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Caesarean Birth in A Social Context: A Content Analysis of Childbirth Narratives

Marissa Cobuzio
marissa.cobuzio@icloud.com

CAESAREAN BIRTH IN A SOCIAL CONTEXT:

A CONTENT ANALYSIS OF CHILDBIRTH NARRATIVES

Marissa Cobuzio

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Faculty sponsor: Dr. Amy Armenia

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Introduction

One day, while scrolling through Facebook, I encountered a picture posted by a mother of a quote that read, "C-section mommas are real moms too." Immediately, I stopped scrolling, and took a minute to ponder exactly what this meant. To me, it seemed clear…*Of course moms who have had caesarean sections are real moms too.* However, this experience urged me to question what the underlying message of this post was trying to convey. If a popular hub of information sharing such as Facebook was suggesting that we needed to honor women who have had caesarean sections, then what were other sources of media saying about the same topic? Ultimately, this post intrigued me to dig deeper into the identities and social policing that women encounter as they share their experiences with giving birth. This thesis is an attempt to uncover why people felt the need to even share that "C-section mommas are real moms too."

Childbirth is a shared life experience among a majority of women. Worldwide, there are 131.4 million babies born ("Birth & Death Rates"). Further, as of 2010, 82 percent of all American women had given birth at least once (Jolly 2018:32). Given that as of 2017, women comprised half of the world population ("Population, Female (% of Total) | Data."), it is imperative to study events, such as childbirth, that are experienced by women worldwide.

Pregnancy and childbearing are often perceived as primarily biological events, with little consideration given to the societal forces that shape the experience of these events. In a society where popular media and scholarly research is oversaturated with biological and medical studies on childbirth, it is important to recognize that the process of pregnancy and birth for women is not entirely individualistic. Social pressures influence all members of society, which extends to women during pregnancy, childbirth, and child rearing events. In addition, larger social forces

affect our very understandings of childbirth – as a natural process or alternatively as a disease or aberration.

Classical sociological theory paves the way for this understanding of actions perceived and interpreted through a social lens. In the 19th Century, Emile Durkheim introduced the idea of social facts, which are social norms and pressures that exist and socially control and constrain human behavior (Durkheim in Calhoun 2013 [1895]). In the case of childbirth and childrearing, the understanding of when it is appropriate to have a child, how one should deliver a baby, and the proper care for a newborn child are guided by a set of social norms that are imposed on women by other members of society.

Further, microsociological theory, or the study of interactions at a person-to-person level, can help us understand how women view themselves during childbirth but also how others view them. Microsociology acknowledges that individuals have "selves" and these "selves" guide and shape their interaction with others in addition to the greater social expectations in any given situation. As Charles Horton Cooley (2013 [1909]) explains, "Social consciousness, or awareness of society, is inseparable from self-consciousness, because we can hardly think of ourselves excepting with reference to a social group of some sort, or of the group except with reference to ourselves" (166). Thus, women rationalize their experience and pregnancy with childbirth both in terms of themselves and others, drawing on previous personal interactions as well as greater societal norms and understanding to interpret and draw conclusions about their individual experiences with childbirth and childrearing.

Therefore, it is important to consider the sociological aspects of childbearing to better understand why women on a national and international scale are giving birth the way they do, based on the ways society as a whole talks about the process of child delivery.

Thus this paper explores the stories women are hearing about birth by looking at the language, themes, messages which surround the public discussions of C-section. These stories can have a powerful effect on women's choices for and understandings of the birth experience. To begin, this thesis will detail a review of relevant literature as it relates to the historical trajectory of childbirth norms and the experiences of women who have caesarean sections in modern day. This background will be the basis for rationalizing findings of the following research questions: What are the language, themes, messages used in popular media, such as parenting magazines and "mommy blogs" and how do they characterize caesarean births for women? Do these sources normalize and rationalize caesarean as mode of child bearing? Where do these sources locate control in the birth process for prospective mothers?

To answer these questions, I conducted a content analysis of two parent blogs and used inductive and deductive approaches to identify the themes and messages in these sources. Findings from the analysis show that shame and failure are among the most common themes surrounding caesarean. Further, there are differences in the concentration of messages between the two mommy blogs, with *Parents* focusing on the scientific and statistical analysis of birth and *ScaryMommy* honing in on the emotional aspects of C-sections. Finally, I discuss the implications of these findings, because the internet and media are a key way to disseminate information to society and in turn have a considerable impact on women's experiences and perceptions of birth.

Literature Review

The following literature review attempts to provide the reader with a basis of knowledge to allow for a richer analysis of the information collected and rationalized in this study. To

achieve this end, this literature review will begin with a summary of the American history of childbirth, from colonial America to the modern feminist demedicalization movement. Due to brevity constraints, this discussion of birth does not provide an in-depth analysis of the intersectionality of race and socioeconomic status on perceptions of birth and other life experiences. Therefore, this literature review is based heavily on the white, married woman's experience in Colonial America. Then, it will delve into modern statistics on caesarean, covering who has caesareans and at what frequency. It will outline prior empirical research on women's experiences of caesareans as well as the reasons caesareans are chosen as a form of birth. Finally, this literature review will use theories of caesarean to help understand and contextualize earlier research and this project.

Historical Changes in Childbirth in the U.S.

Childbirth, the process by which it occurs and how it is viewed in society, is largely a reflection of the time and context in which it is discussed. Thus, it is important to understand the past history of pregnancy and childbirth in order to conceptualize more modern theories and experiences of childbirth.

17th Century- The Home Birth

Childbirth was a keystone of the female experience during colonial America where a large portion of a woman's identity was derived from her ability to rear and raise children. In fact, women often reared children for a period of time longer than they were married (Wertz & Wertz 1989:3). Not only was this a major way in which women found purpose and were deemed worthy by society, it was also a common thread among most women and used as a way to bond and share common ties. As argued by Wertz and Wertz, "Social birth continued into the 19th

century to be the primary occasion on which women expressed their love and care for one another and their mutual experience of life" (Wertz & Wertz 1989:2). Women relied on other women to help assist with childbirth. Women who had relationships with the pregnant mother would come to the house to assist with childcare and household chores during and after the birth; most often these acquaintances provided unpaid help with the expectation that the favor would be returned when the helpers became pregnant (Wertz & Wertz 1989). Some helpers were simply friends, acquaintances, or even neighbors, while others called to attend were midwives, who were often older and more experienced. At the time, this is how women expressed support and nurturing of one another, creating a sense of confidence and solidarity among the group (Wertz & Wertz 1989).

Surprisingly, women, although most often married women, had a considerable amount of agency during this time, including having the freedom to choose their birthing position and the food and wine they consumed during the labor process. Much of this freedom stemmed from the presence of other women who allowed agency and empathized with the birthing mother, often after having given birth themselves. Social support from friends and technical support from midwives allowed this to be a women-directed process (Wertz & Wertz 1989).

Midwives in particular, were called on to play an increasingly prominent role, both providing emotional support and technical guidance to the birthing mother in order to ease her through the frightening process (Wertz & Wertz 1989). Over time, midwives became the center of support and guidance during homebirths and thus were deemed responsible for maintaining "moral and civic order of the state" (Wertz & Wertz 1989:8). It is hard to overestimate the importance of midwives in this era, as they managed a process that was both a cornerstone of women's experiences and ensured the successful reproduction of the population.

Despite female solidarity, support, and agency during birth women were still policed by gender and religious norms throughout pregnancy and during birth (Wertz & Wertz 1989). They wore long skirts to remain modest because childbirth and the newborn baby were meant to be signs of their piety and religious-wholeness, rather than a symbol of an experience that is inherently tied to sexual matters.

18th and 19th Century- The Rise in the Medicalization of Birth

These practices continued for as long as homebirths were commonplace; over time, however, women's agency and control progressively deteriorated as other forces began to exert control. Religion, in specific, played a central role in childbirth as a social practice. In colonial times, midwives were viewed as those able to enact magical spells to promote successful pregnancies and births. As the Protestant religion rose in popularity, though, this sentiment changed. Instead of having a direct effect on the outcome of birth, midwives and pregnant mothers became only "an effective instrument of god's will" (Wertz & Wertz 1989:23). This, along with the fear of death of the child or the mother, began to turn childbirth into a dreadful and, more importantly, passive experience.

This rise of religious-control led to a divide between the natural and spiritual world that became an increasingly separated and defined social construction. Americans gradually intervened on the natural world, again understanding that it was separate to that of the spiritual and religious world; this separation furthered the understanding that because they were independent entities, one sphere of life could have control or power over the other. This new cultural lens, along with doctors' integration into society as more highly trained than midwifes, allowed women to ease into the use of medical staff to assist in their "demystified" and "rationalized" pregnancies and birthing experience (Wertz & Wertz 1989:25). Thus, over time,

the act of childbirth became less of a social gathering with the help of a midwife and more of medical condition to be treated by –exclusively male– doctors.

Perhaps a key transition from female midwives to male doctors was the emergence of the surgeon who began to be recognized as a knowledgeable entity able to deliver live babies. Barber-surgeons, and they alone, were allowed to perform medical operations (Rothman 1991), and surgeries were only performed on women when their pregnancy was deemed abnormal (Wertz & Wertz 1989). Because only men held this position, as they were the ones allowed to experiment with female anatomy and the physiology of birth in formal and instructional settings, they reserved the right to determine what was a normal birth or what needed medical intervention. Further, as they developed tools that revolutionized childbirth, such as the obstetrical forceps invented by Peter Chamberlen, they both garnered power and prestige over midwives while also limiting midwives access to similar tools and knowledge of procedures (Wertz & Wertz 1989). Thus, due to their formal education and claim of increased knowledge, male birth attendants began to charge more than their female counterparts; the increase in cost correlated to their rising symbol of status. Over time then, male medical employees were able to shape the framework of childbirth as one in which all pregnancies and births were abnormal in comparison with the "normal" unpregnant body. In doing so, men monopolized control of childbirth, effectively reducing female midwives participation (Rothman 1991).

The rise in medical intervention was accompanied by an increase of births occurring in hospitals, rather than in the home. This movement may have had some positive benefits for the pregnant mother, such as allowing for a brief one-to-two week break from childcare and other domestic duties. Additionally, birthing in a facility with several trained staff who were assumed to be prepared for emergency situations brought comfort to many pregnant women (Rothman

1991). Yet despite these small advantages, the physical movement from home to hospital undoubtedly marked with it a loss in maternal power and authoritative control (Rothman 1991).

An increase in medicalization brought with it novel challenges. One problem was the perceived need for female modesty in obstetrics and gynecology in a way that would not create an implication of sexual and improper transgressions between female patients and male doctors (Wertz & Wertz 1989). As men became more intimate in female health, women felt an increasing amount of shame in receiving such care; to this end, some women refused medical treatment even in the direst conditions. Women in higher classes also began to hide their pregnancies from the public, secluding themselves from the social world during the nine-month process in order to remain modest (Wertz & Wertz 1989).

Ultimately what resulted from this was dichotomization of the mind and body; women's bodies were contextualized as machines with problems so that male doctors could "fix" them (Lyerly 2005). The result has encouraged women into feeling and viewing their bodies as mere vessels or encasements that hold a child. In turn, as argued by Rothman, "Once the body is conceptualized as a machine, then it is going to be treated in much the same way as any other machine in our society—pushed to be more efficient, more economical, faster, neater, quieter" (Rothman 1991:40).

Therefore, this system relinquished to men the power to deem what was moral and acceptable in settings such as birth (Wertz & Wertz 1989). It also removed women from the once all-present support system that helped them through the birthing process and the obstacles that arose in the weeks that followed.

Early 1900s- Medicalization increases in the era of Twilight Sleep

It is no surprise, then, that a result of this new way of thinking led to even more increases in technological and medical interventions in the natural process of birth. Beginning in the early 1900s, women pushed for a solution to the immense pain endured during childbirth. One resolution that was explored was the use of "Twilight Sleep" during childbirth. This process of birth included a dose of both morphine and scopolamine, the former which helped with pain tolerance and the latter which caused the woman to forget the delivery experience (Wertz & Wertz 1989). Wealthier women pioneered this as a valuable process, arguing that both mother and child were healthier when delivery happened in this way, and so, many women in this time gave birth via this process. Although this mode of delivery was phased out after the discovery of its harmful effects on maternal and child health, the presence of medicine during delivery did not disappear entirely (Wertz & Wertz 1989). Overtime, the use in chemical intervention, such as epidurals to numb pain and oxytocin to induce labor, as well as surgical techniques such as the use of forceps and later caesarean sections, have increased rapidly.

It is important to note that this section does not detail the experience of African slaves or unmarried women living in colonial America. Rather, it presents a history of the experiences of married, affluent white women at the time, and thus is not a complete summary of pregnancy and childbirth for women living in America throughout this time.

1950's to Present- Feminist Demedicalization Movement

The move towards a highly regulated and medicalized experience with birth has been met with a large feminist push towards demedicalization by reincorporating the use of midwives, doulas, and home births and is often referred to as the midwifery model of birth (Rothman 1991). Sociological and feminist scholars such as Barbara Katz Rothman, Barbara Ehrenreich, and

Deirdre English have argued for a reshaping of the current normalized practice of childbirth. The movement really took off with the adaptation of the Lamaze birth technique in the 1950s, where women were encouraged to practice movements that decreased pain so that they were able to assert a more active role in the process of birth. It continued to grow with the addition of the father in the delivery room in the 1970s (Rothman 1991).

The midwifery model is built on the basis that the women's reproductive processes are the base or norm, rather than a deviation or atypical version of the male systems as it is viewed in the medicalized model (Rothman 1991). A major distinction between the views of birth is the difference in language that is used to describe pregnancy and birth. For example, the midwifery model refers to pregnancy as a natural state of being, while the medical model describes pregnancy as a series of symptoms (Rothman 1991:38).

Yet this rise-up of feminist scholars fighting for "natural" birth cannot break through the deeply rooted and capitalist-backed system of medical birth, with the greatest contradiction of a movement towards "natural" birth being countered by a rise of medical and surgical intervention (Rothman 1991). Even among women who chose to give birth at home or without the aid of drugs or surgery, it is still commonplace to have medicalized procedures, such as ultrasounds, fetal genetic testing, and amniocentesis, in the months leading up to the day of birth. Therefore, Rothman argues that rather than reverting to more "natural" births, society is instead moving towards "prepared births," in which birth is no longer a disease and the mother can play an informed role and can make decisions about how and where she'd like to deliver her child (Rothman 1991).

This failure of the movement to cause any significant change in caesarean rates may emerge from a variety of reasons. A lack of cohesiveness of the movement may exist because

activists of varying backgrounds are all converging on the same idea but with different motivations. For example, the push for home births is driven by feminists fighting for reproductive justice, men who want to be with their wives and reclaim the place of birth as their territory, and spiritualists who believe giving birth in the bedroom completes the full circle from conception to birth (Rothman 1991:32).

Further, despite a strong movement by feminist scholars and activists alike, the medical institution continues to play a key role in shaping attitudes towards birth. Even though pregnancy is generally viewed as natural or normal by a majority of American society, doctors still classify pregnancies as low or high risk, indicating that at some level, pregnancy is an abnormal condition, which needs to be treated (Rothman 1991:32).

The technocratic model of birth is based in a male-centric society, so women in medical institutions are both treated through a technocratic *and* patriarchal lens (Rothman 1991). In medicine, the male body is seen as the normal, and the female body, which has several additional processes including menstruation, pregnancy, and menopause, has been deemed as a deviation from the norm. Thus, these "abnormal" body processes have created the false need for increasingly specialized and medicalized care.

Who has Caesareans?

Despite the push back among women to create an era of women's reproduction characterized by a "natural birth" movement, caesarean rates in America have continued to rise. In fact, in the last twenty years, the rate has risen from 20.7% in 1996 to 31.9% in 2016 ("National Vital Statistics Report" 2018). In suit, a study done by Declercq et al (2007) surveyed a sample 1,573 women, most of which filled out a digital version of the survey. Findings of the

women interviewed or questioned revealed that about 1 in 3 women gave birth via caesarean section, which is in line with the national average proving that even within small samples, a considerable number of women are experiencing caesarean section. The World Health Organization, which uses rates of caesarean as one way to gauge quality of maternal care, declared in 1985 that an average estimated percentage of caesarean for a given country should be between 10-15 percent, adjusting for the countries need and resources (Mander 2007). The United States of America has surpassed this recommendation by two times as much. Because the presence of surgical intervention is much higher than recommended, there is a great need to understand why caesarean sections are happening at such a disproportionate rate, especially when the risk of C-section is clear, where mortality is 10-20 times more likely when having a caesarean than giving vaginal birth (Stone in Worman-Ross & Mix 2013).

Rates of caesarean sections vary greatly globally and even among various racial and socioeconomic groups within the United States. Some causes of variation between countries stem from the nation's level of development and their healthcare system. However, Mander (2007) argues that the greatest cause for differences in views on childbirth is the cultural attitudes toward gender and sexuality, and in specific how they are expressed during the birthing process, and the financial and cultural resources of women during childbirth experiences. For example, in India a woman having birth in a privatized hospital setting is 1.7 times more likely to have a caesarean section than in a public hospital (Mander 2007:65). In this sense, financial stability of the mother greatly affects her access to such procedures. Another example of this is evident in Brazil; one study found that up to 98 and 99 percent of women giving birth in private hospital had a caesarean (Mander 2007:66). Status and wealth allows some women to have a personal relationship with their medical attendant, which ensures the birthing experience they

want. Women who did not have the cultural or financial capital to advocate for themselves during the birthing process find the help they need is withheld from them. In fact, "'those with the greatest need for caesarean were the least likely to receive one'" (Mander 2007:67). Similarly, Greece, which has an over supply of specialized doctors, has a 53 percent rate of caesarean sections in private hospitals (Mander 2007:68). In Israel, however, access to caesarean section is correlated with religious affiliation. Jewish women have significantly greater access to private healthcare, while Palestinian women are often subject to traveling far distances to receive the proper healthcare. As a result, they more often have unattended birthing experiences in transport to the hospital, while Jewish women more often give birth under the care of a qualified obstetrician, and in turn, have more caesarean sections (Mander 2007:68-69). Here, cultural attitudes and socioeconomic constraints outweighed females' decision-making power in the birthing process. While some countries regarded caesareans as a form of power and status, others found it shameful as their cultural attitudes believe that spontaneous and demedicalized birth is the most honorable, even when women desperately need medical attention (Mander 2007).

When considering more developed nations, Australia has one of the highest rates of caesarean: 33 percent in 2015 (Jolly 2018:33). Mander speculates that because Australia engages in a consumer culture where privatized healthcare is a sought-after privilege, the increasing rate of caesarean has become normalized and even prized. In contrast, the Netherlands, which has a significant presence of midwives, boasts an 11.2 percent caesarean rate. In fact, as socioeconomic status increases for Dutch citizens, researchers find a decrease in caesarean sections and overall surgery (Mander 2007:71).

In the United States, we see even more troublesome statistics. America utilizes more medical and technological interventions than any other developed nation. In fact, "about 99

percent of U.S. births take place in hospitals, attended by doctors" (Mankiller et al. 1999). With an increased overall rate of medicalization, it is logical to understand how rates of caesarean are among the highest in the world as well. In 2016, the rates of caesarean section in the U.S. averaged 31.9 percent ("National Vital Statistics Report" 2018).

Even among American citizens, rates of medical intervention, especially as they relate to C-sections, are stratified between different race and socioeconomic groups. In 2016, caesarean childbirths were highest among non-Hispanic black women, who give birth via this procedure 36 percent of the time, while the lowest presence of caesarean as a means to give birth was found in American Indian or Alaskan native women with a 28 percent frequency (Fransisco 2017). Yet falling in the middle of the range is both non-Hispanic white women and Hispanic women who had caesareans on average 31 percent in 2016 (Fransisco 2017).

With one third of American women giving birth via caesarean section, this constitutes the need to explore why women have caesarean.

Contemporary Women's Experience

One perceived benefit of increasing medical intervention, and specifically, caesarean sections, was the fulfillment of women's desire for control, which manifests in many different ways and varies among different groups of women. Control is displayed in different ways for different demographics of women and even individual differences between women. For some mothers, medical intervention provides a source of control for their seemingly unpredictable bodies, while for others, maintaining confidence in their knowledge of childbirth and the ability of their bodies to perform without medical intervention was the true form of control (Goodin and Griffiths 2012).

When looking at socioeconomic status, represented by occupational status, women who were in positions of power viewed caesarean and its relationship to control differently than their working class counterparts. For a sample of middle-class women interviewed by Fox and Works (1999), wanting control meant wanting to be mentally present in the decision making of how they gave birth. Specifically for those in positions of power, caesarean gave them the freedom to be mentally present. One participant exclaimed, "Heaven! I would never do it any other way. A caesarean with an epidural. I was awake, everything. Ah, it was just wonderful…hey, I participated in it" (Davis-Floyd 1994:1131). Another in the study had similar sentiments and explained, "…I decided I would prefer to have a Caesarean and so that's what we did. I know some women get all uptight about that but… I didn't feel the least bit cheated and I feel my birth experience was just as happy" (Davis-Floyd 1994:1131). This may be because having agency over birth is a westernized ideal carried forth by middle class women, who view control over their childbirth practices similarly to the control they have in their career (Goodin and Griffiths 2012).

Fear was also cited throughout the literature as a common reason why women elected to have a caesarean section or felt more at ease by having one. This fear is known as tocophobia, or the fear of childbearing (Goodin and Griffiths 2012). This phobia includes fear of pain, of being a "good" mother and putting the child's health first, of impending parenthood, or fear of lack of knowledge, which all ultimately boil down to a fear of not being in control. Childbirth is often spoken about as an insurmountable task or riddled with endless pain, and especially as an event where mothers have little control in terms of pain management and health outcomes (Rafalovich 2016), unless medical intervention is utilized. A survey done by Declercq et al stated that a majority of the women studied had explained they were fearful of their upcoming birth (2007).

Additionally, in a study conducted by Fox and Worts, 65 percent of the women interviewed mentioned being fearful of the pain they had to endure during childbirth (Fox and Worts 1999:336).

Women are also in some ways influenced by society's ideas of what makes a "good mother." In order to successfully achieve the status of a suitable mother, women are often expected to put their child's best interest before their own needs, regardless of the situation. Therefore, a mother's freedom to choose and control her birth can be overshadowed and controlled by her responsibility to protect her baby at all cost. This feeling of obligation and control over the decision making process is governed in many ways by society, even when it is not immediately clear to mothers that their actions are being guided by social pressures to conform (Bryant et al 2007). For example, data collected by Fox and Worts recorded that some women were more worried about the ultimate safety of their baby despite the resulting pain or need for medical intervention. One respondent in the study said, "You just want to have baby. And it's like, 'well, do what you have to do,'" while another remarked, "I was worried about her more than anything ... and the pain just the pain" (334). In different study conducted by Bryant el al (2007), a mother explained, "I didn't feel like it was my choice. But I felt like that's what we needed to do [for the baby]" (1195). In these cases, these women suggest that deferring to medical pressure for c-section is a matter of putting the health of their baby before their own desires; in some ways, the medicalization of birth disempowers women to make choices outside of the medical sphere.

However, this phenomenon is complex, as most women do recognize their own agency and power in their role as mother. In the same way that society can influence a mother's understanding of her role as "mom," a woman's lived experience and personal bias also shapes

this understanding and guides the decision-making process. Thus, while social pressures may affect what women conceptualize as a "good mother" and play a role in shaping their actions, it is not entirely what drives choices women make. Further, cases may exist in which women *want* to act as "mother" in a certain way or even do act make decisions as "mother" in a particular manner that opposes the typical and popular view of a "good mom," but describe their experience to others in a way that fits the mold. Overall, then, women are responding to sometimes contradictory ideologies and forces in both their choices and the justifications of their choices.

These contradictions become visible because while individual mothers in qualitative studies cite a feeling of empowerment during their caesarean, quantitative analysis reveals the opposite. A paper written by Goodwin and Griffiths (2012) found that after their first childbirth experience, "up to 48% after a CS [caesarean section] and 57% after an instrumental delivery, compared to 10% of those women who had a normal delivery" (368) were fearful of future child birthing experiences. This data implies that women who had medical intervention felt powerless during their birthing experiences and, thus, are fearful of similar situations in the future. Additionally, a survey conducted by Declercq et al found that "in comparison with first-time mothers with a vaginal birth, those with a caesarean had different personal traits (less confident as they approached labor)… [and] feelings while giving birth (less capable and powerful)" (Declercq et al 2007:13).

It is clear that there is an obvious disconnect between women's experiences and their perceptions after having a caesarean section. One reason for this divide may be explained by the creation of the docile female body. Worman-Ross and Mix (2013) use Foucault's social theory to argue that the political economy of the body—the necessary way a body must be to function

properly in a capitalistic society—has left women's bodies vulnerable to manipulation. Specifically, Foucault argues that, "[P]ower relations have an immediate hold upon [the body]; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs" (Worman-Ross and Mix 2013:457). In this way, Foucault suggests that a male dominated society has power over the docile and normalized female body and can use it as a form of control. A result of this is that the women's bodies have become a form of male and public property (Worman-Ross and Mix 2013). This is ever present in the current medical model of birth, where male, and now sometimes female, obstetricians enact medicalized and technologized birthing practices *on* the docile female body.

Institutional Context

In addition to maternal choice, outside pressures contribute to the rising rate of medical intervention and caesarean section, decisions made by the medical community, the desire to have status, and societal engrossment in consumerism.

Doctors play a considerable role throughout the course of pregnancy, into the delivery room, and even after the child is born. They assume a role of authority in the situation of pregnancy and childbirth, using their knowledge of the scientific understanding to assert a certain level of control. In America, specifically, scientific information is constructed as the ultimate authority and extends the medical field's control and understanding of the process of childbirth. As detailed by Rothman, *"*The obstetrical perspective on pregnancy and birth is held to be not just one way of looking at it, but to be the truth, the facts, science: other societies may have beliefs about pregnancy, but we believe our medicine has the *facts*" (Rothman 1991:33).

Because doctors assume a role of authority, they also assume some responsibility for a successful delivery process. In this case, the mother and the doctor share power in the delivery

room, but in many cases, doctors reserve the right to make the final or in-the-moment decision about the appropriate course of action. Sometimes foregoing natural birth to perform a caesarean section is a faster or more cost-effective than a women laboring for several days in the delivery room (Fenwick 2007; Savage 2002). Further, in the case of minor or major complications, caesarean section may appear to be a safer option, especially when deemed as such by medical staff.

However, this medical control poses an issue because some doctors do not acknowledge their power in the decision making process. In some cases, the mother who has less knowledge about the statistics and medical outcomes of a caesarean section over a vaginal birth takes the suggestion of the doctor at face value. For example, in a study done by Bryant et al (2007), obstetricians reported that they viewed themselves as guiders of the process rather than active decision makers. This feeling is countered by the laboring woman's understanding of who is in charge. Among interviews conducted with mothers, hospital-based midwives and obstetricians, Bryant et al found that "among respondents, the most widely recognized restriction on women's birthing choices were medical beliefs about what is safe," whereby doctors who deem a certain birth plan unsafe or risky can limit choices for women (Bryant et al 2007:1196). In turn, doctors in this study reported that simply receiving a signature of informed consent for a particular pathway of care represented a mother using her free will to choose a specific procedure for birth (Bryant et al 2007). Nonetheless, receiving a waiver of informed consent to caesarean does *not* equate to a mother choosing to have a c-section; in many cases, that it is a form of relinquishment of power in trusting the doctor to make safe, medically beneficial decisions about the best course of action.

The role of doctors in birth poses a unique and complex display of power and responsibility dynamics. Often, doctors get to make the spur of the moment medical decisions about how the course of delivery will progress, despite women having vision and agency in their birthing process. Even though doctors play a significant role in this decision-making, literature shows that women still feel personally responsible if there are birthing complications, such as the need for surgical birth. They recall that it was their body that failed rather than the medical institution that failed them. Thus, doctors play a visible and very real role during delivery, often influencing or overtly exerting control in the decision making process that can overshadow a woman's right to choose.

Status

Another contextual influence on women's decision of delivery mode is the status one achieves by giving birth a certain way. In the case of caesarean section, status can be gained or lost by delivering through this method. On one hand, a certain sense of luxury and status can be achieved in picking the day of your birth rather than being at will of when your body decides to begin the process of labor. Additionally, access to a hospital with doctors properly trained to complete a caesarean surgery requires a certain level of financial ability. This is indicated in the fact that the countries with the higher average incomes also have higher rates of C-section (Bourgeault et al 2008). Further, choosing to have an elective caesarean gives women access to control over when and how they give birth. Access to power in this sense may also provide a symbol of status for women.

In opposition to this, however, utilization of caesarean as a means to give birth could also result in a loss of status. Arising from the demedicalization movement is a sentiment of "natural birth" as the appropriate way to give birth. Views of "natural birth" vary from birth experienced outside of the hospital, utilizing the assistance of a doula or midwife, or without the use of drugs;

nonetheless, caesarean section almost never falls in the category. Thus, with a society who is increasingly viewing "natural birth," almost exclusively vaginal birth, as the best for mother and baby, women who have a caesarean section may lose social status/capital as they are shamed for their birthing decision.

In the lives of women who have given birth, a culmination of these various pressures act concurrently to shape the birthing and life experience. It would be inadequate to assume that each of these pressures acts independently of each other; instead, a combination of various pressures shape how each woman thinks about herself and her role as a mom, and thus work in concert to create a system that encourages caesarean over vaginal birth. Ultimately, though, this current trend is not one of individual choice, but rather, a societal institution of pressure and control which shapes the way women think about their bodies, their roles as mothers, and they way they must act according to societal gender norms. This is important to note because most scholars and mothers alike who discuss the phenomenon of caesarean section make the assumption that giving birth in this way is an individual choice. In fact, in a study conducted by Bryant et al, almost all of the 36 respondents interviewed, which was comprised of both mothers who had given birth and medical attendants including obstetricians and midwives, viewed mothers as "autonomous individuals entitled to self-determination in their birth experience," rather than speaking about the greater forces which influenced their decision (Bryant et al 2007:1194).

Consumerism

Another external, yet powerful force that shapes the experience of pregnancy and birth for women is the institution of capitalism and consumerism. Capitalism and profit motive influence many aspects of social life, and pregnancy and birth are not immune. Simply put by

Rothman, "Capitalism adds that not only is the body a collection of parts; its parts become commodities" (Rothman 1991:35). Thus, capitalism transforms women's experiences with gestation and delivery into a marketable commodity in order to gain profit.

Consumerism is ever prevalent in the material objects marketed to women during pregnancy such as maternity clothes, hospital bags, pregnancy pillows, and beyond. Further, though, this level of consumerism extends to the use of the body as a material object. Under neoliberal ideology the body is viewed as such: "Individuals are conceptualized as active 'citizens' with rights (to self-determination and commodities) and obligations (to the community and state)… By privileging concepts of self-responsibility and self-management in the private realm of people's lives, neo-liberalism sets up life as a 'project' to be planned and rationalized" (Beck-Gernsheim in Bryant et al 2007). Bryant et al echoes this thought by stating, "Our rights as consumers to self-determination or 'free choice' are paralleled by obligations to prepare for and control our lives, to make the least risky choices and employ modes of 'preventative protection'" (Bryant el al 2007:1195). Therefore, capitalists utilize this desire of safety and predictable outcomes as basis for the creation of purchasable commodities, in the forms of accessories to birth as well as the commodification of delivery itself.

This emerging system of thought leads members of society to seek pathways of action that are controlled and predictable. In regards to pregnancy, obtaining predictability is difficult but has been attempted in the age of consumerism. This is a specifically poignant topic of interest when discussing caesarean section because some view C-section as access to control in the birthing process. Consumerism in this case is a place where women can actively participate in free market consumption, purchasing services from doctors that they feel would benefit them in some way (Bryant et al., 2007). Elective or planned caesarean section is one such service.

Potentially the most impactful way consumerism in birth has risen in presence, however, is through the role of the media. Popular media has introduced and promoted the idea that women are electing to have non-medical c-sections at higher rates than in the past (Mander 2007). Some statistics support this claim; for example, in a report issued by the National Vital Statistics Report, 31.9 percent of women surveyed had a caesarean section and of that population 80 percent of the women were deemed low risk, which one could assume to mean the surgical birth was non-medically necessary. It is important to recognize, however, that low risk does not always indicate an elective caesarean. In fact, in a study done by Declercq et al (2007), of the 252 mothers surveyed, only 1 (0.4%) had a nonmedical elective caesarean, indicating that the presence of pre-planned elective caesarean sections is not as common as we might think.

Theories of Caesarian

What has emerged from this phenomenon of societal pressure resulting in a high level of medicalized birth is a multitude of theories, which attempt to explain how society has reached its current understanding of birth. In methodizing birth in clear and concrete ways, scholars of birth are then able to provide critiques to the current system.

The technocratic model of birth is a framework for understanding how women and outside onlookers view the birthing process, especially as a process that occurs with a mind and body separation. This model emerged as a result of the industrialization and the separation of society from nature through the invention of technology. It is extended to birth, which is often viewed as a natural and uncontrollable biological reality (Davis-Floyd 1994). Present society has deemed the process of birth as inherently a problem and thus has created scientific and technological ways to “fix it” in a way considered safe and controllable (Davis-Floyd 1994).

Specifically, this methodology explains the thought separation society has manifested between mind and body, and, therefore, mom and child, for many women, especially those in positions of power (Davis-Floyd 1994).

This model specifically has manifested from the stories told about what it means to be inherently male or female. In this theory, male bodies became the standard, properly operating machines; then, women's bodies became deviant from the normal and needed to be fixed (Davis-Floyd 1994). In order to sell this theory, society must convince women that their bodies are in fact malfunctioning and in need of medical or technological intervention. Most powerfully, this is enacted by the stories told about pregnancy and childbirth. For example, a 1985 issue of the New England Journal of Medicine published an article that argues in favor of caesarean because "the authors question whether, since birth is such a dangerous and traumatic process for both woman and child, the best obstetric care should perhaps come to include complete removal of the risks of 'normal' labor and delivery" and having a C-section instead (Davis-Floyd 1994:1127).

A more recent theory coined the "one-two punch theory," is a derived and applied version of the technocratic model of birth by which caesarean is a by-product. Specifically, the one-two punch theory provides a conceptual basis by which society can rationalize current birth trends. The one two punch theory acts on the premise that women in childbirth were originally viewed "primitive, dirty, and uncertain, and dangerous," so men were required to intervene and make the process pure, predictable, and safe (Fenwick 2009:1). The first punch requires a removal of an already successful natural process. For childbirth, this is framing the experience as abnormal or of illness and requiring medical intervention as a way to save women. This includes segmenting birth into clear-cut stages and creating standard procedures for how a pregnancy and birth should look, thus isolating them from a once interrupted natural process. Then, punch two

comes with solutions for the artificial problem created. In terms of childbirth, this includes chemical and surgical interventions, such as the use of epidurals and caesarean section to completely avoid the feminine and dangerous aspects of birth and provide order in the process. Fenwick (2009) takes this analogy one step further to describe punch three: the repackaging of this control as inherently natural and necessary. For childbirth, caesarean have become commonplace present-day solution to ensure fetal health during delivery. As caesarean rates rise in highly resourced countries, the procedure becomes normalized and its presence is further manipulated. For example, one physician described a way in which to have a caesarean birth that followed the pattern of vaginal one. Instead of just promoting a natural vaginal birth, this framework allows doctors to cater to a growing demand for natural birth while still maintaining control over the process by which birth is completed.

While these theories provide a clear framework for understanding birth, they also have practical implications in the daily lives of women. In general, an application of both the one-two punch theory and the technocratic model of birth explain how society has reached a point where medical intervention is the norm.

Research Questions

After reviewing the history of childbirth and contemporary trends in various modes of childbearing, it is important to understand what societal influences contribute to a trend of increasing medicalization of birth, despite activism to move away from this. Therefore this study aims to answer the following question: What are the language, themes, messages used in popular media, such as parenting magazines and “mommy blogs” and how do they characterize caesarian

births for women? Do these sources normalize and rationalize caesarean as mode of child bearing? Where do these sources locate control in the birth process for prospective mothers?

Methods

To address these questions, I conducted a content analysis, a type of research that examines published written or oral language and documents to extrapolate common themes and contextualize those meanings in a given time or place. Because content analysis is effective at measuring changes in social attitudes overtime, this mode of research is appropriate for uncovering the narratives and messages told about caesarean sections in public, online spaces (Singleton et al. 1993). To conduct this content analysis, I reviewed two popular parenting blogs to uncover the most common themes associated with caesarean section based on the language used on these two sites.

The unit of analysis being studied is written articles published in one of two different parenting blogs. Parents cited books and popular media, such as TV, as a major source of their information on pregnancy and birth in comparison to traditional places such as education classes (Declercq et al 2007).

The first data source analyzed is the *Parents* website. *Parents* is a monthly magazine publication that "features scientific information on child development." The magazine also has a website with free, online articles. The *Parents* brand is owned by the Meredith Women's Network, which owns several other parental advice-oriented companies including *Parenting.com.* This source provides good insight into the language utilized in a largely commercial environment to talk about pregnancy and childbearing.

The second data source analyzed is ScaryMommy, an online blog. ScaryMommy is an online blog founded in 2008 by one mother and has since grown into a compilation of many authors, of which most are mothers, who contribute articles to the site. This data source allows for an understanding of how individual mothers talk about pregnancy and child rearing.

Sampling

For each of the two sources, I collected the most recent 100 articles as of January 20, 2019. I imported all of these articles as PDFs into NVivo, a qualitative analysis software program. I read through each of these articles and coded them for whether they mentioned caesarean section, to ascertain how commonly this topic appeared in this form of media. For further analysis of themes related to caesarian section, I used only those articles that mentioned caesarean section at least once in the title or body of the article.

Development of Codes

Because this research is both inductive and deductive, I created a list of themes I expected to appear based on previous primary literature. Then, I read the selected articles to confirm the list of the themes already created as well as make additions to the list. Then, I reread the articles and systematically coded specific words, phrases, and paragraphs that invoked the themes previously chosen. The list of themes coded for can be found in Appendix A.

Using this system of coding, I am able to characterize the frequency of a particular concept's presence, whether they are more likely to appear in one source or the other, and the meanings behind the language used.

Referencing Articles

Articles referenced for evidence in this thesis will be denoted "P" for *Parents* or "SM" for *ScaryMommy.* A full list of articles utilized for the content analysis can be found in Appendix B.

Results

The first component of this research sought to determine how prevalent the discussion of caesarean section was in popular media. To this end, I began the study by counting the amount of times the subject of caesarean section was mentioned in the articles used in the study. Of the 200 articles reviewed, at total of 90 mentioned caesarean section. Some of these articles only mentioned it once, while for other articles, the entire subject of the text was about c-sections. Thus, 45% of the articles make reference to caesarean section. A book by Singleton, Straits, and Straits (1993) states that the number of times something is mentioned can be a testament to its cultural or societal importance, especially when analyzing text circulated throughout the popular media. Thus, having a topic mentioned 45 percent of the time is fairly significant, indicating this is a culturally important and widely discussed topic.

Blog Differences

When comparing the two online blog circulations, the frequency of discussion of caesarean section was about equal between the two. *ScaryMommy* had 49 articles that discussed some form of caesarean section in the text body, where as *Parents* had 40 articles. This indicates that among different types of viewers of mom blogs, interest in caesarean discussion remained constant and important.

In addition, the composition of authors on the 90 articles in review was heavily skewed towards women in both sources. Of the 40 text examined from *Parents* women wrote, 35, or 87.5% of the articles. Gender identity was determined by name and picture when applicable. Further, 20% of the articles were written specifically by a doctor and all but one doctor was female. Despite only 20% of the articles being authored in totality by doctors, many more of the articles cite or quote doctors in their discussion. Following in suit, 100% of the articles shared on *ScaryMommy* were written by women. Only 1 article of the 49 specifically distinguished that a medical practitioner, a women's' health physical therapist, had written the article.

Another major difference between *ScaryMommy* and *Parents* is the prose and tone of the article. Most of the articles uploaded to *ScaryMommy* are first-account narrative pieces written by mothers who have been through a particular experience. The articles are written in the form of story telling, with the authors often quoting their own thoughts as well as recounting those who accompanied them in their journey. In contrast, *Parents* is written more from an observatory/warning scientific standpoint and utilizes quotes from doctors and professionals in the field. In fact, statistics were only coded for 7 times total in the *ScaryMommy* articles where as there were 35 codes for utilization of statistics in Parents. This reference to hard science may have been used to incite fear but also provide concrete knowledge to the readers, given that it is a more commercialized source.

Reasons For Caesareans

A common theme throughout both sources was the presence of authors listing the reasons they chose to or needed to have a caesarean section. Between both sources, citing reasons for a caesarean was coded 74 times total. *Parents* more often described the medical reasons a

caesarean could be necessary, including breeched baby, placenta previa, oversized child, prolonged labor, or fetal distress. However, in addition, they make more reference to the concept of elective c-sections. One source even argued, "Today, the majority of cesareans are still performed for medical reasons…but more and more women are requesting to give birth by c-section… According to a report from HealthGrades, a healthcare-information company, the number of elective c-sections -- first-time, preplanned csections with no medical need -- rose 36 percent between 2001 and 2003" (P1). On the other hand, *ScaryMommy* was written by women who gave first-hand accounts of their personal reason for needing or wanting a caesarean.

Nonetheless, both sources discussed the most prevalent reason for caesarean as being an unplanned or emergency event. As one mother describes her emergency section, she says, "I pushed and pushed and refused to give up until the doctors said that an emergency C-Section was necessary as my child's vital signs were dropping" (SM1). Another woman describes a similar experience when she details, "Yes, my uterus is a quitter…so with babies' heart rate going all over the place and me feeling like garbage, into the Operating Room I went" (SM2). Often women discussed their disappointment at delivering via emergency c-section, like one mom who explained, "An emergency C-section isn't the dream outcome when you go into labor. You're tired, you're scared, and you're in pain. You feel completely out of control" (SM3). Overall, however, these feelings of discontent were most often followed by a framing of the caesarean as necessary for the health of the baby and therefore worth it.

One women details her active decision to put the needs of her child before her own emotions. She explains, "A C-section mama must hold onto the strong and fierce love she has for her baby. She lets fear wash over her…and then she lets it drift away. She knows that in this moment, this is what is best for her child, even though 'what's best' means a major surgery with

real wounds and scars. Even though 'what's best' means letting go of a dream or a vision of birth that she's been building up for the last nine months" (SM4). Other mothers explain their moment-of decision to relinquish their desires to save their child in terms of what the doctor deems as the best course of action. These articles make visible the very real pressure women feel to adequately perform the role of mother. Of course most women want for their baby to be safe, but they must also balance this with the perception of acting as a good mother in the eyes of others. Thus, despite many authors expressing their desire for a vaginal birth, they ultimately trust the physician to keep their child healthy, even when that meant putting aside their own wants and needs.

Emotional aspects of C-section

Shame/Failure

One of the most prevalent emotions discussed in the articles was shame, which was often caused by feelings of failure. Numbers show that *Parents'* entries were only coded under "shame" or "failure" six times, while both together were coded in *ScaryMommy* articles 44 times. From this, it can be inferred that women in the community who have been through the process of giving birth share feelings of shame stigma more than the writers of the *Parents* blog which is more heavily concentrated on quotes from doctors and current medical advice.

A majority of the articles that refer to shame are ones that discuss it as failing at birth because they did not "do it right." Some women described being ashamed of themselves, while others talk about feeling actively shamed by their peers. Regardless of what spurred the feeling, shame itself is inherently brought on by judgment or comparison to others because as Scheff explains. "shame… [is] a social emotion arising from viewing one's self from the standpoint of

another…[where] shame occurs when one feels negatively evaluated by self or others" (Britt and Hesie 2000:253). Thus, even when the shame discussed was described by the women as emerging from within themselves, it is still stemming from comparison to others.

Shame was recognized when women described their birthing experience as embarrassing, a failure, or shameful due to their own actions or agency in their birthing experience. For example, one woman explained, "The stigma of a cesarean birth is so very real, and I felt a huge burden of failure as a mom to have not delivered my child in the 'right way'" (P2). Another says, "My eyes were filling with tears of inadequacy and sheer terror -- each salty droplet an embarrassment… How is that possible? I wondered. I should have been pushing, yelling, at the very least sweating. Instead, I lay on a table, feeling useless, while everyone else did the work. I'm failing, I failed were the words that looped through my mind" (P3). Here, both mothers are responding to the social expectation of what it means to deliver a child in the "proper" way.

This feeling of failure manifests as feelings of inadequacy, of not doing birth the "correct" way or feeling the lack of an active role during the delivery. In this sense, women experiencing internalized shame view this feeling as something unique to them and their agency or ability during birth. One women, who had a emergency c-section, explained, "I never dared to say it proudly; rather I shrugged my shoulders and would mumble, 'Unfortunately I had to have a C-section,' to which all the questions of 'Why?' would start. And do you know how all of my 'Why?' answers started? They started with things like, 'I couldn't…' 'My body didn't…' 'I'm not able to…' 'I can't…' My fault. My fault. My fault" (SM5). She explains further, "It didn't matter to me that the C-section saved my son's life and mine. As a matter of fact, for many months after, that actually never entered my mind. Instead, guilt and failure did… Whether or not it was self-induced and unjustified guilt didn't matter to me; I simply could not get over the

thought I had failed as a mother before I had even started" (SM5). Again, this shame manifested from feelings of inadequacy because the mothers themselves felt as they they were not good enough, either physically or mentally, to give birth in the "proper" way.

Many women internalized this shame as the failure to be a "good mom." Although there was not just one way the authors defined a "good mom," many of them bring up the idea of adhering to current social and medical standards about birth as method to achieve such status. When they are unable to follow the popular model, it often leads to feelings of shame or failure. As one mother describes, "In that moment [of birth], I thought I failed—as a planner, as a woman, as a mom. I thought that women's bodies were made for this—this moment, this big event—and my body was failing me when I needed it most. I cried to myself, selfishly, thinking I failed my daughter. She wouldn't enter this world being kissed by all that good bacteria, I wouldn't be able to have delayed cord clamping, and I wouldn't even be able to hold her immediately" (SM6). This mother based her performance as a mother during delivery in comparison to the popular or accepted model of birth and ultimately felt like she did not measure up.

In contrast, though, some mothers rationalized or rectified the feeling of shame by the assertion that this act of caesarean section, although a seeming shameful failure in the eyes of the mother, was what was best for the baby. In many cases throughout the articles, these two codes went hand in hand. To exemplify, in one article, a mother described her delivery experience as such: "The obstetrician swooped in and explained that it wasn't safe to labor any longer; it was time to get the baby out. I felt a brief wave of grief, but no hesitation: 'Yes, do it.' In that very moment—as I traded my own wishes for my child's safety—a mother was born" (SM7). Although she felt her needs were being neglected and subsequent grief about it, she reconciles

this feeling because it was the necessary action for the health of her baby. Yet another mother enacted self-sanctioning as she faced the dilemma of having an unwanted c-section. She describes, “But then, when the baby’s heart rate started dropping hard during contractions, when there was talk of a wrapped cord, and the might turned into an, ‘I’m sorry, this is it,’ I had no more tears. I realized that I had been crying for myself, crying because I had failed at childbirth and become one of those women I had judged. In that moment, all I cared about was our baby, not my pride” (SM8). Again here she is rationalizing this mode of birth despite the shame and stigma that surrounds it because it is what is necessary to have a healthy child; in fact, in this moment she comes to the understanding that in order to be a “good mom” she must go against her own and societal views on how such a mom should deliver their baby. In fact, this rationalization of C-section happened in a more direct form as well, where women used this very argument to help explain to others that they had had a caesarean. This mother wrote further, “It still took me a while to let go of my ego though. I didn’t want people to know about the C-section. Or, if I did tell them, I had to include this convoluted story just to prove to them that I did try, that it was absolutely necessary, that I had a good doctor, not one of those who rushes to intervention” (SM8). The desire to do what is best for the baby while also adhering to societal views of the “best” mode of delivery is convoluted struggle in which many women find themselves; specifically, trying to achieve a “natural” birth in a society where medical delivery is the norm is difficult and often unattainable. Therefore, many mothers assert that their mode of delivery was the best option for their baby as a way to combat judgment by others or themselves.

However, while some women in this category viewed shame as something arising from a failure within themselves, all shame at some level is a result external shame or shame induced by societal comparison. To this end, women felt shamed by other mothers rather than other groups

like doctors or men. In many ways, it manifested as competition. It was well explained by one author who wrote, "Occasionally, you may even hear a somewhat competitive tone slip into these conversations as to which mom was in the most pain or who had it worse during the whole birthing process…sometimes moms who are feeling inadequate or insecure can get caught up in that whole idea that you've got to have that raw, drug-free, natural birth, exclusively breastfeed once the baby is born, and just be an all-around super-human mother in general" (SM9). The competition is often a direct fight for who felt the greatest or the worst or gave birth with the least intervention, but overall it was just women putting others down to rationalize their own delivery experience. One women described the pressure to compete as such: "If you need medication, your birth is somehow lessened. If you need a C-section, you didn't crush birth. If you need to be stitched up, your birth is somehow lessened…Birth itself becomes a competition in which you win or you lose" (SM19). Another women said, "And to top it off, you have all these women going on and on about how happy and complete they feel postpartum, and here you are feeling extremely guilty because you are having a hard time. Damn those Baby Center chat rooms" (SM20). In this case, this mother, like most, felt shame as a direct result of hearing other women talk about their perceived success during delivery.

Although some shaming happened overtly with direct interactions between mothers in person or online, other mothers experienced indirect shaming through popular media. The woman who had previously classified her guilt as internal or self-induced shame went on to say, "With each and every other natural childbirth story I read or saw documented on TV, I cringed in defeat and cursed my broken body, my scar, and my complete and total failure to do something that is seemingly the most natural thing in the world to do: have a damn baby come out the way nature intended it to" (SM5). Another mother encountered a similar experience. She explains, "I

didn't realize that C-section guilt was a thing, but as I searched for C-section information online, I came across a lot of C-section bashing online and on social media. There are lots of people who consider having a C-section 'the easy way out.' There really are some people, who, for religious reasons, think that because you have a C-section, you didn't really give birth. And there really are lots of people, like my friend, who feel guilty for not having a vaginal delivery. Google 'having a C-section is not giving birth,' and you'll see that it's a topic of discussion on countless forums and websites" (SM10).

This is highly related to the history of childbirth and how it has changed over time. Because there has been a push to move towards "natural" birth, or one without the use of medical or surgical intervention, women who end up utilizing these services to help in the birthing process tend to feel shame or like failures.

Many of the authors discuss how we *shouldn't* be judging or shaming mothers, which itself inherently eludes to the fact that women are shamed for this very act. For example, one author remarked, "Don't judge another's vagina by one's own vagina" (SM11), while another explicitly described the need to stop shaming mothers by saying, "Of course, we all know that vaginal birth is not always possible for mothers—and that C-section moms definitely don't need another thing to feel guilty or judged about" (SM12). A "But should you feel less proud of yourself for producing a human being from your own body if your labor finished in less time than the next mom? Nope. Are you more of a woman if you pushed a baby out the "natural" way or had a C-section instead? Nope… No woman should ever feel less-than for not giving birth in a way that someone else thinks is more superior based on a level of pain or any other factor" (SM9).

Pride, Bravery, and Strength

Less prevalent but still important themes discovered were the feelings of pride, strength, and bravery. In the article "From Shame to Pride in Identity Politics," Britt and Heise discuss shame and pride as reflexive emotions, where pride is the opposite of shame of shame in that it "involves feel[ing] positively evaluated by self or others" (Britt and Heise 2000:253). One women describes her feeling of pride as such: "On the day of the birth of my last son (via scheduled C-section), I strutted (waddled) into that hospital like I was on the red carpet of a movie premiere. Not a twinge of guilt, what-ifs, shame, self-doubt, or one ounce of birth humiliation was in my body. What replaced it was a combination of 'I don't give a fuck' and overwhelming gratitude" (SM5). Pride, which was often accompanied by the discussion of brave and strong mothers, was expressed as satisfaction and public announcement of the choice to have a caesarean as a positive and sought after experience.

However, even when women start to frame their experience as one worthy of pride, they still must contest the idea that their birthing process could be perceived as shameful. One author writes, "However you birth your baby, you are an incredible, strong, beautiful mama. Birth matters, and every mother should be able to feel like they are respected, heard, and treated kindly in the delivery room" (SM13). Explaining that mothers *should* be able to feel respected and heard indicates that at some level they are not experiencing those courtesies.

Interestingly, at no point in the 90 articles did women talk about the pride they felt in their bodies or themselves for giving birth via Caesarean section. Instead, their pride stemmed from making the right decision about how to give birth.

Physical Reality

The physical reality of c-section was coded for when the actual aspects of the surgery itself were detailed or there was a description given of the bodily changes that happen after giving birth via caesarean section. Because caesareans are major abdominal surgery, changes to the body after c-sections are common to this group of mothers. Overall, discussion of the physical reality of c-section was mentioned 60 times between the two articles and has been broken down into two sections for further discussion: procedure and post-procedure.

Procedure

Procedure was coded for when the authors of the articles discussed what a caesarean might medically look like as well as what they physically felt during their experience with the process. While it was coded 25 times in total, it was skewed more heavily in presence in *ScaryMommy*. The authors of the articles talk most often about the actual feeling and process of having a c-section.

The author of "6 Things I Wish I'd Known about Having a C-section" detailed her experience with caesarean. She explained, "This is, after all, major surgery. I mean, my husband saw my intestines being pulled out, for crying out loud...Think you won't feel a thing? Think again. While you won't feel them cutting or feel pain, no one told me I'd feel all this tremendous pulling as they pried my son out of my body cavity. My OB warned me 'Okay, you might feel some slight pressure.' Slight? This is not a flu shot, people. I don't call the sensation of someone yanking a bowling ball out of my loins a slight sensation" (SM14). As she mentions, the sensation of tugging and pressure, but not pain, was mentioned by several women. Another

mother said, “The surgery was painless, but there was enormous pressure once they began manipulating the baby. During the last minute before birth, there was tremendous wrenching and tugging that shook my whole body and bobbled my head” (SM7). Thus, common discussion of the procedure included a description of the way it felt for the mother who was having the surgery.

Without explicitly saying so, women described the separation of bodily feeling from their consciousness during the surgery. As described by one mother, “Everybody scrubbed up, moving with a surreal sense of urgency that I’d only ever seen on TV. My husband watched in poorly-disguised horror as our son was excised from my body through a deep incision. “They laid your guts on your chest!” he would later report to me“ (SM15). Further, a female author vividly described the process by saying, “My first son was born 19 years ago via emergency C-section, and I felt I had been biologically sucker-punched. I was totally gutted. Literally, filleted on the table like a rainbow trout” (SM5). This experience provided the basis for the emotional aspects of caesarean given that such intense physical feeling and experience must be rationalized by the mind. Thus, it makes sense when one woman explained her delivery experience in similar terms. She said, “After about half an hour of feeling my insides being pulled and tugged apart and wondering what the hell was taking so long, I don’t feel guilty about having a C-section. After hearing the doctor say that she was having trouble getting through my abdominal muscles and had to ‘be careful not to nick [my] bladder,’ I don’t feel guilty. After listening to metal instruments clanging together and hearing nurses commenting on my loss of blood, I don’t feel guilty. After watching my husband constantly checking the clock and standing up twice to peer over the drape and seeing my insides splayed all over the place, I don’t feel guilty” (SM10). Here she is explaining her emotional response to her physical reality.

Post-procedure

In post-procedure discussion, women talked about the difficulties that accompany major abdominal surgery. The physical consequences of major abdominal surgery can be severe. As one women describes, "If you're likely to get a C-section (i.e., are American) or planning one—don't fret too much. It's really only bad for less than a week. You will re-learn to walk. You will get to cough and laugh without holding a pillow to your stomach…You'll get a badass scar out of it, a fling with Vicodin, and a tummy the texture of Cool Whip. Oh, and a baby. You'll get at least one baby" (SM16). In another mother's words, "I felt like I had been sawed in half by a magician only it wasn't really an illusion. Sure, my lady bits were intact, but I couldn't appreciate that fact on account of the searing pain in my abdomen every time I laughed, coughed, sneezed, or moved. And where my tattered vagina had started to feel reasonably normal reasonably soon after my first three births, my C-section discomfort persisted for weeks" (SM15). These physical ailments impede women's ability to do daily tasks as well as make it difficult to care for a newborn baby. Women may have commonly discussed this topic throughout the articles as a way to show that they have legitimate injuries from their caesarean procedure, thus suggesting they did not just take the "easy way out."

Again, this section is an important topic because discussion of the physical aspects of caesarean sections are often what led into a discussion of the emotional aspects of a c-section. Thus, the physical reality and consequences of having abdominal surgery may be why negative perceptions and emotions continue to surround the discussion of caesarean sections.

Control and Body alienation

Lack of control and gain of control were mentioned at almost identical rates between the two sources. Discussion of the caesarean procedure often created a platform for discussion of the feelings of loss or gain of control.

Lack of control was recognized when women described their birthing experience as not being able to take an active role in the decision-making projects. The author of "Growing Concerns: Doctors Respond to Women's Fears about Labor" explains, "On the birth day itself, you may not be able to control as much as you'd like, so being armed with information goes a long way toward making that event as stress-free as possible… Whether a baby can navigate through the birth canal is not something doctors can necessarily control or predict" (P4). Although this mother describes her lack of control in rather mundane and calm terms, other women described more extreme or intense loss of control. One mother explained, "After being strapped down to a table and feeling like I was about to be crucified… I felt a massive amount of suction and realized that it was my son being pulled out of me at last. I heard him cry, and I watched him get cleaned up, weighed and measured from a distance. I cried, but I couldn't wipe my tears. I couldn't hold my baby right away because my arms were still strapped down, and it took another half hour for them to put me back together and stitch me back up" (SM10). Not only did this mother experience lack of control in decision making, she was physically restrained, resulting in a total loss of body control.

Body alienation is a specific type of loss of control in which the mother felt disconnected from her body or as though she had no control what was happening to it. These situations often manifested when the woman discussed things happening *to* her during pregnancy or her taking a

passive role in the process rather than her taking an active role or being in charge of her own bodily happenings and functioning. Thus, most women used this loss of control as a basis for the disconnect they felt towards their bodies. One woman explains this sentiment perfectly when she said, “A divider went up to shield me from my own numb body…I wasn't giving birth. No, this birth was happening to me… I lay on a table, feeling useless, while everyone else did the work” (P3) while another echos this feeling in her statement, “I thought that I was a mere passenger, copiloting her birth instead of driving it myself” (SM6).

Some women specifically reference their experience with actively losing agency over their own bodies and thus viewing their bodies as objects separate from themselves. One woman details her expectation of her caesarean in this sense. She says, “I just figured they’d wheel me in, I’d lay there like a corpse, and then hours later I’d be sitting up in bed, holding a baby, looking glowing and happy in an adorable robe like Rachel in Friends (SM14). In this case, the thought of relinquishing control to the medical staff did not appear to cause her negative feelings, but some women felt like they had lost something because they were not connected with their bodies during the process. The author of “Why I’m Opting for a VBAC for My Last Pregnancy explained, “I felt like I missed out on the magic of childbirth because I was heavily drugged and couldn’t see, feel, or truly understand what was happening” (SM17). This disappointed sentiment was common among several women who had caesarean sections, but it was not the only emotion derived from the experience.

Although most often women experienced lack of control and body alienation in a negative light, some women reframed this experience in a positive way and in turn were grateful for it. One mother explained, “You can shit-talk the birth industrial complex up and down, but when it’s the only option, the spinal and the knife still welcome you with cold but open arms. As they

were pulling my guts aside, elbow deep into my pelvis, doing the very thing I had never prepared for, all I could feel was gratitude. And sweet relief when I heard that first cry" (SM8). Although less prevalent, this woman viewed her loss of caesarean as positive because it allowed her child to be born safely. Thus, loss of control in the birthing process is not always negative.

In contrast, some women viewed their need to have a caesarean not in terms of loss of control or even gratitude for it, but viewed the mode of delivery as allowing them to gain control of their actions and body. This group of women actively decided for caesarean. One mother explains her experience as such: "I signed the consent form willingly and with relief and enjoyed the final four days of my pregnancy fully. The fear was gone. Yes, I could have tried a vaginal birth. But would you endanger your mental health? Would you risk disappearing for months or years while you fought your way back to feeling safe in your skin? I made a choice—a choice I still stand by. My son, my perfect, beautiful boy was born in an operating room…It's the choice that matters; it's being in control and feeling heard" (SM18).

Conclusion

There are several themes present throughout the articles, which indicate that women who have had caesarean sections often endure negative physical and emotional consequences as a result. In many ways, we can use the theories of caesarean to conceptualize these findings.

The technocratic model directly correlates to the findings presented in the articles. This model discusses the separation of the mind and body as a form of control (Davis-Floyd 1994). This was directly discussed when the authors of the articles talked about feeling the loss of control of their bodily functions as well as in their decision-making process. It was displayed further when women expressed the feeling of body alienation, in which their agency was disconnected from the action happening to their physical bodies. As explained by the

technocratic model of birth, this separation is a form of societal control in which women are convinced of their bodies' inability to perform in the natural and proper way and thus relinquish control to other forces (Davis-Floyd 1994).

The anecdotes of the women's birthing experience also, at some level, align with the one-two punch theory. This theory describes current medicalized birth in a two-step process from its original form. In the first step, societal powers remove a natural process, like vaginal childbirth without the intervention of medicine or doctors, and frame it as unsafe or risky. Then, these same powers "solve" the new societal concern with artificial or technological solutions that can be controlled; in the case of birth, these solutions include medical and surgical delivery (Davis-Floyd 1994). Because all of the women analyzed in this study have given birth via c-section, this model can rationalize the basis for their experiences.

The third punch in this theory is a reframing of the technical solution as inherently natural and necessary (Fenwick 2009). Several of the articles touch on this point. Specifically, the article titled "C-Section is Natural Birth Too" exactly exemplifies this part of the theory. Reframing a non-natural experience as natural is precisely what the third punch of this model references. This aspect of the culture of caesarean section is problematic. It is important to understand that C-sections are *not* natural. While they provide an important role for the delivery of some children, they should be viewed as a medical intervention in the case of emergencies. Promoting the idea that they are natural allows their presence to persist at such high rates in western societies.

While some of the articles can accurately be explained by the first three "punches," many of the articles do not fit into these frameworks. What has emerged is a fourth "punch" of sorts in which women have begun to understand their caesarean as a personal failure. Many of the articles discuss the shame women experience over their birth process, whether they feel it was

necessary or not. Thus, while women now recognize that this mode of birth is not what is best in all cases, their public condemnation of caesarean in an effort to restore demedicalized birth has manifested in harmful and destructive ways for those who need it in cases of emergency. Ultimately, women have found themselves stuck between taking control and giving up control and caught between choosing a medicalized or non-medicalized birth experience, all in the pursuit of achieving the status of "good mother." No matter what decision is made, though, it is hard for mothers to ever fully "measure up," and this can lead to the detrimental discourse and judgment women impose on mothers based on their delivery decisions.

It is clear throughout this thesis that many of the women felt shame when comparing themselves to others, either from personal interactions from other women or from online sources that discuss these topics such as parent blogs and social networking sites. Thus, the results of this research are paramount because the very content analyzed in this thesis influences and teaches moms about how to feel about their bodies or their actions during pregnancy and delivery. Studying the themes and messages disseminated to mothers can help shed light on the culture and experiences of women who have had C-sections and can ultimately help shape future literature about the topic to be more encouraging and uplifting to mothers of all delivery experiences.

This content analysis can be used as a basis for future research. This thesis is only a content analysis of articles in popular parenting blog; immediate future research could be done to understand how the messages shared in these articles affected the readers of the articles.

Further, experiences with birth, like experiences with anything, do not happen in one-dimension or through one lens of lived reality. While women experiencing shame, fear, pride, do so in the role of mother, they also carry other race, socioeconomic status, religion, and even

sexuality/sexual orientation identities with them as well that influence their perception of the world and society's perception of them. Moving forward, future research should be conducted to determine how different groups of women are affected by this topic. While it is now clear that mothers are often shamed for giving birth via caesarean section, an exploration of how different minorities specifically experience this situation will allow steps to be taken to lessen the inequality and hopefully create a welcoming and positive environment for mothers of all identities to experience birth in their own way.

Overall, the sociology of caesarean section is a complex and ever-changing topic that affects women daily all over the world. Many different groups of people play a role in the rates and reasons for the presence, and the implications and consequences of having a caesarean section are vast and far-reaching for mothers. Above all, though, it is imperative that women who have C-sections know that "C-section mommas are real moms too."

Works Cited

"Birth & Death Rates." *Ecology Global Network*. Retrieved November 27, 2018 (http://www.ecology.com/birth-death-rates/).

Britt, Lory and David Heise. 2000. "From Shame to Pride in Identity Politics." Pp. 252–68 in *Self, Identity, and Social Movements*. Minneapolis: University of Minnesota Press.

Bryant, Joanne, Maree Porter, Sally K. Tracy, and Elizabeth A. Sullivan. 2007. "Caesarean Birth: Consumption, Safety, Order, and Good Mothering." *Social Science & Medicine* 65(6):1192–1201.

Bourgeault, Ivy Lynn, Eugene Declercq, Jane Sandall, Sirpa Wrede, Meredith Vanstone, Edwin van Teijlingen, Raymond DeVries, and Cecilia Benoit. 2008. "Too Posh To Push? Comparative Perspectives on Maternal Request Caesarean Sections in Canada, the US, the UK and Finland." Pp. 99–123 in *Advances in Medical Sociology*. Vol. 10. Bingley: Emerald (MCB UP).

Calhoun, Craig, Joseph Gerteis, James Moody, Steven Pfaff, and Indermohan Kirk. 2012. *Classical Sociological Theory, Third Edition*. Wiley-Blackwell.

Cooley, Charles Horton. 2013 [1909]. "Social and Individual Aspects of the Mind." in *Social Organization, A Study of the Larger Mind*. New York: Shocken Books.

Davis-Floyd, R. E. 1994. "The Technocratic Body: American Childbirth as Cultural Expression." *Social Science & Medicine (1982)* 38(8):1125–40.

Declercq, Eugene R., Carol Sakala, Maureen P. Corry, and Sandra Applebaum. 2007. "Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences." *The Journal of Perinatal Education* 16(4):9–14.

Fenwick, Jennifer. 2009. "Caesarean Section: The Ultimate by-Product of the One Two Punch Theory." *Women and Birth* 22(4):107–8.

Fox, Bonnie and Diana Worts. 1999. “Revisiting the Critique of Medicalized Childbirth: A Contribution to the Sociology of Birth.” *Gender and Society* 13(3):326–46.

Fransisco, Kara. 2017. “Childbirth.” in *The Wiley Blackwell Encyclopedia of Family Studies*, edited by C. L. Shehan. Hoboken: Wiley.

Goodin, Mary and Malcolm Griffiths. 2012. “Caesarean Section on Demand.” *Obstetrics, Gynecology & Reproductive Medicine* 22(12):368–70.

Jolly, Natalie. 2018. “Cutting through the Discussion on Caesarean Delivery: Birth Practices as Social Practices.” *Health Sociology Review* 27(1):31–44.

Lyerly, Anne Drapkin. 2006. “Shame, Gender, Birth.” *Hypatia* 21(1):101–18.

Mander, Rosemary. 2007. *Caesarean: Just Another Way of Birth?* Abingdon [UK] ; New York: Routledge.

Mankiller, Wilma P., Gwendolyn Mink, Marysa Navarro, Gloria Steinem, and Barbara Smith. 1999. *The Reader’s Companion to U.S. Women’s History*. Houghton Mifflin Harcourt.

“National Vital Statistics Reports Volume 67, Number 1, January 31, 2018.” 55.

“Population, Female (% of Total) | Data.” Retrieved November 27, 2018 (https://data.worldbank.org/indicator/SP.POP.TOTL.FE.ZS).

Rafalovich, Adam. 2016. “Pain Is the Club: Identity and Membership in the Natural Childbirth Community.” *Qualitative Sociology Review* 12(3):100–116.

Rothman, Barbara K. 1991. *In Labor: Women and Power in the Birthplace*. W W Norton & Co Inc.

Singleton, Royce Jr., Bruce C. Straits, and Margaret Miller Straits. 1993. *Approaches to Social Research*. Second. New York: Oxford University Press.

Savage, Wendy. 2002. “Caesarean Section: Who Chooses – the Woman or Her Doctor?” Pp. 263–83 in *Ethical issues in maternal-fetal medicine*.

Wertz, Richard W. and Wertz, Dorothy C. 1989. *Lying-In: A History of Childbirth in America*. Expanded Edition. New Haven and London: Yale University Press.

Worman-Ross, Kathryn and Tamara L. Mix. 2013. "'I Wanted Empowerment, Healing, and Respect': Homebirth as Challenge to Medical Hegemony." *Sociological Spectrum* 33(5):453–81.

Appendix A.

- Commercialization
    - This section was utilized when the articles made reference to material items that women could use during pregnancy, delivery, or after birth,
- Control
    - Lack of control
        - This code was used for when authors wrote about feeling out of control physically or mentally or having a lack of agency during and post-delivery.
    - Gain of control
        - This section was utilized for when authors wrote about the experience with a caesarean helped them feel more in control or gain agency during or post-delivery.
    - Body alienation
        - This code was recorded when women spoke specifically about feeling mentally or physically disconnected from their bodies, either as a result of pregnancy, delivery, or the way they were treated after giving birth.
- Cost
    - This code was used for when the authors of the articles discussed any financial aspect of having a C-section, either during or after the procedure.

- Emotions
    - Strength
        - This section was used for women who talked about feeling strong or referenced the strength, both mentally and physically, of women who had had caesarean sections.
    - Shame
        - This section was coded for whenever women discussed feeling ashamed of themselves or shamed by others for their birthing choices, experience, or emotions.
    - Pride
        - This code was recorded anytime authors spoke of themselves or others feeling pride when it related to having a caesarean section.
    - Loss
        - Loss was coded for whenever the author spoke about feeling like something was taken or she missed out on an opportunity because of her caesarean section.
    - Guilt
        - Guilt was coded for whenever the author discussed feeling blameworthy for any part of her caesarean, including but not limited to guilty for having the procedure, for wanting the procedure, or for not wanting the procedure even when it was proposed as the best option.

- Gratitude
  - This section was utilized when the women in the articles expressed being thankful for having a caesarean, having access to medical interventions during birth, or for delivering a health baby via caesarean section.
- Fear
  - This code was recorded whenever women expressed fear in any aspect around birth and delivery.
- Failure
  - This section was coded for when women referred to themselves or others as having failed or being failures during the birth of their child.
- Disappointment
  - This code was used when the authors discussed feeling let down by any aspect of their own or others experiences or thoughts about caesarean section.
- Brave
  - Passages were coded as "brave" when authors referred to themselves or others as courageous, brave, or another similar sentiment for having a caesarean section or handling the process or their emotions well.
- Alone
  - This code was utilized when mothers talked about feeling isolated or alone physically or mentally throughout a caesarean or post-delivery.

- Expectation vs. reality
    - This code was used when women discussed the difference between their actual experience with delivery in opposition to things they had heard about birth before either from family, friends, books, or the media
- Physical Reality
    - Pain
        - Any time an author referenced the pain of childbirth, and specifically C-sections, it was coded in this section. This included first-person accounts of feeling pain or women discussing things they had heard about the procedure being painful.
    - Procedure
        - This section encompassed any discussion of what the step by step process of caesarean looks like or how it felt to the women writing the articles.
    - Post-Procedure
        - This code was used to record any discussion of the ramifications or experiences women had with their bodies physically after they had a C-section.
- Preventing C-section
    - This code was used when women talked about the ways they planned and prepared for birth in order to avoid the need for caesarean section.

- Real birth
    - This code was utilized when articles talked about their birth being “real” or “natural” birth without intervention. In different articles the type of intervention varied (medicine, forceps, surgery, birth in hospital).
- Reason
    - Best for baby
        - This was marked when authors stated that the reason for their decisions during delivery was because it was in the best interest for their baby. This code was often used as a rationalization for choosing or needing to have a caesarean.
    - Emergency
        - This code was recorded when moms described their caesarean section as something unplanned, not chosen by them, or last minute due to medical complications
- VBAC
    - This section was used when there was any discussion of vaginal birth after a previous experience with caesarean section

Appendix B.

Parents

P1- The Cutting Edge: A CSection Boom

P2- 1 Mom, 3 Birth Stories: Epidural, C-Section & VBAC

P3- Man Without a Plan

P4- Growing Concerns: Doctors Respond to Women's Fears about Labor

ScaryMommy

SM 1- What Is A Gentle C-Section, And How Do I Plan One?

SM 2- Why We Need To Stop Saying 'I'm Sorry' To Women Who Have C-Sections

SM 3- What I Wish I Knew Before My Second C-Section

SM 4-3 Truths About C-Section Moms

SM 5- For The Last Time, It Just Doesn't Matter How Your Baby Came Into The World

SM 6- I Thought I 'Failed' In Childbirth, And This Is Why

SM 7- C-Section Is Natural Birth Too

SM 8- My Smug Attitude Didn't Save Me From A CSection

SM 9- How You Give Birth Doesn't Define Your Strength

SM 10- I Don't Have C-Section Guilt

SM 11- My Birth Story Is Not For You To Judge

SM 12- Here's Why Pooping During Childbirth Is Actually A Good Thing

SM 13- 7 Things To Know About VBAC Facts

SM 14- 6 Things I Wish I'd Known About Having a C-Section

SM 15- C Sections Aren't 'Easy,' So Let's STFU About Women's Birth Experiences

SM 16- 10 Things That Surprised Me About Having A C-Section

SM 17- Why I'm Opting For A VBAC For My Last Pregnancy

SM 18- Why I Lie About My C-Section

SM 19- When It Comes To Childbirth, There Is No Medal

SM 20- Let's Stop Saying C-Sections Are Easy