great the birth was. I talked about how I had made the decision and how it was "gold" I had found and it cost less and everything.

[When] it came out, when I was actually on TV, it made me out to look like a poverty-stricken loser, who was uneducated, who didn’t know what she had done. I looked like I was so desperate that I had to go to a midwife and have my birth outside of a hospital. I was so mad. They had taken little tiny bits of things I had said and used those. My own grandma said it made me look like I thought I should get the birth free. It was portrayed completely unfairly. They didn’t say that I enjoyed it thoroughly and that I would choose this if I had the choice again. They made it look like I was forced to choose it.

A transcription of the reporter’s comments reveals a hint of why Karma might have felt that homebirth did not receive the fair treatment she had hoped for. This is what the reporter said:

[Karma] delivered a baby in her Provo apartment six weeks ago. Her husband is a BYU student and they couldn’t afford health insurance to cover a hospital birth so she used a midwife... Many people without the security of a job and benefits are just like [Karma]. They want to protect themselves but don’t know or can’t afford their options (Amezcua, 1999).
Although the story on student insurance met a community need, the text of the news report cast the choice of midwifery and homebirth in a negative light by attaching the choice to lack of insurance or financial resources. It did nothing to raise awareness of homebirth as a positive birth alternative.

Reported in the press recently was an independent documentary on birth options, *Born in the U.S.A.* An article described a film that gave a positive portrayal of woman-centered and holistic approaches to birth (Elber, 2000). Birth is a significant life passage that most women go through when important life choices must be made. When decisions are produced without knowledge of all options or is based on misleading or incomplete information, the best interests of the child, mother, family and community may not be served. Because of its groundbreaking focus on woman-centered birth, the film was highly anticipated among those who supported birth practices rarely seen in the media. Unfortunately, even among public broadcast stations, woman-centered birth depictions, including homebirth, do not necessarily get a prime time spot. Of the 140 airings listed on the website for the program, 127 were between 11:30pm and 5:00am (*Born in the U.S.A.*, 2000), meaning most television viewers would not be exposed to this competing view of birth practices available in America.

Over the past 30 years, minorities have been moved from margins of television and given high profile dramatic roles, leads in situation comedies and television news reporting positions. Greenberg and Brand (1994) in an assessment of minority representations in the mass media, note the potential influence of increased visibility, although current data is mixed. “Television serves both to reinforce what is learned outside the television situation and offers the possibility of new information, where little
or none was available” (p. 302). It seems sensible to proactively include homebirth scenes with empowered women attended by midwives in dramatic programming, sitcoms, documentaries, news segments, and other images of birth scenes. This would serve to potentially diminish the impression that birth is the exclusive domain of the medical profession.

George Gerbner, emeritus dean of the Annenberg School of Communication at the University of Pennsylvania, gathered scholars and community leaders in St. Louis, Missouri, in 1996 to form an action group. The Cultural Environment Movement emerged from this original convocation and is actively involved in urging broadcasters and producers to diversify media portrayals. In a recent telephone conversation on cultivation theory initiated by the author (personal communication, November 9, 2000), Gerbner was asked about birth portrayals in the media. He suggested that images in television have become monolithic and predictable and therefore represent a narrow interpretation of the American experience. As he further discussed the standardization of various storylines and depictions, including media-created birth scenes, Gerbner observed that “Media portrayals tend to be one-dimensional and one-directional, and that would include how birth is shown” (personal communication, November 9, 2000). He expressed concern about the monopolizing and centralizing of media ownership, which he claims serves to further homogenize the images and messages. Gerbner suggested that media producers need to be aware of the potential long-term effects of media exposure to messages framed in a way that reinforces existing power structures and cultural practice that benefit a select few (personal communication, November 9, 2000).
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Neil Postman, chair of the department of Culture and Communications at New York University, observed regarding social science research:

The purpose of social research is to rediscover the truths of social life; to comment on and criticize the moral behavior of people; and finally, to put forward metaphors, images, and ideas that can help people live with some measure of understanding and dignity (1988, p. 18).

If that is the purpose of social research then it is appropriate, based on the insights gained from this research, to offer suggestions for modifications in media portrayals of pregnancy and birth.

**Recommendations For Media Action**

Although it is not possible to say to what extent the current state of birth practice in the United States may be connected to frequently broadcast media portrayals, media do continue to support the cultural hegemony of the medical industry over birth practices by marginalizing all other images and choices. Gerbner’s Cultural Indicators Project documented that doctors are over-represented in television programming when compared to real populations (Gerbner, Gross, Morgan & Signorelli, 1986). Gerbner (1978) further mentions in an article about the status of women in the media, that television, acting as the common denominator of the culture, functions to cultivate resistance to change.

Before there can be changes in actual behavior by the media decision-makers, who are consumers as well as producers, there must be changes in attitudes regarding women, pregnancy and birth. Once broader and more holistic beliefs about women and the process of birth are firmly rooted, the changes in content and representation should naturally evolve. It would be beneficial for media decision-makers to understand six key concepts: 1) Women can successfully give birth without medication, technology or the presence of physicians; 2) Birth is naturally and inherently dramatic; 3) Giving birth at
home may be a well-informed, positive and reasonable choice; 4) Giving birth outside of a hospital is not necessarily an emergency; 5) Midwives are well-trained and competent to attend births; and 6) Midwives focus on creating an optimum experience—physically, emotionally, and spiritually—for the birthing woman and her yet-to-be-born child. It would be just as possible to produce an award-winning television show, newscast, or movie by keeping these concepts in mind as it would to continue in the current pattern, which tends to solidify current perceptions of the birth experience.

Within the framework of both Cultivation Theory and Social Cognitive Theory of Mass Communication, the effects seen seems to emerge from repeated images that fit into a predictable monolithic message or the result of the exclusion of competing images. In order to televise a more balanced representation of birth, it seems that there should be more programming in all genres that have scenes which: 1) depict birth as a normal and healthy process; 2) depict women empowered and capable; 3) depict midwives as credible and safe birth attendants; 4) depict women as able to control their own bodies and health decisions; 5) depict the home as a safe and reasonable location for birth; and 6) depict positive birth experiences free of technological and medicinal interventions.

Media producers at all levels and in all genres should recognize that those who will some day give birth, or support someone who is, may be affected by the images portrayed in potentially detrimental ways, especially through the exclusion of positive portrayals of birth options. There should be an overriding responsibility to produce images that will empower women to make choices in the best interest of themselves, their families and their baby. A fairer representation of the process of birth and the of choices
available for both care giver and birthing location may serve to encourage women to consider birth practices from a wider array of options.

In a recent telephone conversation with Gerbner (personal communication, November 9, 2000), he was asked by the author about the absence of homebirth from the media. In response he suggested, “Diversification of media portrayals should include birth. It is a disservice to women to continue to represent one model of birth as the only acceptable pattern” (personal communication, November 9, 2000). Based on observations made during this research and since birth will continue to be woven into countless mass media stories, it seems imperative that the media be made aware of the need of portraying positive birth experiences beyond the traditional birth model.

Recommendations For Future Research

Being open to discovering the unexpected in the unstructured interviews generated the detection of attitudes and behaviors that were not fully developed in this study and deserve further scholarly attention.

In their birth narratives, the women gave rich, descriptive details of the event and their feelings connected with the birth. Those comments are used as the text for this ethnography. Absent from their remarks, however, was any mention of the typical details—weight, length, time of day, or Apgar scores—that one would expect to hear. It is possible that a relaxing of the cultural tradition of quantifying infants may be related to viewing the process and the result in another way. It would be interesting to discover if shifting paradigms regarding birth practice is connected to homebirthing women perceiving their newborns differently or telling their birth stories differently.
Within the context of interviewing actively religious women it would not have been surprising to hear recitations of doctrine, scriptural passages, or pronouncements from prominent church leaders in connection with their homebirth decision. The spirituality that was expressed by these women seems to come from within rather than from the parroting of others' words. This may point toward independent and empowered women and it would be worth looking at homebirthing women for specific qualities of autonomy.

Since there were two women who, after having a home birth experience, chose to use certified nurse-midwives at a birthing center at least once, it would be interesting to learn how frequently this occurs among homebirth mothers and what it may mean regarding their paradigmatic reorientation regarding birth practices. Most of the women in the study expressed some degree of confidence in the medical establishment when they mentioned they would consider turning to traditional medical care should a medical problem arise that could not be handled by their midwife. A dichotomous framing of childbirth practice as either homebirth or hospital-based birth may not fully reflect the spectrum of choices that women currently have. The freedom to choose the environment, caregiver and circumstances surrounding the birth from an array of options may be as important as the actual choice for some women and deserves to be studied more fully.

The historical research that informed this study led to the discovery that the decline in midwifery and birth at home paralleled to a certain extent the adoption of television in the United States. Further exploration of how media-generated perceptions of the birth process influence birth practice among other populations may be indicated.
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In light of the criticism the women in this study received, it would have been understandable to hear discussion of extensive contingency plans. Yet, backup plans for an emergency during birth was infrequently mentioned by these women. The research took place after a successful homebirth was accomplished. As a result no women were interviewed that experienced transport to a medical facility for birth. But the lack of mentioning a strategy for handling unforeseen emergencies raises the question of how homebirth women envision their births and if positive expectations improve outcomes.

There is much talk in education circles regarding the value of media literacy programs to assist students in overcoming the potential effects of media and becoming conversant in the conventions of television and cinematic production. It seems unlikely, however, that training children to understand filming techniques would be effective in broadening perceptions of birthing options in the future. Media literacy may be an inadequate remedy for dealing with the continuing hegemony of traditional medicine and the narrow expression of birth options through media portrayals of birth. An assessment of perceived acceptability and comparative safety of various birth options would be a good foundation for a media effects study.
Appendix A

Letter to Prospective Subjects

Celeste Elain Witt
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20 July 2000

LDS Home Birth Mother

RE: Study of LDS Home Birth Mothers

Dear Friend:

Sixteen years ago, in 1984, I had my first of three home birth experiences. At that time, while living in South Carolina, I knew of no other LDS woman who had voluntarily given birth at home. Since then I have met several. I have always wondered what we all might have in common.

Which brings me to my current research at BYU. I am conducting a study toward a Master's degree in Mass Communication investigating the role of media in birth practices among LDS women. Specifically, I am looking for women who have consciously selected home birth as the option that best suits their needs. I am hoping you will want to participate.

Participation in the study would involve a one-hour individual interview in your home or a group discussion/focus group at my home (near Timpview High School). Demographic information would also be collected for statistical purposes. All information will be kept completely confidential and you will be given a pseudonym protecting your identity within the text of the thesis. The study, as outlined, has both departmental and Institutional Review Board (IRB) approval.

If you would be interested in participating, please return the enclosed postcard. As the research is scheduled to begin soon, your immediate response, if interested, would be appreciated. If you need additional information before making a decision, please call me at 226-4180.

I look forward to hearing your individual birth story and the insights you have on this issue.

Sincerely,

Celeste Elain Witt

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Appendix B

Semi-structured Interview Guide

1. Describe how you saw pregnancy and birth portrayed on television and in movies growing up.
2. Describe how you see pregnancy and birth portrayed on television and in movies now.
3. Before your first pregnancy, how did you imagine your first birth?
4. Do you remember seeing anyone give birth, other than on television or in movies, prior to your own first birth? If so, how did it compare to what you saw on television?
5. From your experience with birth stories in the media, where did the birth normally take place? What was the role of the doctor? The father?
6. Do you remember seeing a birth in the media take place outside of a hospital? If so, how was it portrayed?
7. Do you remember seeing any of the public service announcements called Baby Your Baby? If so, what was your impression?
8. Tell me how your mother described her birth experiences. How do you think that influenced you?
9. How do your female friends and family handle birth as far as location, birth attendant and method of birth?
10. Describe your first exposure to the idea of homebirth.
11. What were the appealing aspects
12. Was there any specific event that triggered your interest in homebirth?
13. How was the decision made to have a homebirth?
14. Was it a joint decision between you and your husband? How did you decide?
15. Who contributed information? How did you determine whom you could trust?
16. Did you experience any resistance or criticism for your decision from friends or family? If so, describe their concerns.
17. To what books, articles, television shows, web sites, or other media, did you turn to for information or validation? How did you determine if information was trustworthy?
18. How did you find and select a midwife?
19. How do you feel choosing homebirth relates to your religious beliefs?
20. Describe your homebirth experience.
Appendix C
Demographic Questionnaire

Name ____________________________

Address ____________________________

Age __________ Name of Spouse ____________ Years married ______

Your religion ______________ Husband’s religion ______________________

Your parents’ religion ________________

Your ethnic origin __________________ Husband’s Age __________

Number of births at home ______ Number at hospital ______

Your education level ______________ Your husband’s education level ______________

If you have a college degree, what is it in? ______________________

Your current or former occupation(s) __________________

____________________________________

Your husband’s occupation ______________________

Your state of birth ______________ State of husband’s birth ______________________

Hours of TV you watched per day ages 12-18? □ 0-2 hours □ 2-4 □ more than 4

Did your family have cable or a satellite dish? □ yes □ no

Hours of TV you watch per day as an adult? □ 0-2 hours □ 2-4 □ more than 4

Do you have cable or a satellite dish? □ yes □ no

Names, ages, sex and birth location of each child

____________________________________

____________________________________

____________________________________

____________________________________
Appendix D

Biographical Sketches of Research Participants

(* indicates an in-depth interview)

Katrina Bachman is a 24-year-old Caucasian. She has been married to Adam, 25, for 3½ years. She is the mother of two children, the last born at home. Katrina was born in Georgia of LDS parents and is of Norwegian-German descent. She has a little bit of college and has worked in a natural foods store. Her husband is a landscape designer. She could not attend the focus group, so she participated in writing to a set of questions.

Joyce Bailey is a 20-year-old Caucasian. She has been married to Keith, 28, for one year. They reside in small split-level home in quiet suburban neighborhood. Five weeks prior to being interviewed she had her first child, a son, at home. Joyce was born in Utah, of LDS parents. She has almost completed her bachelor's degree in recreation. Her husband initiated the discussion of home birth. He is a technical writer.

Brenda Bostwick is a 24-year-old Caucasian. She has been married to Jeremy, 26, for almost four years. She is the mother of two children, both born at home. Brenda was born in Germany of LDS parents. She has two years of college. Her husband works in customer service and has training as an iridologist.

* Annica Brown is a 34-year-old Caucasian. She has been married, to Stanfield, 34, for nine years. She became a convert to LDS faith after her second marriage. She is a mother
of five children, the last four born at home. Two home births were in Illinois and two were in Utah. One of the Illinois homebirths was attended by a male family physician. Annica was born in Arizona of non-LDS parents. She lives in an upscale home in beautiful neighborhood of manicured lawns. She has three years of college and has been trained as a massage therapist. Her husband is a chiropractor.

**Deborah Clarke** is a 32-year-old Caucasian of Scandinavian heritage. She has been married to Jacob, 31, for 9½ years. She is the mother of four children, the last two born at home. She has a B.A. in English. Deborah was born in California of LDS parents. She is certified to teach Bradley Method childbirth preparation classes. She works full time at the university as a technical writer. Her husband is a software project manager.

**Carla Crandall** is a 23-year-old Caucasian. She has been married to Darrin, 25, for 3½ years. She is the mother of two daughters, the last born at home. Carla was born in California of LDS parents. She has a BA in English. Her husband is an optician. She could not attend the focus group, so she participated in writing to a set of questions.

**Paula Ellefsen** is a 21-year-old Caucasian. She has been married to Peter, 27, for 1½ years. She is the mother of one daughter born at home. She is a senior in college. Paula was born in California of LDS parents. Her husband is pursuing a master’s degree.

**Meredith Ellis** is a 27-year-old Caucasian. She had been married to James, 27, for four years. She is the mother of three, the last born at home. Meredith was born in Utah to
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LDS parents. She has two years of college. She has been trained to be a childbirth educator. The three-month-old daughter who was born at home recently diagnosed with congenital disease, which will keep her from ever walking. Her husband is a computer network engineer. She could not attend the focus group, so she participated in writing to a set of questions.

*Amanda Franson* is a 34-year-old Native American. She has been married to Garth, 48, for 12 years. Amanda was born in California of LDS parents. She is the mother of six children, of which two were home births. One of her home births was a son with a congenital heart defect that was known in advance to be non-survivable. She has seven years of college, but has not yet completed a degree. She lives in a small suburban home in quiet neighborhood. She is currently expecting and plans to give birth at home again. Her husband is director of a Native American performing group in which she performs.

*Victoria Gerald* is a 26-year-old Caucasian. She has been married to Robert, 29, for six years. She is the mother of two children, the first born by caesarean section at the hospital and the second born at home. Victoria was born in Virginia of LDS parents. She has a BS in Human Development/Family Science. She is currently expecting and plans to give birth at home. Her husband is an accountant.

*Lisandra Henderson* is a 30-year-old African-American. She has been married to Don, 30, for 5½ years. She is the mother of two children, the first born in hospital and the second at home. Lisandra was born in Washington State of LDS parents. They live in a
lovely multi-level condo tucked away from the main street. She is currently expecting
and plans to give birth at home. She has a B.S. in Human Development. Her husband
has an MBA and is a clothing exporter.

*Marti Jacobs* is a 28-year-old Caucasian. She has been married to Mark, 33, for eight
years. She is the mother of four children, the last one born at home. Marti was born in
Utah of LDS parents. She has high school diploma. Her husband has engineering
degree.

* Hannah Lawson is a 23 year-old Caucasian. She has been married to Jeffrey, 25, for
almost 1½ years. She is the mother of one daughter, born at home in tiny student
apartment. Hannah was born in Utah of LDS parents. She is completing a B.A. in
Family Consumer Science. Her husband is a web page designer; interviewed when
daughter was ten days old.

* Ashley Little* is a-25 year-old Caucasian. She has been married to Carl, 28, for six
years. She is the mother of three children, all born at home, the youngest is four months
old. Ashley was born in Illinois of LDS parents. She has two years of college. Her
husband is computer network engineer.

*Teresa Mackay* is a-23 year-old Caucasian. She has been married to Larry, 25, for 2½
years. She is the mother of one daughter, born at home. Teresa was born in Utah of LDS
parents. She home-schooled her last year in high school, so has no diploma. She is a
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trained labor couch (doula). She is currently expecting and plans to give birth at home. Her husband has degree in mechanical engineering.

Abbey Nelson is a 43-year-old Caucasian. She has been married to Samuel, 43, for 18 years. She is mother of six children, the last two born at home. Her most recent homebirth was at age 41. Abbey was born in Wisconsin, one parent was LDS, the other Catholic. She has a BS in Elementary Education and home-schools her children. Her husband is a paramedic.

Felicity Palmer is a 22-year-old Caucasian. She has been married to Paul, 24, for 2½ years. She is the mother of one son, born at home. She has a BA in recreation and youth leadership. Felicity was born in Honduras of LDS parents. Her husband is a graduate student. She could not attend the focus group, so she participated in writing to a set of questions.

* Sarah Paulsen is a 25-year-old Caucasian. She has been married to Justin, 26, for 1½ years. She is the mother of one daughter, born at home. Sarah was born in Washington of LDS parents. She lives in small student apartment near a university campus. She has BS in Finance. Her husband is a student.

* Hope Richards is a 30-year-old Caucasian. She has been married to Blake, 31, for nine years. She is the mother of three children, the last born at home. Hope was born in Utah of LDS parents. She has three years of college. They live in red brick home on quiet
street. She teaches her three- and six-year-old sons at home, including a Russian immersion program. Her husband is a computer programmer.

*Melinda Rowley* is a 27-year-old Caucasian. She has been married to Martin, 30, for 6½ years. She is the mother of three children, the last two born at home. Melinda was born in Utah of LDS parents. She has one year of college. They live in old home on busy street. She is a trained and practicing labor coach (doula). Her husband is a correction officer for the county.

*Rachel Satterfield* is a 40-year-old Caucasian. She has been married to Derrick, 40, for 18 years. She is the mother of six children, one born at home. She recently lost a six-year-old daughter in a tragic accident. Rachel was born in California to LDS parents. She has completed two years of college. She has worked in a doctor’s office. After her home birth, she had subsequent children with certified nurse-midwives in a birthing center because certified nurse-midwives do not attend homebirths in Utah. Her husband is vice-president of a web design firm. She could not attend the focus group, so she participated in writing to a set of questions.

*Kristine Schultz* is a 32-year-old Caucasian. She has been married to Jordan, 31, for 8½ years. She is the mother of three children, the last born at home. Kristine was born in Arizona of LDS parents. She has a BS in Marriage, Family and Human Development. She is currently expecting and planning to give birth at home. Her husband is marriage and family therapist.
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**Micah Shafer** is a 23-year-old Caucasian. She has been married to Edward, 27, for four years. She is the mother of two children, the first born in the hospital, the second at home. Micah was born in New Mexico of LDS parents. She has one year of college. Her husband is an environmental consultant.

**Natalie Stover** is a 31-year-old Caucasian. She has been married to Sheridan, 30, for 10 years. She is the mother of five children, the last born at home. They live in a rural area. Natalie was born in California of LDS parents. She has a high school diploma. Her husband owns an auto shop.

**Cecelia Stratton** is a 29-year-old Caucasian. She has been married to David, 41, for 9 years. She is the mother of three children, the last born at home. Cecelia was born in Arizona of LDS parents. She has a BS in zoology. She is a La Leche League representative (non-profit organization for training women to breastfeed). Her husband is an attorney and CPA.

**Karen Sullivan** is a 27-year-old Caucasian. She has been married to Kristof, 30, for six years. Together they have had three children, the last born at home. Karen was born in California of LDS parents. She had a BA in accounting. Her husband has a PhD and is a practicing marriage and family therapist.
*Karma Sylvester* is a 25-year-old Caucasian. She has been married to Eli, 26, for five years. She is the mother of two children, the last born at home. Karma was born in Utah of LDS parents. She has some college. Her husband is student.

* Bethany Walker is a 33-year-old Caucasian of English-Welsh descent. She has been married to Jesse, 32, for nine years. She is the mother of three children, the last two born at home. Bethany was born in Texas of LDS parents. She has a BA in Spanish. She has worked previously as a secretary. She lives in a small home on a noisy city street. Last home birth had complications, but turned out fine. Her husband is a computer programmer.

* Stella Washburn is a 32-year-old Caucasian. She has been married to Joel, 35, for twelve years. She is the mother of four children, the last born at home. Stella was born in Utah of LDS parents. She has three years of college. She lives in small home on busy street where she home-schools her children. Her husband is painting contractor.

*Briana Waverly* is a 31-year-old Caucasian. She has been married to Devon, 29, for six years. She is the mother of three children, two born at home. Briana was born in South Africa of LDS parents. When interviewed her youngest was only two weeks old. Her husband is Canadian and is a systems analyst.

Total number of participants: 30
Individual in-depth interviews: 13
Focus group participants or comments submitted by mail: 17
### Woman's Way of Birth versus Obstetric Way of Birth

<table>
<thead>
<tr>
<th>Woman's Way of Birth</th>
<th>Obstetric Way of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cultural definition of birth</strong></td>
<td><strong>Cultural definition of birth</strong></td>
</tr>
<tr>
<td>• Social event</td>
<td>• Potentially pathological process</td>
</tr>
<tr>
<td>• Normal part of women's lives</td>
<td>• Illness</td>
</tr>
<tr>
<td>• Birth is work by the woman and her family and kin</td>
<td>• Birth is work of doctor/nurses/midwives and other experts</td>
</tr>
<tr>
<td>• The woman is a person passing through a major life transition</td>
<td>• The woman is a patient</td>
</tr>
<tr>
<td><strong>The setting for birth</strong></td>
<td><strong>The setting for birth</strong></td>
</tr>
<tr>
<td>• Home or other familiar surrounding</td>
<td>• Hospital, territory alien to the woman</td>
</tr>
<tr>
<td>• Informal system of care</td>
<td>• Bureaucratic, hierarchical system of care</td>
</tr>
<tr>
<td>• In a woman's home or near</td>
<td>• May be distant from woman's home</td>
</tr>
<tr>
<td>• With other women of neighborhood and family</td>
<td>• Woman is separated from those close to her</td>
</tr>
<tr>
<td>• Continuity of care</td>
<td>• Discontinuity of care, e.g. shift changes/woman is moved from one room or one ward to another</td>
</tr>
<tr>
<td>• Woman free to change position and move about</td>
<td>• Woman may not be free to change position and move about</td>
</tr>
<tr>
<td><strong>Caregivers: the support they give and the conduct of labor</strong></td>
<td><strong>Caregivers: the support they give and the conduct of labor</strong></td>
</tr>
<tr>
<td>• Older and more experienced women who are themselves mothers</td>
<td>• Young and older women who have often not themselves had babies, under direction of male obstetricians</td>
</tr>
<tr>
<td>• See birth as a holistic process</td>
<td>• Trained to focus on medical aspects of birth</td>
</tr>
<tr>
<td>• Shared decision-making between caregivers and woman giving birth</td>
<td>• Professional care that is authoritarian</td>
</tr>
<tr>
<td>• No class distinction between caregiver and woman giving birth</td>
<td>• Often class distinction between obstetrician and patients</td>
</tr>
<tr>
<td>• Equal relationship</td>
<td>• Dominant-subordinate relationship</td>
</tr>
<tr>
<td>• Information shared</td>
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</tbody>
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- Personal caring - longer, more frequent and in-depth prenatal visits
- Often strong emotional support
- Verbal and non-verbal encouragement
- Familiar language and imagery used
- Empathy
- Cultural awareness because they are part of the same culture
- Awareness of spiritual significance of birth
- Believes in integrity of birth, uses technology if appropriate and proven

- Information about health, disease, and degree of risk kept secret
- Care depersonalized
- Little emotional support
- Lack of communication
- Use of medical language
- Threatening and often punitive behavior, e.g. commanding scolding, warning
- Little cultural awareness of rituals, beliefs, social behavior, values
- Spiritual aspects of birth ignored or treated as embarrassing
- Values technology, often without proof that it improves birth outcomes

<table>
<thead>
<tr>
<th>Techniques used</th>
<th>Techniques used</th>
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</thead>
<tbody>
<tr>
<td>- Skills to preserve the physiological progress of labor</td>
<td></td>
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<tr>
<td>- Usually intervention-free</td>
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<tr>
<td>- Comfort skill, e.g. massage, hot and cold compresses, holding</td>
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<tr>
<td>- Few resources to handle complicated obstructed labor</td>
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</tbody>
</table>

- No skills to preserve the physiological progress of labor
- Obstetric intervention
- Drugs for pain relief
- Skill and resources to handle complicated and obstructed labor, e.g. intravenous fluids, oxytocin stimulation, surgery

(Kitzinger, 2000)
Mormon Women Choosing Homebirth

Appendix F
Coding Sheet

Theme A: Media-influenced Perceptions of Birth Experience
1. Hospital only acceptable location
2. Frantic/Rushed/noisy
3. Doctor-centered, Doctor all-powerful
4. Woman passive, dependent, incapable, weak, irrational
5. Woman out-of-control
6. Drugs are necessary
7. Birth is scary, painful
8. Anger toward men
9. Women feel victimized
10. Emergency/Crisis
11. Husbands have no real role; helpless, incompetent
12. Birth outside of hospital mistake/emergency/dangerous
13. Process cleaner/shorter/ glamorous
14. Birth is a medical event; unnatural
15. Expect doctors to deliver perfect babies
16. Woman is ugly, fat
17. In bed, on her back
18. Media-influenced expectations

Theme B: Introduction to Homebirth (Initial and Critical)
1. Books/pamphlets/ads
2. Television/movies
3. Social Network

Theme C: Decision-making Process
1. Woman-initiated
2. Study
3. Prayer/Personal revelation
4. Social network
5. Marital consensus

Theme D: Appealing Aspects of Homebirth
1. Control of Environment
2. Control of Attendants
3. Control of Comfort measures
4. Control of Decisions
5. Control of Access to baby
6. Control of Spirituality
7. Woman-to-woman experience, support
8. Female body was created for birth, birth is normal
9. Cost/insurance issues
10. Avoidance of negative experiences connected with traditional birth
11. Consistency of care throughout pregnancy and throughout labor and delivery
12. Home
13. Power
14. Center of attention; doing something different
15. Congruent with religious beliefs

6. Dealing with criticism/resistance
   a. irresponsible/selfish
   b. ignorant/uniformed
   c. brave/courageous/pioneer
   d. indigent/underinsured
   e. crazy/unbalanced
   f. misled/manipulated
   g. archaic/anachronistic/back-to-nature

7. Precipitating experiences
8. Intuition
9. Complex relationship with OB
November 30, 2000

Elain Witt
Department of Communications
Brigham Young University

Dear Elain:

I completed the audit of materials related to your ethnographic study on childbirthing women giving birth at home. An attempt was made to validate trustworthiness, as suggested by Guba (1981) and confirmability and dependability, based on the suggestions of Lincoln and Guba (1985). I examined selected materials which you provided me, including several interview transcripts, field notes, coding notes, and notes on informant profiles, as well as methodological and theoretical memos.

I found that the findings are grounded in the data. Based on the sources provided in the audit trail, I attest that my audit reveals that the study is credible, with findings and processes trustworthy, confirmable, and dependable.

Sincerely,

Lynn Clark Callister, RN, PhD
College of Nursing
Brigham Young University
Mormon Women Choosing Homebirth

References


Church of Jesus Christ of Latter-day Saints. (2000, October 26). Member and statistical records: Statistical data on church membership. Salt Lake City, UT: Author.


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