EMPOWERING WOMEN THROUGH THE BIRTH PROCESS:
MIDWIFERY VS. THE MEDICAL MODEL

A Thesis

Presented to the faculty of the Division of Social Work
California State University, Sacramento

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

by
Lenaea Sanders

SPRING
2013
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Division of Social Work
Abstract

of

EMPOWERING WOMEN THROUGH THE BIRTH PROCESS:

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The relationship between using a midwife vs. a medical model birth and the level of empowerment a woman can achieve through birth was studied. By working with women prior to, during, and for their post partum care, social workers have an opportunity to support women in their search for an empowered birth. This “trickle out effect” is accomplished by harnessing a woman’s perceived sense of empowerment, which means, if an empowered birth is unavailable or simply not invested in, a woman can potentially miss out on a life changing experience. A total of 58 women participated in this study by answering both quantitative and qualitative questions which afforded this researcher with the ability to identify what these particular women as a group felt led to empowerment. This researcher found that for the women in this study, those who had not attained a college degree revealed that they had a higher level of empowerment than their counterparts whom held a Bachelor’s degree or higher. While some women in this study stated that the hospital
setting either limited their ability to make choices, aid in the decision making process, or placed the women in the position of risk when considering the impetus for unnecessary interventions that often occur in the hospital setting; most of the women in this study related that they opted to utilize services provided by the medical model as opposed to working with a midwife. A few of the women stated that they were able to utilize the services of a midwife within the hospital setting. Surprisingly, the research showed that while working with a midwife was a consideration, the women included in this study predominantly sought care in the medical model setting.
DEDICATION

The culmination of this thesis and the completion of this Master’s degree would not have been possible if not for the unconditional love, support and understanding of my mother Mary S. Tucker. I love you mom!

You are MY rock!
ACKNOWLEDGEMENTS

I appreciate this opportunity to acknowledge all of the people who have held my vision firmly in their hearts while I navigated this path. To the women who took the time to participate in this study, I thank you. I am humbled by the depth and breadth of your responses. This work would not exist without your willingness to disclose your intimate birth experiences.

Many thanks to Maura O’Keefe & Dale Russell for stepping in and helping with the completion of this project, your guidance, advice, and expert tutelage helped to mold this work. I would like to express my deepest gratitude to Andrew Bein for personifying mindfulness. He has shown me what a true mentor is. Andy, your continued leadership, supervision and friendship will be treasured always. Also, I would not be here without the love and support of my family, I appreciate all of the wonderful words of encouragement along the way.

To all of you, I am grateful.
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CHAPTER 1

STATEMENT OF THE PROBLEM

The fundamental purpose of this research is to determine if the level of empowerment women garner through an empowered birth experience and whether a midwifery birth (vs. a medical model birth), increases the level of empowerment a woman perceives through her birth process. Finally, can a woman’s level of empowerment provide a sense of self-determination from which to accomplish her life goals?

The nature of this research relates directly to the preamble of the NASW Code of Ethics, which states, “The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people with particular attention to the needs and empowerment of people who are vulnerable, [or] oppressed…” (NASW Code of Ethics, 2012). In this instance, women make up the vulnerable and oppressed population in that they face what can in some cases be considered an antiquated system of care that is resistant to the introduction of “new” best-practices in women’s health.

Research to date on maternal empowerment is limited at best. With the impetus of costly health care, maternal health does not garner mainstream attention. This study will offer a key point of reference to the benefit ratio of midwifery birth vs. medical model birth practices. The level of empowerment in conjunction with birth outcomes as they relate to women and their birth experiences will be analyzed. There are a plethora of pros
and cons to consider when we consider birth. Whether looking at birth from the midwifery perspective or that of the medical model, the desired outcome and focus is a healthy mother & baby.

Midwifery differs from medical model birth practices in that midwives look at the “big picture;” the whole woman is cared for prior to, during and post birth. A woman’s experience is considered and cultivated throughout the period of time a woman works with a midwife, thus instituting a long-standing relationship of support between a woman and her midwife. This relationship also prepares women for their impending birth. The core values of the social work profession speak to the same standards that support the idea of empowering women through their birth experience. The problems associated with the birth process lie in the established practices related to caring for women in the medical model setting.

“Modern hospitals have undergone tremendous technological advances and patient-focused changes over the past 50 years, culminating in facilities that offer world-class care, patient safety, and compassionate attention” (Boucher, 2009).

The nature of a woman’s role in conjunction with the birth of her child has changed dramatically due to the reliance on medical model interventions (i.e., C-sections, inductions, and epidural medication), in addition to a cookie-cutter; one method fits all standard of care.

The capacity to bring forth new life is an aspect of womanhood that should be treasured and revered, especially because some women will not have the opportunity to have children. The reverence for women and the crucial role that they hold in the
continuation of our society have not held the forefront of global consideration. The transition into motherhood through birth is a defining moment in a woman’s life.

It is at this juncture that social workers become another part of the story of women; a part of their birth journey. As social workers, we can walk with women into their empowerment. Historically, the role of a midwife is analogous to that of today’s social worker. Mid-wife equates to “with-woman,” and in order to assist women through their birth process, midwives offer women support, understanding, patience, and the ability to make decisions regarding their birth process.

The relationship between women and social workers mirrors that of the relationship that midwives purport. The NASW Code of Ethics stipulates that the, “core values, embraced by social workers throughout the profession’s history, are the foundation of social work’s unique purpose and perspective: service, social justice, dignity and worth of the person, importance of human relationships, integrity, [and] competence.” Working with women who are in pursuit of an empowerment offers social workers an opportunity to cultivate and hone their skills in the field setting. Birth is a learning experience for both women and social workers; birth has the potential to cultivate a richer understanding of how to reach an empowered birth experience.

**Background of the Problem**

Due to economic pressure and ethical demands within the medical birth model; women have taken a back seat when it comes to determining their birth experiences; particularly when it comes to obtaining an empowered birth. The medical model doesn’t prioritize the needs of women and their families, as evidenced by a constant reliance on
conglomerates of the medical profession (i.e., American Medical Association (AMA), Medical Board of California (MBC), Health Maintenance Organization’s (HMO’s), Medicare, Joint Commission on Accreditation of Healthcare Organizations (JCAHO, the Food and Drug Administration (FDA), Environmental Protection Agency (EPA), Health Information Privacy Protection Act (HIPPA), National Institutes of Health (N.I.H.), (Occupational Safety and Health Administration (OSHA). “Through its political and financial clout, the medical establishment has become the most lucrative business in the country” (Johnson & Rhodes, 2010). Because of these fiscal and often political obligations, women are offered a method of delivery that is often not empowered.

Medical model births tend to regulate birth; most policies are not made with the best interest of the birthing mother in mind. The majority of OB/GYN’s (Obstetrician and/or Gynecologist) have not witnessed a true natural birth. Natural birth takes time; hours. Working with women and focusing on listening to women and their bodies rather than relying on technology, takes time. Supporting women through transitions takes time, but in the medical model, time is money and these practices are not supported. Lengthy births equate to less income for the hospital and the doctor. So, the technology is introduced as a vital mechanism from which to monitor progress, but in reality, the tools become the starter pistol of delivery. Women, their bodies and their babies are invariably behind the proverbial gun.

The end results of incorporating technology and interventions can be: speedy births, pressured deliveries, increased C-sections rate, distress for babies, distress for women and a birth that is disempowered. A “disease oriented approach,” is what Benjamin
Chojnacki (2010) describes as a focus on the diagnosis and treatment of pregnancy complications and the “management of diseases affecting pregnant women and the fetuses they carry.” This notion speaks to the “cookie-cutter” method of care that is being offered to women today. With the midwifery-model, we see a “wellness approach,” according to Chojnacki. He submits that midwives, “apply a more holistic and hands-off approach stating that, “a great deal of trust is placed into the body’s ability to bring about a safe delivery and medical intervention is avoided until absolutely necessary.” This is the type of support women in labor should expect to receive.

With this examination, Chojnacki speaks to the detriment that the “no case is normal until it’s over” method that the medical-model purports. The question then becomes an answer, we want our mothers to be healthy women who produce healthy babies; therefore, prevention should be the ideal when it comes to birth. As women continue to navigate their birth processes, less intervention is called for.

Risking the lives of women and their babies because of fear, money and convenience is not a best-practice. The fear doctors and hospitals have for being sued, the necessity of doctors and hospitals to find ways to charge women for services, and the ability of doctors to make their schedules work for them are priorities that need to be reevaluated.

Chojnacki points out that midwifery “is not financially attractive to hospitals because it results in longer deliveries that lessen the number of potential patients, and does not provide hospitals the opportunity to make a profit through administering billable procedures.” What Chojnacki is pointing out is that labor is inconvenient and the desire
women might have to labor naturally takes too long.

We must look at ways in which we can support women during their births; this is where Midwifery becomes a real option for women. Midwifery offers flexibility on several levels. Some women are able to work with a Midwife in their home. For those women who are either at risk for complications or who are not comfortable birthing at home they may be able to labor in the hospital setting with a Nurse-Midwife.

Flexibility continues to be of great importance with regard to the care of women prior to, during and after the birth process. The basic tenets of Midwifery are to be “with women,” in order to assist women during birth.

Building a trusting relationship (social workers might call this building rapport) is the first step in the process of creating an empowered birth experience. This entails supporting a woman through a self-directed birth experience from the prenatal stage through the post-partum stages. Pressure is removed, fear is explained, and women are supported through all aspects of the birth process.

With many Midwifery assisted births resulting in healthy natural birth outcomes, focusing our attention on the significant differences and important benefits of midwifery are necessary. According to Durand (1992), births assisted by women at The Farm in Tennessee reported that the cesarean section rate was 1.46% and the NNS/NFMS (National Natality/National Fetal Mortality Survey) was 16.46%, while this comparative study was done in 1980 the statistics still speak to several facts.

First, The Farm (Durand, 1992) has an unusually low C-section rate due to the utilization of midwifery practices. Furthermore, there continues to be a lack in the
amount of available research that can be referred to when attempting to gain insight into the care of women who are birthing babies. Midwives have been working with women for centuries and they have evidence to support a woman’s choice to create an empowered birth experience. As medical doctors came into popularity, midwives found themselves displaced. While the midwife movement has seen ebbs and flows in practice, the teachings, practices, and methods midwives have utilized for centuries have survived and are becoming more and more attractive to women who no longer believe they have to settle for the standard, cookie-cutter method of care ascribed to by the majority of those who serve in the medical profession.

Midwives continue to offer women a choice, which cannot necessarily be said of the medical model with respect to the birthing process. With rigid rules, and skyrocketing instances of medical intervention, a hospital birth can no longer be considered convenient, accessible, or desired.

As the increase in intervention(s) continues to rise, the adverse outcomes become more evident. Long-term studies have begun to evidence the effects on children born into traumatic environments, born to drugged mothers, born after cesarean birth, or born when the mother isn’t empowered or supported. The chemicals that drive both birth and the bond between mother and baby are irreplaceable and cannot be imitated by engineered synthetic hormones, such as Pitocin (synthetic hormone). Lessening intervention and increasing the opportunity for empowered women to decide what path their birth will take can limit the incidence of the costly side effects that are synonymous with intervention (i.e., low birth weight, underdeveloped lungs, and even death).
Midwives have understood and believe in the power of a woman and her ability to do what comes naturally. There are distinct differences between a midwifery assisted birth and that of the medical model birth when it comes to providing care to women and their families. This divide is so vast that women, family members, care providers and social workers are beginning to question medical model birth practices and these questions are garnering widespread attention.

As other countries discuss, research and implement midwifery centered practices, we must follow the models that work and formulate an empowered care plan for women in the United States.

A source of power exists for women today, which is not readily accessible for all who might opt to utilize birth as a tool that can enable a woman to increase her sense of empowerment. As we continue to evaluate the work that is being done in social work today, we can see that progress is dependent on the incorporation of mindfulness practices, client-centered care, and increased awareness and coherent program implementation; these practices are central in working with women who seek an empowered birth.

By changing relationships in the medical field from practitioner-led care to a symbiotic relationship with women, we in effect get to learn from women as opposed to “teaching” them. When society as a whole can see clients as social workers do and value the perspective that posits lived experience is valuable caring for women during their birth experiences will be more readily comprehended. Believing in a woman’s power can create a cascade of positive changes in her life and possibly those around her.
Statement of the Research Problem

In our society, and in the social work profession, women have been included in vulnerable and oppressed populations. Social Worker’s are trained to work with vulnerable and oppressed populations as they are at a higher risk of harm. When we look to the medical profession, the practice of catering to the needs of someone who falls into this category is not the normal practice.

Increasing the level of empowerment women perceive after their birth experience is complete can lead to a very powerful and pivotal point in the lives of women. This connection is the catalyst for this research.

Interestingly enough, at the crux of the midwifery/medical model birth debate is power. Understanding the ‘power’ aspect of empowerment during the birthing process will lead to an understanding of why those who support the medical model don’t want to see changes made to birthing practices.

When it comes to birth, policy, and the protection of physicians or hospitals, the almighty dollar comes before the needs of women. The sense of power as it relates to women during birth differs than the sense of power a hospital yields over a labor & delivery ward.

As women deliver babies and begin to marvel at what their bodies can do and relish the notion that they were able to deliver a baby (in some instances) without any pain medication(s) or medical intervention(s). A woman can achieve a heightened sense of power that will remain with her as she goes forward from that place of accomplishment.

Power for the hospitals equate to control and inevitably translates into currency. By
making the physician and/or the HMO the director of care, the hospital profits. “Often there are inherent conflicts of interest, as when doctors have financial investments in laboratories, pharmacies, hospitals, and medical supply companies” (Johnson & Rhodes, 2010). This is evidenced, for instance, by the stark increase in C-section births today.

According to HealthGrades (2012), “the national C-section rate has held steady at 33% since 2009.” According to an international study, Fernando Madalena Volpe of Brazil reports the consensus of researchers recommend that “since the countries with the lowest perinatal mortality rates had Cesarean-section delivery rates below 10%, there would be “no justification in any specific geographic region to have more than 10%–15% Cesarean section births” (Volpe 2012).

By looking at segments of the medical model birth delivery process juxtaposed to that of a midwife assisted birth, we can see stark differences in practice. When a woman meets with her physician, she may be meeting with a physician who is learned in gynecology or she may work with a doctor of obstetrics (OB/GYN); there is a difference between the two. A gynecologist provides medical care related to the needs of women, whereas the obstetrician is a trained surgeon.

The difference again is in the dollars. A surgeon perceives financial gain when they actually perform surgery. Therefore, surgeons make money when C-sections are performed. A C-section is a major surgery. With the medicalization of care, and the influx of regulation, “[it] is difficult to know if a doctor has made a choice based on the needs of the patient or the needs of his or her own pocketbook” (Johnson & Rhodes, 2010).
Another caveat to consider with regard to the hospital setting is that a woman may visit with the same doctor throughout her pregnancy only to find that on the day/night that she goes into labor, her doctor is not available.

Financial Implications

Insurance is a major factor that helps to determine whether or not a woman will be able to benefit from an empowered birth. Due to the inception of managed care, which includes Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO), the care of patients has been passed from medical professionals to an insurance companies bottom line. Managed care programs (HMO’s & PPO’s) “can require that patients receive prior approval before receiving treatment and can refuse to pay physicians or hospitals if they deem that the treatment was unnecessary” (Johnson & Rhodes, 2010, p. 61). By admitting women to a hospital with intention to treat birth as a disease, pregnancy and labor are processed rather than experienced.

This translates into a medical model machine. Women are placed in a wheelchair, transferred to a hospital bed and hooked up to machines. Each of these hospital and/or insurance policy created measures adds to the hospital fees associated with birth.

The demand to speed up the birth process is blatant; by increasing the number of women (admissions) a hospital has, the amount of money they can make increases. Admissions can only go up as space allows, so there is a push to get women in and out as quickly as possible. “Hospitals can profit if a patient is discharged earlier than the allowed time, but they lose money if the patient stays longer. The result of this is that some patients are discharged before they are truly ready to go home” (Johnson & Rhodes,
201, p. 61). This is not only a recipe for increased health risks or infection, but in some cases can lead to death. These practices also speak to the lack of attention the medical model places on “patients.” Women and their goals for self-directed care are not considered in this breakdown of policy which results in missed opportunities for an empowered birth experience. On both sides of the birthing dichotomy stands bureaucracy; policy, regulations, and a fear of change or a lack thereof, which can stifle any forward progress toward empowered births. Ina May Gaskin (More Business of Being Born, 2008) posits the question, “Why do these insurance companies get to be the boss of birth?” When we consider the care of women today, whether a woman chooses a midwifery assisted birth or a medical model birth, at the very least, decisions related to the care of women should be between a woman and her care giver.

Women of differing social strata may perceive vastly different forms/methods of care. More affluent women tend to have better access to midwifery services; a woman from an urban upper-class area might have an easier time locating a midwife than a mom in a more rural area or a woman who lives in an impoverished area.

Also, because of the lack of support some midwives garner in hospitals, women may find it difficult to navigate their way through negative attitudes and SOP’s that govern birth in the hospital setting. “Early in the twentieth century, physicians expanded their practice opportunities by campaigning against midwifery. Using the power of the AMA, they persuaded many states to make it illegal for anyone but a physician to deliver babies” (Johnson & Rhodes, 2010, p. 65-66). Women may find limits in relation to the culture of a hospital or a belief held by particular staff members. Due to the fact that the
people who hold the most power directly affect the outcome of the birth experience and whether it is an empowered one, we must account for personal bias of everyone involved. This means there is a need to investigate how much cultural/medical model beliefs effect the direction of birth. Depending on the environment, a given geographic area may employ professionals who are more inclined to recommend interventions.

**Purpose of the Study**

This study addresses the major trends in maternal health as they relate to birth and empowerment. This research will examine the experience of birth from an empowerment standpoint as this researcher investigated ways in which to support and empower women through the birth process. With the widespread medicalization of birth in the United States, women are being affected without even realizing it. The hope of this researcher is to illuminate available options, bring awareness to the broader population of women, and further the research on this population in order to garner empowered births for all women.

The findings of this research will evaluate which birth method leads to the greatest sense of empowerment for women overall. By looking at the different levels of empowerment women can obtain through birth and how their level of empowerment might either increase or decrease depending on how the birth is achieved; via midwifery vs. that of a medical model birth, we will begin to understand the importance of offering women-centered/women-directed care.

In addition, this research highlights the basic tenants of a social work approach to care in that meeting a woman where she is in her birthing process and providing space for
self-determination and autonomous decision-making, can lead to an experience that helps to shape a woman’s life for years to come. Determining ways in which to support women, by offering women educated choices and providing access to empowered birth experiences, is the underlying goal of this work. Researching Midwifery provides many possible “best-practices” from which to begin improving care. The ability to work with a midwife is not always an option for all women. This study aims to delineate how to bridge the empowerment gap between midwifery practice for all women who are interested and to incorporate midwifery practices in hospital settings in order to provide women who are unable to birth at home more opportunities to have the best and most empowered birth experience attainable. By looking at birth in this manner, a collective answer to achieving an empowered birth experience is possible. Whether looking at birth from the medical model or from a midwifery perspective, the desired outcome and focus is a healthy mother & baby.

Midwifery differs from the medical model birth approach in this instance because midwives look at the “big picture;” the whole woman is cared for prior to, during and post birth. A woman’s experience is considered and cultivated throughout the period of time a woman works with a midwife, thus instituting a long-standing relationship of support between a woman and her midwife. This relationship also prepares women for their impending birth.

This research will address to what degree each method of birth produces a sense of empowerment for women. Due to rigid “standard operating procedures,” births in hospitals tend to be more “cookie-cutter,” and the benefits that are offered tend to yield to
the structure of the hospital environment and to the benefit of the medical staff rather than women. Improving the psyche of women during the birth process and determining at what level the lens of empowerment can be measured will help bring birth and the empowerment of women to the forefront of societal focus. Due to societal constructs and the postmodernity of our society, women’s issues, particularly birth, are not considered a priority. By focusing on the comparison of midwifery birth and medical model birth, we will be able to see how such empowerment can effectively improve not only the lives of the women giving birth, but also the lives of their children, family, friends, and those that come to know her as a woman who has experienced an empowered birth.

What is potentially being missed here is prodigious; when a woman realizes her power and the remarkable nature of her body, her ability, and she can conceptualize her determination; the lasting effects of that knowledge (if properly cultivated and highlighted) can unequivocally affect a woman’s life and her level of empowerment exponentially. This researcher considers this the “trickle out effect.”

Consider for a moment a few scenarios. If someone survives a catastrophic event, all of the endorphins in the body and the knowledge that one must persevere in order to survive begin to flood in. Once the crisis is averted, the sense of ability and empowerment is attained. The knowledge that one was able to “overcome” something difficult is interwoven throughout our society; it’s readily understood. When a student graduates from college, it is believed that they have achieved, reached up and faced challenges in order to claim a degree. Having traversed the demands of college and all of the hurdles associated with collegiate life. A sense of empowerment is realized because
such an undertaking was successful. Knowing that, “I did it,” can be sung from the top of one’s lungs with conviction. This comes from believing in oneself and owning the sense of empowerment that comes with success.

In addition, a societal view that the sense of empowerment one feels at graduation should be the motivator to pursuing a successful career. Thus delineating the notion that empowerment is the root cause of achievement and the direct result of that empowerment is an increased likelihood of success in the future endeavors that one might consider.

Women who have an empowered birth experience the same sense of accomplishment, however, our society does not offer a big enough cheer to congratulate women for such an amazing feat. Our global society is lacking in its support and awe of women. Since women are responsible for birthing our future, a greater, more supportive network of care is warranted. The core values of the social work profession speak to the same standards that support the idea of empowering a woman through her birth. The problems associated with the birth process lie in the established practices related to caring for women. As technology continues to evolve and new practices are introduced, birth has become commonplace rather than momentous.

The nature of a woman’s role in conjunction with birth has changed dramatically due to the reliance on medical model intervention, cookie-cutter care, and C-section births. With the impetus of these practices and with the sweeping changes surrounding birth, the level of empowerment a woman can glean from her experience has taken a backseat for the convenience of the system according to Ina May Gaskin (Lake & Epstein, 2011).
Initially, one might perceive that a woman is the sole bearer of the loss of empowerment through her birth, however, a woman that experiences an empowered birth has an opportunity to effect her children, partner, extended family members and friends either through personal changes she makes in her life based on a heightened sense of accomplishment and self-determination or because of the sense of fulfillment she has due to the level of support she perceived during her birth experience.

The level of empowerment women experience through birth will affect a woman’s family and social relationships too; thus the impact of her experience translates into societal changes. These changes can be generational and eventually historically relative.

Quantifying and understanding the level at which a woman is empowered through her birth is a first step in obtaining measurable evidenced-based standards of care for each woman in a “woman-centered” (Namey & Lyerly, 2010), supportive and informed manner. By approaching the research in this manner, this researcher was able to perceive what is at stake societally when a woman’s opportunity to have an empowered birth is truant.

**Theoretical Framework**

By considering life course theory, the progression women make through the childbirth process becomes a significant crossroads to empowerment. In Schriver (2010), De Jong & Miller (1995) and Saleebey (1992, 1996) reiterate that by adopting a strengths perspective as individuals and as a professional requires a significant paradigm shift away from traditional approaches to practice. De Jon and Miller find that strengths;“assumptions are grounded in the post-structural notion that social workers must
increasingly respect and engage clients’ ways of viewing themselves and their worlds in the helping process.” Or, to put it differently, the strengths perspective asserts that the client’s meaning’ must count for more in the helping process, and scientific labels and theories must count for less” (Shriver, 2010). Women also go through stages during birth, which include the onset of labor, the stages of change during labor and finally birth.

When we consider the work of Erik Erikson, we can see that the changes women go through are akin to Erikson’s stages of development in that they require (in this case) a woman to meet each stage before moving onto to the next. With this process, women are afforded a natural ability to learn and grow at an accelerated pace. This rapid shift to and through new challenges and stages can help women to face and come to terms with their current life situations, past traumatic experiences, and future endeavors. Ego identity is the conscious sense of self that we develop through social interaction. According to Erikson (Hearn, Strayer, Glenham, Koopman, & Marcia, 2012), our ego identity is constantly changing due to new experiences and information that we acquire in our daily interactions with others.

In addition to ego identity, Erikson also believed that a sense of competence motivates behaviors and actions. Each of Erikson's stages (Hearn, Strayer, Glenham, Koopman, & Marcia, 2012), is concerned with becoming competent in an area of life. If the stage is handled well, the person will feel a sense of mastery, which is sometimes referred to as ego strength or ego quality and if the stage is managed poorly, the person will emerge with a sense of inadequacy. “Where this perspective differs from earlier feminist analysis is in the standpoint emphasis on multiplicity and diversity with
women’s experiences. As opposed to proposing a unilateral feminist standpoint…” (Schrifer, 2011).

The role of social worker also demands that we engage with each person on an individual basis. While we may end up working with families, we remain focused on how individuals progress. Social Workers must also ensure that as we look at ways in which to support women, our level of fidelity is determined by looking at the type of care we provide; looking to see that the care provided is individualized and that it meets the specific needs of the person we are working with. This view requires that we have unique approaches, plans, and goals for the people (in this case women) that we work with. “This allows a degree of respect for the particular experience of specific women within the larger universe of “women” (Shriver, 2011).

By looking at birth through the lens of a strengths perspective, we can begin to ascertain the possibilities of shifting our collective perspectives and assumptions about women and birth. “The strengths perspective views all individuals and groups, regardless of their histories, as having value and capabilities, with resources, skills, motivations, and dreams that must be considered when working with them such that they gain more control over their lives” (Johnson & Rhodes, 2010). As women traverse the challenges associated with childbirth, social workers must remain aware that several processes are occurring simultaneously.

Early transitions include major milestones in women’s lives. Once pregnancy is confirmed, a woman’s perspective is forever changed. Additionally, transitions include, changes in relationships, both familial and social, socioeconomic status, motivation, self-
esteem, ego, and the pursuit of education and employment. When working with women, social workers must remain cognizant of the frameworks that will lend support that is supported in the social work community. “Shifting to a feminist model of health care, we must remember to empower women in ways that are meaningful and fulfilling to them. This type of unconditional support ensures better outcomes and patient satisfaction” (Bell, 2012).

Working with women during this significant time in their lives requires that we look to our social work tool box and remove from it any and all tools that might work to increase the probability that a woman has an empowered birth. “To address [the] issues of oppression, injustice, and powerlessness, strengths-based-oriented social work practice incorporates empowerment as both concept and a process” (Miley, O’Melia & DuBois, 2004, p. 91).

As women determine what type of care they want to have during their labor, it is crucial that all women have all of the information that is available. That is not to say that women should be inundated with information and attempt to disseminate what approach most benefits their situation. Rather, our role as social workers demands that we are prepared to work with the people who we aim to support.

Therefore, as social workers, we must remain abreast of the ever changing practices attributed to both the medical model and to midwifery. In order to offer women the best choices, social workers must remain diligent in the process of information gathering. By affording women the ability to receive pertinent, up to date, woman-specific information, they will be better able to seek an empowered birth experience. Gutierrez et al. suggest
“empowerment practice in social work emerged from efforts to develop more effective and responsive services for women and people of color” (1995, p. 534).

Finally, social workers do utilize a women-centered approach is when working with a woman because we recognize the fundamental cornerstone of meeting a person where they are. As a therapeutic/clinical relationship is formed, a rapport is established only after people have some sense of reliability from the social worker they are working with. In order to ensure that our professional/client relationships are healthy we must revere the people we work with. The women who walk into their birth experience, supported and confident in the cultivated relationship with her trusted team of professionals, have an excellent chance of experiencing an empowered birth.

**Definition of Terms**

In relation to the process of birth, the following definitions of terms are provided to aid in interpreting this research.

- **Birthing** equates to the actual delivery of a child, whereas **birth** relates to the overall experience of delivering a child. The people that may support a woman through birth can be one or many of the following: a partner/spouse, family member/friend, a doula, nurse, licensed midwife, nurse-midwife, nurse practitioner, or an OB-GYN.

- **Doula** is a person who specifically attends a birth to lend support to the laboring woman. A Doula is usually trained, but in some instances a friend or family member may act in this role.

- **Intervention.** When considering the term intervention, this relates to introducing
medical or holistic practices that are intended to speed up a labor that has stalled. In the hospital setting, this may include the use of medications, drugs, breaking the water (which is sometimes referred to as stripping the membranes.), C-section, and/or episiotomy. For births that occur outside of a hospital, interventions might include position changes, homeopathic applications, massage, the use of a water bath, stimulation of erogenous zones, perineum (the area between the vagina and the anus) massage, episiotomy, and/or hospital transfer.

- “A "licensed midwife" is an individual who has been issued a license to practice midwifery by the Medical Board of California. The practice of midwifery authorizes the licensee, under the supervision of a licensed physician and surgeon, in active practice, to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment (mbc.ca.gov). For the purposes of California licensure, these allied health care professionals commonly are referred to as licensed midwives (http://www.mbc.ca.gov/allied/midwives.html).”

- A Nurse-midwife is a person who has obtained a nursing degree and has completed additional training in midwifery.

- A Nurse Practitioner is a person who has obtained the degree of nursing and received an advanced degree in nursing. The nurse practitioner acts in a similar role as a physician/doctor.

- Empowerment is the process of increasing the capacity of individuals or groups
to make choices and to transform those choices into desired actions and outcomes. Central to this process are actions, which both build individual and collective assets, and improve the efficiency and fairness of the organizational and institutional context which govern the use of these assets.

(http://search.worldbank.org/all?qterm=empowerment)

- Managed care is a health care delivery system that sends patients to preselected care providers with prearranged agreements on what costs will be covered.
- Medical model refers to the usual practices that occur in the hospital setting.
- Midwifery model refers to midwife practices.
- A Theory is narrower than a perspective. It is a proposition that explains or predicts something. In other words, it is an educated guess, based on both previous knowledge and observations (Johnson & Rhodes, 2010).
- A Perspective is a particular point of view that reelects “taken-for-granted” assumptions or a system of beliefs. Perspectives provide a broad conceptual and value framework within which theory development or selection takes place. (Chess & Norlin, 1991 as cited in Johnson & Rhodes, 2010).
- OB is short for obstetrics or for an obstetrician, a physician who delivers babies.
- GYN is short for gynecology or for a gynecologist, a physician who specializes in treating diseases of the female reproductive organs. The word "gynecology" comes from the Greek gyno, gynaikos meaning woman + logia meaning study, so gynecology literally is the study of women. These days gynecology is
focused largely on disorders of the female reproductive organs.

An obstetrician/gynecologist (OB/GYN) is therefore a physician who both delivers babies and treats diseases of the female reproductive organs.

- **OB-GYN** (obstetrics and gynecology) “are the two surgical/medical specialties that deal with the female reproductive organs in their pregnant and non-pregnant states respectively, and the training prepares practicing OB/GYN’s to be adept at the surgical management of the entire scope of clinical pathology involving female reproductive organs.

- **SOP’s - Standard Operating Procedures**

**Assumptions**

This study looks at those women who were considered “low-risk” by their physicians. It is also assumed that women who are considered low-risk are also at risk for being disempowered. In addition, the context in which women are considered “vulnerable” is related to historical, situational and the societal implications.

This particular population of women (pregnant women), with regard to the patriarchal society we live in and how the systemic inclusion of historical oppression of women relates to a woman’s socioeconomic status, is how “vulnerable” should be interpreted.

Also, the notion that women who are supported during their labor have a better chance at a positive outcome than women who do not is not intended to deter women who do not have a support system from achieving an empowered birth.

This research will help women; no matter what circumstance they may be dealing
with, perceive an empowered birth. The term support here means that having additional information and supportive family members can increase the chance of having an empowered birth. This is not to say that heightened empowerment cannot be reached otherwise.

**Justification**

The intent of this study is to provide the social work community with more information on providing support for pregnant women, specifically low-risk pregnant woman. The hope is that by bringing the information contained in this research to light, a more supportive, “woman-centered” (Namey & Lyerly, 2010) standard of care will be provided to women across all social, economic, cultural strata. In addition, helping to retrain the medical-model culture that is prevalent in medical facilities today to foster a healthy and empowered birth environment for all women. It is the hope of this researcher that women perceive a sense of importance and reverence that is essential in obtaining her increased sense of empowerment.

Highlighting the lack of attention that this vulnerable population is afforded we will be able to “[put] a higher value on our mothers’ lives” (Lake & Epstein, 2008), and by doing so, ensure that women have access to the best care.

The empowerment of women through birth is attainable regardless of the method of delivery a woman chooses; it is the responsibility of those who provide support to this population, i.e., social workers, medical professionals and midwives to provide appropriate “woman-centered” best-practices for care (Namey & Lyerly, 2010). Women who might not otherwise know what options are available to them will have the
opportunity to learn what is available because learned social workers are in place and can provide accurate information to women who seek a different approach to birth.

As a social worker, supporting people where they are, no matter their station, challenges, beliefs, etc., equates to supporting and advocating for what the person whom we are working with wants. This support is very specific, and while it may seem as though only women will be affected with improved care, in all actuality, the benefits of a woman experiencing an empowered birth can extend without limits as a woman moves forward in her life. As the birth experience unfolds; empowerment along with a new sense of confidence in self rises to the surface. Women can translate this newly recognized power into increased success in their lives. By referring back to what a woman was able to accomplish and how it felt to overcome pain, fear and uncertainty, women are able to apply that knowledge to the progression of their lives. In fact, depending on the amount of empowerment women perceive during this time can instigate change in their lives, the lives of their children, partners, family members, friends, co-workers; the list of possibilities are incalculable.

Taking control and owning the power to decide what course of action will occur when it comes to a birth experience can translate into a mirror for a women’s life. Knowing that a woman was able to birth her baby on her own terms (whether through natural childbirth or a medical model birth) remains to be a formidable determinant in the pursuit of empowerment through birth.

Knowledge is power; belief is power, and owning one’s power can lead to a life-changing moment for those who transition in and through the childbirth experience. For
Gutierrez et al., empowerment has multiple characteristics and can occur at multiple levels including individually, at the group level and within the community.

In some instances, the partner or family member or friend offers effective support that helps to enable a woman to reach her goal of an empowered birth. However, there is a downside to this type of support for two reasons:

1) When a woman is giving birth, there is the potential for the spouse/partner to require just as much support as the woman birthing the child. In this instance, the focus of attention can shift and decrease a woman’s sense of support.

2) Some family/friends bring their own opinions and interject during the birth process; this can force the birthing woman to fight multiple battles, having to advocate for her needs with medical professionals and family supporters. If this is the case, a woman can be so concerned with the support team that she does not utilize her energy to support herself, her birth plan, or her ideal of an empowered birth.

What becomes clear through this research is that a woman’s support team, particularly the partner/spouse may require their own support person in order to offer their partner the support she needs during the birthing experience. In addition, midwifery and birth are often looked at from the perspective of a laboring women; it may be necessary to look at this process from the prospective of familial & social supports in order to glean additional best-practices for women.

**Limitations**

This study focuses on the way in which professionals can support a women’s autonomous navigation through her birthing process. In so doing, this study looks at the
relationship between what care is provided and the resulting benefits or lack thereof.

There are limitations in the research due to the small sample size of this study and while this study is focused on birthing procedures, it does not look at options within all births or birthing circumstances such as high-risk pregnancies, severe complications or cultural beliefs. Additional aspects that contribute to ascertaining relevant information regarding midwifery and birth is the overwhelming fact that many women do not entertain the notion that birth can be an experience that can lead to an increased sense of empowerment. This is due to the fact that women haven’t been afforded necessary education about the birth process; options in birth methods, and in most instances have not had access to a strong support team that can foster advocacy during the birthing process.

This research is not designed to be followed rigidly in every case of birth, or to serve as a replacement for sound, case-specific clinical judgment. Nor is the intention to stifle clinical innovation. The complexity of birth is such that practitioners frequently search for better ways of helping women by using their clinical training, experience, judgment, and creativity. However, this research offers a standard, based upon the current research and clinical literature, to inform practitioners about pertinent and practical best-practices that will assist women in finding their sense of empowerment.

The ability for our society to empower women through birth is tangible, the impetus to provide women with a superior level of care is clear; the time has come to implement models that lead to a common goal; healthy empowered women. This research does not consider is that of familial support during the birth experience. Whether we consider
husbands, wives, partners, family members, and friends, these supports come into place and add a certain level of support in some instances. While the focus of this study addresses the woman who is giving birth, research is needed that can address the role of familial and/or social support and how that support affects a woman’s birth process.

Another area of research that is not addressed here is that of the role of male midwives and how the increase in male midwives adds to or detracts from the process of a historically female driven field. The theme of midwifery has, until now, related back to “women, caring for women,” as if midwives who are not male have an inside track when it comes to the care of women during pregnancy and birth. Specific query might encompass the incidence of male midwives gaining more acceptance with/in the medical arena simply due to the notion that Bernecki DeJoy (2010) says is, “[an]… ideologic basis of the medical model [that] comes from medicine’s history as a historically male profession, growing out of a patriarchal society.”

With regard to evidence, formulating an evidence-based practice that can be applied to the measurement of empowerment is not feasible. In order to quantify a measure for this outcome, a new approach must be considered. In order to add validity to what the participants of this study and others have shown, a standardized way to empower and prove the affects of such support are needed.
Chapter 2

REVIEW OF THE LITERATURE

The relationship between using a midwife vs. a medical model birth and the level of empowerment a woman can achieve through birth is an important topic to study. Research to date is limited and further research is warranted. By working with women prior to, during, and for their post partum care, social workers have an opportunity to support women in their search for an empowered birth. The “trickle out effect” is sustainable and can be accomplished by harnessing a woman’s perceived sense of empowerment at the time of her birth. This also makes evident the effects of not having an empowered birth. If an empowered birth is unavailable or simply not emphasized, a woman can potentially miss out on life-changing experience.

The themes that emerged from the literature reviewed speak to the necessary research that needs to be completed. Investigating the aspects of midwifery and the inherent societal implications associated with midwifery, this research found that on many levels, midwifery is a viable option for women today. While midwifery has its place in society, the inclusion of midwifery on a broad scale for women of all socioeconomic levels is absent and this intimates an underutilization of services that have the potential to help women recognize a sense of empowerment that could translate into powerful support throughout their lives. Historically, women have sought the assistance of midwives, however, midwives were initially looked down upon and the myths of old still carry into the rhetoric of the medical profession today.
The potential for empowerment is evidenced by the utilization of midwives over time. An increasing use of medical model practices (induction, epidural, and C-section), have not yet been able to stymie the use of and belief in midwifery. While a woman must, in some cases, actively seek out assistance, midwifery is still a viable option to consider. This researcher found that autonomy is a key piece of achieving a sense of empowerment that can lead to an increase in a woman’s confidence, self-esteem, and drive.

What is clear upon reviewing the research is that with autonomy a woman can reach a level of empowerment that serves her in her life. The sense of empowerment is much greater when autonomy works in conjunction with a woman’s belief in herself and her ability to deliver her child.

By feeling a modicum sense of control and having the ability to decide how to proceed in birth results in women owning the space to move through labor on their own terms. Being able to determine the route of her birth, the interventions that are to occur, who will support her during birth and the location of her birth ultimately culminate in the realization of her empowerment. Empowerment is not definite in that each woman’s experience will vary therefore the result and definition of empowerment will invariably change.

When women consider midwifery, the decision may be linked to spiritual and/or cultural beliefs. Regardless of the type of religion a woman might practice or the cultural background a woman has, midwives and medical professionals must be mindful of the
possible affects a woman’s belief system may hold for her during the birth process.

The research shows that if those in the helping professions address the birthing process with a client-centered approach, a woman has an increased chance to realize her ideal birth, which can translate into a sense of empowerment. The amount of support a woman feels during labor can impact the process of developing a sense of empowerment, and it can also impede upon the birth process, slowing it down, in essence stifling progress or creating an opportunity for intervention(s) to occur.

In order to gain the level of autonomy needed to influence the level of empowerment a woman experiences, a supportive team is required. Interestingly enough, the support person(s) can be made up of a number of varying helpers. Whether partners, family members, friends, midwives, doulas, doctors, nurses or social workers, a supportive team in conjunction with a sense of autonomy and support can culminate in a woman achieving a profound sense of empowerment.

As women face determining which birth method they will pursue, access is the foremost barrier to desired care. Without access, either due to proximity or a lack of knowledge regarding the use of midwives, women are placed at a disadvantage. In some cases women may not be aware of the possibilities inherent in working with a midwife, which in turn can lead to a woman inadvertently foregoing a chance to increase her sense of empowerment.

An economic divide exists when considering the availability of services. The dichotomy of medical professionals who utilize standard “cookie cutter” methods of
delivery versus the midwifery approach that supports an individualized and autonomous care is where the decision regarding birth choice begins. This crossroads seems to allow more affluent moms access to midwifery services while economically disadvantaged moms tend to rely on hospitals to determine the course of their birthing experience. While both methods have the potential to incur medical intervention, it is clear that women who begin in the hospital are at greater risk for intervention and ultimately surgical procedures that may have negative results for both mother and baby.

**Background of the Problem**

The topic of midwifery practices in the United States, and particularly in Northern California, has not been studied at length. This research assessed midwifery and the linkages to birth; specifically empowerment as it relates to current midwifery practices.

In stark comparison to midwifery, the medical model of birth is the usual and customary practice within the modernized world. This research is a necessary study that will help to discern the inherent risks and benefits of utilizing a home birth, rather than opting for the customary hospital based birth in the care of woman who’s pregnancies are considered to be low-risk.

Due to the lack of research on this subject within the United States, this researcher will incorporate findings from research that was conducted outside of the United States. This researcher found that there are several avenues a woman can opt to pursue in relation to her prenatal, birth, and post-partum care (maternal health). It is imperative that the themes that originated from this research be studied more closely in order to delineate the best-practices for women and their families as they circumvent birth
processes; particularly in the United States.

As this literature was reviewed, more questions pertaining to why midwifery assisted birth is not more fully supported by the medical community arose. Several studies that have been completed show the benefit to midwifery births over hospital births with the caveat that this research pertains to women who, in both scenarios, are low-risk and able to make a choice between the hospital, birth center or the home. There seems to be a limited opportunity for home births to occur due, in part, to diminishing midwifery-based childbirth centers/midwife practices that struggle to stay in business and because of the lack of support received from their medically based counterparts.

Why are mothers on the periphery with regard to the issue of childbirth? This researcher investigated medical model and midwifery practices regarding birth, in order to determine if there is a relationship between empowerment and birth process.

In addition, we must look at the social constructs that place women in the position of lay person when it comes to her own body, pregnancy, childbirth process, and labor.

This research will address the ability and knowledge that our care providers are equipped with as they set out to care for women and babies, to deliver healthy infants and to ensure that there is a decrease (as opposed to an increase) of maternal and fetal mortality. Second to the mother/baby unit, empowerment should be the primary concern for any medical professional, whether physician, nurse, midwife, social worker, or doula.

**Purpose of the Study**

Once the aforementioned considerations were addressed, this researcher was then able to categorize the opportunities afforded to women of color or to those women who
are economically disadvantaged. This research focused on the ability to empower women through their childbirth choice, experience and outcome.

**Historical Considerations**

While the historical framework is relevant, the care of women throughout history overlaps with current trends in the care of women. Research shows that in many ways, time changes some aspects of the care provided to women, while other aspects of care management have not changed, or the assumed changes are cloaked in the notion of best practices when, upon investigation, relevant change cannot be perceived.

Initially, the topic of the acceptance of midwives in the medical community was pertinent as the perception of this type of care and the stereotypes that accompany the practice of midwifery emerged. Understanding the similarities and differences, the capability and lack that each discipline is able to perform is significant.

Midwives have been a part of birth since biblical times. In the beginning, midwives were often the older women of a community and in some cases, the only mothers’ assistant available for vast areas. Midwives came to the aid of mothers for centuries as they labored drug free, were able to move throughout their pregnancies, and even grunt and groan as needed. During this period in our history, midwives were often trained solely by lived experience; practice was not based on clinical knowledge or study.

Having a midwife in many instances would be considered a luxury, especially within minority communities. Whether a struggling slave population, a banished American Indian population, Chinese communities and other immigrant populations often birthed their own babies, some with midwives; some without. In fact, midwives
were incorporated into a subservient position in that they were required to deliver the babies of their abusers (masters) and would suffer the consequences of failed births.

**Empowerment.** An aspect of the choices available to women when considering their maternal health is availability and the relationship between accessibility and demographics. Does the ultimate decision of which method a woman pursues depend on socio-economic status and location? Is maternal health predicated on status and wealth, on race and culture?

Ethnic and racial disparities need to be evaluated in relation to maternal health, again, in order to find out what the best practices are for all women. “Access to midwives, doctors, and hospitals varies across the United States, and a woman’s preference for a particular care provider or birth location can be tipped from one option to another due to the availability of birth options” (Miller and Shriver, 2012). The Merriam-Webster Dictionary describes empowerment as follows: “to promote the self-actualization of influence” (2012).

For the purpose of this study, the self-actualization and influence described above will pertain to women through the lens of their birth experience and how this type of knowledge becomes a part of their lives. “… positive birth experiences contribute to a woman’s feeling of accomplishment and self-esteem and lead to psychological growth, empowerment, and easier adaptation to motherhood” (Simkin, 1991; as cited in Overgaard et al., 2012) There are several scenarios that speak to the type of assurance a mother may receive in relation to her level of comfort, the location of her birth, as well as the type of support she receives during labor. In some instances, a woman may find more
comfort in knowing that medical professionals are standing by and at a moments notice, emergency measures can be afforded to the care of mother and baby. In others, “… medical authority can be used to oppress women” (Miller, Shriver, 2012). Some women take solace in the idea that if the pain is too intense, drugs are available to reduce or eliminate pain or, women may want to avoid all aspects of the labor (pain) process and opt for an epidural and/or a C-section.

**Ability to Make Decisions.** As mothers strive to choose what is best for their families and for their own peace of mind, it is important to note that in the United States, the chances of attaining childbirth in a home setting are limited. This predicament is predicated by the fact that certain governing bodies, such as the ACOG (American College of Obstetricians and Gynecologists) or the AMA (American Medical Association), claim that there are not enough “quality” studies that will assure the safety of home childbirth.

The fact remains that the same can be said for hospital childbirths. The National Perinatal Association (NPA) states that home births are not only legitimate, but also recognized as beneficial for mothers. Nancy Lowe (2009), editor of the Association of Women’s Health, Obstetric and Neonatal Nurses speaks to what the NPA has surmised when she says, “[what] is most risky about home childbirth in the United States is that for most women…. there is a scarcity of qualified providers of home childbirth services.” When we look at pregnancy and childbirth, we also must recognize that for low-risk mothers, a woman’s body is made to go through the process of birth and deliver a healthy baby.
Yes, there are instances in which problems may arise, however, the medicalization of a woman’s journey through childbirth seems defeatist from the start. Women are medicalized from the moment they walk into the hospital environment with wheelchairs and hospital gowns. Childbirth is not an illness, but within the medical model, a woman’s place seems to be relegated to patient rather than participant. Lowe (2009) supports this sentiment when she speaks about our system of care in the United States. Because the normality of childbirth is not recognized or supported, women start off at a disadvantage. Also, “those who support normalcy…. [are going against] a system that treats every laboring woman as a surgical case (Lowe, 2009).

Cynthia Gabriel (2011), who wrote Natural Hospital Childbirth, asserts, “natural childbirth is the most instinctive, self-directed, intervention free childbirth possible” (as cited in Childbirth, 2012). In a movie produced by Ricki Lake and Abby Epstein, The Business of Being Born, the question is asked, “Should most births be viewed as a natural life process, or should every delivery be treated as a potentially catastrophic medical emergency” (Epstein & Lake, 2007)?

**Spirituality.** While “a far smaller number of women in the United States reject the mainstream medical-scientific orientation in favor of a religion-centered way of seeing, interpreting, and acting in the world (Miller and Shriver, 2012),” culture and religion play a large role in the selection of specific birth practice with regard to home birth vs. medical model birth choice.
As women opt for home births with midwives or make the decision to birth without any medical professionals in attendance, cultural beliefs and customs play a large part in the decision-making process where birth is concerned. Some women believe that “trusting my God-given maternal instincts was the best and safest way to have my baby” (Miller and Shriver, 2012).

There are several inherent risks to remain cognizant of when we consider providing care and support to pregnant women. Since culture and/or religion can be a driving force in the decision-making process, women who choose to utilize the services of a midwife may opt to do based solely on the nature of cultural or religious norms. “Regardless of their particular birth choices, research in the United States and globally consistently reveals a complex relationship between culture, social organization, and women’s childbirth preferences and practices” (Miller and Shriver, 2012).

In some instances, specific populations are not afforded the information needed to pursue the use of midwifery. With certain expectations within the medical community of under-privilege groups, a consensus is formed that the women of a particular racial or cultural group either would not utilize or pursue that route or option, and/or the same population always utilizes a specific method of birthing, i.e., C-section or a medicated birth.

If women are not educated on the options that are available to them, a disservice is cast upon a population within this already vulnerable population that is oblivious to the opportunity for their empowerment, which therefore, is not considered in their care. Women might also choose this option due to education and conformity to emerging
sociocultural beliefs and an acceptance of these practices. Also, due to the cultural beliefs of hospital staff, and stereotypes or specific expectations of particular groups of women, cultural beliefs may preclude women from seeking an opportunity to realize the benefits of having a midwife assisted birth experience. In this instance the opportunity to utilize choice is diminished and women give in to the demands of family, culture and religious practices. From there, a woman moves forward in her life as a mother and a woman in society that may not realize the power she possess due to the lack of opportunity afforded her.

**Support.** In order to be with women during birth, social workers must align with women and “we must practice feminist, woman and family centered care…” (Bell, 2012). With the advent of technology and the increased dependence on the medical community, a mother can find herself battling those who should be in the position of support and guidance.

Bell (2012) states that, “if we ensure that women are treated as partners in their care and not as passive recipients, women will be empowered and more involved in their healthcare, in turn leading to more positive birth outcomes.”

When the locus of control shifts, women become the driving force behind their birth and labor experiences. Empowerment comes from a sense that a person can direct their power, control it and that can only occur when women are able to make decisions that will ultimately decide the outcome of their birth experience.

Simmonds (2008, as cited in Bell, 2012) posits the notion that, “… feelings need to be addressed because there are well-researched links between a woman’s sense of control
and involvement in decision-making during childbirth, satisfaction, and feelings of confidence and competence as a new mother.”

Another aspect of support lies in continual affirmation of care for women. When we consider the environment that women face upon arrival at a medical facility, we must ask the questions that arise. Who is supposed to be comfortable?

In the field of maternity care, the patient-centered perspective exerts a strong and justified influence on reform and development initiatives as it is well documented that women’s experience of birth and the care provided during this important life event immediate as well as long term effects on their well-being. (Gibbins & Thomas, 2001; Parfitt & Ayers, 2009; as cited in Overgaard et al., 2012)

Women are systematically reduced to adhering to medical procedure when they arrive at a hospital, which can ultimately contribute to the feeling of a ‘good’ versus a ‘bad’ birth outcome, “… negative experiences are associated with a number of complications such as postpartum anxiety, depression, post-traumatic stress syndrome” [PTSD](White, Matthey, Boyd, & Barnett, 2006), “fear of childbirth” (Waldenstrom, Hildingsson, & Ryding, 2006; as cited in Overgaard et al., 2012), “reduced future reproduction” (Gottwall & Waldenstrom, 2002; as cited in Overgaard et al., 2012), “and request for caesarean section” (Tschudin et al., 2009; as cited in Overgaard et al., 2012).

The possibility of a poor birth experiences leading to women who experience PTSD (Post Traumatic Stress Disorder) is very real. When we consider that “PTSD is a term used to describe a collection of biological, emotional, behavioral and cognitive
symptoms, which sometimes occur after exposure to a traumatic event” (Overgaard et al., 2012). If we take the time to recognize what a precarious time birth is for women, we may very well be able to prevent traumatic events occurring and effecting the lives of women and children in the future.

When we think of those persons who are coping with symptoms associated with PTSD, several pictures come to mind. We might consider a veteran, abuse survivor, or a victim of war or natural disaster. Generally, we don’t consider the image of a new mother as someone who could be suffering from symptoms associated with PTSD, however, whether physical or emotional trauma attributed to the birth process, the baby born to a mother who views her experience negatively may vary well experience heightened trauma and exhibit PTSD symptoms.

Specific to cognitive processing in this population is that mothers rarely have an opportunity to avoid their babies, unlike other PTSD populations where the person is able to avoid places or reminders of the event, and are therefore almost flooded to the trauma and forced to process the event consciously. (Dale-Hewitt, V. et al, 2012, pp. 289-296)

Initially, women are treated as though they were patients who are ill. Women who come to the hospital to labor and ultimately deliver children are not usually ill. However, a woman is often required to utilize a wheelchair or hospital gown as soon as the admission process begins.
With this first approach to the care of a woman, the system of care is already chipping away at a woman’s belief in her body “… many women share a faith in technology, science and the institution, and perhaps even a distrust of their own bodies (and of the process of labor and birth)…” (Miller and Shriver, 2012) and only adds to the customary belief that the hospital professional (doctor, nurse, etc.) knows more about how to birth a child than a woman and her body.

After being placed in what some consider a subservient position women are often hooked up to monitors and placed in hospital beds that do not afford comfort. When a women begins the active phase of labor, she often finds herself in a supine position with monitors beeping, I.V.’s attached, drugs introduced, and medical professionals explaining procedures that will happen to her. With medical professionals using force to accomplish their idea of successful birth, women can become depleted and fear can arise. This is the opposite of empowerment and can lead to women relinquishing their power to medical professionals because it is easier. At the point of delivery, if a mother feels unsupported a realization of a bad experience can occur. The notion that a mother who is experiencing a low-risk birth has passed over an opportunity to listen to her body and recognize the ultimate power that is afforded to her naturally is gone and cannot be redeemed.

**Socioeconomic Implications**

In a survey conducted by the Senate Office of Research (SORS) reported “over one-third of licensed midwives who handle home births [report] that they do not have a working relationship with a physician…” (Kersten, 2001).
Lowe (2009) reiterates the ACOG’s resolution in her article, “The “Authorities” Resolve Against Home Birth,” which states that the ACOG at an annual meeting in June of 2008 AMA delegate meeting stated that “the safest place for a baby to be born is in either a hospital or birthing center facility” (Lowe, 2009).

Interestingly, when we look at the medical background of physicians and midwives, we see a marked difference in the ability to cope with and handle a completely natural labor and delivery.

Increasingly, natural birth in hospitals may seem an unrealistic goal, given the climate of doubt fueled by the prevalence of medical routines, the mindset of physicians and nurses who have never attended births with minimal or no interventions, and the increased fear of labor that exists among women in our present culture. (Gabriel, 2012)

With the charge from such revered medical organizations like the AMA or the ACOG, women feel a need to turn to the medical community for childbirth concerns. Fear is used as a bullying tactic by the medical model in relation to women birthing children at home; women are simultaneously being scared out of taking control of their own bodies, pregnancies, labors and ultimately their empowering birth process. In addition, women who do choose to have their babies at home, and find that after attempting to labor at home, they need to transfer to a hospital for emergent care, “… are often treated with disdain and disregard as though their decision to give birth outside the hospital system is irresponsible, reckless, and perhaps immoral” (Lowe, 2009).
A research study performed in British Columbia purported that the instance of medical interventions decreased when women planned a hospital birth with a midwife as opposed to a physician. The study looked at midwives practicing in hospitals and “those who planned a home birth were significantly less likely to experience any of the obstetrical interventions…. (Janssen et al., 2009), which goes to show that the medicalization of birth does not only affect doctors, but in a hospital setting, interventions occur at a higher rate; even with midwives assisting with the delivery.

Lynn Porter Lewallen (2011), a researcher from the University of North Carolina states, “[along] with an increase of operative deliveries, there has been a concomitant increase in medical intervention,” which can lead not only to challenges to the mother but to the unborn baby as well, and by utilizing intervention methods such as, “… epidural anesthesia, and labor induction with oxytocin… make it more likely that additional medical interventions will be needed” (Vincent, 2002).

Logic tells us that having a baby at home is much safer, more comfortable, and necessitates fewer interventions during the laboring and birthing processes. Women need caregivers whose training prepares them to put women, their experience, and their babies first.

While the proclivity to utilize medication based interventions is not precluded when seeking midwifery assisted births, midwives often approach birth with a style akin to the motivational interviewing style in the decision making phase. Questions such as, “What would happen if you had a caesarean? What would happen if you needed stitches?” (Walsh & Devane, 2012) do not dictate a woman’s decision, but rather elicit a discussion.
Midwives are often able to offer a sense of comfort and agency that physicians cannot always offer due to policy constraints.

Financial concerns associated with the care of women have been studied, however comparisons between the cost-benefit ratios of medical model vs. midwifery birth have not been studied extensively. The major concerns that result from this section of the research have been addressed, in part, during the discussion of the historical implications on birth in the United States. It is evident that additional research is needed on this topic due to the lack of information on what drives and motivates the power inherent in the birth process; namely money.

When looking at the medical model we have to take each segment into account and look at these pieces with a microscope in order to truly comprehend why women are pushed to the periphery while their lives and the lives of their newborns are placed in harms way within the medical system of care.

Once a woman enters into a hospital, everything turns from assistance to cost. Delivering a baby in California on average for a low-risk, Medi-Cal covered birth costs approximately $13,143 (mean) according to a California State Health Department (2005). Comparably, a midwife-assisted low-risk birth costs approximately $4,000.

Tosi Marceline, LM, and C.P.M. of Birthstream Midwifery also stipulated that the $4000 price tag includes prenatal care, labor and delivery (no matter how many hours it takes), postpartum care and follow-up home visits the day after birth, at three days after birth and at a final three week post-delivery check-up. (Phone Interview, 2012). This researcher was unable to locate and determine how much insurance companies are
billing, however, in May of 2009, The Washington Street Journal presented an article on “Tallying the Cost To Bring Home Baby,” in which a mother, Anna Wilde Matthews, speaks of her own financial obligations when it came to delivering her newborn son.

Matthews estimated that the overall charge for her labor and delivery was around $36,625 for a three-day stay in a hospital. Another source estimates costs that range from $6200 for an uncomplicated vaginal birth, while an uncomplicated C-section averages $11,500 (Merrill & Steiner, 2006 as cited in Miller & Shriver, 2012). However, with the lack of support from the medical community and the waning support for hospital transfers for midwife practices, the lack of insurance pay-out, and in some instances “...insurance companies do not fully reimburse providers’ fees for home birth, midwifery practice is quickly falling victim to the insurance companies and policy makers at organizations like the AMA and ACOG (Miller & Shriver, 2012). If women are unable to confidently voice their concerns and desires with those entrusted to provide quality care, the ubiquitous medical model practices will continue to ultimately pit women against themselves as they strive to achieve autonomy with regard to their birth experience.

Conclusion

The notion of a mutual interdependence comes to fruition when we consider midwifery. When the health of women and babies are considered from a client-centered perspective, the cost of delivery should not be at the top of the list of concerns.

Of note, substantial changes and improvements in the maternal health arena in the United States have occurred, however, it is imperative that we look closely at what those
changes are and for each advance or gain, we need to be aware of what is intimated by that change. We need to fully understand the overarching sentiments that new approaches offer and what drives these changes in the end. Where financial gain from insurance companies, hospitals, doctors, and licensing boards are concerned, delving into what motivates resulting practice is imperative.

As changes come to fruition, we must recognize and give credence to historical considerations in order to make to necessary changes that are not only appropriate, but that will lead to more effective care and support for laboring women. The process of change will be considerable if empowerment is to be perceived across all facets of care, whether with a hospital birth, birth center birth or a midwifery-assisted birth. The most comprehensive support of women should become the norm.

By turning over the locus of control in women’s health to women, especially with regard to their birthing process; the decision making process can exist in a client-centered, focused, and collaborative relationship. Kelli Haywood, MAT states that, “[we] must meet women where they are and help them realize the choices present to them in their situation, always encouraging them to communicate their wishes and concerns…” (Haywood, 2011). When we examine the status quo and agree that the incidence to change is tangible, transitioning into a new, more healthy method of care will offer women options with regard to their individual and collective birthing experiences.

The inferred autonomy that these practices generate will lead to women experiencing growth and confidence in their choices and the belief that; as a woman, she can accomplish great things. Coming through the birth process is no small feat and
harnessing the power that delivering a baby takes, women can channel that power; not only into empowerment, but also into drive, motivation to change, success, and possible a wholly different look on life goals and aspirations. A woman owning her own power, recognizing that she is indeed strong and able can have positive effects on the rest of her life.

Empowerment can be juxtaposed to the dynamic of religion in many ways. In the same way some trust and believe in their God, faith or spirituality, women can too learn to believe in their own abilities. By looking at and recognizing birth and its processes, women can begin to see how much they have overcome, changes in their bodies, pain, and recognizing the ability to advocate for themselves and her wishes, and that of their families.

As a woman becomes a mother and prepares for labor and delivery there is a belief in the unknown and an understanding that what is to come could be challenging, and still women take the risks inherent in the childbirth process. In some cases, women have multiple children, which speaks to the endurance that is innate in women. Being able to look to that belief system, like religion, can catapult someone to accomplishments that might not have been contemplated previously. This monumental experience, in some cases, a defining moment in a woman’s life, also requires social supports.

Familial support can play a large part in helping a woman discover her sense of empowerment. While going through the process of ensuring that a woman has the birth that she desires, advocating for self may become an overwhelming task and it is important to consider what birth assistants might be able to step in when a woman walks
through the challenges of giving birth. Whether the support person is a family member, friend, doula or midwife, a woman’s support system can be the difference in fulfilling a dream and in turn, a hope for future aspirations.

Keeping in mind the astronomical costs of labor and delivery in The United States is of utmost importance. In order to afford women the opportunity to realize their power and ability, it is imperative that change occurs not only in the system of care, whether medical or midwifery, but also with socioeconomic discipline and fortitude. Medical care often comes at a premium and can limit and in some cases preclude a woman’s access to good care.

In order for birth to offer a woman a new sense of empowerment or to cultivate a sense of the empowerment that has already been realized does not rely on choosing a midwife to assist or preform a delivery, rather the manner is which care is delivered can make the difference in how a woman perceives her care, birth experience, and life after birth. Regardless of a woman’s choice of birth method, care should not be dependent on the insurance a woman carries or the socioeconomic background from which she heralds.

Giving birth is a miracle of the human body in any setting and acknowledging the work that women diligently perform is something that providers must remain cognizant of. As social workers, we must advocate for women by utilizing a client-center, woman and family focused approach to birth. Women are helping to create and shape the children of the future and they should be supported in this endeavor.

Overall, societal concerns must be taken into account. Pressure must be placed on institutions that serve the women who give birth. As a woman progresses through her
pregnancy we must remember that in most cases, she is not ill nor should she be subservient to an antiquated system of care. Practitioners, social workers, midwives, doulas, family members, and friends must surround a woman while she takes this journey to and through birth, in order to ensure that each woman has an empowered birth.
Chapter 3
METHODOLOGY

Study Objectives

This research study utilized both quantitative and qualitative methodologies, the latter in the form of narratives from the participants. A non-probability convenience sample using a snowball sampling technique was implemented. This chapter includes a discussion of the research design, the research questions, variables of interest, study participants, procedures and the protection of human subjects. This chapter will identify the methods utilized to conduct the study and interpret the data related to this research. The headings in this chapter include the following: Study Design, Sampling Procedures, Data Collection Procedures, Instruments, Data Analysis, and the Protection of Human Subjects.

Study Design

This is an exploratory research study that will examine midwifery in relation to whether midwifery practice and application leads to the empowerment of women through their childbirth experiences. A questionnaire (see appendix) was used to illicit information from women who had previously given birth. The questionnaire was broken into two sections and three subsections. This questionnaire incorporates both quantitative and qualitative questions; these represent the two sections. The first subsection of the questionnaire consisted of several sociodemographic categories that allowed this researcher to identify education level, marital status, household income, and age.
The participants then completed a selection of quantitative questions that included answering questions about their birth experiences using direct and Likert Scale questions. In the third section, the participants were asked to answer seven open-ended qualitative questions in narrative form.

**Sampling Procedures**

A total of 58 respondents completed the questionnaire. A convenience sample utilizing a snowball technique was used in order to collect data. This researcher identified women who were known to have given birth to participate in this study. When contacted, the women were asked to refer women to this researcher in order to be included in this study. This researcher also utilized social media to broaden the search for participants. This researcher, through a social media platform, posted information about this study; informing readers about the process of volunteering to participate in this study. Several women responded to the social media post and volunteered to participate in this study. The women who responded to the social media post in turn reposted this researcher’s request for participants on their social media pages, thereby continuing the snowball sampling process. This resulted in women (who were unknown to this researcher) volunteering to participate in this research study.

**Data Collection Procedures**

Once the participants were identified, the women sent their addresses to this researcher who in turn mailed each woman a questionnaire packet. Each questionnaire packet included a consent form, a questionnaire, and a self-addressed stamped envelope.
A total of 58 women returned a questionnaire to this researcher via the U.S. Postal Service. This researcher did not meet any of the women in person to collect the questionnaires in order to maintain the anonymity of the participants.

**Quantitative questions.** Three quantitative research questions were posed in this study.

1. Do women who have midwifery assisted births feel more heard by their caretakers than women who utilize a medical model professional?

2. Do women who have midwifery assisted births have a greater feeling of empowerment than women who have medical professionals assisting with their birth?

3. What socio-demographic variables account for greater levels of empowerment surrounding the birth experience?

For the quantitative portion of the study, the two dependent variables are the level of empowerment and the extent to which participants felt heard by caregivers; the independent variables are several sociodemographic variables such as marital status, education, household income, age and ethnicity well as use of midwifery vs. medical model birth.

The following discusses how the dependent variables in this study were measured. Level of empowerment was measured by asking participants to answer several questions regarding empowerment in relation to their birth experience using a Likert scale (1 = “strongly agree to 5 = “disagree.” These included items such as ability to advocate for
self during the birthing experience, extent to which belief in self increased after birth, extent to which sense of empowerment increased after the birthing experience, etc. (See Appendix questions 6 through 11.) Items 6 through 11 were summed to obtain a total level of empowerment score.

Feeling heard by caretaker was measured by asking the participants to identify the extent to which they felt heard by their caretakers using a Likert scale (1 = “strongly agree to 5 = “disagree”).

One independent variable was type of provider utilized during their birth experience, i.e., use of midwife or use of medical model professional. Other independent variables included sociodemographic variables such as marital status, education, household income, age and ethnicity. These variables were dichotomously coded as follows: Education (1= less than a BA degree, 2= BA or higher); income (1= less than $60,000, 2= higher than $60,000); age (1= under 30 years, 2 = 30 and older); ethnicity (1= Caucasian, 2 = other ethnicities).

Other descriptive variables examined were; birthing positions participants utilized during their birth experience (questions 6), (on these two questions, the participants could indicate more than one answer); whether they had the option to choose a birth method (midwifery vs. medical model birth); if they considered using a birth method other than the method they actually experienced; and if they utilized a birth plan during their birth experience.

Qualitative questions. The participants were asked to answer seven open-ended qualitative questions in narrative form.
The questions asked the women to define empowerment, to explain what preparation helped them achieve an empowered birth, what options were available, how was they were supported, what would help to create an empowered birth, and what their sense of empowerment was after their birth experience. The women were also provided with a final question that asked for additional observations regarding their birthing experience.

This study used a snowball sampling method. Potential subjects were given information pertaining to the study via in person, social media and word of mouth contact. Those interested in participating in the study contacted this researcher in order to obtain a questionnaire.

**Data Analysis**

After data were collected it was entered and analyzed in SPSS. Statistical analyses used included descriptive statistics to describe the sample of women. Independent t test were conducted in order to answer each of the three research questions.

To answer question 1, a t test was conducted with level of feeling heard by caretakers as the outcome variable and midwifery versus medical model professional as the grouping variable. To answer questions 2, an independent t tests was conducted with level of empowerment as the outcome variable and midwifery versus medical model professional as the grouping variable.

To answer question 3, a series of t tests were conducted with level of empowerment as the outcome variable and various sociodemographics as the grouping variable (each recoded as a dichotomous variable).
Data analysis also included qualitative analyses. Participants’ responses to questions were also entered into SPSS. A content analysis was conducted on participants’ responses to the open ended questions and then examined for common themes. These themes were then entered into SPSS. Further discussion of the themes that emerged in the interviews will be discussed in Chapter 4.

**Protection of Human Subjects**

This researcher pursued this thesis topic by researching the available data and developing a thesis proposal. The work was then submitted to the adviser. Once the adviser approved this study, this researcher submitted an application to the division’s human subjects committee for review.

On December 7, 2012, the Committee for the Protection of Human Subjects approved this research study, qualifying the project “minimal risk.” The human subject’s approval number is: 12-13-049.

After this researcher obtained the approval from the human subjects committee, the process of data collection began. The questionnaire (Appendix) was administered to the participants; it was mailed to women who were willing to be a part of this study, which is evidenced by their willingness to provide this researcher with their home address.

Once identified, this researcher mailed a questionnaire, consent form (Appendix), and a pre-addressed stamped envelope to each woman. The consent form that this researcher provided to the participants for this study addressed the level of confidentiality a prospective participant could expect. It included a section that related to the storage of,
access to and the destruction of any and all information that this researcher collected for
the purpose of this study. The collected materials will be destroyed on May 29, 2013.
The return address was that of this researcher; no address was provided for the
participant, which allowed for anonymity. The questionnaire did not solicit any
identifiable information and the women who participated in this study did so voluntarily.

When this researcher received a completed questionnaire, a sequential number
was placed on the envelope (i.e., 1, 2, 3, 4, etc.). Once the envelopes were opened, each
page of the questionnaire was labeled with the number on the outer envelope in order to
prevent confusion and to maintain the validity of each completed questionnaire.
Chapter 4

FINDINGS AND INTERPRETATIONS

Overall Findings

In this chapter, this researcher presents the overall study findings from both the quantitative and qualitative research.

The research was broken into three sections. First, the quantitative data was analyzed by using the Statistical Package for the Social Sciences (SPSS).

The quantitative data analysis began by analyzing socio-demographic information that was provided by the research participants.

Second, the quantitative analysis continued with an evaluation of the research findings that relate to three specific research questions:

1. Do women who have midwifery assisted births feel more heard by their caretakers than women who utilize a medical model professional?

2. Do women who have midwifery assisted births have a greater feeling of empowerment than women who have medical professionals assisting with their birth?

3. What socio-demographic variables account for greater levels of empowerment surrounding the birth experience?

Finally, once the quantitative analysis was complete, this researcher began analyzing the qualitative data.

Descriptive statistics were used to evaluate the themes obtained from the questionnaire.
The participants answered seven open-ended questions and provided narrative responses. The narratives provided this researcher with valuable information and an opportunity to further analyze themes in the SPSS program by converting the themes into variables of interest.

The variables of interest were evaluated using SPSS. The variables/variables of interest that emerged from the quantitative portion and from the qualitative narratives were: family support, choices, education, and empowerment, birthing options, birth method, medical professionals, and feeling heard by caretakers.

These variables were identified in quantitative data and were also emerged from the qualitative analysis. The findings from all three sections are presented in the form of frequency tables and figures below. In addition, this researcher used quotations from the participants’ narrative responses to support the findings.

Specific Findings

A total of 58 women participated in this research study. Table 1 displays the breakdown of the participants’ sociodemographic makeup.

This researcher found that married women were overrepresented, as evidenced by the fact that approximately 89.7% (N=87.9%) of the women were married whereas 12% (N=7) were not.
Table 1

*Socio-Demographic Characteristics of Participants*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
<td>6.9</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Married</td>
<td>51</td>
<td>87.9</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>22</td>
<td>37.9</td>
</tr>
<tr>
<td>Bachelors Level</td>
<td>16</td>
<td>27.6</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>20</td>
<td>34.5</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under $20,00 - $40,000</td>
<td>8</td>
<td>13.8</td>
</tr>
<tr>
<td>$40,000 - $60,000</td>
<td>10</td>
<td>17.2</td>
</tr>
<tr>
<td>$60,000 - Over $70,000</td>
<td>37</td>
<td>63.8</td>
</tr>
<tr>
<td>Income not recorded</td>
<td>3</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Age at time of Birth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>13</td>
<td>22.4</td>
</tr>
<tr>
<td>26-30</td>
<td>26</td>
<td>44.8</td>
</tr>
<tr>
<td>31-35</td>
<td>17</td>
<td>29.3</td>
</tr>
<tr>
<td>36-40</td>
<td>2</td>
<td>3.4</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
<td>6.9</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Caucasian</td>
<td>32</td>
<td>55.2</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>1.7</td>
</tr>
<tr>
<td>Other</td>
<td>20</td>
<td>34.5</td>
</tr>
</tbody>
</table>

*Sociodemographic Table (N=58)*
When evaluating the income levels of the respondents, this researcher found that there were a large percentage (62.1% (N=36) of women who earned higher than $70,000 annually (Table 1 & Figure 1).

The amount of education (Table 1) the participants reported is relatively varied. Of 58 total participants, 37.9% (N=22) stated that they had some college. 27.6% (N=16) of the women held a Bachelor’s degree and 34.5% (N=20) held advanced degrees.

Next, the age of participants at the time of their birth primarily occurred between the ages of 26-30 years of age where N=26 and represents 44.8% of the study participants, followed by women who had their babies between the ages of 31-35 years of age and make up 29.3% of the women (N=17).

Women who had babies between the ages of 21-25 (N=13) represent 22.4% of this population; considerably fewer women 3.4% (N=2) had babies between the ages of 36-40 years of age. The birth professionals (Table 2) that the women worked with during their birth experience are described in Table 2 below. Of the 58 participants, 41.7% of the women (N=48) utilized an OB/GYN for their birth professional.

Surprisingly, nurses followed OB/GYN’s with regard to contact with birthing professionals. Nurses worked with 35.7% (N=41) of the women in this study. Midwives represented 13% of the women (N=15). Some women reported “other” as a professional choice; these women make up a total of 4.3% (N=5) of the women in this study. Of the 58 participants, 3.4% (N=4) of the women reported working with a doula. Finally, 2 women (1.7%) worked with their family practitioners.
Table 2

*Frequency table of the birth professionals who attended births.*

<table>
<thead>
<tr>
<th>Birth Professionals</th>
<th>Responses (N)</th>
<th>Percent</th>
<th>Percent of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBGYN</td>
<td>48</td>
<td>41.7</td>
<td>82.8</td>
</tr>
<tr>
<td>Family Practitioner</td>
<td>2</td>
<td>1.7</td>
<td>3.4</td>
</tr>
<tr>
<td>Midwife</td>
<td>15</td>
<td>13.0</td>
<td>25.9</td>
</tr>
<tr>
<td>Doula</td>
<td>4</td>
<td>3.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Nurse</td>
<td>41</td>
<td>35.7</td>
<td>70.7</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Total</td>
<td>115</td>
<td>100.0</td>
<td>198.3</td>
</tr>
</tbody>
</table>

*Percentages are greater than 100% since participants could indicate more than one professional.*

During a birthing experience a woman may often work with several medical professionals. As noted in Table 2, participants had the ability to identify multiple professionals who assisted during their birth experience.

**Interpretations of the Findings**

**Quantitative Measures.** Three quantitative research questions were posed in this study:

1. Do women who have midwifery assisted births feel more heard by their caretakers than women who utilize a medical model professional?

2. Do women who have midwifery assisted births have a greater feeling of empowerment than women who have medical professionals assisting with their birth?

3. What socio-demographic variables account for greater levels of empowerment surrounding the birth experience?
In order to answer research question 1, “Do women who have midwifery assisted births (N=13) feel more heard by their caretakers than women who utilize a medical model professional? (N=45),” a t-test was conducted with the level of feeling heard by caretakers as the dependent variable, and use of a midwife and/or medical model professional as the grouping variable.

The data did not indicate a significant relationship between the two groups when considering the level of feeling heard (t = 0.6; p >.05). Thus, there was no significant difference between women who used midwife and women who used a medical model profession with regard to feeling heard by their caretakers. In Figures 1 & 2, the percentages of the responses the women provided are highlighted, with regard to feeling heard by their caretakers.

![Figure 1: Heard By Caretakers - Medical](image)

*Figure 1: Frequency: Medical Model Birth & Feeling Heard by Caretakers*
In order to answer research question 2, “Do women who have midwifery assisted births (N=13) have a greater feeling of empowerment than women who have medical professionals assisting with their birth”, a t-test was conducted with level empowerment as the dependent variable, and educational level as the grouping variable, as presented in Table 3 below.

### Table 3

**Midwifery vs. Medical Model Birth and Level of Empowerment (t test Results)**

<table>
<thead>
<tr>
<th>Birth Professional</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery</td>
<td>45</td>
<td>1.9111</td>
<td>1.08339</td>
<td>t = 0.629</td>
<td>0.532</td>
</tr>
<tr>
<td>Medical Model Birth</td>
<td>13</td>
<td>1.6923</td>
<td>1.18213</td>
<td>t = 0.599</td>
<td>0.557</td>
</tr>
</tbody>
</table>

The results indicate that there is a significant difference between the groups, however, contrary to the hypothesis, the women who choose to work with a medical
model professional reported significantly higher levels of empowerment than women who chose a midwifery-assisted birth ($t = -2.2; \ p = .034$).

**Table 4**

*Level of Education and Level of Empowerment (t test Results)*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>t value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No college degree</td>
<td>22</td>
<td>12.7</td>
<td>4.4</td>
<td>$t = 2.499$</td>
<td>0.015</td>
</tr>
<tr>
<td>BA Degree or higher</td>
<td>35</td>
<td>10.0</td>
<td>3.5</td>
<td>$t = 2.367$</td>
<td>0.023</td>
</tr>
</tbody>
</table>

To answer research question 3, “What socio-demographic variables account for greater levels of empowerment surrounding the birth experience, several t-tests were conducted with level empowerment as the dependent variable, and several sociodemographic variables as the independent variables including education, income, ethnicity, and age at birth. The grouping variables were all dichotomously coded. (See Chapter 3).

No significance between group differences emerged for income, ethnicity or age at birth, interestingly, however, the results indicated a statistically significant difference between the participants who had not yet earned a college degree and those who earned a college degree on their level of empowerment.

Those with no college degree ($N= 22$) reported significantly higher levels of empowerment compared to those who earned a Bachelor’s degree or higher ($N=35$) when ($t = 2.5; \ p = .015$), the data show that educational level did influence the level of empowerment the women in this study perceived with the women who held less education experiencing a greater sense of empowerment.
Qualitative Measures.

The following tables and charts help to further identify specific findings found in the qualitative data. The following section contains the figures and tables that describe responses to the 6 variables of interest that emerged from the qualitative analysis are displayed. In Figure 3 & Tables 5-9, the responses the women provided are highlighted.

By evaluating the number of instances each theme was mentioned; this researcher was able to identify the salient themes. Figure 3 displays the 6 themes, which are identified as “variables of interest.”

The variables of interest were found during the qualitative analysis. The number of times participants mentioned each theme on the questionnaire are noted below.

Figure 3. Variables of interest (themes) identified by the participants
Variables of Interest

The following evaluations specifically address the variables of interest found by analyzing the qualitative data. The women who participated in this study mentioned that choices, empowerment and the pursuit of prenatal education would increase the likelihood of having an empowered birth experience.

Several variables that were identified in the quantitative section of the research were also identified during the qualitative analysis. Because of this mirroring of the variables/variables of interest, this researcher is highlighting both the similarities and the dissimilar nature of key two key variables/variables of interest: choices and empowerment.

Choice and empowerment were both identified in the quantitative section and the qualitative section as important aspects of creating/having an empowered birth. The findings of both variables/variables of interest are recorded below.

Empowerment. When the participants had the opportunity to respond freely to open-ended questions during the qualitative portion of the questionnaire, they mentioned empowerment a total of 90 times.

Of the 58 respondents, 56.9% (N=34) answered that they either agreed or strongly agreed to question #11 (Table 5), “After this birthing experience, my sense of empowerment increased.” Of the 58 participants, there were only 10 women (17.2%) who either disagreed or strongly disagreed to question #11.

While questions about empowerment were answered during the qualitative portion
of the questionnaire, it is important to consider that empowerment was mentioned several times in several sections in the qualitative portion of the questionnaire. Overall, empowerment was mentioned in each of the seven qualitative questions.

**Table 5**

*Level of empowerment increased after birth (question #11)*

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>20</td>
<td>34.5</td>
<td>34.5</td>
<td>34.5</td>
</tr>
<tr>
<td>Agree</td>
<td>14</td>
<td>24.1</td>
<td>24.1</td>
<td>58.6</td>
</tr>
<tr>
<td>Neutral</td>
<td>14</td>
<td>24.1</td>
<td>24.1</td>
<td>82.8</td>
</tr>
<tr>
<td>Disagree</td>
<td>6</td>
<td>10.3</td>
<td>10.3</td>
<td>93.1</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>4</td>
<td>6.9</td>
<td>6.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

By asking each woman what her definition of empowerment was, this researcher was better able to categorize the themes that originated from the seven qualitative questions. One woman described empowerment as follows:

“I define empowerment as having broad choices and a supportive environment in which will allow you to make choices which are in your best interest. A second part of empowerment is to have supportive trust so that your wishes are valued by those you care about most.”

Of the 58 participants, 44.8% of the participants (N=26) also mentioned empowerment without being prompted to do so (Table 6). Another important occurrence to consider is the fact that many of the women related having had a prior birth
experience. Depending on the first experience, some women stated that due to a less empowered experience, they sought out more additional information/education than they did in preparation for their first birth experience.

Women who stated they had an empowered first birth (or those who felt that the experience was positive) tended to perform less research prior to their second birth; rather, they attempted to recreate the first birth experience.

**Table 6**

*Empowerment (theme) identified by the participants on the questionnaire*

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td>44.8</td>
<td>44.8</td>
<td>44.8</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>55.2</td>
<td>55.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Another important occurrence to consider is the fact that many of the women related having had a prior birth experience. Depending on the first experience, some women stated that due to a less empowered experience, they sought out more additional information/education than they did in preparation for their first birth experience. Those women who had an empowered birth or those who felt that the experience was positive performed less research and simply attempted to recreate the experience they had during their first birth.

One of the questions the women were asked to answer utilized a Likert scale. The participants were asked whether their level of empowerment increased after their birth experience. Of the 58 participants, 58.6% (N=34) agreed or strongly agreed that their
level of empowerment in fact increased after their birth experience, whereas 24.1% (N=14) of women reported that they were neutral when considering whether their level of empowerment increased after their birth experience (Table 5). The smallest percentage of women 17.247% (N=10) either disagreed or strongly disagreed when considering whether their level of empowerment increased. The following quote is representative of the overall impressions the participants offered, “After I had my son in hospital, without any intervention, I felt like Superwoman… like I could conquer anything. It’s difficult to find another word other than empowered, because that’s exactly how I felt.”

**Choices/Options.** Amongst the women who participated in this research study having choices with regard to their birthing experience was often identified. Surprisingly, more often than not, the women who participated in this study didn’t always have choices during their birth experience.

Of the 58 participants, 46.6% (N=27) reported that they had choices, whereas 53.4% (N=31) of women did not (Table 7). One of the participants stated, “[having] all information available to you on what options you have. That way you can make the best decision.”

**Table 7**

*Frequency table: Participants mentioned choice/options*

<table>
<thead>
<tr>
<th>Choice</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>27</td>
<td>46.6</td>
<td>46.6</td>
<td>46.6</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>53.4</td>
<td>53.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
During the analysis of the identified themes, family support was often referred to on multiple questions (Questionnaire #12-18). Several of the participants stated support was an important aspect of empowerment; the people identified as family support/support persons were spouses, partners, family members, and friends.

Table 8

Frequency table of family support identified in the qualitative data

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>47</td>
<td>81.0</td>
<td>81.0</td>
<td>81.0</td>
</tr>
<tr>
<td>No</td>
<td>11</td>
<td>19.0</td>
<td>19.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Prenatal Education. Of the 58 women who participated in this research study, 56.9% (N=33) of women had similar thoughts that one woman shared, she stated that “being well informed would increase the likelihood of a positive birth experience and it (prenatal education) would inevitably lead to a sense of increased empowerment.”

The consensus from the participants collective responses is that with an increased awareness of what is available; through prenatal education, a woman will be better prepared, one participant surmised, “I felt knowing what to expect empowered me more and made me feel comfortable.” By incorporating prenatal education, an empowered birth may ensue. One woman stated, “childbirth classes [helped] explain what to expect.”

Support. Of the 58 participants 4 women said that they worked with a Doula (see Table 2), or a Midwife (N=15; see Table 2). One statement was representative of several
participants’ responses; this participant stated the following:

Having someone there with experience in natural childbirth who could assure a woman has all the information to truly provide informed consent; someone with experience and the wherewithal to question a test result [or] ask for a re-test, etc., would help create an empowered birthing experience. (Study Participant)

**Power.** Power was mentioned 110 times in the qualitative section. This was often attributed to feeling that their bodies were powerful, having the power to control their birth experience and having the power to overcome their fears. A participant reported, “I felt empowered after [giving] birth because you invest power into your child to survive.”

**Ability to make decisions.** This variable of interest was mentioned 98 times during the analysis of the participants’ narratives. Many of the participants held similar beliefs about decision-making, in that they did not want to feel pressured into any choice. One woman’s narrative speaks to what the women reported overall, “Being able to make decisions for myself and not feel guilty, pressured or discouraged about my choices.”

**Table 9**

*Prenatal education (theme) identified in the qualitative section*

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>33</td>
<td>56.9</td>
<td>56.9</td>
<td>56.9</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>43.1</td>
<td>43.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Summary

This study examined the connections between midwifery and medical model birth. This sentence is not specific enough. This study examined perceived levels of empowerment of women’s experience with birthing. More specifically, it examined whether there were significant differences between those who had a midwifery experience and those who used medical model professionals. In addition, the qualitative portion of the study examined what women felt contributed to their feelings of empowerment during their experience of giving birth.

Contrary to the hypothesis that a midwifery experience would result in greater feeling of empowerment, findings indicated that those who choose a medical model birthing experience reported greater feelings of empowerment. This finding will be discussed more in Chapter 5. However, based on the descriptive statistics and the qualitative data; the findings support the thesis in that women can be empowered through their birth experience.

Women invariably stated that having choices helped to make their births empowered. In addition, the participants identified having a “the ability to make decisions” as central to the foundation of ensuring an increase in the sense of empowerment as it relates to birth experiences.
Chapter 5

CONCLUSION, SUMMARY, AND RECOMMENDATIONS

This researcher analyzed the responses of women who were invited to record their answers to a detailed question regarding their birth experiences. Sociodemographic information was collected and evaluated using SPSS. This researcher was able to capture key pieces of data that provided a fresh perspective on the process of creating an empowered birth experience through their births. This researcher set out to determine whether or not women who utilized a midwife for their birth in turn had a higher level of empowerment than those women who opted medical model birth.

The amount of research available on the study of women, their birthing choices and the findings are limited as is research on utilizing birth as a point from which to empower women. The lack of research on this particular population is significant because the benefit to the lives of women is tangible. With further research on midwifery, birth, and the empowerment of women through birth, social workers will be able to aid women in cultivating an empowered birth. Women are faced with many options once their pregnancies are confirmed and disseminating the information can be challenging, particularly when the perspectives of professional caregivers are appreciated.

Based on a given professionals (midwifery or medical model) bias or belief system of what the right birth method is, women may or may not be provided with all of the options available to them, which can lead to an experience that is not empowered.
The questions this researcher posed via a questionnaire, asked women to recall their birth experiences and evaluate whether their birth was empowered. Additional research is needed in order to further develop the empowerment variables that are identified here.

Chapter 2 provided several themes to pursue. After completing extensive research of the available literature, this researcher focused on understanding the historical implications of midwifery in order to garner an understanding of how midwifery practices differ from medical model birth practices. Another theme that emerged was empowerment; of course this theme is a part of the whole in that this theme is at the crux of this study.

This researcher found that in discussing empowerment; empowerment appeared in several instances throughout this study. Empowerment was identified within several quantitative questions, as this research was performed in order to gain a better understanding of how empowerment through birth can be achieved. What is interesting is that empowerment was mentioned 90 times amongst the 58 participant questionnaires. The women had varied statements in their qualitative responses. One woman explained empowerment in a manner that summarizes what the women had to say in the qualitative section of the questionnaire; she wrote:

“[Empowerment] is having the right to make your own choices regarding your body and the way that you would like to have/deliver you baby. Although my birth plan did not go “according to plan,” I still felt empowered during the experience because I was always involved in each decision that was being made. Also, because my birth experience was so difficult and traumatic, I felt
empowered afterward because I realized that I am even stronger and tougher than I ever could have imagined”

Of note, the identified themes produced in Chapter 2, were also identified secondarily during the evaluation of the qualitative data. Following empowerment, this researcher determined that autonomy was an important theme to pursue as the research suggests that when women have a voice in their birth process, the potential for women to feel empowered increases. This was evident when evaluating what/if a woman was able to have/make choices in relation to her birth. The research and the qualitative data in this study supports the evidence found in the literature review.

Spirituality was also prevalent in the research findings, however; the women in this study did not mention spirituality in regard to their birth experience accounts. The literature spoke to support as an important factor in the development of an empowered birth, which is evident in the outcomes of this study. In some ways, women could consider faith or spirituality a sense of support, and therefore did not specifically name spirituality as a factor. The factors considered in determining a woman’s access to, an empowered birth, a midwife, and access to literature on available options were considered in determining the level of empowerment that these women perceived from their birth experiences; therefore, the socioeconomic status of the women who participated in this study was analyzed.

What became clear through analysis is that women often talked about wanting the opportunity to make choices, to have support, and to decide what happened to their bodies throughout the delivery process. Women also related feeling a sense of belief in
themselves, a desire to learn more about natural child birth, and they often reported completing research or taking classes in preparation of their birth.

It is apparent that a sense of comfort offered by the medical model is high; the availability of emergency medical attention outweighs the concern many women hold and instead creates a sense of comfort and assuredness for women who are birthing their babies. Another consideration is that due to limited information, a lack of insurance, or hearing that other women birthed their babies in the hospital setting, may have influenced a woman’s proclivity toward the hospital setting. The resulting data showed that of 58 participants, 41.7% (N=48) of the women in this study opted for the medical model birth professional (see Table 2) when it came time to deliver their babies. While the women choose to labor in hospital, they did bring midwifery practices and tools to aid them in their journey, several women wrote birth plans while some women mentioned seeking prenatal education or the services of a doula in preparation for their birth experience, they also evaluated birthing techniques used by the women they knew. For the women who utilized available resources to increase the likelihood of a natural birth, the women reported that their “belief in self” increased after their birth experience.

Summary of Study

Through the investigation of social and economic implications, this researcher aimed this study at determining whether the choice of a particular professional (i.e., a midwife vs. a medical model practitioner) would affect the level of empowerment a woman perceived at the conclusion of her birth experience.

In order to understand the relationships and in order to determine whether a
correlation was present, this researcher asked women to provide both quantitative and qualitative information, which was broken down into two sections. By gathering demographic information and asking the women to completion several Likert Scale questions this researcher was able to analyze the data using SPSS.

This researcher was able to use descriptive statistics to run frequency distribution and t tests to evaluate the data; direct quotes from the questionnaire were also used to support the findings. The qualitative portion of the survey was broken into three qualitative questions.

The questions posed to these women were meant to evaluate several aspects of empowerment, which included the following: 1) what was the participants definition of empowerment, 2) what preparation did the participant make prior to her birth experience, 3) what options were available to these her prior to and during birth, 4) what type of support did the participant perceive during their birth experience, 5) what would help create an empowered birth, 6) what was their sense of empowerment after their birth experience, and 7) they were asked to add any additional thoughts they had regarding empowerment and their birth experience .

Because no standard exists that can offer a manner in which to measure the level of empowerment women gain through their birth experience, this research asked women to specify aspects of their birth experiences in order to ascertain what themes were common amongst this small sample of 58 women. By assigning variables to the themes that emerged from the qualitative data, this researcher was able to evaluate the resulting variables of interest. By comparing the variables of interest to the quantitative data, this
researcher was able to discern if there were any correlations (relationships) to either the level of education, income, ethnic background, age or choice of professional that led to an empowered birth. This researcher was also able to use descriptive statistics to identify which themes were prevalent amongst the 58 participants.

This study addressed the nature of the environments that would increase the level of a woman’s empowerment during her birth experience. Originally, this researcher held that by looking at midwifery on social and economic levels, answers would readily show that midwifery is a valuable vehicle for women who are birthing babies. Surprisingly, what the research showed is that the women who didn’t hold a college degree (N=22) felt more empowered (p<.05; p = 0.015) than women who achieved a bachelor’s degree or higher (N=35; p<.05 (p = 0.023), while the number of participants that mentioned natural birth showed no statistical relationship. Interestingly, some of the participants, answered early quantitative questions about their birth choices without regard to their level of empowerment; specifically questions 8-10 asked the women to respond to Likert scales in order to assess how the women perceived their belief in self, if their belief in self increased after this birth experience, whether or not they felt empowered prior to this birth experience, and if their sense of empowerment increase after this birth experience.

The answers provided were drastically different than the responses the women provided in the qualitative section. When the women had the opportunity to respond freely to open-ended qualitative questions, their answers spoke more directly to their perception of empowerment.
Implications for Social Work

The data shows that there are several methods that may work for women who are attempting to navigate the path of their birth experience, for each woman the method will likely change. The outcomes from this study are in alignment with many aspects of the social work profession.

By incorporating the empowerment variables when caring for women who are pregnant, a social worker may support a woman on her path to an empowered birth. Social workers should meet a woman where she is. By approaching a woman without an agenda, her perception of autonomy is greater than if the beliefs of a given practitioner or regulations of a hospital are imposed on her. Scope of practice is another factor to consider when working with this population.

According to the NASW Code of Ethics, social workers have the duty to enhance the well-being of vulnerable populations. In this vain, women who are seeking an empowered birth makeup the vulnerable population and need to be provided care accordingly.

In our work as social workers, we commit to working with vulnerable populations without inflicting harm. With this consideration in mind, helping a woman reach an empowered birth is a positive outcome of the work a woman may do with the help of her social worker; however, failing to do so can potentially create a scenario that does not allow for a woman to reach an empowered birth. The latter is what social workers must remain cognizant of so that no harm comes to women who embark on this journey toward empowerment.
This population will require no less than a woman-centered approach in order to achieve an empowered birth.

**Recommendations**

Because this study utilized a snowball sample, this researcher is precluded from relating the findings of this study to the overall population of women who give birth. This study offers the next researcher a place from which to begin further research, and the analysis in the future will be able to focus on specific areas of interest. In addition, by referring to this study, the research that follows on women and birth should include case studies, the inclusion of birthing/midwifery/medical professionals’ perspectives, and the method of delivery a woman ultimately utilized during her birth.

These additional considerations will allow researchers the opportunity to garner important information as it pertains to women, empowered births, their babies, families, friends and the social workers that come into their lives during the pursuit of obtaining an empowered birth.

**Limitations**

Due to the utilization of convenience sampling, the small sample size, the limits of this researchers budget and the timeframe with which this researcher had to complete this research project; this research is limited to interpreting the outcomes as they relate to the 58 women included in this study. The hope of this researcher was to survey two populations of women, women who experienced midwifery birth and women who encountered a hospital setting for their birth experience. However, it became apparent
that in order to obtain enough participants for this study, the utilization of a snowball sample was necessary. Due to this decision, a majority of the participants in this study reported that they were married, Caucasian, had achieved an advanced degree and earned above $70,000 per year.

The outcome of the snowball sample meant that this researcher was limited in the ability to compare differing socioeconomic backgrounds, education levels and the effect of these variables on a woman’s level of empowerment. In addition, this researcher realized that several key questions were on the questionnaire, they include the following:
1) What interventions were encountered by the participants? 2) What was the specific age of each woman? And finally, the collected data did not produce enough samples of women who had a medical model and/or midwifery model birth experience so that this research could relate to the general population of women.

**Conclusion**

Through the evaluation of the data, this researcher concludes that all women, regardless of the model/method of birth they choose to pursue, can and should have an empowered birth outcome. What we must do is remember that this birth experience has a “trickle-out” effect and empowered women have the potential to make positive changes in their lives and in the lives of others simply by harnessing the sense of empowerment perceived during their birth experiences.

Amongst all of the 58 participants qualitative responses, one statement quantifies this sentiment well, a woman who participated in this study asserted, “I was so empowered after giving birth that I trained for and ran a ½ marathon.” This evidences
the impetus for this research; a woman can achieve an increased sense of empowerment through her birth experience. It is up to care providers (i.e., medical professionals, midwives, and social workers) to ensure that each woman, regardless of her birth choice, has the information and opportunity to attain empowerment through her birth process.
Appendix A
Human Subjects Protocol Application

Request for Review by the Sacramento State Institutional Review Board (IRB)
(Revised 4/2012)

Check only one: New Protocol X

Resubmission____
Continuing Review____

Name of Researcher(s)
Lenaea Sanders Woodworth

Faculty___ Student X
Staff___ Doctoral Candidate ___

Project Title:
The Economic and Social Implications of Midwifery:
Empowering Women Through Birth

Department: Social Work
College: Health and Human Services

Name(s) and affiliation(s) of Researchers:
Lenaea Sanders Woodworth, MSW Student

Funding Agency (if any): N/A

Mailing address:
2633 Fulton Avenue, #19, Sacramento, CA, 95821

(XXX) XXX-XXXX December 12, 2012
Telephone and e-mail address for researcher Anticipated starting date

Dr. Jude Antonyappan judea@saclink.csus.edu
Name of faculty sponsor (for student research) E-mail address of sponsor
1. Summarize the study’s purpose, design, procedures, data analysis plan, and the methods for ensuring the security of the data obtained, including security measures, data handling, retention, data destruction date, and who has access to the data. (Do not attach lengthy grant proposals. Be brief but complete.)

**Purpose:**

This study will address the social and economic implications of midwifery in relation to how midwifery practice and application can lead to the empowerment of women through their childbirth experiences.

**Design:**

This is a descriptive quantitative design that uses a survey method of data collection with non-probability snowball sampling. Themes from the questionnaire will be identified and evidence gathered will speak to the relationship of a woman’s birth choice and the possibility of the empowerment of women who decide to opt for a midwife-assisted birth.

Because this study uses a snowball sampling method, potential subjects will be given information pertaining to the study via flyers. Those interested in participating in the study will contact the researcher to obtain a questionnaire.

**Procedures:**

This researcher will distribute information about this study, including flyers to the potential participants. Those who are interested will contact this researcher and this researcher will provide the participant with the consent form, which explains the benefits and risks associated with this study. A questionnaire and a stamped, postage-paid return envelope will also be provided.

**Data Analysis Plan:**

Data will be analyzed by entering quantitative data into an SPSS program. Potential associations and relationships between variables of interest will be calculated. This researcher will look for and identify themes that result from the questionnaire provided to the women. Once these themes have been identified and categorized; the analysis of the resulting data will be pursued, evaluated and incorporated into the thesis study.

**Security:**

Data collected throughout this study will be kept in a locked file cabinet. The file cabinet will be kept at xxxx xxxxxxx xxx, Sacramento, CA 95821. The collected
materials will be destroyed on May 29, 2013. The questionnaire and the findings of this study are confidential. The study contains no identifying information and all records will be available only to the principal investigator; Lenaea Sanders Woodworth (Researcher) and Dr. Jude Antonyappan (Advisor).

2. Who will participate in this research as subjects (e.g., how many people, from where will you recruit them, using what criteria for inclusion or exclusion)? How will you engage their participation (e.g., what inducements, if any, will be offered)? How will you avoid any conflict of interest as a researcher?

Approximately 30 participants in the area will be asked to complete a questionnaire regarding the socioeconomic implications of midwifery and the level of empowerment of women through birth. The questionnaire will generally take about 20 minutes to complete. There will be no inducements offered for participating in this study, therefore, there is no conflict of interest.

The participants of this study will be limited to women who have given birth. The participants in this study will be recruited through snowball sampling in Northern California. Only those women twenty-one years of age and above that have given birth will participate in the study. Flyers advertising the study would be placed on bulletin board meant for the public.

3. How will informed consent be obtained from the subjects? Attach a copy of the consent form you will use. If a signed written consent will not be obtained, explain what you will do instead and why. (See Appendix C in Guidance and Procedures for examples of consent forms, an example of an assent form for children, and a list of consent form requirements. Also see the section on Informed Consent in Guidance and Procedures.)

The consent form that this researcher will provide to the participants of this study will address the level of confidentiality a prospective participant can expect, and it will include a section that relates to the storage of, access to and the destruction of any and all information that this researcher collects for the purpose of this study. (Please see attached consent form)

4. How will the subjects’ rights to privacy and safety be protected? (See the section on Level of Risk in Guidance and Procedures. For online surveys, also answer the checklist questions at the end of Appendix B in Guidance and Procedures.)

There is no identifying information such as name, phone number, address, etc., that will be collected via the questionnaire, that might link the questionnaire to the participant. The completed questionnaires collected throughout this study will be kept in a locked file cabinet. The file cabinet will be kept at xxxx xxxxxxx xxx, Sacramento, CA 95821. The collected materials will be destroyed on May 29, 2013.
5. Describe the content of any tests, questionnaires, interviews, surveys or other instruments utilized in the research. Attach copies of the questions. What risk of discomfort or harm, if any, is involved in their use?

The questionnaire will only be provided to those subjects who voluntarily express interest in participating in the study. There is no risk of harm or discomfort because all questions are worded specifically to avoid harm. (Please see attached questionnaire)

6. Describe any physical procedures in the research. What risk of discomfort or harm, if any, is involved in their use? (The IRB will seek review and recommendation from a qualified medical professional for any medical procedures.)

N/A

7. Describe any equipment or instruments that will be used in the research. What risk of discomfort or harm, if any, is involved in their use?

N/A

8. Will any drugs or pharmaceuticals be used in the research? If so, describe their use and any possible risk or discomfort. (The IRB will seek review and recommendation from a qualified medical professional for the use of any drugs or pharmaceuticals.)

N/A

9. Taking all aspects of this research into consideration, do you consider the study to be “exempt”, “minimal risk” or “greater than minimal risk”? Explain your reasoning based on the information you have provided in this protocol. (See the section on Level of Risk in Guidance and Procedures.)

Although this study pertains to the method of birth choice women made, this study is devoid of opportunities that will produce strong emotive content; therefore the level of discomfort is minimal; specifically because the questions on the questionnaire are worded in such a way as to avoid any possible strong emotional reactions.

The study is considered as exempt according to 45 CFR 46.101 (b)(2) exemption from 45 CFR part 46 requirements due to the following reasons:

The information obtained and recorded from the survey is done in such a manner that it cannot be identified either directly or through identifiers that are linked to the subjects. There is no signature required on the consent forms and information is gathered via surveys from the voluntarily consenting adult participants. Any disclosure of the human subjects' responses outside the research
does not reasonably place the subjects at risk of criminal or civil liability or be
damaging to the subjects' financial standing, reputation or employability.
Additionally disclosure of the information sought such as preferred birthing
procedures are optional and anonymous. However, if the committee feels that this is
minimal risk the researcher will accept that the risk is not greater than minimal.

For protocols approved as “greater than minimal risk,” the researcher is required to file
semiannual reports with the committee that describe the recruiting of subjects, progress
on the research, interactions with the sponsor, and any adverse occurrences or changes in
approved procedures. In addition, the committee reserves the right to monitor “greater
than minimal risk” research, as it deems appropriate. Failure to file the required progress
reports may result in suspension of approval for the research.

__________________________________________________________  ______________
Signature of Researcher  Date

__________________________________________________________  ______________
Signature of Faculty Sponsor  Date
(for student research)

Signature of your department or division chair confirms that he or she has had an
opportunity to see your human subject’s application.

__________________________________________________________  ______________
Signature of Department/Division Chair  Date
To: Lenaea Sanders-Woodworth    Date: 12/7/2012
From: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “The Economic and Social Implications of Midwifery: Empowering Women Through Birth.”

__X__ approved as __EXEMPT ___X__ MINIMAL RISK

Your human subjects approval number is: 12-13-049. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Maria Dinis, Jude Antonyappan, Teiahsha Bankhead, Serge Lee, Kisun Nam, Maura O’Keefe, Dale Russell, Francis Yuen

Cc: Antonyappan
Appendix C

Informed Consent to Participate in a Study on:

The Economic and Social Implications of Midwifery:
Empowering Women Through Birth

**Please do not include any identifying information**

This study is conducted by Lenaea Sanders Woodworth, who is a graduate student in the Social Work Department at California State University, Sacramento. This study aims to find out how social and economic implications affect birth choice and the level of empowerment that women can achieve through birth. I have been requested to take part in this study because I can provide information on one or more of the following:

A unique perspective of personal experience as it relates to the birth process.
My level of empowerment obtained through birth.
The determination to utilize either midwifery or medical birth models.
Opinions on how empowerment might be achieved through the birth process.

The questionnaire and the findings of this study are confidential. The study contains no identifying information and all records will be available only to the principal investigators, Lenaea Sanders Woodworth (Researcher) and Dr. Jude Antonyappan (Advisor).

At the completion of the study all information will be destroyed and only the compiled content of the questionnaire will be kept. My answers will be strictly confidential and any reports or other published data based on this study will appear only in the form of summary statistics or a condensed account of the themes gathered through qualitative data collection. The completed questionnaire collected for the purpose of this study will be destroyed on: **May 29, 2013.**
I will be one of about 30 participants who will be asked to complete a questionnaire regarding the socioeconomic implications of midwifery or medical model birth choice and the level of empowerment of women through birth. I will be asked what some people consider to be sensitive questions about my birth experience. The questionnaire may generally take about 20 minutes to complete.

My role in this study is voluntary and I am under no obligation to participate. When I agree to participate, I can skip any questions that I'd rather not answer. I am also free to stop completing the questionnaire or not return it at any time.

I agree that having read the details provided in this consent form, and by completing and returning the questionnaire, I provide implied consent, which is also evidenced by voluntarily participating in this study.

There are no risks expected as the researcher is providing a questionnaire that contains no identifying information, which ensures that my dignity and privacy are protected. I have the right not to answer any question that I do not want to answer.

If I have any questions about the study, I can contact the researcher at:

California State University, Department of Social Work  
Attention: Lenaea Sanders Woodworth, MSWII  
6000 J Street, Sacramento, CA 95819  
(XXX) XXX-XXXX  
lsanders18@gmail.com

If I have questions or concerns I may also contact the research advisor for assistance.

Dr. Jude Antonyappan (Thesis Advisor)  
California State University, Sacramento  
Department of Social Work, Mariposa 5023  
(916) 278-7171  
judea@saclink.csus.edu
Appendix D

Study Questionnaire

The Economic and Social Implications of Midwifery:
Empowering Women Through Birth

***Please share only what you feel comfortable disclosing***

Thank you for taking the time to participate in this study.
### General Information

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Education:</th>
<th>Household Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Married</td>
<td>b. Some College</td>
<td>b. $20,000 - $30,000</td>
</tr>
<tr>
<td>c. Single</td>
<td>c. Bachelors Degree</td>
<td>c. $30,000 - $40,000</td>
</tr>
<tr>
<td>d. Separated</td>
<td>d. Master’s Degree</td>
<td>d. $40,000 - $50,000</td>
</tr>
<tr>
<td>e. Divorced</td>
<td>e. Doctoral degree</td>
<td>e. $50,000 - $60,000</td>
</tr>
<tr>
<td>f. Widowed</td>
<td>f. Professional Degree</td>
<td>f. $60,000 - $70,000</td>
</tr>
<tr>
<td>g. Other:_________</td>
<td>g. Other:_________</td>
<td>g. Higher than $70,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthing Method:</th>
<th>Age at time of birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Midwifery – Home</td>
<td>a. 21-25</td>
</tr>
<tr>
<td>b. Midwifery - Birthing Center</td>
<td>a. 26-30</td>
</tr>
<tr>
<td>c. Midwifery - Hospital</td>
<td>b. 31-35</td>
</tr>
<tr>
<td>d. Hospital - Not assisted by a midwife</td>
<td>c. 36-40</td>
</tr>
<tr>
<td>e. Other:_________</td>
<td>d. Over 40</td>
</tr>
</tbody>
</table>

### Race/Ethnicity:

1. Did you have the *option* to choose a birth method?
   a. Yes
   b. No

2. Did you *consider* a birthing method other than the one you experienced?
   a. Yes
   b. No

3. Did you utilize a birth plan for this birth experience?
   a. Yes
   b. No
4. Which medical professionals assisted you during your birth experience?  
(Please circle all that apply.)  
a. OB/GYN  
b. Family Practitioner  
c. Midwife  
d. Doula  
e. Nurse  
f. Other: ____________________________________________________________

5. During my birthing experience, in general, I felt heard by my caretakers:  
(Answer A or B)  

<table>
<thead>
<tr>
<th>A) Medical Birth</th>
<th>B) Midwifery Assisted Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Strongly Agree</td>
<td>a. Strongly Agree</td>
</tr>
<tr>
<td>b. Agree</td>
<td>b. Agree</td>
</tr>
<tr>
<td>c. Neutral</td>
<td>c. Neutral</td>
</tr>
<tr>
<td>d. Strongly Disagree</td>
<td>d. Strongly Disagree</td>
</tr>
<tr>
<td>e. Disagree</td>
<td>e. Disagree</td>
</tr>
</tbody>
</table>

6. Were you able to change into different birthing positions?  
(Please circle positions used.)  
a. Standing  
b. Sitting  
c. Kneeling forward with support on chair seat, birthing ball or head of bed  
d. Standing leaning  
e. Semi-sitting  
f. Squatting  
g. Side lying  
h. Slow dancing/walking  
i. Sitting leaning forward  
j. Hands and knees  
k. Dangle/support squat
7. Were you able to advocate for yourself during this birth experience?
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Strongly Disagree
   e. Disagree

8. I believe in myself.
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Strongly Disagree
   e. Disagree

9. My belief in myself increased after this birth experience.
   a. Strongly agree
   b. Agree
   c. Neutral
   d. Strongly Disagree
   e. Disagree

10. I felt empowered prior to this birth experience.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Strongly Disagree
    e. Disagree

11. After this birthing experience, my sense of empowerment increased.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Strongly Disagree
    e. Disagree

12. How do you define empowerment?

________________________________________________________________________
________________________________________________________________________
13. What were the preparatory processes that helped to make this an empowering experience?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

14. What birth options were available to you for this birth experience?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
15. How were you supported during this birth experience?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

16. What would help create an empowered birthing experience?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
17. What has been your sense of empowerment after your birth experience?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

18. Please describe any additional observations you have about your birthing experience.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
References


Miller, A.C., Shriver, T. (2012). Women’s childbirth preferences and practices in the United States, *Social Science Medicine*, 75(4), 709-716. ISSN 0277-9536, 10.1016/j.socscimed.2012.03.051


