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THE HOME VBAC (VAGINAL BIRTH AFTER CESAREAN) EXPERIENCE

by

KATHRYN ANN GRAFF

A THESIS SUBMITTED TO

THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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Abstract

This study investigates what it means to experience a vaginal home birth after having had a cesarean section. This exploration is hermeneutical in nature, and is written from a feminist perspective. Four women who had experienced a vaginal home birth after having had a cesarean section participated in hermeneutical conversations with the author. These dialogues yielded three distinct conversational topics which were analyzed for themes common across participants, as well themes unique to particular individuals. The conversational topic of "The Original Experience" yielded the following themes: control issues, lack of support, feeling silenced, and depression. The second conversational topic, termed "The Struggle," yielded the themes of confusion, determination/doubt, and choosing silence/finding voice. The last topic, "The Home VBAC Experience," is explored in terms of many themes contributing to form a gestalt. The themes and the research process are discussed in terms of the validity and usefulness of the knowledge gained from this exploration and the process of doing it, to birthing women, families, the medical establishment, and society as a whole.

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I. INTRODUCTION

A. Conception

> The work of birth is ancient . . . passing from generation to generation of women throughout human history. The knowledge and wisdom of birth is woman's heritage . . . The way of birth is universal, weaving an ancient tapestry rich in variety and individuality. Every woman giving birth, each child being born, gives texture and detail to the whole design (Hartigan, 1984, p. 2,3).

This study is undertaken as an exploration of the ancient tapestry created by women through their experience of pregnancy and birthing. Its origins lie in my own experiences with birthing. The profound, personal transformations which have evolved from these experiences are not only the result of becoming a mother and experiencing the wonder, joy, and heartache intrinsic to that role. The transformation, as well, is significantly related to how the experience of pregnancy and birthing has effected my perception of myself as a woman, and my view of women as a whole. This, in turn, has resulted in an ever deepening sense of the marginalization of women within our culture, and a strong conviction about the importance of listening for and hearing women's voices.

My personal journey into the arena of pregnancy and birthing began over nine years ago. At that time, I underwent what was termed

"emergency surgery"--a cesarean section to deliver my eight pound son. After twelve hours of labor, I was diagnosed as having "cephlo-pelvic disproportion," a condition in which the fetal head is thought to be too large to pass through its mother's pelvis, and I was told that all my future births would take place by cesarean section.

This event changed my perception of "me as woman" in fundamental ways. I felt devastated by the fact that pregnancy and labor, instead of climaxing in the pure and natural birth of a baby, had ended in major abdominal surgery. I felt that I had, for the first time in my life, "failed" at reaching a major goal. Even though I had exercised daily, eaten nutritiously, read voraciously, and studiously practiced my Lamaze breathing, my labor had unexpectedly terminated in a cesarean section. In my perception, I had failed at something fundamentally feminine in nature--I had not been able to give birth as women's bodies are designed to do.

The year after my first son's birth was filled with feelings of confusion and ambiguity. I was surprised at the depth and extent to which I felt anger and grief about the cesarean section. Mixed feelings surfaced--anger towards the medical profession which I felt had intervened too quickly, guilt and shame over "failing" my husband, baby, and myself, grief about missing out on a uniquely female event, and

physical pain and exhaustion. This was indeed, a very depressing time for me as a woman, while conversely, it was a joyful time for my husband and I, as we grew fervently attached to our new son.

Thankfully, these feelings of grief and guilt became an impetus for action. I began to read book after book on the physiological, social, and psychological aspects of pregnancy and birthing in an effort to understand "what went wrong" the first time and if it would be possible to avoid the same in future pregnancies. I was surprised and greatly relieved to discover that my feelings were not unique. I joined the Vaginal Birth After Cesarean (VBAC) Support Group, and there spoke with many women, each of whom had been devastated by her experience of cesarean section, and who desired VBAC for future births. I also discovered that most women, after having one cesarean, deliver all subsequent babies by cesarean section. Though research evidence had shown VBAC to be a safer and more desirable alternative than repeat elective cesarean section, it was not widely accepted by the medical community or the public. Political activism thus began to take hold, as I joined a community of women to lobby the government and other health care professionals for wider acceptance of VBAC.

As my second pregnancy began to make itself evident during the winter of 1988-1989, and I began to actively search for medical support

for my own much desired VBAC, I began to realize how difficult the task of rallying this support would be. My desire for a VBAC seemed to be viewed by the doctors I interviewed and, indeed, by people in general, as frivolous. After all, didn't my last pregnancy culminate in the birth of a "healthy" child? Was that not all that mattered? In fact, wasn't I lucky if I could avoid the throes of labor by booking in for a repeat section? I was told by one doctor that some women "even become obsessed" in their desire for a VBAC, the clear connotation being that such a desire was fanatical. My desire, as a woman, to take responsibility for my child's birth, and make informed choices regarding the mode of its delivery was seen as radical and selfish. I became acutely and painfully aware of how difficult it was to question the wisdom and authority of the traditional medical establishment.

In desperation, I turned for support to a small group of midwives in private practice who actively supported VBAC and who encouraged family centered, holistic care, with women taking responsibility for their choices regarding the mode and place of birth. I found myself being increasingly certain that a midwife-assisted home birth would provide me with the largest probability of getting the type of birth experience that my baby and I deserved. On the other hand, I was, at times, terrified that

the medical profession was correct; that in attempting a VBAC, my uterus might burst open, causing death to my unborn child and possibly myself.

This time of great emotional upheaval culminated on the early morning of March 11, 1989, when I awoke with contractions. At 12:40 p.m., my second son was born in our bedroom, joyfully welcomed into my midwife's hands. I was ecstatic. My unmedicated labor had been painful, but my joy and the feeling of empowerment I experienced felt indescribable. In the days, weeks and months following this birth, these feelings lingered and even grew. I was, however, very sensitive to the reaction of those around me. I became an object of curiosity to people. Some women who had delivered only by cesarean section expressed regret about their experiences, while some women who had had only vaginal births wondered why I would go to such great lengths (i.e. resorting to a home birth) to avoid something as common place as a cesarean section. Some people seemed angry with me for going against the medical establishment, while others expressed respect and "awe" for my actions. Two women, who had each had two cesarean sections and were pregnant for the third time, approached me to find out what I had done to avoid a cesarean and expressed a strong desire to do the same. It seemed that each person who approached me to discuss my VBAC birth brought her own knowledge and experience of birth and this influenced the way in

which she perceived what I had done. Reactions seemed to vary from awe, to envy, to empathy, to support, to contempt and a complete lack of understanding of why I had felt a VBAC was important, and to why I had ultimately decided to have my VBAC at home. Yet, I had a sense of how important this VBAC had been to me. Other VBAC women that I talked to seemed to feel similarly. I felt regret that not all women understood my feelings. I experienced sadness for women who had not felt a sense of elation and empowerment through their birth experiences, and anger at a medical establishment which seemed to actively discourage women from asking questions or taking responsibility for their children's birth.

Over the last six years, these feelings have deepened. I feel a sense of commitment to women and their need to take control of the birthing arena. During this time, I have experienced the home births of my third son, and my fourth child--a daughter. My beliefs regarding birth have evolved into a set of deeply held convictions.

It is my belief that the tapestry of birth experience created by each woman and the personal meanings that evolve from its creation are an amalgamation of many influences within a woman's life: what she learned as a child about birth, how society views birth, her level of comfort with her own sexuality, her spirituality, her individual aspirations surrounding birth, and her own experience in giving birth.

My personal belief is that pregnancy and birthing are significant events in a woman's life and, therefore, possess the potential to influence the way in which a woman experiences her female self. I believe myself to be a feminist who, far from adhering to the idea that childbirth and mothering are "shackles" for women to bear, believes that biological differences between men and women should be celebrated. I believe that women and men should take pride and discover greater empowerment in things that are uniquely feminine or masculine. I believe that in creating equality between the sexes, women need to create support systems and structures to serve their unique needs. I believe that birth is a challenge to be met, rather than avoided. I believe that in our North American culture, birthing, historically a woman's arena, has become male-dominated. I believe that the use of advanced technological equipment (i.e. fetal monitors) and too many unnatural birth interventions (i.e. cesarean sections) have become accepted as the norm, rather than the exception, to be used in real medical emergencies. It is my conviction that pregnancy and birthing are deeply psychological and spiritual, as well as physiological processes, and that in the face of ultra-modern technology, the psychological and spiritual elements of pregnancy and birthing are often lost. I believe that it is through valuing and understanding all of the elements involved in pregnancy and birth, that

we can help birthing women to achieve more fulfilling birth experiences. I believe women deserve such opportunities.

It is because of this recognition that there is a need to value and understand women's birth experiences, that the question to be addressed in this study surfaces. The specificity of the question emerges from the impact of my personal experiences and my desire to explore the meanings of similar birth experiences to other women. Thus, the question to be addressed in this study: *How do women who have experienced a vaginal home birth after cesarean section describe their birthing experiences and what meaning do these experiences hold for them?*

B. The Question and Its Organization

This study endeavors to investigate the birth experiences of women who have undergone a vaginal home birth after cesarean section. It intends to probe the life-worlds of four women whose birth circumstances has been such, to explore these women's birth experiences, and to describe the meaning these experiences hold for them. This chapter has endeavored to reflect my personal journey and the context from which the research question has been initiated. My personal belief system has been clearly outlined, as has my focus on this question as being about women.

Chapter II considers the research literature relevant to this question. The legitimacy of the question and its relevance is discussed, by placing the question within a historical context. The history of cesarean section and vaginal birth after cesarean section are reviewed, as well as how these birthing practices relate to the concept of marginalization of women in health care. Psychological, social, and financial implications of VBAC are explored.

Chapter III describes how the question was asked. It describes the most appropriate method and procedure for searching for an answer to the question. The philosophy of hermeneutics is explored, and the relevance of the hermeneutical encounter discussed. This method was chosen because of its symbiotic relationship with the nature of the question, its valuing of participants, and its acknowledgement of the contributions of both the questioner and the interviewer in constructing meaning and the "truth." As well, the relevancy and importance of a feminist stance in research is discussed.

Chapter IV presents the themes as they emerged from interviews with four women who have experienced at least one vaginal home birth after having experienced a cesarean section. These themes are disclosed with reverence and gratitude, as these women shared details of an intimate and personal female experience with me.

Finally, Chapter V discusses the meaning intrinsic to the women's experiences. It describes what has been learned from the study, and reflects upon my personal journey in undertaking this study. Chapter V details how my beliefs and convictions have evolved and been further transformed as a result of undertaking this study.

II. LITERATURE REVIEW

A. Introduction

The aim of this chapter is to set the question under study within a social, historical and feminist context so the legitimacy and relevancy of the question will be clear. This review, therefore, will begin with a review of literature relevant to VBAC, and will then broaden to consider a wider range of factors which have impacted on the nature of birthing within our culture. The history of cesarean section will be examined, as well as the marginalization of women in medicine, particularly in relation to the marginalization of women within the context of birthing. In turn, this marginalization of women in medicine is viewed by the author as just one example of the marginalization of women's experience within our culture. Lastly, therefore, the legitimacy of valuing a feminist construction of reality, of hearing feminine voices, will be explored.

B. The Case for VBAC

The fact that the cesarean section rate in Canada and the United States has risen dramatically over the past twenty years is well documented. A review of the most recent data released and compiled by Statistics Canada reveals that the cesarean section rate in Canada

increased from 5.8 cesarean sections per 100 hospital deliveries in 1970 to 19.5 in 1988/89. The increase is even more dramatic in the United States, where rates rose from 5.5 to 24.7 during the same period. Cesarean section is now one of the most common surgical procedures performed on women (Nair, 1991). Not surprisingly, these dramatic increases have fuelled debate among women and the medical profession regarding the appropriateness of cesarean sections.

The negative physiological and psychological impact of cesarean section on women is well documented. Surgically-delivered women face the daunting task of recovery from major surgery, as well as post-partum recovery. Thus, the physical demands on a cesarean-delivered woman are very great. In addition to these physical demands, the cesarean mother, having "lost control over her childbirth experience, is likely to feel cheated, disappointed, angry, frustrated, guilty, regretful, helpless, and depressed. In addition she may experience a sense of failure, distaste for her scar, and envy of those who have given birth vaginally" (Cohen & Estner, 1983, p. 33). Panuthos (1984) also contends that the cesarean-delivered woman often faces both a difficult physical and emotional process; grieving over the loss of control and participation in the birthing process, as well as the loss of full, if any, participation in the early moments of her baby's life.

In response to public concern over the rising cesarean section rate in Canada, a National Consensus Conference on Aspects of Cesarean Birth was formed in May, 1985, to establish appropriate clinical policies for aspects of cesarean birth. The final statement of the Consensus Conference was released in February, 1986, and its recommendations were fully endorsed by the Society of Obstetricians and Gynecologists of Canada, and the Association of Professors of Obstetrics and Gynecology of Canada (Consensus Report, 1986).

Of primary interest to this study are the recommendations made by the Consensus Conference regarding trial of labor and subsequent vaginal birth for women who have had a previous cesarean section. For seventy years, women who had undergone one cesarean section were automatically designated to deliver all subsequent children by cesarean, because of fear of uterine rupture, an event which can occasionally be catastrophic for both mother and babe. Thus, the dictum coined in 1916 by Dr. Edwin Craigin, "Once a cesarean, always a cesarean," has been rigidly adhered to by medical professionals (Shulman, 1978). However, after rigorous investigation of relevant research published since 1960, the Consensus Conference Report recommended drastic change in this policy, stating the fear of uterine rupture had been drastically overstated, and recommending that trial of labor after a previous cesarean section

should be the recommended and safest course of action for women who meet the following criteria: one low transverse incision from previous cesarean, singleton vertex presentation of fetus, and no absolute indication for cesarean section, such as placenta previa. These guidelines were subsequently revised further in 1991, to recommend trial of labor after two previous cesarean sections, augmentation of labor to be used with caution during trial of labor (as opposed to extreme caution as cited in the 1986 report), and deleting the requirement for antenatal consultation from an obstetrician or surgeon (Norman, Kotovcik, & Lanning, 1993). Automatic repeat cesarean section is recommended in the presence of the following indications: multiple pregnancy, the presence of a longitudinal incision, or other absolute indications for cesarean section in the current pregnancy (i.e. placenta previa).

These recommendations arise from research evidence that document the higher incidence of both infant perinatal mortality (Clark, 1987; Lagercrantz & Slottan, 1986) and maternal mortality (Miller & Sutter, 1985), related to repeat elective cesarean as opposed to VBAC. Miller and Sutter (1985) also report that the risk of post-partum morbidity to be estimated from 3.5 to 10 times as high for repeat cesarean births as for vaginal births.

Despite the very strong recommendations outlined in the 1986 and revised 1991 Consensus Reports, VBAC in Canada continues to be the exception, rather than the norm. However, the VBAC rate over the last ten years has increased. In Canada, the VBAC rate was 3 per 100 previous cesarean deliveries in 1979/80. This rate has risen to 15.6 in 1988/89 (Nair, 1991). In Alberta, in 1986, 10.7% of previously cesarean-delivered women had VBAC, while 89.3% had repeat elective cesarean sections (Health, Economic, and Statistics Branch, 1988). By 1988/89, the VBAC rate in Alberta had risen to 22.5 per 100 previous cesarean deliveries (Nair, 1991). Although these statistics suggest an encouraging rise in the incidence of VBAC, it is important to note, that according to clinical trials, it is reasonable to expect a 73% overall VBAC rate (Flamm, 1985). The fact remains that in 1990, 40% of all cesarean sections involved women who had previously undergone the procedure. This high rate of repeat cesarean section contributes greatly to the total cesarean section rate (Norman et al., 1993). It also suggests that there are still many women who are good candidates for VBAC, but are delivering by repeat cesarean section. Further evidence of this is found by delving further into statistics regarding cesarean section.

In Canada in 1988/89, 38 out of every 100 cesarean deliveries listed previous cesarean as the medical indication for the cesarean

operation (Nair, 1991). Some researchers have concluded that many women who undergo repeat cesarean section are eligible for trial of labor and VBAC according to the guidelines, but that they are not yet being offered the VBAC option by their physicians. They also suggest that the vast majority of women, given the choice of VBAC or repeat cesarean, will choose VBAC. Accordingly, they suggest that further physician and patient education is pertinent and necessary. In fact, they conclude by urging all physicians who perform obstetrics to be strong advocates for VBAC (Norman et al., 1993).

Concern has also been documented about the economic cost of repeat cesareans as opposed to VBAC, because of the higher costs related to surgery and longer hospital stays. Cohen and Estner (1983) state that there are potential tremendous cost savings to be gained by implementing VBAC, and ending the practice of routine repeat cesareans.

Research evidence also points to positive psychological consequences for women who attempt and achieve VBAC. Cohen and Estner (1983) devote a chapter of their book, *Silent Knife*, to descriptive documentations of the labor and post-partum experience of eighty women who have successfully had a VBAC, and who perceived their experience as personally satisfying, rewarding, and as a "healing" process in helping them to overcome the negative feelings they associated with

their previous cesarean. Cohen (1983) says the effects of VBAC "are immeasurable and boundless. It needs to be and can be - a time of peace, exhilaration, joy, and growth" (p. 5).

As well, the book, *The Vaginal Birth After Cesarean Experience* (1987), by Lynn Baptisti-Richards and contributors, documents VBAC birth stories by parents and professionals. These birth stories attest to the joy, triumph and healing experienced by VBAC parents and their birth attendants.

Documentation is also available on how to successfully prepare for a VBAC. Norwood (1984) and Shearer (1982), describe many procedures which they say should be adhered to during labor if a cesarean section is to be avoided, including avoiding routine use of continuous, electronic fetal monitoring and intravenous, encouraging maternal change of position and ambulation during labor, and the presence of an extra support person (in addition to the husband or partner) during labor and delivery. Childbirth educators also recommend that VBAC preparation, as well as including sound advice on nutrition, health, and consumerism, should include the clearing of unresolved negative feelings and attitudes about past births. Panuthos (1984) says that "past pregnancy and childbirth experiences may have so much unreleased emotion attached to them, that a woman finds herself overwhelmed with feelings in the

present pregnancy or birth experience" (p. 56). Cohen (1983) says, "In order for childbirth to lead us to increased well-being, it is important that we know how to release and heal our bodies, minds and spirits of any pain left over from the childbearing process" (p. 70).

Thus, the research evidence is clear. There are too many cesarean sections being performed in this country. The negative physiological, financial and psychological ramifications of cesarean section are well documented, leading one to believe that the need to reduce the incidence of cesarean section is not only prudent, but unquestionable. Increasing the incidence of vaginal birth after cesarean section would dramatically decrease the overall cesarean section rate. The safety and efficacy of VBAC is well researched. Research has also considered the positive psychological impact of VBAC, and factors which may improve the chances of VBAC. Why then, is VBAC not becoming more of the norm? Why is it not more actively promoted by the medical community? Why are more women not more informed regarding their choices surrounding pregnancy and childbirth? Why, in the light of all the research evidence, are the voices of women who do wish to make choices which are not viewed as "mainstream," heard as "radical" and "selfish"? For the answers to these questions, a broader perspective must be examined: one in which the medicalization of childbirth can be placed within a

historical and social context. As one undertakes such an investigation, it becomes apparent that it is impossible to separate historical views of childbirth and cesarean section from historical views of women, and their role and place in society.

C. The Cesarean Section: An Historical Perspective

Accounts of abdominal delivery go back to ancient times. Greek mythology and Scottish legends tell of mortals born in this way, and predict extraordinary futures for those born by cesarean section. Post-mortem cesarean section became law in the Roman kingdom from about 700 B.C., when it was decreed that undelivered women could not be buried until their unborn child had been cut out. In the European literature of the middle ages, the post-mortem cesarean section gained ground from about 1300 on, partially because the Church advocated it in order to try to baptize a live fetus. Few babies survived, but this did not matter, as the goal was to ensure eternal life (Trolle, 1982). Closer investigation of this medieval period, reveals much about historical attitudes towards women and childbirth.

In Europe, during the medieval period and before, sex, procreation, childbirth, and mothering ranked very low in the hierarchy of values. Thus, during the middle ages, female virginity was idealized, just as it

had been for centuries. Blumenfeld-Kosinski (1990) recounts that as early as the first century A.D., virginity was purported as a way for women to strive to reach a level of rationality equal to males. She goes on to say that even a few centuries later, this idea continued. Blumenfeld-Kosinski (1990) quotes Saint Jeremy (340-420) as writing "as long as woman is for birth and children, she is different from man or body from soul, but if she wishes to serve Christ more than the world, she will cease to be a woman and will be called a man" (p. 10).

Thus, during the medieval period, birth was seen as a lowly process, belonging in the domain of women. Mothers, grandmothers, and neighbors would be present at births, as well as the midwife. Birth was viewed as a dangerous, but non-medical process. However, many women and babies did die in childbirth. Infants were taken by cesarean section from mothers who were already dead or near death, in order to allow the child to be baptized, thus insuring its salvation. It is in the beliefs surrounding these early cesarean sections that we first see the profoundly ambiguous and ironic nature of the cesarean operation. Blumenfeld-Kosinski (1990) maintains that:

> In antiquity, children fortunate enough to have survived a cesarean birth were believed to be marked for a special destiny ... but for the mothers of these "fortunate" children, cesarean birth meant death and not life ... (thus) the profound ambiguity surrounding both cesarean

> birth itself and those born by it: their birth involves both mutilation and salvation (p. 1).

She continues to explain that midwives performed the cesarean operation, until male surgeons began to perform cesarean sections around 1400. It was by attendance at cesarean births that male physicians entered the field of obstetrics. Although the arena of birth continued to be considered the exclusive domain of women up to the eighteenth century, men began systematically entering the birth chamber for operative deliveries much earlier. Midwives were excluded from the cesarean operation by the beginning of the 15th century.

The cesarean operation itself gained popularity very slowly, mostly because of the appalling maternal mortality rate, which was approximately 70%, during the 1700's and 1800's. This high mortality rate was mainly due to the high incidence of maternal hemorrhage and septic peritonitis. Progress in the success of the cesarean operation came in the last two decades of the 19th century, with the introduction of antiseptics, and the realization of the importance of closing the uterine wound. The traditional longitudinal incision in the uterus was the preferred method of operating. From the beginning of the 20th century, there were several more developments which improved the outcome of the cesarean operation, culminating in 1921, with the re-introduction of transversal incision in the lower segment of the uterus, a method which

had been tried in earlier years, and then rejected. Since 1975, this technique has remained the standard procedure in most cases in which the cesarean operation is performed, and the cesarean operation is now thought to carry only the same risk as other operative procedures (Trolle, 1982).

D. The Demise of Women Healers

The exclusion of midwives from attendance at cesarean operations by the beginning of the 15th century was but the "first step in a long series of exclusionary and controlling measures aimed at women in medicine" (Blumenfield-Kosinski, 1990, p. 91).

This "first step" has since been followed by many other events, which have worked together to ensure the displacement of midwives from positions of power and authority, and to ensure the power imbalance which today exists between the medical profession and their female patients. Worldwide, before the rise of the modern medical profession, women provided most of the caring and healing work within their domestic roles, as caretakers of children, the elderly, the disabled, and of other women during labor and birth. However, Oakley (1990) contends that the contributions of women throughout history in the role of healer

is not well documented and is not part of the "official" version of health care history, which concentrates on political and economic phenomena, such as professionalization. These phenomena, of course, mostly involve males and thus health care history usually allocates women to invisible and inferior roles. It is very interesting to note, for example, that Dyre Trolle's book, *The History of Cesarean Section* (1982), devotes all of the section on the development of the cesarean section on living women, to those operations done by medical persons. Midwives and their role both in post-mortem cesarean sections and in cesarean sections on living women are not even mentioned. Blumenfeld-Kosinski (1990), as well, points out that the exclusion of women as caretakers of birthing was firstly enabled by two simultaneous factors which worked together: the professionalization of medicine and the witch hunts. She too, suggests that the "understanding of this problem has been hampered by male scholarly bias in the historiography of medicine as well as in that of witchcraft" (p. 92) and says that "since it was this male medical elite that was responsible for most of medical historiography, the history of medicine tended to become that of the medical profession" (p. 93).

The movement to professionalize medicine was systemic and worked in unison with the witch hunts to denigrate midwives. The church, state and the medical profession were all opposed to female

midwifery because there were no external controls on midwives' activities, and no body of legislation controlled what midwives did or where they did it. Oakley (1990) reports that it became more and more apparent midwives represented a threat to the emerging medical profession, the church and the state. Not only did the midwife attend births, but she responded to many of the unique needs of women such as providing advice about contraception, infertility and abortion. Midwives were therefore viewed with deep suspicion because of the power they seemed to hold. It easily followed that they should be one of the main groups accused of witchcraft, an accusation which was synonymous with hostility to women and women's real or imagined power, and a means by which society could rid itself of threatening elements. Thus, witch hunts were a widespread phenomena in Europe between the 14th and 17th centuries, and midwives were likely targets for accusation, charged with destroying infants before or shortly after birth, through their alliance with the devil (Oakley, 1990).

The professionalization of medicine, which took hold during the medieval period, was also very effective in suppressing women healers. Until the 13th century, medical practice was open to all who gained the appropriate university education. However, in most countries, women were barred from universities. By the thirteenth century, medical guilds

only admitted those who had a university licence. By the sixteenth century, medical practitioners were organizing themselves into powerful bodies with authority over the licensing of medical professionals. Thus, women healers and midwives were effectively barred from obtaining the appropriate credentials. A hierarchy of practice developed in which male practitioners who were university-trained cared for the elite, while empirically-trained female healers cared for the working class. However, midwives continued to practice and be the main guardians of birth, both in North America and Europe, until the 19th century. The exception of this rule, continued to be in instances of very difficult and cesarean births (Oakley, 1990).

Cesarean sections have, therefore, been under the control of the male-dominated medical profession for hundreds of years. However, medical interest in taking over and controlling obstetrics in general did not really take hold until the middle to late 19th century, when the medical profession began to argue that obstetrical work should be part of their domain. Oakley (1990) suggests that "Both in North America and Europe, the triumph of obstetricians over midwives as controllers of birth represented the ascendancy of men over women, but the belief that men ought to control birth was never an overt part of the struggle" (p. 32).

In actuality, more basic reasons surfaced, which made the prospect of attending women in childbirth more attractive to the medical profession. Four of the most significant of these reasons were:

1. Practitioners of obstetrics began to hold a world view of pregnancy and birth as pathological, a view which directly opposed that of midwives. Midwives attending women in childbirth, did so from a perspective of childbirth as a natural process, one which they were there to guide and aide. Obstetricians, in deciding how, when and where childbirth happened, took the opposite point of view--childbirth was not normal. "Indeed, its 'normality' consisted of its potential pathology. At any moment, and quite without warning, anything might go wrong in any pregnancy, labor, and delivery, and the presence of the obstetrical expert was needed to step in and put everything right again" (Oakley, 1990, p. 32).

2. Hospitals, under the control of male physicians, needed laboring women in order to teach aspiring physicians about birth.

3. There was money to be made from delivering babies.

4. Attendance at deliveries was a significant way for doctors to get access to new clientele, as not only the birthing woman would become their patient, but often her entire family.

Thus, during the late 19th and early 20th centuries, more and more women began to deliver their babies under the care of an obstetrician, and more and more women were urged to go to the hospital to deliver. However, medicine in the 1920's and 1930's did not offer a safer birth than the option of home birth provided by midwives. A study in Ontario during the 1930's clearly indicated that "modern" obstetrics had not made birth safer for women. In fact, the study concluded that "hospital births resulted in a maternal mortality rate of 5.3 per thousand, while home births had only 2.3 per thousand. Most embarrassing was the finding that rural women, who had more midwives and home births, were better off than their city sisters, who had all the 'advantages' of hospital and medical care" (Barrington, p. 29). However, findings such as these, were usually only documented in medical journals, and so never really reached the eyes and ears of the general public. More and more women chose hospital births, believing they were doing what was best for themselves and their babies. As well, the introduction of blood transfusion and the use of antibiotics in the 1930's finally made hospital births safer than before, and provided cures for hospital-induced infections and doctor-induced hemorrhages (Barrington, p. 29).

E. Home Births and Midwifery Today

Today, midwifery has survived to varying degrees in North America, with midwives being entitled to varying degrees of autonomy depending on where they practice. The movement toward the recognition and regulation of midwifery has been gathering momentum in several Canadian provinces during the last decade. Ontario introduced a Midwifery Act in late 1990, and Alberta quickly followed suit. In conjunction with the movement to recognize and legalize midwifery in Alberta, the Health Disciplines Board of Alberta released its final report and recommendations regarding midwifery in February of 1991. According to this report, "women became increasingly aware during the 1950's and '60's of the extent to which childbirth had come to be seen and treated not as a natural process, but as a medical event. They argue that women giving birth became disenchanted with what had become a highly technical, interventionist, physician-dominated hospital delivery system" (p. 11). The report recommended that midwifery be recognized under the Health Disciplines Act, as an autonomous, self-regulating profession. As well, the safety and legitimacy of midwife-attended home birth was reviewed in depth by the Health Disciplines Board. The Board indicated that all the associations of physicians who submitted briefs to the Health Disciplines Board were opposed to home births because they

felt that home birth was inherently more dangerous, and they (the physicians) consequently argued that midwives should practice only in hospitals under the authority of physicians. Despite this strong recommendation made by the physicians, the Board recommended that home births be included in the scope of practice of midwifery in Alberta. They based this recommendation on their review of a great deal of information on the relative safety of home and hospital birth. As well, the Board commissioned a national consulting firm to review and draw a conclusion from research literature on this topic published during the last five years.

This consulting firm reviewed two recent, extensive literature reviews on home birth published in the Report of the Ontario Task Force on the Implementation of Midwifery (1987) and the British Journal of Obstetrics and Gynaecology (1986). The Health Disciplines Board Investigation of Midwifery Final Report (1991) stated the conclusion of the consulting firm as "there is no conclusive evidence to support the view that giving birth at home is significantly less safe than giving birth in a hospital for carefully selected and properly attended women" (p. VI).

Thus, in July 1992, midwifery was designated under the Health Disciplines Act in Alberta. In January 1993, the Midwifery Regulation Advisory Committee (MRAC) was appointed to develop regulations and

policies to govern midwifery, which included attendance of home births under a midwife's scope of practise. The government of Alberta approved the Standards of Competency and Practice for Midwifery which had been proposed by the MRAC and approved the Midwifery Regulation in November of 1994 (Alberta Labour Press Release, 1995, June 12).

F. Women and the Medical Profession

Although midwifery is currently undergoing a resurgence in Canada, the medicalization of the childbearing process continues. Women who seek alternative forms of care (i.e. midwifery/home birth) face a huge amount of public pressure to conform. Oakley (1982) affirms that "Not only childbearing, but also motherhood has been medicalized, so that any 'good mother' loses her title if she fails to seek out and take professional advice. Once consulting the experts becomes a mark of morality, setting up and using alternative forms of care becomes a sign of rebellion, challenging both the doctors and the conventions of women's role in society" (p. 32).

Miles (1991) in her book, *Women, Health and Medicine*, undertakes an extensive review of research literature relevant to how the medical profession views women. Her analysis strongly suggests that doctors have been very successful at medicalizing pregnancy and childbirth. The

majority of women accept the premise that technological childbirth is safer childbirth, and that the experts (i.e. doctors) "know best." Pregnant women, therefore, assume that whatever care they are receiving has been well researched and must be the best. In turn, obstetricians convey this message with all the power, authority, and prestige that their position holds, and may, in fact, give shorter answers and less technical explanations of problems to female patients. Conversely, and equally as humbling, Graham and Oakley (1986) in Miles (1991) point out that doctors may use highly technical language which patients are unable to understand, for example, in the case of getting a pregnant woman to agree to a procedure which she is initially opposed to. Patients often feel too humiliated to indicate their lack of understanding, and thus do not question further.

This lack of understanding of course leads to lack of information. Lack of information, in turn, breeds powerlessness, and a perpetuation of the balance of power in favor of the medical community. Miles (1991) observes that "obstetricians are in a particularly powerful position amongst doctors: pregnant women cannot escape their sphere of influence, or escape procedures ordered by them" (p. 176).

It is also very apparent that the medical profession has not only perpetuated male-dominated views in the area of obstetrics. Today,

modern medical practices and trends in general continue to reflect a male-oriented view of women. Medical statisticians throughout the western world document higher morbidity rates in women as compared to men, as well as higher consultation rates with doctors for women as opposed to men. Miles (1991) details various explanations for this statistical pattern.

The first explanation supposes that women's health is not really any worse then men's, but that women are more willing to notice their symptoms and seek treatment. The second, supposes that genetics, that is, gender differences interacting with environmental factors and heredity, account for the differences. The third explanation lies in a social causation hypothesis - that the nature of women's lives render them more vulnerable to certain diseases.

Although all of these explanations may suggest reasons for the difference in morbidity and doctor consultation rates between women and men, one must also examine a very complex set of beliefs which may underlie these explanations. Firstly, one must be aware of the contradictory social expectations placed on women related to their health and illness behavior.

On one hand, women are expected to be strong enough to endure the rigours of pregnancy and childbirth, while also assuming

responsibility for childrearing and household tasks. This expectation requires strength and good health. Conversely, women are expected to display traits which suggest weakness, such as modesty, fragility, and sensitivity, in order to conform to our society's definition of femininity (Miles, 1991).

As well, Miles (1991) points to important gender variations in doctor's judgement.

> Doctors, most of whom are male (this is changing, but slowly) tend to hold male-oriented views of women and their problems: the stereotype of the weak, complaining, neurotic woman repeatedly appears in views expressed by doctors. Complaints of female patients can be discussed and devalued, as being 'only in the mind', or 'imaginary', due to their having 'too little' to occupy them (p. 79).

Thus, women often find it difficult to find validation of their complaints from doctors, and doctors more often record emotional and psychological problems as reason for consultation for women than for men (Miles, 1991).

It is also important to realize that there are very real ramifications for women when they do seek medical advice for psychological or emotional problems. In our society, there is a vast difference between how physical and mental illnesses are viewed. Physical illness is thought to be indiscriminate; external forces can cause anyone to become physically ill, therefore, physical illness is beyond an individual's control.

However, emotional or psychological problems are often viewed as being caused by personal weakness, thus personal responsibility is imputed.

> Blame attaches even more readily if the complainant is a woman ... depression, anxiety, agoraphobia, and other problems, which affect women more than men, are widely regarded as signs of weakness, internally endured, which women should not succumb to, but 'shrug off' or ignore ... Underlying the imputation of blame is the general view of women as weak and complaining, a view held by professionals and lay people alike" (Miles, 1991, p. 81).

As well, there is evidence of a certain medical bias in relation to difficulties associated with female physiology. Despite strong evidence of an organic basis for complaints such as nausea during pregnancy, and severe pain during menstruation and childbirth, doctors often continue to attribute their complaints to emotional causes and view women as overstating the pain (Miles, 1991).

G. Women and Truth

As discussed, a patriarchal and patronizing bias toward women and their health-related needs no doubt exists within the medical profession, and within society in general. This bias serves to marginalize women's experience as being of less importance, serves to silence women who seek to speak their reality, and serves to denigrate women's traditional roles as healers and midwives. One of the ways in which this premise can be further explored, is through analysis of the nature of our language: the

terminology used to describe women's role and experience, and the types of "stories" which predominate as being the "truth."

Our language becomes our reality. Reality is created and maintained primarily through talking. It follows that those who control the talk, shape and control the prevalent ways of thinking and being--the reality. Language therefore determines the limits of our world; it is our way of mirroring what is real for us (Bain, 1985). As well, it is evident that those who control the "talk," shape and control not only the meanings of certain terms within our language, but also the types of stories which are told and accepted to be of importance. Power therefore "consists to a large extent in deciding what stories will be told ... male power has made certain stories unthinkable" (Heilbrun, 1988, p. 43, 44). This phenomena has already been evidenced in describing how the historiography of medicine has ignored the contributions of women throughout history, and instead, has largely concentrated on the history of the male medical profession. Further examples lie in exploration of how the meaning of certain terms have evolved, so that terms that originally conveyed positions of stature to women, are now used only in a derogatory sense. A "gossip," for example, was originally a term used to describe a witness to a childbirth. The term "old wife" was historically reserved for traditional women healers and midwives. Old wives' tales

were originally the knowledge relating to sickness and treatment imparted by these traditional women healers. These terms, which once suggested such dignified attributes as wisdom, authority, and eminence, are now used only to refer to disparaging attributes of modern women (Oakley, 1990).

Heilbrun (1988) asserts that throughout the centuries, biographers, autobiographers, and historians have suppressed the reality of female experience, so that what has been written will conform with society's expectations of what "should be" and what is "proper." She maintains that women must begin to tell the truth about their reality as they experience it and that women must begin to see themselves collectively in order to be taken seriously. Rich (1976) in Heilbrun (1988) asserts that it is only in "the willingness of women to share their private and often painful experience that will enable them to achieve a true description of the world, and to free and encourage one another" (p. 68).

H. Conclusion

This chapter has served to provide relevant background information and a context critical to the reader's understanding of the question to be explored. From a strictly physical health perspective, the safety, efficacy, and cost effectiveness of VBAC for most cesarean-delivered women is

undisputed in the literature. The history of women's role as healers and midwives; their demise and current resurgence, as well as current thought regarding the safety of home birth, has been documented. In searching for reasons as to why VBAC is not more prevalent, and why, in fact, the cesarean section rate in our culture is so high, the literature has pointed to reasons related to the long history of patriarchal power in Europe and North America, the medicalization of childbirth, and the continuing presence of a patriarchal perspective in medicine and the subsequent marginalization of women and women's experience.

Thus, the legitimacy of the question addressed in this study becomes apparent. There is a barrage of "objective, scientific" research written from a medical standpoint, attesting to how, when, and where natural births, cesarean sections and VBAC should take place. In comparison, there is very little documentation which considers how, when and where birth should happen from the viewpoint of those who do the birthing. As well, medical research tends to ignore the psychological and emotional impact of medical practice, referring instead solely to measures of presence and/or lack of pathology to judge the efficacy of its practice.

In relation to VBAC specifically, some documentation is available in regard to the nature and impact of the VBAC experience on women

(Cohen & Estner, 1983; Baptisti-Richards, 1987). However, this documentation is limited in comparison to the girth of research attesting to when, where and how VBAC should be undertaken. The voices of VBAC women have not yet been fully heard. Traditional, patriarchal views of what constitutes a topic important enough to research and record continue to result in little value being placed on listening to such women. Their truth, their feminine construction of reality, is devalued and trivialized in the world of objective, scientific research.

The question addressed in this study--*How do women who have experienced a vaginal home birth after cesarean section, describe their birth experience, and what meaning do those experiences hold for them?*--reflects the writer's belief that there is value in and knowledge to be obtained from hearing and exploring women's experiences.

III. METHODOLOGY

Chapter III explores the validity of the feminist stance; and looks at how this feminist perspective impacts the research process. Firstly, however, it presents the specific method of inquiry used to guide this research process.

A. Hermeneutics

When searching for an answer to any question, the questioner must first decide upon what form the search will take. How does one best find an answer to the question? The question addressed in this study--*How do women who have experienced a vaginal home birth after cesarean section describe their birth experience, and what meaning do those experiences hold for them?*--demands an answer to both a "How" and a "What" question. These words tend to indicate the need to describe and explain something. However, the question also asks specifically for a reflection upon the "meaning" of a specific experience to individual women. This fact necessitates that the method of inquiry not only be descriptive in nature, but also able to elicit meaning.

As a researcher, I wish to further explore the experience of birthing and find out what that experience has meant to other women. I desire to

find out more; to stretch the interpretations that I have made based on my own experience, to include those of others who have had a similar experience. Thus, features implicit in the question, as well as an exploration of the researcher's goal in asking it, lead to a discussion of hermeneutics.

Modern hermeneutics, the philosophy of interpretation (Bleicher, 1980), has evolved around two distinct polarities of thought. The first is that of the hermeneutical tradition of Schleiermacher and Dilthey, who suggest that there are distinct principles by which we can guide interpretation, and therefore arrive at objective knowledge (Palmer, 1969). This view is in direct opposition to the feminist stance presented in the latter part of this chapter, and is therefore rejected by this author. The second hermeneutical tradition is that of Heidegger and Gadamer, who propose that hermeneutics be viewed as an exploration of the nature of understanding, and suggest that within this view, objective knowledge is possible (Palmer, 1969). It is this latter perspective which guides the method of inquiry for this research.

Historically, modern society relies heavily on a definition of knowledge that is rooted in what are termed traditional, scientific, objective methods used to explain phenomena. Knowledge becomes

defined in terms of "man," and the agreement between a known object and a knowing subject. Truth is seen as an absolute.

Heidegger rejects this definition of knowledge and the truth. He claims that the human condition is one of being rooted in one's history and experience. It is impossible to step out of this "rootedness," into a purely neutral, value-free way of knowing. Accordingly, Heidegger supports the view that truth cannot be an absolute, but is a state of "uncoveredness" or "unhiddenness." More and/or different truths may always be revealed. Thus, an understanding of the truth, a making of meaning, can be examined, not as an absolute, but as a range of possibilities (Hekman, 1990).

Modern hermeneutics is further elaborated by Gadamer. Traditional hermeneutics saw as its task, the uncovering of meaning from a text, "a meaning synony. .ous with the author's intention" (Hekman, 1990, p. 66). Gadamer goes further with his definition of understanding, explaining that the nature of understanding is always linguistic and based in individual history (Palmer, 1969). Each of us, he contends, can only take in information from our own place and being-in-the-world. We cannot escape our individual histories, language, and traditions. Therefore, we encounter "experiences of truth," rather than one, universal truth. Furthermore, Gadamer asserts that this hermeneutic

understanding, which has always been attributed as applicable only to the human sciences, is actually fundamental to all understanding, including natural scientific understanding. Thus, the objectivity of natural science, and its premise of absolute knowledge and truth is called into question (Hekman, 1990).

Within Gadamer's concept of hermeneutic understanding, the issues of prejudice and tradition are central. The prejudice which Gadamer refers to is the pre-understanding which each of us brings to every interaction, every communication. Thus, to Gadamer, it is this prejudice or pre-understanding, this awareness of our own tradition, that makes understanding and meaning possible. Prejudice, therefore, is not simply "unexamined bias," but an awareness of what we currently believe based on our own history and experience. Understanding thus becomes a process of "fusing of horizons," the interpreter's horizon is fused with the horizon of the author (Hekman, 1990). This meeting of the contextual understanding of the interpreter with what is being interpreted forms the essence of the hermeneutical encounter. This encounter is therefore circular in nature, forming an infinite circle of possible understandings and meanings (Gadamer, 1976).

Palmer (1969) suggests that this hermeneutic circle is one in which the researcher is open to questioning her beliefs. She purports that the

purpose of asking a question and searching for its answer is not simply to predict an outcome and validate one's hypothesis, but to risk shaking one's beliefs through participation and openness to perceiving and understanding the answers that are given. As Gadamer (1976) suggests that each of us perceives the world from our own particular time and place, the possibility exists that we can come to new understandings based on new experiences. In coming to an awareness of our own pre-understandings, we realize all that we do not know, and open ourselves to altering our understanding and transforming pre-existing meanings.

It is this sincere openness to hearing what is to be interpreted that characterizes the "I - thou" relationship characteristic of the hermeneutic encounter (Palmer, 1969). The "thou" of the text is not totally separate from the reader; its meaning exists within an interaction with or in relation to the reader. The reader's understanding of the text is, and always will be, prejudiced by her/his pre-understandings, traditions and language.

Our language, in fact, is the only way in which we can articulate our experience. Accordingly, the way in which we speak ties us to the historicity of our experience. In short, Gadamer would purport that "language speaks us rather than we speak it" (Hekman, 1990). Within this, we are also bound by the finite nature of language. In expressing

an experience, in recording our meanings, there is always a part which remains unsaid. Thus, interpretation involves interpreting what is not said, as well as what is said.

Gadamer's interpretational philosophy, therefore, is one in which he challenges the tradition of objective, absolute science. His thesis that "all knowledge is contextual, historical, and social" (Hekman, 1990, p. 170) undermines current concepts of valid science. This, in turn, provides a basis from which to further examine modern conceptions of objective science. Specifically, this discussion will now turn itself to the exclusion of women from the scientific realm.

B. Women and Knowledge

> We have tried to say that as we are women and people so will we be researchers; that research and life are not separate and divisible but one and the same and must be shown to be so (Stanley & Wise, 1993, p. 184).

Feminists have long questioned the validity and usefulness of the "scientific, objective" approach to research, asserting that it "generalizes from the experience of one section of society, men, to create an explanation of the experience of both men and women, of the organization of society as a whole, and of the power relations within it" (Roberts, 1981, p. 15). The essential and very significant difficulty in

accepting the traditional world view of male objectivity, is that it is really not objective or "value-free" at all. In actuality, this objectivity could be termed "male subjectivity" (Rich, 1979, in Bain, 1985). Reinharz (1992) also contends that a key aspect of feminist thought lies in its belief that there is no one truth, no objective method of arriving at pure knowledge. She argues that the foundations of patriarchal knowledge are built upon a belief that traditional, objective, scientific methods are able to lead one to a state of pure knowing. Embedded within the realm of this "objective science" lie belief systems and sexist methods of research which are an integral part of women's oppression, and which effectively omit or distort the experience of women.

Eichler (1983) distinguishes five distinct ways in which sexism enters into the research process and effectively excludes women and their experiences from various fields of research. Eichler's discussion of these five points are summarized in the following paragraphs.

The first way in which she contends that sexism enters the research process is through the use of sexist language. Examples of this include the use of the word "he" to mean "he and she," but also only "he," and the use of the word "man" to mean "men and women," but also only "men." Eichler suggests that the use of language in this way is not only confusing, but insufficient in its ability to represent all of humankind.

The use of this language, she says, leads the reader most often to think according to sex specific images, rather than images of both men and women.

Secondly, Eichler asserts that often research uses sexist concepts, suggesting a one-sided view of a concept. An example of this is the use of terms such as "conjugal violence," when in the vast majority of cases, "wife battering" more accurately portrays reality.

The third manner by which sexism enters research, according to Eichler, is through the adoption of an androcentric perspective. This, she suggests, occurs when females are mostly ignored in all aspects of the research process. This arises out of a tradition from which general history and knowledge are predominantly the history and knowledge of men. Thus, this androcentric viewpoint either ignores females, or perceives females only in relation to men.

Fourthly, sexist research methods perpetuate biased accounts of the concept under investigation. If, for example, all the questions asked in a particular research study are phrased in a sexist manner, the answers to the questions will be sexist as well.

Lastly, Eichler contends, even if data is collected in a non-sexist way, it may be interpreted in a sexist manner. She suggests that if any one of these types of sexism is apparent in research, the end result of the

research will be sexist. Furthermore, Eichler contends that freeing research from sexism is a crucial aspect in the struggle for women's equality, as by doing so, we are valuing a knowledge base drawn from both men and women.

This analysis of sexism in research consequently leads to a search for a different context from which to undertake the research process; one in which women's experiences and voices, as well as those of men, are heard and valued. Stanley and Wise (1993) clearly present such a context, based on three beliefs which, they contend, are central of feminism and must guide the feminist research process.

Feminism, according to Stanley and Wise (1993), is a set of beliefs and theoretical constructions about the nature of women's oppression and the part this oppression plays within social reality. Thus the belief that women are oppressed is integral to the concept of feminism and is unwaveringly held among feminists. Feminists also believe that the oppression of women has negative consequences on all in society--children and men, as well as women. This state of oppression, feminists assert, must change.

The second belief, key to the argument articulated by Stanley and Wise, is the view that what is personal is also the political. For example, the idea that women are oppressed is widely accepted by women, solely

on the basis of their own experience. This experience of oppression, though it takes many forms, is shared among women. This shared accounting of personal experience leads to the discovery and naming of the political concept--that of sexism. Thus, feminists strongly believe in the essential validity of personal experience, in direct contradiction to the traditional, scientific realm which contends that one must transcend the personal in order to perceive the 'truth." This traditional methodology utilizes a world view which upholds rationality and the mind as somehow superior to emotion and physicality, thus women's experience becomes trivialized as merely subjective. In contrast, Stanley and Wise insist that this distinction between the subjective and objective is false; that it is impossible and undesirable for the researcher to be totally objective. Furthermore, they contend, systems and social structures, power and the political, are best understood and must be examined through that which is personal; the experiences of individuals in everyday life are paramount. Personal experience, therefore, becomes the prime test of a theory, and women's experience constitutes a different and valuable view of reality, or a different way of making sense of the world.

The third construct which Stanley and Wise present as being essential to being feminist, is the possession of feminist consciousness, a consciousness "rooted in the concrete, practical and everyday experiences

of being, and being treated as, a woman" (p. 32). Integral to this feminist consciousness, is the awareness that the basis of women's oppression is best understood through women coming together and hearing each other. These "consciousness raising" activities help women to gain new understandings. Women begin to perceive the same reality differently; that reality is multi-dimensional and contradictory, and that all of these realities are equally "real." Thus, feminist consciousness is characterized by a sort of "double vision."

Stanley and Wise (1993) further articulate how these basic beliefs, intrinsic to feminism, impact specifically upon the research process. The personal, they contend, must be present in feminist research, and the research must utilize the presence of the researcher, who is an ordinary human being with the usual complement of human attributes. This situated, historical nature of the researcher should form the beginning and basis of the research, and causes the researcher to examine where they are in the world, and how the research question came to be. The basis of knowledge for the researcher therefore becomes contingent not only upon the research process, but also upon the researcher's experience of the world. Within the research process, therefore, the presence of the researcher should not be denied, but explored. Research

thus involves interaction or a relationship between the researcher and the researched. Integral to this relationship from the feminist perspective, is the concept of the levelling out of any imbalance of power between researcher and researched. The researcher is not an "objective expert" who is testing an hypothesis on less knowledgeable, and therefore, less powerful subjects. To the contrary, the researcher and the researched are viewed as co-participants in the research process; each with their own history, perspective and knowledge to bring to the research process.

From a feminist stance, the onus falls upon the researcher to work towards levelling out the imbalance of power which often exists between the researcher and the researched. Thus, the researched is not suddenly expected to take responsibility for analyzing the appropriateness of research methods. Instead, research from a feminist stance behooves the researcher to place herself within the research, to expose her own history and experience as being key elements in the creation of knowledge obtained from the process, to allow her own vulnerability to show.

This study will explore one aspect of feminine reality. It values, and indeed reveres women's stories of an ordinary, yet extraordinary female experience; stories which historically have remained unspoken, or have been devalued, ridiculed, and marginalized as being unimportant. Within it, the horizons of the researcher and the researched come together,

freeing women to encourage each other, speak their truth, and weave a description of the reality of their world.

C. The Conversationalists and the Conversations

The conversationalists for this research were generated by a list of women given to the researcher by her midwife, as well as from the researcher's personal knowledge of and contact with VBAC home birth women. The only criteria that the researcher asked of her midwife in generating a list of possible co-researchers was that the women had had at least one cesarean section, followed by at least one vaginal home birth, and that they be open to talking about their experience. The researcher then began contacting women on the list, explaining the nature of the research, and asking if they would be willing to be involved.

At the beginning of the first conversation, the exact number of conversationalists had not yet been determined. Four women were subsequently involved in conversations with the researcher. After being involved in conversations with these four women, I felt saturated. I very much desired to honour the individual nature of each woman's experience, while at the same time hear the communal voice arising from their like experience. After four conversations, this communal voice was strong. I had a definite sense that I was hearing individual versions of

the same story over and over again, yet I was still able to relate individual nuances to individual faces, expressions and gestures. Thus, for me, the end of the fourth conversation signalled a sense of having heard enough; more was not needed.

The four women interviewed were all between the ages of 25 and 35. Two of the women had had one cesarean section, followed by one home birth. Two of the women had had two cesarean sections, followed by one home birth. At the time of the conversations, the VBAC babies ranged in age from approximately 15 months to 5 years of age. All of the women were Canadian, Caucasian, and had some post-secondary education.

The hermeneutical dialogues, themselves, were held in the homes of the co-researchers, in hope that the women would feel comfortable within their own environments. Each conversation was tape-recorded, and later transcribed. At the beginning of each conversation, I explained that my interest in their experience emanated from my own experience, and the fact that I felt that my birthing experiences had had a tremendous impact on me. I suggested that I wished to explore what their home VBAC experience had meant for them, in an effort to understand how this experience is for other women. Confidentiality was assured, as well as their right to answer or not answer questions. A "Consent to Participate"

form was completed (Appendix A). I also suggested that I came to our conversations with my own pre-understanding of what topics might be significant in relation to the home VBAC experience, but that I very much wanted to know and understand what was significant to them. This seemed to be an important element in clarifying how the conversation would proceed, and stemmed from an earlier "pilot" conversation, in which the co-researcher seemed to want me to take the "lead" in the conversation and wholeheartedly direct it. I sensed that this stemmed from her wanting to tell me what I wanted to know, and from my failure in not reassuring her that what I wanted to know about her experience was whatever she wanted to tell me.

Each conversation began with the open-ended question, "Can you tell me about your VBAC home birth experience?" Inevitably, this question was answered with the question, "Where do you want me to start--from my first pregnancy/cesarean?" To this, my answer was, "Please start from wherever feels comfortable to you." Inevitably, the women proceeded by telling me about their first pregnancy and cesarean experience.

Each of the conversations lasted between two and four hours. Two of the four women were contacted again in order to clarify my interpretation of their experiences. As well, after I had summarized the

themes and drafted the format by which I intended to share them, two of the four women were contacted in order to get their response, suggestions, and clarify whether the way in which I intended to proceed made sense and accurately portrayed the experience from their perspective. All of the women were asked before proceeding with the conversation, if they would like to choose a pseudonym by which they would be referred to when writing of their experience, in order to maintain their confidentiality. All of the women immediately said that they felt very comfortable with the use of their real names, and that they did not feel a need to keep their experiences confidential. However, for the purposes of this research project, I have chosen to refer to all co-researchers by pseudonyms.

D. Making Meaning

In working towards creating meaning from each of the conversations, a lengthy and arduous process was undertaken. First, I listened once again to the tapes of the conversations, trying to recognize when emotion blocked words, when silence meant that understanding was being created by facial expressions and gestures, or by simply being with each other with the knowledge of our shared experience. Because the participants knew that I, too, had experienced home VBAC, there was,

in my perception, a sense of immediate trust between us, a level of connecting and understanding that at times, did not seem to require words.

As much as this sense of connection aided the conversations in that words seemed to flow without reservation, it also presented as one of the challenges within the "making meaning" phase of the research. I was very aware when listening to the tapes, that I had to try to not presume understanding. I realized that I listened to and talked with these women surrounded by the filter of my own experience. Before I began listening to the tapes, therefore, I articulated what I believed about VBAC and feminism. This was a process of opening myself to an awareness of my "foreunderstandings." This belief system is presented in Chapter I. Next, I listened to the tapes and read and re-read the transcripts, challenging myself during this process; trying not to impose meanings I expected and/or wanted to find, opening to hearing what significance this experience held for these women as individuals. I later checked the accuracy of my analysis of the women's experience with two of the women, to ensure that the way I was proceeding made sense and was true to their experience.

It seemed very significant to not only have transcripts of the conversations, but to listen to the taped recordings. The tape recordings

revealed aspects of the conversations that the transcriptions couldn't; when emotion caused words to erupt with rage, when a pause meant that the words about to come were being hampered by the choking back of tears.

After taking time to immerse myself in the words of the transcripts and tapes, I began the second stage of making meaning. Each conversation was analyzed in order to identify topics which arose in the conversation. From this analysis, it seemed that three main conversational topics were evident throughout the conversations. Within these conversational topics, a variety of themes emerged. Thus, each conversation was analyzed firstly for the conversational topics within the conversation, and secondly for the themes inherent to each conversational topic. This process is illustrated in Table 1, which records a small part of Jane's discussion around her feelings after her cesarean section.

Table 1: Summarizing a Conversational Transcript: Topic - The Original Experience

	Conversation	*Summary Statements*
K:	Did you have visitors? What was that like for you?	
J:	Ah, my family did, you know, it was nice to see my brothers and sisters and stuff, but a lot of times, you know, somebody was helping me get out of bed and walk to the bathroom more, I was crying or upset and it wasn't nice for other people to come in and see me like that.	She felt people were uncomfortable seeing her distress.
K:	Didn't you feel they understood what was happening for you?	
J:	Ah, no, no. It really felt, I mean a lot of visitors, the literature that I was given, like the, all the pretty books with the beautiful babies and mommies and everything was flowers and stuff. I felt more like you would feel if you had been beaten up and raped the day before your wedding. But yet ...	She felt she was "supposed to" feel ecstatic; in reality, she felt violated.
K:	But yet ... please go on.	
J:	And then expected to go to your wedding feeling wonderful and happy, with everybody giving you congratulations. That's how it felt.	She was supposed to pretend to feel otherwise.
K:	That's a wonderful analogy actually.	
J:	And, that's exactly what I felt like. I felt really, really horrible and everybody was coming in and saying, 'well congratulations, isn't this wonderful! And there was nothing wonderful about it. They, you know, I wanted	

to breast feed my baby and I wanted to have him as soon as possible, but I was not in any shape to look after a baby.

K. Ah hah.

J: I didn't really want them to bring him to me. I wanted them to bring him to me but I didn't want them to bring him to me because I wasn't ready. And, and I was sent home, I was not in shape to look after a baby.

J. feels ambiguous/confused ... sent home, without hearing from her - if she was ready.

... and then my husband would come into the room and I would just feel like, oh no, don't, don't even touch me because I felt like I'd been really handled, and I just, and I didn't want anyone to touch me. I just, and I couldn't even imagine anyone else wanting to touch me because I felt extremely ugly, I felt really like I was sick, and really hurt. Like an animal laying dying on the side of the road or something. It's not something sexy that you want to look up and cuddle.

Felt violated, handled, ugly, and sick.

No. Ah, so it was a long time, and I talked with my husband about it, and I said I don't want to have another one. But whenever I said that, it made me feel really, really sad, because I really did want to have two children. And even though it made me feel safer when I said I'm not going to have another one, it made me feel really sad. And ... you know, as a couple of years went by and I started to feel a little bit better and I joined a Pre & Post-Natal Fitness class, Aerobics class, and I had contact with other mothers, because we moved two weeks after Doug was born. We moved out here from Edmonton.

Felt sad.

K: Wow! So you had that to deal with too.

J: And I didn't know anybody out here. And I, Mark started working late hours, he was working all the time.

K:	What was that like for you?	
J:	He was colicky. I was depressed. Ah, he cried for hours and hours. And ... it was the most horrible year of my life and I had the most beautiful little wonderful baby and I was so mixed up. Ah, because I just loved him so much and I'd never felt so horrible. It's ...	I was so mixed up. I'd never felt so horrible

---

Finally, the conversational topics and themes were summarized, by clustering similar statements from each conversation under one conversational topic firstly; and secondly, by clustering these similar statements under a specific theme within the conversational topic.

Table 2 illustrates the clustering of summary statements into themes within a conversational topic.

Table 2: Clustering Statements into Themes: Topic - The Original Experience

Summary Statements	*Themes*
J. felt people were uncomfortable seeing her distress	feeling silenced
J. felt she was 'supposed to' feel ecstatic; morality, she felt violated	feeling silenced
J. felt she was supposed to pretend she felt differently than she did	feeling silenced
J. sent home without anyone asking her if she was ready	feeling silenced
J. feels ambiguous/confused	confusion
J. felt violated, handled, ugly, sick	depression
J. felt sad	depression
J. was so mixed up	confusion
J. had never felt so horrible	depression

This procedure was undertaken for each conversation. Participants were compared in order to find themes common to their experience, and themes unique to them.

Chapter IV presents the themes, as they surfaced for me, from hermeneutical conversations with four women who had experienced VBAC home birth.

IV. THE THEMES

Chapter IV presents an image of the home VBAC experience as described by the co-researchers involved in this project. Its function is to uncover the meanings intrinsic to this experience by sharing the conversational topics and themes which emerged during the conversations. As the conversations were analyzed, it became apparent that the home VBAC experience could not adequately be perceived through only discussing what the act of giving birth at home after having had a cesarean section had been like. What became apparent was that this experience seemed to be evolutionary in nature, spanning in time from the women's initial pregnancy and birth experience, that of cesarean section, to the present time, where the meanings that had developed as a result of having had a home VBAC lingered. Thus, images of transformation and metamorphosis became apparent.

The work of this chapter, therefore, becomes one of describing this continuum of experience, and the conversational topics and themes inherent to it. Three distinct conversational topics were evident. The first topic centered around experiences and feelings surrounding the women's initial pregnancy and birthing experience by cesarean section. The second topic recounts the themes which emerged as the women

described what I have decided to term "the struggle"; the time between the cesarean section and the home VBAC. The last topic is that of the themes which emerged during the women's discussion of the VBAC itself, and any meanings which linger for these women to the present time. At times, the lines between the topics are blurred, and the themes don't always fit exactly into neat categories under each conversational topic. However, for clarity and ease in discussing the themes, I have chosen to group the themes around the conversational topic which they best seem to fit.

A. The Original Experience

The first conversational topic to be discussed centers around the women's experience of having given birth by cesarean section. It became apparent very early in the conversations that all of these women felt that this was where they needed to start when relating their experience; that without this experience, the home VBAC would not have held so much meaning for them. All of the women described their experience of cesarean section in detail, and many common themes emerged which I have chosen to group under the following headings: control issues, lack of support, feeling silenced, and depression.

Control Issues

This theme centers around these women's experience surrounding the issue of control. It is prevalent not only in their stories about their cesarean birth experience, but also in their experience of being pregnant and receiving prenatal care. It embodies two separate, and slightly different aspects, both which have to do with feeling a lack of control. The first is a sense that they "gave" control to the doctors who performed the cesarean section, thus they felt some sense of having control, and voluntarily giving it away. It differs slightly from the second aspect, that of having things "done" to them. This second aspect involves feelings of having control taken without their permission, even if they protested

The concept of turning over control seemed to stem from some underlying issues. Firstly, the women were fearful: they were frightened of labor and delivery and frightened during labor and delivery. These women put their trust in their doctors, and adhered to a belief system in which the doctor is all-knowing. Therefore, they seemed to believe that the doctor knew best and they should do whatever their doctors told them was best to do.

For Teresa, fear of what would happen during labor and birth seemed to lead to a form of denial; if she didn't find out what was going to happen, she wouldn't have to face reality. She says:

> I was actually quite horrified about what was going to be happening, like that was, as far as labor-delivery ... And in

> fact, I think, I was scared to do too much reading ... I didn't really want to know what I was in for.

This fearfulness led these women to trust, to put their faith in their doctors and allow their doctors to take care of them. In essence, this meant turning over control, submitting to whatever procedures the medical profession suggested without question. Janet put it this way:

> He's a doctor, I mean he's got a good education, he's professional, you have to trust him, because if you don't trust him, what else, what have you got left?

Charlotte recounts her feelings upon being told she was to have a cesarean:

> And they said, because I was too small, is what they said, pelvic disproportion ... which upset me, but then I thought, well, they know best.

Teresa speaks of her experience:

> And I took it for granted that everything was going to be absolutely fine and I was just going to, it was going to be just fine. I mean, I didn't think about it until I had to. And in fact, I think the denial went to the extent of putting all my faith into conventional medicine. You know, like I thought, I'll get a really good doctor and make sure that everything is really just perfect. And I was, I had no qualms about the fact that everything was going to be just fine. You know, I was just going to do whatever.

When Teresa then finds out her baby is in a breech position and the doctor recommends a cesarean, she submits without question. She recalls:

> I did not question him, I was terrified, horrified. The way he put it was that, well you can try, but, if this is

> what happens, then you lost your baby ... I accepted that, I trusted that, I thought I have a good doctor - I trusted him.

The concept of having control taken without their permission finds its voice in how these women viewed their bodies as being totally under the control of others. More than this, however, was the sense that the people around them during the birth were only focused on their physical bodies, not on them as feeling and thinking people. Therefore, they felt that procedures were done to them without discussion and without their expressed permission. This seemed to lead to a sense of violation; they felt they were treated with not only a lack of respect, but a disregard for their need and right to make decisions which would effect the outcome of their labor. Jane's voice speaks powerfully about this issue:

> They (the medical staff) talked amongst themselves or they talked to my doctor over the phone, or you know, it's like they were deciding things for you or they talked to my husband, but they didn't talk to me. They didn't say, they didn't tell me that they could turn down the IV. There was no discussion -- like I was an animal, not, not, not an intelligent, spiritual, emotional being at all. Just a thing. I mean, I could have been a cat, although I've seen vets treat cats and dogs with much more respect and dignity than I was being treated with.

And later, when Jane is actually on the operating table, she recalls:

> And on the operating table, they had me, I felt like I was being crucified, right. My arms out like this ...

Thus, a sense of compartmentalization was present: birth became solely a physical process, not an emotional or spiritual event. Doctors

had control of this physical process and the women felt little effort was directed towards them as people. This, in turn, seemed to lead the women to having a sense of disconnectedness with their bodies; their body and what was happening to it was separate from them as people. Charlotte speaks of being given an epidural anesthetic:

> First they give you the needle in your back, and you have to roll up in a ball, as tight as you can. It's uncomfortable, and then they have to be very careful to get the needle in the right area. And that didn't work the first time; he had to do it again. And then they strap your arms, they put an IV in, they put you on the ... respirator, or the, you know, the other machine. Ah, it was just very scary. And they, I asked if I could watch, and they said, 'no,' which kind of bothered me because I thought I could handle it, and I thought, well if I can't it doesn't really matter if I faint because I'm laying down anyway ... you're frozen from your nipple line down to your toes, and you can't feel anything. And they're kind of lifting your legs in the air, and that's your body, and you can't even associate with it ... they lift you to change your pads, and, you know, and they just lift you and do whatever because you can't feel it anyway ...

Lack of Support

The theme of feeling unsupported is central in all of these women's conversations in relation to their cesarean section. It also related closely to the concept of feeling abandoned; feeling that they did not have either the kind of or amount of support that they needed during what seemed to them to be an emotionally difficult time. However, the concept of abandonment as it was discussed by these women also embodies another

critical aspect; that of being unsupported by those that they expected they would feel supported by. In some cases, this meant feeling abandoned and, therefore, unsupported by their partners, while at other times, it meant feeling a lack of support and understanding from their doctors and other medical professionals while they were in labor or undergoing the cesarean operation itself. This feeling of being unsupported and abandoned by the medical profession is closely tied to the issue of having control taken from them, and is personified in descriptions of feeling dehumanized; of feeling that their bodies were simply objects undergoing a medical procedure, and that none of their other needs, emotional and/or spiritual were being addressed. Thus it seems that in taking control of their bodies, other aspects of their humanity were ignored, and therefore abandoned.

The conversation I had with Jane abounded with references to this feeling of being abandoned. She says:

> My doctor came in and he did a vaginal exam and the TV was on. Now we didn't have a TV and I didn't watch TV for 10 years. There was no TV in our house, and I didn't like TV, so this TV was supposed to be on for my appreciation or something. There was a chair between me and the TV, so I couldn't see it anyways. And the news was on, and the doctor was doing a vaginal exam and his head was turned at the TV and the nurse was watching the TV ... And I really felt like a piece of meat or an object laying on the table that they were working on, not really like a person. He never ever talked to me as if I was really an

> intelligent, thinking person, a feeling person, just another "preggie" that he was working on, you know.

Later she says:

> Oh, you know, when all those other women were going and having their babies, we were left abandoned in the inducing room for a very long time, like a number of hours ...

Charlotte describes her reaction during her cesarean operation:

> I was crying a lot. A lot. And nobody, I remember too, nobody even said like it's okay, or ... Nobody said anything. I think they just kind of ignored me because I was really sobbing.

Jane, in speaking of her experience, is also able to show how this sense of feeling abandoned added to her submissiveness, her inability to assert what she wanted and needed:

> They decided that it wasn't working, the time was up, I had to have a cesarean. And they gave me a piece of paper to sign and I really did not want to have a cesarean. I really didn't want to go into surgery but ... When my husband had gone to get some supper, and I was there, perfectly alone ... except for this nurse who was watching TV, and giving me a piece of paper and a pen, and they told me that I needed a cesarean. What do you do? Unless, unless, I mean, and I was absolutely in no position to start arguing with anyone. I mean, the best I could do was ... (crying) ... And I was crying all, I was crying at that point a lot, almost constantly; the pain was just too much. I was very exhausted, it was as if I'd been in labor for a long time by then. And so, I signed the paper, I mean, you've got to trust them. They tell you that you need one ...

Feeling Silenced

All of the women involved in the conversations expressed a sense of not feeling understood; thus the intense adverse emotions that they experienced after their cesarean section were not able to be voiced. These women seemed to be in a state of shock, both physical and mental. They couldn't believe how "badly" their births had gone, and were now left in a state of disappointment, pain, and grief because they had not birthed in the way they had expected to. However, their feelings of loss and sadness over having had a cesarean were not validated by those around them. They felt that no one understood how they were feeling, and that they weren't supposed to feel what they were feeling. There was a definite sense that no one wanted to hear about their disappointment and grief, that it wasn't right for them to feel that way, and that they were, in fact, abnormal or odd. The lack of support for their feelings drove them to silence. Charlotte describes her experience:

> After the first section, I felt kind of like, just shut up and be quiet, nobody wants to hear what you have to say. And the same old thing, just be happy you've a healthy baby, and there's nothing more to say. You have a healthy baby so just carry on.

She continues:

> And then I heard other people say, well so and so had a section and she's up and around, what's wrong with you? So it kind of makes you feel like, yeah, what is wrong with me?

Gail says:

> I think they (the medical staff) thought I was kind of weird too ... I was looking for someone to talk to for a long time, so I guess I was trying to grab somebody, and say what the hell is going on? Do you realize how much my head hurts? ... But I don't think anybody understood how damned bad I felt, and I had never thought, I thought this is worse than childbirth being here in this hospital with this gorgeous baby that I can't relate to because I'm sick ...

Jane uses a very powerful metaphor to describe how intensely she felt driven to silence:

> ... the literature that I was given ... all the pretty books with the beautiful babies and mommies and everything was flowers and stuff. I felt more like you would feel if you had been beaten up and raped the day before your wedding. And then expected to go to your wedding feeling wonderful and happy, with everybody giving you congratulations. That's how it felt. And, that's exactly what I felt like. I felt really, really horrible and everybody was coming in and saying, 'Well, congratulations, isn't this wonderful!' And there was nothing wonderful about it.

Depression

The theme of depression culminates the conversational topic of themes emerging from the original experience of cesarean section. It represents a fitting ending to the discussion surrounding this conversational topic, because, in a word, it embodies how each of the women describe feeling in the days and months after their cesarean section. As well, it would seem that the issues discussed in the previous sections, that of feeling a loss of control and of feeling unsupported and silenced, were an integral part of the sense of depression these women

experienced. The feeling of depression was in strong contrast to how they expected to feel after giving birth, and to how they felt when they first learned they were pregnant.

It is very interesting to consider that three of the four women involved in the conversations began relating their stories by sharing how excited, special and changed they felt when they first realized that they were pregnant. The knowledge that they were pregnant seemed to make them feel not only exhilarated, but powerful and healthy. Teresa described it this way:

> ... and I just felt different, all, right off the bat. There was something different. I wasn't the same person anymore, and I just wanted to tell everyone ... I was just very, very healthy; very, very hungry all the time. I felt great. I felt like somebody had given me like a super mega vitamin every morning. I just felt like I could climb mountains.

Jane speaks of her initial euphoria:

> Well, when I got pregnant the first time, I was really excited. I was really, really happy. In fact, I remember going for my run in the morning and was running along just thinking about being pregnant and, you know, you're running, you're using up all the energy you have, but all of a sudden I'd leap into the air because I was so excited.

These quotes are in a sharp comparison to how these women described feeling after giving birth by cesarean section. Thus, there is some sense of being set up; because their expectations were so much

different from reality, they had a very hard time dealing with the reality of their experience and their feelings surrounding it. Gail says:

> I remember thinking of all people in the world to blow it, it's me. I felt so informed and so confident and strong and had great support; like my husband was fabulous, up 'till the point that I had decided I had blown it.

The women involved in these conversations all voiced a feeling of being let down after having their cesarean. Depression seemed to find its expression in a multitude of feelings: confusion, grief, regret, humiliation, shame, anger, and feelings of inadequacy. Not all of the women expressed feeling each of these emotions, but all expressed some of them to varying degrees, and all in all, the sum total was that of a state of depression. This feeling of depression; of coming down after giving birth by cesarean section seem to involve a sense of self-recrimination; that somehow the cesarean had been their fault. In regard to her second cesarean in hospital, Charlotte says:

> If I would just have been stronger or would have known more, I could have, it would have come out differently ...

Gail says:

> I was so angry with myself because of all these limitations that I perceived as having begun when I didn't push right ... I felt so very angry with myself, and so very hard on myself, and so confused, and so the few kind things that people said to me just destroyed me, like it gave an opportunity for that other side to come out, the side that wasn't angry, the side that was so very sorry, really sad ...

Teresa describes her feelings after having had a second cesarean section:

> And it was just down, down, down, down, down baaaa, to nothing. You know, like, here's my section again ... But that's when the other emotions started kicking in -- the guilt, like, what did I do wrong? ... How come I can't have babies the right way? The inadequacy, the ... you know, all that kind of stuff kicked in with that second section, because I got sick, I got ... I thought it was my fault, not the fact that I'd come in to the hospital and been jabbed with five million exams ... like I was coming down, down, down, down, down, you know. And it was just ugly. It was awful.

Jane describes the depth of her feeling while in hospital after her cesarean:

> ... extremely intense feelings, just extremely intense. The things that they asked me to do really had to get done, like I was under an enormous amount of pressure, extreme anxiety. I cried all the time, all the time, and I couldn't stop myself ... And lots of people came to visit and it was, it was just too much because I was really upset. I felt like, like I'd been in a car accident and I, I felt like my whole body was in a state of emergency ...

For Jane, this state of depression continued for a long time after her hospital stay, and was characterized by feelings of confusion and very low self-esteem. She says:

> ... even getting to the point where I was ready to have sex again, I, I'd think, okay, maybe we can do it and then my husband would come into the room and I would just feel like oh, no, don't, don't even touch me because I felt like I'd been really handled, and I just, and I didn't want anyone to touch me. I just, and I couldn't even imagine anyone else wanting to touch me because I felt extremely ugly, I felt really like I was sick, and really

> hurt. Like an animal laying dying on the side of the road ...

B. The Struggle

The second conversational topic which was common to all of the conversations was that which I have chosen to call "The Struggle." Embodied in this topic is a roller-coaster of emotions and events which the women describe as happening between their cesarean and home VBAC deliveries.

This conversational topic is characterized by conflict and dichotomies of experience. It seemed to me to represent a time of disintegration; of feelings about self, and of long-held belief systems. Because what these women had thought and expected to happen did not happen, their prior beliefs were forced to disintegrate, and a cognitive and emotional dissonance resulted. This dissonance is characterized by feelings of uneasiness, agitation, and disorder. In short, a time of conflict, confusion and ambivalence were apparent. The work of this section is, therefore, to present these images of disharmony and the processes the women describe in their search to regain a sense of equilibrium. The themes which seem to embody this period of struggle include: confusion, determination/doubt, and choosing silence/finding voice.

Confusion

The theme of confusion or of feeling confused is immediately apparent even as these women describe the depth of the depression they were experiencing after their cesarean sections. This sense of confusion seemed to arise not only from a sense of disbelief that the birth could have gone so "bad" as to result in a cesarean section, but also because these women described such extremes of experience. On one hand, they were totally in love and ecstatic about their new babies, and felt that they should feel joyful and content, while on the other hand, they knew their reality was that they felt depressed and sad. This state of being felt incongruous and difficult, and therefore, became a source of struggle. Gail described this phenomenon in this way:

> It was awful, absolutely gross, because I had a gorgeous, perfectly healthy boy who was hungry, he was so hungry, and I was this person who had had major surgery, and spent two days with a spinal headache and was in a strange country with no friends ... feeling like I'm so glad that there's this gorgeous baby, and I'm not up to whatever the job is of taking care of him ... I felt so bad, I never felt so horrible in my life ... like I can't believe I'm in this mess, I've had this spinal, and I have this incision, and I have this beautiful baby who deserves more than I can give it ... this is awful.

Jane says:

> He (the baby) was colicky. It was depressed. Ah, he cried for hours and hours. And (pause) it was the most horrible year of my life and I had the most beautiful little wonderful baby and I was so mixed up. Ah, because I just loved him so much and I'd never felt so horrible ...

Determination/Doubt

This period of struggle also seemed to be characterized by a period of extremely ambivalent feelings concerning the certainty and uncertainty of having a home VBAC. However, it was evident that this ambivalence was not about whether or not to submit to a repeat cesarean section. These women were determined. They had decided that if they were to have another baby, they would do everything within their power to ensure that the birth would be different from what they had experienced giving birth by cesarean section. This determination seemed to be born at least in part from anger; an anger which was highly motivating and triggered a firm resolve to not repeat their prior experience.

This anger seemed to be primarily directed towards the medical profession and/or the medical model of childbirth. As these women began to question the validity of their cesarean sections, they began to experience a profound anger towards the profession in which they had placed their trust, and which they felt had not only abused that trust, but tried to control them as well. Gail says:

> ... I was just furious, and I hung up the phone and I thought, 'Well, that will be the last time I will see these people' (her doctor and the doctor's receptionist), like I thought 'How dare they do this?' I thought, also, 'Like they have treated me like a child and I'm not, and you (her doctor) have picked the wrong cookie to push around', and it really, really strengthened my resolve ... it was actually the same day that I got on the phone and I phoned the midwives, getting me that angry worked

> to get me over to that side of the fence where I wanted to be ...

Jane, too, voiced strong feelings of anger and resentment towards the medical profession, stemming from her belief that many of the interventions which were imposed on her in labor were not only unnecessary but inhumane:

> I am furious! I could really hit somebody because of that. Why couldn't they have turned the IV down? Why couldn't they just have turned the IV down so that the contractions would be manageable and maybe, maybe couldn't they have turned it off? Why couldn't he have left the water intact? ... I didn't know that they could turn down the IV and the pain would ... I don't think that's fair. And I don't think that's morally right to do that.

This anger seemed to be a compelling force for these women. They became determined to change the nature of their birth experience with their next pregnancy. Gail says:

> I said to her (her doctor), I'd rather have my second baby in a parking lot than go through what I did ...

Jane put it this way:

> ... eventually I started thinking I would like to have another baby, but I really, really did not want to go, didn't want to repeat that (her first experience). And I knew that if I was going to have a second baby, it had to be completely different.

Charlotte said:

> Well, after my second section, I knew again that I was terrified and I didn't want to have another cesarean. I was just terrified and I knew I wanted to have another

> baby, but I thought come hell or high water, I'm not going in there (the operating theatre) again, I won't. I won't do it.

The struggle within this theme of determination/doubt arises once again from a sense of incongruity. These women's need and determination to have a completely different birth experience was inharmonious with the sense of doubt they experienced. Although there is a real sense of loss of confidence, trust and respect for the medical profession and its approach to childbirth, there is also a gnawing fear that the medical profession was right; that their bodies will not be able to birth their babies and that they do, in fact, require a cesarean section in order to give birth. These women fear that their initial experience will repeat itself; or worse yet, that if they take responsibility for their child's birth and deliver at home, the baby or they may be irrevocably damaged.

Gail had been the patient of the same general practitioner for a twenty year period. She felt she knew her doctor well, and that her doctor knew and understood her. This doctor had not been involved in Gail's first birth, as Gail had given birth while living in another country. When Gail told her doctor she was pregnant with her second child and considering a home birth, she felt a distinct change in the dynamic between her and her doctor; a change which surprised her, and also caused her to further lose confidence in the medical profession. Gail says:

> When I saw her (the doctor) face change, that I dared to be 11 weeks pregnant without notifying a physician, when I saw her face change, it really threw me, like I thought, 'Who the hell are you? Like I thought I knew you, I trusted you, how can this be happening?' ... all of a sudden this doctor who I had known and got along with for twenty years turned into Dr. Frankenstein or something ... She stopped talking to me, she stopped listening to me ...

However, parallel to this loss of confidence in traditional medicine seemed to be a sense of fear; a fear that perhaps they should continue to trust doctors and traditional childbirth approaches, doubt in their ability to give birth naturally, and a lack of trust in themselves. Teresa says:

> So I questioned it (home birth) actually, all the way through. I hadn't intended on a home birth ... all the doctors that I talked to ... said it's very high risk to have a vaginal delivery after cesarean because you could rupture the uterus, and if you rupture the uterus, you're dead ... It was just horrible, you know, when I think about it, it was horrifying because I was just so scared to [illegible] make the decision to have a home birth and ... what if? What if things don't go right? ... What if? What if? I couldn't live with myself, you know. I couldn't live with the stigma, I couldn't live with what other people would think, say, do ...

Jane speaks of the emotional stress this conflict caused for her:

> ... at the beginning when I found out I was pregnant I wanted to be pregnant, but I still cried. Because there was still, you never know, something could go wrong while I'm in labor, and I could end up in the hospital having a C-section again. I mean, it could happen and I wanted to do absolutely everything in my power to prevent it from happening ...

These feelings are echoed by Charlotte:

> And I never said anything to him (the doctor) that I was going to see a midwife. I wanted to keep going to him

> and see if something would change, and he still says, 'No, you can't have a vaginal birth because you could rupture, uterine rupture, and more or less, he did say to me one day, 'you could kill the baby, and it will die', and it was horrible. Horrible! And really questioning, 'Am I doing the right thing?'

Choosing Silence/Finding Voice

Within the period of the struggle -- the time between their cesarean sections and their home VBAC's -- all of these women described a dichotomy which I have chosen to call "Choosing Silence/Finding Voice." This dichotomy of experience is one of feeling supported versus feeling non-supported, of choosing to remain silent about their feelings regarding their cesarean sections and planned home births with some people, while finding support and encouragement to speak their truth in the presence of others.

All of the women described an experience in which they finally felt "heard"; a time in which they found someone who validated the negative emotions they carried regarding their cesarean sections, and in which they finally felt safe enough to express all of their emotions and describe their experience in a way which felt authentic to them. Jane remembers attending a meeting of women interested in alternate methods of childbirth and recounting her birth story there:

> And when it was my turn, I was really shaken up by hearing all of these wonderful experiences and I had, I mean, nothing

> even resembling it, nothing ... There was a baby in the end. Yeah. And so I told them my story (sighs) ... And, oh, then, you know, they finished, they finished all, everyone introducing themselves this way and we, we had a little break to have some coffee and stuff. And two, a couple of women, actually, three or four, all came and hugged me, and you know, cried with me, and talked to me about, it doesn't have to be that bad and if you need someone to talk to, here's my phone number and stuff like this. It was real support, and that is probably what really started me thinking that maybe I could have a second one (baby) ...

Charlotte described her experience like this:

> So, a friend of mine had had a VBAC, and so I didn't know her well, but I thought there's no harm in trying, so I just went, and actually, just went for a visit because she had a baby and I didn't go to find any information or anything, but it just came out and when you have kind of that same experience, it's easier to (pause) connect. And so that turned into a long visit (laughs), and she told me about her things and I'd never talked to anybody about my sections and how I felt, and it just felt good to get it out and not feel like, just shut up and be quiet ... And so we talked about sections and then she talked about her home birth. It was a home birth. And, I just felt quite powerful about it when I left, and she gave me a book to read called *Silent Knife*, and I think I read the first seven chapters that night, and I phoned the midwife the next morning.

All of the women, when planning their home births, began gathering whatever support they could find around them. This support came in the form of supportive friends, women of like experience, and the midwives to whom they looked for prenatal care. Thus, within the group of supportive people, the women finally felt free to tell their stories, their devastation surrounding their cesarean experience and their desire for a

different kind of birth experience. This support empowered them to find their voices and speak about what was real and true for them.

Although all of the women described finding this support in some form, they also described the overwhelmingly experience of the contrasting situation. As well as this new sense of finding voice, of finally being able to tell their stories and feel supported, was a sense of needing to choose silence. These women all described choosing to be silent to greater or lesser extent with those they felt would not understand or support their choice of home birth. This represented yet another struggle; they felt they were either not being totally honest with people whom they had traditionally been emotionally close to, or they faced the reality of having to deal with discord between themselves and family and friends. These women chose silence partially out of fear and self-protection (How could I stand the judgement if my choice is wrong?) and out of a sense of not being able to withstand the pressure that people who did not understand their choice might put on them to change their mind. Teresa says:

> You know, the hardest thing of all was my nurse friends ... I mean, they're totally bought into conventional medical approaches to childbirth, labor, delivery, the whole smear ... and they were very non-supportive ...

With the exception of two close friends who attended the birth, Charlotte and her partner did not share their plans for a home birth with any of their family or friends. Charlotte recounted:

> 'We didn't tell anybody that we were even thinking about it. And then we did finally say that we were thinking about just a vaginal birth. That's all we ever did say. We didn't say anything about it being at home or anything ... because there's no support, and plus, they (non-supportive friends and family) kind of put a lot of pressure on you, unnecessary pressure that you don't need, and they try to frighten you. That you are going to harm the baby or it's a stupid thing to do, and you just don't need that. It takes a lot of strength and a lot of working through to have it (a home VBAC).

Gail speaks of her experience:

> When I first heard about it (home birth), I couldn't imagine taking that much responsibility, or I thought immediately of my friends who were 'Once a cesarean, always a cesarean' people, you know, and I thought 'Let's get this straight,' they'd be thinking, 'Not only are you NOT going to have another C-section automatically at week 38, but you're going to have this baby at home? You must be out of your mind!'

When Gail and her husband make public their decision to birth at home, Gail says:

> The rest of the family thought I was crazy ... a few of them tried to work on my husband, but I knew they thought I was nuts and I was crazy the whole time ... it caused a serious rift with one section of the family because one of my husband's sisters is a nurse, so that pretty much explains how that goes ...

C. The VBAC Experience

The last topic of conversation which these women shared is that of the home VBAC itself, as well as any feelings surrounding that experience which lingered for them until the time of the interview. Many powerful words surfaced for me as I read and re-read the transcripts of these women's voices in their descriptions of their home births and what it has meant to them, words such as: gestalt, transformation, integration, interconnectivity, empowerment, and healing. As the women described the nature of this experience, it did indeed seem to me that to attempt to break this experience into distinct themes would not do justice to the holistic nature of it; in short, the home VBAC experience, for these women, does seem to be more than the sum of its parts. In this section, therefore, it seems appropriate to work from the premise of the home VBAC as a gestalt, and to describe this gestalt in as holistic a way as possible.

All of the women, in some form, described their VBAC home birth as a holistic experience. Charlotte said:

> It's (the home birth) about having a baby. It wasn't about a part of your body.

This seemingly simple statement actually captures the essence of the difference between the women's experience of cesarean section in hospital and their home births. For them, their cesarean sections had been experiences in which there seemed to be a separation between their

emotional and spiritual selves, and their physical bodies. They felt the prior was ignored; they became their reproductive organs. The home birth, conversely, was an experience about having a baby. For these women, having a baby was an experience which contained many elements other than that of a purely physical nature; their bodies, minds, and spirits were all integral parts of the process.

Because they viewed pregnancy, birth and motherhood as more than a physical process, the type of support and care offered by midwives appealed to these women. They felt that the midwives they saw not only supported their emotional selves as well as monitoring the physical changes in their bodies, but that the midwives placed the locus of control on the women's shoulders. As well, they felt that the type of care offered by midwives stressed pregnancy and birth as being natural and healthy. These differences stood in stark contrast to the women's prior experiences with traditional medicine. Teresa says:

> And I found that seeing Debbie (the midwife) was not anything at all like what it had been going to the doctor ... It wasn't like you go the clinic and there's something wrong. You, it's not like, like, it's a medical type of thing. With Debbie and going to the clinic there, it was more like a wellness type of thing ... it was just natural. It was just healthy. It was just everything was good about it. You were pregnant, it was wonderful and you were going to go through labor and delivery; that was never questioned, and everything was going to be just fine. It was all very, everyone was very positive, very encouraging ... it was different in the sense that going to

> the doctor they were always looking for something to be wrong ...

Gail says:

> I knew right away when I came in the door that this (the midwife's clinic) was different and I felt, and I knew right away from the way I was being talked to, the questions I was asked, I was being treated like a grown-up ... and she explained you know, right away that when you come in you do your own urine testing, you do your own weight ... you know, you go to your obstetrician's office, you know, you have your 5 minute appointment, it's all a mystery, you know, you pee in a cup, and they have an employee who comes to dip the urine stick in to see what color it turns, it's so stupid, why can't I do it myself in the bathroom? Because it's a mystery.

In contrast to her visit to the doctor's office, Gail describes a visit to the midwife:

> A midwife's visit, you know, you spend 2 minutes at the first of the interview, getting a fundus measurement, and you telling her what the little stick did in the urine, and all the rest of it, which can go on for an hour if it needs to, but most of that time is spent talking about your life, and not in a gabby sense, but in a sense of how you feel about the pregnancy, how are the demands of the family going, are you feeling stressed out, or are you feeling good about things ... dealing with the midwives is about -- How is your life?

Gail also felt she was given not only the locus of control for what happened during labor and delivery, but also knew that in deciding to have a home birth, she also accepted the responsibility for it. She says:

> Melanie (the midwife) had said right at the beginning that they (the midwives) don't do much of anything (during labor and birth), that they are persons that have some ideas and some tips, but birth is the mom's job ...

There was also a sense that the midwives were real people, with real lives and real problems. These women, therefore, felt that they developed a close, supportive, and meaningful relationship with their midwife. In contrast, their relationships with their doctors often had felt very superficial. Jane described a visit to her obstetrician like this:

> ... you would wait for an hour at least in his waiting room, and it was always packed when your appointment was, and he would spend about two or three minutes (with you) ... and he was very slick, and just like a salesman or something, he would come in, he'd have his spiel that he was saying, pull on his glove, he'd, oh he'd, he was always doing internal exams, I don't know, the midwife did not do internal exams very often ...

This holistic type of care which was provided by the midwives seemed to lead these women to not only trust their midwives, but feel safe in their presence. Teresa says:

> The midwife was very encouraging. I felt (pause) very confident in her skills ... she just seemed, she was just so competent, so sure of herself, so experienced ...

Gail says:

> So much about birth depends on who's around you and how they feel about birth ... and so if you're in a hospital where they believe things can go wrong, guess what, things go wrong, and if you are surrounded by people that believe birth is not a problem, then birth tends not to be a problem ...

As they trusted and felt safe with their midwives, suggestions made to them by their midwives during labor became very empowering for these

women and helped them to find the strength to do what they needed to do to deliver their babies. Gail, for example, labored at home with her second son, and was having a great deal of difficulty with the second stage. Although she was trying to push, little progress was being made in the descent of the baby through the birth canal. She describes this experience, and how she became empowered to push her baby out like this:

> ... and Debbie (the midwife) says, 'Does it feel like a wall that you can't get through?', and I said, 'YES!' and she says, 'You can get through it, you have to push past it, come up to it, and push right past it.' And that was just exactly what I needed and exactly how it felt ... like Deb knew exactly how I felt, and she described it and if she said you can go through it, by God, you can go through it ... I felt like this was possible, like because she described it exactly perfectly, I knew it was possible, if she could dream it, I could do it, and I remember feeling when I got one push in, and I had gone up to the wall and past it and through, and I thought, 'Yes, that's it!, that's it! That's the way it's supposed to feel ... this is great!' ... and then I knew that everything was going to be OK, and I knew I could really do it!

Jane shares a similar experience of being in labor and finding strength through a suggestion made by her midwife:

> I remember before I laid down on my side when I was standing up, I said, I was shaking my head and I said, 'I CAN'T DO IT ANYMORE!' and Dawn (the midwife) said, she looked in my eyes and she said, 'Jane, you have sources of strength that you haven't even begun to tap.' And as soon as she said it, it was true ...

This sense of being empowered through their home VBAC was described by all of the women, and, in fact, becomes one of the legacies of this experience for them. This feeling of being powerful and in control is again directly opposite from their cesarean experience in which they felt helpless. As well, there is a sense of personal transformation through the realization of feeling empowered; that somehow they have become someone different than they were before. Teresa says:

> ... and how many times do you hear women thanking their doctor for delivering their baby? Like they (the women) had no part in it? You know, like they've been removed from it somehow, and what Dawn as a midwife did for me was empower me, that this is your baby, this is your delivery ... I'm (the midwife) here, I'll help you, but it was me. I did it, not a doctor or not the midwife ...

She continues later to say:

> I felt far more confident in myself (after the home VBAC). I would say the confidence level. And I found out that I could do it, and I did an excellent job at it too, you know ...

Charlotte says:

> I know it (the home VBAC experience) has given me, like oodles of strength ... I really feel like, the more and more I do things, that I can manage, and I can overcome any kind of thing. So it may take a while but, I know how to stand up for myself now and speak up ... and it doesn't have anything to do with showing power to anybody else, it has to do with showing power to yourself ...

She goes on to say:

> ... It's a whole other person I think I've become. I'm not who I used to be ...

Jane chose to describe her feelings of empowerment and transformation by describing two very powerful visualizations, one which she remembers from a VBAC preparation class, and one in the form of a dream which she had shortly after her home birth. The contrast between the images she describes is striking, and Jane reported that these images have been very, very meaningful to her. She reported the first image like this:

> You were supposed to visualize being at a water's edge and there was a boat there. And we were to take all of the emotional baggage and everything to do with our first birth and load it into the boat, and push it out into the water. And I remember loading all this in and imaging myself pushing it out into the water, but there was this big chain that was chained to me and I couldn't let the boat go. I had to get an axe and I had to hit this chain. Whack! Whack! And finally let that boat go. And watch it go out, drift away, and wave good-bye. Let it go. And a lot of times this image would come back to me and I would still see that boat. That boat was still out there, you know. I hadn't gotten rid of that boat. That boat was out, out there on the horizon ...

The second image is one she remembers from a dream she had shortly after her vaginal home birth. She described this image as follows:

> After Greg was born, that night, he was all snuggled up beside me, I had a dream and in the dream I was on a boat in the middle of the lake. It was absolutely, it was a huge, huge, lake, I mean, it was horizon to horizon, it was fresh water. And I jumped out of the boat and I dove into the water, and I was swimming, and it was absolutely clear; it was just extremely beautiful. There were all these things lying down at the bottom of the lake, and I picked

> them up and they were, they were the things I'd loaded into that boat ... They were lying at the bottom of the lake, and I was free, I was swimming ...

Thus, for the women involved in these conversations, the VBAC home birth experience seemed to represent a crossing of a threshold; a moment or time of revelation in which they had a new understanding of themselves and their being in the world. There is no doubt that this was a joyful, healing experience for these women, which brought with it a sense of re-integration; of things coming together; of a beautiful calm after a storm. The euphoria they describe upon delivering their babies at home is undeniable. Teresa described her feelings:

> I just remember being quite elated, quite ... just totally high ... just thinking, WOW, this is just wonderful ... I just remember really, incredibly, overwhelming feelings of relief, of happiness ... of just incredulous, incredulousness, like WOW, this happened ...

Gail's words echo Tracy's:

> It's an astounding experience ... I couldn't believe it, like I'm in my house, I've got this fabulous baby, all these wonderful women around like who I really trusted ... I was feeling like this is great, doesn't everybody know I've just had this baby! The baby is great, and I'm great ... it was a rush, it was incredible ... everybody was so happy ... and I was so happy ...

Jane's words speak to the harmony and peacefulness which she experienced:

> ... and I felt really happy and really at peace. I felt like a human being, you know. I felt like a mother with a

> new baby. I mean, that's what you're supposed to feel like, that's how it should be ...

And later she says:

> Ah, the second birth was a really healing experience ... I would never go to a hospital to have a baby, not ever again.

This sentiment, of being glad that they had delivered their baby at home, was echoed by all of the women involved in the conversations.

Teresa says:

> It (the home birth) was one of the best decisions I've ever made, you know, to go with it. And ah, I don't regret it for a second ...

And Charlotte says:

> I'm so glad it happened that way (at home). I wouldn't, I wouldn't have had it any other way ...

For two of the women involved in the conversations, the VBAC home birth experience also held a spiritual component. This spiritual component was very much linked to their feelings of being healed and getting in touch with their own power. However, it also holds an element of being aware of something beyond themselves.

Jane described a vision which for her is linked to her VBAC experience which captures this spiritual essence:

> I was walking surrounded by brilliant white light ... and it was a real spiritual vision, it was really joyful! ... I was just surrounded by this white, white light. It was just an incredible, wonderful vision of spiritual strength ...

The nature of the spirituality which Gail describes is once again linked to feelings of empowerment, and of going beyond herself to feeling a bond with women throughout the ages, who have labored and delivered children. She seemed to feel that the home VBAC experience had not only helped to get her in touch with her own power, but that of all women. She says:

> After the home birth, I definitely had a sense of knowing women through the ages and felt an indebtedness to them ... and I felt so powerful! Like, if we as women can do this (give birth), we can do anything! If women did not know how to do this, or were not willing to do it, our species would not survive.

Thus, the women involved in these conversations all describe their home births as empowering, healing, and euphoric; and as an experience which changed their sense of self in a powerful way.

An additional legacy of this experience is one of anger. Although the women had experienced feeling angry about their cesarean experience before, the fulfillment of their dream of a home birth, with it gifts of healing, empowerment, and joy, seemed to further illuminate the untenable nature of their cesarean experience. It became crystal clear to these women that the birth experience could be very different from what they had experienced giving birth by cesarean section. Though not all of the women identified themselves as feminists, all of the women expressed anger at a male-dominated medical model of birthing, and expressed a

yearning for a more holistic, female-oriented model. Teresa expressed it this way:

> Definitely I felt angry after Sophie was born, and I realized I could do it (have a vaginal birth). Because I think conventional medicine set me up. I think I went through two totally unnecessary major surgeries; the first one because the obstetrician couldn't tell a head from a bum, and the second because, because of all the internal exams caused me to become infected ... my cesareans were caused basically by conventional medicine ...

She continues:

> I guess it is because for whatever reason, men have felt the need to take control of it (birth) ... the one thing that they really don't have any control over, they took control of it. And I don't think they have done a very good job ... Leave me alone - that's what Deb (the midwife) did ... she left me alone and I was fine. There is a kind of an aggressive attitude, I guess -- male-dominated conventional medicine. The attitude is like, let's get that baby out of there. It's a real aggressive kind of view of birthing ...

Jane says it this way:

> The medical profession, especially when it comes to childbirth, I mean, it's all dominated and run by males. And it's all male thinking. And giving birth has absolutely nothing to do with men or male thinking. It all has to do with women and female thinking, and it is very different ... Men do not think the same way women do, and so how can a man have any real idea or real empathy for what is happening and what is going on, how can he know? ...

V. DISCUSSION

> Birth, the will of creation to exist, is incarnate in women ... given to us to know. Birthing energy empowers and teaches us (Hartigan, 1984, p. 2).

This chapter begins with a synopsis of the themes presented in Chapter IV. This synopsis serves to retell the women's stories; to present a snapshot which depicts a collaborative vision of the basic nature of the home VBAC experience for the researcher and the four women involved in hermeneutical conversations in this study. The chapter continues by reflecting upon my journey as a researcher, and compels me to ponder questions associated with the "personal as political" in regard to home VBAC, and the sociopolitical ramifications of the results of this study. The implications of this study for changes in the medical structure, for counselling, and for further research are explored. Finally, the wisdom and knowledge which can be claimed by women through their birthing experience is acknowledged and honored.

A. The Synopsis

A woman becomes pregnant. She is young and articulate, and views herself as capable, independent and assertive. She very much

wants to become a mother to the life that grows within her. She is excited and energized by her pregnancy, and somewhat in awe of the power inherent in her female body. She is proud of her pregnant body and thrilled with the possibility that it holds.

Like all of her friends, the woman seeks medical advice for counsel through her pregnancy. She is sometimes taken aback by the short duration of these monthly and then weekly consultations, but reassures herself that the advice she is getting comes from a knowledgeable, professional source. She accepts the advice with little reservation, forcing back into her unconscious any vague feelings of doubt which may surface. She goes forward through her pregnancy, trusting that she is doing everything she should to guarantee her a beautiful and healthy baby.

Labour begins. The baby's birth is imminent. The woman is reeling with shock and disbelief. How come everything is going so badly? Why isn't her body doing what it is supposed to do? Why isn't anybody talking to her? Why does it all hurt so much? Why didn't anybody tell her it would be like this? The baby is born by cesarean section.

The woman falls in love with her baby. The baby is so beautiful, so perfect, in sharp contrast to her. She is ugly. She has failed. Her head

screams with self-recrimination. Her heart grieves the birth that should have been.

Friends come. The woman puts on a brave face and fake smile. Her friends gush over the baby and tell her how lucky she is. A lovely baby and no episiotomy - WOW! The woman breaks. She cries. She withdraws. Her friends are incredulous. What in the world is the matter with her? They ask and she asks the same question of herself. Her friends withdraw.

The woman takes her baby home and tries to forget. She does her best to get on with her life as a mother, and loves her baby more and more. She pretends nothing is the matter, but secretly feels violated, angry, responsible, sad, and confused. She is angry with herself for feeling this way, yet feels herself slipping further and further into the void.

After a time, the woman toys with the idea of having another baby. No, she is too terrified; too vulnerable to succumbing to her view of herself as inadequate, unfeminine. She meets someone - another young mom. They begin to chat, and soon they begin to talk about their children's births. Her anxiety level rises. Her walls go up.

Suddenly, the walls come tumbling down. This other mom "gets it." She listens and understands. She hears her, soothes her, validates her.

She is no longer alone with her anguish. Her new found friend tells her about other ways to birth; about midwives, home birth, and VBAC.

The woman becomes pregnant. She feels hopeful. She feels terrified. She feels safe. She feels unsafe. She undertakes her own research. She considers home birth. She visits her doctor. He talks about repeat cesarean. She talks about VBAC. She continued to consider home birth. She feels alienated from the medical profession, yet feels she needs their stamp of approval to attempt a vaginal birth. She wants to birth at home. She wants to birth in hospital. She feels angry, confused, scared and determined. Secretly, she begins to see a midwife and plans for a home birth. She gathers support from a few women whom she sees as "believers." With many of her friends, she remains silent. At times, she feels insecure and tormented. She doesn't know what to do.

The woman's labor begins. She calls the midwife. She feels determined. The labor feels hard, but she feels in control. Everyone talks to her, supports her, reassures her, and comforts her. Her baby is born at home. She is overwhelmed. She can't believe it. They were wrong. She was right. She has given birth to her baby as women throughout the ages have done. She now understands the inherent power in this process. She feels proud, powerful, joyful, confident and victorious. She

is filled with exhilaration. She senses a peacefulness which had been missing for a long time. She is a new person; changed, strengthened, empowered, healed. She falls in love with her new baby.

And yet, some anger lingers ...

B. Home VBAC: The Personal is the Political

In many ways, the stories shared by these women mirror other documented accounts of the emotionally devastating effect of cesarean section on many women, and the healing, empowering effect of a subsequent vaginal birth for these women (Baptisti-Richards, 1987; Cohen & Estner, 1983; Panuthos, 1984). However, two aspects of the continuum of experiences discussed by women in this study are not as well documented in other literature, and deserve further thought and analysis. These two aspects are: (1) the presence of a time of overwhelming emotional "struggle" between their cesarean and VBAC deliveries; and (2) the anger which each of the women described as being a legacy of the cesarean/home VBAC experience. These two aspects are viewed by this researcher as related, and will be discussed in relation to their implications for the caretaking of pregnant and birthing women, counselling, and topics which demand further research consideration.

In Chapter IV, the conversational topic of "The Struggle" is documented, revealing the themes of confusion, determination/doubt, and choosing silence/finding voice. These themes expose the women's internal and external "struggles." The women had to struggle not only with their internal belief system about their ability to vaginally birth their babies, and where it would be safe to do so, but also had to confront a massive social and political structure which told them that what they very much wanted to do (i.e. have a vaginal birth at home) was selfish and foolish. This time of "struggle" took a toll on these women, and created a great emotional upheaval within them. This upheaval and uncertainty culminated in a very positive way in the birthing of their babies at home; an experience which they described as healing, empowering and transforming. However, their stories, their experiences, also culminate in expressions of anger.

Heilbrun (1988) suggests that women who dare to speak their truth, are very often faced with the "ridicule, misery, and anxiety (that) the patriarchy holds in store for those who express their anger about the enforced destiny of women ... Even today, after two decades of feminism, young women shy away from an emphatic statement of anger at the patriarchy" (p. 125).

Yet, speak their truth, these women did. Within the context of these hermeneutical conversations, these women expressed their anger eloquently, unapologetically, and forcefully. They are angry that they had to endure the "struggle." Their anger is aimed at the patriarchy, at the power structures inherent in the traditional medical establishment, and its unyielding structure which often confines and directs women to a medically imposed manner of birthing, a manner which they found to be disempowering and unfeeling. Their home VBAC experience, on the other hand, provided these women with the opportunity to connect with and claim the power inherent in the birth process. They emerged from it empowered not only to express, but also able to name and target their anger.

Thus, in essence, the home VBAC experience for these women, served to be a "consciousness-raising" event, in which the personal, concrete experience of what it is to be, and be treated as a woman in our society, breeds a feminist consciousness (Stanley & Wise, 1993). This feminist consciousness is grounded in their personal experience, in their valuing of their individual and collective "truth," and necessitates an exploration of the personal as the political in regard to VBAC and home birth.

Over the past twenty years, feminists have critiqued many of the sexist assumptions central to a variety of academic disciplines such as sociology, psychology, and philosophy. Sherwin (1992) suggests that the practice of medicine and biomedical ethics have, until recently, escaped rigorous scrutiny by feminists. She elaborates that, because many authors in biomedical ethics do show some sensitivity to feminist ideals (i.e. use of gender-inclusive language, the defense of women's right to choose in matters of reproductive technology), and because individually, most doctors and health professionals try to provide optimal health care service to patients, the insidious and sometimes subtle nature of sexism and oppression by the medical structure is not always recognized. In other words, individual practices appear innocent when examined on their own, and oppressive patterns are therefore not recognized and are unconsciously accepted by oppressed women (Sherwin, 1992).

In regard to VBAC and home birth, it would therefore seem important not to focus only on individual women's stories, and the practices of individual doctors, but at how the institution of medicine, the medical structure, reinforces sexist assumptions which impact the care given to not only birthing women, but all women seeking health care.

The stories of the women involved in this study attest to paternalistic treatment given to them by physicians, and to how, before

their cesarean experience, the women themselves were quite accepting of this treatment. This fact emphasizes the hierarchical model of our current medical structure, with physicians holding a distinct power advantage, and asserting authority over women's health. This power as healer is often maintained by promoting fear, rather than strength, on the part of patients, with physicians maintaining their power advantage through the withholding of and "parcelling out" of information (Miles, 1991; Sherwin, 1992). This model stems from a long-standing historical tradition, which has served to pathologize and medicalize childbirth, and has placed pregnancy and childbirth squarely within the scope of medical practice controlled by physicians, and away from midwives (Barrington, 1985; Blumenfeld-Kosinski, 1990; Oakley, 1990).

According to Barrington (1985), "Modern Obstetrics clouds birth with a disfiguring fear, instead of enhancing it with a visionary confidence ... The belief that birth is a crisis clearly creates crises" (p. 20). Many authors (Cohen & Estner, 1983; Faludi, 1991; Miles, 1991; Oakley, 1990; Sherwin, 1992) document this medicalization of childbirth, and it is a lived reality for the women involved in this study. Their experiences with childbirth within the medical, disease-oriented traditional medical establishment, ultimately ended for each of them in a state of feeling depressed. It is interesting to observe that this state of depression could

also be pathologized as a medical disorder, if viewed from a medical framework. However, from a feminist stance, this depression is justifiably viewed from a sociopolitical standpoint. Thus, what is one woman's depression when viewed individually, becomes a flagship of women's oppression when the women's experiences are viewed collectively.

Conversely, the women involved in this study, also spoke of the empowering and victorious nature of their home VBAC's, and spoke positively and enthusiastically about the type of care they received from their midwives. The women felt that they were given information and support from their midwives in order to make informed decisions. They perceived their midwives as offering a more holistic type of care, in which their emotional and spiritual well-being, as well as their physical safety was valued. These women spoke of the value of longer prenatal consultations with their midwives (as opposed to the short duration of their visits to the doctor's office), and attested to feeling safe and having control over their birth experience when giving birth at home. These benefits, ascribed to the type of care offered by midwives, are also well documented (Barrington, 1985; Cohen & Estner, 1983; Oakley, 1990), and also reflects the midwife's belief in levelling out power imbalances which may exist between she and her client.

Thus, the results of this study speak for a need for dramatic changes in the traditional medical structure. The model of care for pregnant and birthing women modelled by midwives should be the basis for the maternity care of all women and babies. This model of care could and should be available to women whether they choose to birth in hospital or at home, whether they have had or are having cesarean sections or vaginal births. Women should have information provided to them so that their decisions surrounding their pregnancy and birth are informed. The holistic nature of birthing must be acknowledged, and its impact on the emotional, spiritual, and physical lives of women validated and valued. The paternalistic and hierarchical nature of current medical practices as it pertains to birthing women must stop. Doctors should become active proponents of VBAC, and must recognize its value to the physical, emotional, and spiritual well-being of patients, as well as its cost effectiveness. Women who make an informed choice to birth their babies at home should be treated with respect, and be able to gain access to support systems (i.e. publicly funded midwives, supportive "back-up" physicians should they require transport to hospital).

This call for action, for the need to change the medical structure in order to more effectively meet the need of birthing women, is not new (Cohen & Estner, 1985; Barrington, 1985). Some changes are being

realized. The rise in the VBAC rate in Canada over the last ten years, and the current movement to regulate midwifery in some Canadian provinces are examples of positive changes. These changes, however, are slow and are fraught with obstacles. This analysis suggests that the reasons for these obstacles, and the slow rate of change, are embedded within a sociopolitical understanding of women's health issues, at the basis of which is the oppression of women in our society. Thus, there is no one personal solution to this oppression. What is required is a massive transformation of not only the medical structure, but a large-scale social transformation as well (Sherwin, 1992). Integral to this concept is the idea that women, alone, cannot change either the medical or social structure which oppresses women.

Our patriarchal society and the powerful traditions which are a part of it are run, by and large, by men. Most physicians currently practicing are men, or are women trained under a patriarchal-based system of medical traditions. It is my belief that the majority of the medical practitioners do not set out to cheat birthing women in patronizing and paternalistic ways. However, the effect of being trained in powerful medical institutions in a society which bestows a great deal of power on physicians, creates a system in which physicians continue practices which oppress women, and maintain the power imbalance between

themselves and their birthing patients. Physicians are simply doing what they have been trained to do. But, it is not enough for physicians to set out with good intentions. They, along with birthing women, must act to transform the doctor/patient relationship and medical structure, so that it no longer perpetuates oppression. From a feminist standpoint, this transformation would result in a recognition of social, as well as physiological aspects to health and birthing, would resist hierarchical structures, and would be concerned with empowering patients, by providing them with all the relevant information to make decisions regarding their own health. Within such a framework, the medicalization of childbirth would also be transformed. Of course, specific instances of pregnancy and childbirth requiring medical intervention and assistance will continue. However, the pathologizing of pregnancy in general within the medical structure must stop, and be replaced with an attitude of pregnancy as a normal, healthy condition (Sherwin, 1992).

C. Implications for Research and Counselling

Throughout the process of undertaking this study, I have repeatedly been struck by the willingness of the women who talked with me to share the intimate realities of their home VBAC experiences. These women displayed openness and honesty, and allowed themselves to

expose a continuum of emotions in my presence. This willingness to show vulnerability, to feel and name what they were really feeling, is for me, a legacy of this research process. I am struck by the courage, fortitude, and perseverance evident within each of the women's stories, and in their sharing of their stories with me. The above-named attributes--courage, fortitude, and perseverance--are not commonly or traditionally attributed to women; yet their presence is glaringly obvious in each of these women.

Thus, the process undertaken in this study has taught me, in a very personal way, how women value truth that is personal and grounded in their own experience. The women I have spoken with have struggled to claim the power of their own minds and bodies, and have shared the darkness of their private, intimate experience, so that it has become shared, public knowledge. My work has been to present their voices, and also include my own.

My voice has framed this argument. I have worked to go beyond simply hearing a variety of viewpoints and objectively describe them. Rather, my work has been to trust, to connect, to enter into each woman's perspective, while at the same time not to abandon myself to their perspectives. My search has been for a "connected knowing," a "collaborative vision" (Belenky, Clinchy, Goldberger & Tarule, 1986). This

collaborative vision is richer, multi-dimensional, and more powerful than the vision with which I entered this study. Thus, for me, through the process of this study, the ideas postulated by the philosophers Heidegger and Gadamer, and by feminists such as Stanley and Wise, Reinharz, and Eichler, have proven themselves to be real, valid and necessary.

The process of doing this study, and the results of it, also suggest implications for counselling of women and areas demanding further research consideration.

The women involved in this study each attested to the enormous amount of emotional upheaval, the depression, and the "struggle" which they encountered in relation to their feelings surrounding their birthing experiences. Each of them spoke of feeling that their emotions, in regard to their cesarean births, were not validated by their caregivers, friends, or society. These women struggled to overcome, and somehow found the support and strength to birth their babies in a manner consistent with their internal belief systems, despite societal pressure to "conform." However, the number of women having VBAC's at home is minute, compared to the number of women considered medically "eligible" for VBAC. This fact begs many questions: How many post-cesarean mothers are left feeling depressed and are unable to find validation in order to voice their depression? Do women who choose home VBAC experience

their cesareans in a more negative way than most women who undergo cesarean section? If so, why? If not, how and why are home VBAC mothers choosing home birth, while other women choose repeat cesarean section? If all women who have given birth either vaginally, or by cesarean section, with or without any type of medical intervention, were given emotional support, and their feelings validated as real and true, would they make different birthing choices in subsequent pregnancies? If so, what would those choices be?

It is certainly here that implications for counselling become apparent. Therapists need to be aware that emotions related to birthing experiences may be yet another factor leading to depression. From a feminist standpoint, an understanding by the therapist of the sociopolitical factors which may be at the root of these emotions is imperative. As well, the ability to validate the emotions of the birthing woman, and to aide in defining their experience in light of the sociopolitical circumstances surrounding it, seems essential. This study also suggests that, for women who have undergone traumatic birthing experiences, a subsequent, more fulfilling birth experience can aide in emotional healing. The therapist's work, from a feminist standpoint, therefore, may be one of advocating a proactive approach to childbirth on the part of the client. This does not mean that it is the therapist's job,

nor should it be, to advocate home birth for her clients. Rather, the therapist should advocate for the client to seek out information, so that she can make birthing choices which are appropriate for her, whether at home or in the hospital.

D. Personal Transformations

Throughout the process of doing this study, I have been constantly in a process of "coming-to-know." This process has challenged me in unique ways. I had to be constantly vigilant when listening to the conversations and picking out the themes, to bracket my own pre-understandings, and understand how they interact with the words of the women to create meaning. I have come to realize the importance of the "I - thou" relationship characteristic of the hermeneutic encounter (Palmer, 1969).

An example of this became apparent to me as I explored spiritual aspects of the home VBAC experience. I realized that a spiritual component was within the experience of only two of the four women I talked with. I also realized that a spiritual component to birthing was an integral part of my own experience, and thus, I hoped to find it in the experiences of all the other women, and had to come to terms with the fact it wasn't there.

Other aspects of the home VBAC experience have become much more salient and meaningful for me as a result of this study. In particular, I have developed an acute awareness of the difficulties inherent in the "struggle," the second major conversational topic that this study addressed in Chapter IV. As well, the passionate expressions of anger which the women voiced, have evoked in me a stronger awareness of my own anger, and a clearer vision of what feminism means to me, as well as a willingness to clearly and openly voice my feminist beliefs.

I, therefore, have been further transformed by this research experience, and feel I am emerging from it stronger, more confident, and more powerful.

E. Preserving the Blueprint

This study has explored the birthing experiences of four women only. The results of this study are, therefore, limited. They cannot be generalized to assume they reflect the experiences of all women who have undergone cesarean sections, or who have had VBAC home births. However, this study does reflect the experiences of four specific women whose initial birth experiences ended in cesarean section. This experience effectively barred them from coming to know the wisdom and power intrinsic to the age-old process of women giving birth. Through their courage and determination, these women went on to have home

births. They came to know and trust birthing energy, the strength of their own bodies, and the capability of their minds to know what was right for them. Modern medical science, from their/my/our perspective often invalidates or ignores the importance of this knowledge and the process of coming-to-know it. These women needed to reclaim the holistic nature of birthing. This need, their willingness to "go to the wall" to ensure their need was met, and their consequent sense of empowerment and fulfillment, offers a girth of information to those interested and/or willing to hear it. Their stories, their wisdom, can be and is shared, and offers much to all who are concerned with the well-being of mothers and babies, and the oppression of women in our society. These women fought to and succeeded in preserving the blueprint of natural birth, so that they, in turn, can pass it to their daughters. Their collective voice is strong.

> Trusting ourselves, we who are born of the ancient wisdom and power of women find our own strong and individual ways to give birth. Our portraits of dignity, pain, courage, strength, and love bring beauty and grace to the tapestry of birth" (Hartigan, 1984, p. 16).

References

Alberta Labour, Professions and Occupations. Press Release, 1995, June 12.

Bain, H. (1985). Being feminist: living with a man. Doctoral Dissertation: Department of Educational Psychology, University of Alberta.

Baptisti-Richards, L. (1987). The Vaginal Birth After Cesarean Experience. Massachusetts: Bergin and Garvey.

Barrington, E. (1985). Midwifery is Catching. Toronto: NC Press Limited.

Belenky, M., Clinchy, B., Goldberger, N., Tarule, J. (1986). Women's Ways of Knowing: The Development of Self, Voice, and Mind. United States: Basic Books.

Bleicher, J. (1980). Contemporary Hermeneutics: Hermeneutics as Method, Philosophy, and Critique. London: Routledge and Kegan Paul.

Blumenfeld-Kosinski, R. (1990). Not of Woman Born: Representations of Caesarean Birth in Medieval and Renaissance Culture. New York: Cornell University Press.

Clark, C. (1987). Vaginal Birth After Cesarean Section. International Journal of Childbirth Education, 2, 22.

Cohen, N. W. & Estner, L. J. (1983). Silent Knife: Cesearean Prevention and Vaginal Birth After Cesearean. Massachusetts: Bergin and Garvey.

Faludi, S. (1991). Blacklash: The Undeclared War Against American Women. New York: Doubleday.

Eichler, M. (1983). Sexism in Research and Its Policy Implications. The Criaw Papers, No. 6, Ottawa.

Flamm, B. L. (1985). Vaginal Birth After Cesarean Section: Controversies Old andNew. Clinical Obstetrics and Gynecology, 28, 735.

Gadamer, H. G. (1976). Philosophical Hermeneutics. Los Angeles: University of California Press.

Hartigan, H. (1984). Women in Birth. New York: Artemis.

Health, Economics, and Statistics Branch, Alberta Hospitals and Medical Care (AHMC). February-April, 1988.

Health Disciplines Board Investigation of Midwifery, Final Report and Recommendations. (1991). Alberta Health Disciplines Board, Edmonton, Alberta.

Heilbrun, C. (1988). Writing a Woman's Life. New York: Ballantine Books.

Hekman, S. (1990). Gender and Knowledge: Elements of a Postmodern Feminism. Boston: Northeastern University Press.

Lagercrantz, H. & Slottan, T. (1986). The stress of being born. Scientific American, April, pp. 100-107.

Miles, A. (1991). Women, Health and Medicine. Philadelphia: Open University Press.

Miller, C. F. & Sutter, C. S. (1985). Vaginal Birth After Cesearean. Journal of Obstetric and Gynecological Nursing, September/ October, 385.

Nair, C. (1991). Trends on Cesarean Section Deliveries in Canada. Health Reports, 3 (3): 203-19.

National Concensus Conference on Aspects of Cesearean Birth, Final Statement. (1986). Canadian Medical Association Journal, 134, 1348-1352.

Norman, P., Kostovcik, S., Lanning, A. (1993). Elective Repeat Cesarean Sections: How Many Could Be Vaginal Births? Canadian Medical Association Journal, 149 (4): 431-5.

Norwood, C. (1984). How to Avoid a Cesearean Section. New York: Simon and Schuster.

Oakley, A. (1990). Helpers in Childbirth: Midwifery Today. New York: Hemisphere Publishing Corporation.

Palmer, R. E. (1969). Hermeneutics. Evanston: Northwestern University Press.

Panuthos, C. (1984). Transformation Through Birth: A Woman's Guide. Massachusetts: Bergin and Garvey.

Reinharz, S. (1992). Feminist Methods in Social Research. New York: Oxford University Press.

Roberts, H. (1981). Doing Feminist Research. London: Routledge and Kegan Paul Ltd.

Shearer, E. (1982). Preventing unnecessary ceseareans - a guide to labor management and detailed bibliography. Ceseareans/Support Education and Concern Newsletter.

Sherwin, S. (1992). No Longer Patient: Feminist Ethics and Health Care. Philadelphia: Temple University Press.

Shulman, N. S. (1978). Labour and vaginal delivery after cesearean birth: a survey of contemporary opinion. Ceseareans/Support Education and Concern Newsletter.

Stanley, L. & Wise, S. (1993). Breaking Out Again: Feminist Ontology and Epistemology. London: Routledge.

Trolle, D. (1982). The History of Caesarean Section. Copenhagen: University Library.

Appendix A

CONSENT TO PARTICIPATE

I, _____, voluntarily consent to participate in (an) interview(s) with Kathryn Graff, a graduate student in the Department of Educational Psychology at the University of Alberta. I understand that the purpose of the interview is to provide information regarding my perceptions of my experience of having a home VBAC . I also understand that the interview process will take place at a time and place convenient to me, and that the process may take up to 5 hours of my time.

I understand that the information given by me will be used solely for research purposes and published in the form of a thesis or otherwise. I further understand that my identity will remain confidential, and that every effort will be made to remove identifying information. I agree to allow the interview to be tape-recorded with the understanding that the tapes will be erased when the research project is complete. I understand that I have the right to withdraw my consent to participate at any time during the interview process, and that in such a case, the information that I have given will not be used in the research project.

Date: _____ **Signed:** _____

Witness: _____