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The Meaning of “Control” for Childbearing Women in the US

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Abstract

Childbearing women, healthcare providers, and commentators on birth broadly identify control as an important issue during childbirth; however, control is rarely defined in literature on the topic. Here we seek to deconstruct the term *control* as used by childbearing women to better understand the issues and concepts underpinning it. Based on qualitative interviews with 101 parous women in the United States, we analyze meanings of control within the context of birth narratives. We find these meanings correspond to five distinct domains: self-determination, respect, personal security, attachment, and knowledge. We also find ambivalence about this term and concept, in that half our sample recognizes “you cannot control birth”. Together, these findings call into question the usefulness of the term for measuring quality or improving maternity care and highlight other concepts which may be more fruitfully explored.

Keywords

USA; control; childbirth; good birth; meaning; woman-centered care

INTRODUCTION

The quality of maternity care in the US has received considerable attention in recent years, most notably with efforts to contain cost and advance “patient-centered” outcomes across medicine (Conway & Clancy, 2009). Patient-centered care in birth presents particular challenges, given divergent views about the nature of technology and the goals of care (Lyerly, 2006). Despite their differences, childbearing women, healthcare providers, and commentators on birth in many high-income Western countries have identified control as an important issue during childbirth. From the Labor Agency Scale to measure women's expectations and experiences of personal control during childbirth (Hodnett & Simmons-Tropea, 1987) to recent surveys of childbearing women (Declercq, Sakala, Corry, Applebaum, & Risher, 2002, 2006), the literature is replete with evidence that perceived control (or lack thereof) is of significance to childbearing women (Ayers & Pickering, 2005; DiMatteo, Kahn & Berry, 1993; Gibbins & Thomsen, 2001; Green, Coupland, & Kitzinger, 1990; Hall & Holloway, 1998; Larkin, Begley, & Declan, 2009; Melender, 2006) and relates

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to birth satisfaction (Christiaens & Bracke, 2007; Doering, Entwisle, & Quinlan, 1980; Goodman, Mackey, & Tavakoli, 2004; Green & Baston, 2003; Knapp, 1996; Lavender, Walkinshaw, & Walton, 1999; Mackey, 1995, 1998; Simkin, 1991). More broadly, control has been proposed as a central theme across the social sciences (Gibbs, 1990), with various disciplines characterizing and applying the term differently to address particular concepts (Diamond, 1990).

Despite apparent agreement about its importance, control is rarely defined in scholarly publications on childbirth. Where definitions are provided (Knapp, 1996, p. 7; Lavender et al., 1999, p. 42; VandeVusse, 1999, p. 176), they vary widely and often conflate different meanings. As Simkin notes, “the meaning of ‘being in control’ seems to have many dimensions that are not easily distinguished from one another” (1991, p. 209). Fox & Worts (1999) describe a few of these dimensions within the context of medicalized childbirth. Others use the rubric of “internal” and “external” control to categorize interpretations or expressions of control (Green & Baston, 2003; Lavender et al., 1999; Sargent & Stark, 1989; Simkin, 1991; VandeVusse, 1999), though as an analytical distinction rather than a definition. Further, there is evidence of diversity in the salience of both the term and concept of control in birth among social classes (Davis-Floyd, 1994; Lazarus, 1994; Martin, 1990; Nelson, 1983; Zadoroznyj, 1999) and by women's choice of birth location (Cunningham, 1993; Davis-Floyd, 1992; Hodnett, 1989; Martin, 1987; Viisainen, 2001).

A better understanding of the meaning of control in the context of birth is important, for at least four reasons. First, because there is no agreed-upon definition for the term *control*, women, researchers, and healthcare providers may or may not be speaking of the same phenomena in analyses of control in birth. When the term *control* is used in quantitative surveys, diverse interpretations may raise questions about face validity. Second, much of the qualitative data on the subject is drawn from small or homogenous samples, potentially narrowing the term's meaning. Third, since the term *control* appears in childbirth literature from countries in North America, the Commonwealth, and Europe – where health care systems, cultural norms, and birth ideology differ in potentially relevant ways – the concept may provide insight on other meaningful features of birth shared across the developed world. And fourth, in many places, historical and current debates about maternity care focus on issues of power and control, variously defined (Block, 2007; DeVries, Benoit, Van Teijlingen, & Wrede, 2001; Rothman, 1991; Tew, 1998). Creating a model of care that addresses women's individual needs is therefore contingent upon understanding the many ways that *control* may be expressed or interpreted.

In this article we seek to deconstruct the term *control*, as used by childbearing women in the US, to better understand the fundamental issues and concepts underpinning this complex (and ubiquitous) term. With the current corpus of literature and lacunae in mind, we analyze birth narratives collected from a diverse sample of 101 parous women. Our aims are to elucidate the meanings of control in childbirth, as expressed by women themselves; to discuss their relationship to other central aspects of a woman's birth experience; and to suggest how the concept of control may inform approaches to maternity care practice and policy.

METHODS

The data for this analysis were collected as part of a broader initiative called the Good Birth Project, the aim of which is to discern what constitutes a “good” birth experience, from American birthing women's perspectives. To collect women's views about birth in their own words, we conducted qualitative, in-depth interviews according to a semi-structured guide. Interviews included in this analysis were conducted between April 2006 and July 2009.

After obtaining informed consent, we asked women to describe their birth experience(s), highlighting what made the experience(s) good and/or bad. We then asked follow-up questions on 12 topics deemed salient from a literature review (preparation, mode of delivery, complications, control, social support, safety, location, relationship with provider, self-esteem, pain, use of technology, and postpartum). Primiparae were interviewed twice, once during the third trimester of pregnancy to discuss expectations, and again two to six months postpartum to discuss the birth experience. Multiparae were interviewed once, two to six months postpartum, and were asked about each of their birth experiences sequentially. Women also provided information on demographic characteristics and pregnancy and birth history. The research design and interview guides, as well as sampling, recruitment, and consent procedures, were approved by the Duke University School of Medicine's Institutional Review Board, which is subject to the US Code of Federal Regulations governing research with human subjects.

Sample

To capture the diversity of birthing experiences in the US, we developed a purposive sampling frame that included women who had given birth in various venues (academic medical centers, community hospitals, birth centers, home), experienced different modes of delivery (vaginal, unplanned cesarean, planned cesarean, vaginal birth after cesarean (VBAC)), with a range of providers (maternal-fetal specialists, obstetricians, midwives, general practitioners), and with differing pregnancy risk status. Compared with national trends, we intentionally oversampled women who had out-of-hospital births to maximize the range of experiences. We also worked to maximize sociodemographic diversity, including race, age, socioeconomic status, and parity. Our sample includes 39 primiparous and 62 multiparous women, for a total of 101 women, 131 in-depth interviews, and 201 discrete birth experiences. Sample characteristics are reported in Table 1.

Most women in the sample were respondents to recruitment fliers placed in maternity care settings and were screened for eligibility according to the study sampling parameters. We also asked local providers to refer women with certain characteristics as necessary to broaden diversity (e.g., African American women who had home births). The majority of participants were drawn from a metropolitan area in the Southeastern United States that is served by two large academic medical centers, several affiliated community hospitals, one free-standing birth center, and a handful of home birth midwifery practices, though births described occurred in geographic regions across the US. We also interviewed women in Washington, District of Columbia, for representation from a more urban context.

Analysis

All in-depth interviews were recorded and transcribed verbatim. As interviews were completed, we (the authors) independently reviewed transcripts, made notes, and discussed our impressions, forming a codebook in the process (MacQueen, McLellan, Kay, & Milstein, 1998). After the first 20 in-depth interviews, the codebook was formalized and we began content coding of the data using NVivo software (QSR, 2008). To assess inter-coder reliability, we continued to independently read and code every fifth, and later every tenth, interview, to check that our understanding of concepts and codes remained in agreement. Coding discrepancies were discussed and reconciled by recoding or revising code definitions. This process continued in an iterative manner, with new codes added and previously coded data re-coded as applicable. Following the initial round of "open" coding, we reviewed our codebook and condensed and linked codes into thematically and conceptually related categories (Strauss & Corbin, 1990).

Following our initial analysis, we identified five primary domains related to a “good” birth experience, which, interestingly, roughly parallel five of the six core dimensions of well-being posited by Powers and Faden (2006). These include self-determination, respect, personal security, attachment, and knowledge. The term and concept of *control* was present and coded in the text, but did not strike us as a stand-alone domain of the same explanatory value as the others; control seemed to fit into both none and many of the primary domains. To explore how control might feature in women's schema of a “good” birth, we followed Quinn's (2005) methodology and performed a key word concept analysis of the complete set of narratives. We searched our data and thematically coded any discussion of control that had not been previously coded as part of the larger coding process. We also applied codes signifying whether the woman had used the term spontaneously or had been asked a question about control. The findings from our concept analysis are reported below. All names have been changed to protect the confidentiality of research participants. Quotations are attributed by pseudonym, race/ethnicity, age in years, and location of birth(s). Cesarean and VBAC deliveries are noted; all others are vaginal births.

FINDINGS

Forty-six percent of women in our sample spontaneously mentioned the term *control*. Our data collection instrument provided for follow-up on the issue of control with women who did not mention it within their narratives, and many of these women were still able to define what it meant to them or express their perceptions of control during their experience(s). We therefore include all thematically codeable discussions of control (N=72 women) in our analysis of its meanings, whether spontaneous or solicited.

Our codebook contained 16 sub-codes for control after the final iteration of coding for the control concept analysis (see Table 2). In interpreting the meaning of women's expressions of control coded at these sub-codes, we were able to cluster the sub-codes around the five broader domains which are described in more detail below. In some cases, women's narratives about control provided definitions of the term *control*; in others, they provided less a definition than a commentary on an aspect of control. Both are included in the concept analysis, and are distinguished where appropriate. Unless stated otherwise, narrative segments presented here are exemplary of widely shared ideas.

Self-determination

One essential dimension of well-being identified by Powers and Faden (2006) is self-determination, which we too identified as a key domain in our larger analysis of what constitutes a “good” birth from women's perspectives. By self-determination, we are referring to the ability to have a birth that is shaped and guided by one's own inclinations and values rather than those of others.

Our concept analysis revealed that, like control, self-determination is multi-faceted, encompassing notions of authority, decision-making, agency and presence (see Table 2). Whether speaking of control of their bodies and what happened to them, pain management, the environment, or events of labor, self-determination emerged as the most prominent meaning of control among women in our sample. Of the 72 women who discussed control, 50 (69%) defined or provided examples of control in terms of one of these meanings of self-determination.

Women's expressions of control as self-determination often took the form of phrases such as “in control of” or “having control over” one's birth and the concomitant events. A mother of three, who had births at a hospital, home, and birth center stated:

From all the reading I had done, I knew that hospitals had rules and that if they didn't make sense to me I wasn't going to follow them. I wanted to be in control of what happened to me, even if something was necessary to be done, like having a C-section, I wanted my permission asked, I wanted it described, why it was necessary, and I wanted to be able to be the one to make the decision. (Jill, European American, 28)

Evident here are reflections of control as “the perception of the power of choice” (Wildman, Secrest, & Keatley, 2008, p. 401). A primipara reflecting on her birth echoed this sentiment:

I got to say when I wanted pain meds and when I didn't. And I had a little button I could push to give myself more of the epidural and I pushed that sucker a lot during the pushing. That gave me a feeling of control. I didn't have nurses saying, “Here take these drugs and don't ask why”. ... I felt like [my husband] and I and [the midwife] and our nurse were all working together and that I was an active participant. I mean that's kind of obvious, I was the one pushing, but I just felt so incredibly involved and in control. (Lainey, European American, 27, hospital birth)

The subthemes of self-determination further explicate how women understand or experience control in the context of in birth. For some women, control was associated with authority and the amount of “directing” she could do during birth, making vivid the role of power. We see this in Jill's statement above, that if hospital rules “didn't make sense to me, I wasn't going to follow them”. By staking her authority and resisting the imposition of others' views, she was able to “be in control”. Similarly, Julie wanted to direct the process of her birth just as she would any other event in her life, thus exemplifying a definition of control as directing or orchestrating the birth experience:

I think I looked at [scheduling my inductions] more of as a convenience and, yeah, you know what? I do, I like to control everything. But here's what I would say: I don't necessarily feel like I wanted or felt the need to exert control over the birth experience much more than everything else in my life, which I do like to control. That's a good point. I like to control everything... I didn't necessarily think of the birth as like something I needed to control more than everything else. (Julie, European American, 37, 4 hospital births)

Other women defined control as self-determination in terms of meaningful access to options or choices:

Control would have to be, ability to accept or decline. Say “yes” or “no”. Just to be able to know what is going on. To have a doctor come in and say, “Well I'm doing this”. It's better to say, “Would you prefer we do this, or do you want to ...?” Options, you have to have options. If not then you're not in control. (Shae, African American, 26, 3 hospital births)

A third definition of control as self-determination relates to agency. Agency in this context refers to the woman as “the birther”, the person experiencing labor and bringing the baby forth. This meaning highlights women's perceptions of the physiological fact that she is the primary agent of her child's birth, apart from her situation regarding authority or choice.

I was fully in charge. I had to go through it, there was nobody or nothing that could take the pain away from me, that could take me away from being in charge of it. (Monica, European American, 38, 1 cesarean, 3 hospital VBACs, 1 home VBAC)

I mean I felt in control the whole time. I had to be in control the whole time because I'm the one that has to push (laughs).

(Aneesa, African American, 23, 1 unplanned cesarean, 1 hospital VBAC)

These women equate agency and control, and in so doing, emphasize the “self” in self-determination.

A final meaning of control as self-determination relates to the value placed on “presence” or being “in the moment”. The experience of presence was often linked to a degree of focus and awareness women experienced (or aspired to) by virtue of a calm or managed birth environment, or as a result of a state of mind undistracted by the needs of others, pain, or pain medication:

Well, I've never done drugs in my life, never. I never have drunk more than I should, just because I want to be in control. I want to be aware and make good decisions for myself. (Margot, mixed ethnicity, 45, 1 hospital birth, 1 planned cesarean birth)

For me personally... being in control is high up there (laughs) because with both of them, having an epidural allowed me to be able to focus more on what's going on, and I don't think that I would have been able to enjoy the situation if I didn't have that. (Elena, European American, 32, 2 hospital births)

For each of these women, being “in control” was linked to the experience of being able to focus on the birth.

Respect

Another dimension of women's definitions of control is within the broad domain of respect. With regard to control, women conceptualize the importance of respect in two ways: self-respect or dignity and the respect (for her) of those attending the birth. Self-respect was often expressed by women in terms of “maintaining control” of themselves during labor, by not screaming or acting in other ways that they felt would later compromise their feelings of dignity. Julie explains, “Control? ... Remember when I was telling you I didn't want to be like writhing around the bed and screaming and swearing – so I think it was nice that I felt in control that I didn't do those things. That made me feel good about myself”.

This parallels the concept of “internal” control discussed by others, yet self-control of this sort need not necessarily pertain to the body or behavior:

I don't think I really realized how (laughs), how my mind kind of got in there and (exhale) I guess there was the control in the sense of being in the way. Like, maybe my expectation of how I thought I should be and how things were. So probably self-control is really where that aspect of it...more where the challenges were... and what shaped my perceptions of the birth. (Holly, European American, 37, home birth transfer to hospital)

For Holly, self-control relates to management of her mental processes, and her sense that she failed to discipline her thoughts.

Where a total of 15 women (21%) defined control in terms of their own behaviors and self-respect, one explicitly noted the need for respect from healthcare providers in order to fully feel control – of herself and the situation: “So, knowing that your needs are going to be met and you're going to be respected, it helps you maintain control” (Ada, European American, 27, 2 hospital births, 1 home birth). This theme was echoed in discussions of authority and agency as well.

Personal Security

Another definition of control relates to personal security, which encompasses feelings of physical safety and emotional and psychological attributes of security, such as comfort and

confidence in one's surroundings. Women provided two broad definitions of control in birth related to feelings of personal security: order or management of the birth experience, and minimization of anxiety or fear. The former is most often expressed by phrases like “under control” or, in the negative instance, “out of control”. By invoking the term *control* here, women articulate a desire for organization and a sense that things are managed – in contrast to perceived disorder or chaos.

So to me when I think of control I just think of everything being laid out. Like all the tools are there ... if something's going a little bit wrong, they can kind of put everything back on track. You know, “The baby's in a little stress? Here we'll take care of it. Done”. Versus, out of control, possibly being at home, the baby's in stress, we don't have the tools we need, everybody's real nervous and scared. (Danielle, European American, 32, 1 hospital birth, 1 unplanned home birth)

Many women also defined control in terms of reducing or eliminating anxiety about the birth and thereby enhancing their sense of personal security. For instance, Betty, whose fourth birth was complicated by what she understood to be life-threatening pre-eclampsia, linked fear with control as personal security in this way: “It was a frightening experience, so I guess whenever you are in a frightening experience you don't feel in control. That's right. You don't feel in control like you normally do”. (Betty, European American, 39, 3 hospital births, 1 unplanned cesarean, 1 hospital VBAC)

The relationship between perceptions of control and fear crossed into other domains as well. For instance, Beth references control as knowledge, while Grace discusses control in regard to authority, but both are speaking about personal security or safety directly related to perceived control:

To me [control] means that I know what's going on... I can tell the things that are happening with my body are normal, I'm not scared about them. (Beth, European American, 24, 2 hospital births, 1 birth center birth, 1 unassisted home birth)

I think the doctor has more control than me ... I feel like they hold more authority, and they command what you can do, I tend to follow their authoritation [sic], to be safe, to feel safe. I don't have any knowledge to fight against it, and I wanted to sort of go with relatively easy, more convenient way. Not convenient, but comfortable way. But I felt like they knew what they're doing. I'm not complaining, just I feel like they have more control. But not in a bad way. (Grace, Asian, 29, 1 cesarean birth)

In total, 36 women (47%) defined control using one of these meanings of personal security, with the majority referring to a sense of order or management, often reflecting on a case where such was lacking.

Attachment

Attachment – emotional closeness or a sense of connectedness to other people involved in the birthing event – is also a domain of the “good” birth linked to the language of control. Two meanings of control that emerged from women's narratives fall within this domain. The first is trust:

I think the control thing was just trusting that the doctors and my obstetrician and everyone knew what they were doing. And even trusting the NICU doctors and ... like the cardiologist, trusting that and trying to stay calm and trying to stay in control and know that they knew what they were doing. (Sian, European American, 30, 1 high-risk cesarean birth)

You know, the thing is, trust. I believe I trusted the doctors at [the hospital]. And ...because they have a good reputation. And I think if I didn't have that, then I'd be, I wouldn't feel there was the control. (Margot)

Again attachment overlaps with other domains. For these women, having a sense of control, here meaning and stemming from “trust” in others, lessened fear and enhanced personal security. Central in each narrative, however, is the existence of a trusting relationship between woman and provider, a dimension of attachment.

Attachment as connectedness to providers or loved ones is also linked with control, as Kristen's experience illustrates:

I went onto my back and they couldn't find the baby's heart. Which all of the sudden again, you know, out of control. I'm feeling very much out of control. And at that point my doctor wasn't there. There was an anesthesiologist, there was a resident I had never met, there was a nurse who was wonderful, and some other people who - I didn't know anybody. My husband was off in the corner, couldn't see him... and I was just looking around at all of these people I didn't know and knowing that they couldn't find my baby's heart beat. (European American, 31, 2 hospital births)

The imagery in Kristen's description is vivid – linking a lack of control to feelings of isolation or abandonment – with her husband in a corner while she is attended by providers whom she does not know. Yet for some women, a stranger or non-intimate friend is adequate to counter feelings of abandonment and restore a sense of control as attachment. As Betty said, “I didn't want to be there alone ... and it helped to have someone to actually just talk to, like a friend ... that turned me around right there. I started feeling more in control and I started thinking positively”.

Knowledge

The final domain of a “good” birth which also characterized meanings of control is knowledge. Knowledge here connotes access to information, understanding, intuition, and familiarity with the physical and psychological aspects of birth. For Cara, knowledge was clearly an integral part of control:

I knew, like when something would happen, I would go, “Oh, oh yeah, I read about this. This is how it's supposed to be”. Like even, I remember when I was pushing and I felt like he was coming out the wrong hole, I felt in control because I had read about it and knew that is a normal feeling. And so when I say control, it felt like “I'm doing this, I know what my body's doing, it can do this”. (Cara, European American, 35, 1 cesarean birth, 1 VBAC)

Similarly, Nicole perceived control during her birth because she knew what was happening, even though she perceived no physical control over her body:

I was kind of passively letting my body do what it was going to do instead of feeling like I was trying to work towards something, but I still felt like I was – you know I was out of control because I couldn't control it, but I wasn't out of control like mentally. I was still kind of with the process, I knew what was happening, and I think that helped a lot. (Nicole, European American, 25, 1 birth center birth)

Lack of control

One of the paradoxes of birth Nicole alludes to is that women and providers alike often endeavor to control what is, in many ways, not a controllable experience – and not by virtue of particular systems of maternity care but because of the nature of birth itself. Despite, or in

addition to, the various definitions, meanings, and experiences of control women provided in their birth narratives, a large number also recognized (often non-normatively) an absence of control in or over birth. Thirty-five (49%) explicitly expressed sentiments similar to those of a first-time mother who said, “You don't really have control over what's going to happen” with birth. Additionally, of the 72 women who discussed control, 40 (56%) described feeling lack of control during their birth experience(s); 19 (26%) expressed that they felt the provider had more control; 17 (24%) reported actively relinquishing control to someone trusted; 14 (19%) spoke of “surrendering” control or “going with the flow”, rather than trying to affect the birth; and nine (13%) expressed that control was not important to them. Perceptions of the absence of control in birth add yet another layer of complexity to what women mean – or need, or hope for – when they talk about control in relation to birth.

DISCUSSION

That women can – and should – control their reproduction has been a fundamental premise of women's health discourse on a breadth of topics from contraception to fertility. But the meanings of control as understood by childbearing women themselves have not been adequately described. “Because the sense of ‘being in control’ is essentially subjective”, note Green and Bastion, “it is important to try and understand just what a woman means by this, rather than making assumptions that may be inappropriate. Furthermore, caregivers need to understand what leads a women to feel ‘in control’ or ‘not in control’, in these different senses, both in terms of the events of labor and their antecedents” (2003, p. 236). Our data reflect the salience of control with respect to birth and indicate that *control* is a complex and polysemous term. We found American women's use of *control* corresponds to five distinct domains positively linked to birth: self-determination, respect, personal security, attachment, and/or knowledge. Indeed, the term was often linked to a broad notion of the “good” in birth.

Given this, we might argue that a careful construction of *control*, one specific to these domains, may hold potential for assessing quality in the context of maternity care. However, we also found considerable ambivalence with regard to the term *control*: Half of our sample recognized that “you cannot control birth”. Thus, even if the term *control* were carefully articulated, its usefulness as a concept for quality measurement is limited, as is its appropriateness as a goal of care - in the US maternity care system and other places where control is important to childbearing women.

As our review of literature suggests, control is a salient issue for women in many different settings, and has been shown positively associated with birth for women from Australia, Canada, Europe, and the United Kingdom. It is striking that this issue of control - however multiply defined - resonates with women across cultures and maternity care systems, whether they are typically cared for by midwives or obstetricians, at home or in a medical setting. And while we cannot be sure that *control* means precisely the same things to women beyond our US sample, Melender (2006) and Fox and Worts (1999) found similar *multiplicity* of meaning for the term *control* related to childbirth in Finland and Canada, respectively.

Together, the notable prevalence of the term *control* and its diversity of meanings raise broad questions about the framing of maternity care debates. On one level, these findings challenge the usefulness of midwifery/obstetrics or holistic/technocratic dualisms as platforms for advancing the interests of women, especially as those interests are understood and expressed by women. These common professional and philosophical frames for maternity care debates are not only deeply polarizing, but may be unproductively so, since the constellation of issues evoked by the term *control* seems important to women in various

contexts. This finding suggests that attention to the needs, values, and expectations of women themselves has profound potential for depolarizing debates about maternity care and for pursuing what some have called *women-centered* care.

Yet on another level, these findings highlight some of the challenges - both linguistic and conceptual - that an approach beginning with women engenders. Leap (2009) and others question the appropriateness of the term “women-centered” care, arguing instead for the term “*woman-centered*” as a means to “shift the emphasis onto each individual woman’s needs and situation” (p. 13). The concern mirrors philosopher Elizabeth Spelman’s unmasking of the problematic tendency, inherent even in Western feminist thought, to conceptualize, discuss, and theorize about “an essential ‘woman-ness’ that all women have and share despite racial, religious, class, ethnic, and cultural differences among us” (1988, p. ix). She reveals the dangers of extracting a woman from the context of her life and assuming that what makes women similar is more important than what makes them different, highlighting the tension between individual and group perspectives. Indeed, the diversity with which women use a term as familiar and prevalent as *control* underlines the importance of careful and contextualized attention to diverse women’s views, and lends credence to the case for individualized *woman-centered* care. As Fox and Worts conclude, “Control means different things to different women... Thus, more important than control (narrowly defined) seems to be whether a woman’s needs are addressed - however the woman in question defines them” (1999, p. 340).

Furthermore, the broad and varied use of the term *control* – sometimes held as an ideal, sometimes acknowledged as inaccessible – points to a larger challenge for theory and practice around maternity care. As Linda Layne eloquently argues, the notion that women can control their reproduction is a double-edged sword: “The liberal emphasis on self-determination that has been used effectively to secure for women the right to contraception and abortion”, she argues, “is often understood that we have the right, ability, and responsibility to ‘control our fertility’” (Layne, 2003). An unintended consequence she identifies in the context of pregnancy loss is a broad-based assumption that women are responsible for their miscarriages. As subtler losses often occur in the context of pregnancies carried to term, women may also feel responsible for these. Indeed, to the degree that childbearing women endorse the importance of control, link it closely with diverse notions of the good birth, then articulate the degree to which it is out of reach, control’s double edge comes into sharp relief. Particularly in the context of an American culture that encourages women to take control of their birth – from the crafting of birth plans, to hiring of doulas, to setting up their “Best Birth” (Lake & Epstein, 2009) – the mantra of control may lead women to feelings of shame and loss when a birth does not go as planned (Lyerly, 2006). Since control is often synonymous with the “good”, an absence of control due to institutional structures or human physiology may leave blame for a less than perfect birth squarely in the lap of the birthing woman.

An alternative approach which might avoid these untoward consequences would de-emphasize *control* and instead focus on its constitutive meanings. This approach would avoid couching discussions about central issues of birth and maternity care in a catch-all term with multiple important meanings. In the prenatal period, it may allow women to be more specific about their goals for the experience of birth – feelings of agency or authority, or relationships of respect and trust – rather than striving for an amorphous sense of control. Prenatal and perinatal communication between women and health care providers may also benefit from shifting dialogue away from a presumption of conflict over power (control) to more constructive identification of complementary or shared priorities. Finally, while operationalizing the concept of control is difficult in a maternity care setting because of its myriad meanings, we may have better success addressing the more specific concerns of self-

determination, respect, knowledge, attachment, and personal security to improve birthing women's experiences individually, and to begin to address challenges and limitations of maternity care systems more generally.

Though this comprehensive analysis of the term *control* in the context of birth presents opportunities for improving maternity care, we must consider the limitations of our study. Study participants were recruited primarily from the Southeastern US in an area with two major academic medical centers. This may limit generalizability two ways: publicly and privately insured women in this area have relatively good access to health care and recently developed technologies, which could influence their thinking about birth; and the area attracts a highly-educated workforce, which may skew upward the education level of the sample. However, compared to other qualitative studies on birth and quality, our sample was relatively large and included a diversity of racial and socioeconomic characteristics, pregnancy history, birthing location, and attendant.

Our sample may reflect some self-selection bias, since participants responded to fliers and were enrolled if they fell within the sampling parameters. We do not know if they differ significantly from women who did not volunteer or could not participate. That said, the recruitment method was held constant across the predefined sampling characteristics, limiting the effects of race or birth type on self-selection bias. Self-selection in this case may also be a strength, since women eager to discuss their births typically have had a memorable birth – good or bad – and have reflected critically on its meaning, providing rich qualitative data.

We purposely oversampled women who gave birth outside of a hospital setting to ensure thematic saturation among this group. This limits the representativeness of the sample for the US population, but may increase the data's relevance for maternity care systems where midwifery care and out-of-hospital birth are more common. Finally, we limited our analysis for this paper to parous women, but recognize that nulliparous women's interpretations of the term *control* may differ. Antepartum interviews with first-time mothers (N=39) provide some indication that prospective meanings of control in childbirth show a range of definitions comprising those presented in the analysis of parous women here. Furthermore, women's reflective assessments of (rather than expectations for) their births are predominantly what endures for childbearing women, making parous women's perspectives most relevant to a project aimed at improving outcomes that matter most to women.

Despite these limitations, our study is the first to deconstruct the term *control* in the context of a racially, socioeconomically diverse population of women who have given birth in a variety of settings. Our findings suggest that the term *control* has several meanings linked to notions of the “good” in the context of birth for some women; but for others, it either lacks meaning or imposes an ideal that is unreachable and may predispose women to guilt or shame. Because the relevance, meanings, and feasibility of enacting control in birth vary widely, the term should be used with care in understanding, describing, or measuring quality in the context of maternity care. In the end, de-emphasizing the term *control* may help lead the way toward a maternity care system that fosters the sort of birth – agential, dignified, accompanied, considered – that women hope for and deserve.

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Table 1

Demographic Characteristics of Women Participating in the Good Birth Project^a

Characteristic	Multiparae (n=62)		Primiparae (n=39)		TOTAL (n=101)	
	n	%	n	%	n	%
Mean age in years						
at interview	31.1		29.2		30.2	
at first birth	26.1		29.2		27.7	
Ethnicity						
African American	19	31%	10	26%	29	29%
Asian	3	5%	5	13%	8	8%
European American	31	50%	18	46%	49	49%
Hispanic	6	10%	6	15%	12	12%
Other	3	5%	0	0%	3	3%
Education						
some high school	8	13%	2	5%	10	10%
high school degree	5	8%	4	10%	9	9%
some college	8	13%	4	10%	12	12%
college degree	21	34%	10	26%	31	32%
graduate degree	20	32%	17	44%	37	37%
Annual household income						
<\$20,000	10	16%	6	15%	16	16%
\$20,000 - \$50,000	12	19%	8	21%	20	20%
\$50,000 - \$100,000	18	29%	10	26%	28	28%
>\$100,000	19	31%	12	31%	31	31%
Married	46	74%	30	77%	76	75%
Parity (range)	2.6 (2-7)		1			
At least one high risk pregnancy	25	40%	6	15%	31	31%
At least one cesarean delivery	24	39%	13	33%	37	37%
Total births	162		39		201	
Location of Delivery^b						

Characteristic	Multiparae (n=62)		Primiparae (n=39)		TOTAL (n=101)	
	n	%	n	%	n	%
Hospital	52	84%	25	64%	77	76%
Birth center	14	23%	6	15%	20	20%
Home	10	16%	3	8%	13	13%
Mode of Delivery^b						
Vaginal	48	77%	22	56%	70	69%
VBAC	7	11%	0	0%	7	7%
Planned cesarean	10	16%	5	13%	15	15%
Unplanned cesarean	19	31%	8	21%	27	27%

^a Rows within a category column may not total 100% as not all participants provided demographic information and 5 primiparas were lost to follow up before their postpartum interview.

^b Numbers and percentages here reflect the number of women in our sample who experienced at least one birth in this setting or via this mode of delivery; because women with multiple birth experiences may be counted in more than one category, rows within these categories exceed 100% and n > 62 (multiparas), N > 101 (total).

Table 2

Sub-codes used to label expressions of control, and code application frequency.

Code name	Code definition Used to label discussions where <i>control</i> narrative refers to:	Domain of Good Birth	Women's Narratives with Code Applied (N=72)	
			n	%
Self-determination	a woman's desire to determine courses of action in her birth, related to her body, the environment, and decisions.	Self-determination	30	41.7
Authority	the authority or personal power of the birthing woman (or the provider) to influence or command events or behavior.		18	25
Directing	directing, ordering, or taking charge of events and people related to a woman's birth.		7	9.7
Choice/Decision-making	the availability of choices and a woman's engagement in decision-making.		26	36.1
Agency/Only I can do this	a woman's sense of herself as the agent in her birth, as the "birther" and essential actor in the experience.		15	20.8
Presence	the ability of a woman to be present and aware during her birth experience, to allow her to focus.		7	9.7
Self, no scream-swear	a woman's management or discipline of her own behavior, thoughts or actions in birth.	Respect	15	20.8
Respect	being listened to, acknowledged, and well-regarded by others during birth.		1	1.4
Managed, in order	maintenance of a sense of order, planning, organization, and/or that things are managed – in contrast to perceived disorder or chaos.	Personal security	29	40.3
Not scared	lack of fear about birth.		3	4.2
Know what's going on	a woman's sense that she has the information she needs.	Knowledge	13	18.1
Trust	trust in those caring for her and the closeness she feels to them.	Attachment	3	4.2
Lacking	an absence or lack of perceived control during birth.	Absence of control	40	55.6
Can't control birth	the uncontrollable nature of the physiologic processes of birth.		34	47.2
By provider	the perception that health care providers have (more) control in birth.		19	26.4
Relinquished, given to someone trusted	the conscious decision to give control to someone else who is trusted.	(Attachment)	17	23.6
Surrender to process, go with flow	the conscious decision to allow birth to follow its natural course, without imposing control.	(Personal security)	14	19.4
Not important/ didn't want	the non-importance of control, or a woman's sense that she did not want control of the process.		9	12.5