Grand Multiparous Mothers' Embodied Experiences of Natural and Technological Altered Births

Susan E. Fleming, PhD, RN, Perinatal CNS

Roxanne Vandermause, PhD, RN

Michele Shaw, PhD, RN

Billie Severtsen, PhD, RN

ABSTRACT

In-depth interviews of a purposive sample ($n = 14$) of grand multipara mothers (five or more births) was conducted to investigate the mothers' embodied experiences of natural, technologically altered births and oxytocin inductions in U.S. hospitals from 1973 to 2007. A comprehensive secondary analysis of the lived experiences of natural birth and the high use of technology and oxytocin during birth, which was found in an original theme of a previous study, was explored. An overarching theme emerged of *Embodiment of Birthing in U.S. Hospitals*. Two patterns: *Embodied Technological Altered Natural Births* and *Embodied Technologically Altered Induced Births* were uncovered. Childbirth educators, doulas, and nurses are an integral part of creating changes in hospital settings, which discourage nonmedically indicated inductions and encourages changes in hospitals.

The Journal of Perinatal Education, 26(2), 85–95, <http://dx.doi.org/10.1891/1058-1243.26.2.85>

Keywords: childbirth educators, doulas, oxytocin, childbirth

Birth is a time when a woman is, in essence, embodied in the experience. Birth is temporal and conspicuously “natural” to the physical aspect of being human. The birthing body on one end of the continuum has been viewed as purposeful and efficient and at the other end of the continuum as a seriously malfunctioning apparatus that is unfit for purpose and requires scientific advances, along with continuous surveillance (Fleming, Smart, & Eide, 2011; Fleming & Vandermause, 2011; Hunter, 2006;

Walsh, 2009a, 2009b, 2010). Embodiment during birth can be described as the body which a birthing woman embraces during her birth. Is her body allowed to freely move and work with the fetus in a

Childbirth educators, doulas, and nurses are an integral part of creating changes in hospital settings, which discourage nonmedically indicated inductions and encourages changes in hospitals.

The birthing body on one end of the continuum has been viewed as purposeful and efficient and at the other end of the continuum as a seriously malfunctioning apparatus that is unfit for purpose and requires scientific advances, along with continuous surveillance.

harmonizing fashion as the fetus is expelled? Or has her body been restricted as appendages (e.g., fetal monitor lines, IV lines) have been added?

Most births occur somewhere along the continuum of efficiency to challenge. Empirical science today is derived from Cartesian duality: a perspective that is oriented to a mind–body split, which objectifies the body. When the body is objectified, it is viewed as a sum of parts. Like parts of a machine, these body parts are subject to failure. This perspective can be seen in maternal science, where a woman's body is viewed as subject to breakage; diagnostic terms of the body in labor, such as *failure to progress* or *incompetent cervix*, are common (Hunter, 2006; Simkin et al., 2012; Walsh, 2009a, 2009b, 2010). The question must be raised: Has the human body failed in giving birth? Do providers use technology, such as medication (oxytocin), to fix and repair the dysfunctional uterus? In this article, an alternative, ontological perspective will be explored to consider the birthing experience. Such a perspective points to “what it means to be” (Heidegger, 1971) and includes focused attention on the embodied experience of birth. What does it mean to be embodied, during a hospital birth, using oxytocin inductions?

Merleau-Ponty, a philosopher known for his focus on the experience of the physical body stated, “We know not through our intellect but through our experience” (Merleau-Ponty, 1962). Interested in this Pontian perspective, the researchers of this investigation conducted an in-depth analysis of an original theme from a prior study of grand multiparous childbearing women who had shared their embodied experiences of birthing in U.S. hospitals over decades of births (Fleming & Vandermause, 2011). Grand multiparas are characteristically described as mothers having five or more birthing experiences (Varney, Kriebs, & Geger, 2004). Grand

multiparae in this study described experiences that suggested they had mastered the labor experience, “I now knew what to expect; I now was able to listen to my body and assist with pushing the baby out.” Merleau-Ponty stated, “Because we are in the world, we are condemned to meaning, and we cannot do or say anything without its acquiring a name in history” (Merleau-Ponty, 1962, p. xxii). Is it possible that grand multiparae's gripping birthing experiences can provide the meaning to evidence-based physiological and technologically altered birthing experiences? This article introduces embodiment in technology-enhanced birthing as an important addition to understanding birth.

BACKGROUND

Childbirth is a salient embodied experience and is impressively innate. The lived experience of the embodiment of birthing is nearly absent in extant maternal–newborn literature. Motherhood is a major life transition and represents a time of emotional and physiological change (Redshaw & Martin, 2011). The embodiment of birthing, from a mother's perception, still remains obscure, and tensions consequently arise (Walsh, 2009a, 2009b). Merleau-Ponty was known for his focus on phenomenology of perception, in which an overlapping physiological and psychological sense of the body image is perceived and experienced (Merleau-Ponty, 1962). Normal physiological birthing and the subtle hormonal surge that accompanies fear, pain, and stress are not completely investigated or understood (Romano & Lothian, 2008).

Bezruchka (2012) investigated the deteriorating international ranking of the United States from a public health perspective. He found that the mortality for gestational age–specific (22–36 weeks) preterm infants born in the United States was comparable to rates found in other industrialized nations, primarily European countries. However, it is remarkable that for infants born 37 weeks or later, the U.S. infant mortality/morbidity rates are considerably higher (MacDorman & Mathews, 2009). This discovery correlates with Clark et al.'s (2010) findings that newborns born from an induction during the early term (37–38 weeks) have an increased risk of morbidity and mortality, particularly respiratory difficulties; furthermore, mothers are susceptible to a higher rate of cesarean births. Intermountain Health, which is a vertically integrated health-care system found in the Western

Grand multiparas are characteristically described as mothers having five or more birthing experiences.

United States and operates 21 hospitals, instituted new guidelines to reduce their nonmedically indicated births more than 39 weeks from an all-time high of 28% in 2001 to a strikingly lower rate of a mere 3% in 2005, which they continue to maintain. During this astounding change of practice, Inter-mountain Health witnessed a remarkable drop of stillbirths in the 37–38 week gestational near-term neonates, which was cut in half during this period (Oshiro, Henry, Wilson, Branch, & Varner, 2009). In the United States, inductions of labor of singleton births rose from 9.5% in 1990 to an all-time high in 2010 of 23.8%; by 2012, it had decreased slightly to 23.3% (Osterman & Martin, 2014).

Recently, there has been a nationwide concerted effort to educate birth consumers regarding the dangers of elective inductions. Lamaze International for parents published an article to inform parents of the dangers of early inductions and cesarean births (Lamaze International, 2014). Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) launched "Go the Full 40" campaign in 2012, whereas March of Dimes launched a campaign to reduce elective inductions prior to 39 weeks called *Healthy Babies are Worth the Wait*, with intent to change attitudes of consumers and providers of birthing to reduce elective inductions (March of Dimes, 2014; Ruhl & Cockey, 2014). Nevertheless, anecdotal evidence echoes the hospital hallways with women saying that their physicians allow them to electively choose to birth at a time of their or their providers' convenience. For several decades, the American College of Obstetricians and Gynecologists and the Centers for Disease Control and Prevention have reinforced that elective inductions prior to 39 completed weeks are not acceptable (ACOG, 2013; CDC, 2013). Are mothers and providers listening? Do these birthing stories give voice to these statistics?

METHODOLOGY AND METHOD

Heideggerian phenomenology is a scholarly approach that provides a research method that strives to interpret the meaning of experience (Diekelmann & Magnussen Ironside, 2006; Healy, 2011; Smythe, 2011). As an origin of inquiry, this method explicates and illuminates experiences that are often unnoticed in clinical practice (Smythe, 2011). This scholarly approach was deemed appropriate because birth may be considered one of the most primal of human experiences. These stories were chosen

specifically to answer the research question, "What is the nature of embodiment during technologically altered or oxytocin-induced births in U.S. hospitals as experienced by grand multiparae?"

Method and International Review Board Approval

The focus of this in-depth secondary analysis was to investigate technologically altered birthing experiences embedded in a larger, previous study and to extend the meaning of the original theme of embodiment during pregnancy, birthing, and feeding (Fleming & Vandermause, 2011). To answer the research question, the following specific aims were employed:

1. Extract technologically altered or oxytocin-induced birthing experiences embedded in the first theme "Embodiment of Pregnancy, Birthing, and Feeding" of the original larger study.
2. Illuminate and interpret the technologically altered embodied experiences of birthing relevant to the multiparae.

University institutional review board granted a human subjects certification of exemption to conduct this research.

Data Collection and Analysis

The data were collected in this unique hermeneutic approach with a purposive intent of extracting embedded birthing experiences found in the original transcripts that were linked to technology alterations or oxytocin inductions. Then a research team of content and/or methodology experts met and discussed the transcripts that were extracted. The initial interview question was "I'm interested in the nature of childbirth in U.S. hospitals by grand multiparous women. Tell me about your birth experience. Is there a situation that you recall?" The interviews lasted approximately 60–120 minutes dependent on the data that the participants were willing to share.

A purposive sample ($n = 14$) of English-speaking grand multiparae women (five or more birthing experiences) with at least four births in a U.S. hospital setting, with at least one birth before and after 1996 (representing the start of a 12-year consecutive increase in cesarean births nationwide) were recruited from professional and personal contacts (Martin et al., 2013). They shared compelling stories of their 116 births from 1974 to 2007. These women experienced a low epidural rate (17%) and a very low cesarean birth rate (6%). The participants of this study spoke

of a plethora of normal physiological births. Seventy-nine percent ($n = 92$) of their total births ($n = 116$) were unmedicated. This sample was religiously and ethnically diverse (Fleming & Vandermause, 2011). Validity was established through the primary criteria of credibility, authenticity, criticality, and integrity. These criteria were the guiding principles, which represented the truthfulness of the findings (Whittemore, Chase, & Mandle, 2001).

RESULTS

The new theme resulting from an in-depth secondary analysis of the original data (Fleming & Vandermause, 2011) is *Embodiment of Birthing in U.S. Hospitals* (this theme was found embedded in the first theme “Embodiment of Pregnancy, Birthing, and Feeding”). Two new patterns were subsumed: *Embodied Technological Altered Natural Births* and *Embodied Technologically Altered Induced Births*.

This study examined the embodied experiences of the women during birthing in its natural state as well as with technology. Birthings during inductions were examined as a means to understand the full experience of the embodiment of an oxytocin induction in a hospital, a place where technology and birthing intersect.

Embodied Technological Altered Natural Births

Technology begets technology. The women often shared their perceptions of technology would help them during birthing (Fleming & Vandermause, 2011). Birth takes on a new sense of embodiment as the woman and fetus end their synchronized relationship and complete the immense undertaking of becoming two separate “beings” through expulsion (Fleming & Vandermause, 2011). If the woman can relax, a normal physiological birth can transpire without concern. With *Bobbie’s* (five vaginal births) first birth, she did not use a fetal monitor and was sensitive to her fetuses’ cues during birthing. However, this decision not to use a monitor created tension during her birth.

Bobbie: I remember with the first (1st) birth, I had taken a birthing class called the Bradley method . . . natural way to have babies. I remember that our hospitals . . . were not quite yet equipped for natural. They were still very much into the . . . we’re going to give you an epidural. We’re going to do this . . . You know? Procedure. I came in, and within about 20 minutes, my water broke. And I had opted not to have an IV, which was

very strange for them . . . so they were just kind of watching me . . . they got to a point where they felt like the baby was a little bit in distress . . . I asked them to get me a pushing bar . . . they were not really used to that either . . . my OB doctor was there, but he stood against the wall and he watched me deliver this baby . . . it was a very stressful delivery.

Even though Bobbie had taken charge of her birth, the provider and staff were not receptive. For her fourth birth, she succumbed to the use of a fetal monitor. Unlike her previous birth, she found herself in a fearful state of being frozen in bed and responding to the monitor instead of her fetus. She spoke of this remarkable embodied birthing experience.

Bobbie (five vaginal births): With him (4th baby), I was in a position (not moving—frozen)—the nurse says, “Why don’t you change positions?” So I did. So I rolled and the baby rolled and turned, and then we had a torpedo. I could always feel the baby shift, and then I knew.

Bobbie understood the synchronized relationship that existed with her and her fetuses that occurred during birthing. Was it “fear” that impeded her ability to move during her fourth birth? Can a simple technological intervention, such as a fetal monitor, interfere with the mother responding to her body cues?

Embodied Technologically Altered Induced Births

As the births progressed over time, many participants found the providers were not welcoming their late (overdue) births, and most often, the participants agreed. A few of the participants agreed to inductions and not to an epidural. Most of the participants of this study found the pain associated with the induction to be excruciating compared to their previous natural births. *Rachel’s* (nine vaginal births) fourth pregnancy was late, and her physician insisted on inducing her with oxytocin. She went on to speak of the fetal monitors used during her unmedicated induction.

Rachel (nine vaginal births): Sometimes the monitors were really uncomfortable, and other times, they weren’t. Well, I was glad to know I was having the contractions. Otherwise, it was just constant pain . . . I remember getting in there, and my emotions were a mess. I was not in control.

And I am in control. When I'm having my babies, I am in control . . . I know what's going on. I'm paying attention. I'm listening to the doctor and I'm in control.

Rachel, as well as many of the participants, stated that with oxytocin contractions, the pain can be continuous, and some of them found the monitor a welcoming way to keep track of the contractions. A few participants shared that with an epidural, even though they had mastered the art of "pushing" with their earlier births; the timing of pushing was now dependent on the feedback they received from the nurses and physicians.

Sam (seven vaginal births, one cesarean) knew if she had a cesarean birth that might set a limit on her future children. "And I knew if I'd have a cesarean, I'd be limited to how many children I could have." With her first three births, it was acceptable to be late. However, times and birthing practices were changing. Sam's birthing stories provides a striking example of the increasing use of technology and the increasing use of oxytocin to induce labor. Sam, like the other women in this study, had chosen to birth in a hospital because she felt it would be safe; however, like the other women, she often reluctantly agreed to procedures suggested. She later stated,

Sam: . . . Pitocin (oxytocin) is wicked! . . . And my next one, I was induced. And the labor was extremely hard. I can remember wanting to bang my head it hurt so bad, but I held in there.

Interviewer: . . . you seem to have strong feelings about that.

Sam: Like how hard the contractions are? (laughter)

Interviewer: Yeah. Well, what'd you think?

Sam: I can't go into labor.

Sadly, Sam was losing confidence in her ability to give birth. At the end with her 8th baby, she did end up with a cesarean birth and she mentions that it was for the health of the baby. Sam describes her unfortunate experience of an oxytocin induction with her last baby. This description was in-depth and extremely detailed. She had mulled over this experience time and time again. It was tragic. The baby

only lived to be 3 1/2 years old and was never able to hold up her head. Could this story describe a terrible outcome of an oxytocin induction where an abruption can happen? It is considered a side effect of hyperstimulation of the uterus (American Congress of Obstetricians and Gynecologists [ACOG], 2009). Does this occur often in practice and go unnoticed? The second induction was 1 week later. Was the physician's intention to conservatively stimulate the labor with oxytocin? Rather than jump to cesarean birth? When the induction was unsuccessful, the choice was made to wait 1 more week for the second induction. Sam immediately noticed a decrease in fetal movement and did not say anything to the practitioners, who were not aware of this misfortune.

Sam: And then my last one . . . They induced me two (2) different days (one week apart). I never felt pain. I only got to 3 cm the first time and 2.5 cm a week later. So I didn't progress . . . when her shortage of oxygen showed up, I was just about done . . . And actually if you went back to the first time I was induced—this is the part that always bothers me—I wish I would have said something, I guess. When I got done, they unhooked me from the Pitocin and immediately the contractions were done. And I went home, I go, "(husband's name reference) I'm so worried because the baby's not moving like she should be." And he said, "What do you mean?" And I said, "When I lay on my right side, she kicks the bed . . . and I can feel her move . . . maybe one move, but that's all. When she has hiccups, she hiccups once or twice so I know she's alive, but that's all. Instead of 20 minutes of hiccups, I only have a minute—or 1 hiccup, maybe 2 hiccups."

Interviewer: Much different than the other babies.

Sam: Even than her before. I think she reacted to the Pitocin, and I didn't know it. And so every time I would, um, try to get her to move—if I lay on like the couch, put my feet on the arm and go sideways, the baby will move. And that's how I've always been able to wake my baby up and to make sure everything's okay. And with her, I would do it and she would move, but it'd be only one tiny movement. She wouldn't continually move. Where normally, she'd move for maybe a half an hour or an hour and exhaust me with all the movement and kicking and pushing. And she just literally told me

she was alive. That was all. There'd be the tiniest amount. And I should've called the doctor, but I didn't 'cause I thought, well, she's going to say she's had a busy day, Pitocin all day, and then the gel all night to where she's just worn out. And that made sense to me. But I interpreted this myself.

Interviewer: Yeah.

Sam: So then, um, when she said she wanted to induce again, I was more than happy because I wanted to get the baby here. Something was wrong.

Sam's baby girl was born via an emergency cesarean birth. She was physically challenged. It was determined that she had an abrupted placenta. How long the placenta was abrupted remains unknown. Had the oxytocin induction the week prior abrupted the placenta? Sam noticed changes immediately when she arrived home after that first induction. Would have things been different if Sam had told the physicians her changes to the declining fetuses responsiveness right after discharge? Does oxytocin prematurely abrupt the placenta during birth? Was this birth induced with high levels of oxytocin? Was an induction at 2–3 cm too early? More research on the exact effect of oxytocin is warranted.

Jill (nine vaginal births) had experienced five vaginal births very naturally and shared that birthing was a very easy process. Like several of the other participants, their earlier births were often quick and unmedicated, yet often late (overdue by dates). Not only were they induced, many were now subject to a birthing experience during which a "near miss" or an actual cesarean resulted. Many women shared and/or were told that their uteruses were "tired." Jill shared her sixth birth, as she stated, "You know, an hour. By this time, it was—you know, I'd walk in and an hour later I'd have the baby. Three pushes and they're out." She was induced and everything changed.

Jill: They just used Pitocin. I was having contractions, but like before where the contractions were actually doing something—my uterus wasn't responding like it had in the past (with previous augmentations of ruptured membranes) . . . they had to start cranking up the Pitocin because it just . . . it really wasn't doing a whole lot—first that I'd been induced. Second, I didn't walk in the hospital and have a baby. So that was very strange for me.

With her prior births, she would go in and give birth within hours, this birth was taking time and the contractions were not effective.

Jill: . . . my uterus wasn't responding. The contractions weren't going anywhere. I wasn't in pain, but . . . it just wasn't happening . . . the baby . . . they had the fetal monitor, and her heart rate would go down. She was in distress . . . the heart rate. So now I'm kind of panicked. Like, you know, is the baby—they called my doctor in. And he said, "Don't worry." You know? "We will schedule a C-section." . . . and the nurse said, "We've got everything ready if you need it."

It was not looking good for either Jill or her baby. Was cesarean birth the answer? Had Jill's uterus given up? Pay close attention as Jill's physician makes an important choice.

Jill (the doctor): . . . he stood there, and it seemed like forever. But he was trying to decide what to do. And he said, "You know, your body has done this so much before. I think . . . I think it's going to go ahead and happen naturally." And I'm thinking to myself, "Are you kidding me?"

Jill's physician chose to stop the induction and allow labor to progress physiologically without intervention. Jill was accepting of cesarean birth. Was this extremely calm proficient mother now becoming fearful? Did her physician sense this? Had this physician experienced many births without inducing labor and resorted to his intuition based on his previous experiences and made a decisive plan to stop the interventions? What exactly the physician was thinking is not explicitly expressed.

Euphoric Birthing. Colleen (nine vaginal births) had the only home birth, her third birth, in this study. This 1 birth out of 116 births represented 86% of the births of this study, which is remarkably similar to the 1.4% average of out-of-hospital births in the United States (Martin et al., 2013). Note how she describes this salient birth.

Colleen: . . . it was very cool. The lights were down. Never felt endangered. In a bed in a home. I felt myself have this baby. You know, I felt him come totally out of the birth canal. You know? It was a total burning birth.

Colleen often referred back to this birth and the awe-inspiring experience, which her home birth had bestowed her. It was interesting that she brought up that she never felt endangered. It was Colleen's husband that wanted her to have hospital births; she did have asthma. He told her, "I need to see a white coat sometime."

Expulsion. Rachel (nine vaginal births) gives a detailed account of pushing out her baby. Because she was coached to push prior to her urge to push with her first two births, she recounted how she did not become aware of the right way to push until her third birth where she was told not to push.

Rachel: . . . with my first pushes, I don't think I was doing it right. With the first two (births), I just pushed the way I thought I was supposed to, and I didn't feel the urge. Then with the third one (birth), I had to do some real training on pushing 'cause I had to stop and start (she was in an elevator). I remember thinking there's a way to push. I remember them (childbirth classes) always telling me, "Don't push with your face. Don't strain." . . . I thought that's really true 'cause it's a lot of wasted effort that didn't have any effect . . . Push from the lower part of your body and breathe during the push. I thought if I could breathe while I was pushing, I was doing it right. But if I held my breath, it wasn't—it didn't have the same effect. I do remember that. I hadn't really thought about that too much . . . I remember telling myself . . . "Breathe. Don't hold your breath." Push from the upper waist down . . . squeeze those muscles. Don't squeeze the perineal muscles . . . 'cause then it's like I felt like I was closing it in. So I just had to think in my head, "Open up the bottom part of your body and let that thing out and push from the top."

Rachel used the evidence-based practice of open glottis pushing as she describes pushing this baby out with her first epidural baby (Gillesby et al., 2010; Simpson & James, 2005). She has been taught this in her Lamaze class, and her body was recalling her teachings and her previous experiences of pushing babies out unmedicated. She speaks of remembering "them" (childbirth educators) always telling her. Even though Rachel was a woman experienced with unmedicated births who felt comfortable with pushing, she was induced for her last three babies and spoke of depending on the time to push as suggested by the hospital staff. Currently, the extant literature

supports open glottis pushing as well as a delayed pushing as being the best method for fetal well-being (Gillesby et al., 2010; Simpson & James, 2005). Simpson and James conducted a randomized controlled trial that evaluated the effects of fetal well-being by measuring the fetus's oxygen saturation using an open glottis and delaying pushing with an epidural.

Furthermore, researchers (Gillesby) found by delaying the onset of pushing 2 hours for nulliparous women with epidural anesthesia, there was a 27% decrease in time spent of active pushing, thus producing a decrease in maternal fatigue. Even today, we see the hold your breath and "one-two-three PUSH" (closed glottis pushing) still occurring in hospitals quite frequently as demonstrated by reality-based birthing television shows (Morris & McInerney, 2010). Could it be that these evidence-based practices do not resonate with intrapartum nurses, midwives, and physicians? Perhaps, these deeply descriptive stories will.

DISCUSSION

The primary aim of this article was to conduct an in-depth secondary analysis and to extract technologically altered or oxytocin-induced birthing experiences and extend the interpretation of the original theme (Fleming & Vandermause, 2011). These paradigm-birthing experiences shared in this study did reflect the state of increasing use of technology and inductions during birthing in the United States. These compelling stories of this study inform the reader about the mother's experience when technology dominates the birth, particularly during an oxytocin induction, where the cascade of interventions prevailed. Moreover, technology-altered birthing warrants an in-depth investigation, especially the effects that oxytocin has on the laboring mother or fetus.

Hospitals, providers, and consumers need to commit to change. Hospital and/or national policies need to be enacted to reduce inductions, thus reducing cesarean births primarily with nulliparas (who have a higher induction rate), such as when Intermountain Healthcare Initiative (IHI) required providers to obtain permission from the obstetric chair or attending perinatologist prior to pursuing an elective early term induction. IHI recognized that many of their inductions lacked medical documentation; however, they most frequently occurred Monday–Friday. Thus, they took on a multidisciplinary (e.g., physicians, nurse-midwives, intrapartum nurses, consumers) approach. They recognized that educating providers was not sufficient; therefore, they implemented in-

stitutional guidelines and policies. They found having a supportive nursing staff and medical directors allowed for this change to take place. Institutional commitment is warranted to reduce and sustain a reduction in elective inductions (Oshiro et al., 2009).

Romano and Lothian (2008) named six evidence-based care practices that promote and support normal physiological birthing (i.e., avoiding medically unnecessary labor induction, allowing freedom of movement for the laboring woman, providing continuous labor support, avoiding routine interventions and restrictions, encouraging spontaneous pushing in nonsupine positions, and keeping mothers and babies together after birth without restrictions on breastfeeding). These evidence-based practices are derived from the World Health Organization and Lamaze (Lothian, 2006). Lothian updated the evidence of Healthy Birth Practice #4 in 2014 as she reviewed the current literature. Her recommendations include having a woman stay at home until in active labor (6 cm; Lothian, 2014).

The birthing evidence-based practices were abundant in these participants' stories; however, it was often a struggle to keep them remaining in their births as inductions and technology increased. Most of the women in this study had gone to prepared birthing classes such as Lamaze and strived to remain natural; however, what will birthing look like in a society that has witnessed a surge of electronic media (e.g., Internet, smart phones, television) where women are seen self-educating for birth in an unguided manner? (Fleming, Vandermause, & Shaw, 2014).

A recent large national study ($n = 2,229$) explored the prevalence of birth satisfaction among women desiring to birth at home or at birth centers (Fleming et al., 2016). The Birth Satisfaction Scale was used to quantify women's experiences of childbirth between variables such as birth types, birth settings, and providers. Overall, satisfaction was higher for women with vaginal births compared with cesarean births. High quality maternal birth care cannot be achieved unless the childbearing woman is satisfied. Essential concepts of birth satisfaction include being respected, in control, and listened to (Hollins Martin & Fleming, 2011; Hollins Martin & Martin,

2014). We must educate women and hospital staff. We can do this through quality prenatal education.

In this study, when the women were able to relax, an euphoric embodied experience happened regardless of whether it was an unmedicated birth, epidural assisted birth, or even a cesarean birth. However, it primarily happened with natural births where women had shared natural birthing practices taught to them in earlier classes that promoted natural birthing. With this sample, when the women remained faithful to natural birthing, they expressed confidence in birthing and were able to trust in their own powers.

IMPLICATIONS FOR PRACTICE

This in-depth secondary analysis of an original theme of embodiment elucidated the magnitude and value of listening to childbearing women's emotional and physical sensations of pregnancy and birthing. Creating a welcoming atmosphere where educators, doulas, and nurses are talking, sharing, listening and where childbearing women are encouraged to share their innermost feelings and sensations are needed. Educators, doulas, and intrapartum nurses are an integral part of keeping birth physiological. Childbirth educators and doulas can remind and/or inform intrapartum nurses that their own association (AWHONN) launched a campaign "Don't Rush Me . . . Go the Full 40" as a public health strategy to promote spontaneous labor and normal births (Ruhl & Cockey, 2014) and that doulas and childbirth educators are an important aspect of making normal physiological births happen. Doulas can be helpful for the first-time mother by being with her and helping her determine when she is in active labor and should come to the hospital. They can inform mothers that epidurals may provide excellent pain relief, but that relief comes at a cost (Lothian, 2014). Offering women evidence-based programs such as *Centering Pregnancy*, which empower women to take an essential part in the shared decision making of their birth, has resulted in lower preterm births and is deemed necessary (Bell, 2012). Elective oxytocin inductions are not warranted. Evidence-based practices, such as delayed pushing and encouraging open glottis pushing, as suggested by the participants and the current body of research, needs to be implemented into current clinical practice and become the norm (Gillesby et al., 2010; Simpson & James, 2005).

Childbearing women need to be encouraged to actively attend childbirth classes where they

Making changes in hospital settings, which allows for birthing to start on its own and offers childbearing women a safe place to relax and experience physiological birthing, needs to be encouraged and commended.

TABLE 1
Implications for Clinical Practice to Encourage Normal Physiological Births

Topics	Setting	Providers Involved ^a	Implication
Promote classes	Home, hospital, clinic	1–5	Educated women of the benefits of physiological birthing
Listening to mothers	Home, hospital, clinic	1–5	Listen to childbearing women's emotional and physical sensations of pregnancy and birthing
Speak to intrapartum nurses	Hospital, clinic	1, 2, 4	Remind nurses of AWHONN's Campaign "Don't Rush Me . . . Go the Full 40"
Speak to physicians	Hospital, clinic	1–3, 5	Acknowledge that ACOG has reinforced that elective inductions prior to 39 completed weeks are not acceptable since 1996 (ACOG, 1996, 2013).
Stories from this article	Home, hospital, clinic	1–5	Stories can provide meaning and share with providers and mothers as deemed appropriate.
Meet mothers at home for early labor	Home	2	Doulas can be effective during labor for first-time mothers by helping her determine when she is in active labor and should come to the hospital.
Speak at nursing staff, meetings, or hospital-based classes	Hospital, clinic	1–4	Share and reinforce evidence-based classes and practice.
Birth plans	Home, hospital, clinic	1–4	Share with mothers and nurses importance of birth plans. Encourage respect.

Note. AWHONN = Association of Women's Health, Obstetric and Neonatal Nurses; ACOG = American College of Obstetricians and Gynecologists.

^aProviders involved: 1 = childbirth educators; 2 = doulas; 3 = midwives; 4 = nurses; 5 = physicians.

can physically and mentally prepare for their upcoming birth. Birth plans need to be encouraged and respected by hospital staff (Carlton, Callister, Christiaens, & Walker, 2009; Lothian, 2006, 2014; Simkin, 2011; Table 1).

Finally, birthing providers need to realize that suffering during birthing is a common phenomenon experienced, regardless if there is pain relief. Many women of this study referred to suffering during birth, even when they had received an epidural. Does pain that is experienced during birth give women the rite of passage into motherhood? Does the pain of labor prepare women to face the daunting challenges of raising children? (Walsh, 2009a, 2009b). Can we equate the pain and triumph expressed by marathon runners, similarly found with childbearing women who describe euphoric births? We must move toward a holistic women-centered model to "care" and depart from our biomedical thinking to "cure"; birth is not an illness (Hunter, 2006). Changes in policies that allow for physiological births to transpire need to be commended and instituted.

CONCLUSION

The lived experience of embodiment during hospital birthing is currently absent in the extant literature

(Walsh, 2010). This study shares many experiences and provides the qualitative evidence to support and promote normal physiological birthing. These grand multiparae had developed "phronesis," or practical wisdom as they became masters of birthing. Their stories can change the perception of birthing with oxytocin inductions in U.S. hospitals. These compelling stories can offer readers an "optimal grip" on birthing in technologically advanced hospitals where the aspects of natural birthing and high technology intersect (Merleau-Ponty, 1962). Making changes in hospital settings, which allows for birthing to start on its own and offers childbearing women a safe place to relax and experience physiological birthing, needs to be encouraged and commended. All childbearing women need to be offered the opportunity, if desired, of experiencing a "euphoric birth" as their first embodied birthing experience they can share with their baby and join the prestigious alliance of "motherhood."

REFERENCES

- American College of Obstetricians and Gynecologists. (2013). Nonmedically indicated early-term deliveries. Committee Opinion No. 561. *Obstetrics & Gynecology*, 121, 911–915. Retrieved from http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Nonmedically_Indicated_Early-Term_Deliveries

- American Congress of Obstetricians and Gynecologists. (2009). ACOG Practice Bulletin No. 107: Induction of Labor. *Obstetrics and Gynecology*, 114(2 Pt. 1), 386–397.
- Bell, K. (2012). Centering pregnancy: Changing the system, empowering women and strengthening families. *International Journal of Childbirth Education*, 27(1), 70–76.
- Bezruchka, S. (2012). The hurrier I go the behinder I get: The deteriorating international ranking of the U.S. health status. *Annual Review of Public Health*, 33, 157–173. <http://dx.doi.org/10.1146/annurev-publhealth-031811-124649>
- Carlton, T., Callister, L. C., Christiaens, G., & Walker, D. (2009). Labor and delivery nurses' perceptions of caring for childbearing women in nurse-managed birthing units. *MCN. The American Journal of Maternal Child Nursing*, 34(1), 50–56. <http://dx.doi.org/10.1097/01.NMC.0000343866.95108.f>
- Centers for Disease Control and Prevention. (2013). *Preterm birth*. Retrieved from <http://www.cdc.gov/reproductive-health/MaternalInfantHealth/PretermBirth.htm>
- Clark, S., Frye, D., Meyers, J., Belfort, M., Dildy, G., Kofford, S., . . . Perlin, J. (2010). Reduction in elective delivery at <39 weeks of gestation: Comparative effectiveness of 3 approaches to change and the impact on neonatal intensive care admission and stillbirth. *American Journal of Obstetrics and Gynecology*, 203, 449.e1–449.e6.
- Diekelmann, N., & Magnussen Ironside, P. (2006). Hermeneutics. In J. J. Fitzpatrick & M. Wallace (Eds.), *Encyclopedia of nursing research* (2nd ed., pp. 260–262). New York, NY: Springer Publishing.
- Fleming, S., Donovan-Batson, C., Burduli, E., Barbosa-Leiker, C., Hollins Martin, C. J., & Martin, C. R. (2016). Birth Satisfaction Scale/Birth Satisfaction Scale-Revised (BSS/BSS-R): A large scale United States planned home birth and birth centre survey. *Midwifery*, 41, 9–15. <http://dx.doi.org/10.1016/j.midw.2016.07.008>
- Fleming, S., Smart, D., & Eide P. (2011). Grand multiparous women's perceptions of birthing, nursing care, and childbirth technology. *The Journal of Perinatal Education*, 20(2), 108–117. <http://dx.doi.org/10.1891/1058-1243.20.2.108>
- Fleming, S., & Vandermause, R. (2011). Grand multiparae's evolving experiences of birthing and technology in U.S. hospitals. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 40(6), 742–752. <http://dx.doi.org/10.1111/j.1552-6909.2011.01304.x>
- Fleming, S., Vandermause, R., & Shaw, M. (2014). First-time mothers preparing for birthing in an electronic world: Internet and mobile technology. *Journal of Reproductive and Infant Psychology*, 32(3), 240–253. <http://dx.doi.org/10.1080/02646838.2014.886104>
- Gillesby, E., Burns, S., Dempsey, A., Kirby, S., Mogensen, K., Naylor, K., . . . Whelan, B. (2010). Comparison of delayed versus immediate pushing during second stage of labor for nulliparous women with epidural anesthesia. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 39(6), 635–644.
- Healy, M. (2011). Heidegger's contribution to hermeneutic phenomenological research. In G. Thomson, F. Dykes, & S. Downe (Eds.). *Qualitative research in midwifery and childbirth* (215–231). London, United Kingdom: Routledge Taylor Francis.
- Heidegger, M. (1971). *On the way to language* (P. D. Hertz, Trans.). San Francisco, CA: Harper Collins.
- Hollins Martin, C. J., & Fleming, V. (2011). The Birth Satisfaction Scale. *International Journal of Health Care Quality Assurance*, 24(2), 124–135.
- Hollins Martin, C. J., & Martin, C. (2014). Development and psychometric properties of the Birth Satisfaction Scale-Revised (BSS-R). *Midwifery*, 30, 610–619 <http://dx.doi.org/10.1016/j.midw.2013.10.006>
- Hunter, L. (2006). Women give birth and pizzas are delivered: Language and Western childbirth paradigms. *Journal of Midwifery and Women's Health*, 51, 119–24.
- Lamaze International (2014). *Prevent prematurity!! Beware of early inductions*. Retrieved from <http://www.lamaze.org/p/bl/et/blogid=16&blogaid=255>
- Lothian, J. A. (2006). Birth plans: The good, the bad, and the future. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 35, 295–303. <http://dx.doi.org/10.1111/j.1552-6909.2006.00042.x>
- Lothian, J. (2014). Promoting optimal care in childbirth. *The Journal of Perinatal Education*, 23(4), 174–177. <http://dx.doi.org/10.1891/1058-1243.23.4.174>
- MacDorman, M., & Mathews, T. (2009). *Behind international rankings of infant mortality: How the United States compares with Europe*. Hyattsville, MD: National Center Health Statistics.
- March of Dimes. (2014). *Healthy babies are worth the wait*. Retrieved from <http://www.marchofdimes.com/professionals/healthy-babies-are-worth-the-wait.aspx>
- Martin, J. A., Hamilton, B. E., Osterman, M. J. K., Curtin, S. C., & Mathews, T. J. (2013). Births: Final data for 2012. *National Vital Statistics Reports*, 62(9), 1–68. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, United Kingdom: Routledge & Kegan Paul.
- Morris, T., & McInerney, K. (2010). Media representations of pregnancy and childbirth: An analysis of reality television programs in the United States. *Birth*, 37, 134–140. <http://dx.doi.org/10.1111/j.1523-536X.2010.00393.x>
- Oshiro, B., Henry, E., Wilson, J., Branch, D., & Varner, M. (2009). Decreasing elective deliveries before 39 weeks of gestation in an integrated health care system. *Obstetrics & Gynecology*, 113, 804–811.
- Osterman, M., & Martin, J. (2014). Recent declines in induction of labor by gestational age. *NCHS Data Brief*, (155), 1–8.
- Redshaw, M., & Martin, C. (2011). Motherhood: A natural progression and a major transition. *Journal of Reproductive and Infant Psychology*, 29(4), 305–307.
- Romano, A. M., & Lothian, J. A. (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37, 94–105. <http://dx.doi.org/10.1111/j.1552-6909.2007.00210.x>
- Ruhl, C., & Cockey, C. (2014, June). "Don't rush me . . . go the full 40" As a public health strategy to promote spontaneous labor & normal birth. Paper presented at

- the AWHONN 2014 Annual Convention, Orlando, FL. Retrieved from <https://awhonn.confex.com/awhonn/2014/webprogram/Paper10744.html>
- Simkin, P. (2011). Pain, suffering, and trauma in labor and prevention of subsequent posttraumatic stress disorder. *The Journal of Perinatal Education*, 20(3), 166–176.
- Simkin, P., Stewart, M., Shearer, B., Glantz, J., Rooks, J., Lysterly, A., . . . Keirse, M. (2012). The language of birth. *Birth*, 39(2), 156–164.
- Simpson, K., & James, D. (2005). Effects of immediate versus delayed pushing during second-stage labor on fetal well-being: A randomized clinical trial. *Nursing Research*, 54(3), 149–157. <http://dx.doi.org/10.1097/2F00006199-200505000-00002>
- Smythe, E. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative research in midwifery and childbirth* (pp. 35–54). London, United Kingdom: Routledge.
- Varney, H., Kriebs, J. M., & Geger, C. L. (2004). *Varney's midwifery* (4th ed.). Sudbury, MA: Jones and Bartlett Publishers.
- Walsh, D. (2009a). Embodiment: A crucial concept for midwives. *British Journal of Midwifery*, 17(5), 278.
- Walsh, D. (2009b). *It's good for women to suffer the pain of a natural childbirth, says medical chief*. Retrieved from <http://www.theguardian.com/lifeandstyle/2009/jul/12/pregnancy-pain-natural-birth-yoga>
- Walsh, D. (2010). Childbirth embodiment: Problematic aspects of current understandings. *Sociology of Health & Illness*, 32(3), 486–501. <http://dx.doi.org/10.1111/j.1467-9566.2009.01207.x>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11, 522–537. <http://dx.doi.org/10.1177/104973201129119299>
- SUSAN E. FLEMING earned a diploma in nursing from Los Angeles County Hospital, a PhD and BSN degree from Washington State University, and a MN degree accompanied by a Nurse Educator certificate and a Perinatal Clinical Nurse Specialist certificate from the University of Washington, School of Nursing Seattle. She spent many years teaching childbirth classes and working labor and delivery (L&D) and postpartum. She just started a post-master's certified nurse-midwife (CNM) program at Seattle University. She currently teaches OB theory and clinical coordinator as an assistant professor at Seattle University, College of Nursing. ROXANNE VANDERMAUSE received her PhD from University of Wisconsin in Madison. Currently, she is an endowed chair for advancing nursing practice at University of Missouri Saint Louis. Her expertise is in qualitative methodologies and working with women and addictions. MICHELE SHAW earned her initial nursing degree from Pacific Lutheran University. Recently, she earned a PhD from University of Arizona, Tucson. She has worked as a staff nurse in labor and delivery, antepartum, postpartum, and in home health-care settings interviewing mothers. She currently teaches research and is an associate professor at Washington State University, College of Nursing. BILLIE SEVERTSEN earned a nursing diploma from Sacred Heart School of Nursing (Spokane), a BSc from Gonzaga University (Spokane), an MSN from Columbia University (New York), and a PhD from Gonzaga University. Her clinical expertise is in the area of nursing ethics and ethical decision making. She currently teaches ethics and epistemology as an associate professor at Washington State University, College of Nursing.