READING THE BODY, WRITING THE BODY: WOMEN’S EXPERIENCES OF GIVING BIRTH SHARED ON THE INTERNET

A Dissertation

by

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ABSTRACT

In my dissertation, I apply a reproductive justice framework to a discourse analysis of twenty-three birth narratives from four websites. I argue that women share their narratives of giving birth on the internet in order to find a virtual close-knit community that they may find lacking in their physical lives; however, these communities are complicated by the natural birth ideology that informs modern Western conceptions of birth. Thus, I conclude that discourse communities of birth on the internet may provide some form of connection for new mothers but are not as straightforwardly supportive as they may at first appear.

DEDICATION

To my mom, who made it possible for me to become a mother by giving birth to me and who literally helped me birth my first child and this dissertation.

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Contributors

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NOMENCLATURE

BTA	Birth Trauma Association
BWF	Birth Without Fear
ESP	Exposing the Silence Project
MN	Mama Natural

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CHAPTER I INTRODUCTION

Women's written narratives of giving birth have become a prevalent part of discourse in motherhood communities on the internet. Women who have recently given birth or who are preparing to give birth seek out the experiences of other women in order to learn more about what to expect or to find experiences similar to their own. Women may use autobiographical narratives, such as birth stories to serve multiple purposes by sharing them publicly. Life writing scholars Sidonie Smith and Julie Watson argue "In autobiographical narratives, imaginative acts of remembering always intersect with such rhetorical acts as assertion, justification, judgment, conviction, and interrogation" (7). By sharing their experiences of giving birth in an online community, these women extend beyond merely accurately representing their experiences to assert their beliefs about birthing and the medical care they received. They also seek to justify the decisions they made during the birth if those decisions differed from their original intent. Their choice of which online community to share their narratives with also communicates important information about the women's narrative intent.

For this dissertation, I studied birth narratives written by women and shared on the websites, *Birth Without Fear, Mama Natural, Exposing the Silence Project,* and *Birth Trauma Association*. I conclude that women's written narratives seek to represent their embodied experience of giving birth; however, the ideology of "natural" birth that pervades the discourse communities they seek to join, ultimately influence the genre of narrative that the women are able to create and share with fellow mothers. While birth narratives may be written by partners, birth support attendants, or medical care providers, the narratives on these sites are written by women who identify as biological mothers. I explain my purpose in analyzing narratives written by women and shared on these four specific sites. I also define terms that are relevant to the

intersecting communities and disciplines that are the subject of this dissertation. Additionally, my own experiences as a mother who not only read, but also shared my own experience giving birth with others online deeply informs my approach to studying birth narratives and online discourse communities of mothers. I explain my own background as well as the experience I had in sharing my own written narrative of giving birth to my first son. Finally, I summarize each of the chapters that form this dissertation.

"Natural" Birth Ideology

Contemporary narratives of women's experiences giving birth in the United States are heavily influenced by a neoliberal medical system and by neoliberal values that are present in the medical system. According to Anne Teresa Demo, "the basic philosophy of neoliberalism assumes that the social good is maximized when states embrace free markets, dismantle social programs, and easy regulatory constraints" (6). The free market medical system in the United States has adopted these principles. This both allows and puts the responsibility for making choices concerning birth upon the consumer, or mother. Popular understanding of the history of birth emphasizes that until early twentieth century, most births occurred at home and were attended by either just a fellow mother or a midwife if one was available. Rudimentary medicine resulted in the death of either the mother or child as a risk of giving birth was accepted. Families may have had many children because it was understood that not all of them would survive birth much less reach adulthood. The professionalization of obstetrics, often by male doctors, pushed most midwives out of the profession in the United States. By the mid-twentieth century the majority of births in the United States took place in a hospital under very specific prescribed directions of a male OB-GYN, including medications such as "twilight sleep," which left women

without a clear memory of the birth experience.[1] Rather than being treated as a unique experience, women were expected to submit to the policies and procedures of the hospital when giving birth. This led to what is primarily known as the "medical model" of birth.

Out-of-hospital, physiologic[2] midwife-attended birth regained popularity in the 1960s and 1970s with the rise of renewed interest in natural health treatments. Women who wished to avoid having their bodies regulated by the medical system often turned to lay midwives to accompany their births at home. The goal of this movement was to avoid contact with the medical system; thus, the midwives began to operate primarily outside of or as an alternate to the medical system. This is significant because the perception of midwives in the United States was different than in other parts of the West, including Europe. While home births and midwives have largely been viewed with suspicion in the United States, in Europe and the UK midwives are professionals who operate within the maternity system in hospitals. While the narratives from *Birth Trauma Association* (a UK based organization) demonstrate that not all midwife attended births have positive outcomes for the birthing women, the difference in the way that physiologic, midwife attended birth operates in the United States versus Europe and the UK matter.

The rise of consumer-driven postfeminist approaches to women's health in the United States in the 1990s and early 2000s has contributed to the formation of what I argue is "natural" birth ideology. Tasha Dubriwny defines postfeminism as "the shift from objectification to subjectification; the emphasis upon self-surveillance, monitory, and discipline; a focus upon

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[1] After the birth of my first son I attempted to interview my grandmother about her experiences giving birth four times during the 1940s and 1950s and she had no memory of the experience at all. She could tell me about who she left her older children with when she had to go to the hospital and where my grandfather was when she went into labor but could not give any details about the actual births. This leads me to believe that she was likely one of the women who received "twilight sleep."

[2] I use the term physiologic, which is the medical term for unmedicated birth because 1) it is the medical term for a birth that takes place without medical intervention and 2) because it is not loaded with ideological implications as the term "natural" is.

individualism, choice and empowerment…and an emphasis on consumerism and the commodification of difference" (23). The perception of women as healthcare consumers may contribute to rising dissatisfaction with the medical model of hospitalized birth. Particularly, the documentary *The Business of Being Born* highlights ways that hospital infrastructure and business model contribute to negative birth experiences for women in the United States. Although midwife attended birth still accounts for a minority of births in the United States, there has been a change in the overall attitude toward physiologic birth. Through positive depictions of birth from books by midwife Ina May Gaskin, who was seen as primarily a fringe figure in the arena of home birth but has since been highlighted in the documentary *The Business of Being Born*, physiologic birth is becoming widely recognized by prospective mothers as a normal way for women's bodies to give birth. This has led some groups to become strict adherents and believe strongly that physiologic birth is the "right choice" and that any medical intervention in the birth process makes it no longer "natural." Lori Beth De Hertogh and Kim Hensley Owens argue that this can cause polarization around the issues of birth, which can ultimately position medicalized births as disabled. I theorize that this strict belief in physiologic birth has developed into a "natural" birth ideology because of the neoliberal influence upon the medical system in the United States.

Neoliberalism reconciles women's desire to give birth free from medical intervention with the heavily medicalized birth dominant in the United States through an emphasis on self-responsibility. By placing responsibility upon the individual to make the right choice for the birth, neoliberalism implies that pregnant women are able to reduce risk and uncertainty. As Dubriwny has discussed extensively, a postfeminist definition of women's health emphasizes the importance for women of making the right individual choices for their healthcare. Rather than

acknowledging that the history of birth and medicine in the United States makes access to midwifery difficult and the expense of medical insurance further limits women's maternity care options, neoliberalism places the responsibility upon individual women to make choices that will lead to the birth of a healthy baby. When women accept that a "natural" birth is their responsibility to achieve, they seek to effect this change by making consumer-based choices to create a birth experience that they can control. This fits in well with the neoliberal prioritization of the economy because it turns pregnancy and birth into an industry, motivating women to pay for additional services such as a doula[3] or special supplements during pregnancy (Seigel). Thus, women end up focusing on aspects of the pregnancy and birth that they can control through economic means rather than considering the systems that affect the birth choices that are available to them.

The effect that neoliberalism has upon birth in the United States currently is placing responsibility for positive birth outcomes upon individuals such as women (De Hertogh and Hensley Owens) or OBGYNs (Morris) while also glossing over the very real impact that the medical infrastructure has upon women's choices. By framing birth as a medical event fraught with uncertainty, medical care providers may convince women that they are unlikely to achieve the physiologic birth that they desire or at least that doing so involves considerable risk. Women receive conflicting messages about their own agency in giving birth. As Marika Seigel posits, a message of self-responsibility during pregnancy leads many to believe they will have some control over the birth and its outcome. However, medical care providers and some pregnancy manuals tell women not to have any expectations about the birth because the birth outcome is

[3] While a midwife is trained to deliver babies and can serve as the primary attendant for a woman in labor, a doula is a lay companion who may be trained in supportive, comforting techniques such a massage and can also help the woman advocate for herself during labor (Rysdam 2019).

uncertain. They urge women to trust that medicine can save them from the risks of complications that are attendant with birth. While many women who embrace “natural” birth ideology would like to give birth at home or a birth center attended by a midwife, they may not have access to these resources because midwives are not very common in the United States. Additionally, midwives and birth centers may not be covered by a woman’s health insurance, and she may not be able to afford to pay for their birth on her own. Other women decide to lean into the goal of a physiologic birth by writing birth plans they bring with them to the hospital in hopes that their plans will be respected by their medical care providers (Hensley Owens). The possibility of some unforeseen emergency or even just an uncooperative body, however, can be used to justify medical interventions. The women writing these narratives are at times deeply critical of the individual health care experiences that they had, but do not critique the larger systems that permit, and in some cases create, the circumstances of these births. Ultimately, the conflicts between the belief in “natural” birth and the reality of a medical system that does not always support this plan result in women who feel the need to justify the birth experience they had.

Writing birth narratives is one way that women attempt to rhetorically control their birth experience after the fact (Hensley Owens). Birth narratives that reflect a positive experience of birth reinforce “natural” birth ideology when women claim responsibility for making choices that led to a positive birth experience. However, if the birth did not take place as planned, the women use the rhetoric of responsibility and risk to explain their choices to allow medical interventions. De Hertogh argues that “natural” birth ideology can be deployed by positive birth narratives to isolate women whose birth experiences were not positive or did not otherwise fit into this ideology. I would add that analyzing narratives that describe traumatic birth experiences can further demonstrate the conflict between “natural” birth ideology and women’s actual

experiences of birth. By attempting to portray an embodied experience of giving birth, the narratives I analyze avoid simple definitions of either "natural" or medicalized birth. While these two views may be commonly positioned as adversaries, the narratives challenge this perception. The current popular advice books and films that promote physiologic birth do tend toward a binary perspective of birth and it is not uncommon to hear medical care providers disparage women who desire to have a physiologic birth. Both of these perspectives are present in the narratives that I analyze as well.

Neoliberalism and Contemporary Birth Practices

Neoliberalism dominates the discourse of birth narratives on the internet. First, as scholars Dubriwny, Hensley Owens, and Amy Koerber argue, women's health care in the early twenty-first century is deeply steeped in a form of neoliberalism defined as postfeminism. These scholars as well as many others in rhetoric of health and medicine consider women's health to be a subject for rhetorical scholarship because the messages that women receive (Dubriwny) and then share (Hensley Owens and Koerber) with each other have a significant effect upon how women's health is constructed. Dubriwny asserts, "Through the positioning of women as vulnerable empowered subjects, women's health issues are depoliticized at the same time that some women's lives (namely, the lives of women who are white, upper to middle class, and heterosexual) are constrained to a narrow sphere of domestic activity" (3). The birth narratives that I analyze are a strong example of such positioning of women. Additionally, these scholars point to the illusion of choice in neoliberal society. The illusion of choice as referenced earlier is a neoliberal concept that allows responsibility for making good choices to be placed entirely upon individuals rather than allowing for critique of the larger systems that affect people's lives. For instance, women may desire a physiologic out-of-hospital birth, but because the legislation

has made it extremely restrictive for midwives to practice in their area their options have been limited. However, women writing birth narratives typically believe that they do have a choice of provider when delivering their babies, so they may take responsibility for a choice to give birth at a hospital with an OB-GYN even if that is the only viable option for them.

As theorized by Ulrich Beck, the concept of risk and the necessity of making the right choice to create uncertainty are heavily emphasized in the early twenty-first century. Birth is treated as a medical event that involves a significant amount of risk to both mother and child. The emphasis in the labor and delivery room is on the medical equipment that is used to monitor the health of the patients and the ability to treat any medical emergencies that may occur during or after the birth. The arrangement of the labor and delivery room space communicates messages about the risk that is involved with giving birth and the necessity of trusting the medical care provider as the ultimate authority.[4] The cultural emphasis is also placed upon mothers and their extreme willingness to sacrifice themselves for the good of their children (Buchanan, O' Brien Hallstein). This translates to the view that all of a woman's plans for giving birth cannot consider the ultimate risk of this event. Thus, once women assert some sense of agency (encouraged by postfeminism), they find that the medical care providers remind them that birth is uncertain, and the only thing that matters is the birth of a healthy baby. As has long been demonstrated by scholars of birth (Morton, Martin, Morris, Solinger), this approach to birth is not in the best interest of the mother's health and well-being, which has resulted in the high maternal mortality and morbidity rates in the United States. Theresa Morris has argued that the litigious practices in the United States are often a driving factor in the decisions that doctors make when attending

[4] Hammond, Homer, and Foureur (2014) discuss the arrangement of the labor and delivery room space in the hospital as a workspace. On the other hand, Katz Rothman and Simonds, and Weisman argue that a hospital labor and delivery room is not a conducive space for vaginal delivery in *Motherhood and Space* (2005). They advocate for choosing home birth over a hospital birth in order for women to assert more control over the birth environment.

birthing women (186). While women often express concerns about feeling responsible for the birth outcome, doctors also face negative repercussions if either the baby or mother do not survive. Thus, the risk present in birth creates a double bind for both women and the medical care providers who attend them. However, the narratives I've analyzed for this dissertation are particularly useful for analysis because they reflect birth experiences that do not fit neatly into either perspective.

Definition of Terms

Before moving into a further discussion of the narratives I studied and their authors, it is helpful to clearly define the important terms for my analysis. As a rhetorician studying narratives that deal with a medical experience, I begin by defining the rhetorical terms that inform the method of my analysis as well as the specific medical terms that are significant to the birth experience and may not be familiar to a general audience. The narratives that form the sample for this discourse analysis are a genre of life writing that women use to form discourse communities on the internet. A discourse community is defined as a group or organization that forms around a shared interest and uses a common language, including idioms, slang, and commonplaces that form a kind of shorthand that members of the community are able to use to communicate and form stronger bonds with each other. Additionally, as Ann M. Johns points out, the language used by discourse community members can be weaponized to exclude those who are excluded as members of the community. While the community may not intentionally exclude interested members, if an interested member finds that her particular lived experience is not reflected in the discourse of the community, she may not feel welcomed and will either give up on finding support for her experience or she may seek out another community whose discourse she can more readily identify with.

I argue that women looking for a community that they can join on the internet deploy life writing about their personal experience to appeal to an audience of other women with similar experiences. From a rhetorical perspective, life writing is a fruitful genre for studying because of its frequent deployment in discourse communities by the group members seeking to form connections with each other. According to Smith and Watson, "We understand *life writing* as a general term for writing that takes a life, one's own or another's as its subject" (4). While memoir and autobiography are commonly perceived as the most formal genres of life writing, through reading and then writing their own narratives, women have created a new genre in the form of birth narratives. These narratives continue to serve as the beginning of women's community formation on the internet because of their significance for women as the beginning of their identity and experience as mothers. Hensley Owens writes, "Although childbirth is an ideologically significant experience across all cultures, and although modern American women increasingly write about childbirth (in birth plans and online birth narratives, for example) both childbirth itself and women's writings about childbirth are undertheorized from a rhetorical perspective" (1). By analyzing the pervasive influence of "natural" birth ideology on birth narratives as a genre of life writing on the internet, I add to the understanding of contemporary birth discourse.

Additionally, through the lens of rhetoric and health and medicine I analyze narratives from two specific different perspectives. Judy Segal argues, "rhetorical study – essentially, the study of persuasion – is a good means of illuminating and recasting problems in health and medicine. *Health* is the more encompassing term for our study; typically, in Western culture, *medicine* provides the set of terms through which health is primarily understood" (1). My study is concerned with the deployment of narratives for community formation and maintenance;

however, because these are narratives of medical events, the women often make arguments about the medical system and its treatment of women. Throughout the analysis, I consider women's access to medical care and their responses to the care that they received. At this time, when maternal mortality and morbidity are of great concern in the United States particularly, I think it is important to value the shared experiences of women. Thus, I believe rhetoric of health and medicine provides useful tools for analysis of the narratives.

Understanding how trauma is defined in the narratives is also important because two of the websites that form my data set portray exclusively traumatic birth narratives. While many women write and share positive narratives of giving birth, other women do not have such a positive experience and find themselves turning from the websites that feature primarily positive birth experiences to form discourse communities with other women who have had traumatic births. This raises questions about what is defined as trauma in birth. Alyssa Colton states in her analysis of traumatic birth stories in memoir, "What these stories tell us is that the rubric under which women give birth makes it a traumatic event" (690). In the narratives that I analyze, the women wrestle with defining their birth experience as traumatic. Since, the women define trauma for themselves in the birth narratives, they often use some concessions within the narratives to explain that while they believe that they experienced trauma giving birth, they acknowledge that others have had more traumatic experiences. As I will discuss in the methods section of the next chapter, in choosing traumatic narratives to analyze, I also avoided the most traumatic narratives (child loss) in order to respect the privacy of these women. However, as maternal health and morbidity in the United States becomes the focus of increasing research across disciplines, it is extremely important to consider the traumatic birth narratives that women

share on the internet in order to better understand the messages that they seek to communicate publicly regarding their private experience of giving birth.

Authors of Birth Narratives

The narratives that form the sample for the discourse analysis that I examine in this dissertation are written by women who are biological mothers. These women have chosen to recreate their experience of giving birth through a written narrative and share it on a publicly available website. However, biological mothers are not the only people who share narratives about births. Fathers or other support partners sometimes share narratives as witnesses of the birth. In her book, Pollock comments that in her interviews with women that when a partner is present, the woman tends to defer to the memory of the partner as more accurate than her own memory of the birth. Pollock and Martin perceive that women demonstrate a deferral to the partner as an authority on the birth experience because of a patriarchal belief that women are untrustworthy in reporting about their bodily experiences. When medical providers share narratives of births that they attended, they also focus on their own expertise as medical care providers and can be dismissive of women's accounts of their embodied experience. These narratives have existed primarily in textbook form. However, as E. Johanna Hartelius writes, it is difficult for medical providers to respond to women's experiences because mothers are perceived as possessing expertise on their own birth experience. While women are perceived as experts on their own experience, as Martin and Pollock point out, they may be hesitant to exert this expertise.

In addition, the narratives on the websites examined here, do not usually include specific identifying information. The lack of specific demographic information on these four websites makes it more difficult to consider whether or not the experiences presented on these sites may

be from birthing person from marginalized backgrounds. In recent years, birth narratives representing BIPOC and LGBTQ experiences have begun to be more represented in communities specific to their experiences. It seems likely that when looking for information online, pregnant persons tend to self-select for their own experiences. While the narratives that are analyzed here represent women's embodied experience of giving birth, their experiences may not necessarily be well-rounded or represent a variety of birth experiences One of the particular drawbacks to these narratives is their potential to alienate audiences that cannot relate to the experiences they represent. DeHertogh comments that when seeking out a supportive birth community on the internet, women often look to see their own experience mirrored in the narratives that they read online. However, this does have the effect of allowing women to avoid experiences unlike their own. In her study of how blackness is portrayed on the internet, Safiya Noble asserts that the internet is not immune to the concept of white privilege. She argues that the algorithms that affect our experience of the internet, demonstrate racial bias against Blacks specifically. Considering the sociological research about the marginalization of women of color as mothers, it appears likely that Black women's narratives of giving birth would also be marginalized by the algorithms that affect our research experience. Although I will discuss my selection method in greater detail in the literature review and methods chapter that follows this introduction, I think it is important to note that the reproductive justice movement's concerns with the birth experiences of all birthing persons means that more research needs to be done into birth narratives representing marginalized experiences, which is a limitation of this study. I hope in further research to turn my attention to these experiences specifically.

Personal Experience with Birth Narratives

I first began reading birth narratives on the internet while pregnant with my first child. I had planned to have a physiologic birth attended by a midwife at a free-standing birth center and found that my local library did not have books that addressed this choice. Although this is not included in my analysis because it is not addressed in the narratives from my sample, my desire to pursue an out-of-hospital physiologic birth had precedent on both sides of the family. My mother delivered one child at home, which I remember because I was 7 at the time. My mother-in-law delivered 6 of her 7 children out-of-hospital as well. Thus, I felt supported by both of the major maternal influences in my life when choosing where to give birth. I did not know many women of my generation who had given birth with a midwife, at a birth center, so I was looking to find narratives that would show me what to expect when I gave birth. I searched the internet for narratives of births at a birth center but was primarily only able to find home birth narratives. I read these narratives eagerly and hoped to have such a beautiful, peaceful birth experience. I was able to successfully give birth with only minor medical interventions[5] at the birth center. In some ways my son's birth did not resemble the narratives I had read while pregnant because the delivery was difficult, but afterward I felt very triumphant about my physiologic birth experience. I was an occasional blogger at the time, so I eagerly wrote a narrative in several parts detailing the labor and delivery. Several of my friends and family members read the entire narrative and responded positively. In fact, some friends who did not have any children commented that if they chose to have children later, they would like to have an unmedicated

[5] I ended up having an episiotomy because the baby's heart rate was beginning to dip between contractions and he was clearly stuck.

birth as well. Following my first delivery, I had a very positive impression of a) giving birth and b) choosing to share it online.

In both of my subsequent births, I spent some time during the pregnancy reading birth narratives online in an effort to prepare myself mentally for the upcoming delivery. However, as I become less involved in sharing my life online, I elected not to share narratives of those births. I did write detailed narratives of both births and my third son's birth has since become the subject of an article on the rhetoric of the labor and delivery room.[6] My third son's birth also occurred during my first semester as a PhD student. While my first son was born during my master's program and my second son was born just after I graduated, I did not begin to consider myself a scholar until I started as a PhD student. As a somewhat naïve white, housewife I had not recognized just how privileged my birth experiences had been. However, as Katherine Goldstein, host of *The Double Shift* podcast says, motherhood radicalized me. As a PhD student grappling with the realities of neoliberal motherhood, I found myself increasingly dissatisfied with this system that put all of the responsibility upon me to be the ideal student, teacher, wife, and mother. The birth of my third son during my first semester as a PhD student altered my plan of study and I began to pursue opportunities to study written representations of motherhood. I then recognized that the advent of the internet provided the opportunity for women to write and share about their everyday experiences of motherhood including the transformative experience of giving birth.

As I have grown into my scholarly identity, I continue to approach these birth narratives from a critical perspective that recognizes just the pervasiveness of neoliberalism in the everyday

[6] This article, "Rhetorically Constructing the Birthing Woman's Patient Identity Through the Labor and Delivery Room" critiques the hospital labor and delivery room as a rhetorical space and considers its potential effect upon birthing women through an autoethnography of my own experience giving birth in a hospital.

lives of mothers. Thus, while I am at times critical of the medical treatment that women received while giving birth or the acceptance of “natural” birth ideology, I have tremendous empathy for these women. Throughout the births of my three children, I very much embraced “natural” birth and it has only been through this study that I have begun to see the complexity of birth discourse in the West and how it contributes to great inequities in women’s birth experiences. As a middle-class, college educated, white woman, I had the opportunity to “achieve” an unmedicated birth, but the neoliberal medical system was content for me to believe that this was my achievement rather than recognizing how privileged my experience was. While my experiences with giving birth and sharing birth narratives online helps me to identify with my research subjects, as a scholar of rhetoric and motherhood, I am able to identify the systems that persuade women to accept “natural” birth ideology as the right way to give birth, which often leads to feelings of disappointment, failure, and guilt, emotions that contemporary mothers are all-too-familiar with. These systems are often hidden by the pervasive messages of empowerment and responsibility that are propagated by “natural” birth ideology. In the following section, I outline the chapters of my dissertation in order to guide the reader through the argument that I am making about the rhetorical use of the birth narratives by the women who choose to write and share them on the internet.

Outline of Dissertation Chapters

The second chapter, which follows this introduction, reviews the relevant literature to connect the intersecting threads of scholarship that shape the argument of my dissertation as well as thoroughly explains the scope of my qualitative research study. In this chapter, I review relevant literature on women’s life writing, digital rhetoric, and rhetoric of health and medicine through a feminist lens to posit that women’s narratives written and shared in the public space of

the internet attempt to form community with other women who share similar birth experiences. Following the literature review, I turn to an explanation of the qualitative research method that I employed to study my texts as well as a discussion of the samples I collected for analysis. Methods for studying digital texts continue to be an area of exploration for digital rhetoric scholars because the internet is an everchanging database for texts. I believe that applying discourse analysis to analyze how discourse communities of birth form in public spaces such as websites contributes to the field of digital rhetoric because it allows for rich analysis of these texts and brings to light further understanding of the influence of neoliberalism upon contemporary birth discourse.

The third chapter "Sharing the Private Publicly," argues that women share their narratives of giving birth on the internet for a variety of complex reasons strongly connected to the social turn of the internet and its intersection with life writing. As Della Pollock asserts, when women give birth, public and private become complex issues that they must navigate when deciding where and how to share their narrative of giving birth. While Pollock concerns herself with women's oral sharing of birth narratives, I argue that this concept of public and private is amplified by the digital turn in sharing personal narratives. I am particularly concerned with how women construct birth as a private event, while simultaneously choosing to share the birth experience in a public facing online space. I contend that women are able to achieve this by sharing their narratives on websites that they are not personally associated with, but rather contribute to anonymously if they so choose. Thus, while collective blogs are not a new digital genre, their use by women to achieve some privacy while sharing an intimate event publicly makes this an important genre for study. In addition, women's motivations for sharing their birth narratives include a desire to form an online community with other women who have had similar

experiences. As has been discussed by scholars of mother blogs (Gilmore, Morrison, Van Cleaf), the isolation that women experience when their children are young often leads them to seek community through the convenience of the internet.

In the fourth chapter, "Considering Commonplaces of Birth," I turn to a close study of how these discourse communities are formed and boundaries maintained. I argue that women use commonplaces as a rhetorical move to form discourse communities around their experience of giving birth. These commonplaces also reveal the boundaries that are set up to reinforce the polarization and isolation that may be present on the social internet when women seek out community but find themselves excluded. As De Hertogh points out, when women write very assertively in favor of "natural" birth, this may have the effect of causing other means for giving birth to be figured as disabled or "unnatural." I argue that women use particular commonplaces (Crowley), to demonstrate that they identify with the experiences written about in the community they wish to join. However, the commonplaces, which are arguments that are commonly understood by the community, may have the effect of isolating women who do not identify with the birth experiences that are represented in the narratives (De Hertogh). I assert that women who do not find their experience reflected in the narratives supportive of "natural" birth featured on *Birth Without Fear* and *Mama Natural* may be more likely to either use the commonplaces to resist the rhetoric of "natural" birth or if those commonplaces are not available to them, may choose to seek out a different discourse community that more accurately reflects their own experience of giving birth. If they feel that their birth experience was traumatic, they may turn to sites featuring traumatic narratives such as *Exposing the Silence Project* and *Birth Trauma Association* as a community that will be supportive of their narratives. While women may choose to post their narratives to sites that reflect their personal experience and align with their goals

(form community, activism, etc.), all of the narratives use similar commonplaces surrounding birth. These similarities reveal that "natural" birth ideology is the common thread that these narratives all share because it has become such a pervasive part of Western understanding of birth that can serve to undermine the intent of the women sharing their experiences of giving birth.

The fifth chapter, "When is the Right Time to Give Birth?" explores how the concept of time plays an important role in the narratives that women share of their birth experiences. *kairos* is an important characteristic in rhetoric that has been theorized by Segal as crucial in the construction of the patient by the medical care provider as they attempt to gain the trust of their patient. For this project, I am interested in two ways that time plays an important role in these birth narratives. The first party of the chapter considers how *kronos* (ordinary time) and *kairos* (a critical or climatic moment) interact and conflict within the birth narratives. I'm particularly concerned with how women represent the period following birth in the narratives because the postpartum period typically illustrates their reflections on the overall birth experience. While it is not usually considered part of the birth by the medical community, these women specifically point to the repercussions from the birth that they experienced during the postpartum period. It is often in the postpartum section of the narrative that women describe their reasons for sharing the birth narrative. Secondly, the concepts of time that underlie popular understandings of birth are so significant that they have shaped the entire genre of the birth narrative. I consider how this genre takes form through frequent references to time. Neoliberal pressure to reproduce rather than innovate on the internet is also demonstrated through the ways women choose to represent time in their birth narratives. I argue that this connects to chapter three by providing some additional explanation of women's choices to share their private narratives publicly while also

revealing more of the rhetorical moves that women deploy in constructing and framing their birth narratives.

In the conclusion of the dissertation, I address two final issues regarding this study of birth narratives on the internet. First, I seek to draw connections between the rhetorical moves that this discourse analysis reveals are present in the birth narratives and contribute to the formation and maintenance of the four communities I studied. I argue that the connection between these four communities is primarily "natural" birth ideology, which forms just the beginning of neoliberal influence on contemporary motherhood. Other women such as Sharon Hayes and Andrea O' Reilly have pointed to the influence of "intensive mothering" on contemporary motherhood, but as of yet none have pointed to "natural" birth ideology as the conception (pun intended) of the immense pressure women feel to make the right choices for their families while putting their own needs last. Women's desire to have a physiologic birth (which respects their agency) comes into conflict with this ideology, which can lead to feelings that the birth was traumatic. Ultimately, this trauma can affect their feelings of fitness for motherhood in the end. While the birth narratives present in my discourse analysis represent a view of birth as presented on the internet, the changing nature of the internet leads to opportunities for women to share other perspectives of birth through other digital genres. I conclude my dissertation with a discussion of the possibilities for future study of birth discourse as it represented by women through the use of other digital genres including podcasts (*The Birth Hour*) and video blogs (primarily on YouTube).

CHAPTER II LITERATURE REVIEW AND METHODS

Introduction

In this chapter, I contextualize my project with a literature review of recent scholarship on birth narratives (Colton, Cosslett, De Hertogh, Hensley Owens, and Pollock) and women's digital life writing (Blair, Gaijala, and Tulley, Gilmore, Kido Lopez, Morrison, and Van Cleaf). Birth narratives are a form of life writing that have found a digital and public platform on the internet. Representations of embodied experience through life writing published in a public space such as the internet are particularly visible in the sharing of such an intimate event as a birth. In this literature review I consider the discourse of birth narratives scholarship that my project contributes to. Additionally, I connect the themes from the birth narratives I analyze to the larger themes in studies of women's digital life writing dating back to the early 2000s.

The neoliberal institution of motherhood that Adrienne Rich argues is pervasive in Western culture, has operated to increasingly isolate women as new mothers from previous communities of support that they may have had in previous generations and that are common in cultures that embrace multigenerational households. Thus, scholars such as Borda, Gilmore, Morrison, and Van Cleaf posit that the rise of the social internet has seen an increasing number of women seeking and finding a community of other mothers online that they can identify with. These communities are established on various websites as well as increasingly on social media platforms such as Facebook, Instagram, and Twitter. The data I analyze has been collected from four sites that where women are invited to share their narratives of giving birth. While not all of the birth narrative sites I examined have the same aim, they do all tend toward an activist approach to birth. These sites have a goal of creating a community around the experiences and

mobilizing the community to advocate for women's health and improvements to the medical care women receive when giving birth.

Pre-digital scholarship on women's birth narratives, both written and oral, provide a foundation for analysis of post-digital narratives. Many of the themes present in the pre-digital narratives such as women's desire for agency and concern for sharing with an appropriate audience persist. Women faced barriers in sharing their written birth narratives before the widespread availability of the internet (Cosslett). However, they did frequently share them orally (Pollock). Examinations of birth narratives on the internet by Colton, De Hertogh, and Hensley Owens primarily focus on pre-social media era narratives. Discourse on motherhood more generally (Palmer-Mehta and Shuler and Yam) demonstrates the transformative power of social media on internet communities. Palmer-Mehta and Shuler and Yam use innovative methods scholars in the field of rhetoric can use to understand the complexities of social interactions on the internet in the twenty-first century. For my study, I return to a focus on websites that serve as collections or anthologies of birth narratives because they have not yet been widely studied by rhetoric scholars and because they represent a bridge between early individualized blogs on the internet and social media platforms that use algorithms to widely circulate some narratives while discretely making other narratives difficult to find.

Following the literature review, I discuss the data that I have selected for my study as well as the methods I used for choosing and analyzing the data. This section of the chapter considers some of the challenges in selecting from among the vast array of birth narratives currently available on the internet. I provide a rationale for discourse analysis as a particularly useful qualitative research approach for considering communities on the internet.

The narratives that form the data sample I collected for this discourse analysis through purposive sampling focus on sites that consider themselves activist organizations dedicated to improving the experience that women have in giving birth in the United States and the UK. They all recognize that the standard medicalized, hospital experience of maternity that rose to prominence in the twentieth century tends to follow a method of care that prioritizes keeping the system running smoothly over the health of the woman cared for. This fits within a model of activism called reproductive justice, which emphasizes a woman's right to choose in regard to all forms of maternity (Ross and Solinger). Ross and Solinger write, "Reproductive justice analysis allows us to understand that some fertile people are disciplined for pregnancies or for exercising reproductive autonomy, while others are honored for the same things" (139). While some women (usually white middle and upper class) are encouraged to reproduce and may find access to contraception or abortion is restricted, other birthing persons (BIPOC, working-class, or queer and transgender) find that many barriers exist to their desire to become parents. Although none of the four sites explicitly refer to the reproductive justice framework, their overall aims appear to support this view of reproduction by emphasizing the importance of women's agency in choosing how to give birth and the necessity of safe and humane treatment during birth. In this analysis, I have chosen two sites that tend to privilege unmedicated birth and two sites that actively share stories of traumatic birth as part of their efforts to change the standards for maternal care in the United States and the UK primarily. While the narratives on these sites are different due to the emphasis placed on different aspects of birth, they all follow specific genre conventions that will be discussed in chapter five.

Understanding scholarship on pre-digital birth and maternal narratives establishes and problematizes women's limited options for sharing their birth stories. As Tess Cosslett argues,

women had few options for publishing their birth narratives of the cost and difficulty associated with print publishing. Thus, the few birth narratives present in print, are featured in women's memoirs, typically those with a focus on motherhood. While Cosslett considers primarily fictional narratives of birth featured in twentieth century literature, Jo Malin points to another possible reason women are less likely to have their birth narratives or other stories of motherhood shared widely in print. In the epilogue of *Voice of the Mother: Embedded Maternal Narratives in Twentieth-Century Women's Autobiographies*, she writes about her own experience of becoming a mother and the time-consuming nature of caring for young children. This experience leads Malin to theorize that women are not sharing their narratives of birth or early motherhood because they simply do not have the time or the support system postpartum that would allow them to think and reflect critically on the experience and institution that shapes their experience. She further posits that once a woman has the time to begin this work, she often no longer finds it as urgent as she may have when her children were younger. While I agree that Malin raises some valuable points, I would present a few notable exceptions to her theory. First, Anne Lamott's, *Operating Instructions: A Journal of my Son's First Year* is composed from journal entries that Lamott wrote during her pregnancy and the year following the birth of her son. Although edited for clarity, the memoir was published while her son was quite young. Another less famous example is that of Rachel Cusk, who authored *A Life's Work: On Becoming a Mother*. In the beginning of her memoir of early motherhood she describes the process of adjusting to and learning to continue writing in the midst of the work of caring for young children. These memoirs point to some of the challenges that the women faced in writing and sharing their experiences, but also the necessity of asserting some agency over the experience of becoming a mother.

Cosslett also points to a problem of silencing women's stories that Della Pollock addresses more blatantly in her text, *Telling Bodies, Performing Birth.* While women often shared their stories orally with their community (Pollock), the dominant textual narratives of birth have primarily been written by medical care providers (Cosslett). Both Cosslett and Pollock consider this questioning of women's own knowledge of their embodied experience as a form of oppression. The advent of the internet greatly expanded women's options for sharing their birth narratives by making self-publishing a viable option as well as providing the opportunity to reach a larger audience while also giving rise to an entirely new genre of life writing. While both Cosslett (through fiction) and Malin (through nonfiction) consider pre-digital narratives of giving birth, they do so primarily through the lens of a non-maternal account of birth. However, Cosslett identifies the problem of silencing as being problematic because the only narratives of births that she could find were present in handbooks written by doctors either for women preparing to give birth or for doctors-in-training. Thus, presenting the narrative from a medical professional's perspective removes any possibility of an experiential focus in the re-telling of the birth. As a literary scholar, rather than a social scientist, Cosslett chooses to limit her consideration of birth narratives to those that are published in traditional formats, such as books, but she does lament the lack of women's experience that can be drawn upon in pre-digital written narratives.

In contrast, Pollock, a social scientist, does seek to examine women's experiences of giving birth through oral narratives. Her text considers women's performances of the birth narrative that occur when women choose to share their narratives orally. Although at times using questionable methods (for instance Pollock interviews primarily close friends or acquaintances she may have power over), *Telling Bodies, Performing Birth* remains very important to study of birth narratives because of the focus on women's agency the text has. In addition to raising

questions about what it means to perform an oral narrative, Pollock also begins to consider how women use silence for effect when sharing their stories. Her consideration of silence is similar to that of Cheryl Glenn in *Unspoken*. Glenn considers the possible rhetorical power that comes through strategic use of silence. She writes, "uses of silence – just like speech – are gendered, with the already-empowered using silence to maintain their power and the already-weak performing simply another iteration of a regulatory norm" (22). While some women may choose to remain silent on details of the birth experience that they do not want shared publicly, others may exert some control over the memory of the birth experience by selectively sharing the story with those they trust as a way of maintaining power. In other cases, by choosing to remain silent on the topic of bodily details that are not usually discussed in public, they may perform the mystery that is associated with birth. My project applies both theories of performance (Pollock) and silence as a rhetorical move (Glenn) to the presentation of birth narratives in digital spaces. I am concerned with how the birth narratives place the focus on particular details of the birth while remaining silent (by leaving out details) on other aspects of the birth experience. Pollock is concerned with the performance of the birth narrative by her interview subjects in their interviews with her, but she does not tend to extrapolate upon the possibilities of a larger audience for the birth narratives. Thus, while she acknowledges that women have long shared their experiences of giving birth orally with other women, she does not focus too much on the circumstances in which these narratives are shared. The communities that mothers form with each other to connect their shared experiences becomes a concern of scholars of both digital rhetoric and life writing.

Research on "mommy blogging" offers context for women's online discourse communities. Lori Kido Lopez, Aimee Morrison, and Kara Van Cleaf have all considered

"mommy blogging" as a form of life writing that expands opportunities for mother/writers to form discourse communities. As Kido Lopez explains, blogs focused on the experience of motherhood build community among mothers and may resist the negative aspect of the institution of motherhood that are strongly addressed by Adrienne Rich and Lindal Buchanan. Lopez, Morrison, and Van Cleaf point toward some of the issues raised by authors focusing specifically on birth narratives, such as the possibility of privileging one way of giving birth and then shaming mothers whose births did not conform to that model. In addition, by focusing on specific bloggers and multiple posts or texts from their blogs, these scholars consider the ways that women construct an identity for themselves online. However, these scholars are primarily focused on the individual characteristics that make these bloggers popular, which is one of. the features that individual platforms on the internet such as blogs create. As the quantity of content on the internet increases substantially and the focus of interactions turns to social media, an opportunity to consider the discourse of specific groups (such as mothers) or around topics (birth) has arisen. By analyzing narratives posted to collective blogs on four separate websites, I contribute to scholarship of birth discourse specifically through the concept of commonplaces. In the case of "mommy bloggers" or women whose primary content focuses on aspects of their identity as mothers, sharing stories of giving birth can be the genesis of the blog as well as motherhood. Although none of these authors are specifically focused on the birth narrative, they do point to important issues around studying women's discourse communities online.

The idea that women specifically began writing blogs and participating in internet critiques of the institution of motherhood while also publicly performing motherhood is an important focus for rhetoricians who have also begun to study women's writing online. An early exploration of women's online writing as resistance to cultural expectations of women as

mothers is raised by Koerber. In 2001, she writes about the presence of mommy bloggers (although that term had not become part of the cultural lexicon at this time), in blog rings. Although blog rings seem an antiquated method for connecting with other like-minded individuals on the internet in today's social media age, the concept of the blog ring offers an explicit illustration of online discourse communities. Women who identified as blogging primarily about motherhood would link up with other similar blogs, which would then allow them to find even more mothers who were blogging and potentially reach a larger audience. Koerber argues that critics tend to define writing as resistance too narrowly and that the mere presence of women writers foregrounding discussions and critiques of motherhood on the internet (which she calls "noise") is notable enough to be considered resistance. However, she does not focus on the concept of circulation in her discussion of blog rings. While critiques of online discourse communities in 2001 may have focused on the importance of writing on the internet spurring people to act as a form on resistance, Koerber's argument seems to apply even more strongly today when people can have tremendous influence simply by crafting a compelling internet identity for themselves. The idea that participating in an online discourse is resistance is commonly accepted today in part because the world has become so connected through wide-spread access to the internet.

A more recent example of resistance through online discourse about motherhood comes from Palmer-Mehta and Shuler, who write about the Facebook community *Sanctimommy.* They focus on the ways that this community, which was formed by a woman with the username Thea Sanctimo, connects around a sarcastic critique of perceived motherhood perfection in online posts. Palmer-Mehta and Shuler consider ways that this critique discourse has the potential to be leveled at institutions of motherhood and the systems that perpetuate the institution, but instead

tends to serve as a kind of catharsis for frustrated mothers who find that by critiquing the self-righteousness of other mothers they ease some of the guilt or pain that they experience regarding their own failures as mothers. In addition, this form of discourse seems to also critique any instances of less-than-completely authentic motherhood that are performed online. This points toward a prevalent anxiety that people have expressed about online discourse currently around the concept of authenticity and the pressure that women feel to present only the entirely positive side of themselves as mothers and their family when sharing on the internet. The reality of motherhood is that it is both positive and negative. There are happy smiling moments that are often followed by epic meltdowns. However, the current social media climate of the internet tends to focus on presenting a unified or coherent identity for the public, so that a larger audience will be attracted to your "brand." Women may find that their presentation of themselves appeals to a large audience and leads to financial opportunities through advertisements or product endorsements. However, in order to continue capitalizing on this commodification of self and by extension family, the women may have to present a one-sided version of themselves for the internet. Palmer-Mehta and Shuler point out how this functioned on the *Sanctimommy* group when the creator felt that she needed to separate herself from the group, which largely functioned to critique sincere attempts to mother well that tend toward self-righteousness and perfectionism. She did so by writing a biography of herself, "Thea Sanctimo" which emphasized she is a sincere mom attempting to mother well, that she was then able to post to the group.

Finally, Jennifer Borda discusses the potential for women to capitalize on the internet presence in order to provide income for themselves and their families. In her survey and discussion of several prominent "mommy blogs," Borda traces the conceptions of these blogs and the establishment of a consistent identity, or brand, which then allows the women to

establish a large following or readership. The audience opens up opportunities for bloggers who desire it to make money through either advertising on their blogs or product sponsorships in exchange for reviews. Borda does not discuss the ways that some women use product sponsorships for giveaways on their blogs, which they can then leverage to grow an even larger following, but that practice is in keeping with her overall argument. While Borda comments that women value the opportunity to profit from their writing, which began as a hobby and a way to connect with other mothers on the internet, she also considers some of the complications that can arise with the monetization of "mommy blogging." As Palmer-Mehta and Shuler discuss the questions of authenticity that online discourse communities raise, Borda also focuses on whether or not the "mommy bloggers" who monetize their blogs maintain the authenticity in their writing that originally drew readers to their blogs. She is specifically concerned with issues such as how and when women disclose sponsorships or discuss their reasons for allowing monetization of their blogs. Borda specifically mentions that when women share tragic or emotionally difficult circumstances in their lives, they often see a spike in their readership in part because it is titillating to read scary or difficult circumstances that others are facing or because the readers can identify with the specific circumstance that the woman writes about. Another issue surrounding authenticity on the internet, is the ways that women present the intimate details of their lives on the internet. This can be a complication that women must face when deciding how they will write and share their birth narratives on the public space of the internet.

While Koerber, Palmer-Mehta Shuler, and Borda discuss the rhetoric of women's "mommy blogging" communities as a critique of motherhood, others specifically consider digital birth narratives, offer the scholarship that is perhaps closest to my own, in that the texts they consider include the same specific subject matter. Fewer authors have considered the specific

narratives of giving birth that women share on the internet perhaps because it is a relatively recent genre. However, I argue that these narratives have an important role to play in part because they offer an intersection of life writing by considering the experiences of motherhood and writing about health and medicine because birth is largely considered a medical event in the West. I also find it challenging to consider how the rapidly changing environment of the social media landscape calls for and challenges the research methods that are used in studying these narratives.

In providing an early intervention into the rhetorical study of women's birth narrative, Hensley Owens argues that birth narratives can provide a lens into "how women accept, negotiate, and/or resist various subject positions in and through their birth writing" (14). Although she does examine some birth narratives, in her text, Hensley Owens uses them primarily as the contrast to the birth plans that her research subject wrote prior to giving birth and shared with her. Hensley Owens focuses on whether or not women's attempts at rhetorical interventions through writing birth plans actually had any bearing on the outcome of the birth experience. For instance, if a woman writes in her birth plan that she does not wish to have any unnecessary medical interventions she questions whether the factual account of the birth demonstrates that this is how the birth proceeded. Perhaps, most interestingly, Hensley Owens explores how women wrestle in their narratives with any discrepancies between the births that they had planned and the birth experience that actually took place. She comments, "the act of writing and posting an online birth story does, for the women in this story, seem to have beneficial emotional, psychological, and even physical effects" (113). By making public the intimate act of giving birth the women whose stories Hensley Owens examined and later interviewed regarding their birth plans revealed that writing their experience and also seeking an

audience for that narrative provides women with some rhetorical agency even when they may feel that they lacked agency during the birth itself. It is important to consider that the birth narratives that Hensley Owens examined were written and published in what is known as Web 1.0.[7] Thus, the narratives were collected and published on sites owned and operated by individual women or small groups of women who were interested in sharing the experiences of giving birth online. However, the constraints of Web 1.0 mean that the only social interaction between these narratives is their juxtaposition on the site itself.

Considering the greater social possibilities of sharing birth narratives on Web 2.0 is the subject of De Hertogh's work on the site *Birth Without Fear*. In her article, De Hertogh argues, "as the community rewrites medical rhetorics of disempowerment and disability, they inadvertently reinscribe a 'new normal' that idealizes and romanticizes 'natural childbirth'" (para. 3). By situating the concept of considering pregnancy and birth in the realm of feminist disability studies, De Hertogh opens up the range of perceptions of sites such as *Birth Without Fear*. She argues that how pregnancy and birth are described on the internet creates a kind of binary that privileges the idea of "natural" while making other kinds of birth appear disordered or disabled. De Hertogh claims that this kind of binary is antithetical to the mission of an activist site such as *Birth Without Fear* according to creator January Harshe. Important to De Hertogh is the concept of Health 2.0, where important issues regarding health are crowd-sourced through asking for and receiving advice based on the experience of others as patients rather than actual medical experts. For instance, pregnant women and new mothers may turn to a trusted social media group for advice on treating pregnancy symptoms rather than calling their medical care

[7] The primary demarcation between Web 1.0 and what is currently considered Web 2.0 is the turn toward social media that took place around the end of the first decade of the twenty-first century. Rather than being centered around websites as it had been previously, social interaction on the internet and even consumption of news and entertainment began taking place on social media platforms particularly Facebook.

providers' office. This practice has the potential to lead to false or misleading information being propagated by well-meaning, but not medically trained participants in the discourse community. De Hertogh's argument is complex because she considers ways that birth is figured as a medical disability in the natural birth community, which puts forth a new definition of birth. However, there are several other ways in which the rhetoric of Health 2.0 spaces may operate on the internet and become particularly important to mothers as they make decisions regarding the health care of their children.[8] Some Health 2.0 discourse communities may truly include multiple points of view; however, it is important to note that users on the internet tend to gravitate toward groups or spaces that reinforce opinions they already hold or experiences they have had. Thus, if a person who already embraces holistic medicine asks for advice from a group that reinforces this ideal, they may receive advice that is either unhelpful or encourages them to avoid needed medical assistance. *Birth Without Fear,* the site that De Hertogh examines in her article is important because it is popular and representative of a particular birth discourse community. I join with the work of Hensley Owens and De Hertogh by focusing specifically on the rhetoric of birth narratives that contribute to the formation of internet discourse communities about birth and the reinforcement of "natural" birth ideology through these narratives.

Methods

Research Design

Discourse analysis is the qualitative research approach that forms the primary methods of data collections and analysis for this project. According to Barbara Johnstone, "Discourse

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[8] Anytime someone who is not a medical expert (i.e. licensed physician) is advocating for an alternative treatment approach for medical conditions, it is important to consider what the motivating factor is for them. For instance, alternative medicine has become huge in motherhood communities on the internet, but typically the most vocal mothers in these circles are women who are selling a product, such as essential oils. Thus, their motivation for advocating alternative medicine is at least in part motivated by a desire to earn some additional income.

analysis has shed light on how meaning can be created via arrangement of chunks of information across a series of sentences" (6). In addition to focusing on the language structures (such as grammar), analyses may consider the text's content for themes or issues (Gee 8) By analyzing the details of birth narratives through discourse analysis, I hope to demonstrate some ways that these narratives contribute to the discourse communities centered on mothers and birth experiences on the internet. Scholars of discourse analysis such as Johnstone and Gee typically conceive of discourse communities and discourse analysis as primarily applicable to transcripts of oral communication among members of a group. However, the internet as a site of discourse is constantly evolving and scholars such as those discussed above, who study media on the internet are attempting to find and create new methods to study this discourse. Discourse analysis is a useful qualitative approach specifically for studying written texts shared on the internet because of the rise of social interaction taking place in this context. There has been skepticism about the potential for online community because of the lack of proximity by the participants (Blair, Gaijala, and Tulley); however, the social turn of the internet shows that largely social interaction is increasingly common online regardless of the physical location of the participants. Increasingly, social science scholars note that millennials and younger are performing the majority of their social interaction online rather than in person. This is one reason that I argue that using discourse analysis for analyzing internet texts is a useful tool.

For the purpose of this study, I am interested in the specific social language that is used through the development of patterns across several birth narratives on multiple sites. For this project birth narratives as personal narratives women have written about their own experiences giving birth and shared publicly on the internet through websites that serve as collection points or anthologies for the birth narratives. While women often write and share their birth narratives

on personal blogs or through other social media platforms, the primary data for my analysis is collected from these public sites. I have chosen these sites because they are likely to attract an audience of readers who are specifically interested in birth narratives both reading and sharing them. After an abbreviated IRB review, it was determined that as this study concerns published texts exclusively it does not constitute human subject research.

Study Instruments

For this discourse analysis, I will be working specifically with a tool that Gee calls "the social languages tool" (162). Through reading and studying many online birth narratives, I have observed that they possess specific features that form a genre of digital life writing. Word choice, grammatical structures, and patterns of grammatical structures form specific social languages. By studying the ways that the collection of birth narratives contributes to the creation of a social language, I add to understanding of how women use the narratives in forming discourse communities on the internet. One of the biggest concerns of my analysis is the possible differences between the narratives posted to the sites based on the different emphasis placed on the type of birth. The following questions will be used to guide my analysis of the birth narratives:

1) What is the narrative structure that is typically used in the birth narratives?

This is an overarching or guiding question for my analysis. A first reading of the narratives revealed some of the similarities and differences in the narrative structure that the texts follow.

2) How are particular terms or phrases used as commonplaces that may serve as shorthand to describe potentially complex medical events or procedures?

I designed this question to help me to pay particular attention to words and phrases that women use repeatedly in discussing birth as a medical event. While birth is a medical event that women

experience, they often use language that differs from the medical establishment particularly on the internet and social media sites to discuss these medical experiences.

3) What is the situated meaning of these commonplace terms?

Specific terms and phrases identified as commonplace terms allow me to delve more deeply into the situated meaning that these terms may have in the context of the birth narrative. Determining if these terms have specific meaning that may or may not correspond with formal or medical definitions, facilitated analysis of their relevance to the social language of the birth narrative.

4) What are the ways that different perceptions of time are represented throughout the narrative text?

Finally, this question was used to determine how representations of time in the narratives may influence the narrative structure that defines the birth narrative as a genre. Since birth is an event in which time is carefully measured by the medical care providers, the ways women describe time in their written narratives is significant. Throughout the analysis, this question informs the methods that I use to pay careful attention to time.

I analyze the six most recent birth narratives as of 27 February, 2019 (ranging from 7 June 2018 – 2 October 2018) posted to four different birth story websites: *Birth Without Fear* (https://birthwithoutfearblog.com/category/birth-without-fear-topics/birth-stories/), *Exposing the Silence Project* (https://www.exposingthesilenceproject.com/birth-story-journal), *Mama Natural* (https://www.mamanatural.com/birth-stories/), and *Birth Trauma Association* (https://www.birthtraumaassociation.org.uk/).

Sample Selection Strategy

A comprehensive bibliography of birth narratives on the Internet does not exist; thus, I have selected four specific sites for this discourse analysis based on their potential for reaching a

very large audience. A Google search for "birth stories" in early 2019 returned *Birth Without Fear* and *Mama Natural* as two of the highest results. At the time I began my study (spring 2019), the four websites I selected for my data collection provided examples of both positive and traumatic birth narratives. I am particularly interested in the narratives from these four websites because they provide strong portrayals of the ideology of "natural birth" influenced by neoliberalism that I believe contributes to women's perception of pregnancy and birth in the United States. The women (identified by first names) authors are located throughout the United States and the UK, but demographic details (such as race and age) are only occasionally revealed if relevant to the narrative. For instance, a woman may share her age in the narrative if her pregnancy was considered high risk due to age. In order to avoid bias in my sample selection, I chose the six most recently published narratives on each site as of (February 2019) and thus reflect the current state of the discourse surrounding birth narratives on those sites.

The website *Birth Without Fear,* created by January Harshe in 2010 was first chosen for analysis. The sample (six narratives) from this site tend to follow a pattern of focusing on positive portrayals of birth. *Birth Without Fear* argues that their mission is to accept all birth narratives as legitimate birth stories, but the narratives actually present on the site privilege "natural" birth and are positive in tone. *Mama Natural* explicitly privileges the unmedicated birth narrative through the interview style narratives presented on this site. One reason for this specific emphasis is that the creator of the site, offers an online course and some supplements for women to help them prepare to give birth without the aid of medication. Thus, the birth narratives posted on this site are used as a form of advertisement for the products that are on offer through the website. I chose both of these websites because of their popularity on Google.

While many births are positive, the growing awareness of maternal mortality and morbidity (Morton) makes it appear that sites which primarily present positive stories of giving birth are overlooking the experiences of a growing number of women. I wondered if perhaps women who experienced traumatic births had found or created separate discourse communities around their own experiences. This caused me to search for traumatic birth narratives. *Exposing the Silence Project* created by Lindsay Askins and Cristen Pascucci in 2015 was discovered by searching for "traumatic birth stories." The narratives in *Exposing the Silence Project* have the potential to reveal differences between narratives perceived as normal and those that are not. *Exposing the Silence Project* has a limited number of narratives on their site right now because the focus of their project is on the creation of a documentary. The founders of the site travel around the United States speaking at birth conferences and interviewing women about their births for their documentary, but their site does have a small selection of written narratives that women have submitted to the site. These narratives serve to illustrate for the visitor the message about obstetric violence and trauma that the women share in their documentary. In the UK, the *Traumatic Birth Association*, has formed to provide advocacy and support for women who have had traumatic births or trauma associated with the birth experience. This site has a wide array of narratives organized by specific categories rather than chronologically. Unless the narrative itself mentions a specific date, the site does not have a clear marker of when the narrative was posted to the site. Thus, I chose the first narrative from six of the categories on *Traumatic Birth Association*. I hope that choosing disparate websites allows for a broader understanding of the discourse surrounding birth among mothers on the Internet. I am particularly interested in studying the differences between the narratives published on *Birth Without Fear, Mama Natural, Exposing the Silence Project,* and *Traumatic Birth Association* because they will likely represent

very different discourse on birth, care providers, hospitals, and birth outcomes. As my research questions demonstrate, I am interested in the role the birth narratives play in the discourse community of these four sites and particularly how these specific discourse communities focus on a specific kind of birth while also demonstrating the pervasiveness of "natural" birth ideology across birth discourse on the internet.

Data Collection and Management Plans

I have used a Google Chrome browser for the Internet searches to collect the narratives. Although my focus is not considering the ways that different search engines prioritize search results, it is important to note that other search engines would likely yield different results because the algorithms operate differently. For stability, the selected narratives were downloaded and saved to my laptop computer after personally identifying information has been removed from the documents. I then uploaded the documents to the project I created in the text analytics program, Dedoose. The coded narratives are saved within the program for analysis. The analysis was saved to my laptop as well. The table just below, Birth Narrative Data, provides a brief overview of each narrative as well as pertinent details. I have labeled the narratives using an acronym for each website and numbered them: *Birth Without Fear (BWF), Exposing the Silence Project (ESP), Mama Natural (MN),* and *Birth Trauma Association (BTA)*.

Table 1

Birth Narrative	**Location**	**Outcome**	**Plot points**	**Significant codes**
BWF #1	Birth Center	Vaginal	Positive physiologic birth, midwife attended, with long lead up to active labor	Signs of labor, encouragement, support person, midwife

Table 1 cont.

Birth Narrative	**Location**	**Outcome**	**Plot points**	**Significant codes**
BWF #2	Home	Vaginal	Positive 4th physiologic birth at home, midwife attended, quick second stage of labor	Previous births, pain, fear, pain management, joy, reflection
BWF #3	Home	Vaginal	Positive physiologic birth, midwife attended, long lead up to labor, very specific time stamps	Contractions, labor, pain, family, writing the narrative
BWF #4	Hospital	Cesarean	After long labor at home, non-emergent C-section after VBAC for third birth	Previous births, labor, interaction with care provider, OBGYN, doula, support person, reading birth narratives, writing the narrative
BWF #5	Hospital	Cesarean	Planned family-centered C-section, positive birth because woman had agency in making decisions about birth	Choice, writing the narrative, interaction with care provider, OBGYN, encouragement, interaction with baby
BWF #6	Hospital	Vaginal	Planned VBAC following two traumatic C-sections deliveries, used epidural, smooth delivery	Previous births, interactions with care provider, OBGYN, pain management
ESP #1	Hospital	Cesarean	Traumatic emergency C-section, wrong medication, woman felt pain, husband observed C-section	Induction, pain, pain management, cesarean, interaction with care provider, OBGYN
ESP #2	Hospital	Vaginal	Traumatic vaginal delivery, felt pressured to accept interventions by OBGYN and nurses, unwanted medical interventions on baby	Choice, intervention, interaction with medical care provider, nurse, respected (not)

Table 1 cont.

Birth Narrative	Location	Outcome	Plot points	Significant codes
ESP #3	Hospital	Cesarean	Traumatic C-section, long labor, altercation with OBGYN resulted in firing and accepted C-section from new OBGYN	Labor, intervention, interaction with medical care provider, OBGYN, respected (not), Postpartum depression
ESP #4	Hospital	Cesarean	Traumatic labor and C-section, reaction to incorrectly administered epidural, failure to progress, led to C-section	Intervention, medical complication, interaction with care provider, OBGYN, nurse, rude, consent
ESP #5	Hospital	Vaginal	Traumatic delivery, felt disrespected by OBGYN and nurse alike, advocated for natural birth practices, but had to fight to avoid interventions	Labor, natural birth, interaction with medical care provider, OBGYN, nurse, respected (not), intervention, postpartum depression
MN #1	Home	Vaginal	Peaceful home delivery, midwife attended, emphasized importance of choice and preparation	Signs of labor, interaction with medical care provider, midwife, advice, reading birth narratives
MN #2	Home	Vaginal	Positive physiologic birth at home, midwife attended, emphasized the mental work required to endure pain of delivery without medication	Pain management, previous births, contractions, advice, support person
MN #3	Home	Vaginal	Positive physiologic birth at home, midwife attended, over two weeks past due date, speedy labor and delivery	Husband, support person, pain management, interaction with baby
MN #4	Birth Center	Vaginal	Positive physiologic birth at birth center, midwife attended, joyful experience, emphasized importance of anticipating birth rather than dreading it	Contractions, labor, progress, support person, encouragement, reading birth narratives

Table 1 cont.

Birth Narrative	**Location**	**Outcome**	**Plot points**	**Significant codes**
MN #5	Birth Center	Vaginal	Positive VBAC at birth center, midwife attended, long lead time to birth, joyful feeling afterward	Labor, previous births, progress, mindset, birth preparations, planning next birth
MN #6	Hospital	Vaginal	Positive physiologic birth at hospital, labored primarily at home, smooth delivery at hospital, emphasized pain of giving birth	Pain management, doula, going to hospital, dilation, comparison to other births
BTA #1	Hospital	Cesarean	Traumatic C-section delivery, cascade of interventions, failure to progress, chose VBAC for next birth	Epidural, pain management, contractions, interaction with medical care provider, midwife, anesthesiologist, intervention
BTA #2	Hospital	Vaginal	Traumatic forceps delivery resulted in severe tear, still not recovered five years postpartum, majority of narrative describes seeking treatment for lingering pain	Pain, pain management, postpartum care, postpartum depression, interaction with medical care provider
BTA #3	Hospital	Vaginal	Traumatic vacuum assisted delivery, emergency intervention due to fetal distress, wished for C-section in hindsight because of complications with vaginal delivery	Contractions, pain, pain management, dilation, intervention, interaction with medical care provider, postpartum care
BTA #4	Hospital	Vaginal	Traumatic postpartum hemorrhage following fairly straightforward vaginal delivery, long recovery made caring for her new baby difficult	Medical complication, postpartum care, complication, baby, PTSD, rest

Table 1 cont.

Birth Narrative	Location	Outcome	Plot points	Significant codes
BTA #5	Hospital	Vaginal	Traumatic breech delivery without much medical assistance as nurses did not believe she was in labor after going into labor early and requiring medical intervention to stop	Reading birth narratives, previous births, medical complication, intervention, lonely, pain, questioning labor
BTA #6	Hospital	Vaginal	Traumatic episiotomy assisted delivery resulted in tearing and postpartum hemorrhage, long and difficult recovery from birth	Pain, dilation, episiotomy, intervention, blood

Analysis

I hoped that by focusing on the discourse of the birth narratives, I would be able to see the similarities and differences in the narratives and discourse community that forms around the particular kinds of birth that are written about on the internet. In conducting the discourse analysis, I coded the narratives using Dedoose to determine relevant themes based on the questions listed above. I began with a base of codes relevant to birth, but the list of codes quickly expanded as I discovered the great variety of language women use in writing their birth narratives. The codes fell into several categories including the medical terms surrounding the birth, interactions with care providers throughout the birth, a woman's feelings about the birth, as well as the many non-medical terms that are used to refer to the medical aspects of birth. These categories were created through the process of the first coding of the narratives. Once I finished the coding process, I read each one using the subquestions listed above as a guide to determine the themes and commonplaces that were relevant as answers to them. I then coded the narratives a second time to narrow down which themes appeared most clearly related to the main question

of my study. Using Dedoose also allowed me to analyze the frequency and context of the codes more easily.

Study limitations

The lack of clear demographic information regarding the authors of the narratives is a limitation of the genre, but I see it as a useful affordance of this genre as well. Not knowing details regarding race or class of the women who are writing these narratives allows the discourse analysis to focus on the genre conventions more exclusively. Some information about demographics may be deduced from considering that the authors of the narratives are literate women with computer access. However, by focusing on just a few popular websites on the Internet, the analysis may not be completely clear about the potential self-selecting nature of the women who submit narratives to these websites. I argue that the narratives themselves demonstrate that the discourse communities form around the particular kind of birth a woman experiences, but it is unclear how or in what way intersections of class and race are evident in the narratives because they are largely absent. While the internet is perceived as a democratic platform for sharing about the details of one's personal life, women may feel like they cannot share their narrative if their birth story does not fit with the genre conventions that they see on these websites. In addition, choosing to focus some of my analysis on "traumatic birth narratives," limits the perspective of the analysis. It may take on a more negative tone than a survey of websites with a general focus or a different kind of focus. This study is also limited by choosing to focus exclusively on narratives written by mothers. A different study might focus on different writers, for example, fathers or medical professionals, and might yield a very different social language.

The method of discourse analysis is a qualitative approach to study texts that allows for a consideration of how communities are formed and the effect of the text on the members of the community. I see discourse analysis as a useful tool that can be used for studying discourse communities on the internet, and I hope that through this discourse analysis of birth narratives to contribute to the methods and approaches that scholars take to studying the rapidly changing landscape of the internet.

CHAPTER III SHARING THE PRIVATE PUBLICLY

Introduction

Motherhood can be an incredibly isolating experience for women as they find themselves responsible for the survival of another completely helpless human being, notes Andrea O' Reilly. While earlier more communal societies allowed the responsibility of childcare to be more broadly distributed across extended family and friends, women in the United States today find themselves primarily responsible for providing and finding childcare. As Amy Westervelt comments, women entered the workforce in large numbers in the twentieth century, but rather than splitting the childcare and household responsibilities evenly with their male partners the burden of childcare arrangements still falls largely on them. This stems from the very early labor that women must do to bring a new child into the world and sustain their life during infancy. Without very conscious effort by both partners, it is very easy for the mother to remain the default primary parent. As family structures change in the twenty-first century, observing queer families and non-partnered parents may have the opportunity to change the default division of family responsibilities. Hays created the term "intensive mothering" to describe this concept that one person (usually mothers) should be primarily responsible for meeting the needs of her children and should be willing to sacrifice everything in order to prioritize their children. Intensive mothering requires so much effort that women do not have time to pursue the companionship of other mothers who might provide them with support. Thus, the parenting ideology has caused the insular, nuclear family to sometimes be the only social focus of mothers (particularly of young children).

The cooperative relationship between patriarchy and neoliberalism emphasizes the necessity of women as unpaid domestic workers and childcare providers. In a society that

strongly relies upon capitalist values of making money and improving one's financial standing, the work household chores and raising children do not immediately appear to contribute to the goals of neoliberalism. However, the role of the free market in seeking to produce a profit and turn citizens into consumers has provided a role for mothers. It benefits neoliberalism to keep mothers isolated from each other because if they are not able to depend upon each other they will turn to experts (medical, psychological, nutritional) in order to learn how to care for their own children, which will benefit capitalist industry aimed at mothers. Women have counteracted this isolation through storytelling, a multipurpose rhetorical tool that they have used to connect with each other and impart knowledge about the embodied experience of motherhood (Pollock). Experiences that have been considered specific to women, such as birth are often shared through storytelling. As Pollock notes, this is specifically true of birth because of the perceived privacy of the event. However, the arrival of the internet has created an antidote for this isolation and reliance on experts. Gilmore, Morrison, and Van Cleaf have noted that the widespread availability of the internet has allowed women to find community without feeling as if they are neglecting their duty to care for their children. I argue that one of the reasons women share their narratives of giving birth publicly on the internet is the desire to create and share more knowledge of the birth experience with a community of birthing women.

In this chapter, I focus on the tension between the perception of birth as a private event and the women's choice to share the experience publicly with an audience on the internet. The four websites that I collected my sample of narratives from are public forums. Thus, the women who elect to share their narratives on them have no way of knowing for sure who their audience will be. However, as I posit in this chapter, through their own experience with the website, the narratives make some assumptions about the audience that will read them. Although the websites

themselves are publicly available the women indicate through their narratives that they construct their audience as sympathetic, which may allow them to be more comfortable with sharing their private birth experience. In considering the goals that women have in sharing their birth experiences publicly on the internet, I first examine how women construct the concept of privacy in giving birth. I then turn to the rhetorical tools that these women use to reconcile the concept of privacy with the public sharing of the birth experience. For instance, the women may choose to avoid sharing certain details of the birth experience in their construction of the birth narrative in order to protect their privacy. Finally, I explore the ultimate aims women have in sharing their narratives with an unknown audience.

Women who share their birth narratives online build on a tradition of the oral sharing of birth narratives. These oral narratives, as Della Pollock has shown, rely on a careful conception of audience. She finds that the women she interviews are careful about who they are willing to share their experience of giving birth with and particularly about how detailed their sharing will be. She claims particularly that women do not share details about the pain associated with giving birth with all of their audiences. Rather, they consider the rhetorical situation and only share with an audience, such as other mothers who can relate to their experience or with pregnant women who may want to learn from their experiences of the pain of giving birth. I found through my discourse analysis that the authors of the narratives in my sample reveal some of their reasons for sharing their births publicly in the narratives themselves. These reasons include a desire to find an audience who can identify with them as well as give advice to pregnant women and are similar to the reasons Pollock advances. However, I argue by choosing to publish their birth narrative on a website, these women have less control over who their ultimate audience will be, which may change their motivation for sharing because they are aware of the more public nature

of the platform. Through their prior experience reading other narratives on the website, these women assume that their audience may be composed at least partly of other women with similar birth experiences and pregnant women seeking advice on giving birth.

Narratives as Birth Education

Several of the authors in my data set view their narratives of giving birth as a form of education for pregnant persons or persons trying to conceive. I argue that before actually giving birth, women do not always know what to expect because the education they receive from the medical system often maintains rather than dispels the mystery surrounding birth. According to scholars of rhetoric of health and medicine[9], medical care providers tend to focus more providing accurate medical care than on providing education about medicine to their patients. In the case of birth, this can lead to problems for first-time mothers who may feel anxious about this experience that is completely unknown to them. Thus, rather than turn to pregnancy manuals such as Seigel writes about in her book, women in the early twenty-first century more frequently turn to the internet for their birth education.[10] Additionally, when women have difficulty finding printed materials about the birth experience they wish to have[11] they look for that narrative reflected in stories online. Hensley Owens argues, “the authors of online birth plan advice exhort women to assert feminist rhetorical agency over their births without recognizing that their advice can also inadvertently thwart opportunities for the success of those assertions" (39). In her view,

[9] Segal particularly considers the complications that occur when medical care providers and their patients (or the patients’ families are not communicating clearly about the same topic. Since the medical care provider attempts to convince the patient to accept a particular course of treatment, she argues that this is a rhetorical situation.
[10] Birth education on the internet is becoming something of an industry for women who have the means to pay for a more specialized birth education than they would typically receive from a hospital provided birth education course. Online birth classes also provide the convenience of allowing women and their partners to complete the class at a time that is easiest for them.
[11] While pregnancy manuals give lots of helpful advice for such practical details as what to pack to bring to the hospital and sometimes even templates for writing birth plans, the majority of them leave quite a bit of mystery around the experience of giving birth such as how to determine when labor has really started or what is happening during “transition.”

women often desire to share their narratives because they want to assist women with achieving a birth where they have agency over the birth, but that is complicated by the unique experiences of giving birth that each woman will have. Her study, which focuses on a sample of women who composed both birth plans and later a narrative of the birth itself, tends to consider the individual birth experience. Whereas my discourse analysis considers the collective possibilities of choosing to post the narratives alongside those of other women. For instance, a narrative posted to a collective rather than individual blog may reach a larger audience due to its ties with a more public organization. In contrast to sharing her narrative orally (with a present audience) or on a personal blog or social media site (where many of the readers will be known to her) when a woman chooses to post her narrative to a collective blog, she cedes all direct control over the audience for her narrative. Education as primary purpose for sharing the birth narrative on the internet may signal the desire for a large public audience.

Written by women recounting their own experiences, these narratives differ from the pregnancy manuals that women may have previously read in order to learn more about the experience of giving birth. Cosslett, writing before the rise of the internet as a popular form for sharing personal experience, comments that birth narratives shared in pregnancy manuals tend to present the narrative from the perspective of the medical care provider who is the author. Thus, she argues that these narratives do not accurately portray the embodied experience of giving birth, which would be valuable for women readers. Cosslett writes, “the story has been taken away from women by the ‘audience perspective’ of fathers, or, more influentially, doctors” (2). By describing their embodied experience in a narrative, women attempt to assert control over the story that is told about the birth. Thus, women seek out birth narratives written by other women because they want to know the details about birth that are typically kept private. They are

looking for an experience that they can identify with or that can give them a clue about what to expect to feel physically when they give birth. Women readers look to online narratives of giving birth to provide some embodied expertise from women who have already given birth. This concept of personal experience as expertise that women look for in reading birth narratives is theorized by Hartelius. She argues, "A rhetorical view of expertise, finally, prioritizes the audience. It accounts for audience members' deferential or participatory relationship to experts as a negotiated response to the latter's expectations" (164). Some women express the expectation that their audience is looking for an experience that mirrors either their experience or the experience that they hope to have when sharing their birth narratives. In constructing the embodied experience of giving birth, women must negotiate their role as experts of their own experience with the necessity of presenting a narrative that other women can identify with.

Narratives Used for Identity Formation

The re-telling of the birth experience through the written narrative often demonstrates the conflict between theory and reality that occurred when the birth a woman had planned does not take place. The concept of identity in connection with the performance of a birth narrative is crucial for Pollock, who writes, "What is the meaning and significance of its birth story-performance? How is pain practiced in and by birth stories? How is it made to mean – and to mean differently?" (118). The birth narrative as a meaning making genre holds particular significance for scholars of birth such as Cosslett and Pollock. Additionally, once women have given birth, they share the story of giving birth as a way to construct and make sense of the experience. Hensley Owens argues that women who wrote birth plans use the birth narrative to re-construct and take charge of shaping the narrative that is ultimately told about their birth experience. The experience of giving birth can cause a woman to feel very out of control and can

leave her with many questions about the nature of the birth experience itself, as discussed above. For the women Hensley Owens writes about, "composing childbirth narratives allows women the opportunity to relive the bodily experience of birth emotionally and psychologically, often allowing them to reassert rhetorical agency over their births in doing so" (116). By writing the birth narrative women are able to reflect upon the experience and consider how they wish to feel about the birth and the care they received. On some occasions, the women alter their beliefs about birth based on lived experience rather than simply the knowledge they received from medical care providers or from reading about birth.

Scholars of women's health issues have noted that the use of narratives in online spaces can be tied to issues of identity. Dubriwny asks some specific questions about narratives that can be applied to birth narratives and the issues of identity that appear in discourse communities of birth. She asks, "what narratives are created about women's health and, through those narratives, what identities are being constructed for women?" (7). Dubriwny considers celebrity narratives of elective mastectomy, a method for preventing breast cancer. She argues that those narratives may serve to reinforce neoliberal values of individual agency and the necessity of making the right choice being placed upon women. Women learn to identify their value as mothers with their ability to make good choices while pregnant and preparing to give birth. Scholars' concerns about how identity is formed and perhaps constricted by circulation of the narratives online are informed by a version of postfeminism that overlooks structures of inequality that may ultimately affect women's health experiences. Through the construction and sharing of a birth narrative, these women are able to demonstrate the moment when the postfeminist emphasis on agency comes into conflict with their lived experience of birth.

Websites Provide Privacy

While women construct birth as a private event in their birth narratives, they choose to share their experiences in open online spaces for a variety of complex reasons. However, they navigate the seeming conflict between private experience and public sharing through a rhetorical choice of posting the narratives on websites that they are not personally associated with, but whose philosophy of birth they agree with. Posting a narrative on a website with a specific perspective allows the women to also rhetorically construct the audience that they hope to reach with their narrative. The tensions between constructing birth as a private event and sharing that narrative publicly on the internet are mediated through the choice to post the narratives to collective blogs rather than on personal sites that they may be more deeply connected to. I begin my analysis by tracing the construction of privacy in the birth narratives and the perceived lack of respect for their privacy that can be a site of conflict for women in the narratives. I then explore the narrative tools women use to discuss the influence of reading or hearing other birth narratives on their own birth experience, which may in turn affect their motives for sharing their own narratives. Additionally, prior experience with the websites that host birth narratives and their communities may allow women to feel more comfortable with sharing their own narratives online. Within the narratives themselves, women often reveal their reasons for sharing their birth narratives publicly. By explaining their reasons for publishing their narrative, the women also demonstrate who they construct as their audience. Finally, I focus on the ways that the narratives on these sites form part of the discourse of birth online through their explicit messages about the ideology of birth.

Birth constructed as private

By examining these internet-published narratives, we can get a sense of how the writers conceive of their audience and construct birth as a private experience. Women may seek to maintain some privacy regarding their birth experience by electing to leave some details out of their written narrative because birth is a bodily function. It is also important to consider what may be left out of the narratives regarding the level of detail that women are willing to share. Simply put, the narratives demonstrate that women desire a great deal of privacy when giving birth and some level of control over the privacy they have while giving birth. Women want privacy while giving birth because it is essentially a bodily function. The uterus contracts out of the woman's control and the pushing reflex kicks in when she is ready to give birth to the baby. She also may feel a complete lack of control of her body, which is one reason that she may want privacy. Ina May Gaskin, a midwife and author on birth, writes that the cervix is similar to the sphincter and can only relax enough to push the baby out when a woman feels comfortable. She also argues that a woman who feels no control of her own body may really dislike having other people around because she is afraid of being embarrassed. In several narratives, women express some frustration or feeling of being violated when there are people in the labor and delivery room for the birth who they did not ask to be there. It is a common practice in teaching hospitals for residents and nursing students to conduct some of their hands-on learning by accompanying experienced OB-GYNs and nurses while delivering the baby. There can easily be half a dozen medical professionals in the room and the woman may have only asked one of them (the OB-GYN) to be there. For many women, simply being reduced to a spectacle while giving birth is enough to cause them to believe that their privacy has been violated, which they often relate in their narratives.

The loss of physical control over her body during labor can mean that the woman is also not under control of the medical system as well. This may be one of the central conflicts between unmedicated birth and the medical system. It is clear from multiple stories of women being pushed to accept medical interventions that medical care providers can seem impatient rather than allowing women's bodies to behave "naturally" and deliver the baby on their own time. If the woman's body is out of control, it is very difficult for the medical care provider to predict the direction that the labor will take. For instance, they have no way to know at what rate the labor will progress. Additionally, they can really only know if the baby is the right position to be delivered if the medical care provider is able to reach inside the woman's vagina and feel the position of the baby. We have the means through medical monitors to measure the length and intensity of contractions as well as the baby's and mother's heart rate; however, the monitors cannot predict how the labor will continue and at what point the mother's body will be ready to deliver the baby. This conflict between medical care providers and birthing women's desires for control of the birth may appear central to the narratives; however, the woman's own desire to end the pain and struggle of giving birth adds an additional complication to this issue of control. A woman who is frightened by the loss of control during the labor process may feel that the offer of some control over the situation from the doctor will solve her problems by reducing the unknowns. In many instances, all of the unknowns around birth, such as when labor will begin, what it will feel like, how long it will last, or whether or not there will be a complication with the baby are offered some resolution by the medical system. For instance, induction seems to guarantee a clear beginning for the birth, but it does not always work well. Some women's bodies simply do not respond well to medical induction. Additionally, pain relief can help a woman who is too stressed out by the lack of control to relax, but that can sometimes cause the

labor to slow or even stall. The issue of who is in control of the birth, whether the woman's body or her medical care provider, can be crucial to the construction of privacy in the birth narrative. Later in this chapter, I will explore instances in the narratives where women share some stories of feeling that their privacy has been violated by medical care providers who wrest control of the birth from them. While one may wonder why a woman would choose to share this potentially embarrassing invasion of privacy publicly, the narratives also often refer to education as the primary reason that women are willing to share their birth experiences.

The issue of privacy in giving birth is reflected in birth narratives as women struggle to reconcile their desire to give birth with privacy and the lack of control that they feel that they had over the birth itself. They may become particularly concerned with a perceived lack of respect for their privacy on the part of their medical care providers. One woman points out, "We were at a learning hospital so within seconds there were four OBs between my legs, four pediatricians by the warmer, about eight nurses scattered around, and three anesthesiologists in the back of the room" (BWF #6). While it may seem like an exaggeration that nearly twenty medical care providers were present for the birth of her child, this woman emphasizes that many people she had not even met before were there and because education for those students was valued over her birth experience, she had no control over their presence. Juxtaposed with this description of the large group of medical care providers is an exhortation from the doctor for her to deliver the baby: "PUSH! I pushed. And I pushed. And I pushed again" (BWF #6). The point this woman makes with her birth narrative is that while she is trying to deliver her child, many medical care providers are seemingly receiving a front row seat to the show and she is not particularly pleased by that. One reason that this woman finds her experience giving birth invasive is the lack of

control that she has over who attends the birth; however, she ultimately keeps her critique to a minimum because she is framing the birth experience as positive.

While this woman offers a fairly subtle critique of the lack of privacy she experienced during the birth, other women are more openly critical of their birth experience. Another woman writes, “There was no respect for my labor, or my choices, or me as a human being. I had my husband, my mother, and sister there for support and was still treated as a disobedient child by the medical staff (ESP #5). In this narrative, the author uses a metaphor of being treated as a child to explain the ways that her medical care providers particularly demonstrated that they did not have respect for her autonomy or ability to make good decisions about the way her birth should proceed. The woman begins her narrative by stating her preference for a “natural” birth and says that throughout the pregnancy her doctor was supportive. However, as soon as she arrived at the hospital for the delivery the nurses and doctor were dismissive of her wishes and ignored her attempts to assert agency over the birth experience. It is telling that this woman, who may have expected that her birthing partners would be able to support her when she was in labor, instead found herself humiliated by her medical care providers in front of them. The public disrespect of their autonomy operates for these women as the most significant reason that they believe in privacy as important for their birthing process. For both of these women, the lack of respect for their autonomy is portrayed as an invasion of their privacy and the negative experience is significant enough that they would share it in constructing the narrative of their birth experience. The choice to share experiences of intrusions on their privacy is important for these women, but not necessarily surprising to see on the internet. However, there are some women for whom prior experiences of trauma can threaten their desired privacy while giving birth and their narratives demonstrate a more significant level of trauma than these narratives.

Autonomy, Control, and Trauma

When women have some strong negative physical experiences in their past, particularly such as sexual assault, they value privacy and autonomy in order to feel safe while giving birth. One example demonstrates why women find a negative birth experience triggering for them: "as a rape survivor, having control taken from me is a trigger, which is why I wanted a medication-free birth" (ESP #5). This narrative provides a clear explanation for why women might find an unmedicated birth appealing, even if it will be more painful. While they may not be in complete control over their bodies during labor, women find that they have more trust in their bodies than in the medical system that may assert control through the use of continuous monitoring, Pitocin through an IV that requires tethering to cords, or epidural that deadens her from the waist down. However, many women do not have the opportunity to assert control even over the choice of where to give birth. The author of this narrative continues, "I wanted a home birth however, insurance would only cover a hospital birth and the ob-gyn practice with two male doctors" (ESP #5). Although she does not make a direct connection between her fear of losing control and the necessity of giving birth attended by a male ob-gyn, it is likely that for this woman, being unable to choose her preferred location for giving birth, began the loss of autonomy in her process of giving birth.

Some women describe birth as a triggering event for prior trauma, while other women writing narratives of traumatic birth, argue that the loss of control during birth is the cause of trauma for them. In chapter five, I will discuss in greater detail how the trauma from giving birth affects women's recovery and early motherhood. As Colton writes, "the birth story is of particular interest in that it raises questions about the nature of trauma and how, and by whom, a traumatic event is defined" (679). In this analysis, I assert that *Birth Trauma Association* and

Exposing the Silence Project allow women to define trauma for themselves. Here I will explore a specific example of an instance where a woman writes about the loss of control that she experienced while delivering her child and the writing of the narrative itself. In writing the narrative of giving birth, this woman specifically seems to be attempting to regain control over an experience where the loss of control was the cause of trauma for her. She writes,

> It has now been three years since the birth and as a result of PN PTSD I now suffer from anxiety and panic attacks. I don't seem to be able to cope with stressful situations in the same way I did before and often find it difficult to organize my thoughts. I think I am still on 'high alert' from the trauma and this continues to impact on my life. My overwhelming lasting feelings are that of lack of control, I had no control over what happened to me and as a result of this struggle with situations in which I feel out of control again. Unfortunately my partner and I recently separated, I have no doubt that my PN PTSD has had a part to play in this. (BTA #4)

For this woman, the experience of giving birth was so traumatic that she believes it has had a lasting impact on her over the course of several years. She states clearly that she is writing the narrative three years after giving birth, but still has such symptoms as anxiety and panic attacks as well an inability to "cope with stressful situations" and "difficult to organize my thoughts." She points directly to lack of control as the cause of this lasting trauma because the birth, which she had anticipated as a positive experience through becoming a mother had instead turned out to be a very negative experience. She claims that this is the reason that situations where she feels out of control act as triggers for her. Ultimately, she believes that the trauma she experienced from being out of control while giving birth contributed to her separation from her partner. This narrative is a powerful example of the trauma that may occur when a woman believes she had no

control over the events that occurred while giving birth. Trauma is certainly not the memory that a woman would like to associate with the beginning of her child's life. While they may certainly not wish to be traumatized by giving birth, some women believe that they do not have an option when making medical decisions for both their own and their child's safety.

Women must balance happiness about giving birth safely and having a healthy child with assertions about their desire to have more rights in choosing how to give birth. As in the above examples, they may feel that their experience giving birth was unpleasant or even traumatic, but there is a strong strand of postfeminist logic in women's health that places the responsibility on women to be grateful because their child was born healthy and they survived the delivery. However, this argument directly contradicts the necessity for women to make their own choices about giving birth. According to Dubriwny, "women's health activists made arguments about self-determination that emphasized the importance of women's agency in making choices about their own healthcare" (18). Thus, a woman may have received many messages that she needs to make the best choice for herself and her child when giving birth, but ultimately her actual birth experience seems to downplay her sense of agency when giving birth. One woman writes, "Xander is healthy. I am healthy. For this, I am thankful beyond words. I am thankful that a safe C-section was performed, that it was necessary" (ESP #3). She begins the conclusion of the narrative by expressing gratitude for the medical care that she received and that it resulted in a healthy baby. She acknowledges that while the medical intervention was not planned (or desired), she recognizes that it was necessary. For her, as well as many other women, they have made some plans for how they want the birth to take place, but they have to admit that they are not birth experts and that the medical care providers are able to make decisions that protect the lives of both mother and child.

The use of gratitude to describe their birth experience is a rhetorical device women may use to frame any critiques of the medical system or the birth itself. In many birth narratives, but especially in the traumatic birth narratives, the woman may want to clearly express their dissatisfaction with the overall birth experience, and particularly the treatment they received from their medical care providers. Contemporary birth practices emphasize the importance of gratitude for a healthy baby over every other concern when giving birth and women reflect this belief in their rhetorical use of gratitude in their narratives. Thus, they use expressions of gratitude to demonstrate their appreciation for appropriate medical interventions. Additionally, a woman may feel that her audience will criticize her for failing to be properly grateful to have a healthy child. Narrative *ESP* #3, from the site *Exposing the Silence Project*, is also self-conscious that it may not be the worst or most traumatic narrative on the website. As Colton writes, women define their birth experiences for themselves and by choosing to upload her narrative to this site, this woman argues that her birth experience was traumatic. Although it ends well, she does not choose to end the narrative happily and simply.

This woman, while expressing the requisite gratitude feels compelled to argue that women need more agency to make decisions about giving birth. She walks a fine line between happiness/gratitude and a critique of the circumstances that led to her traumatic experience of giving birth. This is a rhetorically significant skill for this writer to use in persuading women that there are more than just individual choices at play when a woman gives birth. She argues, "mothers have a right in any situation to ask questions and stand up for themselves throughout the delivery experience. Everyone deserves informed consent, which is not necessarily the standard these days" (ESP #3). While she critiques the standard of care that she feels removed her choices from her while giving birth, she is careful to avoid arguing against medical

interventions. Rather than take a strong stance against medical interventions as "natural" birth ideology does, this woman reconciles her own experience giving birth, which involved a medical intervention with her desire for agency. Although she does not state that teaching women to assert their agency is her explicit goal for writing her narrative, this strong statement near the end of her narrative indicates that she has the expectation that other women may benefit from reading her narrative. It also has a tone of railing against the loss of control that she felt when her questions were not answered and she was unable to stand up for herself. While women use their narratives to demonstrate how their privacy was violated, they may feel that they are comfortable sharing their narratives on their chosen website because they have some prior experience with reading birth narratives on that site and believe that the community will be welcoming to their experience.

Reading Narratives as Blueprints for Possible Birth Outcomes

Reading or hearing other birth narratives may influence women's choice to share their own narratives. Thus, they may already be familiar with the community of the website before choosing to share their own narrative there. Women often relate in the narratives that their first experience with reading birth narratives was part of their preparation for giving birth. In the early twenty-first century, the internet is quickly becoming the most frequently looked to source for education on any topic. So, for these women, the websites are not only a source of potential community, but also give them details of the embodied experience of giving birth. Solinger and Ross comment, "in contemporary society, mothers receive a great deal of conflicting parental advice, much of it impossible for many parents to follow – to breastfeed or not, to discipline or not, or to work or not" (172). While the internet may not resolve the conflicts between ideologies of birth, the women who seek out birth narratives trust that the experience described in the

narratives is true and may shed some light on the mystery of birth. An important aspect of postfeminist health directives[12] is preparing well for the unknown experience of giving birth. This may involve reading birth narratives or participating in a birth class where a woman learns about birth narratives. One woman writes, "I read books on natural childbirth, and my husband I did the Mama Natural Birth Classes. At 28 weeks my midwife had me start eating 6 dates a day, and at 36 weeks I started drinking red raspberry leaf tea" (MN #1). This narrative posted to *Mama Natural,* a website that endorses natural birth in many forms, operates as a sort of testimonial as well as a description of giving birth. For this woman, consuming forms a large part of the birth preparation. According to Seigel, "purchasing the right products is represented as a means to managing risk in pregnancy and childbirth – pregnancy is articulated to consumption" (122). The idea that consumption is the way to achieve the kind of birth that a woman wants is a particularly neoliberal capitalist way of perceiving birth. While some women are able to consume their way to the birth experience that they wish to have, others are not so fortunate. After the birth, these women are left feeling as if they had only made different choices, then they would have been able to consume their way to a better birth.

Additionally, some women find that watching birth videos helps them to prepare mentally for the birth experience. According to Hartelius, "the privileged position of first-person expertise makes it impossible to impart epistemology. Several experts bespeak this privilege and the impossibility of sharing the perspective that comes with lived experience" (23). By sharing their narratives of giving birth, these women attempt to offer their birth experience for other women to learn from; however, in most cases they do not offer a specific interpretation of their

[12] Dubriwny argues that postfeminism is an ideology that directs women exactly which decisions they need to make about their health not only to protect their own productivity as citizens in a neoliberal society, but also so that they provide care for their families.

experience. This leaves the reader to make their own interpretation of the experience, which can be problematic. Thus, while they acknowledge the challenge of attempting to learn about birth in detail, by reading or watching about another woman's experience, these women still assert the benefits of reading women's narratives of giving birth. They may not have the exact same experience as the narratives that they read, but the overall experience that they hope to have may be reflected in the perspective of the narratives. Hensley Owens also argues that in writing their birth narratives, women "seem to be writing against a model of passive acceptance of medical interventions, acquiring multiple types of knowledge" (44). The women who seek out sites featuring birth narratives prior to giving birth may do so because they already approach birth with a sense of agency and desire to resist the dominant narrative of a medicalized birth. Thus, by reading narratives written by women about the embodied experience of giving birth, these women expect to learn about a variety of birth experiences, some of which they may wish to emulate in their own birth experience and some which they wish to avoid.

While some women express positive experiences with reading birth narratives prior to birth, for other women, reading the narratives after giving birth can be a very negative experience overall. This can be the result when women have perhaps had a very hopeful view of how they expect the birth experience to turn out and then have a negative experience giving birth. One woman writes about her experience,

> I couldn't read birth stories without feeling sad, disappointed, and even jealous of these other women achieving their drug-free vaginal births and VBACS. My sweet doula sat me down and told me, 'You're only thinking of this one way. But what about these 'what ifs?' What if you HADN'T had a cesarean? What if you HADN'T followed your instinct? You birthed a beautiful baby. Be kind to yourself. (BWF #4).

I argue that the woman's choice of website for posting the birth narrative contributes to the framing of a narrative as either positive or traumatic. Although she ultimately frames her birth experience as positive by posting it to the *Birth Without Fear* website, this woman clearly had some lasting negative feelings about the outcome of the birth experience. She openly acknowledges that following the birth, reading narratives that portrayed the birth experience that she had hoped to have was difficult for her and left her with many negative feelings. Although she doesn't offer a timeline for when she read the narratives following the birth of her baby, the mention of her doula offering support suggests that this likely occurred within the early postpartum period. The doula, who is physically present in her life, and witnessed her birth, is able to help this woman have a different perspective of her birth experience. By asking her to consider how her choices while giving birth ultimately enabled her to deliver "a beautiful baby," the doula rather than the narratives allows this woman to alter her thoughts about the birth experience (BWF #4). I argue that this woman's experience with negative feelings about reading birth narratives, reflects the complicated experience of looking to someone else's personal experience to make sense of one's own experience, which due to many circumstances was necessarily unique that Hartelius points to.

For some women the birth experience leaves them with such negative feelings that they struggle to reconcile those feelings with the positive experiences of others. Another woman writes,

> I had a session of counselling and felt like I was able to start putting the whole thing behind me. I still had some issues for example I felt pea green with envy at anyone who had a 'normal' birth…Jealousy is a horrible emotion and I feel guilty for feeling this way

> especially because I understand…others have not been as lucky and have been through far worse than me. (BTA #4)

She does not specifically mention reading other birth narratives as the cause of her jealousy; however, it is clear that she became aware of other women's experiences giving birth. This points to one of the major concerns of this chapter. While birth is often portrayed as a mysterious event or private event, after they give birth women are eager to share and compare their experiences to those of others. However, if the birth does not go as planned and a woman feels shame or guilt afterward, she may feel jealousy of women who had "normal" births. By placing the responsibility for the birth outcome upon the birthing woman, neoliberalism contributes to these negative feelings associated with an unplanned for birth outcome. This example also refers to my earlier point about the necessity of deploying gratitude to avoid alienating readers. In the narrative the woman also writes, "may I add truly am grateful that yes I am here and my baby is alive and well" (BTA #4). Combined with her reference to women whose birth outcomes are not as positive as hers, I argue that for this woman it is important to acknowledge the tension between jealousy and guilt and gratitude. These narratives demonstrate that women have complicated relationships with reading or hearing the birth narratives of other women, which may make them particularly conscious of how their own narrative will be perceived by their audience. Thus, they attempt to maintain some balance between negative feelings about the birth experience and happiness that they have a healthy child.

Publicly Sharing Birth on the Internet

Women often share their reasons for sharing their birth narratives publicly on the internet. By explaining their reasons for publishing their narratives, the women also demonstrate who they construct as their audience and who they hope will accept them as part of their chosen birthing

community. Some women have very explicit goals of providing advice to other women who are looking for new or other information about giving birth. Additionally, they may feel that they can only give advice that is in keeping with the overall aim of the website. For instance, this woman advises, “watch peaceful birth videos, only allow people to tell you their positive birth stories, surround yourself with what you DO want your birth to be like” (MN #2). This woman falls into line with the primarily “natural” birth focus of the *Mama Natural* website and the community’s overall trend toward endorsing postfeminist agency in giving birth. She encourages her audience to also be selective about the kind of information that they choose to ingest about giving birth. This advice clearly indicates her strong belief in women’s ability to influence their birth outcome by preparing themselves well for the birth that they want to have and making the appropriate choices. In sharing their narratives of giving birth, Hensley Owens posits, “this distribution provides unprecedented opportunities but also the distribution is not always straightforward or unimpeded” (91). The advent of the internet and particularly web 2.0 has certainly increased opportunities for circulating new embodied knowledge of the experience of giving birth. Web 2.0 can be seen as an extension of the prior circles of family and friends that women relied upon to learn about pregnancy and birth. However, Hensley Owens notes that by choosing a particular birth community to share their narratives with, women potentially close down the possibility of their narrative reaching a larger community. For instance, women who are not as interested in “natural” birth may not take the time to read the narratives on a site like *Mama Natural.* However, it is possible that women who choose to share on this site are primarily interested in reaching an audience of women who hold the same beliefs about birth that they do. In this narrative, the implication is that “natural” birth is the right choice and the advice seems to

offer the possibility of controlling a birth outcome through good consumption of information about giving birth.

The narratives posted to *Mama Natural* and some on other sites as well enact a particular kind of feminist work that resists what is seen as the dominant medical approach to birth. Seigel writes, "within feminist circles, there has also been much critiquing of the medical, technological, and intervention-heavy approach to childbirth, an approach that, critics argue, frequently alienates women, makes them feel out of control of the birthing process, and facilitates unnecessary, painful, and sometime traumatic procedures" (7-8). I posit that the websites have the possibility of functioning as feminist circles and all of the sites in this discourse analysis offer the kind of critique that Seigel describes. The woman discussed above, offers an alternative to losing control of the birth process by giving very strong advice. She continues, "don't get into your head when you're in labor. You can do anything for a minute or two, get through each contraction. You can do anything for an hour, just take it one hour at a time" (MN #2). This woman is very assertive in informing women exactly how she believes they can achieve a "natural" birth like the one that she was able to have. She addresses her audience directly, which indicates that she expects her audience to be composed of women who are currently pregnant or who are at least interested in exploring how to give birth. This rhetorical approach could be negative toward the potential audience; however, it appears that this woman is familiar with the community she participates in and recognizes that this approach is deemed acceptable to the community. While it is possible that her direct instructions to her audience may create some conflict for members of the audience who are not looking for advice or who have a different ideology of birth, there are some who would probably welcome such clear instructions

that are different from those they receive from the medical care providers and more popular instructions for birth such as the manuals Seigel studies.

In addition to offering advice on preparing for birth that is informed by “natural” birth ideology, some women desire to provide a story of giving birth that may not be normal, but they hope that their audience may be able to identify with. I argue throughout this dissertation that the ways women construct their narratives of giving birth relate to their identity as a particular kind of birthing mother. Much birth discourse focuses on a binary, either “natural” birth ideology or a completely medicalized view of birth. While it is tempting to sort these narratives into either pro or anti “natural” birth camps, I offer that the narratives themselves resist such simple definition. This is in part related to how the women identify themselves as birthing women and the kind of birth they were able to have. There are narratives where women write that they had planned for an unmedicated birth, but due to circumstances clearly outside of their control, they ended up choosing a medical intervention birth for the health and safety of both themselves and their babies. One woman writes, “as someone who has personally travelled this road, I share the story of my second child’s birth, a family-centered, gentle cesarean, in the hopes that it can bring healing and comfort to others whose birth stories may not have gone *quite* as planned” (BWF #5). This woman refers first to her own birth experience as a journey. She wants her audience to understand that this birth may not have been her initial choice, but overall, she uses positive language to describe the birth. “Family-centered” and “gentle” are both terms that are not typically associated with a caesarean, which is usually considered the most invasive medical procedure associated with giving birth, but this woman asserts that this was her experience of giving birth for the second time.

Although she did not have the birth outcome that she had planned, this woman uses specific language in order to construct a narrative that is still acceptable to her chosen discourse community. She invites an audience of women who were not able to have the birth experience that they had planned for to find comfort in identifying with her experience. Interestingly, she avoids mentioning negative births or traumatic births in relationship to her audience. Additionally, she softens the language by claiming her birth as one that did not go "quite as planned." Although she did not have the triumphant birth often associated with the website *Birth Without Fear*, where the narrative was posted, this woman appeals to her own expertise to reach her audience. According to Hartelius, "everyone is regarded as an expert on their own life; reporting one's own experience does not require special training. Every individual presumably 'knows' herself. There is thus a level of unquestioned authority when a person speaks about her personal life" (118). This woman refers to her own expertise as a birthing woman to appeal to her audience. Although others might be tempted to offer their advice on what she could have done differently in order to achieve a birth more like the one she had planned, her own knowledge about her experience giving birth closes down some of those critiques. She obviously knows and understands why the events of the happened as they did during the birth. While this woman appeals to her own expertise and understanding of the birth, other women who have birth experiences outside of their control, feel that they are left with a lack of clear understanding of their births.

Some women (primarily experiencing traumatic births) express a desire to warn other women with their narratives. These women wish to help other women avoid the trauma that occurred during their own labor and delivery. This may appear as a common theme when women

are describing their purpose in reliving the traumatic experience of giving birth in order to write up the birth narrative to share on the internet. One woman writes,

> for as long as I can remember I wanted and envisioned a certain birth scenario for my family, but we did not get it. Nonetheless, I want to document what happened. My son['s]…birth…ended up being very traumatic.[13] It's hard for me to go through and relive that time, but I am hoping to prevent similar episode for other people. (ESP #3).

As with many narratives, this woman begins by explaining that she had planned (although she does not specify if she wrote a birth plan) a particular kind of birth experience. Of note, she mentions her family rather than just herself in the plan for the birth. Many women tend to focus on themselves when planning their births, but this woman acknowledges the experience will affect her entire family. She then transitions to stating that she plans to use the narrative for two purposes: 1) to document the birth experience; 2) prevent other women from having similarly traumatic experiences. While this woman is not very specific here about the effect of the trauma from her birth experience, other women discuss the effects of the trauma on their postpartum recovery

Before giving birth, it is difficult to imagine what the postpartum experience will be like and many women receive little education on it as well. I will discuss in greater detail the inclusion of postpartum information in chapter five because it is significant to ways women construct time in the birth narratives. Some women juxtapose a discussion of postpartum experience with their reasons for sharing their birth narrative. This woman writes, "I suffered from post-partum depression after his delivery. I had flashbacks of being assaulted…I struggled

[13] In this narrative, the woman included some specific details regarding her birth experience and child that could be used to identify either her or the child. So, I have chosen to redact those details because it will not actually detract from the meaning of the narrative.

to bond with my son…I want to protect women from what I went through" (ESP #5). For this woman, her experience giving birth triggered memories of being assaulted, which caused many problems during her recovery from the birth. She also records that it was not until she began medication and therapy six months postpartum that she began to recover from the birth trauma. By choosing to share that she took both medication and attended therapy, this woman normalizes seeking help to recover from a negative birth experience postpartum. It may appear to be a small detail to include at the conclusion of the birth narrative, but it is rhetorically significant that this woman feels either comfortable enough or strongly enough that she would include such personal information about her mental health. Sharing personal experiences online that have been traditionally stigmatized can be a great benefit of these narratives that Hartelius speaks to because it is impossible for the audience to refute the personal experience of giving birth by another woman. This woman also hints at the stigma around sharing negative birth experiences, which may cause women to hide their negative birth experiences.

Sites such as *Exposing the Silence Project* and *Birth Trauma Association* attempt to provide space for women to share narratives that they may otherwise hesitate to publicize because it is not the common perspective of birth. According to Colton, "writing these narratives can be seen as a site at which the social and discursive practices of the individual, the community, and the larger culture are interrogated and from which they may be effectively altered" (686-687). These two websites allow women to form communities that resist a simple or overly positive view of birth. Additionally, these narratives like the one above openly share trauma that resulted from the birth experience, resist the neoliberal impulse to claim self-responsibility for the birth outcome. Thus, these sites and the women who choose to share their narratives on them endeavor to alter the landscape of birth discourse on the internet. I argue that

these traumatic birth sites specifically offer some challenges to the simple binary that often gets drawn when women discuss the experience of giving birth. For example, “it’s been over five years since I had my first son and I would like to expose my medical issues since the birth to anyone who wants to listen” writes one mother of her birth narrative (BTA #2). Although she is not clear about who her audience is, this woman clearly wants others to understand that her birth experience was traumatic and that even several years later is still an important issue for her. While the women writing about their traumatic births typically focus on the negative aspects of the birth experience in order to educate their audiences, other women are not as straightforwardly positive or negative.

As they experience complicated emotions around the experience of giving birth, women try to reconcile a birth that did not take place as they had planned with the outcome of a healthy baby. Their narratives often reflect some hesitance or conflicted feelings that they are still trying to reconcile while constructing the birth experience after the fact. For instance, one woman writes, “the decisions made that day were mine alone. I chose the decision I could live with and now, over half a year later…I did the best I could do…I think I will probably always have moments when I wonder ‘what if,’ but I no longer feel like I failed” (BWF #4). She absorbs responsibility for choosing a cesarean delivery, although she had planned to have a vaginal delivery, but the responsibility does not necessarily make her happy. Rather, at least six months after the delivery, she continues to question whether or not the “decision I could live with,” was the right one. She also expresses some of her own reflective process, which may have led her to share her birth narrative. However, she claims that just because she still has questions does not mean that she feels as if she failed as a birthing woman. Ultimately, the message that she wishes to communicate to her readers is one of identification. She says, “I hope that other women

reading this, possibly in the same situation, will know that they aren't alone. It's hard when VBAC doesn't happen. Those feelings of disappointment, sadness, and anger are real" (BWF #4). The audience that she hopes to reach with her narrative is one of women, who also did not experience a birth that went according to plan. If they read her narrative, then hopefully they will feel as if someone understands their feelings. She even goes so far as to name the feelings that she experienced about the birth and comments that it is alright to not feel alright about the birth outcome. Hensley Owens argues that "composing childbirth narratives allows women the opportunity to relive the bodily experience of birth emotionally and psychologically, often allowing them to reassert rhetorical agency over their births in doing so" (116). This woman composes a narrative that gives space for complicated and conflicted feelings about the experience of giving birth, but also seeks to reassure her audience about the validity of their own feelings. Sharing narratives that both accurately represent a woman's experience of giving birth and validate the experiences and feelings of the audience is a vital part of the community formation that is the subject of this dissertation.

The narratives on these sites form part of the discourse of birth online through their implicit messages about the ideology of birth. Earlier studies of online blogging about birth and motherhood, (Borda, Morrison, Van Cleaf) focused exclusively on blogs written and published by individuals about their experiences. In Web 1.0 women used a variety of tactics including blogrings and blogrolls, as well as hyperlinking to each other's sites to form a community of writing mothers. However, with the advent of Web 2.0, primarily defined by the ubiquitous use of social media, connections are made more quickly and technology, such as hashtags and the conglomeration of sites under one company with many users, has tended to make blogs less popular. This follows from the impulse in digital technology to view new as better. However, the

four websites that form this discourse analysis are collective blogs. They are published by an individual or group but feature many contributors sharing their narratives of giving birth. The women who offer their narratives on these sites, do not typically submit more than one narrative; thus, once they have received the emotional satisfaction of having shared their narrative, they can leave the site behind. Additionally, they are not required to share any information about themselves that is personally identifiable like they would by posting to social media about their births. By presenting the narratives as a collection, these four websites act as anthologies, with each providing a different view of birth. While one of the sites, *Birth Without Fear*, purports to offer a variety of narratives that present a range of birth experiences, the other three have a very specific birth experience that they offer and values that they want to impart to their readers. However, I argue throughout this dissertation that each website also communicates to the audience that "natural" birth is the dominant ideology in online birth discourse.

Conclusion

One facet of the websites as discourse communities is the deployment of personal narrative to identify and connect with each other. The audience seeks out the personal birth experiences of other women as discussed above. Morrison argues, "the emotional reciprocity of personal mommy blogging organizes an intimate public whose ways relating, choice of central topics, and emotional cadence are set by writers in relation to one another, in a mutually reinforcing loop of group production/consumption that creates texts and community at the same time" (44). While Morrison writes about individual blogs, I agree that her point extends perhaps even more intensively on the collective blogs. One reason women read birth narratives is to learn more about the embodied experience prior to giving birth themselves. Familiarity with the content of the other narratives on the sites also dictates the formation of the narratives they

choose to write and share. For instance, in one of the narratives from *Birth Without Fear* the actual events of the birth more closely resemble the traumatic births posted to *Exposing the Silence Project* and *Birth Trauma Association*. I contend that because the narratives posted to *Birth Without Fear* are framed as positive, this narrative uses the language choices commiserate with the positive "natural" birth narratives. After giving birth, women may recognize that their own experience were similar or different from the narratives they had previously read. The blog then invites them to add their own unique embodied experience to the collection in the "reinforcing loop of group production/consumption" that Morrison discusses (44). Additionally, they may also find that after giving birth they want to connect more with the community of women who influenced them before giving birth or whose narratives they can closely identify with. As Seigel comments, "each pregnant woman and pregnancy is unique, in other words, based on its relationship to risk" (117). One of the reinforcing or community formation functions of the collective blog is the ways that it allows women to recognize the uniqueness of their own experience giving birth. For first time mothers, this may be particularly helpful because they do not have any prior experience of their own to relate to. Thus, when they compare their own experience to those of the narratives on the blogs, they may be able to better identify and describe aspects of the birth they experienced. Thus, these two features of the collective blogs make them a rather unique source of community for birth discourse online.

The websites are also more easily discovered by people looking for birth narratives to read online or even just more information about birth from the perspective of birthing women. While a Google search may return some results of individuals' blogs, the collective blogs are more likely to have participated in the practice of purchasing a higher ranking on the search results. Also, by collecting narratives from many women, they are likely to have garnered a

larger number of views, which will make them easier for women to find through search results The websites also may offer visitors more opportunities to participate in a community than an individual blog or social media profile would. While individual narratives may seem less effective than more academic texts that provide quantitative analysis of statistics, the narratives themselves may actually have a strong rhetorical effect because of the nature of collected stories. When women read many narratives on sites such as the four discussed here, they may begin to form a composite of what a particular kind of birth will look like. For instance, if they read many narratives of unmedicated births, they may end up collecting several strategies that they believe will help them to achieve an unmedicated birth. On the other hand, by reading the traumatic birth narratives, they may reach certain conclusions about the attitudes and treatment of women by their medical care providers. Although the narratives do not tend to put the focus on critiquing the medical system as a whole, the narratives may have that effect when read collectively. Patterns and arguments about the relationship to birth also appear when the narratives are read collectively, which is not as likely to occur when birth narratives are posted individually.

Birth narratives posted to individuals' social media accounts such as Instagram do not have the same effect. If a woman posts a narrative of giving birth to social media, such as Instagram or Facebook, it is likely to reach a smaller audience than if published to a collective blog. Content on social media typically only reaches an audience of people who already follow the user of the account. Thus, a woman's friends and family may see her narrative of giving birth when posted to social media, but they may not be interested in forming a birth discourse community with her and may not offer the same kind of support that women find in reading birth narratives on a collective blog. The primary exception to this narrow audience is the use of hashtags to make the narratives more publicly visible. If a woman has a public social media

account, then she may use relevant hashtags to make her post more visible to an audience of interested strangers. However, on Instagram particularly, but on other social media platforms as well, a post may be discovered once, but unless she saves the post, the woman may not be able to find the post again because the social media algorithms influence what we are able to see. Additionally, the individual birth narratives reinforce the prevailing belief that birth is a unique and individual experience, rather than a cyclical experience that will likely follow a pattern. While the websites discussed here overtly include narratives that agree with the prevailing ideology of the website, the algorithms that dictate what and how we see what is posted to social media operate more covertly. As many scholars of digital rhetoric have explored, the algorithms have the effect of curating our experience of the internet without our even realizing it. This complicates attempts to read and understand the rhetorical effect of narratives posted on social media platforms, while also illuminating some additional reasons that women may choose a collective blog as the site to post their birth narrative.

The collecting of narratives on these websites also lends themselves to a sense of intentionality. Women have to choose to share their narratives on a specific site based upon their own framing of the narrative as fitting in more with one particular discourse of birth than another. Once they choose a particular discourse community to post their narrative to, women are also able to achieve some privacy/anonymity by posting on someone else's website. While the narratives could be constructed as no longer theirs once they post them to another site, women also have the opportunity to share freely their own experience of giving birth and share it in a space that would not be easily traced back to them because they have the choice of whether or not to use their own names. The collective blogs do have a feature of greater permanence than the social media by having an address that interested readers can bookmark and easily return to;

however, the identity associated with the sites is that of the owner/publisher rather than the women who post their narratives to the site. This may have the effect of providing a sense of identity protection to women who may otherwise be hesitant to share private details of their birth experience on the internet. I argue that this is a relevant argument particularly in the early twenty-first century when concerns about how information posted to the internet may actually affect people's real lives. As women construct the birth experience through a written narrative, how this narrative may form part of their internet identity becomes a great concern.

In the chapters that follow, I will consider how women use commonplace arguments to gain membership in their preferred discourse community and how the descriptions of time throughout the narratives demonstrate women's prevailing concerns regarding their birth experience. Although the commonplaces used in the various sites do not usually explicitly address "natural" birth ideology, I argue that these narratives demonstrate how pervasive this ideology is in birth centered discourse communities on the internet. Smith and Watson argue that "these examples suggest how the politics of remembering – what is recollected and what is obscured – is central to the cultural production of knowledge about the past, and thus to the terms of an individual's self-knowledge" (25). In the chapter on time, I will consider how the construction of the narratives as a genre of life writing foregrounds particular aspects of the birth experience depending upon the site where the narrative is posted and leaves out certain details of the birth such as the experience of pain. Women use these common aspects of their narratives to better fit into their desired discourse community and to hopefully reach a larger audience. One of the primary goals of the birth narratives in this sample is to help other women have better birth experiences by creating shared embodied knowledge of the birth experience.

CHAPTER IV CONSIDERING COMMONPLACES OF BIRTH

Introduction

The rhetorical devices that participants use to form and maintain discourse communities on the internet are important for women seeking to join an internet discourse community through sharing their birth narratives. As discussed in the previous chapter, the internet appears to be the most frequently referenced source for knowledge and community that women turn to in the early twenty-first century. Women turn to internet searches to learn more about pregnancy and birth, which may lead them to read birth narratives. Some women may be content to read and consume online birth narratives for their educational aspects, and that is as far as they choose to participate in the community. However, after giving birth themselves, some women wish to write and share their birth experience with a community of other mothers who have had similar experiences. I am interested in ways that women write and share their narratives within a specific birth community on the internet. This chapter turns to a discussion of the commonplaces or *topoi* that women use to frame the narrative that they write about the embodied experience of giving birth. Women consistently use commonplaces to demonstrate to members of the discourse community that they understand birth discourse in the community. I demonstrate in this chapter that the use of commonplaces can be complicated when their potential for exclusivity isolates or prevents some readers from gaining access to a discourse community.

In this chapter, I argue that women using commonplaces in writing birth narratives contributes to the form and maintains birth discourse communities on the internet. The communities differ based on the value and beliefs about birth held by the community members. Commonplaces are a defining characteristic of *Birth Without Fear, Mama Natural, Exposing the Silence Project,* and *Birth Trauma Association*, and all four of these discourse communities are

informed by the ideology of "natural" birth through these commonplaces. I begin by defining commonplaces as identified by classical Greek rhetoricians and applied to contemporary discourse communities by modern rhetoricians and linguists (Crowley, Gee, Johns). I then consider the boundaries and parameters of the discourse communities and how the use of commonplaces may differ between closed internet forums and public websites. An analysis of the most prominent commonplaces used in the narratives demonstrates how they contribute to formation of these discourse communities. Through this discussion, I argue that these commonplaces are significant to the narratives because the communities do not have specific sets of guidelines for admittance. Some of the commonplaces may be used to promote the values of the discourse community through their positive portrayal and reinforcement. However, they may also perform a function to exclude participants who do not share these values by subtly communicating that only members with particular experiences and beliefs about birth are welcome. The commonplaces community members use may both demonstrate that they fit into the community as well as sometimes resist the dominant discourse present in the community.

According to Aristotle, commonplaces are those topics of argument that are kept in store, in an easy place to access mentally, to aid the rhetor in extemporaneous speaking. They are used often because the topics will appeal to the audience. While it is important for the rhetorician to choose an appropriate topic that will successfully persuade their audience, they do not have to provide all of the logical steps in an argument. The rhetor does not have to provide a detailed argument when using a commonplace because they expect the audience to be familiar with the commonplace. According to Crowley, "In ancient rhetorics the defining characteristic of a commonplace was not its truth value but the frequency of its use; that is, the chief mark of a commonplace is its wide dispersal among members of a community" (70). While the lack of

specificity employed can make commonplaces challenging to recognize, discourse analysis of several texts from these four websites can assist in the identification and definition of some of the most frequently used commonplaces within the community.

Within the context of discourse communities, I focus on commonplaces in this project. While scholars such as Gee look at school groups and Crowley examines political rhetoric, as I examined in chapter three, the four websites that I used for my sample also serve as sites for discourse communities about birth that form on the internet. According to these scholars one of the defining characteristics of discourse communities is the use of specialized language with agreed upon meanings by the members of the group. For instance, women commonly discuss specialized medical language within their birth narratives such as Cesarean, epidural, and Pitocin without providing any definition or explanation of the procedures. The lack of definition may be confusing for readers who are unfamiliar with the terms particularly because of the negative argument that many of the narratives make about these medical aspects of birth. I am particularly concerned with the rhetoric of commonplaces because "each of these commonplaces presupposes and encapsulates fairly extensive arguments that not often uttered but that can be deduced and reconstructed" (Crowley 70). For instance, when women write about making the "right" choices for giving birth, they implicitly mean choices that promote a physiologic birth. Thus, it is important to consider the contexts of the websites where these narratives have been posted in order to understand how the commonplaces function within the discourse communities. At times, the commonplaces and the underlying ideology become so deeply engrained in the narratives and the communities that they resemble what Pierre Bourdieu calls habitus.[14]

[14] Habitus is the way of seeing the world that a person has adopted so deeply that they may no longer be aware of their underlying beliefs. According to Pierre Bourdieu, habitus is a combination of both physical and mental habits that are deeply engrained primarily through unconscious processes. Habitus is the means by which moral behavior is regulated as well.

Ultimately, the narratives present across all four of the websites consistently rely upon a commonplace of "natural" birth as the right choice for women who want the best birth experience for their baby, which I will trace throughout the chapter. But first, in the next section, I will define these four websites as discourse communities by comparing them to other internet forums that have been studied as sites for women to share their health experiences.

Boundaries and Parameters for Discourse Communities

The boundaries and parameters of discourse communities are often informal and based upon a shared interest, such as a Dungeons and Dragons gaming group or a group of friends who unite around their shared love a particular genre of music. However, others such as a specific college student organization may have formal rules around who is permitted to participate in the group and how the group members are allowed to join. In studying discourse communities on the internet, scholars such as De Hertogh argue that "understanding this process is important as it brings critical attention to how feminism evolves in digital spaces, knowledge that can benefit individuals working in feminist studies, medical professions, classrooms, and communities within cyberspace and beyond" (para. 4). It is crucial that scholars work to understand the means that women use to develop these communities on the internet. In her study of bereavement sites that women who have experienced the loss of a child create, Nesbitt writes, "I argue that these sites provide for bereaved women a public outlet more powerful than a face-to-face support group or other means for healing" (46). Others, such as Dubriwny, consider women's narratives of postpartum depression shard on the internet, another health experience that is not typically talked about. The ability to discover other women who have had similar experiences and possibly similar challenges to healing from the experience, is one of the benefits of a more loosely defined discourse community such as the sites that Nesbitt studies. Women may also

seek to share their narratives in online discourse communities rather than with just their local community because they seek to advocate for a particular perspective of birth or better treatment of birthing women and they find an outlet for it on the internet.

There are some major differences between closed discourse communities, such as forums or social media groups, and public facing websites, which operate more loosely. While some earlier studies of discourse communities (Nesbitt, Hensley Owens) focus on personal websites that link to each other, as the internet has expanded through the first two decades of the twenty-first century, discourse communities have tended to form in more structured ways and are hosted on social media platforms. Forums or closed social media groups often require approval from the administrator to join and post or comment in the group. Although there is not necessarily a way for the administrator to verify the identity of the individual seeking admittance to the group, merely the process of going through approval can serve to deter anyone who has not actually had the experience that the group is bonded around. For instance, women join groups based upon their due dates, on *BabyCenter,* a popular site that hosts forums for pregnant women. In such groups, the administrator often takes an active role in monitoring the discourse by removing or asking the original poster to remove discussions that are off topic from the stated purpose of the group. Women in these groups are able to feel fairly confident that the audience they are addressing is composed of other women with similar experiences and knowledge about the health experience they are united around.

The four websites that I drew my research sample from represent a transition from earlier blog rings composed of personal sites and new groups on social media platforms. These websites represent anthologies of discourse communities that differ from both early internet communities such as blog rings and current private spaces on social media platforms. As there is more content

on the internet to explore, there are more behind the scenes platforms and algorithms making decisions for us about how our experience is curated. Although closed groups may appear to provide women with the privacy, they may desire to share sometimes painful experiences related to health and medicine, these four websites have specific purposes in collecting narratives from many women and presenting them publicly. Three of the four websites (*Birth Without Fear, Birth Trauma Association,* and *Exposing the Silence Project*) portray themselves as activist sites that aim to change the treatment of pregnant and birthing women, while the fourth website (*Mama Natural*) primarily uses women's narratives to promote the business that sponsor the website.

Positive Birth Experiences

Birth Without Fear aims to normalize women's experiences and choices about giving birth (Harshe). While the website purports to support all women's birth experiences and does not explicitly request positive birth narratives, my discourse analysis reveals that a sampling of narratives from the site are only positive examples of giving birth. Since I began my research on this site back in 2017, all of the narratives (about fifty) I have read on *Birth Without Fear* are positive. The narratives on both *Birth Without Fear* and *Mama Natural* demonstrate that women tend to attribute their overall positive birth experiences to the individual choices that they made regarding the birth. Therefore, I argue that individual choices are a crucial commonplace because they lead to a positive birth experience. These two commonplaces inform the discourse that is able to take place within the community. Thus, women who have had positive, empowering experiences of giving birth may feel comfortable sharing their narratives on this website because they have had their experience affirmed by these very narratives. However, the overwhelmingly positive narratives tend to shut down or foreclose the possibility of discourse around birth that is

not particularly positive. Dissenting or even just different birth experiences tend to be suppressed by the message of that individual choices lead to positive birth experiences, but this is not done intentionally. Rather, Crowley writes, "commonplaces are part of the discursive machinery that hides the flow of difference, that firms up identity and sameness within a community" (73). While the websites Birth *Without Fear* and *Mama Natural* do not actively prevent women from sharing narratives that are not framed as positive birth experiences, the neoliberal imperative for women to make responsible choices about birth acts as a commonplace that will lead to a positive birth outcome.

This commonplace of positivity is present from the very beginning of the narratives. One woman writes, "Birth is an amazing, beautiful thing!" (*BWF* #1). Another woman writes, "I was 41+1 weeks pregnant. I woke up to a small gush and quickly ran to the restroom. Broken water – Check. Bloody show – Check. YES!!! It's baby time! My water has never broken at the start of labor before, but I had dozens of dreams that it would this time around, so I really wasn't too surprised" (*BWF* #4). Both of these women begin their description of the birth with strong positive associations. While some women may anxiously await the beginning of labor, particularly with the first birth, in re-writing the experience, these two women frame the beginning of the narrative very positively. They frame the experience of becoming a mother positively as well. From the beginning of both of these narratives, the reader is prepared to read a positive description of birth.

The focus on women's individual choices about giving birth is a part of neoliberal ideology around women's health (Dubriwny) that places responsibility for the birth outcome upon the birthing woman. Seigel argues that there are specific ways that this responsibility affects pregnant women as they are preparing to give birth from choice of medical care provider

to who should witness the birth of their children. Neoliberal ideology individualizes choices that women may have no control over such as medical care provider, while subtly positioning one choice as the right choice in these birth narratives. Throughout the narratives on both *Birth Without Fear* and *Mama Natural* women tend to attribute their overall positive birth experiences to the individual choices that they made regarding the birth. While it is possible that individual choice may have some effect on birth outcome, the narratives do not typically acknowledge the uncertainty of birth or the possibility that women may lack choices. Thus, in the narratives on *Birth Without Fear* and *Mama Natural* the choice operates as a commonplace by allowing women to point definitively to a particular choice of "natural" birth as the primary reason they were able to have a positive birth experience. For instance, "The Mama Natural Birth Class helped us prepare for our natural childbirth, reviewed all of our options, and convinced us that we were making the right choice" (*Mama Natural* #1) writes one woman. She writes confidently that there are right and wrong choices when it comes to birth and she believes that she made the right choice in order to have the birth experience that she desired. Another woman reflects on the decisions she made about giving birth: "The decisions made that day were mine alone. I chose the decision I could live with and now, over half a year later, I truly can accept that. Her birth story is unique to her. I did the best I could do and I am so grateful that the choices I made led to a beautiful, healthy, joyful baby girl" (*BWF* #4). This woman begins by accepting responsibility for the choices that she made, which ultimately resulted in a different outcome than she had anticipated; however, she later acknowledges that the birth is unique. This admission seems to hint at the possibility that no matter the good choices that a woman makes about the birth, the outcome may still be different than originally planned. The woman also demonstrates feeling of responsibility for the birth outcome by saying "I did the best I could do" and then using language

from the medical discourse of birth to return to a positive description of the birth. She may also be deflecting from any implication of failure on her part by framing the birth as positive. As discussed in chapter 3, by expressing gratitude for the baby's healthy birth, this woman conforms to the genre convention for birth narratives that any disappointment or critique of the birth must be accompanied by gratitude in order for the framing of the narrative to be positive overall.

Although many group participants use the commonplaces of positivity and individual choices in sharing their birth narratives on *Birth Without Fear* and *Mama Natural,* some women find that those commonplaces do not accurately reflect their experiences giving birth. Ann M. Johns (68 - 69) argues that potential group members of a discourse community may challenge the values and beliefs of the established group because their experience has been different than what they see reflected in the dominant group discourse. Some women who read the narratives on these two sites but who did not have positive birth experiences find that they will either have to use different rhetorical moves in their overall narrative by using the discourse of gratitude such as the woman above or find a way to challenge the dominant discourse of the community. The example of a woman using a discourse of gratefulness to fit into these communities exists as a middle ground between positive affirmation of "natural" birth ideology and medicalized birth that simply will not fit into the community. A woman is able to use the commonplaces present within the discourse community while also reconciling that personal choice will not always result in the ideal birth outcome.

Not all women who read their own experience against these narratives find that they are able to use the dominant discourse to describe their experience. According to Crowley, the hidden ideology of the commonplaces used by a discourse community may be revealed when the commonplaces are deployed as gatekeeping mechanisms that attempt to prevent entry into the

community by those the group deems unsuitable to participate. This may be the case for communities with some formal membership because there are actual boundaries preventing someone from gaining entry, as in the case of groups hosted on social media platforms; however, they are always subject to members revolting or introducing change to the group. The gatekeeping function of commonplaces in the birth discourse communities may be seen as similar and seek to introduce a further application because the commonplaces in birth discourse communities may unintentionally exclude potential participants. In her analysis of *Birth Without Fear's* Facebook group, De Hertogh argues that women may feel excluded from a supposedly inclusive community, if they feel that the commonplaces privilege a particular kind of birth experiences that is unlike their own. The *Birth Without Fear* community may promote all kinds of birth as valid and healthy as long as the woman chooses it, but De Hertogh points out that "natural" birth is viewed as the default "normal." She argues that this causes women who did not have "natural" births whether by choice or necessity to feel as if their body is somehow disabled because it did not achieve a "natural" birth. While De Hertogh is concerned with the authority of dominant discourse to disempower individual women, I turn to a consideration of the formation of alternative communities that may support a wider view of birth discourse on the internet. As discussed in chapter 2, questioning the location of negative or traumatic birth experiences led me to explore those discourse communities.

Birth Trauma

On *Exposing the Silence Project* and *Birth Trauma Association*, the women share narratives that they self-define as traumatic. These two websites, rather than attempting to sell a birth related service to women, offer a space for them to share their experience as well as attempting to change the maternal health care system that they perceive as perpetuating traumatic

births. Neither website attempts to tell women whether or not the birth that they experienced was traumatic; however, through reading the collection of narratives on the websites, it is possible to draw conclusions about what the commonplace of trauma is. As discussed in the chapter, women tend to define a birth as traumatic when they perceive that some violence was done to them during the process of delivering their baby. So, that violence could be emotional (through verbal abuse) or physical (being coerced into accepting an intervention without consenting). Thus, the narratives on the two websites use the commonplace of trauma to fit their narratives into the community that gives agency to them for sharing and defining their experiences.

Women writing traumatic narratives use a much more medicalized discourse; however, they do not provide any definitions for those terms. Rather, they expect that their intended audience is familiar with the terms either from their own education about birth or from their own experience giving birth. One reason that I posit the traumatic narratives feature a much higher use of medical terms is that the women writing them found themselves experiencing more of the medical interventions than women sharing their narratives on *Birth Without Fear* or *Mama Natural*. These interventions include not only the Cesarean that women almost universally attempt to avoid, but also "episiotomy," "forceps," "Pitocin," and "epidural." Women also discuss a fairly frequent invasive aspect of giving birth, the cervical exam. When using the medical terminology, the women will mention a medical term that is relevant to their experience, such "forceps," without explaining that forceps are a tool used for reaching into the mother and grasping the baby by the head and pulling it out. Particularly in the conclusions of the traumatic birth narratives, women emphasize the mental and emotional struggles that they had with recovering from the birth. Thus, while they use medical language in the narratives, women tend

to assume their audience in the traumatic birth community are already familiar with the terms and thus they do not feel the need to accurately define them.

Medical Interventions

Although not as prominent as sites such as *Birth Without Fear*, two particular websites, *Birth Trauma Association* and *Exposing the Silence Project* host narratives of traumatic birth experiences. On these two sites, women are able to read and then share about birth experiences that do not reflect the positive perspective of birth that dominates other sites. Additionally, most of the narratives on these two sites center around an unwanted medical intervention that women experienced during the course of their labor and delivery. This argument about medical interventions is present not only in birth narratives framed as traumatic, but also in positively constructed birth narratives is an important commonplace of birth discourse. This commonplace is simply that medical interventions such as Cesareans are negative and should be avoided in planning a birth.

In analyzing the narratives, I coded for examples of this commonplace based upon two specific occurrences in the narratives. First, in primarily traumatic narratives, but also within some of the positive narratives, women actually used the word "intervention" to discuss their attitude toward medical procedures during birth. Not all women used the word "intervention" to describe unwanted medical procedures; however, I identified instances of this commonplace where medical procedures did occur. Thus, I coded 33 excerpts within the narratives using the code "intervention." The following are some examples of this commonplace within the narratives, which demonstrate that this commonplace reinforces the risk and uncertainty discourse that are important to neoliberal ideology specifically regarding women's health. Dubriwny argues throughout *The Vulnerable Empowered Woman* that postfeminist logic

conditions women to accept that eliminating risk is crucial for protecting not only their own health, but also the lives of their families: “The discourses of risk that surround women draw directly from a postfeminist logic and contribute to the crafting of a postfeminist healthy citizen” claims Dubriwny (32). Thus, risk discourse constantly operates as one lens that women view their own health experiences through. One woman writes about her prenatal care experience, which caused her to be anxious about the possibility of interventions during the birth, "I felt unsafe continuing care with my provider when he told me he would ‘use defensive medicine against [me]’ meaning provide medical intervention regardless of consent in nonemergent situations” (*ESP* #2). As she reflects upon her experience, this woman points to even her pre-birthing interactions with the doctors as causing conflicts around their differing perspectives on the risks of giving birth. While she has a negative perspective of medical interventions, the medical care provider she interacts with believes that they may be absolutely necessary in order to have a safe delivery. In the narrative above, the woman perceives that her doctor is concerned with mitigating risk of liability and she disagrees with his willingness to overrule her right to choices in giving birth.

Women address risk discourse through the use of the intervention commonplaces in other narratives as well. One woman writes, “But there was a doctor who… assured me that he was aware that I wanted the least intervention as possible. He claimed that he was equipped to help someone like me who all along had wanted a home birth” (*ESP* #3). According to this narrative, the medical care provider demonstrates awareness that women may view interventions as negative unless completely necessary, particularly if those women favor “natural” birth by electing for an out-of-hospital location for the delivery of their children. While this woman contextualizes this conversation within the discourse when seeking medical assistance to give

birth becomes necessary, she is still adamant about avoiding medical interventions as much as possible. She specifically wishes to avoid a Cesarean because she does not believe that she will ultimately need one in order to safely deliver her baby. Finally, even women who do not have traumatic births tend to discuss their desire to avoid interventions within their narratives. For instance, “my baby deserves the best shot at birth with no intervention (if we needed it, we needed it and thank goodness medicine exists but let's use the best chance possible!)” writes a mother who made extensive preparations for a physiologic birth (*MN* #3). This woman asserts that choosing to avoid interventions is the right choice for her birth but adds the caveat that medical interventions are good when necessary. She expresses gratitude for modern medicine to provide interventions in cases where they are necessary such as a breech baby or placenta previa (two fairly common conditions that are usually treated by Cesarean). In contrast to this statement, she privileges birth without intervention by claiming that is what she wants for her baby. However, this statement is loaded with the “natural” birth ideology that is promoted on the *Mama Natural* website. While some women are able to achieve their desired physiologic birth and happily share the experience that they take personal responsibility for, this is not the case for other women who are unable to avoid medical interventions while giving birth.

In many birth narratives that women write, they do not explicitly name their desire to avoid medical interventions; however, the underlying commonplace is that medical interventions are primarily negative and should be avoided. In traumatic narratives particularly, women often recount their resistance to the medical interventions that they received. One woman reflects on receiving a medical intervention that she did not expect to need: “It was dark when I was awakened by someone shoving a needle in my arm. I ask again and she says ‘These are antibiotics, you have a blood infection.’ Interesting, since I didn't when I got there” (*ESP* #4).

This example is wry in pointing out that she ends up receiving a medical intervention for an infection that she implies was caused by the treatment, iatrogenic harm, that she received at the hospital. In this narrative, the argument is implicitly that had the treatment been less invasive from the beginning, the additional medical intervention may not have been necessary. She also points out receiving medical treatment without the medical care provider specifically asking for consent. There is some assumed authority on the part of the medical care provider that need for treatment overrules providing information to the patient. Another woman reports, "The doctor then smacked a catheter up me with no warning" (*BTA* #3). She is shocked to find herself subjected to a medical intervention that appeared unrelated to the birth taking place. Although women typically receive a catheter in conjunction with epidural (pain relief) while in labor, this narrative provides no such context. Her vivid description communicates to her audience (presumably other mothers and pregnant women) that she believes a medical intervention should be avoided but at times is out of the woman's control. In both of these narratives doctors who perceived the intervention as a matter of emergency acted without receiving explicit permission from the birthing woman. The women in traumatic narratives particularly seem to be more focused on the lack of choice they have about medical interventions than about the interventions themselves. The women in these examples tend to focus on the risks that they associate with receiving medical interventions rather than the risks of avoiding medical intervention.

In *Risky Rhetoric,* J. Blake Scott argues that risk can be constructed in multiple ways within a specific medical circumstance. He writes "an analysis of the risky, at-risk, and healthy bodies interpellated by testing arguments, bodies that are discursive constructions but that nonetheless shape modes of embodiment and material practices" (37) are intertwined in an analysis of HIV and AIDS testing. Scott argues that some bodies are framed as at greater risk for

a positive test because of their perceived risky behavior, but the potential of receiving a positive test may be seen as risky by the prospective HIV and AIDS patients. The medical circumstance of birth is also constructed as risky in multiple ways that are reflected in women's use of the commonplace of medical interventions. The women in my narrative sample often portray the medical care providers as viewing birth as inherently risky and in need of medical intervention. The doctors' goal is primarily to deliver a healthy baby, which is also motivated by a desire to avoid litigation as discussed in chapter three (Morris). Thus, as the woman recounts with horror in *ESP* #2, the doctor expresses his plan to provide medical intervention as he sees fit without first receiving explicit permission from her. Birthing women in these narratives, on the other hand, tend to construct receiving unwanted medical interventions as the risk they are taking by giving birth at a hospital under the care of medical care providers with different views of risk as the woman in *MN* #3 writes. Her desire to avoid medical interventions is part of what leads her to prepare so carefully for the birth of her child. Ultimately, this commonplace reflects the competing risk discourses that are present in contemporary birth practices between the medical approach and "natural" birth ideology. This commonplace works hand-in-hand with another commonplace that women frequently assert throughout their narratives as a form of both giving advice to their audience as well as justifying the birth that ultimately took place.

Partnership with Medical Care Providers

The importance of women's needs to be listened to and communicated with by their medical care providers is asserted throughout the narratives. The authors of these narratives are concerned both while giving birth themselves and for the women who read their narratives that speech is their primary means for asserting agency during the birth process. Hensley Owens writes that women construct birth plans in order to communicate with their medical care

providers their vision of how the birth will take place. However, as she points out, the actual circumstances of the birth often render the birth plan useless, which leads women to reconstruct the birth experience using a birth narrative that attempts to regain agency over how the birth is perceived. The women in the narrative sample I used do not explicitly recount writing a birth plan prior to giving birth; however, they do discuss multiple ways that they used their speech to attempt to influence the course of the birth.

Some women, specifically in positive narratives, but also occasionally in the traumatic narratives as well, write in praise of medical care providers who listened to their concerns and explained their medical recommendations. For instance, "they [the midwives] had me stop and breathe in between contractions to avoid tearing. They said I did a great job at this even though I didn't even realize it!" (*BWF* #1). The commonplace of partnership used here highlights the trust that exists between the birthing woman and midwives who assisted her in delivering her baby. Rather than being at odds with her medical care team, this woman praises their partnership because it empowered her birth experience. At times a woman writes about the midwife deferring to her personal experience in determining the best course of action. This woman writes, "I told her what I had been experiencing including my doubts about it possibly just being prodromal labor. She told me that she could leave now to come over or I could wait to call her if I wanted more time alone with Andrew to see how things progressed" (*BWF* #3). In this narrative, not only does the midwife listen to the woman's description of her symptoms, she leaves the decision about the next steps to take up to the woman as well. The unstated argument in this narrative is that the midwife and woman are also partners in the birth process. This partnership is demonstrated in this quote when both the woman and her midwife occupy the speaking role. We do not see one person as the dominant decision maker throughout the birth.

Both are able to share their knowledge, which allows the woman to make informed decisions about the birth.

Women have a positive impression of the medical care provider when the care provider confirms rather than discounts their embodied experience even if they are giving birth for the first time and are not experts on birth. This commonplace reinforces the argument that birth is a "natural" physical event and that the woman has an intuitive knowledge of the experience, which should be supported by rather than diminished by the medical care provider in order to have the most peaceful and positive birth. The narratives on *Mama Natural* particularly use this commonplace in order to encourage midwife-supported birth as superior or most likely to result in a physiologic birth. One woman writes, "around 9 AM I called my midwife and talked through what was happening and she agreed that she thought it was the real deal" (*MN* #1). Rather than immediately go to the midwife, where the midwife can physically witness whether or not the woman is in labor and delivery is imminent, this woman describes talking with her midwife on the phone. While on the phone, the midwife is able to listen to her describe the contractions and perhaps can even determine whether or not the woman is likely in active labor based upon her breathing through the contractions.[15] As in the instance above from *Birth Without Fear*, the midwife in this example listens to the woman as an expert on her own body and confirms her expertise. However, in other examples, women are given new information by their medical care provider, but again feel relief rather than chastised that they are not laboring properly. This woman claims, "when I arrived at the birth center to my happy surprise she [the midwife] informed me I was already fully dilated and could begin pushing when I was ready" (*MN* #4).

[15] Kristin Marie Bivens (2019) describes this concept of sonically diagnosing patient symptoms as earwitnessing. Having previously called midwives to discuss potential labor before three births, I have discussed how they listen to women's breathing during contractions to diagnose how hard she is laboring.

Although she does not explain this, the author of this narrative had previously labored at home for as long as possible and has been quite successful at it as evidenced by the fact that she is rewarded with the information that she is nearly done with the delivery by the time she even arrives at the birth center. Although these examples come from women writing on the *Birth Without Fear* and *Mama Natural* websites who later report very positive birth experiences, this commonplace of a relationship based upon mutual trust between the medical care provider and the birthing woman is also present in traumatic birth narratives.

The partnership commonplace is often further cemented by women who contrast positive interactions and a prior negative experience with a medical care provider. A woman who shared her narrative on *Exposing the Silence Project* relates, "from the time I ever thought about having a baby I wanted to have a home birth. Many years ago…I started my search for a home birth midwife because we wanted to establish a relationship long before even getting pregnant. That search was successful and we put a plan in place" (*ESP* #3). Clearly this woman values a positive relationship with a medical care provider who supports her desire for a home birth because she went to the length to obtain the midwife's services before even becoming pregnant. However, a narrative that started out so positively turns once the woman has a medical complication that prevents her from being able to have a home birth.

Once at the hospital to deliver her child, the woman and the OB-GYN on-call have a conflict, where she argues that he is misconstruing her attitude toward the birth: "He called me a 'crazy home-birther'… He claimed to be 'the best doctor in northeast Ohio to do a surgery on a home-birther like me'…We were really being pressured and insulted" (*ESP* #3). Although she had initially desired to have a home birth because of the medical complication she accepts the necessity of a hospital delivery; however, she is still resistant to a C-section, which the doctor

feels is necessary. She believes that the doctor is not speaking respectfully to her. Eventually, she and her husband insist that another doctor attend her, which involves a much more positive experience with the medical care provider. She praises him, “A well-known and respected obstetrician…arrived and cared for me. He sat on my bed and calmly explained several reasons why a C- section delivery was the safest and best route for me and my baby…All I had wanted was a reasonable explanation, just a conversation about why, out of nowhere, I needed to deliver Xander via C-section” (*ESP* #3). For this woman, giving birth via C-section departs significantly from what she had planned and described at the beginning of the narrative, but she ultimately claims that the treatment she received from the first medical care provider is the source of her trauma rather than the unwanted medical intervention. In the narrative, her descriptions of the treatment she received from the two doctors highlight the source of her trauma. She explains that she valued the medical care provider who listened to her and took the time to discuss the necessity of the medical procedure more than she wanted to avoid the medical intervention. Her primary trauma was caused by the medical care provider who refused to listen to her questions and refused to give an explanation for the medical procedures he felt were necessary.

In other traumatic birth narratives, women are particularly critical of medical care providers who they believe did not listen to or pay attention to them while they were in labor. One woman writes, “I already had an IV so I asked what they were doing. The nurse would NOT speak. I asked several times and tried to pull my arm away. She left and immediately two other nurses came in, one shoved me down while the other one finished my arm and checked my temperature” (ESP #4). This woman describes feelings particularly upset because the nurses are uncommunicative while treating her, which left her feeling hesitant about whether or not the treatment was necessary. It is important to include in the narrative because of the trauma she

believes was caused through mistreatment by the medical care providers. Another woman writes, “within a minute or so the room filled with nurses and doctors, a few in theatre outfits. They lay me flat on my back and completely ignored me and my husband when we asked if I was ok” (*BTA* #6). In her case not only do the medical professionals avoid listening to her, but they also ignore her spouse who is simply concerned about her well-being. In both of these examples, the women critique the medical care providers for failing to listen to them, which they feel is their only means for asserting agency over their bodies while giving birth. However, in the first example, the woman actually attempts to resist the nurse who will not communicate with her. In the second example, the woman has a spouse to support her; however, he also has no agency. Several of the narratives demonstrate that when women do not have a strong partnership with their medical care providers, they turn to support from a partner, close friend, or someone they have hired to work with them such as a doula.

Support During Birth

Throughout the birth narratives that they relate women establish a commonplace that support from a spouse, mother, or hired doula is important for the birth process. In some instances, the support that they received is positive when the women feel that the birth experience brings them closer to their immediate family or friends who witness the event for them. Martin and Pollock both write that women may even defer to the expertise of a supportive spouse when describing their own experience of giving birth because they believe that a witness rather than participant may have a more objective and clear view of the facts of the birth. When interviewing their research subjects, Martin and Pollock noted that the presence of this support person may have had undue influence upon the narratives that the women were willing to share. I argue that regardless of this possible influence, like the women interviewed by Martin and

Pollock, the authors I discuss have accepted the commonplace that having at least one non-medical support person with them throughout the labor and delivery is crucial for their successful birth. Throughout history women are portrayed as giving birth while accompanied by other women (Hunter). The movement to hospital birth in the twentieth century separated women from this community of women, but the rise of the nuclear family construct invited spouses into the labor and delivery room. It is now expected that if there is a partner involved, then that partner will accompany the birthing woman to provide support for her.[16] In the twenty-first century, more and more birthing people do not have partners (Hunter). Some birthing persons without partners elect to hire a doula to accompany them through the birth process. This further allows for the neoliberal reinforcement of personal responsibility and creation of capital through the developing industry of labor support. While many doulas donate their time while training and occasionally afterwards, the service is not inexpensive and may only be available on a limited basis because it is so specialized (Rysdam). Many of the examples I relate here describe the positive experience of being accompanied by a doula; however, we cannot overlook the reality that it is a privilege rather than a service that women are automatically entitled to when giving birth.

Women write about the support that they received while giving birth and, in some instances, recommend hiring professional support from a doula. One of the benefits that women relate about their support team is that they are able to be with them prior to traveling to the birth center or hospital for delivery of the baby. For instance, "I arrived to the hospital at 7 cm dilated, so at home up until that point, laying in my bed with one leg hanging and my doula massaging

[16] The COVID-19 pandemic has had a significant effect upon the experience of giving birth by limiting the number of people allowed to accompany women while giving birth. At some points during the pandemic women have not been able to bring anyone with them to the hospital when giving birth.

my back relieved my discomfort" comments one woman about the experience of laboring primarily at home (*MN* #6). She relates that she was supported by and received some pain relief from the doula who accompanied her. This particular woman does not discuss the presence of any other labor support, so it is possible she would have been alone while laboring at home if not for the presence of the doula.[17] Another woman also describes in greater detail the support provided by her doula, "my wonderful doula Crystal arrived. She was quick to offer help…She rubbed my back and shoulders and feet and prayed for me. She whispered words of encouragement" (*BWF* #4). In any event, the women who receive support from a doula or family member express that they are grateful that they are not alone while laboring to bring their baby into the world. While these women are able to have support through their positive birth experiences, this is not the case for all women. Other women express gratitude that they received support from family members or doulas in what turned out to be a traumatic birth.

The descriptions that these women share of the interactions with their support people during the traumatic births are vivid and demonstrate their importance for emotional support especially. For one woman, the moment just before she goes to the operating room for an emergency C-section stands out so beautifully in her narrative. She reflects, "my husband and I shared one last moment together before her arrival. Always my rock, he whispered tenderly in my ear, "You're so brave. We're gonna meet her soon, babe." He kissed my neck, my cheek, my lips, and I smiled at him with tears in my eyes" (*BWF* #5). Although the outcome of her delivery is quite different than this woman had planned, in the moment before her daughter is born, her husband affirms her choice and expresses his love for her. Thus, this woman affirms the

[17] As modern assistive reproductive technologies have made it more feasible for single women to give birth, the doula industry provides an important support service for women who might otherwise labor alone before traveling to the birth center or hospital for the birth of their children.

commonplace that emotional support is important for her well-being throughout the birth experience. Another woman writes about her experience giving birth and credits the midwife who attended her with support, which is different from the support that most of the women report receiving. She writes, "I was taken up to delivery and waiting for me was my partner, my mum and dad…The same midwife who had delivered my daughter was about to finish her shift, I will always be grateful to her…I wish more than anything that that lovely midwife had stayed" (*BTA* #4). For this woman, who was attended by more than one midwife, this particular interaction stands out to her because the midwife who had delivered her baby was supportive and treated the woman with greater kindness than the other midwives who cared for her postpartum. For both of these women, the emotional support that they received while making the difficult decisions about how to give birth helped them in narrating birth outcomes that were different than they had anticipated and describing the trauma of the birth itself.

However, in many of the traumatic narratives, the women express frustration and guilt that not only did they experience trauma from the birth, but their partner did as well. This is particularly evident when women reflect upon the recovery from the birth and the additional challenges that they and their partners faced as they not only adapted to parenthood, but also worked to recover from the trauma. A sub-type of the partnership commonplace is the concept that the partner is not adequately informed about the woman or their child's health during or following the birth. One woman relates that following the birth of their child her husband received, "no mention of whether she or I were alright. He came rushing back to the hospital and he told me later that all the way there he was scared our daughter was dead. He didn't know what state I would be in or whether I would kill him for not being there" (*BTA* #5). In this birth narrative, the woman writes that the labor was long, so the husband had gone home to care for

another child, but then the delivery happened quickly and he was informed via phone call that his child had been born and he needed to come back to the hospital. The woman's description of her husband's emotional distress both about not being present for the birth of his child and over the complete unknown about their health on his way back to the hospital clearly indicates that the husband experienced trauma through this experience as well as the birthing woman. Another woman describes her husband's experience of her recovery following the birth of their child: "my husband feels totally helpless, which he is when I have a bout of pain and it makes me grumpy, irritable and incredibly sad and despondent, words I would never usually use to describe myself" (*BTA* #2). Although she and the baby have both survived the birth and are now considered healthy, in the narrative she describes how her ongoing health problems affect her not only physically, but also make her husband deeply unhappy as well. The birth may be over, but for this woman and her husband, the trauma remains and she describes that he is unable to properly fulfill the role of supportive spouse that is expected in birth narratives.

In another birth narrative, the woman takes the bold step of including her husband's perspective of a part of the delivery of their child. It is unclear from the narrative if the husband actually wrote this part of the narrative or if the woman is writing it in her husband's voice about the birth. Choosing to include the husband's perspective in this narrative is significant because the medical care providers initially include the husband to help support and comfort his wife while the baby is being delivered by C-section, but then following the delivery, he is left out of the loop of knowledge about his wife and child and their recovery. He describes his feelings during this time: "I am in the hall alone for I don't know how long. They finally bring me my daughter but I am so beside myself that I couldn't even register what this thing was at first. I'm so sure her mother is dead" (*ESP* #1). In contrast to positive birth narratives where even

following the C-section, the woman and her husband are able to greet their new baby together, in this narrative the husband and wife are separated and the husband is too worried about his wife's well-being to even register that he is meeting his new daughter. When he attempts to get information about his wife the response is vague and none of the medical personnel are helpful: "she looks confused and says, 'she should be fine I don't know ask the nurse.' Over the next two hours I asked everyone, no one would tell me where my wife was or if she was even alive" (*ESP* #1). The husband's feelings of loneliness and fear are palpable in this portion of the narrative. The woman uses her husband's portion of the narrative to communicate the trauma of the birth as experienced by a support person rather than just the woman. Although the husband believes that his wife is very ill and possibly dead, in the end, the woman is fine and recovering from the delivery as normal, but the hospital was just particularly uncommunicative. This commonplace of receiving support from another person is present in the narrative even when the woman cedes some of the narrative space to give voice to her spouse's experience of the birth. In this instance, the spouse experiences trauma not only from the emergency Cesarean itself, but also from the treatment he received from the hospital staff as well. While neither of the narrators explicitly name the trauma that occurred because this is a commonplace, they do not feel the need to name it for the audience to understand and sympathize with their experience.

Significance of Commonplaces

Commonplaces are used to create cohesion within a group by using them similarly (Crowley), which causes narratives on *Birth Without Fear* and *Mama Natural* to be framed as positive and supportive of "natural" birth while the narratives on *Exposing the Silence Project* and *Birth Trauma Association* highlight the trauma of birth. The commonplaces present in the birth narratives on these websites are deployed differently primarily based upon whether or not

the author frames the birth depicted as either a positive or traumatic experience. Women in the positive narratives may use the commonplaces to make arguments about the importance of making the correct individual choices about giving birth in order to achieve a positive birth experience. They claim that they are able to avoid unwanted medical interventions by preparing particularly for the experience of giving birth physiologically, which includes surrounding themselves with a supportive team of medical care providers who listen and either a spouse or doula who will advocate for them when needed. The traumatic birth narratives often use these commonplaces to emphasize that no matter how well a woman prepares for the birth experience, she cannot predict exactly how her body and baby will respond to the labor process. This can be interpreted at times as a lack of agency. Thus, these women claim that due to the risky and unpredictable nature of giving birth, some unwanted medical interventions cannot be avoided in order to protect the life of the mother and child. Despite their attempts to choose supportive medical care providers, due to circumstances outside of their control (lack of choice through NHS in the UK and luck of the call in the US) many of the women report feeling traumatized because of the treatment they received from the medical care providers that attended them throughout the birth experience. While there appears to be a binary here between the two types of birth experience I analyzed, it is just not that simple. Commonplaces can also be used to resist cohesion or a simplistic interpretation of birth. Some of the narratives do this, such as narrative number four on *Birth Without Fear,* which depicts a rather traumatic emergency C-section birth from a positive frame. Additionally, a number of the traumatic birth narratives point out instances where they were not treated well by medical care providers and contrast them with other medical care providers who were supportive of them. Finally, there is an underlying

ideology that influences not only the births themselves that the women experience, but also the decision to write and share the narratives in an internet community.

Commonplaces Support "Natural" Birth Ideology

Throughout the commonplaces found on these four websites, there is a significant underlying pervasive emphasis on "natural" birth as an ideology that the women are possibly not even aware of. As Bourdieu points out, when an ideology or habitus becomes so entrenched, the writer is no longer even aware of it. Even if they declare that all women should be able to give birth however they choose, the ideals of "natural" birth which force women to take responsibility for their choices as influencing the ultimate outcome of the birth. Commonplaces are significant to these narratives because the communities do not have specific set of guidelines for admittance. Rather, community members use commonplaces to demonstrate that they fit into the community as well as sometimes resist the dominant discourse present in the community. Through using commonplaces in their narratives, women demonstrate that they are familiar with the conventions of the birth narratives on a specific website and their narrative will fit into the community on that site.

Commonplaces are crucial for women to participate on these four websites because the websites are not closed communities and do not have distinct boundaries. As discussed in the introduction, some discourse communities on the internet, such as Facebook groups, include specific guidelines for participation in the group, i.e., no hate speech or incivility to fellow group members. They may also stipulate that off topic posts/discussions are not allowed. In some ways, the closed communities normalize the commonplaces through their rules and guidelines, which makes the discourse on the websites particularly crucial to consider how these commonplaces are formed and used by the authors. Reading and then occasionally writing and sharing their own

narratives on the website of their choosing is the primary means that women use for interacting on these websites. If a woman uses commonplaces well in her narrative, then she may be accepted into the community; however, none of the four websites have specific stipulations for being allowed to share their narrative. Since these websites are not closed communities, most of the exclusion that happens (as discussed by Crowley) is self-selected. Thus, rather than being told by the group that they cannot share their narrative because it does not fit, women read narratives on the website and then decide whether or not their narrative will fit with the overall discourse of the group. Some of this is likely dependent upon whether or not the women are able to identify with the commonplaces that are used by the narratives already present on the website. For instance, if a woman experienced a highly medicalized (but uncomplicated) birth, she may not feel comfortable sharing her experience on a website where commonplaces that emphasize "natural" birth ideals are used heavily.[18] In this instance, she may also not feel as if her narrative belongs on a traumatic birth website either because it was medical, but not traumatic. Thus, she may self-select not to write and share her narrative even if she enjoyed reading birth narratives and hoped to join a birth discourse community online.

Similar commonplaces may be used across all four of the websites; however, the ways that women choose to deploy them in the narratives helps to define and cement the shared discourse of each group. Read separately from the websites, the narratives take on the particular attitudes toward birth that are common on the website where they were posted. For instance, all of the narratives in my data set from the *Mama Natural* website have specifically approached

[1818] This happens to me in conversation pretty frequently. When women find out that I study birth, they often volunteer their birth experiences, but I've also had women tell me that they feel uncomfortable sharing their birth experience when most of their friend group has had a different experience than they did. Specifically, a woman who had uncomplicated hospital births with an epidural didn't feel like she could share her experience among most of our friends because a lot of them had chosen home births or physiologic births.

preparing for birth from a "natural" perspective. The women provide many details about the experience of preparing to give birth and emphasize the importance of the right kind of preparation in order to achieve a physiologic birth. Additionally, the narratives contain almost no information about the postpartum period because the website does not offer any specific postpartum services. The narratives on the website are formatted as interviews and there is a specific question that the authors respond to that asks the women about the benefit of careful preparation for giving birth. Thus, this website and the narratives posted to it do not attempt to hide the economic purpose of the website.[19] *Mama Natural* particularly reflects the neoliberal imperative to find a means for capitalizing on the self. As written about in *The Motherhood Business*, boutique mother/baby focused businesses have become very popular in the early twenty-first century. While this emphasis is tied to the definitive goal of the *Mama Natural* website, which is to market the creator of *Mama Natural's* products to potential clients, the other websites have fewer clear ways of cementing the shared discourse of the group. The *Birth Without Fear* website seems to straddle a divide between commercial websites such as *Mama Natural* and the straightforwardly activist sites such as *Exposing the Silence Project* and *Birth Trauma Association*. January Harshe, the creator of *Birth Without Fear*, appears to have activist goals such as normalizing all choices about birth and has popularized slogans such as "all birth is birth." This does make it appear that she is offering the website as a platform for women to find community and share their own birth experiences. However, the website features a shop with merchandise such as shirts and mugs, but also helpful labor products such notecards with 'birth affirmations' written on them. Finally, she has written a book recently and one cannot visit the

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[19] The creator of *Mama Natural* specifically offers online classes on preparing to give birth "naturally" and caring for baby after giving birth. She has also written several books, which she sells on the website.

Birth Without Fear website without seeing many ads and blog posts about the book. Although none of the narratives from *Birth Without Fear* mention the commercial aspects of the community, it does affect the shape of the overall community through mentions in the narratives of the products used to support the birth

As discussed in chapter three, women writing narratives on these websites expect that their primary audience are other women who share their familiarity with the birth experience. However, the frequent use of medical terms without clear definition can easily alienate an audience that is not very familiar process of giving birth. While the narratives are personal, so it is understandable that women do not attempt any formal definitions, they also use terms that someone who has not given birth themselves may not have heard before, and they may not understand the argument against medical interventions that the women make. The use of medical terms can be one way that women maintain some boundaries in the birth narratives. Not all of the narratives deploy the use of medical terminology equally. For instance, the websites that feature a primarily "natural" focused discourse use fewer medical terms. Rather, they use terms that are common from specific education programs such as Bradley or Hypnobirthing such as "waves," "pressure," and "visualizing." One woman writes, "I also had a few 'tools' to use during contractions. Sometimes I breathed in essential oils. I also had what is called a worry stone, and I squeezed it in my hand as I contracted…I forced myself to stay focused and began fixing my gaze on the lit candle as I contracted" (*BWF* #2). For this woman, rather than planning to use the medical tools available at the hospital, she plans to have a physiologic birth and has prepared by collecting some alternative medicine (essential oils, worry stone) and by staying mentally focused during the birth. This narrative relies upon the commonplace that mental preparation for achieving a physiologic birth as do some other narratives as well. This woman shares, "I wrote

birth affirmations and hung them in my birthing space. I would read them in the days leading up to birth. In labor when I would have a negative thought like, ‘I can't do this.’ I would replace it with one of my birth affirmations” (*MN* #2). Although most women will not have the ability to prepare the birthing space themselves prior to the birth, because this woman chose to birth at home, she was able to prepare the space and mentally prepare for the birth by placing some birth affirmations in the same and reading them while she prepares to give birth. Rather than discussing the medical specifics of the birth process, these women use the “natural” language that they are comfortable with from their own preparations for giving birth.

Conclusion

This chapter has examined several commonplaces, which I argue function within the birth narratives to form four different birth discourse communities. However, I also assert that the narratives on all four of the websites, although they are not specifically about physiologic birth, tend to primarily promote a “natural” view of birth. The commonplaces work to reinforce the ideology of “natural” birth. First, while most of the narratives from *Birth Without Fear* describe physiologic births outside of a hospital, there are also some narratives of non-physiologic birth; however, those narratives typically express some regret about the outcome because they did not meet the ideal that the women were hoping for. For example, one woman writes, “The self-doubt that comes in can suffocate you and it felt like nobody really understood WHY I was upset. My baby was healthy after all and my recovery had been as easy as it could have been. Yet still, I felt like I had let myself and my daughter down” (*BWF* #4). Although she clarifies that both she and the baby were healthy, this woman is upset because she did not have the VBAC that she was strongly hoping for and that she had read about in other narratives on the website. Additionally, all of the narratives on *Mama Natural* explicitly embrace the ideology of

“natural” birth through the emphasis on the importance of careful appropriate preparations for giving birth as Seigel discusses in *The Rhetoric of Pregnancy*. In giving advice to other women preparing to give birth, one woman specifically states, “Watch peaceful birth videos, only allow people to tell you their positive birth stories, surround yourself with what you DO want your birth to be like. Don't get into your head when you're in labor. You can do anything for a minute or two, get through each contraction. You can do anything for an hour,” (*MN* #2). The frequent use of the second person several times in this short quote emphasizes the importance this woman as well as the other narratives from *Mama Natural* place upon personal responsibility for making the right choices when giving birth.

Finally, unlike the narratives that are framed so positively on *Birth Without Fear* and *Mama Natural*, the traumatic birth narratives are not positive, but they still reflect an adherence to “natural” birth ideology through their feelings of disappointment that they were unable to achieve a physiologic birth. Rather than completely accepting responsibility for the birth outcome, these women sometimes express anger or sadness that the choice was taken away from them. While they do present some critique of the medical system, the authors of the birth narratives tend to be fairly focused on the violence done against them and their children by particularly care providers as singular examples rather than systemic problems. However, one woman does claim, “The whole experience was horrible. The majority of staff seemed uncaring and if Hannah had been my first baby she would have been my last. Thank you for listening. Sharing my story with people who've 'been there' has made me feel better’ (*BTA* #5). Here she references the community that she has shared with as providing comfort for her because she has realized that she is not the only person to have had a traumatic birth experience. For this woman as well as many of the other narrative writers, the commonplaces used by the community

actually help them to connect with other women who have had similar experiences, which is crucial when they do not know anyone personally who has had a similar birth experience. When collected together on the websites the narratives reveal these commonplaces that would otherwise be hidden.

CHAPTER V WHEN IS THE RIGHT TIME TO GIVE BIRTH?

Introduction

Stories of women giving birth in their cars or only making it to the hospital just in time to deliver the baby stick in the popular imagination, but the reality is labor and delivery often takes a very long time and evade attempts to predict how they will progress. Medical descriptions of time during pregnancy and birth are so prevalent that they tend to dominate medical and "natural" discourses of birth. For instance, pregnancy is described as "nine months" or sometimes "trimesters." During labor, the body is expected to contract regularly and "counting contractions" is one way to determine if a woman is in labor. Finally, as recovery in the postpartum period is becoming better understood, the first three months following the birth are now described as "the fourth trimester."[20] My discourse analysis of birth narratives reveals that the rhetorical concepts of *kronos* and *kairos* are used throughout birth narratives. Women use these concepts to demonstrate the conflicts between the desire to eliminate uncertainty and risk from the birth experience and "natural" birth ideology's insistence that a woman's body will automatically birth the baby at just the right moment.

In this chapter, I argue that descriptions of time within the birth narratives demonstrate the conflict between the *kronos* which both medical care providers and mothers appeal to in order to eliminate uncertainty and risk from the birth experience and the "natural" birth reliance upon the woman's body to birth at the *kairotic* moment that will facilitate the smoothest birth experience. *Kairos* is timeliness or an awareness of the rhetorical situation that will allow the rhetor to take advantage of an opportunity for persuasion. The other Greek term for time, *kronos,*

[20] Harvey Karp (2002) is the first to use this term. However, "the fourth trimester" is often focused on the development of the new baby rather than on the healing process that the woman's body is going through.

is used to refer to chronological or sequential time. In other words, *kronos* can be used to describe a regular passing of time. I begin by considering the role of *kairos* in rhetoric of health and medicine literature particularly in the area of reproduction. I then analyze the use of time related descriptions within the birth narratives themselves to illustrate how the descriptions reflect and sometimes resist the descriptions of time that are used by the medical field. Descriptions of time within the postpartum period are significant to the birth narratives, particularly those about traumatic birth, which raise some previously overlooked aspects of medical mistreatment women receive while recovering from giving birth. Finally, I consider the use of time to structure the birth narratives because the use of time within the narratives also influences how the women ultimately choose to use the structure to resist the *kronos* they are faced with while giving birth.

***Kairos* and the Rhetoric of Health and Medicine**

Kairos, or the persuasive use of argument at the opportune time, holds significance in interactions between medical care providers and their patients. While scholars are often concerned with this interaction in regard to the medical care providers' desire to persuade patients to accept radical or new treatment that they may be skeptical about, pioneering rhetoric of health and medicine scholar Segal considers how *kairos* affects the construction of the patient as audience. She identifies the significance of *kairos* as, "a way of making sense of both the medical past and the medical present. It helps illuminate the current medico-cultural moment when popular and medical interests converge on certain themes" (Segal 36). In our current "medico-cultural moment" of maternity care in the West, it is crucial to understand the discourse that medical care providers rely upon and resist when appealing to *kairos* to assist women in giving birth to a healthy baby. Segal also writes, "the rhetoric of noncompliance is not only that

the good advice of a place and time is not necessarily always good advice" (151). Women who attempt to follow the advice of "natural" birth proponents but who encounter an unexpected medical complication may discover that the advice is not helpful or even good advice in the moment. Thus, considering the role of advice and noncompliance in birth narratives is important for understanding the *kairos* of the birth experience.

While Segal points to the significance of *kairos* in the construction of the patient and medical care provider interaction, Seigel considers the role of time in pregnancy manuals that advise women about the best way to have a healthy pregnancy and to ultimately deliver a healthy baby. Seigel argues, "the 'health value of the nine months before birth' refers to the health of the 'babe,' not of the mother. The commandments in hygiene are to be enforced for the 'wellbeing of the babe' – any benefits for the mother are coincidental" (44). Thus, the focus of the pregnancy manual is on growing a healthy product (the baby), which will satisfy the woman's desire for a child and ultimately provide a new citizen to support the neoliberal economy. By constructing the health of the baby as foremost in importance and the mother's health as sacrificial or incidental, the pregnancy manual subtly positions the mother as willing to sacrifice everything, including her health for the good of her child. However, Seigel points out that for nine months the mother and child are connected and thus the body of the mother is policed and restricted because of the effect that she will have on the health of the child. In preparing to give birth, women often receive education that emphasizes "anything that affects the maternal body, in other words, affects the fetal one as well and has the potential to disrupt its development" (46). This rhetorical move also persuades women that they can affect the outcome of the birth by making the right preparations for the birth. This places responsibility upon the women when there are birth complications that cannot be prevented and, in some cases, cannot be predicted

either. In a *kairotic* moment, the woman is forced to make a different choice when giving birth because of the risk and uncertainty about birth discussed in the previous chapter.

While women are exhorted to assume complete responsibility for the health of their baby during the nine months of pregnancy, Robin Jensen considers the role of *kairos* present in the often-long pre-conception process that women struggling with infertility experience. She explains, "argumentative warrants related to efficiency, opportunity, and urgency – what rhetorical scholars refer to as appeals to *kairos*, or 'timeliness' – both held this integrated, medicalized account of infertility together and supported an emergent 'doctrine of prevention'" (Jensen 132). According to Jensen, infertility is perceived as a condition that women primarily experience when they wait too long to begin procreating. Thus, *kairos* is of utmost importance not only in deciding when to get pregnant. Jensen continues, "*kairos* entails a forecasting of events and consideration of the possible outcomes of intervening in said events, rhetorically or otherwise" (149). The reality that time continues to play a pivotal role in the reproductive processes for women especially necessitates the importance of *kairos* for medical care providers who seek to both help infertile women conceive, while also not promising more than they are medically able to provide for the women. Artificial reproductive technologies promise a *kairotic* intervention such as egg freezing for young women not ready for motherhood, and IVF for women who are infertile. Additionally, these services are more expensive than typical prenatal and birth services and often not covered by health insurance. This means that only women who have access to capital through their own or a spouse's income or loans may be able to afford these infertility treatments. Women facing infertility may find they are unexpectedly unable to become biological mothers because of their financial status. Thus, infertility treatments can represent an additional way that motherhood is influenced by contemporary neoliberalism.

Considering the use of rhetorical concepts of time such as *kronos* and *kairos* allows scholars to explore how contemporary birth practices treat the uncertainty and risk that are inherent in discourse of reproduction. Seigel and Jensen consider the role of *kairos* in rhetorics of reproduction, but they are not alone in observing the importance of timing in women's reproduction. Sociologists Westfall and Benoit completed a study examining women's perceptions of time in relationship to their experience of giving birth. They note, "one woman became increasingly defensive as her team of midwives put more and more pressure on her to consent to medical intervention. Though she believed her pregnancy was normal and her baby was fine, she described how 'with the pressure of their guidelines and their policies and procedures, it was really hard to stay focused and to stay positive" (1404). This example addresses two issues related to the interaction between time and birth that women also describe in birth narratives. First, this woman, believing the baby is still healthy, attempts to begin labor spontaneously rather than allowing the medical intervention of induction merely because the pregnancy has continued past the due date. The question of when a woman will go into labor spontaneously or how she can know that labor has begun is a common theme of timing discussed in the birth narratives. Subsequently, there are specific "guidelines," "policies," and "procedures" that medical care providers are obligated to follow when attending birthing women. This can lead to conflicts between women and their medical care providers as well as causing disappointment for women who may feel that their bodies are not behaving as they expect them to. However, Westfall and Benoit note that women do not always cite conflicts with medical care providers as relating to timing when giving birth. They also claim, "for a few women, other non-health related factors shaped their decision to intervene in their pregnancy. Some male partners had used up vacation time waiting for the pregnancy to end, time that they'd planned to spend

with the new baby and assisting their partner in her recovery" (1404). Their point about timing demonstrates ways that Western society is structured around *kronos* or ordinary time, but that birth simply evades this kind of enforced structure. Rather, birth is fraught with uncertainty about when it will take place and risk about whether or not it will take place in a healthy way.

Uncertainty, Risk, and Neoliberal Conceptions of Time

As noted above, within the narratives, the descriptions of time demonstrate conflicts between a desire for birth to take place on *kronos* or regular time and uncertain or *kairotic* moments that intervene and may change the expected course of the birth. For instance, the desire to control the timing of the birth is deeply connected to the neoliberal concept of uncertainty and risk. Controlling the timing of the birth allows for at least a perceived elimination of risk. While medical care providers are often accused of attempting to control the timing of birth by inducing labor or coercing women to have Cesarean sections in time for them to go home for the day, women may be just as eager to give birth. This may be especially evident when women who have out-of-town visitors elect to be induced on or very near their due dates rather than opting for the spontaneous onset of labor, which can be very delayed for a first-time mother. However, "natural" birth ideology appears to resist this narrative by claiming that a woman's body will naturally know the right time (*kairos)* for birthing the baby. This can lead to frustration for a woman when her body does not appear to cooperate if she does not go into labor spontaneously. Some women in the narratives express feelings of guilt because they followed all of the instructions from "natural" birth experts, but their bodies did not cooperate and they did not experience the *kairos* that they had anticipated would lead to a smooth delivery of their babies. Guilty feelings appear when women write justifications for choosing to allow medical interventions during the birth.

Not only do concepts of time as present in the birth narratives demonstrate some common themes of how women experience time while giving birth, they also influence the structure of the narratives. All of the birth narratives in the sample follow a linear or chronological pattern. This makes it somewhat easy to identify a structure to the narratives, i.e., begins with start of labor, climaxes with birth of baby or conflict that leads to medical intervention, and concludes with a description of postpartum recovery. Given the neoliberal imperative to reproduce already established genres on the internet, there may be pressure to conform to a chronological structure even if the birth itself did not follow a regular (*kronos*) schedule. One feature of the collective blogs that I examine is the striking similarity between the narrative structures on each website. This similarly suggests that by reading examples of the birth narrative before writing their own women tend to unconsciously begin to re-tell or structure their own narrative in a similar format. While it can help the woman's narrative to fit in with the other narratives on the websites, the compilation of many similar structured narratives may give the impression that all births occur similarly. The exception, or possibly a resistance to this pattern, occurs when women choose to write more extensively about the postpartum period. While the birth is viewed as complete by the medical field once the baby and placenta have been delivered, the new mother has to undergo a period of recovery and adjusting to her new body. Six weeks is the marker at which women will be seen by their medical care provider in order to confirm that her reproductive system has healed from the physical trauma of birth because the average woman has finished postpartum bleeding (lochia). However, as the below examples illustrate, many women have not fully recovered from giving birth at this point. Additionally, she may spend some of that time mentally and emotionally making peace with the birth experience. Her narrative, then, is not complete at the moment of a successful reproduction.

Descriptions of Time in Birth Narratives

Throughout the birth narratives, time is used significantly to describe the beginning of labor, but many of the uses demonstrate how slippery this concept is. For instance, for first time mothers who have never experienced labor before, it can be challenging to recognize when labor is actually beginning. They may recognize that something is beginning to happen, but particularly for women who are birthing at home or a birth center, they may be uncertain when active labor is beginning. Some women write about calling their medical care provider to discuss whether or not labor is actually beginning. One woman writes about excitedly watching for signs that labor is beginning: "I woke up at 5am to losing my mucus plug and having bloody show. I later texted our midwife and she said that it could be early signs of labor or could still be weeks away. I tried not to get too excited because I knew it could still be a while, but these were the first actual labor signs I had" (*BWF* #1). Although active labor has not begun, this woman eagerly recounts her first contact with her midwife to confirm that she may be getting closer to giving birth. She is also precise in recording the time that she experienced these symptoms. In the birth narratives, some women tend to use precise measures of time in order to demonstrate their clear knowledge of the birth experience. While they are creating this narrative for an audience as is evidenced by the choice to share it publicly, the use of precise markers of time may also serve as their own record of giving birth.[21] By demonstrating how she questioned the beginning of labor this woman is both clear about the timing and shows that she looked for confirmation that labor was imminent. Another woman writes,

[21] In giving birth a second and third time, I drew upon my memory of giving birth previously to communicate with my midwife about how I anticipated the birth to take place and throughout the birth.

> I had been having false contractions off and on for about a week or so before I actually went into labor. On the morning of the birth, I woke up around 6:30 with contractions again, but had a feeling that these were different. I remembered what my midwife had said about knowing if they are real if they continue for longer than an hour after moving or switching positions…Around 9 AM I called my midwife and talked through what was happening and she agreed that she thought it was the real deal (*MN* #1).

This woman seeks to differentiate between the false labor contractions that she had experienced before by explaining the information that she had received from her midwife about how to identify real labor contractions. By passing on information from the midwife her text also provides informal education for her audience. When women relate over the phone confirmation with their medical care providers about the beginning of labor, it is always a midwife in my sample. It appears that out-of-hospital deliveries with a midwife more often rely upon a partnership between the woman and her midwife listening to her descriptions of the contractions she is experiencing. This is not typically the case when a woman plans to deliver her baby at a hospital in my sample.

Along with discerning the beginning of labor, judging the appropriate time to go to the hospital for the birth is crucial for women who have been laboring at home. Women who plan to give birth at the hospital are often exhorted to labor at home by their medical care provider in order to comply with hospital guidelines for admitting laboring women to the hospital. In this example, the woman writes about the beginning of labor and the transition to the hospital, "I went into labour with my first child on a Sunday morning, and managed well through the day at home. By the evening the contractions were becoming more painful, and being unsure, we went into hospital. I was examined and told that I was only 2cm dilated, so not in proper labour yet,

which felt very demoralising after a day of contractions. I stayed in hospital but there was a shortage of midwives for that shift" (*BTA* #1). In the narrative, this woman expresses disappointment because she believed that she had judged the right time to come to the hospital correctly, but the medical care providers did not agree with her. Additionally, she expresses some feelings that the amount of time she had already labored at home was being ignored or at least overlooked by the midwives who were supposed to be helping her. This contrasts with the women who spoke with their midwives in order to confirm the beginning of labor rather than assuming that they are in labor and then arriving at the hospital expecting to be far progressed. While this woman had a disappointing experience going to the hospital, another woman reports an unpleasant beginning to her labor. She writes, "I went into labor at 4am the day after my doctor's appointment…I got to the hospital at 6am in extreme pain and was left alone in a room except to be periodically yelled at by a random nurse…they hooked me up to several monitors until almost 9am when some doctor strolled in for half a minute to tell me I was fine" (*ESP* #4). This woman is also precise about time at the beginning of labor by noting first the time she woke up in labor, the time she arrived at the hospital and finally, the time she was first attended by a doctor. It is important to note that she does not directly reference any experience of contractions as the beginning of labor. Instead, she writes that that she was in pain. Rather than discussing their symptoms of labor with them as the women describe their conversations with their midwives, these two women describe two ways that labor and progress is identified at the hospital. The first woman writes about receiving a cervical check when she arrives at the hospital, which is one way that medical care providers use in combination with contractions to identify labor. Active labor is typically classified as 4-5 cm dilation and many hospitals will not

admit women unless they have reached that stage of labor or if they are high risk.[22] At the hospital, monitors are used to measure the length and intensity of contractions. Rather than discussing how the woman is feeling i.e. the amount of pain she is in or observing how her body is physically responding to the contractions, the medical care providers often rely upon the monitors to identify whether or not the labor appears to be very far along. Once labor has been confirmed, whether at home or at the hospital, women's descriptions of time passing tend to become less frequent and specific.

Women describe the passing of time in labor, specifically in relationship to contractions and dilation, but otherwise may be vague about how much time is passing or how they are aware of the passing of time. For instance, women often combine the mundane/quotidian experiences of normal life with the life changing experience of giving birth. The rhetorical move most often associated with these uses of time is identification. When women write about these everyday experiences in contrast with the experience of birth it appeals to readers who may be able to easily identify with their experience. About the beginning of labor one woman writes, "about half an hour later I gave up on sleep and went downstairs to make some coffee" (*BWF* #4). This woman is awakened by contractions, which she recognizes as potentially the beginning of labor, so she simply starts her day the way that many people begin their daily routine. Thus, the beginning of labor for her begins almost like the beginning of a normal day. However, another woman combines a fairly vague description of time passing, with a specific notation of the time when a change occurs during her labor. She writes, "I had mild, irregular contractions for the next hour but by 2 am they were becoming regular and more intense" (*MN* #4). Although she is

[22] According to the *American College of Obstetricians and Gynecologists*, active labor begins when a woman is between 4-6 cm dilated and admission to the hospital is not advisable before then unless a woman is at high risk of complications during the birth (2-3).

not clear about the difference between mild and intense contractions, it is clear from the time notations of one hour and "2 am" that she was keeping track of the contractions in some way in order to determine the amount of time between contractions. Although women reading the narrative may not as easily identify with this woman's discussion of her contraction tracking, she does provide some helpful if indirect advice for other women who are preparing for labor.

In describing the passage of time during labor and delivery, women use references to time differently depending upon the location of the birth. The emphasis on time in the narratives is more intense in hospital births versus at a birth center or at home. This is particularly evident in the examples above where the women giving birth at the hospital are specific about the passage of time at the hospital. Women are made more aware of the passage of time in the hospital setting because the hospital operates much more on a schedule. For instance, doctors come to check on women at regular intervals, and nurses and other staff also change shifts at specific times. Thus, it makes sense in the example above that the woman who arrives at the hospital at 6:30 am is checked on by the doctor at 9 am when they have just arrived at the hospital and are checking on all of their patients for the first time that morning. The *kronos* or regular time that the hospital infrastructure operates on may serve to make women as well as their medical care providers more aware of the passage of time. I have theorized elsewhere that hospital infrastructure tends to heavily influence the ways that time is expected to pass for a woman in labor.[23] The narratives demonstrate that women are aware of the passage of time during birth at the hospital and record it more precisely than in the home births. In one example, a woman writes, "I was then left on the machine in pain for at least four hours; it was only when

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[23] In an article under review "Rhetorically Constructing the Birthing Woman through Labor and Delivery Room," I argue through an autoethnography of my experience giving birth at a hospital that the labor and delivery room space affects a woman's agency during the birth.

other women on the ward heard me crying that a midwife came to see me. From this point I realized there was a lack of communication between staff and that as the midwives were so busy you could easily be 'forgotten about,'" (*BTA* #4). This woman observes going four hours "on the machine" (Pitocin for contractions) without being checked on. Although she does not say how frequently she expected to be checked on, it is clear from her comment that she was easily "forgotten about" that she was aware that this was not part of normal hospital practice. She is also aware of time passing because there is at least one clock in the room. Finally, while time is more prominently noted in births that take place in the hospital, it is also more of a focus in traumatic birth narratives. This is reflected in the data because the code for "time" appears much more densely in traumatic narratives than in "normal" narratives. For instance, 79% of the excerpts coded as related to "time" occurred in narratives of hospital births. Thus, the passage of time within narratives of hospital birth are much more prominent in part because of the overall emphasis placed upon timing of birth in the medical field.

Similar to the discussion of commonplace arguments where women refer commonly accepted beliefs about birth to appeal to their audience, when referencing "time" in their narratives women often rely upon simplified or outdated medical concepts of the passage of time in labor and delivery. For instance, women are often expected to dilate 1 cm per hour until the cervix has expanded to 10 cm in diameter. Although this is no longer widely believed to be the standard that progress in labor should be measured by,[24] women in the narratives still frequently reference this concept regarding their own progress in labor. First time mothers commonly have long labors before successfully delivering their babies; however, hospitals and medical care

[24] According to Jeremy L. Neal et. al. (2010), the expectation of dilating 1 cm per hour, based on the Friedman's Curve, is unrealistically stringent. Nulliparous (firs time) mothers often take much longer to deliver their children.

providers frequently have a policy that once the water breaks, the woman must deliver her baby within 24 hours or she will be required to have a Cesarean. For instance, one woman writes, “because I am a VBAC, we were told that we would be staying put, but that we would not be on any clock – meaning that even if my water was broken for over 24 hours as long as the baby and I were doing well we would be able to continue labor as long as we needed to” (*BWF* #4). While this woman is fortunate to be cared for by providers who are not restricting her to the 24-hour delivery mark, she is still aware that this is usual policy when a woman is giving birth at a hospital. She does explain that the medical care providers want her to stay at the hospital so that they can carefully monitor her and the baby, but that as long as they are able to determine that both are well the hospital will not enforce the restrictive policy. In describing her labor, another woman uses fairly vague terms to discuss the passage of time and its relationship to dilation. She explains, “a little while later I felt something warm and wet on my thighs and reached down. My hand came back up covered in blood” (*BWF* #6). She does not clearly indicate here how long she has been in labor or whether or not the presence of blood is surprising to her. However, she continues, “I called my nurse and she brought in the doctor. I was 9 ½ cm with an anterior lip. She asked again about breaking my water…I agreed and she ruptured it. There was a little meconium in the water, but baby still looked good on the monitor. They left us alone so I could finish dilating” (*BWF* 6). The change in her condition with the presence of blood prompts the woman to call the doctor to come check on her and they discover that she is nearly ready to deliver the baby. However, the doctor advocates that a medical intervention in the form of water breaking is required in order for her body to be fully ready to deliver the baby. Thus, in order to help her labor fit into the *kronos* of a normal delivery, the doctor seeks to persuade the woman to allow a *kairotic* intervention. In this narrative, the woman’s experience of giving birth

demonstrates the interactions between the expected progression of labor and then the interventions that are sometimes required in order to help the birth progress. In this birth narrative, the woman does not frame the interaction between expected timing and the actual timing of birth negatively. Rather, she accepts that the intervention was necessary and ultimately frames her birth positively; however, this is not always the case. In traumatic birth narratives women often have a much different view of the problems that can result when the birth does not take place on the hospital's expected schedule.

In traumatic narratives women write about negotiating with their medical care providers around time while in labor. Specifically, this reveals that birthing women and medical professionals may have different expectations about the amount of time that the birth will take. Women who have internalized certain beliefs about the value of "natural" birth may feel strongly that induction should be avoided and that they should be allowed to take as long as necessary to labor and deliver the baby. This can lead to conflicts, particularly for first time mothers who may feel that their medical care provider is not supportive of their plan for delivery. In her careful recording of giving birth, one woman writes, "at 9:15 Dr. X[25] came to give me an epidural while I was still contracting and displayed at an 8. Immediately after I was given the epidural the nurse turned off my oxytocin then told me I would need a c-section because I stopped progressing" (*ESP* #1). Although the narrative indicates that the woman had been in labor for quite a while, she believed that having dilated 8 cm indicated she was nearly ready to begin the pushing phase of labor, known as the second stage. This prompts the following reaction: "I told them to give me more time and that I didn't want a cesarean. They continued to push a c-section" (*ESP* #1). She

[25] I've inserted X here in place of the doctor's real name which the woman used in the narrative. I'm sure from the overall attitude that this woman has toward this doctor that she is using his name purposefully, but for this analysis, I did not feel that it was necessary to keep the real name in this excerpt.

clearly believes that if given a little more time to labor she will be able to finish dilating and avoid the c-section. However, it is unclear in the narrative, why the doctors believed she had stopped dilating and that they did not think she would progress any further on her own. This excerpt from this narrative specifically demonstrates that this woman believes that if given enough time her body would be able to successfully birth on her own. This woman attempts to negotiate with her medical care provider during the labor to have more time before resorting to Cesarean, which is seen as the ultimate medical intervention.

Many women desire to give birth with a midwife either at home or at a birth center because they believe the midwife will not follow such a rigid schedule for the birth but ultimately these women find that they are unable to access the birth scenario that they desire. For many women this is impossible due to either lack of access to midwives or because their health insurance does not cover midwife attended deliveries. Thus, hospital birth, while far from the ideal that many women subscribe to because it can make "natural" birth more difficult, is still the normal way of giving birth in the United States. Hensley Owens points out that one way women attempt to assert control over their births when they feel that the medical care provider may not be fully supportive is through writing a birth plan ahead of time. In the following example, this woman certainly planned ahead of time in order to try to influence the birth outcome and avoid medical interventions. She writes, "it led me to ultimately decide that I didn't want to risk a home birth with this condition. As a result, I asked my home birth midwife if we could establish a different plan. Ultimately, we decided that I would labor at home until 'transition' time, at which point I would go to the hospital" (*ESP* #3). Although she had planned for a home birth and had secured the services of a midwife, this woman has a medical condition that causes her to decide a home birth would be unsafe. However, she still believes strongly that a "natural" birth is

the best option for her and asks her midwife for help with creating a plan. The woman writes that staying at home to labor outside of the hospital will have the best chance of helping her to avoid medical interventions. Many women make this kind of plan for laboring at home; however, if they have not given birth before then they do not know if they have reached “transition” or if they are still in the early stages of labor. Thus, timing when to go to the hospital when they’ve been laboring at home can be both difficult and disappointing for women. This woman believes that she will be able to labor at home until “transition” because her midwife will be with her until she goes to the hospital. The “transition” that this woman writes about is also portrayed as a *kairotic* moment because this is the time when the woman’s body finishes dilating her cervix and she becomes ready to deliver the baby. Many women report that “transition” is also the most difficult part of labor because it is very painful, and they often begin to despair that labor will ever end. Many women believe that if a birthing woman is able to endure the “transition” then she will be able to deliver her baby without a medical intervention. However, for some women even getting to the point of “transition” may require negotiating with or even subversively resisting medical care providers who are insistent about time-based schedules.

The infrastructure of the hospital requires that women follow prescribed policies that are not based on women’s individual needs, but rather upon the most efficient way to care for several laboring women at once. While many women are not familiar with hospital policies or do not bother to include them in their narratives, in some traumatic birth narratives it is clear that these policies play a significant role in the unfolding of the birth. This woman writes, “the nurse came into my room and began screaming at me that I was not allowed to be without my monitors. I asked to compromise and do 15 minutes on the monitor and then 45 minutes free off the monitor. She said that was not ‘allowed’” (*ESP* #5). Many hospitals require that women wear

monitors constantly while they are in labor, but this is restrictive for women who may want to follow a more "natural" approach to labor. Thus, this woman attempts to negotiate with the nurse for some time off of the monitor, while still allowing the medical care providers to carefully measure the health of the baby and her progress in labor. However, the nurse is unwilling or unable to negotiate with the woman, which the woman describes as disruptive to her labor process. Ultimately, the woman chooses to resist the restrictions of the hospital: "when she'd leave, I'd remove the monitors and go back to laboring on the toilet" (*ESP* #5). The woman paints a clear picture of the back and forth battle she has with the medical care provider who is committed to upholding the *kronos* of the hospital policies. Although she does not write specifically about how long this part of her labor lasts, she shows that some of the time she is in bed with the monitors on being watched by the nurse, while the rest of the time she takes the monitors off and labors alone in the bathroom, which she prefers. The contrast here is quite stark between what the hospital requires and how the woman prefers to labor.

Women also find themselves in conflict with medical care providers around the timing of when their labor should begin. It is common for first time mothers to have spontaneous labor begin between 40-42 weeks pregnant, but they may face a lot of pressure from medical care providers to induce at 40 weeks rather than waiting for spontaneous beginning of labor. Women often describe wishing to avoid medical induction of labor because of a concern about a cascade of interventions that may ultimately lead to a Cesarean. One woman writes about her experience with induction: "when I was 12 days overdue I went into hospital to be induced on a Saturday morning and waited 12 hours to be seen by a registrar as the hospital was so busy…I saw a lot of women come and go to have their babies whilst on that ward and could not wait for it to be me!" (*BTA* #4). This woman has gone overdue with her baby to almost the 42 week mark, but

ultimately decides to be induced. The choice to wait until almost two weeks past her due date, indicates that she was hopeful that her body would begin the labor process on its own. However, even though medical care providers often urge overdue women to be induced, that does not mean that the women will be able to be induced right away. Hospitals have limited capacity to care for birthing women, which means that inductions are often pushed back a little or even a lot. In this narrative the birthing woman describes her frustration at being forced to wait for the desired induction because of the *kronos* of the hospital. While this woman followed the medical advice to avoid going past 42 weeks, some women who are deeply committed to "natural" birth ideology believe that waiting even longer is fine because their bodies will eventually give birth. One woman writes after the birth of her child, "I told my baby she was safe on this side of my belly, too. She was 17 days late so I wanted to assure her she was loved and we could take care of her!" (*MN* #3). This woman explains her child's late arrival by ascribing agency to the baby and believing that the fetus remains safe inside her, which is typically the concern with allowing women to continue the pregnancy beyond the due date. There is no evidence that the baby actively initiates the birth process, but rather than accept responsibility that she did not follow medical advice, this woman claims that her child was not ready to be born until well past her due date.[26] Finally, another woman describes the anxiety to end pregnancy that can hit once a woman reaches her due date. She observes, "at 41 weeks 1 day, I was tired. Weeks of nightly (and daily) prodromal labor had left me exhausted, depleted. My whole body ached to finally hold my little girl" (*BWF* #5). The due date is perceived by modern society as a *kairotic* moment when a

[26] The due date concept is complicated. A woman's due date is calculated based on the date of her last menstrual cycle, which is expected to be a regular 28 day cycle. However, since not every woman has a 28-day cycle and not every woman ovulates on the same day of her cycle there can be discrepancies in a woman's actual due date. The initial due date calculation may be changed if a woman has an ultrasound early in her pregnancy because the early estimations of due date based on fetus size and development can more accurately date the pregnancy then.

woman's body transitions from being pregnant and working hard to keep the baby inside, to expel the baby from her body through labor. However, this narrative excerpt demonstrates that this is often not the case for women. While some women may show no signs of impending labor before they give birth, the body can spend several weeks preparing for labor through prodromal labor also known as Braxton Hicks contractions. For this woman, those practice contractions took a mental as well as physical toll her body. Although prodromal labor may not be as painful as real labor, the mental work of constantly questioning if this time it is really labor can cause the final days of pregnancy to seem interminable and this excerpt captures that feeling well. These three examples from three different websites, lend credence to the concept that continuing to be pregnant past the due date is common for women.

While the due date shapes the focus of the timing of the beginning of the birth, once a woman goes into labor, she may find that her body does not conform to the medical beliefs about the progress of a woman in labor. Women demonstrate in the narratives that they can experience conflict with their medical care providers when they fail to conform to the outdated standard of dilating 1 cm per hour during labor. One woman writes, "the next hour was strange… people giving me every type of check, blood pressure, temperature every 5 minutes, and fetal monitoring. My doctor finally shows up about 8pm and lectures me on 'failure to progress'" (*ESP* #4). For this woman, for at least part of her labor she was under almost constant monitoring by her medical care providers. However, during this time she does not describe how she was laboring, such as how regular and painful her contractions were and whether or not she is experiencing transition. Rather, receiving medical treatment is the primary focus. The lecture she receives from her doctor about "failure to progress" means that her body was not conforming to the hospital's expectations for the timeframe that the labor and delivery would follow. It is

unclear why she was receiving so much monitoring and close attention from the medical care providers if everything was fine with the baby, so it does not make sense that there was concern about a failure to progress. The lecture from the doctor also follows the language of agency and blame that women often employ in the narratives. While this woman is frustrated by the expectations of her medical care provider, other women feel that they are personally lacking when the labor does not progress as quickly as they are hoping “it was discouraging to feel like things weren’t progressing until we finally felt we had to call the midwife to come in and check things out. Turns out I was nearly complete despite the irregularity and that’s when I knew (relieved!) it was time” (*MN* #5). While she was laboring for an unspecified amount of time, this woman felt discouraged that she did not seem to be making any progress toward the delivery. However, at a particular moment (she does not say exactly when or how she determined it was the right time), she called for her midwife to come check on her to see if she was any closer to delivering her baby. In this excerpt the woman swings from discouragement to relief as her midwife informs her that she has completely dilated, and it is “time!” to deliver the baby. Thus, even when the birth goes smoothly, the norms around expectations for how long labor should take can cause women to struggle through the birth process.

Postpartum and Time

Most education about pregnancy and birth focuses on the nine months leading up to and then the “three stages” of birth and little time is spent on the postpartum period of time. However, in the birth narratives, women extend their narratives beyond the birth of the baby to include some of the postpartum period. When using descriptions of time, women often discuss the postpartum period of recovering from the birth. Specifically, they may describe the ways that the birth affected their experience recovering from the birth and early motherhood. For many

women the postpartum/recovery period contributes to the trauma they experienced from the birth because they feel isolated or even uncared for by their medical care providers. One woman writes about the period just following the birth of her child, "8 hours later I was helped to sit up on the side of the bed and fainted. I thought I was going to die again. I did not hold my son for almost 24 hours apart from the initial moment after he was born. I could not even lift a mug to drink. I could not change a nappy, breast feed or hold him" (*BTA* #6). Due to the trauma from giving birth, this woman writes that she was unable to even sit up on her own several hours after giving birth and is unable to bond with her child by holding him for a day after giving birth. Experts on mother/child relationship and women's recovery from giving birth emphasize the importance of spending time together directly following the birth of the child. In many cases, including home or birth center births, women are primarily responsible for caring for their new babies within a few hours of giving birth. However, this woman reports that she was not able to experience normal postpartum activities such as even holding her baby.

In some examples the woman experiences complications immediately following the birth such as postpartum hemorrhage, while other women find that the postpartum recovery period is lengthy and reveals just how traumatic the birth experience had been. Another woman writes about the extensive timeframe that she was recovering from giving birth: "Looking back, I know I was suffering from post natal depression (my son was 14 months old). Had I been my normal self I may have asked for help and advice, but it would have been nice if someone had offered" (*BTA* #5). This woman writes that she was isolated and alone suffering from postpartum depression for over a year after the birth of her child. With some time and space from the immediacy of the early days of mother, she is able to identify the problem she was having. However, she points out that her recovery could have gone more smoothly if someone else, such

as a medical care provider had offered some help for her mental health. Finally, while postpartum depression has been identified as a common problem for women recovering from the birth of a child, another woman describes the lasting effects of trauma during birth: "I felt absolutely horrible psychologically. Some of this emotion was due to normal post-partum hormones, but most resulted from the trauma. I had been scared to death. I experienced tremendous anxiety at home after the birth…I was suspicious of strangers and had constant fear" (*ESP* #3). The trauma that she experienced while giving birth does not immediately go away as her body recovers physically. Rather, it causes some significant problems interactions with other people, particularly medical care providers. In contrast to the often *kairotic* moments women describe in narratives of giving birth, during the postpartum period they place emphasis on the monotony of *kronos* or daily regular time. Although the woman has experienced trauma during the birth (which may be a *kairotic* moment), the aftermath of postpartum recovery and adjustment to motherhood is daily and ongoing. Birth trauma may have a significant mental impact upon women during their postpartum recovery, but the medical care they receive can also be the cause of significant trauma for women.

Morton, a sociologist, specifically considers the high maternal mortality and morbidity rate in the United States and connects it to the failure of hospitals to carefully monitor or care for newly postpartum women. Many of the traumatic medical events related in the narratives actually took place after the birth of the child when the woman should have been recovering, but instead experience a complication that has to be treated in order for her healing to begin. One woman describes her postpartum complication: "by day five I was in so much pain and another midwife said how well I was doing because of all the trauma, but no one asked about pain relief…it was beginning to dawn on me I'd been treated very badly and now to top things off I

was in pain just getting up and down the stairs" (*BTA* #3). While this woman continues to experience intense pain following the trauma she experienced giving birth, she is given empathy from medical care providers, but does not actually receive help from them. She specifically states that none of her medical care providers ask her about how much pain she is in or whether or not she needs some relief from the pain. She claims that she was hesitant to ask for help because "if I'd been prescribed bed rest things would have been a different story, but I didn't want to fail my son" (*BTA* #3). Pointing back to the idea that by asking for help she would be failing her new son, this woman claims that had the medical care providers prescribed her bed rest following the birth she may have actually had a smoother recovery. This woman points out that one of the major challenges for new mothers is the process of caring for a new completely dependent human being while recovering from a physical trauma. Some women will bleed for six weeks postpartum and yet they are expected to care for their babies and act as if they are fine. On top of the physical trauma of birth, many women experience difficulty with emotionally recovering from a traumatic birth. One woman writes, "the months passed, I tried to move on from what had happened to me but I still frustrated at the way I had been treated by some of the staff in hospital…The nights were long, I didn't sleep much and this did little for my state of mind" (*BTA* #4). Although she is home and physically recovering from the birth, this woman does not find her state of mind improving at all. She recounts specifically that over several months she is not able to sleep as she continues to question how she was treated during the birth of her child. Finally, "about seven months passed and I could see I was getting worse and not better, I decided to go to a local women's centre and told them my story…I was relieved someone was finally helping me" (*BTA* #4). In this case, finding a sympathetic ear who will listen and empathize with

her traumatic delivery helps the woman experience some relief from the frustration she felt. Although not a physical solution, this woman finds storytelling to be a cathartic experience.

Not all women have the struggles postpartum that these women recount. There are some women who are able to have a positive postpartum experience and the describe the time with happiness. The women writing positive birth narratives emphasize that the choices they made for the birth allows the time following the birth to be one of peace and happiness. They also do not tend to share as much information about the postpartum period if it was a positive experience. Rather, these women tend to focus on the period just following the birth of the baby and emphasize the joy that they feel at becoming a mother. There is a marked contrast between the experiences of women recovering from traumatic births who discuss the challenges of feeling out of control with the women who believe that their choices allowed them to have positive birth experiences and helped them to experience a smoother postpartum experience. One woman writes, "when I saw her face, I started crying. She was the most beautiful thing I had ever seen. Aaron cried too because he realized we were both healthy and safe. We laid there for a few minutes, all of us crying…those first few moments together were something I'll never forget" (*BWF* #1). Although she is not very clear about how long they remained this way, it is a beautiful scene of the new family together. Another woman writes about the change in attitude that she experiences immediately once her baby is born: "the relief and euphoric feelings of your baby entering the world and into your arms is like nothing I've experienced. It erases all the weeks and months of any discomfort, or negative feelings you may have had as a pregnant mother…my husband and I were laughing and crying at the same time. It was amazing!" (*BWF* #2). According to this woman, the birth of her child is the reward that she receives for all of the months of being pregnant and preparing for motherhood. As Seigel discusses the significance in

the advice manuals that women prepare for the birth of the child by making the right choices as a consumer of foods and products designed specifically for pregnant women to support and guarantee the health of the baby, this emphasizes that the birth has offered her a payoff for any suffering she experienced. While these two women report positive emotions immediately following a birth that turned out as they had planned, it is possible for women to experience these emotions even when the outcome is not as they had planned.

Many women, despite their many plans for giving birth, end up with a different outcome that they had hoped for. However, if the baby and mother are still healthy, the woman often relates positive emotions immediately following the birth. This may be the case for a cesarean as well as a vaginal delivery. One woman specifically claims, "before we knew it the drape was being lowered and the anesthesiologist was lifting my back up a bit so that Eric and I could watch our daughter being born. I cried and cried. She was here. 32+ hours after my water broke" (*BWF* #4). Although this woman had not planned to have a Cesarean, she and her husband were still able to see their child coming into the world which prompts a very emotional response from her. It may not have been her original plan; however, the woman writes that her wishes were still respected by her medical provider. While women on *Birth Without Fear* often recount the importance of this for their positive birth experience, according to this woman, "she was quickly looked over while Dr. C did his best to get her as much cord blood as possible, while still keeping me safe…as requested she hadn't been bathed or weighed or measured. None of that mattered" (*BWF* #4). For this woman having a healthy baby is what really matters. She claims that none of her other requests mattered, even though they were respected by her medical care provider.

While she claims that none of this actually mattered to her, other women are particularly upset when their wishes after the birth are not respected. Sometimes women write that even though they were hoping and planning for some time to bond alone with the baby after giving birth, this does not take place and they were unhappy about this outcome. For instance, "I saw my baby was no longer receiving supplemental oxygen but the staff did not give him to me for another 13 minutes, time which they instead used for an unconsented, non-emergency x-ray and routine measurements, as the doctor ordered they do before letting me hold him" (*ESP* #2) writes one woman. This woman uses a very specific number about the time that she is separated from her baby. It's not clear from the narrative how she knows that they were apart for exactly that length of time, but it could be from having read the chart associated with her child's birth. Although women are not typically offered access to their medical charts following the delivery, many women seek this out when they experience a traumatic birth because they want to understand exactly what happened and try to make sense of the reason for the trauma they experienced. Additionally, the woman does not say whether or not there was reason for the additional physical check-ups on her baby, but it seems that the doctor was concerned from thorough check-up the baby received. Thus, there appears to be some discrepancy between the woman's perception of what should happen after the birth and the doctor's belief in the necessity of some medical interventions in order to make sure the baby is healthy. Another woman writes about a more forceful experience following the birth of her child: "they took my son and gave him to my husband however. I wasn't allowed to move. My son was born at 10:02 pm, taken away somewhere… and they brought him in about an hour later" (*ESP* #4). Rather than immediately giving her the baby to bond with, the nurses give the baby to the woman's husband while they care for her following the birth. She points out that she is not able to hold her son for

an hour after his birth. Although she does not say that she had planned for bonding with her son immediately after giving birth, it is possible to assume that she wanted to have a similar experience to the women above who had positive experiences bonding with their babies following the birth. Thus, the unfortunate inability to spend time with their baby can be troubling for women who have waited and potentially suffered for nine months, only to miss out on spending crucial time with their babies immediately after giving birth. References to time throughout the narrative, often demonstrate the importance of timing in the process of birth itself and the contrast between women who have positive experiences giving birth with those women who experienced trauma while giving birth.

Structure of Birth Narratives

Once a woman has decided to share her experience giving birth with others on the internet and has decided on the discourse community that best reflects her own experience, she then must decide the form that her narrative should take. Of the four websites used in this study, three of them do not provide clear instructions for women on the structure that their narratives should take. The exception is *Mama Natural* where, as previously discussed, the narratives take on an interview form, with questions that specifically focus on emphasizing the ways that women incorporated particular natural techniques or products in helping them prepare for giving birth. If women generally do not receive any specific instructions or advice for their birth narratives, it seems possible that the narratives themselves would not follow any kind of particular structure or pattern. However, in the narratives I examined, there is an overarching guiding principle that not only provides a specific structure for the narratives themselves but is also used by women to help them construct their memory of the birth. Not only do women use

expressions of time to describe how the birth took place, but time also shapes the overall structure of the birth narrative as genre.

In contrasting their narratives of giving birth, women use *kairos* and *kronos* as important guiding principles depending upon the situation. The narratives used in this discourse analysis demonstrate that time is so significant in the birth experience that women cannot avoid frequent references to it as they attempt to explain the birth to others. Thus, the birth narratives follow a linear or chronological structure that makes somewhat frequent references to the passage of time during the birth. Additionally, references to time in the narratives demonstrates that artificial concepts of the relationship between time and labor are used to frame and assert some control over the birth itself. However, the narratives demonstrate that while there are similarities in the labor and delivery process, each one also has some unique features that resist this possibility of control. The expectation that most births would follow a standard pattern is an example of *kronos* in the medical system's view of birth. Women tend to use these time-related descriptions in their narratives even when their experience giving birth did not resemble this norm. As discussed earlier, women whose experience does not match with the presumed *kronos* of birth, may express either conflict with their medical care givers over this issue or frustration with their own bodies failure to conform. They may then structure their birth narratives using these concepts of time but take care to explain how or why their experience did not fit within the norm.

All of the birth narrative examined in this discourse analysis followed a linear or chronological progression beginning sometime shortly before the birth and concluding with a discussion of the aftermath of the birth. One pattern I identified in these birth narratives relates to the manner in which the narratives begin. They usually open in one of two ways: a) either with the beginning of labor or b) by providing some background on previous births. The biggest factor

that influences how the narrative opens seems to be whether or not the woman has given birth before. For instance, if this is not her first birth, the opening paragraphs describes the woman's previous births with an emphasis on her feelings about she experienced from these births: "Although I enjoyed the homebirthing experience of my boys, I had some fear which caused my labors to [be] more like a roller-coaster, and somewhat painful. For my daughter, I knew I wanted to have a peaceful, pain-free birth" writes one woman (*BWF* #2). By providing context, the woman puts the current birth narrative into conversation with not only other home birth narratives, but also her own previous births. In contrast, another narrative begins by relating the woman's strong emotions around the date that she would give birth, but then quickly transitions to describing the beginning of her labor: "The next morning, Wednesday, March 1st, I woke up at 5 am to losing my mucus plug and having bloody show" (*BWF* #1). Once the women describe how they know that the labor is beginning and the birth is imminent, the narratives diverge in the descriptions of the progression of labor.

While the narratives follow the different natural patterns that the labor may take, there is one turning point that seems to be common between all of them, specifically, when the women describe the first contact with their medical care providers. In the case of medical labor inductions or planned Cesarean sections, this contact usually happens near the beginning. For instance, one woman writes, "as I completed the hospital admission forms and surgical consents…the room was filled with laughter and love…and I was calm and content. As my dreams of having a VBAC faded into the distance, I eagerly anticipated meeting my daughter" (*BWF* #5). Her description of beginning the birth process clearly involves contact with the medical system through completion of forms and admission to the hospital. For her this is not an unhappy process because it has been planned for, and she is looking forward to meeting her new

baby. However, in the narratives that include a spontaneous beginning of labor, as discussed above, the women decide to contact the medical care provider at the point where they are confident that labor has truly begun. A woman writes of her first contact with the medical care providers: “I got to the hospital at 6 am in extreme pain” (*ESP* #4). Her choice to go to the hospital is prompted by her conviction that labor has indeed begun, while others may not be as confident and instead seek the reassurance of their provider. For example, “I texted my midwife Sara: ‘I’ve been having contractions for a few hours but they haven’t been consistent…and now I can’t remember when exactly I should call you?’” writes another woman preparing for a home birth (*BWF* #3). This woman, although she is nervous about whether or not she is in labor, feels comfortable enough with her medical care provider that she sends her a text message to check in instead of formally traveling to a hospital as the two women above do. No matter how these women make the decision to contact a medical care provider for the first time, they do typically provide a reason for their choice. In the example above, it appears that the woman feels she needs to provide a rationale when contacting the medical care provider: “I think they’re starting to pick up but I’m also not sure if it’s prodromal labor” (*BWF* #3). She feels that there is a change happening with her possible labor that requires some confirmation from the medical care provider, which prompts her contact. In the birth narrative, once the medical care provider is contacted, they often end up directing the woman’s actions and from the tone of the narratives, they may also speed up the birth process.

As might be expected, the climax of the narrative is the birth of the baby. The climax is often portrayed by the women as a *kairotic* moment for them. Not only does a new person arrive in the world, but for first time mothers this represents the beginning of a new identity for them. In constructing their narratives, the women use *kairos* to make the moment of birth the focal

point because this is the moment when their lives change dramatically. This is important to the narrative arc of these stories for the writers, but it is not always a positive moment. The differences in the narratives from two very different websites becomes most apparent in how the climax of the birth is portrayed. In these narratives from *Birth Without Fear*, the birth of the baby is portrayed positively: "she was here. 32+ hours after my water broke…she was perfect and pink and loud and tiny and COVERED in meconium…and I had only ever seen anything that beautiful two other times in my life" (*BWF* #4). Although this is a birth that includes events that could be construed as traumatic (a planned VBAC that ends in Cesarean), the woman chooses to portray it positively and specifically uses the climax to illustrate her feelings of joy at the birth of her child. However, in the narratives from *Exposing the Silence Project*, the birth/climax is shown in a negative light. An example of this comes from one woman who writes, "barely after I responded they started cutting into me. The unbelievable pain from being cut into is indescribable. I felt everything…the hell I was in continued as the surgery continued until finally they put me to sleep" (*ESP* #1). While this excerpt from the narrative is horrific, it is important to note that it does not actually describe the birth of the baby. Rather, the experience of a Cesarean without appropriate pain medication stands out to this woman as is the most significant or climatic portion of the birth. Additionally, she was unconscious by the time the baby was delivered and her husband had been forced to leave the operating room. What should have been a joyful moment of experiencing the birth of her child is instead a moment of trauma for both the birthing woman and her partner who witnessed the pain she experienced during the surgical delivery of her child.

The birth narratives conclude positively or negatively depending on how the women choose to reflect upon the process of giving birth. Many of the birth narratives describe the

woman's emotional responses to the birth. They may be positive overall, as in this narrative: "it was a perfect birth. Even though I had a planned a natural birth, I don't feel guilty about the epidural. It allowed me to relax and truly enjoy the perfect birth of my daughter" (*BWF* #6). The woman describes the birth as perfect, but then uses that language to sandwich a justification for deviating from her original plan to give birth without medication. This narrative like many of them, concludes not only with a description of her emotions about giving birth, but also some comparison of the birth to her plans for giving birth. Another woman writes, "the self-doubt that comes in can suffocate you and it felt like nobody really understood WHY I was upset. My baby was healthy after all and my recovery had been as easy as it could have been. Yet still, I felt like I had let myself and my daughter down" (*BWF* #4). This narrative acknowledges that the physical health of the mother and baby constitutes a successful birth for most people, but the overall birth has had some significant negative effects upon her belief in herself as a mother. In other birth narratives, the woman ends by explicitly describing her struggle with postpartum anxiety or depression as part of her recovery process following the birth. One woman concludes her narrative, "I suffered from post-partum depression after his delivery. I had flashbacks of being assaulted. I couldn't let my husband touch me for months and I struggled to bond with my son" (*ESP* #4). For this particular woman, naming the effects of the trauma she experienced while giving birth is crucial because it emphasizes the importance of having a positive birth experience for her. Women who experienced traumatic births may choose to emphasize struggles during their postpartum period because they want their readers to be left with the impression that a negative birth experience may have a lasting impact upon the woman even if both she and the baby are ultimately healthy. Finally, the conclusion of the narratives is often reflective and frames whether or not the author perceives her birth experience as overall positive or negative. In

fact, in the conclusion women may also discuss how long their recovery from the birth lasted, and sometimes they clarify how much time has elapsed between the birth and writing of the narrative.

Conclusion

References to time are often used as a commonplace in birth narratives, particularly when we consider that pregnancy and birth are often intricately connected to time. Leading up to the birth, both Jensen and Seigel describe the emphasis on timing in first doing the important work of getting pregnant, then making the responsible decisions during the pregnancy that will hopefully lead to a positive birth. However, as Seigel points out, despite the neoliberal responsibility that women feel about making the right decisions that will protect the health of the baby, the risk attendant with birth is not completely within their control. As several of the narratives portray attempting to assert some control over the birth through the decisions made during pregnancy, ultimately, women are not able to control when they spontaneously go into labor. Thus, they either have to wait for the *kairos* of going into labor or accede to the pressure of *kronos* that they may feel from their medical care providers to allow a medical induction in order to set the time of the birth. Descriptions and markers of time appear frequently throughout the narratives as they are used both to frame and shape the structure of the narrative, as well as to describe ways that the women experienced time passing during the birth of their children. When the women use time as a framing device, they are able to write narratives that conforms to the genre self-created by the discourse community that hosts the narratives. The narratives also reveal ways that the expected *kronos* of the birth as set by medical discourse of birth may come into conflict with *kairotic* moments as described by Segal. Traumatic birth narratives specifically include moments when birthing women are persuaded by the medical care provider to accept

medical interventions that they had previously planned to avoid. One way that women indicate the significance of these moments of *kairos* is through noting the specific time that the moment happened. This may be the time of day or at which point in the labor the intervention occurred. This aspect of the traumatic narratives stands in contrast to the positive and "natural" birth narratives which tend to place the emotional climax at the birth of the baby.

Finally, the descriptions of time that women use in the narratives demonstrate the conflict between the *kronos* of birth that is often promoted by the medical field and the *kairos* of birth taking place in its own time when the woman's body is ready. This is particularly evident when women place emphasis on their interactions with medical care providers around medical interventions rather than on the happy part of giving birth when the baby is born. These references to time highlight the ways that both women and their medical care providers often desire to control the birth and reduce the sense of uncertainty. However, "natural" birth ideology emphasizes the importance of allowing the uncertainty to exist but offers the possibility of exerting control over the birth by making the right choices during pregnancy. When it comes time for the woman to give birth, her adherence to "natural" birth ideology may cause conflicts with the medical care provider if her labor does not begin or proceed as she expected that it would. In the conclusion, I will discuss ways that the birth narratives demonstrate an acceptance of "natural" birth ideology and introduce the new genres that women use to share their experiences of giving birth that provide further opportunities for study.

CHAPTER VI CONCLUSION

Introduction

The discourse analysis presented in this dissertation reveals significant rhetorical aspects of birth narratives that women write and share publicly on the internet. In this conclusion, I aim to connect threads between the rhetorical moves that the women writers deploy in their birth narratives in order to form and maintain supportive communities of birth discourse on the internet. As discussed throughout this dissertation, women reconcile sharing the private experience of giving birth publicly on the internet by using commonplaces that demonstrate their familiarity with their desired community as well as specific and vague expressions of time that influence the structure of their narratives. These narratives specifically reveal the pervasive influence of "natural" birth ideology that is present throughout birth discourse on the internet, which is tied to neoliberalism. Ultimately, the beginning of neoliberal influence on the institution of motherhood in pregnancy and birth discourse affects women's beliefs about and confidence in themselves as mothers.

As the internet is an ever evolving and changing infrastructure for communication and discourse, new genres for sharing birth experiences continue to emerge. Here I begin to explore two new genres that women use to share their birth experiences and that represent opportunities for further research and analysis. *The Birth Hour* podcast is an example of the audio podcast genre for sharing birth narratives. In this podcast, the host/creator interviews women about their births that represent a variety of experiences. This podcast represents another example of women using their narratives of giving birth for economic gain. Vlogging and sharing everyday life experiences on YouTube has also become a popular form for sharing birth experiences. While women who write and share textual narratives are able to selectively share details in order to

maintain privacy, women who share videos of their birth experiences often emphasize that they are showing all of the details. However, with the use of editing it is clear that some selectivity is involved. Discourse analysis is an appropriate and helpful method for researching and writing about text on the internet, but I recognize that audio and video will need other methods in order to study them well. My goal is to extend my current analysis of birth narratives to address how "natural" birth ideology is present and adapts to audio and video genres of birth narratives in my first book project. The presence of "natural" birth ideology continues to be a dominant feature in birth discourse on the internet as I have shown through my analysis of textual birth narratives. I hope to gain further insight into this aspect of online birth discourse through an exploration of birth podcasts and birth vlogs.

Major Findings

By using discourse analysis and coding my narratives using Dedoose, I was able to discover that the major findings of my research coalesce around a specific ideology of birth. While I began by considering that the positive and traumatic birth narratives would reveal different perspectives of birth, instead the analysis revealed that their underlying similarities in the ways that women view birth despite the major differences in the birth outcomes. Additionally, the birth communities differ in their purpose, but that is due primarily to the experience that the narratives present rather than the beliefs about birth that the women writers hold. For instance, *Birth Without Fear* and *Mama Natural*, which primarily present positive birth narratives have different purposes for sharing the narratives. *Birth Without Fear* purports to provide a community where a range of birth experiences can be accepted. However, all of the narratives from *Birth Without Fear* used in this discourse analysis are positive portrayals of "natural" birth. The *Mama Natural* website, on the other hand, advertises the birth preparation

business of the creator through sharing narratives of women who used her services and ultimately achieved positive birth outcomes. *Exposing the Silence Project* and *Birth Trauma Association* are both activist websites that present traumatic birth narratives in an effort to publicize the too common experience of obstetric violence that causes many traumatic births in the U.S. and UK. While these communities differ in their purpose, the narratives presented on the websites collectively reveal the following major themes that ultimately reflect the pervasive quality of "natural" birth ideology in contemporary birth practices.

Individual Choice

The discourse analysis I conducted reveals that while there are some significant differences between narratives that portray birth as primarily a positive experience and narratives that depict traumatic births, there is one major similarity between the narratives on the four websites, which ultimately shaped this dissertation. "Natural" birth ideology positions women as individually responsible for making choices about giving birth that will enable them to control the birth outcome and achieve a beautiful physiologic birth. The hidden rhetoric of "natural" birth ideology urges women to consider aspects of birth such as medical care provider and birth location as options that they can choose rather than considering the structural and systemic inequalities that may limit their choices. In their narratives, women often relate the importance of choice and its relationship to controlling the birth experience by claiming that making the right choices led to a positive experience, while in traumatic narratives women express anger or frustration that the ability to choose was taken from them. Neoliberal ideology is pervasive in genres of life writing around birth on the internet from taking responsibility for the birth outcome to attempting to monetize the experience through advertisements and sponsorships.

Self-Responsibility

Women writing birth narratives claim responsibility for the birth outcome even when the birth experience caused them trauma, which follows them into motherhood. Neoliberalism holds individuals responsible for controlling their own fate, which can cause medical care providers and women to have competing views that are shaped by the potential for litigation depending on the birth outcome. As Morris argues, the explosion of non-emergency Cesarean surgeries in the United States compared to the rest of the developed world is heavily influenced by the propensity for litigation surrounding birth. Women are able to sue the medical care provider/hospital for up to 18 years following the delivery of their babies (Morris 145), which can cause medical care providers to be averse to any risk to the health of the baby during the birth. Therefore, medical care providers may take a different view of risk and desire to minimize any risk to the health of the baby or mother, which can lead to pressuring women to consent to medical interventions such as induction or Cesarean surgery when women who believe in "natural" birth ideology may feel that they are unnecessary. Strong advocates of "natural" birth ideology argue that women should trust their bodies and assume some risk, such as allowing women to go up to 42 weeks or longer without pressuring them to allow an induction, is acceptable in birth because it is normal and will ultimately result in a more peaceful birth experience. While I recognize women's desire for autonomy in making decisions about giving birth is positive, the positioning of women and medical care providers as holding conflicting views of the best way to give birth is too simplistic. Both medical care providers and birthing women claim responsibility for the birth outcome because of the influence of neoliberalism on contemporary birth practices in the United States. Medical care providers fear the possibility that women who have a birth complication will blame them and decide to sue them, which could

harm their reputation and cause their malpractice insurance to rise, so they are constantly looking for signs that something is not going well with the birth. Proponents of “natural” birth argue that birth is normal, and women should just trust that their bodies will give birth to a healthy baby without medical assistance in most cases. The narratives that I analyzed demonstrate that women’s lived experience is not as black and white.

Technology of Self Supports Individuality

While autobiographical life writing is typically considered a technology of self, as theorized by Foucault, the narratives analyzed in this dissertation resist such a simple classification because they collectively form a more complicated view of contemporary birth practices in the United States and Great Britain. Individually, the birth narratives appear to reinforce “natural” birth ideology. This is primarily demonstrated through the value that the women place upon individual choice to determine the outcome of the birth experience in the narratives. Specifically, both positive and traumatic birth narratives emphasize that making the “right” choices when preparing to give birth is important to facilitate a “natural birth,” which is the best kind of birth. Although the writers of traumatic birth narratives may not have experienced an unmedicated birth due to either birth complications or obstetric violence, they still tend to hold up “natural birth” as an ideal that they were ultimately unable to achieve. They also tend to accept at least partial responsibility for their failure to achieve this goal. Additionally, rather by taking responsibility for the birth outcome, both writers of positive and traumatic birth narratives focus on the individual choices rather than on systemic influences on their birth experiences. This is one of the features of life writing that critics of neoliberalism tend to emphasize in their writing (McRobbie, Gilmore, Smith and Watson). For instance, the positive birth narratives in this sample are primarily midwife attended, out-of-hospital births, which

statistics indicate is a rather rare occurrence in the United States because a) midwives are often excluded from delivering in hospitals and b) health insurers often refuse to cover the services up front and many women may not be able to pay out-of-pocket and wait for reimbursement. Thus, the positive birth narratives may hold up an ideal of “natural birth” that women want but are not able to easily achieve. Readers of these narratives may desire such a birth, but since they do not have access to midwifery care, they either feel as if they cannot hope to achieve such a birth or they may try to replicate the experience of a “natural birth” in a hospital setting. Additionally, the individual narratives tend to overlook issues of race, class, and gender that scholars of birth have pointed out recently are influences on birth outcomes and ultimately women’s health as well. While it is normal that women writers of their own birth experience would be concerned primarily with their own experiences, they also often overlook privileges that they may or may not have had when giving birth.

Collectively the narratives demonstrate that birth is unpredictable and the birth itself resists attempts to control and plan for a specific birth experience. As discussed earlier, medical care providers often view birth as uncertain and risky, which they use to justify medical interventions such as induction and Cesarean in order to exert control over the births they attend. This view is often based in the reality that there are medically necessary Cesareans and inductions that are used to protect the lives of the mother and baby. On the other hand, “natural” birth ideology strongly asserts that women’s bodies will give birth on their own if given enough time and good preparation for a physiologic birth. Thus, in the narratives women who have been influenced by “natural” birth ideology often express frustration when their bodies do not conform to their expectations. For instance, they may be planning to give birth without the aid of medication, but some women’s bodies do not go into labor naturally and when this is the case,

they come into conflict with the medical care providers. The narratives reflect both births that go according to plan and those where the labor does not go smoothly or according to "natural" birth ideology. Traumatic birth narratives often highlight such instances where there is a conflict between the woman and her medical care provider because the timing of the birth is not taking place according to plan. As discussed extensively in chapter five, the medical system expects birth to proceed according to *kronos* or regular time and responds to occasions that do not conform to the norm by insisting that a medical intervention is necessary. Women describe the conflict between themselves and medical care providers through the rhetorical concept of *kairos*. They often see the moment when a medical care provider coerced or forced a medical intervention upon them during labor as the primary source of the trauma they experienced while giving birth. I argue that paying attention to how women define trauma during the birth could help with creating new policies and procedures that result in better maternity care and birth outcomes in the United States. As I further discussed in chapter five, the trauma experienced while giving birth can also be the source of lasting problems for women while they are attempting to recover postpartum. The unavailability of medical care providers who are willing to discuss and care for women during the postpartum period also contributes to delayed physical, mental, and emotionally healing for the women in these narratives.[27] Part of the significance of these narratives is their collective demonstration of the patterns and beliefs that govern contemporary birth practices. For instance, one occurrence of birth trauma that causes PTSD may be dismissed as individual experience due to the individualizing nature of birth narratives; however, when collected on a website such as *Exposing the Silence Project* or *Birth Trauma*

[27] Part of this problem in the United States is due to lack of available postpartum care. Women giving birth in the hospital and discharged a day or two after, are usually only seen by their medical care provider once 6 weeks after the birth. At that visit the medical care provider simply does not have the time to discuss the birth experience and their decisions at length with their patient.

Association, it is difficult to ignore or discount the problem within maternity care that these women identify.

The narratives themselves, while following certain genre conventions and appealing to commonplace arguments, elide and resist easy definitions and analysis. Women use certain genre conventions such as following a linear or chronological timeline for their narratives possibly in order to fit in with the other narratives presented on the website that they are submitting to. Additionally, they may have a specific moment they highlight as the climax of the birth experience in the narrative; however, the moment that they identify as the climax differs depending upon the specific viewpoint of the narrative. For instance, in the positive birth narratives, the birth of the baby is described with excitement as the climax of the narrative because it is a moment of great joy and pleasure. On the other hand, in traumatic birth narratives, women tend to reference a conflict with a medical care provider or a medical intervention, often described as obstetric violence. Thus, the women follow different genre conventions depending on the aims of the community they want to join. Commonplaces are also prominent rhetorical moves that women use to join the discourse community that fits their perception of their birth experience most closely. These commonplaces tend to reinforce "natural" birth ideology regardless of whether the community they appear in focuses on positive or traumatic birth experiences. For example, women in both positive and traumatic narratives argue that medical interventions are risky and should be avoided if possible when giving birth. The positive narratives emphasize the good choices that the women made in order to be able to give birth without medical interventions. Traumatic narratives, in contrast, express women's disappointment with their inability to avoid medical interventions despite their efforts. However, women may also use the commonplaces to resist the rhetoric of a community when their birth

experience does not fit as easily into the dominant discourse. For instance, there is a narrative on the *Birth Without Fear* website that ends up as an emergency Cesarean even though the woman attempted a VBAC. Although the details of the birth indicate that it could easily be described as traumatic, this woman uses the rhetorical move of expressing gratitude for a healthy baby in order to fit into a positive birth discourse community. Additionally, she accepts responsibility for the birth outcome by emphasizing that she made the choice to have a Cesarean once it was medically indicated that it was necessary. Through the use of both gratitude and responsibility she is able to frame her birth experience as positive rather than traumatic. These anomalies in the birth narratives demonstrate that the discourse communities are not as homogenous in their position towards birth as they may at first appear. It is also possible that these conventions occur frequently in the corpus of birth narratives but did not happen to appear frequently in my sample.

Opportunities for Future Research

As the representations of self on the internet trend away from text to visual representations on social media sites such as Facebook, Instagram, and YouTube, women have begun to present their experiences through photos, audio podcasts, and vlogs (video blogs). In the final section of this conclusion, I will discuss the opportunities for further study that I believe these new genres present. As the genres of self-representation on the internet are rapidly changing, rhetoric scholars of reproduction are beginning to accept women's audio and video narratives of giving birth as serious areas for study. I am specifically interested in how the genres of audio podcast and vlog offer affordances that either extend or challenge our perceptions of the birth narrative.

Literature Review

Although audio podcasts have been popular for at least a decade, and have tremendous potential for rhetorical study, they have been primarily considered as a pedagogical strategy in the composition classroom rather than as subjects of rhetorical study. Podcast studies is gradually increasing in popularity, but few scholars have made more than passing mention of podcasts focused specifically on motherhood and birth. Marjorie Jolles has written about her experience listening to *The Longest Shortest Time,* a popular, honest take on motherhood in an article about the slow parenting movement. Additionally, Eva-Sabine Zehelein has argued that podcasts are transdisciplinary and uses a podcast about single motherhood, *Not by Accident* as her case study. Yasmin Nair and Eugenia Williamson specifically address issues of reproduction in podcasts in their article which looks primarily at abortion rhetoric. I argue that there is need for studies of birth narrative podcasts because this continues to be a thriving genre of audio podcast. In addition to *The Birth Hour,* a podcast where the host interviews women about their experiences giving birth, there is a podcast *Birth Stories in Color*, a podcast for BIPOC individuals to share their birthing experiences. While text birth narratives typically reflect a middle-class white woman's experience of giving birth, audio podcasts exist that are specifically interested in representing birth experiences from marginalized groups. However, birth podcasts on audio platforms are not the only new genre that allows birthing persons from marginalized backgrounds to find an audience of other individuals who are interested in their experiences.

Rhetoricians have begun studying birth videos on the internet, but opportunities for further study remain as even more women elect to share the birth experience via video. Ashley Mack has studied home birth videos on YouTube as women's performance of self-sacrifice by electing to give birth at home without the option of any pain relief. She theorizes that this form

of performative birth narrative is one way that women demonstrate their adherence to the ideology of intensive mothering that emphasizes the importance of sacrificing everything (including her own health) for the health and safety of the baby. Mack's article presents an early look at video representations of birth on the internet but is limited to home births. As the genre of vlogging gains popularity, using YouTube as a platform for sharing videos of giving birth has become more mainstream rather than being limited to women who have chosen to give birth at home. As of this writing (fall 2020), a search for "birth vlogs" on YouTube returns over 6,000,000 results. While at least some of them are likely clips from films or videos of animals giving birth, the majority are women who want to make their experience of giving birth public for the world to see. When I first began watching birth videos on YouTube in 2012, the majority of the videos were home births attended by a midwife or unassisted births. However, by 2016 when I began studying and writing about birth narratives, the genre of birth vlog as I attempt to define it was now taking place largely in hospitals. I see these birth vlogs as riffing or presenting a new take on the traditional video blog genre made popular on YouTube by kids with high quality cell phone cameras and easy access to the internet. Sharon Yam has also written about birth narratives posted in photograph format on Instagram and a web series of birth videos produced by *Romper*. She is particularly concerned with birthing persons from marginalized groups including BIPOC, working class, and queer or transgender persons whose birth experiences are outside of the mainstream. Yam acknowledges that the *Romper* series focuses on working class women of color, which makes attempts at representation, but comments that they do not go so far as to represent queer or transgender births. She argues that a true reproductive justice approach to representations of birth experiences would be inclusive of gender as well as race and class. As with my research on birth narratives, in order to find marginalized groups and

experiences represented in birth vlogs, the researcher has to specifically search for those birth vlogs in order to find and study them. However, there are some additional possibilities for studying birth vlogs and audio podcasts in addition to intersectionality that demonstrate economic aspects of neoliberalism that representing the self on the internet facilitates.

Audio Podcasts

Birth podcasts such as *The Birth Hour* are extremely prolific as women eagerly share the birth experiences with the host and by extension with the audience. For many women, appearing on a podcast serves as an opportunity for them to increase the publicity for their own mother/baby-based business. In *the Motherhood Business*, Jen Borda discusses the ways that women who wish to stay at home with their children and contribute financially to their families start mother/baby-based businesses and use their own stories to market the business. Sharing narratives of giving birth allows these women to use an audio podcast as further platform for advertising their business. A study of a sample of transcripts from *The Birth Hour* comparing them to samples from other birth story podcasts such as *Birth Stories in Color*, *Birthful*, *Birth Story Podcast*, and *the Positive Birth Story Podcast* could consider the extent neoliberal motherhood influences the narratives in these podcasts. While the textual representations of birth narratives are primarily a personal representation of self in order to better connect with a community that shares a similar experience or belief about birth, the podcasts and vlogs present a different facet of neoliberalism. Through these very public facing platforms, women are able to more easily monetize their experience. The opportunities for people to make money on the internet just by presenting themselves as a particular kind of person on the internet at this moment in the twenty-first century appear endless. Women often do this when they share a very personal part of their lives such as the experience of giving birth.

Vlogs on YouTube

Women share their birth experiences on YouTube for a variety of reasons, but by making these videos public on the internet, they are almost certainly seeking a wider audience than just interested family and friends. Prior to the internet, people did video tape their births, but usually only shared them with a limited audience. However, when women share their birth experience on YouTube, they want others to watch their video and interact with it by liking, subscribing, or commenting on their video. As with text birth narratives, where women share their narratives because they are inspired by reading other narratives, women share their individual birth vlogs as a response to other birth videos that they have seen. This can be implied by the similar titles that women often employ for their videos, such as "Raw and Real Labor and Delivery vlog." Additionally, as I have discussed elsewhere, these birth videos tend to follow a specific pattern. As I explored in chapter five, the pressure when positing a narrative of self on the internet is to conform to the already established pattern rather than to innovate and create new forms of the genre. This is amplified on YouTube where just a glance at the results shows very similar titles, descriptions, and thumbnails of beautifully made-up emotional women holding a baby. It is important to note that these videos of birth are typically not the only video a woman shares on YouTube. The birth video is part of an ongoing series of lifestyle videos that the woman shares on YouTube. There is a not insignificant number of people who make money by sharing videos of their everyday lives on YouTube and the birth vlog becomes part of woman's brand or how she presents herself to an interested audience on the internet.

While it may seem strange that birth videos would have a large audience, they are popular. As of this writing, several of the most popular birth vlogs on YouTube have over 30 million views. The textual birth narratives provide a lens into the private world of birth; however, they are limited by the perspective of the writer. Throughout this dissertation I have defended the importance of the woman's perspective in the narratives, but it is worth noting that certain aspects of the birth may be overlooked in the telling of the story. The vlogs on YouTube often purport to be providing a more objective perspective of the birth taking place. For instance, the titles or description may reference that is the "real," "raw," "emotional," perspective of birth. Although the creators are careful to avoid making a false claim that the birth video is unedited, there is an implication that the intimate or gross details of the birth were not being hidden through editing. Another reason that the birth vlogs may be so popular is that the creators of birth vlogs already have a well-established audience of subscribers on YouTube. Some other channels grow and develop from the beginning of pregnancy through the birth of the baby and ultimately become mom/family vlogs. By watching birth videos on YouTube that have been monetized, the audience affirms the woman's experience by helping her to profit somewhat from making the video. Women who do not have a skill for making that they can directly turn into a business as discussed in *The Motherhood Business* may discover that their interest and affinity for recording their everyday lives and taking carefully curated pictures may allow them to make money through ad-revenue on YouTube and product sponsorships if they are able to attract a large enough audience. For women who make money regularly on their YouTube channel, the birth video may not necessarily directly contribute to their income; however, by increasing the feeling of intimacy that the audience feels with the birthing woman, they may indirectly open up new revenue opportunities for women.

Final Thoughts

My interest in studying audio podcasts and vlogs as new genres of birth narrative extends beyond the novelty of a different presentation of birth. As I have alluded to earlier in this section, I believe that these new genres have particularly strong ties to the neoliberal imperative to create economic gain from representations of the self. It is important to keep these market driven aspects of neoliberalism in relationship to birth in the forefront when studying and writing about birth narratives for several reasons. First, healthcare disparities in the U.S. medical system reveals the ability of those with means to afford higher quality treatment and more respect from their medical care providers in order to achieve the ideal birth that they desire. Usually these people are middle to upper class white women whom Natalie Fixmer-Oraiz points out fit the model of appropriate mother in neoliberal thought. She discusses ways that neoliberalism and U.S. society specifically protects and values the motherhood of these women. By studying birth podcasts and vlogs from BIPOC or queer birthing people, we may be able to see these disparities highlighted in their birth narratives. Alternatively, as healthcare providers work to change these disparities that have been widely identified, the narratives may also demonstrate positive experiences that marginalized birthing people have had. Additionally, it is important to remember that neoliberal discourses of risk and uncertainty around birth often play out in a concern for losing money through litigation that may cause OB-GYNs to pressure birthing people to make decisions that will mitigate risk for the doctor such as allowing unwanted medical interventions. Watching these conversations play out or seeing women's immediate reactions to them on birth vlogs could be particularly revealing as the video genre allows the viewer to see the context of the birth taking place. For instance, the birthing environment can influence the birthing experience, but the women in text narratives do not usually describe the

birthing environment, unless they were giving birth at home. As I've mentioned already, home birth is still uncommon and privileged in the United States, so having a clearer idea of how the typical hospital labor and delivery room could give further context for some of the healthcare disparities that marginalized groups may experience.

Finally, it is crucial to consider the ways that women's experiences of giving birth influence their beliefs about motherhood. Much has been written about the modern institution of motherhood beginning with Adrienne Rich who in the 1980s first considers the institution of motherhood as separate from the experience of mothering in *Of Woman Born*. Although Rich did not necessarily consider that not everyone who is the primary caretaker of children is a woman, by separating this role of "mother" from the personhood of a woman by viewing it as a verb, she allowed for future scholars who would be able to critique the neoliberal value placed on certain mothers and protecting their right to give birth and mother. Reproductive Justice argues that all women's/person's rights to choose when/how to reproduce and to care for their children safely must be protected. This stands in direct contrast to the neoliberal ideal of motherhood, which places responsibility solely on the individual without considering the systems that may either restrict access to contraception (usually white women) or force contraception and even tubal ligation (mostly women of color), while queer persons find that their reproductive needs are often completely overlooked. Rhetoricians of reproduction often focus on access to avoid reproduction through contraception or abortion. This is a privileged view of reproduction that tends to focus primarily on the concerns of middle to upper class white women. BIPOC and working-class people have long found that their rights to birth and parent children have been threatened by the medical system's attempts to exert control over them. A growing number of scholars recognize that the right to give birth safely is tied into concerns of reproductive justice

and increasingly a concern in the United States and thus are turning their attention to birth narratives and representations of birth in popular culture. Storytelling through personal narratives have been discussed as one way that women cling to the truth of their experience when the patriarchy and the neoliberal ideology of “natural” birth are used to discredit and enforce a different narrative. However, up to this point, the narratives that are able to be shared on the internet have been primarily those of women who have the means to access the internet and who are comfortable asserting their perspective. As I have sought to point out throughout my analysis, the narratives on these four websites reflect the dominant discourse of “natural” birth ideology that has been used to enforce the concept of individual choice and responsibility, which can distract women from the critiquing the systems that are often the cause of traumatic births. Additionally, it is important to consider the fact that women assert over and over again in their narratives the effort they must exert in order to have their wishes for a safe birth that supports rather than diminishes their own bodies’ ability to give birth. There are significant problems with a system for giving birth that requires women to fight for their rights to give birth safely and with some agency. The women who are writing and sharing traumatic birth narratives feel comfortable with sharing experiences that are painful and that demonstrate ways that their personal agency and, in some cases, their physical autonomy was violated by their medical care providers. As Hensley Owens points out, this is one way that they may attempt to exert some control over the narrative that is told about their birth experience. However, there are women who do not feel comfortable sharing their birth experiences publicly on the internet, so that is ultimately a potential pitfall of studying these narratives. I believe that further research into other genres such as the audio podcasts and vlogs discussed above through the lens of reproductive justice that considers the influence of “natural” birth ideology upon the birth experiences of

BIPOC, working-class, and queer or transgender birthing persons should be done. My work on textual birth narratives and "natural" birth ideology also contributes to the understanding of neoliberal influence on women as mothers from the beginning of motherhood.

Although scholars of motherhood such as Rich, Hays, and O'Reilly have been writing about the problems attendant with the institution of motherhood since the 1980s, the recent COVID-19 pandemic is bringing this crisis into sharp relief. Allison Westervelt points out in *Forget Having it All,* a broad overview of the pressures that contemporary mothers face, that mothers in the United States specifically are in crisis because they are typically working both outside the home to provide economically for their families and covering the primary parenting, cooking, and housekeeping duties at home. However, by removing the childcare (provided by schools) that women have long relied upon, the COVID-19 pandemic is making clear (hopefully) for all the world to see that women are being asked to handle far more work than they are capable of doing well. It is little wonder that motherhood is increasingly unappealing to women and girls who are able to choose an alternative. When women are influenced by "natural" birth ideology to embrace the value of individual choice and responsibility to achieve a physiologic birth then it will not only cause them shame and guilt if they are unable to achieve their desired birth because of either birth complications with their bodies or systemic issues that are beyond their control, it will also cause them to continue believing that individual choice and responsibility are the values that matter the most when parenting their children. As Hays has pointed out, a central tenant of neoliberal motherhood is the concept that the mother is the right/only person who should prioritize childcare. This causes women to look for ways to add income to their family while also trying to care for their children. The advent of the internet to provide income generating opportunities has allowed women to work from home somewhat

productively. As scholars of motherhood seek to understand the structural and ideological issues that mothers face, they can serve to help mothers continue fighting to have their work valued and hopefully compensated through study of mother's presence on the internet and the rhetorical moves that they use to create community and monetize their lives as mothers.

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