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Understanding the Discourses of Traumatic Birth and the Transition to Motherhood Using Relational Dialectics Theory

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UNDERSTANDING THE DISCOURSES OF TRAUMATIC BIRTH AND THE TRANSITION
TO MOTHERHOOD USING RELATIONAL DIALECTICS THEORY

by

Valerie Cronin-Fisher

A Dissertation Submitted in
Partial Fulfillment of the
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ABSTRACT

UNDERSTANDING THE DISCOURSES OF TRAUMATIC BIRTH AND THE TRANSITION TO MOTHERHOOD USING RELATIONAL DIALECTICS THEORY

by

Valerie Cronin-Fisher

The University of Wisconsin-Milwaukee, 2018
Under the Supervision of Dr. Lindsay M. Timmerman

The majority of existing research regarding birth and the transition to motherhood focuses on the physical health outcomes of mother and baby, often ignoring the social and emotional impact of the birth process (Leggett, 2014). The lack of focus on social and emotional outcomes for new mothers may be especially harmful for those who experience traumatic birth, as it is subjective in nature and is often overlooked as a routine birth by health professionals (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Beck, 2004a). Traumatic childbirth is defined as an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant (Beck, 2004a). Framed by relational dialectics theory (Baxter, 2011), the current investigation sought to understand women's meaning making processes in publicly shared stories about birth trauma and transition to motherhood. Contrapuntal analysis (Baxter, 2011) was used to identify culturally dominant systems of meaning embedded in women's talk about traumatic birth and their transition to motherhood. Forty-one women's stories recounting traumatic births were analyzed within a variety of contexts (e.g., natural birth, cesarean, premie). The dominant discourse of intensive motherhood informed much of women's talk about pregnancy, traumatic birth, and transition to motherhood. Discursive interplay was also identified during pregnancy, birth, and motherhood communication through the struggle between the discourse of intensive motherhood and the discourse of

individualism through negating, countering, and entertaining. Mothers only distanced themselves from the discourse of intensive motherhood when they spoke about their traumatic birth on an individual level, outside their role as mother, as women were largely supported intensive motherhood.

Keywords: relational dialectics theory, traumatic birth, transition to motherhood, contrapuntal analysis

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DEDICATION

This dissertation is dedicated to my son, Stuart Cronin Fisher, who opened my eyes and heart to birth and motherhood. Thank you for helping me find my passion.

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I. Introduction

The lack of communication research surrounding birth and the transition to motherhood is troubling, as a study of 2,500 individuals aged 21-64 ranked the birth of a first child as the sixth most stressful life event on a list of 102 events, falling between separation from one's spouse and the inability to acquire treatment for an illness or injury (Dohwrenwend, Krasnoff, Askenasy, & Dohwrenwend, 1978). While other relationship transitions are widely documented in social science research (e.g., marriage), the transition to parenthood is a time of disequilibrium as parents are faced with new roles, circumstances, and demands, but remains understudied comparatively (Glade, Roy, & Vira, 2005). While limited, research focusing on the transition to parenthood has found that couples who have children see a greater deterioration after the birth of a child when compared to couples who do not have children over the same period of time (Doss, Rhoades, Stanley, & Markman, 2010; Huston & Vangelisti, 1995). Though scholars have begun to investigate challenges during the transition to parenthood, little research exists regarding the lasting effects of a woman's birth experience and her subsequent transition to motherhood from a communication perspective.

Perceptions about childbirth behavior are culturally shaped and conditioned from an early age (Miller, 2007; Oakley, 1980). Media is filled with images about what is to be expected during childbirth, usually depicting a woman rushing to the hospital in pain and fear, looking to her doctor to help make decisions and save the mother and/or baby (Leggett, 2014). Women are conditioned to expect labor to go a certain way, and those notions dictate the way many women make sense of their labor and delivery and participate in the discourse of childbirth and motherhood. While preparing for birth women often construct expectations about birth and mothering that are not reflected in their reality (Sterk, 2002). Unrealistic birth and early

motherhood expectations may stem from inconsistent advice and support (Choi, Henshaw, Baker, & Tree, 2005). In addition to mixed messages about birth and the transition to motherhood, a lack of social and instrumental support during this time often leads to increased anxiety and uncertainty during this period (Collett, 2005; Paris & Dubus, 2005; Salonen, Kaunonen, Astedt-Kurki, Jarvenpaa, & Tarkka, 2008). Though women often seek information while preparing for new motherhood, some still report feeling blindsided because existing research couldn't have prepared them for the reality of birth and motherhood (Stamp, 1994; Sterk, 2002).

The current discourse of pregnancy and birth is treated largely as pathological; something that needs to be managed or treated, like an illness. This cultural view leads most women to choose to give birth in a hospital setting in an attempt to secure a sense of safety and control, but as a consequence promotes the controlled atmosphere of birth, often leading to greater medical interventions (Crossley, 2007). In less developed countries than the United States, birth is understood as a complex process that weaves together physical, emotional, and spiritual meaning (Lowis & McCaffery, 2004). However, in the United States, dimensions of maternal subjectivity (e.g., birth experience and satisfaction) are largely left out of evidence-based obstetrics research, instead focusing primarily on objective outcomes (e.g., morbidity) (Wendland, 2007). Obstetric assessment of “risk” is determined by rates of potential physical pathology such as increased stress for baby (e.g., heart rate issues) or complications for the mother (e.g., infection, detachment of placenta, hemorrhage), ignoring the more complex parameters of negative outcomes that may occur during birth, such as the trauma associated with unwanted monitoring and intervention (Kassebaum et al., 2014; Kitzinger, 2012). Obstetricians, who assume the majority of power in the American birthing system, have a primary goal of a physically healthy

mother and baby (Kitzinger, 2012). As a result, doctors privilege the biological and physiological aspects of the birth process, leaving out emotional and relational aspects (Leggett, 2014; Lewis & McCaffery, 2004). The lack of focus on emotional and relational health complicates women's experiences.

While giving birth in the United States is largely pathologized, urging women to rely on doctors, the dominant culture also expects women to take their birth in stride as it is the pathway to motherhood, one of the highest feminine honors (Hays, 1996). Becoming a mother and caring for a new baby is framed as natural and instinctive. Thus, women are conditioned to make sense of their experiences through relying on experts (e.g., medical professionals) for assistance when possible; while at the same time a woman is expected to know what to do naturally by following her instincts (Miller, 2007). Conflicting messages complicate women's meaning making experience during birth and the transition to motherhood. Women's experiences during childbirth are often minimized, especially as long as the birth resulted in a physically healthy mother and baby. However, research has shown that birth experiences are not forgotten: "women evaluate the success of their childbirths in a more holistic way than the medical frame of reference allows" (Oakley, 1980, p. 27; Miller, 2007). For birthing women, the end goal of birth is much more complicated than just producing a healthy baby; the experience matters to them, but is often diminished.

Women are often forced to move beyond their birth(s) in order to start caring for the new baby. In addition, women may experience mixed emotions because while their birth may have been difficult, it ended with a healthy mother and baby (Miller, 2007). While all women are impacted by their birth experiences, there is a subset of women who experience a traumatic birth. These women are faced with making sense of their birth and transition to motherhood in relation

to the dominant discourse — which frames birth as an event that needs medical intervention, while also viewing motherhood as natural and an honor — after experiencing mental and or physical trauma during birth (Hays, 1996). Traumatic births are those that include the experience of threatened safety for the health of the mother or her baby (Beck, 2004a). Thus, women who experience a traumatic birth may have trouble situating their experience in the culture of birth and motherhood, especially if the birth ended with a healthy mother and baby. This narrow focus of how a woman should give birth and adjust to life with a new baby further marginalizes mothers' experiences as not legitimate, resulting in negative outcomes for mothers' well-being after experiencing a traumatic birth, as well as their transition to motherhood (Wendland, 2007).

Little is known about women's communication and meaning making of a traumatic birth experience and transition to motherhood, as childbirth has largely been on the periphery of social science research (Oakley, 1980; Thomas, 2013). Sterk (2002) conducted 131 narrative interviews seeking to understand women's experiences during birth. Sterk's investigation found that birth and becoming a mother means as many different things as there are different women filled with complicated feelings:

It means finally experiencing an orgasm; humiliation from being bound to bed, having to use a bedpan, and being shaved; tremendous joy at the birth of a long-anticipated daughter or son; heart wrenching sorrow at the death of a baby; resentment at botched episiotomies that limit sexual stimulation; pleasure at touching a baby's head crowning between legs; joy at pulling a baby out of one's own body. (Sterk, 2002, p. 2)

These experiences, known only to birthing women, are continuously lost in literature created by observers (e.g., doctors and nurses) (Sterk, 2002).

Additionally, women are told they will forget the pain and details of birth once they hold their baby, but the reality is that many women do not forget or feel differently about a difficult birth, even twenty years later (Simkin, 1991). Because childbirth and the transition to motherhood is a biological, cultural, and relational event, understanding women's experiences of traumatic child birth and the transition to motherhood using relational dialectics theory (RDT) will shed light on the complexity of traumatic birth. RDT is an especially good fit for this study, as the contradictory values and concepts evident within birth and motherhood discourse may limit or restrict women's communication when trying to share their unique and underrepresented experiences with birth trauma and their transition to motherhood. Additionally, this analysis provides a means to understanding discourses impacting women's subjective outcomes in a variety of relationships (e.g., family, friends, medical). RDT supplies a theoretical framework as well as a method (contrapuntal analysis) to guide analysis of women's traumatic birth experiences and the interplay of birth and motherhood discourse during women's meaning making processes (Baxter, 2011). To understand these contradictory values, the following section highlights the history of birth as well as discourses shaping pregnancy, birth, and motherhood culture.

II. Relevant Literature

History of Birth

Childbirth is as much of a social process as it is a biological process (Davis-Floyd, 1993; Oakley 1980). Historically, birth has been experienced as a relational act, taking place in communities filled with closely bonded women (Kitzinger, 2012). In American culture, there is an almost unchallenged assumption that the medicalization of childbirth (e.g., fetal and maternal

monitoring, interventions to speed up labor, pain management) is not only superior to natural birth, but has improved women's experience in childbirth (Cassidy, 2006).

The transition from natural to medicalized childbirth has not happened overnight. While birth-related mortality rates in the United States decreased over the 20th century (from 100 infant deaths per 1,000 live births in 1900 to 6.89 infant deaths per 1,000 in 2000), mortality rates have not significantly declined in recent years (MacDorman & Mathews, 2008). In fact, the U.S. falls behind a vast number of other nations when caring for birthing women and managing pregnancy-related complications; the maternal mortality rate over the past 20 years has risen at a rate comparable to war-torn and impoverished countries (Kassebaum et al., 2014). The United States ranks 60th in the world for maternal mortality, below virtually every other developed nation. Additionally, the national U.S. cesarean section rate has not always been so high; when first recorded in 1965 the cesarean rate was 4.5%, a rate that is on par with the necessity of cesareans for low-risk American women (Johnson & Daviss, 2005; Stapleton, Osbourne, & Illuzzi, 2013; Taffel, Placek, & Liss, 1987). After rising sharply for more than a decade, the national cesarean rate leveled off at 32.8% in 2010 and 2011 (Martin et al., 2012). One in three women in the U.S. are subject to major abdominal surgery — a cesarean birth — that puts her at greater risk of short- and long-term repercussions, including infection, blood clots, emergency hysterectomy, and a challenging recovery (“Childbirth Connection,” 2012). The reasons for an increased number of cesarean sections lie in part due to a lack of patient knowledge of the birthing process, and the overall difficulty of giving birth (Rehavi & Johnson, 2013).

As long as women have been giving birth, people have wondered why they have a more difficult time than other mammals, as birth is a natural physiological process (Cassidy, 2006). Many mammals are able to give birth in isolation with little indication of pain, with few

complications, and then pick up where they left off as soon as their babies are born (Cassidy, 2006). The answer to this question can in part be explained by evolution. When humans started walking upright they developed smaller pelvises as a consequence; the size of a human newborn's head has also increased dramatically, making birth more difficult (Lewin, 1983). Due to these changes in human physiology, a human baby must twist to narrowly fit out of a woman's pelvis (Lewin, 1982). Unlike other mammals, it is thought that women started fearing birth around two million years ago (Trevathan, 1987).

As the human brain became capable of understanding that birth can be dangerous, the onset (or even anticipation) of labor led to fear. The emotional experience of fear has been associated with the hormone epinephrine (adrenaline), which can slow or stop contractions, leading to a longer and more complicated labor (Trevathan, 1987). Fear of childbirth is based somewhat in the experience of uterine contractions, and labor in general.

Before pregnancy, the uterus is the size of a fist and weighs less than two ounces, but at the time of birth the uterus has become the largest and strongest organ in the body, weighing as much as two pounds (Lieberman, 1992). During labor, the uterus works on autopilot (like the heart), tightening around the abdomen like a strong charley horse that often results in women having difficulty talking, thinking of things other than labor, or even opening their eyes (Owens, 2009). Along with uterine contractions, women experience pain or discomfort as the cervix opens and the baby descends (pressing on surrounding fallopian tubes, bowels, bladder, and spine) (Lieberman, 1992). While some animals (who have plenty of room in their birth canal) give birth in as little as two minutes, women have a more difficult time giving birth and are the only mammal that seeks assistance to accomplish the task (Cassidy, 2006). To ease the fear of

birth women have looked to those around them to make it through their births, even if it means following someone else's rules.

In addition to physical pain, there is pain associated with having something done to your body that you do not want, which is another source of discomfort for birthing women. Women often experience unwanted interventions during the course of their labor and delivery (Wertz & Wertz, 1989). Over the last 100 years the use of medicalized interventions, including internal fetal monitoring, episiotomy, caesarean section, and increased use of drugs for labor augmentation and pain management have left many women feeling a loss of agency and control during birth (Kitzinger, 2006). Additionally, women who choose more natural approaches to birth are faced with increased blame if something goes wrong. In comparison, medicalized births include medical professionals as responsible parties (alongside the mother) when making decisions during birth (a welcomed shift for many women) (Scamella & Aleszewski, 2012). Regardless of approach to labor and delivery, almost all laboring women surround themselves with others who they believe can help in the process, and this impulse to call for help may be an adaptive response to reduce mortality, as women are more likely than other mammals to experience bumps in the road during birth (Trevathan, 1987).

Communication During Birth

Women seek a range of medical and emotional support based on their anticipated physical and mental needs at the time of their birth. Research has found that women choose a variety of birth attendants in hopes of controlling the potential risks they perceive (Miller & Shriver, 2012). Women rate the most helpful components of labor support as:

- emotional support (continuous presence, reassurance, encouragement, and praise);
- physical support (comfort measures aimed at decreasing hunger, thirst, or pain);

information and advice about what is happening and how to cope; advocacy (respecting her decisions and helping to communicate those to the health care team); and caregiver support of the partner/husband. (Rosen, 2004, p. 24)

Based on these needs any and all birth attendants could potentially provide the support needed, but based on their cultural roles this does not always occur. Birth attendants range from medical professionals to relational partners, and their unique roles with regard to communication are discussed below.

Obstetricians. For most women in the United States birth is seen as a medical event, and they look to authoritative figures including obstetricians (OBs) in hopes of having the safest birth possible (MacKenzie Bryers & Van Teijlingen, 2010). OBs perform cesarean sections and other sophisticated birth interventions (Cassidy, 2006). While many women feel a heightened sense of safety under the care of an OB, there is an inherent power discrepancy that can hinder doctor/patient communication. Previous research examining doctor/patient communication found OBs exerting power in three ways: interrupting a patient who demonstrated knowledge or competence, reasserting their own medical knowledge and superiority, and by silencing a patient (Pizzini, 1991). In recent years there has been a greater push for shared decision making during childbirth between doctor and patient, but in a high stress situation women often feel a loss of control when making decisions with their doctor(s) (Matthias, 2009).

Midwives. Many practicing midwives in the U.S. have advanced nursing degrees and are known as Certified Nurse Midwives (CNMs). Similar to obstetricians, 96% of CNMs work in a hospital setting (the rest are equally split between home births and free-standing birth centers) (Miller & Shriver, 2012). Birthing women choose to work with CNMs because they feel it provides them with the safety of a hospital birth, but removes the assembly line mindset often

associated with hospitals and OBs (Davis-Floyd, 1993). CNMs' philosophies are based in a holistic approach to birth with minimal interventions and focus on in-depth patient education and support (Miller & Shriver, 2012). Midwives are trained in a range of vaginal births, but do not perform cesareans (Cassidy, 2006).

Doulas. While the popularity of doulas has increased in recent years, their purpose is unknown to many (DONA International, 2005). Doulas are (often certified) professionals who serve as labor companions experienced in childbirth and are present through the entire birth process (whereas doctors and nurses pop in and out of the room, attending to multiple patients simultaneously). The scope of a practicing doula is limited to providing informational, emotional, and physical support before, during, and after the birth of a child (DONA International, 2005). A doula serves as a mother's advocate, providing a sympathetic but informed ear while the mother makes decisions during labor and birth (e.g., epidural, Pitocin, episiotomy, cesarean section) (Hazard, Callister, Birkhead, & Nichols, 2009). When compared to birth partners (romantic partners, family, and/or friends), a doula has an extensive understanding of the birthing process and can help not only support the laboring woman, but provide support and insight as to how the partner can help their loved one through labor. Additionally, research has found that the presence of a doula leads to positive birth outcomes (Martin et al., 2012).

Ongoing research in the United States and Europe has continuously found that having a psychological caregiver during childbirth leads to positive outcomes including shorter labors, lower cesarean rates, lower epidural rates, and less dissatisfaction with childbirth experiences (Akhavan & Edge, 2012; Gilliland, 2011), as well as improved APGAR scores and initial breastfeeding in newborns (Gruber, Cupito, & Dobson, 2013). While doulas are an increasingly

popular way to gain emotional and physical support during birth, close relational partners also take on the birth support role.

Close others. Historically, friends and family have been present during a woman's birth until it became more medicalized in the 20th century (Cassidy, 2006). In the 1970s and 1980s fathers and other close family and friends started entering the delivery room once again (Cassidy, 2006). While a large review of birth support studies found that the unwavering presence of a female relative or a caring individual in general during birth can have a positive influence on a birthing woman's physical and emotional outcomes (Rosen, 2004), many close others feel out of sorts when trying to help their loved one, as they do not know what to expect or how to help during birth (Gilliand, 2002). This inexperience and uncertainty has led birthing women and their partners to take childbirth classes (e.g., Lamaze, Bradley Method) which teach mothers and partners how to cope, communicate, and provide support during labor and birth (Cassidy, 2006). While women communicate in a variety of contexts while pregnant and birthing, there is little known about women's experience of traumatic birth as well as their subsequent transition to motherhood.

Childbirth Trauma Minimization and Outcomes

The experience of childbirth trauma is subjective, as research in this area has found that births that are perceived as traumatic by the mother are often viewed as routine by care providers (Alder, Stadlmayr, Tschudin, & Bitzer, 2006; Beck, 2004a). Traumatic childbirth is defined as “an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror” (Beck, 2004a, p. 28). Common triggers for birth trauma include unexpected medical interventions, pain beyond coping ability, care from

providers that was uncaring, unsafe, or inhumane, and/or the threat of injury or death for mother and/or baby resulting in lasting physical or emotional effects after birth (Beck, 2004b).

The experience of birth trauma has also been associated with negative communication interactions with romantic partners and the new baby (Ayers, Eagle, & Waring, 2006). Women who have suffered a traumatic birth often feel they have no one to turn to and that close others expect them to “move on” after the birth (Thomas, 2013). After experiencing a traumatic birth women typically respond in one of two ways: completely avoiding thinking and talking about the event, or feeling the desire to talk about the event repeatedly (Thomas, 2013). In addition, mothers who have experienced a traumatic birth have reported a loss of sexual feelings, blame for their partner, and/or lack of feelings of support (Ayers et al., 2006). These women also report a difficult bonding period with their baby, manifesting in behaviors including disassociation, overprotection, and anxiety (Zimmerman, 2013). Mothers who have a difficult time bonding with their baby also report feelings of guilt, in that bonding with the baby should be natural (Thomas, 2013).

Beck (2006) found that for some women who have experienced birth trauma a child’s birthday is not always a happy time, but instead a time when negative feelings resurface. Fear of childbirth is often heightened in women who have suffered from depression in the past, who have experienced trauma previously (in childbirth and/or sexual assault), and who experience birth with a high level of intervention (i.e., forceps, vacuum, or cesarean births) (Beck 2004a, 2004b). Nilsson and Lundgren (2007) note that women’s fear of childbirth, often diagnosed as post-traumatic stress disorder (PTSD), is not unusual as it is a common reaction to surviving a pathological event. While birth interventions have become a common occurrence in the U.S., little is known about the communicative role in birth trauma, and how women situate their

experiences and transition to motherhood in relation to the dominant discourses of pregnancy, birth, and motherhood. Though each phase has unique communicative and cultural characteristics, all three phases are interrelated and dualistic in nature.

Discourse of Pregnancy

In the U.S. most women have limited experience with birth before getting pregnant, and turn to mainstream media for information seeking (Declercq, Sakala, Corry, & Applebaum, 2006). Women have reported watching reality shows (e.g., *A Baby Story*) to gain a better understanding of the birthing process, and to prepare for their own births (Morris & McInerey, 2010). The representations of women's birthing experiences frame women as largely disabled during the birthing process (e.g., confined to a bed, unable to communicate aside from screaming, looking to medical professionals for help). Women are socialized to accept birth culture without question, often functioning as incapable agents during pregnancy due to fear of pain, complications, and the unknown (Wolf, 2003). Media representations of the birthing process are problematic, creating and perpetuating cultural norms that frame women as incapable and disabled when giving birth (Owens, 2009). Morris and McInerey (2010) performed a content analysis of 85 reality-based birth television shows, depicting 123 births, and concluded that women's bodies were typically portrayed as incapable of birthing a baby without medical intervention. These findings suggest reality-based birth television shows fail to provide women with an accurate representation of birth in the U.S., instead instilling fear and often promoting interventions as a solution to managing pain and worries during birth. American norms and practices potentially hurt women physically and emotionally while preparing for birth due to conflicting information (Sterk, 2002).

When a woman becomes pregnant she is often forced to give up her private space and becomes property of society (Byrom, Edwards, & Bick, 2009). When seeking information about birth, women are bombarded with a myriad of often conflicting information from media, as well as close others (e.g., friends and family), about the proper (and safe) way to give birth, and what to expect during the birth process (Cassidy, 2006). Additionally, pregnant women face unsolicited advice from strangers, close others, and medical professionals about a range of subjects, including what is safe to eat or drink, and how much to rest and work (Byrom et al., 2009). During this time women find their identity coming into question as focus shifts from them as an individual to their unborn baby, and their upcoming transition to being a mother (Foster, 2005). The advice women receive places them on shaky ground as they navigate their beliefs about birth and motherhood. On one hand, women are told they don't know anything about birth and motherhood and need to seek information from others (e.g., close others, medical professionals), while on the other hand, they are told that birth and motherhood is natural and instinctive.

Research regarding major popular press publications has found the information provided about expecting and new mothers may be problematic. In more detail, Dobris and White-Mills (2006) examined the extremely popular book *What to Expect When You're Expecting* for competing themes that appear simultaneously to empower women while reducing their ability to know their intuition and body, and suggest birthing women should seek validation from their husbands and/or doctors (Dobris & White-Mills, 2006). Further, a study of non-fiction books targeting women interested in natural childbirth found contradictory information suggesting women should follow their own path and advocate for themselves, while also discussing the proper process for creating a perfect birth and choosing the right birth support and staff, which

the authors admit is improbable at best (Mansfield, 2008). Based on the inconsistent information evident in pregnancy culture women often report loss of control (Zimmerman, 2013). Pregnant women are faced with a wide range of information that shapes the way they prepare and understand their upcoming birth.

Discourse of Birth

Unprecedented medical and technological advances occurring over the last century have led to increased faith and dependence on medical technology. In today's society, medical and technological knowledge is privileged over bodily knowledge, which is the intuitive, tacit understanding of what one's body is doing, can do, or must do (Owens, 2009). Medical technology presents a sense of control over one's own health (e.g., through induction a woman can decide when she will have her baby). This increasing dependence on medical technology has been negatively correlated with reliance on bodily knowledge (Owens, 2009). Because the course of hospital births is largely determined by technological interventions rather than bodily knowledge, healthcare providers using medical technology perpetuate its power while silencing bodily knowledge. Birthing women find themselves stuck in the middle as medical technology can silence women, rather than supplement bodily knowledge (Owens, 2009). Systemically, women are told they are incapable of making proper decisions during birth and thus give power and agency to medical professionals due to fear of risk and complications during birth.

Risk is a result of differences in the perception of potential danger and reality, which Skolbekken (1995) frames as a "set of paradoxes" (p. 291). For example, in the context of birth there is no statistical evidence that the increased use of fetal monitoring (used to assess risk) leads to better outcomes for mother and/or baby, yet fetal monitoring continues to be used as a risk analysis tool (Skolbekken, 1995). The U.S. has adopted a worst-case approach to birth by

treating every woman as if she is at risk, which often leads to interventions and complications (Van Teijlingen et al., 2009). Additionally, risk reduction research fails to include data on the social and cultural consequences of this approach, including generating fear of things we once deemed harmless (Scamella & Alaszewski, 2012). Regardless, women often trust medical professionals during birth as they are afraid of what will happen if they were to follow what their body tells them to do during birth.

In opposition to medicalized birth knowledge is natural birth knowledge, which frames birth as a natural, physiological process (Sterk, 2002). Some women go against the grain, aiming for a more natural birth within a hospital setting by working with a midwife, or giving birth in a birth center or at home to avoid unwanted interventions (and risk). The majority of natural birth literature is written to empower women to trust their body knowledge in order to achieve an unmedicated birth where she feels safe and in control of her birth (Gaskin, 2003). Achieving an unmedicated birth is viewed as the best way to give birth, and much of natural birth literature does not include birth in hospital settings (Cassidy, 2006). Access to free-standing birth clinics that offer a more woman-centered and holistic approach to birth are limited and/or not covered by insurance, which leads most women to give birth in high-intervention settings even if they would prefer otherwise (Jackson, Dahlen, & Schmied, 2011). Much of birth literature is written from one of two extremes — the perspective of medical is best, or that natural is best — even though many women’s desires and experiences exist somewhere in between, and remain largely underrepresented (Cassidy, 2006).

The social construction of risk management has had a profound impact on birth culture. In response to the fear of the unknown during birth, women increasingly choose to write birth plans after educating themselves through the internet, books, and reading/listening to other

women's birth plans (Owens, 2009). Specifically, women write birth plans in hopes of controlling their birth experience, spelling out their wishes regarding interventions (e.g., labor induction, pain management, epidurals, episiotomies, and cesarean section deliveries) (Owens, 2009). Through birth plan research women often develop a sense of agency for their birth; however, research has found that birth plans are largely unassociated with perceptions of positive birth outcomes (Crossley, 2007). One reason for negative perceptions of birth is the strict structuring of a woman's labor, and when a woman's birth does not model her birth plan she can come to mourn the birth that could have been (Crossley, 2007). The inability for a woman's body to follow the common hospital protocol based on time is often anxiety-inducing (e.g., a woman should dilate a certain amount each hour) (Maher, 2008). Not following the common protocol can spark uncertainty for the mother where she perceives something as going wrong (e.g., increased medical intervention, distress of mother and/or baby).

Additionally, research has demonstrated that women have a more challenging transition to motherhood after experiencing a difficult or traumatic birth (Zimmerman, 2013). While birth interventions are certainly needed in some cases, it is imperative to understand who is benefitting from birth interventions, and at what cost to the mother's experience of childbirth and her transition to motherhood (Legget, 2014). The dualistic nature of the dominant culture of pregnancy and birth can also be seen in the discourse of motherhood.

Discourse of Motherhood

Largely missing from motherhood discourse is the adjustment that accompanies the transition to motherhood. After enduring a trying medical event (birth) women are immediately faced with new responsibilities caring for a tiny, fragile, mysterious, and completely dependent baby, in addition to healing from the birth themselves (Gattoni, 2013; Senior, 2014). Unlike

many developed countries, women in the U.S. spend very little time in the hospital after giving birth, and are faced with short maternity (and paternity) leave from work, leaving many women to heal physically on their own while also tending to the needs of a new baby (Cassidy, 2006). Once maternity leave is over, dual-career couples have less time to seek social support from family, friends, neighbors, and new parenting social groups, which historically have been crucial for new mothers (Gattoni, 2013). Because of these changes women have less shared experience with their friends and family members when coping with the challenges of new motherhood, often leaving them feeling overwhelmed (Gattoni, 2013).

Birthing women have grown up in a culture that undervalues mothering and naturalizes the skills and hard work that mothering involves (Everingham, Heading, & Connor, 2006). While the culture of motherhood suggests that taking on the role of mother should be natural, that is not most women's experience (Senoir, 2014). During the transition to motherhood, women find themselves caught between the social and cultural expectations of what motherhood should look like, and their reality as a new mother. When a new mother's experiences are not congruent with cultural and social norms, she struggles to communicate her feelings of being different (Miller, 2007). New mothers' perceptions of being different have been associated with lower self-esteem and self-confidence, negative impacts on mental health, and difficulty communicating their experiences as new mothers (Miller, 2007). Villain and Ryan (1997) present this notion as a "mother crisis," in that:

women experience tremendous guilt, shame, and anxiety over their performance as mothers, feelings brought on by both internally held and externally imposed myths concerning motherhood. It often includes conflict commonly experienced by women facing enormous pressure to live up to modern-day standards of motherhood. (p. 4)

Women are expected to transition to motherhood seamlessly, as though caring for a new baby is something that should come naturally and organically.

Miller (2007) conducted a longitudinal study following women from pregnancy through new motherhood examining the influence of popular motherhood culture on women's expectations and lived experiences of birth and the transition to motherhood. Women in this study struggled to make sense of the promises of early motherhood (e.g., nature, instincts) which proved to be much different than their lived experiences (Miller, 2007). While many women notice a discrepancy between their expectations and reality, mothers are faced with societal pressures to conform to share their experience in an idealized way, and demonstrate their ability to be an intensive mother (Heisler & Ellis, 2008).

The main tenets of intensive motherhood include joyfully taking on the primary responsibility of her child(ren), putting her child(ren) at the center of childcare (always put them first), and viewing her child(ren) as sacred, innocent, and pure (Hays, 1996). This dominant cultural narrative suggests that mothers are the best people to understand and nurture their children. Additionally, a mother should always be present for her children, and continuously put her children's needs above her own (Gattoni, 2013). Intensive mothers are expected to leave behind their own interests and hobbies and to dedicate more time to their role as a mother and meeting the needs of their family. These rigid expectations often leave mothers feeling as though they are not good enough, while also feeling their identity and autonomy constrained by the weight of new motherhood (Mille, 2007).

Another way women rate their own ability to mother instinctively is through their experience with breastfeeding. Breastfeeding may be the prototypical example of what it means to be a "natural" mother. Breastfeeding literature largely frames breastfeeding as pure and

natural, and an act that requires little to no support (Wall, 2001). Breastfeeding resources often underrepresent and/or minimize differences between women, and the very real difficulties women often experience when attempting to breastfeed and when navigating through their breastfeeding relationship (Wall, 2001). Additionally, while motherhood is framed as a natural and organic transition, in recent decades women have been expected to rely on others' expertise when making child-related decisions, a practice known as scientific mothering.

Scientific mothering runs culturally parallel to the reliance on doctors during birth in that mothers should depend on "experts" when making decisions about childrearing (Gattoni, 2013). Scientific mothering creates a sense of control for new mothers (during a time when they often feel out of control) by providing guidelines for play, sleep, and eating schedules (Kinser, 2010). Mother's health information seeking has moved away from women's social networks (e.g., family and friends) to being supervised by experts, including doctors, nurses, hospitals, and other medical professionals (Drentea & Moren-Cross, 2011). On a larger scale, women's mothering knowledge production has become increasingly complicated as it puts women between a rock and a hard place. Specifically, a mother should be able to follow her instincts while parenting, but these instincts should not always be relied upon, as authority figures know best. This duality guides mothering culture and practice, making confidence often unachievable. While the constraints of motherhood culture influence all mothers, the duality of birth and transition to motherhood discourse may be made worse for women who have experienced a traumatic birth. These women typically have a more difficult transition to motherhood (Zimmerman, 2013). In effect, experiencing a traumatic birth compounds the problem by adding another element of feeling that they are not mothering correctly (e.g., feeling responsible for birth-related complications, experiencing difficulty bonding with the new baby).

Relational Dialectics Theory

Relational dialectics theory (RDT), created by Baxter and Montgomery (1996), and later revised and extended by Baxter (2011), situates the human communication experience as competing discourses that are voiced by individuals to create meaning in a given utterance. Relational communication is filled with unique characteristics including power, openness, and communication norms (Miller Day, 2008), and RDT provides a theoretical framework and method to tap into these features. In addition to relationship specific characteristics, RDT is heavily influenced by Bakhtin (1981, 1984, 1990), positing that when individuals speak they give voice to cultural discourses. While communicating, individuals situate their talk within multiple systems of meaning that compete, oppose, struggle, and rest on one another in a given utterance (Baxter & Braithwaite, 2008).

Much of existing communication research presents communication as a dichotomy of public vs. private. Specifically, public matters are conceptualized as places where individuals meet to discuss mutual interests and come to a common understanding (e.g., discussing the social roles of being a worker, citizen, or neighbor); conversely, private matters consist of family and close relationship issues (e.g., responsibilities within the house, love, childrearing). Presenting close relationship communication as a public/private binary undermines the complexity of communication in close relationships. Instead of furthering this notion of a binary, RDT suggests that the understanding of public vs. private communication is instead bidirectional (Suter, 2017). Baxter and Braithwaite (2008) suggest that individual communication is influenced by relational (e.g., struggling with autonomy and connection) as well as cultural systems (discourse of individualism) when making meaning (Suter, 2017). RDT, along with other social constructionist theories, suggests that culture is largely relational in that relationship communication shapes

culture, and culture shapes relationships. Much can be learned from the interplay between individual experiences and social culture. This interplay is largely seen through discourses. Discourses are part of a larger cultural system and do not belong solely to the individual speaking, but instead are a part of a larger utterance chain (Baxter, 2011).

The utterance chain represents communication in response to, and in anticipation of, past and future interactions (Baxter, 2011). Specifically, the utterance chain consists of four utterance (chain) links where dialectical tensions are rooted: proximal already-spoken, proximal not-yet-spoken, distal already-spoken, and distal not-yet-spoken (Baxter, 2011). Given the interest of birth and motherhood communication, the distal already-spoken and the distal not-yet-spoken are particularly relevant aspects of the utterance chain in this project (Suter, Seurer, Webb, Grewe, & Koenig Kellas, 2015). The distal already-spoken link in the utterance chain pertains to statements based on public discourse in the culture at large regarding relationships and families; distal already-spoken provide “symbolic life” when voiced by speakers (e.g., intensive motherhood) (Baxter, 2011, p. 50; Suter, 2017). The distal not-yet-spoken part of the utterance chain centers on past utterances in opposition to interactions that have not yet taken place, focusing not only on the relational partner, but the superaddressee (e.g., not wanting to disclose a difficult labor and bonding period with baby, because they do not want to be labeled as a bad mother) (Baxter, 2011). The superaddressee can be thought of as generalized others, or other people as a whole (Baxter, 2011). Conversations that have already occurred, as well as ones to come, provide both cultural and relational discourses, and may inform whether and how women’s talk is influenced by the larger birth culture, and how their communication about their birth(s) is in anticipation or response to what “others” would think based on social and relational norms.

Within the context of close relationships, competing discourses rarely occupy equal power (Carr & Wang, 2012). Discourses often struggle to become accepted discourse, as one discourse frequently becomes dominant and others become marginalized within an utterance (Carr & Wang, 2012). When discourses are dominant within an interaction they take on the centripetal position, or the center of the meaning making process (Carr & Wang, 2012). Centripetal positions often become dominant because they are made legitimate through social acceptance (e.g., doctor knows best, intensive motherhood) (Baxter, 2011). Conversely, discourses given less power take the centrifugal position (e.g., I know my own body best, I don't accept the standards of intensive motherhood) (Carr & Wang, 2012). Centrifugal discourses are frequently "considered as non-normative, unnatural, or deviant" in the meaning making process (Carr & Wang, 2012, p. 44). Through the interplay of centripetal and centrifugal discourses, meaning is established within an interaction (Baxter, 2011). Through the competition between centripetal and centrifugal discourses, culturally dominant meaning is either reproduced or new meanings are made (Baxter, 2011).

RDT does not strive for prediction or generalizability, and instead focuses on highlighting the interpersonal meaning making process. RDT has been best used inductively in interpretive research (Baxter & Norwood, 2015). Instead of privileging the human experience as a whole, RDT seeks rich understanding where individual perspectives and examples of talk lead to nuanced examples of discursive struggle in the interpersonal meaning making process (Baxter & Norwood, 2015).

RDT is especially relevant to underrepresented demographics and contexts within interpersonal communication that are often silenced by mainstream culture, because it seeks to understand a range of experiences and how those experiences are situated within the larger

culture (Baxter, 2011). RDT has successfully been used to understand discourse-dependent families, which are families who do not meet the dominant cultural ideal of family (e.g., adoption, same-sex parenthood) (Baker, 2017; Suter, Baxter, Seurer, & Thomas, 2014; Suter et al., 2015). Discourse-dependent families are faced with making sense of their non-aligning experiences in relation to the dominant discourse of biological, nuclear family by reinforcing and/or recreating the culture of family and parenthood. RDT has been a useful tool for understanding marginalized family experiences.

In the context of parenthood, RDT has been used to understand the meaning of “family” in online narratives of adoptive foster parents (Suter et al., 2014). Within these narratives two discourses were juxtaposed: the discourse of biological normativity, and the discourse of constitutive kinning (Suter et al., 2014). Due to the dominant discourse of biological normativity, foster parents addressed concerns such as looking similar to the child and disclosing fears of their family being perceived as less legitimate than biological families. Additionally, foster parent narratives constructed family in a way that highlighted action and effect. Specifically, families are created through communication and expression of love (Suter et al., 2014). Through the intersection of these discourses, family communication scholarship moves beyond categorical definitions of family and sheds light on the messy meaning making process of family as influenced by relationship factors as well as the culture at large.

Similarly, Norwood and Baxter (2011) used RDT to investigate online letters that adoption-seeking parents wrote to potential birth mothers. Competing discourses were identified as parents tried to connect with potential birth mothers by presenting “good” vs. “bad” elements of parenthood, the role of the adoptive family, and the role of the birth mother (Norwood & Baxter, 2011). Potential parents spoke to the feelings of being torn when communicating their

feelings within the existing culture that presents adoption as both selfish and selfless. Potential adoptive parents also privileged a positive construction of adoption instead of adoption as a last resort. Further, potential adoptive parents created a hybrid between discourses when discussing the familial triad (birth mother, adoptive parents, and the child). Birth mothers were defined as an equally good parent because they love their child in a sacrificial way, rather than the nurturing way adoptive parents would (Norwood & Baxter, 2011). This hybrid allowed the birth mother to be portrayed as a good mother, even if she is not the ideal parent for the baby. This hybridization highlights the application of RDT in identifying the complexity of social and relational communication. Understanding marginalized family experiences allows marginalized, or centrifugal discourses to mix with dominant, centripetal discourse to create relational meaning.

Specifically within motherhood research, RDT has been used to understand queer mothers' talk about co-motherhood (Suter et al., 2015). Competing discourses were identified as the discourse of essential motherhood, and the discourse of queer motherhood. While queer mothers were impacted by the culturally dominant discourse of essential motherhood (i.e., children only have one authentic biological mother), they presented the discourse of queer motherhood as central, or centripetal, in order to situate their experiences as legitimate. Queer mothers presented motherhood as more than biological, disconnected monomaterialism (i.e., the idea that there can only be one true mother), and destabilized the role of patriarch (Suter et al., 2015). Women's privilege of the discourse of queer motherhood in their talk widens the definition of motherhood to indicate the key features of motherhood as emotional closeness, positivity, and love/care for their child (Suter et al., 2015). While results of this study ultimately highlight the pervasiveness of the dominant discourse of essential motherhood and the marginalized discourse of queer motherhood, in several cases these discourses went beyond their

competing relationship and combined to yield a new understanding of motherhood (Suter, 2015). Queer mothers discussed the possibility of one mother providing the egg, and the other carrying the baby (Suter, 2015). Also, through story telling the two discourses were not always presented in opposition, as the nonbiological mother at times spoke of her experience as a sense of joy and wholeness, and also queer co-mothers couples competed for the floor during focus groups to share their story. The transformative potential of RDT provides an opportunity to rectify oppressive cultural discourses, and resists, critiques, and possibly transforms communication in both private and public areas (Suter, 2015).

RDT is relevant to traumatic birth experiences, as there is limited information about the way individuals make sense of themselves in relation to the American birth culture (Sterk, 2002). While mothers in Sterk's (2002) study were not discourse dependent in regards to the meaning of family (all women were married to the biological father, and gave birth to a biologically related baby), mothers may be discourse dependent regarding the culture of intensive motherhood, and have a difficult time situating their experiences in relation to the dominant culture of intensive motherhood. RDT helps us understand how dominant motherhood discourse shapes the social reality of birth trauma and the transition to motherhood in the U.S., and how meaning making of these birthing experiences are perpetuated — or newly created — interpersonally and systemically (Baxter, 2011).

Moore (2017) considered the role of agency as a relevant aspect situating oneself in relation to the culture of birth and new motherhood. Agency consists of self-definition and self-direction informed by the symbolic conditions of a culture and/or context (e.g., what it means to be a good mother). That is, women make sense of who they are as a birthing woman and mother based on their perceptions of the world around them. Understanding a woman's perceptions of

the American birthing culture and how that informs her decision making (e.g., choosing a care provider, researching birth interventions) and experience is needed. RDT offers an opportunity to investigate both dominant and marginalized discourses surrounding birth and motherhood (often missing from research), and how those discourses shape women's meaning making process of traumatic birth and their subsequent transition to motherhood.

Building upon the existing literature, the current investigation aims to understand how women who have experienced a traumatic birth situate themselves, as well those who surrounded them during birth and the early transition to motherhood (e.g., medical professionals, romantic partners, family, friends), in the current birth and motherhood culture. The findings of this project will highlight the capacity qualitative research has to reveal complicated communication and experiences (Harter, Japp, & Beck, 2005). The talk I will be using for this project will be from *The Birth Hour*, a popular podcast where women share a range of birth experiences. Based on pregnancy, birth, and motherhood culture, the following research questions are posed:

RQ1: What discourses of birth and motherhood are present in mothers' talk about their traumatic birth experience(s)?

RQ2: What discourses of birth and motherhood are present in mothers' talk during the transition to motherhood after experiencing a traumatic birth?

III. Method

Understanding women's traumatic birth experiences through discourse serves as a critical tool for making sense of marginalized human experiences: "Narratives (and narrators) can get mangled at the boundaries of powerful institutions" (Linde, 2001, p. 520). When individuals share their experiences with institutions and representatives of those institutions (in this case,

hospitals and doctors) their stories are often cherry-picked and/or altered to conform to specified forms (e.g., leaving out the emotional side of the birth outcomes), and to frame their stories for self-serving reasons corresponding to the institution's assessment of what is important. Mishler (1986) explained this phenomenon through his example of doctor/patient communication where the narrator explained their experience holistically, yet doctors transformed their descriptions into technical and medical categories for analysis. In the context of birth, the master narrative is one that portrays women as incapable and in need of medicalization, which alters the way women make sense of their birthing process culturally and communicatively (Walker, 2012).

The telling of stories describing women's experiences during birth is present in many cultures (Akhavan & Edge, 2012). These stories often include experiences during pregnancy, preparation for birth, labor, and the birth itself. The telling and re-telling of birth stories along with other personal experiences situate women within broader social, cultural, and medical arenas (Carson et al., 2016). During the 20th century the way birth was discussed changed significantly. As healthcare became more medicalized, stories began emphasizing the role of the physician as an expert who identified and treated women's pain and complications (Dean, 2017); this model frames birth as a medical problem in need of medical intervention, increasing obstetrician authority, and often downplaying female birthing experts such as midwives and doulas (Hahn, 1995). Women came to be seen as having a diminished role in their birthing process; a secondary character in their own birth stories (Hahn, 1995).

Though birth experiences are shared, their prevalence often fades away after the baby is born and the mother attempts to adjust to her new life. While the telling of birth stories decreases over time, research on sharing birth stories has found that they serve multiple functions, including: entertainment/rite of passage, social comparison, or a means for processing the

experience (Bylund, 2005). For women who have experienced difficult or traumatic births, simply not sharing their experience has been associated with mental health decline, social isolation, and deep depression (Beck, 2004; Zimmerman, 2013).

Critical Rationale

This investigation used qualitative research methods including an interpretive lens and discourse analysis to shed light on the communicative complexity of women's traumatic birth and transition to motherhood. In addition to yielding practical applications for counselors, medical professionals, and close others, understanding meanings of birth and motherhood informs mother's experiences. Utilizing RDT for this analysis identified competing discourses and considered the influence of power on multiple levels. This approach was selected because little is known about how women who have experienced traumatic birth resist stigmatization and potentially (re)define what it means to give birth and adjust to new motherhood. Additionally, RDT was a strong framework for this project because Baxter (2011) posits that stories hold dialogic potential — multiple viewpoints are present at the same time, thus traumatic birth experiences are a fruitful place to look for competing discourses. I specifically looked for double-voiced discursive interplay within talk, including negating (total rejection of competing discourses, often seen through comments of “wrongness”), countering (offering limited legitimacy, often seen through words such as “but,” “although,” and “however”), and/or entertaining (considering multiple world views or general ambivalence, often seen through comments including “could,” “may,” “might”) within multiple discourses within one utterance. Underrepresented truths of birth and motherhood were identified through the intersection of dominant and marginalized discourses, as well as the influence of power.

Power has been included within the discipline of interpersonal communication largely as a phenomenon that can be measured (e.g., social influence) (Baxter & Asbury, 2015). While communication research has addressed power through furthering the understanding of status, dominance, and authority, the manifestation of power rarely goes beyond social influence and identification of competing discourses (Miller, 2017). For this project, power can be conceptualized as interrelated hierarchies made legitimate through knowledge claims of what is true and real (Foucault, 1980). Therefore, power is unstable, plural, and not something that individuals or groups “have” or “hold” over others (Miller, 2017, p. 6). This understanding of power serves birth communication well as it creates a space to challenge what is common knowledge or widely accepted. Framing power as interrelated to knowledge gives voice to marginalized populations when considering what is and ought to be (Baxter & Asbury, 2015). For example, focusing on women’s traumatic birth experiences creates knowledge beyond the value of “healthy mother, healthy baby” to include the experience of traumatic birth that resulted in a physically healthy mother and baby. Challenging the norms of birth culture as more than a means to an end is the first step in valuing the birthing process emotionally and relationally. While the dominant culture of birth and motherhood has a strong foothold in the way women make sense of their experiences communicatively, it has become increasingly popular for individuals to turn to (and participate in) podcasts that aim to share unique experiences such as traumatic birth. Podcasts provide an outlet for knowledge creation and power development.

Storytelling and Podcasts

There has been an ongoing presence of storytelling of key life events throughout history. Narration has been seen as a valuable source of knowledge creation and sense making of social life (Larkin, Begley, & Devane, 2009). Through storytelling individuals learn what to expect

from the world, and how one should navigate certain situations and relationships. They help individuals make sense of the world, particularly in the chaotic and often uncertain realm of health (Sharf, Harter, Yamasaki, & Haidet, 2011). With regard to birth, communication research suggests that women often learn about birth and pregnancy through birth stories, and hearing birth stories while pregnant helps women cope with their pregnancies (Munro, Kornelsen, & Hutton, 2009). Further, birth stories incorporate pregnant women in birth and motherhood culture (Savage, 2001). Stories not only consist of personal experiences, but imbedded within them are the cultural beliefs, norms, and values women bring to their birth and transition to motherhood (Vos, Anthony, & O’Hair, 2014). Stories are particularly valuable as they provide a thick description of the messages women receive, and how those messages are incorporated in their decision making (Hopfer & Clippard, 2011).

Additionally, stories are told to those around them to gain cultural legitimation of a lived disruption or experience (Becker, 1997). Stories are shared both face to face (with friends, family, and strangers) as well as online (through blogs, forums, social support websites), and it has become increasingly popular for individuals to turn to (and participate in) podcasts that aim to share unique experiences — such as, for instance, traumatic birth. Podcasts provide an outlet for knowledge creation and power development.

Over the last decade there has been a spike in publicly available, do it yourself, media content that has shaken up media culture (Jenkins, 2006). Podcasts, one example of this DIY content, are defined as “audio and video files that can be downloaded to a desktop computer, iPod, or other portable media player for playback later” (McClung & Johnson, 2010, p. 83). Conventional television and radio are often available through podcast, but podcasts also include original content made by amateurs (sometimes even from the comfort of their own home)

(Meserko, 2015). Apple Inc. has attained over one billion podcast subscriptions, with podcasting content downloaded in over 100 different languages (Mogg, 2013). Further, according to the Pew Research report in 2017, 50% of American adults have listened to a podcast at least once, and 25% of Americans have listened to a podcast within the last month. Individual media content has been created to produce messages within an existing culture, or to disrupt cultural power dynamics (Meserko, 2015). Further, podcasts have become an instrumental site for individuals to pursue authenticity (Meserko, 2015). Gauntlet (2011) suggests that “making is connecting,” and when individuals make or participate in podcasts they are to some degree motivated by establishing more intimate connections with others, and a more authentic presentation of themselves (p. 121). While identity and authenticity are complicated concepts, it is important to note that crafting and expressing oneself digitally does not necessarily mean that those messages shared are less authentic than face to face messages (Baym, 2010).

While podcasts have been used as an avenue to share one’s authentic self, they have also been an effective means for promoting healthy behavior (Mou & Lin, 2015). Podcasts have been linked to helping individuals lose weight by increasing knowledge while also decreasing the cognitive load associated with weight loss (Turner-McGrievy et al., 2009). The implementation of podcasts has also produced positive outcomes in child nutrition for parents (Stenger et al., 2013), and has proven to be a successful pedagogical tool for college student learning (Huntsberger & Stavitsky, 2007). Thus, podcasts serve not only as an outlet for self-identification and expression, they also serve as a tool for education, and have the potential to shape beliefs and behavior (Mou & Lin, 2015).

The Birth Hour Podcast

“*The Birth Hour* helps expecting and new mothers understand their birthing options through authentic birth stories so they are informed and empowered going into pregnancy, birth and postpartum” (thebirthhour.com, 2018). *The Birth Hour* is a place for women to share their birth stories along with pregnancy and postpartum struggles, triumphs, and resources. Through the podcast, *The Birth Hour* aims to connect with expecting and new mothers on a personal level by including a wide range of experiences. Listeners can hear *The Birth Hour* episodes via iTunes, Stitcher, Google Play and dozens of additional podcast directories, and on YouTube as well as their website. As of this writing, *The Birth Hour* is well received with a five-star (out of five) rating on iTunes based on 588 ratings. *The Birth Hour* is listened to by many women, with 250,000 downloads per month (according to creator Bryn Huntpalmer, on August 8th, 2017). *The Birth Hour* also has an Instagram account (with 162,000 followers) where pictures and introductions of women’s stories are posted. *The Birth Hour* reaches a vast audience, with a mission to empower and inform women through personal narrative. The discourse shared on *The Birth Hour* may participate in the replication and/or creation of birth and motherhood discourse. Knowing that podcasts serve as a place for individuals to share their true selves, it will be valuable to see what messages about birth and motherhood are shared by women who have experienced a traumatic birth.

Data and Procedures

To gain access to birth stories, I used a public domain website/podcast, *The Birth Hour*, or thebirthhour.com to collect examples of women’s talk about a traumatic birth and transition to motherhood. *The Birth Hour* website serves as a resource for women involved in all stages of reproduction, and obtains the majority of its content from user submissions/interviews. To be featured on *The Birth Hour*, women complete a Google document survey asking for their name,

email, Skype username, phone number, number of children, number of birth stories planned to share, a “check all that apply” list regarding birth description (e.g., hospital birth, home birth, vaginal birth after cesarean [VBAC], water birth, family-centered cesarean [e.g., a clear partition for mom to see the birth, holding the baby soon after birth], twins, surrogate, preemie, postpartum depression, infertility, and adoption). Then, women are prompted to describe their births in three to four sentences, and any unique perspectives their story will offer other women. Women are also asked demographic questions including location, age, and ethnicity. Finally, women are prompted to note any brands or companies they could speak to if they were to sponsor an episode on *The Birth Hour* podcast.

The website is divided into several sections, including: birth stories, blog, and members. For this study I only focused on the birth stories. In this section, stories are listed in sixteen categories: adoption, birth center, breech, cesarean, home birth, hospital, hypnobirthing, infertility, international (women outside the U.S.), loss, postpartum depression, preemie, surrogate, twins, VBAC, and water birth. Because the focus of this project is on birth trauma and the early transition to motherhood in United States, the adoption, international, and surrogate categories were not included in my analysis.

Bryn Huntpalmer, the creator and host of *The Birth Hour*, is a mother of two and conducts all of the birth story interviews. Each interview includes four overarching sections: a description of the mother and a little bit about her family, pregnancy, and birth preparation; the birth story; postpartum experience; and any advice or message they would like to share with listeners. To gather birth trauma experiences for this project, *The Birth Hour* data was limited to episodes where birth trauma is a central frame of the story, resulting in 41 podcast interviews and 49 traumatic birth stories (some women recalled more than one traumatic birth experience during

their interview). The inclusion criterion consisted of talk about a birth experience that fit within the following definition of traumatic birth: “an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror” (Beck, 2004a, p. 28). Interviews meeting this criterion were transcribed in their entirety.

Interview lengths ranged from 24 to 94 minutes ($M = 48$ min). Women shared their birth stories from across the U.S.: West ($n = 15$), Midwest ($n = 6$), Northeast ($n = 6$), South ($n = 9$), or not reported ($n = 5$). The majority of mothers did not disclose their race ($n = 39$); however, two women identified themselves as black. All mothers were in committed relationships at the time of their traumatic birth: married ($n = 39$), engaged ($n = 1$), partnered ($n = 1$). Women’s traumatic birth stories were shared among their other birth stories (some traumatic, some not). Women’s number of births ranged from one to six, but the majority were at the low end of that range, as 73% of the sample had 1-2 births ($M = 1.85$). Forty-nine births (64%) were described as traumatic, and were included in the analysis of traumatic births. Traumatic births were associated with both midwives and doctors: midwife traumatic ($n = 10$), doctor traumatic ($n = 38$), not reported ($n = 1$). The age of children at the time of the interview ranged from one month old to 17 years old ($M = 4.54$ years). The majority of traumatic births were not attended by a doula ($n = 38$), but some were ($n = 11$). The majority of traumatic births were associated with some sort of difficulty with the addition of a new baby ($n = 41$); some women didn’t talk about their transition difficulty ($n = 6$), and two mothers mentioned an easy or seamless transition.

Establishing Credibility

Due to the interpretive nature of this project it was incredibly important to maintain validity through all stages of analysis. Validity in this case pertains to accurately representing

individuals' realities in a credible way (Creswell & Miller, 2000). To maintain validity each stage of analysis was treated with careful organization and rigor. To begin, podcast interviews were transcribed by me and a research assistant, which provided me with additional exposure to the data. After transcription was complete I wrote analytic memos, taking note of salient quotes, initial connections to other interviews, and any notions of bias or slant during the interview (Rubin & Rubin, 2012). Additionally, after each interview was transcribed I summarized its content (focusing on particular insights), why I included it in my analysis, and how long the interview lasted (Rubin & Rubin, 2012). These memos were especially useful for this large data set when identifying themes across interviews. After initial themes were created I engaged in data conferencing, a method of peer validation (Braithwaite, Allen, & Moore, 2017). I organized a meeting with scholars skilled in interpersonal qualitative communication research, where I gained feedback on analytical categories as well as theoretical applications. In the following section a description of contrapuntal analysis provide insight into my coding and theme creation.

Theoretical Considerations and Contrapuntal Analysis

The Birth Hour interviews were analyzed using contrapuntal analysis (Baxter, 2011), a type of discourse analysis intended to identify the interplay of competing cultural discourses used in conjunction with RDT. Specifically, my analysis consisted of three steps. First, I identified discourses within women's talk, then I looked for competing discourses, and finally I identified interplay between discourses in order for mothers to construct meaning (Norwood & Baxter, 2011). Before coding began I read over the transcripts several times to become holistically familiar with the data.

To begin analysis, I engaged in open-coding procedures to locate discourses, which are treated as thematic categories in the initial stages of contrapuntal analysis (Baxter, 2011). To

identify discourses a textual segment must respond to a general analytic question of meaning: “What does it mean to be pregnant, give birth, or transition to motherhood?” I maintained the women’s language choices in my coding process to stay close to their stories. This practice, known as *in vivo coding*, consists of labeling sections of data using direct words and/or phrases (Strauss, 1987). After identifying initial themes (i.e., discourses), themes were compared and assigned to new or existing categories until no new themes were identified (Baxter, 2011).

Once discourses were identified, I determined whether any discourses were in competition with one another. The struggle between discourses can be seen through double-voiced discursive interplay: synchronic interplay and discursive transformation (Suter et al., 2015). Synchronic interplay suggests that through talk people negate, counter, or entertain a given discourse (Baxter, 2011). *Negating* consists of total rejection of competing discourses, often seen through comments of “wrongness” (e.g., “I had no shame sending my baby to the nursery after 36 hours of labor, no one should have to care for a baby 24/7 after what I went through”). *Countering* can be found when a dominant discourse is replaced with an alternative discourse — limited legitimacy often seen through words such as: “but,” “although,” “even,” “just,” and “however.” For instance, in the example, “I told my husband to feed the baby formula even though I knew it would hurt my breastfeeding relationship,” the use of *even though* counters the expectation that a mother should breastfeed. *Entertaining* is found when a speaker presents a discourse as one of several possible discursive positions (i.e., considers multiple world views or general ambivalence statements including: “could,” “may,” “might”) in one utterance (Baxter, 2011). For instance, in this example, two discursive positions are evident — getting help and not getting help: “If I don’t start feeling better soon I might get help for my postpartum depression.” Additionally, *discursive transformation* consists of individuals creating a new

meaning by not using discourses in opposition to one another and instead using the discourses to create something new (Baxter, 2011). Discursive transformation is often seen in one of two ways, discursive hybridization or aesthetic moments (Baxter, 2011). Discursive hybridization presents two often competing discourses as no longer in opposition. Aesthetic moments occur when discourses mix in a way that profoundly reconstructs each system of meaning (Baxter, 2011). To prime myself for the competition of discourses I used the process of unfolding (i.e., considering the conversation at large) to position myself in a way to understand these women, and what previous interactions (distal already-spoken) and future interactions (distal not-yet-spoken) could be informing the way they are talking about their birth experience(s) (Baxter, 2011).

Once competing discourses were identified, I examined the relationship between the birth culture at large and how these women speak in support of, against, or in relation to larger cultural norms of birth and motherhood (Baxter, 2011). To identify the type of interplay between competing discourses I explored how discourses were situated as the dominant, centripetal discourse or as the marginalized, centrifugal discourse. This interplay of discourses illustrates how women who have experienced a traumatic birth negate, counter, and/or entertain the dominant discourse of pregnancy, birth, and motherhood (Baxter, 2011).

IV. Findings

Research question one asked about what discourses of birth and motherhood are present in mothers' talk about their traumatic birth experience(s). Results of the contrapuntal analysis revealed the culturally dominant discourse of intensive motherhood in women's talk about traumatic birth experiences. Women's talk evoked tenets of intensive motherhood during pregnancy, birth, and their transition to motherhood and considered intensive motherhood

behavior as “good” and anything outside of intensive motherhood as “bad” or “less than”.

Women relied on the pre-existing (distal-already spoken) value of motherhood that childcare is the primary responsibility of the mother, and that mothers should put their child’s needs above their own autonomy and identity (Gattoni, 2013). Notions of intensive motherhood can be seen through women’s talk about how a “good” mother experiences pregnancy, gives birth, and transitions to motherhood. While many women did not feel they were successfully enacting the values of intensive motherhood during pregnancy, birth, and motherhood, their talk suggests that intensive motherhood behavior is the best way to mother.

Discourses of Intensive Mothering During Pregnancy

While reflecting on their preparations for birth, many women spoke to the dominant discourse of intensive motherhood, or what it means to be a “good” mother. Intensive mothering can be seen through several themes: *mothers should birth like the strong women before them*, *good pregnancies are natural and uneventful*, and *good births are a result of planning and control*. Additionally, interplay with the dominant discourse of intensive motherhood was identified through the theme, *bad pregnancies are unplanned*. Intensive mothering standards provided a measuring stick for women to rate their pregnancies, and beginning the road to motherhood unplanned was not consistent with intensive motherhood or how pregnancy *should* be. Many women wanted to birth as their mother and/or close relatives did, and looked up to their close others while preparing for motherhood.

Mothers should birth like the strong women before them. Women looked to their close relatives’ birth stories when planning their births; they felt empowered by close others who had natural births. Many women noted that they planned on having a natural, unmedicated, and uncomplicated birth because that is what women close to them had done, thus they could do it

too. While preparing for her first birth, Katie recalled family stories that shaped her understanding and hopes for her upcoming birth:

I had just an intrinsic trust in my body and what I could do, and I come from a large family, and I've grown up hearing birth stories — and my mother had all but one of her children unmedicated, and most of my aunts did the same thing — and so I kind of already knew that that's what I wanted to do. (I-43, 32-35¹)

Katie felt as though she had no reason to fear birth, because her mother and aunts had unmedicated births so her birth would be no different. Katie trusted her body and felt there was no reason to fear birth based on the stories she heard from close women in her life. Similarly, Allison believed she would be able to achieve a natural birth, based on her mother's experience:

My mom had three natural births. I have two other sisters, so I grew up knowing that she had three natural births, and so I kind of knew from a really early age that that's what I wanted just because that's what my mom did — and you kind of do what your mom does, haha. (I- 227, 24-27).

From an early age Allison's view of birth was influenced by her mother's natural births.

Because of this when it came time for Allison to prepare for birth she had hopes of modeling her mother's behavior. Women who wanted to birth like the close women before them had a great deal of respect for them, and viewed giving birth unmedicated and naturally as the “right” way to give birth, and an early representation of what kind of mother they would be.

Another theme that emerged from the data was the notion that good pregnancies are natural and uneventful.

¹ All quotes will conclude with an I- number (indicating the podcast interview number). The subsequent numbers indicate the line(s) where the quote can be found in the respective transcript.

Good pregnancies are natural and uneventful. Women had high hopes for their births consistent with intensive motherhood, and often felt capable of their desired birth when their pregnancies were uneventful and made them feel beautiful. Uneventful pregnancies often set the stage for women's plans for birth because their first chapter of motherhood, pregnancy, went as desired. Ashlee recalled feeling beautiful during her pregnancy:

So I had a really very typical, very healthy pregnancy with him. I felt great, loved being pregnant; I felt more beautiful than I ever had. (I-24, 43-44)

Before experiencing complications, Ashlee recalled feeling great in the early weeks of her pregnancy. The adjustment to carrying a baby felt natural, and beautiful. This notion is consistent with dominant discourse that pregnancy and motherhood is what women do naturally. Kacey also discussed how her pregnancy was "flawless":

Okay I just turned 29 when I had Max, and my entire pregnancy was flawless. I remember for the first several months feeling great all the time, even through my first trimester. I never had any morning sickness or anything — the joke with me and my husband often was "surely they'd tell me if I wasn't really pregnant, right?" I just felt normal; it was a really wonderful experience. (I-34, 19-23).

Similar to Ashlee, Kacey felt great during her pregnancy. She enjoyed growing her baby and felt that it was a natural transition. Kacey's pregnancy gave her the confidence to plan for an unmedicated birth, as her experience with pregnancy felt natural. Additionally, many women reported feeling good about planning their birth, and felt a sense of control based on their research and planning.

Good births are a result of planning and control. Another theme that emerged during women's reflection on their pregnancy after experiencing a traumatic birth was the notion that

birth can be controlled through knowledge and preparation. Women were already embracing the dominant discourse of intensive motherhood in their pregnancies and plans for birth. Women wanted to do what was best for their babies, and as a result they made birth plans. Sarah discussed her plan to have a natural birth through knowledge and preparation:

I'm a very Type-A person and I had a very thoroughly researched birth plan, and I was — as all new moms do — I was going for natural, no drugs, no C-section. All of this very natural normal birth was my goal in my plan. (I-5, 37-40)

Sarah felt she would be able to achieve the birth she wanted through her self-education and planning. Sarah wanted as little intervention as possible, which she believed was best for the baby, and is a natural, normal birth. Similarly, Lauren discussed how she made a birth plan for every situation that may come up during her delivery:

Yeah, we definitely made a birth plan; I actually still have it. I think it's three pages long — it was kind of ridiculous — so I hear a lot of people say “I don't want to make a birth plan, because I don't want to get my hopes up and then it not work out because it's not really my control,” and I don't think I'm fully in [agreement] with those people. But I think I went kind of the opposite way, where I created my birth plan, and that was my plan and that is what was gonna happen, and there was no give and take. Even though I made a birth plan for if we had to transfer to the hospital, or if we ended up having to have a caesarean, I made a plan for all those things, but it was kind of like ‘but that's not gonna happen,’ like, that will never happen. (I-149, 90-97)

While creating her birth plan, Lauren prepared for every possible complication that may arise and how she wanted to handle it. Lauren felt a responsibility — along with a sense of control — by planning her response to every possible birth intervention. Lauren's exhaustive preparation

made her feel confident that her birth would go as expected because she researched and planned for it. She also agreed that preparation leads to results and her planning would improve her chances of having her desired birth. Looking ahead to the transition to motherhood, Christy talked about her confidence in her work/life balance and how preparation would be the key to success:

So, when I became pregnant I had had a successful career or two, and had gone back to school, and I just felt very much like I had done so much as an independent woman that I was fully ready to embrace this experience. So, I entered it, really you know, prepared. I was able to be flexible with my, my work hours, and I just read as much as I possibly could (I-63, 35-39).

Not only did Christy have plans for her birth, but she also created a lifestyle that would allow her to put her role as mother first, consistent with values of intensive motherhood. Before she became a mother she had already made the distinction that she would no longer be an independent woman once her baby was born, and planned her school and life around her new role. While many women felt their preparation for birth and motherhood were consistent with intensive motherhood, women who had an unplanned pregnancy did not have the same sense of control.

Identifying interplay: Bad pregnancies are unplanned. While many women spoke directly to the dominant discourse of intensive motherhood and aligned their plans with what it means to be a “good” mother during pregnancy, some women did not directly situate their experiences within intensive motherhood, and can be seen through the theme, *bad pregnancies are unplanned*. Some women had a difficult time accepting their new role as mother when they learned of an unplanned pregnancy. Women described their pregnancy as a threat to their

individuality, which negates the intensive motherhood value that women should always want to put their children before themselves, and cherish the opportunity to be a mother. Phoenix described difficulty in her realization that she was going to be a mother:

I was really upset. I just felt like I wasn't a part of me as I was transitioning into motherhood... Sometimes we get mad when we have a big change in our life, and I think if maybe I was more happy about it, I would, I wouldn't be so strong-willed to do everything that I can to make motherhood as different as possible. I think that's why I was upset, because I was expecting, you know, to have to do all the things that were expected of being a mother [in] society and I don't want that. (I-182, 25-32)

From early on Phoenix felt the weight of intensive motherhood, and didn't want to conform. She felt as though her individuality was threatened and the expectations of motherhood were constricting. Phoenix only found relief when she decided that she could mother however she wanted, even if it didn't align with intensive motherhood. In this next example, Christine recalled her initial reaction to finding out she was having a fourth baby:

The day I found out that I was pregnant with my son I was very shocked and surprised, and when I went to go tell my husband that I was pregnant, he was super excited — and I was like really, how can you be excited? We are not prepared for another child in this house... our three children before, they were all c-sections and two years apart. I was exhausted. I was at home already with the three girls, and I wasn't prepared for the fourth. (I-194,11-18)

Christine recalled feeling at odds with her husband about having another baby. Christine negated the dominant discourse of intensive motherhood by talking about how she was not ready for another baby, as she was already exhausted by her role as a mother of three. Similarly, Jordan

was not excited about her pregnancy at first, as she was in a new city, and felt that her baby was taking everything out of her:

So I was scared. I was young and I was in a new city, a new state and didn't have any friends yet. I didn't even have a gynecologist set up, so at work I was asking around like, "who do you guys go to for gynecological care?" and they gave me the name of a doctor, and I was like, "okay." So I went to her, and Matt went with me, and we had a blood test done and started off on our pregnancy with our first, and it was pretty average of a pregnancy. I was really sick the first few months lost a bunch of weight. Could hardly get out of bed, ended up having to quit my job, so that kind of started off my track of being a stay-at-home mom. I was caring for my unborn child that was taking everything out of me, and we just kind of trucked along and prepared to bring a baby into our one-bedroom apartment. (I-188, 37-45)

Jordan was not ready for a baby, and felt forced into being a stay-at-home mom, and constrained by her pregnancy. Jordan also spoke about her threatened individuality during pregnancy, and how the event of becoming pregnant derailed her plans. Jordan did not embrace her pregnancy, and instead felt like her unborn baby was already taking everything out of her. Next, women recalled their traumatic birth experiences situating themselves in relation to the dominant discourse of intensive motherhood.

Discourses of Intensive Mothering During Traumatic Birth

Three themes emerged as unique to women who have experienced a traumatic birth: *bad birth is something that happens to you*, *bad birth disconnects mind and body*, and *bad birth is isolating and unnatural*. These themes illustrate how women situated their births in relation to the dominant discourse of intensive motherhood. In these themes, women reference the dominant

discourse of intensive motherhood when conceptualizing their ideal birth: a natural, uneventful birth where the mother is in control and protects her baby from unwanted interventions, leading to a natural bonding period filled with nursing and cuddles. As birth plans derailed, women struggled with wanting to do what is best physically for the baby, while also feeling unsure about whether interventions were necessary, leading mothers to feel a loss of agency. Many mothers who experienced a traumatic birth mentioned feeling their birth was something they were not a part of; they were subject to unwanted interventions, and felt disassociated from their mind and body. Women also discussed how they were separated from their husbands and/or babies during or shortly after delivery, feeling alone, which was something they didn't expect to happen. Once these mothers meet their babies, their interactions felt unnatural and difficult.

Bad birth is something that happens to you. Traumatic birth was fraught with unwanted interventions and a loss of agency and their ability to be an intensive mother. Marissa reflected on meeting her doula at the hospital and discussing the unwanted interventions that had taken place during her labor:

So at that point it was just a huge snowball; everything went out of my control and I just — I can't even really remember everything that happened from that point on. I know I ended up having internal monitoring, I know I ended up with an epidural, and by the time my doula got there, she was like, “what happened?” and I said, “this guy just like hijacked my birth.” (I-41, 218-222)

After being denied when trying to advocate for herself (by asking to increase Pitocin slowly, so she would be able to resist other interventions), Marissa felt that once she gave in to one intervention, they all piled up, and she found herself in a place not knowing how she got there

when talking with her doula. Jennifer offered a similar sentiment, sharing that her birth spiraled out of control:

I was very groggy and really out of it, and then them not showing me my daughter — it just, like the entire birth that I had planned and hoped for went in a complete opposite direction. Even though I was educated to all of these things and interventions and I said no so many many times, eventually you just say yes to one and then, you know, they just keep kind of spiraling out of control a little bit. (I-192, 60-64)

Jennifer tried to advocate for herself, but her education regarding the birth process had little effect on the interventions she was subjected to during her birth. Similar to Marissa's experience, Jennifer agreed to one intervention and then she lost track of how things escalated from there. In this next example, Ashlee found herself giving birth vaginally at just 28 weeks, and she described the fear that accompanied her emergency delivery:

They allowed me to continue to labor vaginally, but again, I was scared and I wasn't prepared to be giving birth, so I was very loud and I was being held down. I was being told not to push, or to push, and it was exactly the opposite of everything that I had hoped and planned for my first birth experience. You know it was not peaceful, it was not in my own home, it was not at term, and then I had to beg to be able to even see my son before they took him away to the NICU. (I-124, 59-64)

Ashlee recalled a birth that was the opposite of what she wanted. While she was happy she was able to deliver vaginally (consistent with her birth plan and the culture of intensive motherhood) she was terrified to be having a premature baby in an emergency situation. She was being yelled at and held down, not in control of the birth of her baby. In this next example, Marissa provides more detail about the cascade of interventions she experienced during birth:

They put the thing where they put it into her head to monitor the contractions and monitor her, and he (husband) was like “I don't know,” and I'm like, “well this is a perfectly round little scab on her head, so I don't think there's any other explanation for that.” But you know I'm sure there was a question — or like, notification — like, we have to do this, but at that point I felt so unsupported and so lost in what was happening that I was just, kind of like, whatever. (I-41, 319-324)

While talking with her husband post-birth, Marissa discussed whether or not they consented to internal fetal monitoring. She felt completely lost and unsupported and didn't remember all that had happened to her and her baby. Marissa felt her ability to be an intensive mother was stripped from her, and it became clear when she was unable to identify the cause of a tiny scab on her baby's head. Another theme that emerged was the separation of mind and body during traumatic birth.

Bad birth disconnects mind and body. Another way women felt uninvolved in their delivery was experiencing feelings of being detached, or a disconnection between mind and body during birth. While mothers had hoped to feel capable and competent (consistent with intensive motherhood) during their birth, traumatic birth created a barrier between mind and body, as their body did not respond how they wanted during the birth process. This notion was made worse when health professionals commented on a mother's body/mind not acting properly during birth. Sarah mentioned individuals telling her to just relax in order to let her body dilate, but she felt that was not the issue:

The nurses kept telling me, “you need to relax, you need to relax so you can finish dilating,” and I - I was trying really hard to stay calm, which was really difficult, but I - I didn't really feel like me relaxing had [anything] to do with it, that's kind of how I felt.

Like I'm panicking in my head; I don't really think that that's gonna affect how much I'm dilating, like it's just gonna do it on its own. I kind of felt like a little disconnected from my body almost, that my body was just doing what it needed to do and I really didn't have much to say in the matter, they kept telling me “you need to relax.” (I-5, 128-134)

Sarah felt as though her body and her mind were not working as one, and she had no control over how her body was working through labor. Sarah felt undermined by the hospital staff in that she wasn't laboring correctly, and that her mind was holding her back. Ally, overdue by one week, reflected on her experience of being forgotten about during a doctor's visit at 41 weeks, during a non-stress test where she was feeling resentment toward herself just before birth:

I just remember being, like, so furious — like, how could you forget about this pregnant mom stuck in this room, and like, I wasn't dilated. They told me there is no baby coming for weeks, and it was just, like, so depressing, and I just remember this, like, deep resentment almost that I started to feel towards my body. Not necessarily towards my baby, but just my body for not doing what it was supposed to do, or what all my friends' bodies were doing, or what I just imagined people's bodies did when they gave birth. (I-105, 69-77)

Ally started her delivery feeling disconnected from her body. All she wanted to do was to go into labor on her own (like her friends, and seemingly every other woman), but the predictions from the doctor of “no labor for weeks” made her feel incapable. The messages about her inability to go into labor on her own influenced her thoughts about her body during labor and delivery the next day. In this next example Alexandra talked about feeling disconnected during her cesarean birth:

We got to the O.R. and they [...] did the spinal, and my husband came in and they had him out in less than five minutes, and it's kinda — for me, it was such a cold and detached birth. You know, granted I was also in a crappy situation, but you had envisioned this whole thing in your mind leading up to the to the birth of your child, and it was nothing what I had imagined — like... oh my god, I can't wait to see if it's a boy, it's a girl, you're always waiting for those words, and I remember them saying, “happy birthday, it's a boy!” and I wasn't even fazed by it. (I-133, 133-139)

Alexandra planned for a natural birth consistent with intensive motherhood and fantasized about learning the sex of her baby after a difficult experience with infertility. However, due to her unplanned cesarean, she felt detached from her birth because it was nothing like she had imagined, and she felt her birth was something she didn't have an active role in. Another feature of traumatic birth was feelings of loneliness, and an unnatural start to family life.

Bad birth is isolating and unnatural. Consistent with intensive motherhood, mothers dreamed of pulling their babies onto their chest, beginning family life with nursing, cuddling, and doting over their babies with their husbands by their side. So when things didn't go as planned, mothers had a difficult time negotiating what should happen next after the birth (because they were often unable to hold their babies right away), and when the mother was able to meet her baby it was often awkward, and/or hazy due to an uncomfortable physical position, pain medication, exhaustion, or physical pain. Ashlee went through the trauma of being under general anesthesia during an emergency cesarean after the loss of one of her twins, and woke up alone:

The decision was made to deliver emergency caesarean, so the shift in environment happened pretty immediately there, and they prepped to deliver. So at 11:11 that morning

Nova was born, and they delivered Aurora's body a minute later, and um, and then immediately I lost sight of everything that was happening. I had a panic attack during my delivery, so I had to be - I had to be put under completely, so I woke up in recovery by myself. And I feel like we had navigated trauma after trauma already, but I don't know that I've ever been more scared in my life as waking up in recovery by myself. I didn't know if Nova was alive, [or] what was going on with her, and I didn't know where Aurora was, and all I wanted — I think of as any mom would want — where are my babies? (I-24, 289-297)

Before her cesarean, Ashlee had just learned that one of her twins had not survived a necessary surgery to save one or both of the twins. After complications from that surgery, Ashlee had an emergency delivery and woke up completely alone, and with no idea if the other twin was alive, stripped of her role of intensive mother. Kacey reflected on her husband bringing her baby over to see her briefly, but leaving while she was moved to recovery:

The first time Adam brought him over to see me, I dry heaved, and it just wasn't the most pleasant experience. And so after that Adam took him (crying), and I was in an enormous amount of pain and very, very uncomfortable, and so they kept me in the post-op room for a little while to help get me calmed down. And then we went back to our room and all of our family was there waiting for us, and - and I made sure to tell Adam, though, when we were leaving, that I didn't want anyone else to hold him before I got to hold him. Because I could just see that happening, see him just being passed around to all of our family before I even had a chance. So Adam made sure that happened, and we got to have a little bit of time — just the three of us — before all the family came in. (I-34, 100-109)

Kacey disliked the way she was introduced to her son, as she was in an extreme amount of pain and vomiting. Additionally, she was separated from her husband and son while she was in recovery, and had to make sure extended family would not be able to hold their new son before she got the chance. Kacey had hoped to bond effortlessly with her baby right away, but when that wasn't possible she made sure she would still be able to hold her son before extended family. Similarly, after a traumatic birth where her body was not receptive to pain medication, Natalie reflected on the pain she felt when she woke up, and how she didn't want to meet her son:

I just woke up to them pushing on my freshly sewn womb, and I was just screaming. I just remember waking up screaming, and thinking *people are gonna think that I'm being murdered and tortured right now and I'm waking up all the precious babies* — that's all. I see my husband, like in the distance, trying to bring our son over, and I'm just like — no, like, I don't want to meet him in this state, like this is not how it's supposed to happen. Like I am not supposed to meet him like this. I'm supposed to be happy, and these are supposed to be tears of joy and victory, not like something was stolen from me, not like I'm being tortured. (I-113,169-179)

Natalie didn't want to meet her son when she was in extreme pain, and felt the experience of meeting her son was stolen from her. Even when she was in complete physical and emotional turmoil Natalie felt the weight of intensive motherhood, as she felt she should be happy and should have it all together when she met her son for the first time. While most women spoke to the dominant discourse of intensive motherhood as the best way to mother even when faced with a traumatic birth, some mothers separated themselves and focused on their experience on an individual level. Interplay with the dominant discourse of intensive motherhood during traumatic

birth was identified when women made meaning of their experience as an individual through the theme, *birth isn't all about the baby*.

Identifying interplay: Birth isn't all about the baby. While the majority of women made sense of their traumatic birth experience by speaking to the dominant discourse of intensive motherhood (in that their ability to be an intensive mother was taken from them, or they did their best to enact this role regardless of the circumstances), some women countered the dominant discourse by considering their competing feelings about being an intensive mother, or doing what is “best” and doing what they wanted to do as an individual. In this first example Erin framed her separation from her son as a positive bonding time for her husband and son, but also felt the pressure of intensive motherhood when she was separated from her baby after surgery:

I didn't really realize that I would be alone right now, which, luckily I was fine. I didn't feel that separation anxiety and I felt okay. It was just for, [it] probably ended up being 15 minutes that my husband had my son in the recovery area. Which, when I look back on [it] I think I could have been kind of sad about [it] because you know it's not that instant, like, mother-son bonding time that you look forward to. But when they wheeled me over the image of seeing him sitting there in this totally empty room with my son — holding him, talking to him — I felt like it was such a special bonding for them that they got, like, 15 minutes, which usually isn't allotted to the dad. That he got to kind of welcome him into the world, and be the person to talk to him, and - I don't know, I just, it just brought me so much joy that he's so cute, he's so safe in my husband's arms. (I-46, 255-263)

While Erin felt okay being alone after her surgery, she had trouble making sense of her feelings when separated from her son. When thinking of her experience on an individual level, outside her husband and son, she felt sad. When dreaming of her birth, Erin pictured an instant mother-son bond after birth (intensive motherhood), but when that was not possible she countered the dominant discourse and communicated happiness that her husband was able to build an immediate bond, something most fathers do not get to do.

Alexandra noted feeling alone during a prolonged separation after her cesarean section because her doctor told her to go upstairs and start pumping right away before meeting her son in the NICU:

I didn't get to see him for a couple of hours. I want to say [it] took maybe like 4-5 hours before they let me go down to the NICU — they had kept me in the recovery room for a while — and when they took me up to my room - when the doctor was closing me up, she said, “I want you to go upstairs and I want you to pump right away; that's like the best thing you can do right now,” so I did that for a while. But yeah, everybody had seen him before me, and that, for me, sucked that I had waited such a long time to see him, and I was only able to see them through a couple of pictures that everybody was showing me after they would visit him in the NICU. (I-133,147-153)

Alexandra countered the discourse of intensive motherhood by discussing that while she did “the right thing” by going straight to pumping breastmilk for her baby after her surgery, it kept her from doing what she (as an individual) really wanted to do, which was see her baby. Alexandra explained that enacting intensive motherhood behavior, putting the baby before herself by pumping, “sucked.” Erin also countered the dominant discourse of intensive motherhood when she met her son awkwardly while she was laying down during surgery:

My husband brought him to me, but to be honest I - I didn't really want to hold him. I know that sounds so un-maternal, but I just felt, like, awkward — I'm laying down flat and I gave him a kiss, and I want - I wanted to see him but I wasn't in the position to hold him, so that was fine. (I-46, 138-141)

Erin recalled feeling awkward when first meeting her son because she wasn't really in a place to hold him comfortably, and didn't want to, which she felt okay about. Erin countered the dominant discourse by explaining that while the maternal (intensive mother) thing to do in this situation was to want to hold her baby regardless of the situation, she decided not to hold him while she was getting stitched up in surgery because as an individual it didn't feel right. Many women situated their transition to motherhood after a traumatic birth in relation to the dominant discourse of intensive motherhood.

Discourses of Intensive Motherhood During the Transition to Motherhood After a Traumatic Birth

The second research question asked what discourses of birth and motherhood are present in mothers' talk during the transition to motherhood after experiencing a traumatic birth. Similar to the results of research question one, mothers relied heavily on the dominant discourse of intensive motherhood. Themes that emerged during the transition to motherhood can be seen through the framing of what it means to be a “good” or “bad” mother. Elements of “good” mothering were consistent with intensive motherhood and include: *a good mother breastfeeds her baby*, and *a good mother puts complete focus on her baby*. These themes can be seen through talk where women felt they were successful in their role as an intensive mother during the transition to motherhood, and when they felt being an intensive mother was a healing experience after a traumatic birth. Specifically, women noted a positive breastfeeding and bonding

relationship with their baby, and also that their immersion in their new role as mother kept them from dwelling on their difficult birth.

Women who viewed their transition to motherhood as complicated by their traumatic birth framed their experience as “bad,” and noted that it was difficult to enact the desired role of intensive mother. Themes included: *bad births result in difficult recoveries*, *bad mothers have difficulty breastfeeding*, and *bad mothers dwell on negative birth experiences*. In each of these themes women felt that there was something standing in the way of them successfully adopting the role of intensive mother. After a traumatic birth women often felt that they were not being the best mother possible because they had to spend extra time healing physically, sometimes having to be separated from their baby for additional corrective surgeries. Also, women felt like failures when they were unable to breastfeed their babies, as breastfeeding is seen as a selfless, nurturing act. Women also felt guilty for being preoccupied with their traumatic birth — they felt that they should be able to move past their traumatic experience and enjoy motherhood, but struggled to do so. While many of the themes in this category speak to the dominant discourse of intensive motherhood as the best way to mother, when it came to discussing postpartum depression women were able to separate themselves from the dominant discourse of intensive motherhood, and negated the tenets of intensive motherhood, describing their thoughts and behaviors as opposite to the ideal, intensive mother.

A good mother breastfeeds her baby. After experiencing a traumatic birth some women found it healing to bring their baby home. New mothers spoke to the dominant discourse of intensive motherhood. The first way that women were able to heal was through establishing a healthy breastfeeding relationship with their baby. Providing breastmilk served as a way for

mothers to quantify their ability to mother, and helped restore confidence in their bodies. After giving birth twice prematurely, Ashlee found it healing to breastfeed her babies:

I haven't been able to carry any of my children to term, and there was a lot of struggle with my body afterwards. Being able to breastfeed successfully with both Xavior and Nova I think gave me a form of physical healing and emotional healing, that without it, I don't know where I would be. I would have struggled emotionally a lot more if we hadn't been able to forge that bond, and to be able to connect with them, so physically [it] has been really important in both of their stories as well. (I-24, 338-346).

Ashlee felt that she would have had a much harder time bonding with her babies after difficult births if it hadn't been for positive breastfeeding experiences. Ashlee's ability to embody an intensive mother by breastfeeding her babies helped her heal from birth trauma, and instill confidence in her body and ability to mother.

Diana echoed the notion that forming a successful breastfeeding relationship was healing: I was recovering from surgery and breastfeeding was very, very hard. One thing that I wish that people talked about more is that I think that when you have a really traumatic birth — and perhaps even just a surgical birth — it could really impact breastfeeding in a lot of different ways. I think that, you know, bodies are sensitive, and bodies know when they've been traumatized or hurt, and my body - it took me a full five days before my milk came in, and it was very, very challenging breastfeeding. [It was] super painful for a long, long time — there were many, many times that I wanted to give up and stop breastfeeding, but we eventually continued breastfeeding until he was two years old, which is awesome. I'm so, so grateful that that was able to work out for us. I think that a lot of moms that have a birth that perhaps doesn't go quite the way that they wanted it to

go, or they feel like they did something wrong, when that breastfeeding relationship ends up being so successful, that can be really healing and it definitely was for me. (I-138, 292-303)

While Diana had a difficult time establishing her breastfeeding relationship due to healing from a cesarean, she was thankful that she was able to breastfeed until her son was two years old. Diana sacrificed and endured the early struggles and pain of breastfeeding consistent with intensive motherhood and always putting baby first. Another way women worked through their birth trauma was by putting their experience on the back burner and focusing on their baby.

A good mother puts complete focus on her baby. Some women successfully coped with their transition to motherhood after a traumatic birth by putting their focus on their new role as mother. After giving birth via cesarean, Caitlin felt that as soon as her baby was born and healthy, she was able to put the birth behind her:

Andrew (husband) did his best to distract me through the pressure, and the tug and pull. About five minutes into surgery Dr. B held Cooper up over the curtain, and it was the greatest moment of our lives. Um, sorry (crying), like, you know, like the entire day didn't matter anymore — I mean it felt like someone took my heart out and just squeezed it. He was so beautiful and he was screaming and he had so much hair. (I-185, 261-265)

Caitlin felt that she was able to put her traumatic birth behind her because she had a healthy baby and could move forward as a mother and family. Even though her birth was traumatic, the birth of her son helped her forget the experience. Lauren recalled coming out of a fog around three months postpartum, but before then she didn't reflect much on her traumatic birth:

I think once I came out of the, like, kind of fog of that 'fourth trimester' I call it, this first three months — I think that's when I started kind of going over everything in my mind,

and really like regretting certain things and questioning certain things. And you know it took me over a year to kind of accept it, and kind of start to look forward to maybe future births being more healing, and you know, things like that. But those first three months really were great; I think I was just kind of in the zone of, like, new mommyhood, and I didn't let myself really think about the birth as much. So I did struggle with it later on, but in that immediate postpartum period things are really wonderful. (I-49, 319-325)

Lauren avoided thinking about her birth in the early weeks and months after she brought her baby home, and because of that, she reflects on the time as wonderful. Lauren compartmentalized her birth experience during the early months of her transition to motherhood. Because she was able to focus solely on her baby (intensive motherhood) she felt that her experience as a new mother went well. Women's ability to be intensive mothers was often complicated by difficult recoveries post-birth.

Bad births result in difficult recoveries. A difficult physical recovery made some mothers' transition to motherhood especially challenging. Instead of bringing their baby home and focusing on building a relationship with their baby, many women suffered from major complications from their births. Natalie had prolonged complications after an episiotomy:

It was pretty rough — recovery was long, and I couldn't really walk very well [or] sit well and it's graphic, but anytime I would go to have a bowel movement, I mean it felt like shards of glass were coming out, it was so painful. So after about four weeks of that I called my OB and said, “you know this just doesn't seem right,” and they had me come in. They said [...] “we think you have hemorrhoids,” you know, try this and this and you'll get better, and it just - it wasn't helping, so at my six-week checkup they said “we will send you to a specialist.” And this wonderful surgeon, he took one look and he said,

“you have a serious anal fissure from the episiotomy, and you have to have surgery to fix it,” so within a week I was having surgery. (I-195, 22-29)

Natalie had difficulty walking and sitting, and finally ended up needing surgery after her six-week follow-up appointment. During the early weeks of motherhood Natalie struggled with extreme pain and had to advocate for herself in order to get the medical attention she needed for her physical recovery. Shelby also had complications due to an episiotomy that had lasting effects:

It was a partial fourth degree tear so I had to be stitched up, and that was a really challenging part of recovery. As it turns out, at six weeks I still was not healed — I had some granulation tissue that hadn't been caught during my previous visits, so I had to have a couple more procedures after that. Before, I was crying in the bathroom every time I had to go pee... I wasn't able to give her the gentle birth that I wanted, and then my recovery was so long and challenging, and, you know, sex is painful in certain positions for years after that, because I had scar tissue and all of that. (I-85, 146-161)

Shelby had a difficult time healing and recovering after bringing her baby home, and was still dealing with complications years after her baby was born. Due to her difficult physical recovery, she was constantly reminded of her traumatic birth. Jen talked about how overwhelming it was to care for a baby while also trying to care for herself:

Just learning how to be a new mom — having this, you know, physical situation happening, trying to have my baby latch, all at once. So it was definitely really overwhelming. I had the surgery, and then that week later I went back and they were able to see that everything was healing, so I didn't have to go back for another five weeks after that. But then when I went back [...] six weeks after the surgery, I told my doctor, I

was like, “everything feels really good but I just feel like there's maybe, like, a little bit extra skin or something going on, I'm not really sure.” It just felt, like, a little tight, so he ended up looking and seeing that I had discovered that I had a granuloma, which is basically just a little bit of extra skin. So when my body was healing, like, just a little tiny bit of my body had kind of over-healed, so then I had to have that removed. So it was just another thing where once a week I went to the OB's office, and they used silver nitrate to remove it — basically burned that little piece off until it was gone. So I wasn't, like, fully given the green light for anything until about 15 weeks after I had my baby. (I-89, 296-308)

Jen was out of commission physically for fifteen weeks after her delivery, which complicated her ability to breastfeed her baby and care for her baby and herself. In addition to a difficult recovery, some women's inability to breastfeed was harmful to their transition to motherhood.

Bad mothers have difficulty breastfeeding. After experiencing a traumatic birth, and feeling like their bodies had failed them in childbirth, many women carried that guilt when they struggled breastfeeding their baby. Erica reflected on her stress from her baby's feeding schedule and feeling as though her cesarean was the reason for her difficulty breastfeeding:

So someone else — my husband or someone else who was helping me — would then finger-feed her supplements; we did formula or pumped milk. Basically, between the c-section and the birth not going how I wanted, and not being able to feed my daughter, and not getting any sleep because of this crazy schedule, I was absolutely losing my mind. It's really hard, and also part of me thought I was having these issues because of the c-section, which just made me feel even worse. (I-58, 205-210)

Erica was overwhelmed by the new schedule of feeding the baby and trying to establish a breastfeeding relationship. She so badly wanted to do the “right” thing by breastfeeding her baby, and pushed herself to the limit trying to do so. Erica also felt that her cesarean birth contributed to her difficulty breastfeeding, and thought that if her birth would have gone differently she may not have had the same issues. Similarly, after experiencing a traumatic birth with her first baby, Christy felt constrained by her breastfeeding relationship after the birth of her second baby:

That commitment to doing things, you know, like committing to try to do it as well as I did the first time — as well as I thought that I could the first time. I guess that's the only thing I sort of set myself up for. It's a bit harder going back in, having had a little bit of freedom in between, you know? I didn't have a lot of time after stopping breastfeeding before I thought “okay, I'm back in it,” and I felt committed to doing it for as long as I had the first time. (I-63, 282-389)

Christy felt that she needed to breastfeed her second baby as long as her first, even though she felt differently about it this time because she was also caring for a toddler. She put her own feelings on the back burner in order to give her second son the same intensive bonding experience as her first baby, even though she felt breastfeeding the second time around was constraining. Ally also talked about her struggles breastfeeding:

So I quit breastfeeding and I instantly felt like I failed — like I felt like I was some ‘worst mom ever.’ I had, like, friends sending emails telling me they didn't think I loved my baby because I wouldn't try hard enough to breastfeed, and I should get rid of a pacifier because if she didn't have a pacifier she would want my nipple more. And I just remembered, like, I was so overwhelmed by finding out what motherhood was for me,

and it's not the dreamy Disneyland experience that I had hoped for, prayed for, or imagined. (I-105, 196-208)

Ally felt like a failure after deciding to stop breastfeeding, and received hurtful messages saying she was “doing it wrong,” and was not being an intensive mother. Ally’s difficult birth and struggles with breastfeeding made her experience as a new mom more difficult than she had hoped. Anna recalled a huge pressure to make breastfeeding work, and had a negative view of formula:

But I was breastfeeding her and she wasn't, it just wasn't working, she wasn't latching. We were up at one point for six hours straight, her just screaming because she couldn't get any milk, and finally the pediatrician was just like, “okay, just keep coming back every single day, and we're gonna weigh her, and if she doesn't gain weight then you're gonna have to supplement with formula,” and at the time I had this negative idea of what formula was. Now it's completely not like that, but at the time it was like, [...] “I can't get my baby formula,” so I just kept trying, kept trying, and [after] around five days she started to actually gain weight, so I was able to breastfeed and I didn't have to supplement with formula until like eight months postpartum, which was - which was pretty nice. But I definitely went through postpartum depression a lot from lack of sleep. (I-139, 171-182)

Anna was able to make breastfeeding work, but it was at the expense of her own rest and development of postpartum depression. Anna so badly wanted to be an intensive mother and breastfeed her baby, and while it was very difficult she forced the relationship to work. Another theme that emerged from the data was the notion that mothers shouldn’t focus on their negative birth experiences.

Identifying interplay: Bad mothers dwell on negative birth experiences. While mothers had been through traumatic births and difficult transitions to motherhood, a common interplay of discourses during this time was exemplified through women entertaining their individual experience of traumatic birth as significant, but also downplaying their experience because it resulted in a healthy mother and baby and they enjoyed being an intensive mother. Elizabeth had trouble making sense of her experience of traumatic birth while also being thankful for her new role as mother:

You know, I had a lot of unresolved feelings about the c-section and I was embarrassed to admit that I was disappointed about it, and I couldn't separate the fact that I was overjoyed and so thrilled that my daughter was here with the fact that I was so disappointed in how she got here. You know, like I couldn't - I felt like it was going to be taking away from the fact that she was born if I said that I didn't like how she was born.

(I-16, 135-140)

Elizabeth entertained her individual traumatic experience, but had trouble separating her feelings about her traumatic birth from the dominant discourse of intensive motherhood, as she was overjoyed to be a mother and was happy to have a healthy daughter. Elizabeth wanted to work through her traumatic birth on an individual level, but felt that it would take away from the excitement she felt as a new mother. Similarly, Kacey felt guilty about her feelings regarding her traumatic birth:

You know, it doesn't equally equate that I couldn't have this very traumatic experience but obviously, I still love my son very much, but I do sometimes feel guilty about that. (I-

34, 114-115)

Kacey identified with the dominant discourse of intensive motherhood, as she was happy she had her son, but entertained her individuality in the experience because she was unhappy with how her son was born. Kacey had trouble making sense of her traumatic experience as an individual while also embracing her new role as mother, and that made her feel guilty. Natalie noted similar feelings during her transition to motherhood:

I just wanted people - I so badly wanted people to know how grateful I was that I had two miracle babies. I also just didn't want to be invalidated, [...] you know, from the great loss; that that was a big loss in our birth. (I-113, 196-198)

Natalie had a difficult time communicating about her traumatic birth because she didn't want anything to take away from her positive feelings about the birth of her son. Earlier, Natalie was faced with a wide range of emotions as she struggled with conceiving her biological son. She didn't want to take away from the happiness she felt as a mother consistent with intensive motherhood, but entertains the fact that she was deeply affected as an individual by her traumatic birth. Another place where interplay emerged was when women talked about their experience with postpartum depression.

Identifying interplay: Negating intensive motherhood through postpartum depression. A number of women who had a difficult transition to motherhood spoke about their struggles with postpartum depression. Mothers who talked about these experiences negated the dominant discourse of intensive motherhood, and recalled feeling opposite of an intensive mother. Interestingly, women who shared this did not speak shamefully of their experience, but instead wanted to shed light on this issue for other women who are going through it. Ally opened up about sharing her experience and her negative thoughts about her baby and new motherhood:

Yeah, I really wanted to share it, especially because a lot of people talk about like ‘baby blues,’ right? Like, “that was kind of sad,” and [they] cried over little things and then it was over. But, like, I remember telling my husband at one point, like, “I’m not going to do this, because I know that this is wrong and I have a conscience, but, like, I understand now why moms drown their babies in bathtubs.” Like, I’m not [going to]. It’s something so horrific for me to say to you, and I feel, like, a little bit nervous saying that out for everyone to hear, but, like, I understood that darkness, and I’m not the only one, right? Like, I know I’m not the only one. (I-105, 246-251)

Ally wanted to share her experience with postpartum depression in an effort to lift the stigma of postpartum depression. While she was nervous to share her dark thoughts about harming her baby as they are inconsistent with intensive motherhood, she confidently states that she knows that she is not the only one who experienced those thoughts about their baby and motherhood. Christine shared her experience with postpartum depression, and struggling with her fear of raising a black boy in today’s society, while healing from a cesarean and caring for her three other children:

It was just me against the world, me and this newborn baby that I had to take care of, plus the other three children, and plus we’re in a city where we don’t have any family. My mom had left soon after the baby was born; my mother-in-law came into town and she was here for a little while, but I just felt so lonely. I didn’t know what to do; I was sad. I was in the house I would rather clean than hold my baby. I would rather sleep or hide than hold my baby. I didn’t - I didn’t know what to do because I was just so afraid of the world. What was gonna happen with him? I was afraid that I would hurt him, I was feeling disconnected from everybody, my husband, my other three children, and the baby.

I no longer wanted to be a mom. I no longer wanted to be in our circumstance and I did not know how to handle it. (I-194, 63-71)

Christine negated the dominant discourse of intensive motherhood by discussing her experience with postpartum depression and feeling like she did not want to be a mother anymore. Christine explained that she was overwhelmed by her role as mother and had little to no desire to perform intensive motherhood behaviors (e.g., feed her new baby, hold her new baby, connect with her other children). Christine felt lonely and disconnected from everyone close to her.

Other Findings

During my contrapuntal analysis two themes emerged outside my research questions that warrant attention. First, only two women in this sample made note of their race, but it was also only these women who felt their race contributed to their traumatic birth experience and transition to motherhood. Second, many mothers talked about the role of their spouse during their traumatic birth and the lack of focus/inclusion provided to them during the traumatic birth. Both of these themes require future investigation.

The influence of race on traumatic birth and the transition to motherhood. From the time Denene became visibly pregnant, she noticed a difference in the way she was treated as a woman of color in comparison to pregnant white women. Denene recalled feeling invisible when recalling her experience commuting to work while pregnant:

The issue with being a black woman in America sometimes is that you're invisible and people don't really see you coming. They don't notice you and if they do, they don't really give you the respect that they would white women. To be candid, I'm not playing the victim or the race card; I'm saying what is true. So I would get on the train with my belly out to here, and you know men would sit down in the seats and literally sit there with

their manspreading legs all the way across the seats, and their New York Times spread from one arm to the other, and my belly would literally be sitting in their faces and they wouldn't offer a seat. Or you know they would see me kind of rumbling around the train hurking and jerking and it just never occurred to them, “okay this woman is six months pregnant, maybe I should give her my seat or maybe I should ask her if she's okay.” My legs would be swollen, no one would notice. (I-79, 107-116).

Unlike the other stories within this sample, Denene noted feeling invisible. Denene's story provides evidence of everyday discrimination. On a similar note, when Christine found out she was unexpectedly pregnant, she not only worried about herself on an individual level (seen through the theme *bad births are unplanned* above), but she shuddered with fear when she found out she would be raising a black boy in today's society:

So after I got over the shock [of the unplanned pregnancy] I was okay. I began to embrace it until we found out what we were having, when I found out I was having a boy... I became sad. I was really sad to find out that we were having a boy, because during the time we found out was during the time a lot of shootings were happening of black boys, and I was worried that my son would be a statistic. I honestly struggled through the entire pregnancy emotionally. I tried to explain it to different people how I was feeling — people would say, “oh well as long as you raise him right he'll be fine,” and I was like, “no, that doesn't matter, it doesn't matter how I raise him because it'll still be a black boy and he'll be tall and he will be a big black boy” based on my my family's history. I was just afraid of the future for him and no one seemed to get what I was trying to say. (I-194, 24-37)

Throughout her pregnancy, Christine worried about the future of her son outside her control and/or child-rearing abilities. Unlike the other women in this study, Christine was already concerned about the racism and racial profiling that her son would be subjected to as a black boy and man, which took a toll on her emotionally throughout her pregnancy and transition to bringing her baby home.

Race was also a contributing factor for black women's traumatic birth experiences. Racial discrimination was seen clearly in Denene's story when she recalled her daughter being drug tested without her approval:

They cleaned her up and they gave her back to me. I noticed a prick in her foot and was like "what is that?" You know why, why, why does my baby's foot have this prick in it? It turns out that they had given her a drug test to make sure that I wasn't on drugs. I was just shocked, like, "wait what?" I've never taken drugs in my life, and I don't recall anybody asking me if they could test my baby for drugs, and what would possess them to think that I would be on drugs for them to test my baby for drugs. I was told that it was just standard procedure. I would later find out that standard procedure — I am saying that with my fingers in the air and making air quotes — was standard procedure for black women, not for anyone else. (I-79, 265-278)

Denene was treated as less than after the birth of her baby, and was given no authority when making decisions for her child. This discrimination was echoed later in her story when she discussed her husband coming to support her in the hospital after the birth:

So my husband comes with flowers and comes to see me and the nurse tells him that he can't be there, and I'm like "excuse me?" and she says, "well you know, only the fathers of the children can be here," and I'm like, "well that's the father of my child." [She says,]

“well, it has to be a spouse,” and I'm like, “that's my husband,” and she looks at me and then she looks at him. She says, “you're married?” and now I'm ready to have a second baby — you know, like maybe a cow. Like, “what are you talking about? I just told you that's my husband, this is my ring on my finger, yes that's my husband and I would really like him to stay with me.” So you know just the shock ran across her face that there was this black woman with the husband who was there supporting her. (I-79, 293-301)

Throughout these instances these women faced additional challenges because of their race. They were treated as less than, and worried about the immediate health as well as the long-term future for their children due to discrimination. In this next quote, Denene reflects on her birth and provides a call for future research on black women and traumatic birth:

So I didn't really mention it, but this kind of interaction, I would later go on to find out, is sort of what happens to black women during pregnancy and during birth and during postpartum. You know what happens when your doctor isn't attentive, isn't as attentive to the needs of you and your baby [...] and in your pregnancy isn't as invested in making sure you're okay. It's almost like that contempt; you can feel it. That stress; you can feel it, the stress of [...] feeling like you're not in the best, most capable hands can transfer down to your baby, and I really do believe that plays a significant role in why birth rates are so low in the African American community, and why infant mortality is so high in the African American community. (I-79, 411-418)

Denene highlights the stress associated with being a birthing black woman, and how microaggressions contribute to worry, subpar medical care, and a discrepancy in birth outcomes between white women and women of color.

Fathers as bystanders during traumatic birth. Another theme that emerged within the data was the role — or lack thereof — for fathers during traumatic birth. Mothers noted the difficulty their husbands experienced during their traumatic birth, justifying future research. During her second birth Kathleen discussed her emergency cesarean and how her husband was terrified:

I was so out of it that I was like, “yeah, sure, whatever.” I wasn't that scared, I had complete trust and faith in [the doctor], but my husband was terrified. Everyone in the room just burst into activity. They put the bed back together, they were throwing furniture out of the way. My call light in the room was wrapped around the side of the bed, so they were, like, trying to wheel the bed out — it got stuck and I couldn't pull it out, so they had to unwrap it, and David was like, “this taking an agonizingly long time.” And so on the way to the OR my doctor told my husband, “this isn't good” and he wasn't going to be able to be there because they didn't have time to scrub him up or anything, and one of the nurses came up to him and told him, “we'll take care of your wife,” but she couldn't say anything about our baby. He was just convinced that the baby was dead by this point or dying. (I-27, 440-450)

Kathleen's husband was terrified about the health of his wife and unborn child. While Kathleen recalled feeling “out of it,” her husband was receiving scary messages from the doctor and nurses, and was left feeling helpless as he was unable to attend the surgery due to its urgency. Similarly, Kacey recalled the difficulty her husband had comforting her during traumatic birth and experiencing it firsthand himself:

I was just really panicked. My husband, who gets queasy at the sight of blood, was just absolutely freaked out. He said that it was so weird because behind the curtain he can see

me, but on the other side of the curtain he could see my body, open. He said it was just like an animal cut open on a table. It was the most bizarre thing ever, so he was also going through this this experience in his own way — at the same time, [he was] trying to comfort me and be there for me. (I-34, 65-70)

Kacey discussed how her husband had a difficult time processing the birth experience as it was happening, and also providing his wife the support he wanted to give her. Similarly, Courtney recounted how her husband was certain she was going to die on the operating table:

They told me that when Jackson came out he had ripped my uterus, and when they were scrambling to fix my uterus, they nicked my bladder. So then they had to go in and try to fix my bladder, and so while this was happening I was losing a lot of blood. I started hemorrhaging, and my husband told me that he just was sitting there holding this new baby that we had planned together. We'd gone through this pregnancy together. Up until this point I am conscious but totally not with it, and the doctor is just shouting all these orders. He says all he remembers is seeing towels soaked with blood just being thrown on the floor and everyone yelling and kind of talking quickly and the doctor giving orders. He just said that he thought that I was gonna die right there on the table in front of him, and he was gonna be a single dad. Thinking back on that it also makes me sad.

(I-180,172-186)

After a planned pregnancy and a healthy baby, Courtney's husband had a difficult time when Courtney's birth took a turn for the worse as they were sewing her up. While not applicable to the research questions of this project, these two themes provide greater context to the experience of traumatic birth within these *Birth Hour* stories.

V. Discussion

Using Baxter's (2011) RDT, the current investigation provides a glimpse into women's meaning making processes of traumatic birth and the transition to motherhood in relation to the dominant discourse of intensive motherhood. This dominant discourse is rooted in self-sacrifice, selflessness, and presenting perfection (Douglas & Michaels, 2004). Findings from the contrapuntal analysis (Baxter, 2011) show deeply embedded cultural expectations of mothering behavior and the pressure to live up to intensive motherhood standards, even when their experience did not align with the dominant discourse. These embodied expectations were largely seen through women's talk once they became pregnant and continued through their transition to motherhood, even after experiencing a traumatic birth. Theoretical and practical implications of the findings, limitations of this investigation, and directions for future research are discussed below.

Discourses of Intensive Motherhood During Pregnancy, Birth, and Motherhood

Pregnancy. While mothers did not describe their traumatic birth experiences as consistent with intensive motherhood, they presented their stories in a way that positioned intensive motherhood as the best way to mother. During pregnancy, the discourse of intensive motherhood was privileged in three themes: (1) *mothers should birth like the strong women before them*, (2) *good pregnancies are natural and uneventful*, and (3) *good births are a result of planning and control*.

First, pregnant mothers were influenced by the strong (intensive) mothers in their social network, and wanted to birth similarly to them. Especially in the context of natural, unmedicated births, pregnant mothers felt as though they could also give birth naturally because those close to them were able to do so. This theme is consistent with existing research, as Carson et al. (2016) found that birth stories situate the role of woman/mother in social, cultural, and medical areas.

Women especially held tight to birth stories that were success stories of the type of birth they wanted to achieve. Through birth stories women learned about what birth was like, and what to expect physically. Delivering a baby naturally and with the baby's best interest in mind was framed as the first sacrifice intensive mothers make.

The second theme, *good pregnancies are natural and uneventful*, was presented as an early extension of intensive mothering. When a woman had an uneventful, enjoyable pregnancy she felt a natural progression toward motherhood during this transitional stage. Much of the natural birth literature presents pregnancy and birth as a natural physiological process (Gaskin, 2003), and women who were hoping for natural unmedicated births felt hopeful that they would be able to achieve their desired birth when their pregnancy was progressing without complication. Mothers who had confidence in their bodies due to uneventful pregnancies felt prepared to execute their desired birth plan.

As women neared their delivery many created birth plans, and felt their knowledge and preparation would help them control their birth and do what is best for their baby. Birth plans were a direct performance of intensive mothering, in that a woman presented her medical staff with a hard copy version of her wishes for her birth. While reflecting on their birth plans, mothers often did so in relation to their traumatic birth, in that things didn't go as planned. Existing research has found that although pregnant women often feel empowered by creating their birth plan, rarely do their wishes come to fruition, and birth plans overall are not associated with better birth outcomes (Crossley, 2007). While women felt they were being responsible, intensive mothers by creating birth plans, not being able to *follow* their birth plans resulted in negative feelings about themselves as well as their births.

Birth. During birth the discourse of intensive motherhood was privileged through three themes: (1) *bad birth is something that happens to you*, (2) *bad birth disconnects mind and body*, and (3) *bad birth is isolating and unnatural*. In opposition to a good birth consistent with intensive motherhood, women who experience traumatic birth felt a loss of control over their body and birth. While women's traumatic birth experiences were not consistent with notions of intensive motherhood, they presented their births as a loss of what could have been.

When mothers tried to advocate for themselves by asking questions or suggesting alternatives to interventions, they were often denied. Further, many women recalled agreeing to one intervention, and then not remembering consenting to the intervention(s) that followed. Often mothers felt that their birth experience was taken from them, and they were unable to have an active role in their births. Many women recalled hurtful messages from medical staff about their inability to go in to labor, or labor correctly. Mothers often felt a loss of connection to their birth, and felt a disconnection between their mind and body. In their minds they wanted to go into labor on their own and labor naturally with continuous dilation. While many women wanted to labor following the hospital protocol, they felt like they weren't doing it correctly when their body was not following the protocol. When a woman did not follow the average dilation per hour, they were told to relax, or were offered interventions to speed up labor. This finding is consistent with existing research, as hospitals continue to follow a model of dilation that does not represent most women's labors, and the cost of this protocol for the birthing mother is increased anxiety and loss of confidence (Cossley, 2007). When women already felt that they were not laboring correctly, it complicated their ability to feel in control, and to embody intensive mothering behavior.

This notion was also seen during the physical birth of the baby. When birth was facilitated by intervention (e.g., cesarean section, forceps, vacuum), mothers often felt their birth was happening *to* them; they felt no control over the process, and reported a separation between their mind and body. Especially during unplanned cesarean sections, women recalled feeling detached, scared, “out of it” from pain medication, and already mourning the birth that could have been. Once the baby was born, traumatic birth also presented a difficult time for mother/baby bonding. Mothers were either getting stitched up and/or sent to recovery, and/or the baby was being whisked away to the NICU. Mothers recalled the difficulty of not being able to hold their babies directly after birth and provide that initial comfort and bonding consistent with the discourse of intensive motherhood. Additionally, while thinking about their upcoming births, women expected to spend their early minutes/hours after birth with their baby and husband, but this often was not the case after a traumatic birth. Mothers often told their husbands to go with the baby to the NICU or recovery, even when she also needed support during surgery and recovery. While this act is selfless and consistent with the discourse of intensive motherhood, women felt this separation was not how birth recovery was supposed to be.

Motherhood. The transition to motherhood after a traumatic birth also yielded an interesting connection to the dominant discourse of intensive motherhood. Some mothers found their successful execution of intensive mothering behavior as healing, as seen through the themes (1) *a good mother breastfeeds her baby*, and (2) *a good mother puts complete focus on her baby*. Breastfeeding was seen an act of selfless, intensive mothering. After experiencing a traumatic birth women often felt wronged by their body, because it did not do what women’s bodies are designed to do. Breastfeeding, for some women, was healing, as it instilled confidence in their body — as a mother, they were able to provide nourishment for their new baby. Breastfeeding

was a physical manifestation of their mothering abilities. Additionally, being able to follow one's plan to breastfeed helped some mothers find a sense of control in their new role as mother. Some women also discussed their seamless transition to motherhood, as they put the emotional baggage of their traumatic birth to the side and completely focused on their new baby and their new role as mother. This notion is consistent with intensive mothering, as women are expected to always put their child first.

While all mothers viewed intensive mothering behavior as ideal, traumatic birth often left new mothers feeling robbed from their ability to be an intensive mother during their transition to motherhood. This notion is seen through the themes (3) *bad births result in difficult recoveries*, and (4) *bad mothers have difficulty breastfeeding*. Many women had a difficult time healing physically from their traumatic birth and found it difficult to care for themselves and their babies. Some women had ongoing doctor visits, as well as reconstructive surgeries, in the weeks following their births. Difficult recoveries after birth often included difficulty breastfeeding.

Similar to the mothers who found breastfeeding healing, almost all women planned to breastfeed, and when they were unable to it was another way their body had failed them and their baby. Women spoke of pushing themselves to their physical and mental limits trying to breastfeed (trying to live up to the dominant discourse of intensive motherhood), while also receiving harmful messages suggesting that they were not trying hard enough. Inability to breastfeed left many mothers feeling lower than ever, and contributed to other postpartum worries. New mothers had a difficult time communicating their difficulty with new motherhood, which is supported by existing research.

Foster (2005) found that new mothers often hide their true feelings regarding motherhood, and instead present a mask in front of others. Due to the pressure to conform to intensive motherhood expectations (e.g., being the primary caregiver, always putting their children first, viewing their children as their greatest gift), there is a conspiracy of silence where mothers feel as though they are expected to keep their full range of emotions and experiences as new mothers under wraps (Foster, 2005). When women's experiences do not line up with how things *should be*, previous research has found that women do not feel comfortable sharing their taboo experiences, as they do not align with intensive motherhood (Miller, 2007).

Interplay: Discourse of individualism. Discursive interplay emerged within pregnancy, birth, and the transition to motherhood when mothers talked about their traumatic births as individuals, separate from their babies. Specifically, the discourse of individualism took on the centrifugal, marginalized role in competition with the dominant, centripetal discourse of intensive motherhood. Because the discourse of intensive motherhood centers a mother's identity around her child, women had a difficult time communicating their traumatic birth experience on an individual level. The marginalized discourse of individualism in this context competed with the dominant discourse of intensive motherhood in order to make sense of pregnancy, birth, and motherhood after experiencing a traumatic birth.

A common discourse found within close relationship communication, individualism (i.e., personhood), suggests that being an individual is privately owned. Within every individual there are unique thoughts and motivations controlled exclusively by the individual (Lannamann, 1992, 1995). The discourse of individualism is rooted in existing independently, outside tradition, and free of societal constraints (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985). While

individualism is relevant to family communication research, it is also widely accepted in American culture.

Within this data the discourse of individualism is situated in competition with the discourse of intensive motherhood, highlights the complexity of the intersection of mother's identity and culture. Mothers struggled to make sense of their experiences as they were caught between the discourse of individualism (identity as an individual) and the discourse of intensive motherhood (identity as intertwined with their child). These results are consistent with existing research. Stamp (1994) found that new mothers experienced a tension in giving themselves to their babies. Mothers wanted to meet the needs of their babies, but felt burdened and overwhelmed by the new 24-hour-a-day role (Stamp, 1994).

During pregnancy, in women's talk within the theme *identifying interplay: bad pregnancies are unplanned*, women negated the dominant discourse of intensive motherhood, as an unplanned pregnancy threw a wrench into women's individual plans and needs. Instead of viewing pregnancy as the greatest gift, some mothers found their unplanned pregnancy as constricting to their personal and career goals. Before becoming unexpectedly pregnant some women were happy with their individual identity and felt that becoming a mother would take away from who they are. Some mothers were already overwhelmed by their role as mother, and were not ready to care for another baby. Others were forced to quit their job due to pregnancy complications even when they would have rather kept working. Women separated themselves from their upcoming role as mother and instead focused on the costs of becoming pregnant.

During birth, interplay with the dominant discourse of intensive motherhood was seen through countering in the theme, *birth isn't all about the baby*. Within this theme, mothers' talk offered limited legitimacy to the dominant discourse of intensive motherhood, and also presented

the discourse of individualism during traumatic birth. While mothers wanted to do what is best (most intensive) for their babies, they also spoke to individual wants and needs during birth such as feeling obligated to hold their new baby in the operating room, but also not wanting to because they were overwhelmed and uncomfortable. While women consistently put the needs of their babies before their own during traumatic birth, they communicated that those choices were not done without loss on an individual level. Mothers pumped milk after surgery instead of seeing their babies, and supported father/baby bonding while the mother was in surgery even though she truly longed for that instant connection.

The transition to motherhood also identified discursive interplay in the theme, *bad mothers dwell on negative birth experiences*. Mothers had a difficult time separating their traumatic birth experience from the outcome they were thankful for: a healthy baby. Many mothers identified with the dominant discourse of intensive motherhood and were so thankful to have their babies, but entertained the discourse of individualism in that the means of getting their desired result (a healthy baby) was traumatic. Women felt guilty for wanting to work through their difficult feelings from their traumatic birth, because things could have been worse. Talking about their traumatic birth, for some women, felt like they would be undeservedly taking the focus off of their new baby, or that it would mean they were not thankful for the outcome.

Women's talk rejected (through negating) the dominant discourse of intensive motherhood when discussing experiences of postpartum depression (PPD). PPD is a "major health problem for many women, characterized by the disabling symptoms of dysphoria, emotional lability, insomnia, confusion, significant anxiety, guilt, and suicidal ideation" (Letourneau, Duffett-leger, Dennis, Stewart, & Tryphonopoulos, 2011, p. 42). While much of motherhood culture is painted as fulfilling, loving, and natural, PPD is discussed honestly in both

the media and medical community (Everingham et al., 2006). PPD has become less stigmatized for women seeking treatment, and many women experience positive outcomes from existing therapies (Everingham et al., 2006).

Although an important discussion has been started regarding PPD as a debilitating condition, the fact that it is a medical condition — something a mother cannot control — may be the reason it is discussed so openly both within this data, as well as the culture at large. PPD provides a clinical explanation as to why a woman is not adopting intensive motherhood behavior. This discussion potentially opens the door to discussing unfavorable thoughts and feelings about new motherhood, as it separates non-intensive behaviors from intensive motherhood identity.

The evolving identity of a mother may also in part explain women's interplay with the dominant discourse of intensive motherhood, as identity is not stable. While previous research has found that mothers solidify their identity as mother around eight-to-nine months postpartum (Miller, 2007), findings from this analysis may suggest otherwise. Mothers in this study reflected on their traumatic birth and transition to motherhood, on average, 4.5 years after birth, and still presented clashes within their identity as an individual and identity as a mother. Also, it is important to note that many women did enjoy elements of being a new mother, which further complicates the communication after a traumatic birth and the transition to motherhood. The high risk, high reward emotions associated with birth and new motherhood may make it difficult for mothers to engage in sense making. The experience of going from feeling relief and gratitude for being able to go home with a healthy baby after a traumatic birth, to tending to an inconsolable baby while also recovering from birth complications can be hard to fathom. These notions are echoed in existing close relationship research.

Connecting findings from this project with existing research, Raval (2012) used RDT to investigate the discourse of individualism in Indian runaway boys' talk. In her study, Raval (2012) posited that Western, individualistic cultures have a clearer separation between mother and child in comparison to collectivistic cultures (e.g., when a mother decides to stop nursing she never nurses her child again). While on a broad cultural level this may be true, notions of individuality do not exist in a vacuum outside the value of family and relational connection. Existing research notes complicated tensions experienced within close relationships in the U.S. (Sahlstein & Dun, 2008; Sahlstein, Maguire, & Timmerman, 2009). The first iteration of RDT has yielded complex experiences between the tension of autonomy and connection, and role struggles. Relevant to the existing study, Sahlstein et al. (2009) found that mothers with deployed (military) husbands had a range of experiences with the tension between autonomy and connection. Some mothers had a difficult time performing autonomy as they still felt connected to their deployed husbands, and wanted them to be a part of the family decision making (e.g., correcting their children's behavior) (Sahlstein et al., 2009). While some mothers in this study balanced autonomy and connection, many mothers engaged in denial (of connection) by fully taking on the autonomous role of sole authority figure within the family while their husband was deployed (Sahlstein et al., 2009). In order to function during deployment some mothers had to suspend their connection to their husband, taking on a single mother identity/role.

The relationship between autonomy and connection in mothers' experiences of their husband's deployment is not different than the discursive struggle between individualism and intensive motherhood during and after traumatic birth. These findings taken together suggest that women's individual identity and role enactment as mother are not static. This connection to existing research may also partially explain the emergence of the discourse of individualism

during interplay, as women had to often deny or suspend their role as intensive mother to in order to talk about their traumatic birth.

Theoretical Applications

Sahlstein Parcell and Baker (2018) highlight three important outcomes from RDT research: findings present a communicative/relational experience in a more relatable way, findings expose power dynamics within talk, and findings lead to translational considerations to promote social change (practical applications). Findings from this project address all of these important considerations. In addition to providing insight into women's traumatic birth experiences and transition to motherhood, this project also contributes to the larger study of marginalized birth experiences. By intersecting critical health and motherhood communication, this project highlights RDT's ability to identify power within talk. Women within this study largely identified intensive motherhood as the correct way to mother, but often did not feel their experience was representative of intensive motherhood and felt sad or guilty as a result. While women largely privileged the discourse of intensive motherhood, contrapuntal analysis provided a tool to identify the deviant, marginalized discourse of individualism. Seen through the interplay of these discourses is a fracture of the discourse of intensive motherhood, potentially making room for a wider representation of birth and motherhood experiences. While the discourse of intensive motherhood fails to represent many women's mothering experiences, the findings from this project demonstrate the inadequacy of the dominant discourse of intensive motherhood to capture women's traumatic birth experiences.

Absent from my findings was the construction of discursive hybrids and/or transformations. Women within this data did not combine or separate the boundaries of intensive motherhood and the discourse of individualism. The centripetal, dominant discourse of intensive

motherhood in women's meaning-making processes may make it exceptionally difficult for mothers to move beyond the polemic framing of intensive motherhood and individualism; in the truest form of intensive motherhood a mother's identity is shaped by her role as mother, thus making it difficult to discuss birth and the transition to motherhood outside of this role.

Additionally, women in this study were largely privileged (i.e., married, educated, middle to upper class socioeconomic status, flexible careers/stay at home moms), which provides less room for women to speak against intensive motherhood because they have seemingly fewer obstacles in the way of being the "ideal mother." Women who identify further outside the discourse of intensive motherhood (e.g., non-white, lower socioeconomic status, single, non-heterosexual women) may be more readily able to reject the discourse of intensive motherhood, and engage in discursive hybrids and/or transformations. Differences between intensive motherhood and individualism underscore the importance of taking context into account when studying how motherhood is discursively constructed.

Practical Applications

Applications for mothers and close others. The contrapuntal analysis provided a rich understanding of the dominant discourse of intensive motherhood, as well as interplay with the marginalized discourse of individualism during traumatic birth and the transition to motherhood. Women's talk largely spoke to the dominant discourse of intensive motherhood as ideal, but did not situate their experience as consistent with intensive motherhood, which demonstrates the need for public and family birth and motherhood education. It is probable that the dominant discourse of intensive motherhood may be keeping women from sharing their stories and seeking help when they need it. At the end of many of these women's stories, they mention that talking about their experience and connecting with other women who went through something similar

led to healing. Close others helping women through a traumatic birth should provide a safe space where women can talk about their traumatic experience without judgment or advice. It is imperative for close others not to “silver line” women’s traumatic birth experiences (e.g., talking about how lucky they are to be ok). Creating safe spaces for women to share their experiences works towards a diverse understanding of birth and motherhood, and stops women from feeling like they need to accept or reframe their traumatic experience as positive. Findings from this study have the potential to unite women in their traumatic birth experiences and difficulty with the transition to motherhood, showing that there is not a ‘one size fits all’ traumatic birth experience.

This project also adds to the body of research suggesting that mothers’ birth and new motherhood experiences are difficult to make sense of, and sheds light on the intricacy of traumatic birth on a physical, emotional, and relational level. Identifying the complexity of traumatic birth and the transition to motherhood aids close relationship communication during this time. Previous research indicates that support from family and friends can alleviate some of the worries and stresses new mothers experience and help them feel more capable and confident in their abilities as a mother (Glade et al., 2005). Knowing that women who experience traumatic birth are likely grappling with more than just sleepless nights may help close others support new mothers better. In addition to instrumental support (e.g., meals, housework, childcare) new mothers need to be reassured regarding their ability to mother, and understanding the convoluted identity of new mothers may also help with the sense making process. Additionally, new mothers need to understand that they can be thankful for a healthy baby, but likely still need to work through their traumatic birth experience. Highlighting the complexity of traumatic birth from a

communication perspective also results in a call to action for clinicians to do more, and for women to expect more from their care providers.

Applications for clinicians. There currently exists a discrepancy regarding traumatic birth between the mothers who experience it, and the care providers who oversee it, as many births identified as traumatic by the mother are not perceived as traumatic by their care provider (Alder et al., 2006; Beck, 2004a). In an attempt to understand this discrepancy, this project moved beyond physical birth outcomes (e.g., morbidity) and sought to understand how traumatic birth is talked about and made sense of. Findings from this study suggest that traumatic birth takes place in a variety of contexts, but perceptions of traumatic birth are heavily influenced by the discourse of intensive motherhood as well as the discourse of individuality. Going into birth, women in this study had a particular way they envisioned themselves giving birth that demonstrated their ability to be an intensive mother. Traumatic birth largely resulted in a loss of agency, seen through the competing discourses of intensive motherhood and individualism. In order for clinicians to address the discrepancy between patient and provider and the contributing factors that lead to traumatic birth, care providers must consider the cultural expectations mothers embody, as well as their identity as an individual during birth.

Clinicians must first investigate how their own behavior is contributing to traumatic birth, specifically by listening to women's experiences and stories. Identifying particular communication behaviors as well as hospital practices that contribute to women's perceptions of traumatic birth is essential. Clinicians should value the mother's experience during birth, not only focusing on the baby. For example, family centered cesarean sections help break down the dominant discourse of intensive motherhood by caring about the mother's experience during surgery. Offering a clear partition (so the mother can see her baby be born), following as many

elements of women's birth wishes when possible (e.g., delayed cord clamping, immediate skin to skin) are a few ways some clinicians are changing their procedures.

Additionally, understanding that women who have experienced traumatic birth may be constrained by the dominant discourse of intensive motherhood may help professionals working with new mothers pick up on any indirectly communicated issues that new mothers express. As discussed in chapter one, new mothers often struggle to communicate their feelings of being different than the ideal mother, resulting in dips in self-esteem, mental health, and communicating emotion (Miller, 2007). It may also be beneficial for health care providers to reevaluate the way they screen for PPD and other post-partum issues, as these symptoms may not be blatantly obvious through questionnaires. One particular way clinicians may support women who have experienced traumatic birth and/or a difficult transition to motherhood would be to provide resources/pamphlets regarding the complexity of the birth experience, and the individual challenges that women experience during the transition to motherhood.

Limitations

Women's stories of traumatic birth shared on *The Birth Hour* resulted in nuanced accounts of traumatic birth, a valuable site for contrapuntal analysis. However, since *The Birth Hour* interviews followed a mainly narrative interviewing format and were recorded for a podcast (not by me, and not for research purposes), I was unable to ask follow-up questions regarding my specific research questions. Through my analysis of these particular birth stories, I may have lost out on important insights that could have been reached when conducting my own semi-structured interviews.

In positioning mothers' talk about traumatic birth and the influence of intensive motherhood culture, it is important to note where this discourse comes from, as well as its

influence on this particular sample. The formation of cultural ideals exists inherently within the dominant (powerful) culture. Thus, the discourse of intensive motherhood, along with other dominant ideologies of motherhood, are based in notions created by white, middle to upper class, heterosexual women, which inherently does not capture women's experiences collectively (Park, 2013). Additionally, many of the women included in this study disclosed that they had flexible jobs, or that they stayed home during their child's early months/years, and all except two women were married at the time of their birth (the other two were also in serious committed relationships; i.e., engaged or partnered). The mothers in this study were also very well educated (many of them discussed their credentials), and were knowledgeable about birth at the time of their interview on *The Birth Hour*, which may inform their experience.

While only two women identified their race in this sample, they both were women of color, and identified their race as a complication to their treatment during birth as well as their transition to motherhood. Women's traumatic birth experiences and transition to motherhood may be constructed differently by women who identify with other educational, socioeconomic, and racial statuses. Talk about intensive motherhood and individualism may look different for women who do not have maternity leave and/or work full time, as well as women who do not have the instrumental and emotional support of their husbands. Women who identify further outside the discourse of intensive motherhood may be better able to reject or recreate the meaning of motherhood. I am optimistic that in identifying women's range of experiences regarding motherhood and traumatic birth we may begin to provide a greater understanding of the myriad ways that mothers give birth and mother, potentially loosening the constraints of the discourse of intensive motherhood.

Future Directions

Although this study identified the influence of intensive motherhood on pregnancy, birth, and motherhood after experiencing a traumatic birth, the interview protocol used on *The Birth Hour* may have only skimmed the surface of what women experience after a traumatic birth. Future research should conduct semi-structured interviews to more deeply examine the relationship between intensive motherhood on traumatic birth and the transition to motherhood. Semi-structured interviews may result in more discursive interplay (e.g., negating, countering, entertaining) with the dominant discourse (Baxter, 2011). Specifically asking questions with contrapuntal analysis in mind would be useful (e.g., “when thinking about your traumatic birth, is there anything you wish you could talk about, but feel like you can’t?”), and having the ability to ask follow-up questions may yield more specific instances of interplay with the dominant discourse. This project has only shown the proverbial tip of the iceberg of women’s experiences with traumatic birth and their transition to motherhood. Though intensive motherhood has a stronghold on the way women make sense of and talk about new motherhood, more research is needed to understand the lack of communication regarding traumatic birth in order to resist the dominant discourse of intensive motherhood and paint a more well-rounded picture of what motherhood is really like.

Only two women of this sample disclosed their race and felt that race was a contributor to their traumatic birth experience. Both women who disclosed their race identified as black, and future research must address the role of communication in the discrepancy of birth care between white women and women of color. The statistics are staggering, as the infant mortality rate for black Americans is twice the rate of white Americans (CDC, 2017; Rosenthal & Lobel, 2011). The primary contributor to this discrepancy in infant mortality is the occurrence of preterm births and low birth weights (Bediako, BeLue, & Hillemeier, 2015). While seemingly a biological or

health issue, Braveman et al. (2017) found one contributor to be prolonged psychological stress due to racial discrimination. This finding is consistent with a larger body of health research linking adverse health outcomes with racial discrimination (Lewis, Cogburn, & Williams, 2015). Future research must uncover communication behaviors that are contributing to this disparity, along with the role of racial discrimination in traumatic birth. RDT serves as a useful theory for understanding women of color's traumatic birth experiences as women's talk may speak to different discourses (other than intensive motherhood and individualism), or evoke these discourses differently, leading to a nuanced understanding of this experience.

While additional research is undoubtedly needed to understand women's traumatic birth experiences and transition to motherhood, an interesting theme that emerged in the data was the role of the father during traumatic birth. While fathers played an important role in these women's births, they were also lost in the shuffle of traumatic birth. In several instances mothers reported that their husbands were unaware of their rights in the birth process, and were unsupported by hospital staff. In one specific example, Elizabeth recalled recovering from her unplanned cesarean and having to tell her husband that he could pick up their baby out of the bassinet. In this case, the father was unaware of what to do in this kind of situation. This finding isn't surprising as there is little research on how fathers communicate during traumatic birth, and how they cope with watching their wife's and/or child's life being threatened. Over the last twenty years fathers have been largely present for their children's births, yet similar to mothers, fathers are dissatisfied with their role in the birth process, especially when births are complicated (Lindberg & Engstrom, 2013). Elmir and Schmied (2016) found that men who witnessed traumatic births recalled feeling "shock" and "panic," as they feared for the life of their partner and/or baby (p. 68). This study also found that fathers felt unprepared for birth complications and

felt feelings of failure as they were not able to protect and advocate for their partner and baby. Thus, fathers' experiences with traumatic birth is another important site for future research.

In summary, this study illustrates the communicative meaning-making process of traumatic birth and the transition to motherhood. The role and performance expectations put forth by the dominant discourse of intensive motherhood heavily influenced mothers' talk about their traumatic birth and transition to motherhood. Although not many women felt as though their experience aligned with intensive motherhood, they spoke to the notion that intensive motherhood was the best way to mother. While the discourse of intensive motherhood suggests that a mother's identity is intertwined with her children, interplay was evident with the marginalized discourse of individualism. Only when a mother talked about herself as an individual, separate from her child, was interplay identified. Throughout pregnancy, birth, and the transition to motherhood women's discussion of their experience on an individual level competed with the dominant discourse of intensive motherhood. As women continue to share their experiences with traumatic birth on an individual level, we will be able to understand the implications of traumatic birth due to the pervasiveness of intensive motherhood culture.

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- Challenge students to integrate communication theory and research into assignments
- Discuss communication issues in-depth through class discussion
- Encourage students to improve their close relationship communication by engaging in a semester-long research-based reflection assignment

COMMUN 101: Introduction to Interpersonal Communication, 2012–2016

UW-Milwaukee, standalone sections (40 students), 2013-2016

UW-Milwaukee, discussion sections (66 students), 2012-2013

- Challenge students to communicate more effectively in their daily lives
- Discuss communication issues in-depth through class discussion
- Utilize group work so that students learn how to communicate effectively in teams to complete tasks or answer questions
- Facilitate in-depth activities to create a deeper understanding of information covered in lecture

COMMUN 114: Interpersonal Communication, 2016

Elmhurst College, 1 section (20 students)

- Challenge students to communicate more effectively in their daily lives
- Discuss communication issues in-depth through class discussion
- Complete a semester group project so that students learn how to communicate effectively in teams to complete tasks

- Facilitate in-depth activities to create a deeper understanding of information covered in lecture

COMMUN 103: Public Speaking, 2014

UW-Milwaukee, 1 standalone sections (20 students)

- Challenged students to analyze and adapt messages to audience
- Helped students develop the process and elements of effective speaking
- Facilitated the construction and delivery of presentations that incorporate the appropriate use of content, organization, language, vocalics, kinesics, eye contact, appearance, visual aids, and time constraint

RESEARCH

PUBLICATIONS

- Cole, A. W., Anderson, C., Bunton, T. E., Cherney, M. R., **Cronin Fisher, V.**, Draeger Jr., R., Fetherston, M., Motel, L., Nicolini, K. M., Peck, B., & Allen, M. (2017) Student predisposition to instructor feedback and perceptions of teaching presence predict motivation toward online courses. *Online Learning*.
- Cronin-Fisher, V.** (2017). Partial correlation. In Allen, M. (Ed.), *The SAGE encyclopedia of communication research methods*. Thousand Oaks, CA: Sage.
- Odom, L., Baker, B. M. A., Sahlstein Parcell, E., & **Cronin-Fisher, V.** (2015). Communication and female date initiation: Differences in perceptions based on assertiveness of initiator. *Iowa Journal of Communication*, 47, 177-196.
- Cronin-Fisher, V.** (2015). Dos and don'ts of relational conflict. In McCornack, S., Parcell, E., Timmerman, L., Baker, B. M. A., Cronin-Fisher, V., Dorsett, N. A., Jagiello, K. L., Johnson, R. L., & Peck, B. (3rd ed. CUSTOM), *Reflect and relate: An introduction to interpersonal communication* (pp. 20-23). Boston, MA: Bedford/St. Martin's.
- Cronin-Fisher, V.** (2015). Dysfunctional relationship beliefs. In McCornack, S., Parcell, E., Timmerman, L., Baker, B. M. A., Cronin-Fisher, V., Dorsett, N. A., Jagiello, K. L., Johnson, R. L., & Peck, B. (3rd ed. CUSTOM), *Reflect and relate: An introduction to interpersonal communication* (pp. 23-24). Boston, MA: Bedford/St. Martin's.

CONFERENCE PRESENTATIONS

- Timmerman, L. M., **Cronin-Fisher, V.**, & Jagiello, K. (2018, July). *Stigmatized disclosure: Topics and reasons for withholding from close others*. Paper to be presented at the International Association for Relationship Research Conference, Fort Collins, CO.
- Cronin-Fisher, V. A.**, Parcell, E. (2018, April). "Those who say new motherhood is natural, well, so is walking and that takes about a year to learn": Making sense of dissatisfaction during the transition to motherhood through relational dialectics theory. Paper to be presented at the Central States Communication Association Convention, Milwaukee, WI.

- Cronin-Fisher, V. A.**, (2018, April). *And doula makes three: Unpacking birth narratives*. Paper to be presented at the Central States Communication Association Convention, Milwaukee, WI.
- Cherney, M. R., **Cronin-Fisher, V. A.**, & Sparrow, D. (2018, April). "*Communicative Cues of Emotion in Text Based CMC*". Paper to be presented at the Central States Communication Association Convention, Milwaukee, WI.
- Cronin-Fisher, V.A.**, & Gross, C. M. (2017, November). "*Protective or possessive, call it passive or aggressive*": *Communicative responses to jealousy within friendships during a time of uncertainty*, Paper presented at the National Communication Association Conference, Dallas, TX.
- Cronin-Fisher, V.A.**, & Jagiello, K. (2016, November). "*I didn't deserve any of that, and neither does anyone else*": *A qualitative analysis of the framing of online postings regarding ex-romantic partners*, Paper presented at the National Communication Association Conference, Philadelphia, PA.
- Nicolini, K. M. & **Cronin-Fisher, V.A.**, (2016, November). Viewer Discretion Advised: Parental control and mediation strategies for televised sexual content. Paper presented at the National Communication Association Conference, Philadelphia, PA.
- Cronin-Fisher, V.A.** (2015, November). *Control, care, and disability: Reclaiming the American birthing process*. Poster presented at the National Communication Association Convention, Las Vegas, NV.
- Cronin-Fisher V. A.**, & Kohler, K.V. (2015, April). *Village bicycle or nun? Understanding college women's talk about sex in female friendships through a relational dialectics perspective*. Paper presented at the Central States Communication Association Convention, Madison, WI.
- Gross, C. M., & **Cronin-Fisher, V. A.** (2015, April). *Weathering the storm: The association between uncertainty reduction and coping with a major life stressor for married individuals*. Paper presented at the Central States Communication Association Convention, Madison, WI.
- Zmyslinski-Seelig, A. N., **Cronin-Fisher, V. A.**, & Gross, C. M. (2013, October). *Honey, take out the trash: Types of demand/withdraw in marital relationships*. Paper presented at the International Association of Relationship Research Conference, Louisville, KY.
- Cronin, V. A.** (2011, May). *Serial arguing: The influence of implicit theories of relationships and coping strategies*. Poster Presented at the Research and Performance Showcase, Elmhurst, IL.
- Cronin, V. A.** (2011, April). *Serial arguing: The influence of implicit theories of relationships and coping strategies*. Poster Presented at the conference of the Associated Colleges of the Chicago Area, Elmhurst, IL.

INVITED ACADEMIC PRESENTATIONS

- Cronin-Fisher, V.A.** (2016, November). *Navigating the waters of new motherhood*. Presentation to the Teen Parent Connection New Parents' Group, Naperville, IL.

Cronin-Fisher, V.A. (2013, August). *Improving interpersonal communication: Making a lasting impression*. Presentation to the Office of Admissions at the Milwaukee Institute of Art and Design, Milwaukee, WI.

AWARDS AND RECOGNITIONS

Renee A. Meyers Scholarship, Awarded for excellence in teaching, research, and service, UWM, Fall 2017, \$2,000

Advanced Opportunity Fellowship, UWM, 2017-2018

Amelia Lucas Memorial Fund Scholarship, Awarded to support research, UWM, Fall 2017, \$175

Teaching Recognition Award, Department of Communication, UWM, 2016-2017

Advanced Opportunity Fellowship, UWM, 2016-2017

Amelia Lucas Memorial Fund Scholarship, Awarded to support research, UWM, Spring 2017, \$250

Melvin H. Miller Doctoral Teaching Award, Department of Communication, UWM, 2015-2016

Amelia Lucas Memorial Fund Scholarship, Awarded to support research, UWM, Fall 2016, \$250

Chancellor's Award, UWM, 2014–2015, \$10,000

Melvin H. Miller Award for Outstanding Master's Research, Department of Communication, UWM, 2014

Chancellor's Award, University of Wisconsin-Milwaukee, 2012-2013, \$1,000

SERVICE

DEPARTMENTAL AND UNIVERSITY SERVICE

Judge, UW System Undergraduate Research Symposium (Spring 2017, Spring 2016, Spring 2015, Spring 2014, Spring 2013)

Nontraditional Graduate Student Mentor, Department of Communication, UWM (Fall 2016)

Volunteer, NCA Graduate Recruiting Fair (Fall 2015)

Faculty Committee Liaison, Department of Communication, UWM (Spring 2015)

Volunteer, CSCA Graduate Recruiting Fair (Spring 2015)

Master's Student Mentor Coordinator, UWM (2013-2014)

Public Speaking Showcase Judge, UWM (2012)

Events Coordinator, Department of Communication, UWM (Spring 2013)

President, Lambda Pi Eta, Elmhurst College (2011–2012)

PROFESSIONAL SERVICE

Reviewer, Graduate Student Caucus, Central States Communication Association (2017)
Reviewer, Graduate Student Caucus, Central States Communication Association (2016)
Volunteer, National Communication Association (2015)
Reviewer, Graduate Student Caucus, Central States Communication Association (2015)

GRANTS

Elmhurst College Research Grant to support the project titled, “The influence of implicit theories of relationships and coping strategies,” \$3,000 (2011, Summer)

PROFESSIONAL ASSOCIATION MEMBERSHIPS

National Communication Association (2011–present)
Central States Communication Association (2015–present)
International Association for Relationship Research (2013– present)

[Positionality](#)