Birth Observation Among African American Women Prior to Pregnancy

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ABSTRACT

A focused ethnography among African American college students who had observed a live birth prior to their own pregnancy was pursued. Women described two reasons to attend births: curiosity about birth, or a desire to support the birth mother. Women attended the births of friends, family members, or saw their mother give birth to a younger sibling. Themes included pain, operative or traumatic birth, and surprise at the length and/or stages of labor. Some language suggested lingering trauma. Future expectations included painful labor, operative birth or damage, or traumatic labor and birth. Other women felt closer to the infant, or felt more prepared for their own births after observing birth. Prior personal experiences at birth should be explored prenatally.

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INTRODUCTION

There are clear disparities in outcomes for African American (AA) women and infants during birth. In the United States, AA infants are almost twice as likely as White infants to be born too soon (13.93% vs. 9.05%) (Martin et al., 2018), or to die in the period around birth (11.22/1,000 vs. 5.07/1,000) (Murphy et al., 2015). Low-risk AA women are 30% more likely to give birth prematurely than a low-risk White mother (Whitehead & Helms, 2010). AA women are more likely than White women to be birthed by cesarean surgery (36% vs. 30.9%), a surgery intended for situations in which risks to the infant outweigh potential risks for the mother or risks for maternal injury outweigh the common risks of abdominal surgery (Martin et al., 2018). The most recent results for maternal mortality in the United States are

from 2011 to 2013 (Centers for Disease Control and Prevention, 2017) and the rate of maternal mortality in the United States for AA women is 43.5/100,000, while for White women it is 12.7/100,000.

Allostatic load refers to the levels of “wear and tear” on the body which occur in response to excessive stress, or poor management of a process called allostasis which involves maintaining stability despite change (McEwen, 2007). There are indications that elevated levels of fear may increase the allostatic load. Individual, internalized, and institutional racism have all been implicated as causes for the increased allostatic load of AA women (Brody et al., 2014; Fiscella & Williams, 2004). Fear, anxiety, and increased allostatic load have been linked to low birth weight, late preterm birth, and increased risk of cesarean surgery (Laursen et al., 2009; McDonald et

al., 2014). AA women in a recent study were much more likely to report chronic worrying about discrimination related to race, particularly AA women who were older, were married, or were of higher socioeconomic or educational status. Controlling for chronic worry about discrimination made the difference in preterm birth between AA and White mothers statistically insignificant (Braveman et al., 2017). The constructions of AA women about birth, due to different perinatal outcomes, life experiences, cultural perspectives, and practices have been shown to be different than those of White women (Redshaw & Heikkilä, 2011). The distress caused by the care that is experienced adds stress to the AA pregnant woman (Brubaker, 2007).

The psyche or mental/emotional state of the pregnant woman may affect the course of the pregnancy, labor, and birth. Women who have their constructions about pregnancy and birth validated by experience generally develop a positive self-evaluation after birth and a better mother–baby relationship (Henriksen et al., 2017). Women revise prenatal constructions during postpartum to make sense of their birth experience. Realistic constructions may reduce or avoid cognitive dissonance and improve women's postpartum mental health (Brubaker, 2007). Understanding the sources of the constructions of AA women enables providers to give meaningful information, comprehend patient priorities, and support positive constructions with our care. There were indications (Moore, 2014) that young women in the AA community are attending births prior to having their own children. In a Canadian study of women who desired to have children, personally attending a birth was found to reduce fear of birth (Stoll & Hall, 2013). However, Stoll and Hall only sampled women intending to have children, excluding those who may choose not to have children due to their fears; also this study did not address racial background or issues related to vulnerable groups (2013).

Providers are commonly aware of the potential impact of prior birth experiences for multiparous women (Maimburg et al., 2016; Ryding et al., 2015). In experience as a provider, the researcher had observed young AA women at births, and had later

observed the elevated fear in the accounts of previously witnessed births as a researcher. The question that this research sought to answer was if it was possible that viewing the birth of other women altered the constructions of AA women prior to their first pregnancy.

DESIGN AND METHODS

The author, a Caucasian nurse-midwife, pursued a focused ethnography aimed at understanding the experience of birth observation and the cognitive constructions of AA women regarding birth after they had personally seen a birth, but had not given birth. Stahlke Wall (2015) notes that in focused ethnography, classic hallmarks like fieldwork may be missing, and researchers may have previous or more detailed knowledge about aspects of the situation. AA women who were attending a public university, and could read, write, and speak English, were recruited through a university service that allows students to volunteer as participants for academic credit. Data collection consisted of a semi-structured, digitally recorded interview in a private campus space, at an appointment time of each participant's choosing. Atlas-ti 8 software was used to organize transcribed data for themes, and assist in analysis. Saturation occurred at 9 participants; an additional 5 participants were interviewed for a total of 14 participants.

FINDINGS

Expectations

Women came to these births with one of two general expectations: they had a desire to see the birth, or they were there to provide support. Birth in the United States occurs in a hospital for 98.38% of women (Martin et al., 2018). In many parts of the United States, students see a film about reproduction and birth as part of a high school health class. YouTube videos about birth are easily found. Searching Google for the term “live birth vlog” in July 2019 yielded over 300 thousand video results (Google search, July 1, 2019). Despite exposure in school, and the wide availability of video images, curiosity about the process of birth remains. Seeing an actual birth was felt to be beneficial even if these young women had seen childbirth videos in a high school class or elsewhere.

Support in a general sense is considered in anthropologic terms as a requirement of human birth (Buck, 2011). Pelvic evolutionary changes that

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accommodate upright posture, as well as the large fetal head and helplessness of the human infant, created a situation in which the birthing woman will need some assistance. Some of the needed support is physical, for mother, infant, or both individuals. Issues with pelvic navigation, the umbilical cord, or infant respiratory difficulties require the assistance of another person. Women may begin to hemorrhage immediately after birth. The anthropologic term used is obligate midwifery (Buck, 2011). Support may also take the form of ensuring a safe space for the mother to give birth or providing an environment that they find psychologically safe, and which provides emotional support (Downe et al., 2018).

The Desire to See the Birth. The desire to see the birth was described by participants as “because I wanted to see it (*Monifa*¹),” “I just told her, like it was fun to be there (*Gaby*),” or because of a desire to have that experience “. . . volunteered to go just to experience—like to see actually (*Demi*).” Curiosity was sometimes driven by the need to evaluate possible professional choices “. . . seen the whole thing when it was coming out because I always wanted to be an OB/GYN (*Chloe*).”

The Desire to Provide Support. Many young women felt that they needed to be there to support and help the woman. Some of these women came because the birthing woman asked her to be there “No, she just, you know, wanted me to be there, you know (*Jamila*),” “she wanted somebody that could support her, that wouldn’t be negative—that she could, like, trust—& I was that person for her (*Lakedra*).” Other women felt strongly that women need a person for emotional support “I wanted to be in there for it, I wanted to be in there because, I wanted to be in there for her (*Ellie*).” Women accompanied siblings “The first one I saw was my sister. . . this was about 4 years ago (*Kayla*),” “My sister asked me to go with her . . . we have a really close relationship (*Alyssa*),” their own mother “I saw my mom give birth to my brothers & sisters. I’m the oldest (*Brianna*),” or friends “. . . we have a group of friends. We knew she was going to have a baby soon & we were driving back in town & we get a call, ‘Oh! She’s in labor’ (*Nevaeh*).”

Experiences

Length of Labor and Its Stages/Phases. Women were surprised at the length of the process. Some women learned birth could be fast “She pushed—the baby

just came out—like—a ‘slip and slide.’ It just came out (*Kayla*)”; others expected it to be longer than what is seen in the media but not as long as it actually was “I knew it was painful, but it’s just to see the whole thing, I see how long of a process it is, and how painful it is, all through it . . . in person, it’s like—hours (*Lakedra*).” Women commented that birth was hard and media portrayals aren’t accurate “they lie to you in the media . . . they show ‘em pushing, and then—and since the baby is out everyone is just like . . . nothing happened (*Gaby*).”

Women also learned that birth can be calm, or be very dramatic. “You know, you expect it to be a lot of screaming & (mimics patterned breathing) & all that other stuff, but my friend she was calm (*Haley*).” They saw a disconnect between the mother’s state and the emotional state of the health-care team, “. . . thing that stuck out the most was just how calm the doctors was—like, . . . just sitting back, . . .—& she’s . . . screaming & pushing, he’s like, ‘it’s okay’ (*Demi*).”

Pain. Women understand that the process of birth can be painful, but the expectation is that the pain ends with the birth of the infant. In the United States, many women use epidural anesthesia to control the pain of labor. Epidural anesthesia has a failure rate of approximately 9%–12% (Kingsley & McGlenan, 2017), and these women sometimes experienced watching a birth with failed pain relief “. . . my first aunt . . . she had [an] epidural but it wasn’t working for her . . . she was feeling pain . . . the drugs didn’t really take any effect on her (*Ellie*).” One participant did ask if “a white person would create, like, a fairy-tale birth story (*Alyssa*)?” She went on to share that since her family included both white and AA members, she had noticed racial differences in the birth stories which women told, with the AA births being harder “[one aunt—White] sayin’ it was the best time of her life [one aunt—AA] sayin’ . . . ‘I had the epidural, and I still felt this and that, and I had stitches up to this, and now I can’t walk’ (*Alyssa*).” When I asked this participant if she thought that the differences were related to the fact that some of her family members were White, and not AA, she didn’t think race was the issue. At times participants made comments referencing the race of the mother

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that they saw, but women did not want to say that the race of the mother affected the care that was given.

Damage. Women weren't expecting the episiotomy "But I saw them like cut—oh my God, and I just—it wasn't cute like they make it seem . . . it's serious. It looked very painful and very uncomfortable (*Ellie*)," or how much the perineum stretches ". . . private area, about that it was big—and I was—I was 'Oh, my God!' I don't want to have babies at the same head [size]. Yeah, it—it stretched out a lot (*Chloe*)."¹ One participant had said the birth was "disgusting," so I asked her what the worst part was, and she said, "Seeing it stretch (*Demi*)."² The repair was a surprise as well: "I didn't know you had to get stitches sometimes & stuff like that (*Haley*)."³

Operative Birth. In 2017, 36% of AA women in the United States gave birth via cesarean surgery (Martin et al., 2018), but these young women were not expecting to see or be involved in these births. One participant accompanied the birthing mother to the operating room, but said "[When] I saw my niece, I didn't see her face—I saw like, the process of her being born [CS] . . . it was stuck in my head for a long time (*Alyssa*)."⁴ Cesarean surgery can be the end of a labor that failed to progress, and one participant noted ". . . she wasn't [dilating] . . . she said, for a doctor to . . . tell you . . . the pain you just experienced . . . was for nothing, she said it's just very discouraging (*Lakedra*)."⁵ "My sister, she was breech . . . so, they did the cesarean for her (*Gaby*)."⁶

Positive Experiences. Some of the women felt that seeing the actual birth was helpful, "Well, I feel like watching the birth, preparation for actually giving birth—it shows you what to expect (*Imani*)."⁷ ". . . to [finally] have an experience of it because I came in there clueless (*Jamila*)."⁸ Seeing birth was felt to be beneficial even if they had seen childbirth videos in a high school class or elsewhere "Yeah, I'd rather see her (family member) have a baby first, than

before I have a baby (*Brianna*)."⁹ Women felt particularly connected to the baby, if they saw the birth, "I remember taking her picture and I remember first seeing her like that . . . I saw her from birth to now (age 10) . . . this kid has really made me love kids more (*Haley*)."¹⁰

Preparation

Women reported seeing videos in their health education classes during high school, and some reported that they talked to their mothers before attending the birth. Preparation by a mother or another family member was more common if the girl was seeing a family member give birth ". . . my mom was telling me that it could be like really scary and . . . that I might be rushed out the room (*Felicia*)," but preparation did not always happen. One participant saw her mother give birth to a sibling when she was 7–8 years old, and noted "I knew she was pregnant and going to have a baby" but when I asked if anyone had talked to her before the birth about what was going to happen, she replied, "No, not really, not really (*Brianna*)."¹¹ Preparation did not result in a particular difference of perception, because videos were noted to be incomplete ". . . but it didn't show the whole process, you know—the umbilical cord and stuff like that—everything coming out and the sack, it didn't show all of that (*Haley*)," and verbal descriptions from mothers and other family members often focused on how you would feel afterward "It's going to all be worth it in the end . . . she [her mother] told me the pain is just temporary but the love is very, very good (*Demi*)."¹²

Future Plans

Some of these young women wondered how painful their births might be, "it's gonna hurt, but I don't—like, I would try to do natural, but if it hurts too bad, then yeah, I will get an epidural (*Brianna*)," thought about having a water birth, "having it at home, in the little water over there (*Felicia*)," or said that their major concern was being in pain and how people might react "I don't want to seem like I'm just screaming if I was in pain and everybody just looking at me crazy, you know (*Jamila*)."¹³ One young woman volunteered that she had been told that "it feels like death—like you are just literally about to die right there, till you have the birth (*Chloe*)."¹⁴

Women expressed concern about vaginal damage and possible operative birth. "I don't think I'm going to have kids at all, after that (*Chloe*)."¹⁵ After seeing her sister give birth, a participant said it was

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“something she wasn’t looking forward to (*Demi*)” and another considered adoption, but then decided “I just have to go through with it (*Ellie*).” There were fears that something might go wrong during birth “Is anything going right, or is everything going wrong (*Imani*),” and concern about the repair; after being asked if she thought it would be painful, “Yeah . . . that’s what I think (*Kayla*).” Some of these participants observed births with unexpected interventions like manual extraction of a placenta, or a more extensive perineal repair. Other participants were concerned about vaginal stretching after watching what they described as an uneventful vaginal birth.

Discussion

In this focused ethnography, women described coming to a birth to help or coming to learn. Some of the young women were prepared in some way for the experience and very interested in being there but felt that the preparation didn’t encompass all of their concerns and questions. They expressed a desire to see the experience for themselves so that they could personally evaluate the process. Throughout the comments and themes, both negative and positive, there is a common thread of “not being told” or “not knowing.” Lack of trust related to inequities in care, knowledge of the history of unequal treatment in care and in research, and personal experience with poor care, and racist behavior by providers leads to situations in which health information is obtained from friends, family, or social media. These sources are more credible in the eyes of the patients than medical providers and sources based on scientific and medical evidence (Prather et al., 2016; Roberson, 2019).

These young AA women voiced some common concerns about birth. Fears related to terrible pain or unrelieved pain were expressed by these women and echoed concerns voiced elsewhere (Moore, 2014). Unrelieved labor pain is a concern for AA women (Morris & Schulman, 2014; Redshaw & Heikkilä, 2011) and minority women complain commonly that medical, midwifery, and nursing staff do not take their pain seriously, or work to relieve it (Jomeen & Redshaw, 2013). Extreme pain and lack of relief of pain have been linked to traumatic births, and post-traumatic stress disorder (PTSD) following the birth, for some women (James, 2015).

Negative ideas about oneself and one’s place in the world have also been linked to the development

of PTSD in birthing women. Internalized racism, fear, and a perceived lack of control over her own birth experience can leave a birthing woman feeling traumatized (Alderdice et al., 2019; James, 2015). Younger mothers (<20 years old) fear intervention, and despite a higher vaginal birth rate, they also fear cesarean surgery (Henderson & Redshaw, 2016). Unexpected outcomes like cesarean surgery, or vaginal repair resulted in strong images that participants found intrusive and upsetting in this study, and these young women had similar fears about intervention. A recent meta-synthesis found that women held fears related to the following issues: the unknown, the potential for injury, pain, their capacity to give birth, losing control, and adequacy of support from care providers (Sheen & Slade, 2018). It is possible that the concerns about pain and damage expressed among these women create negative expectations and fears which persist when these women become pregnant themselves. Fear among AA women can add to the allostatic load experienced during the pregnancy, and increase anxiety and depression, which is linked to a greater risk of low birth weight, late preterm birth, and risk of cesarean surgery (Laursen et al., 2009; McDonald et al., 2014). Fear of pain and fear of vaginal damage were found to be the two most common reasons that young women who had never given birth cited for requesting an elective cesarean surgery (Stoll et al., 2017).

Implications

This is a small, qualitative study of university students; this may limit the transferability of the results. The extent of birth attendance by AA children, adolescents, and young women prior to their own pregnancy and birth is unknown; it is not completely clear if this is a practice that is more common in the AA community versus other racial or ethnic groups here in the United States. These young women carried definite ideas and impressions from seeing birth firsthand. The topic needs to be explored in more depth, and the extent of the practice should be determined in future research.

Physicians, nurses, and other providers need to realize that some of the persons present during a birth may have little to no experience and knowledge about birth. Some are there because they

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themselves wanted to attend out of personal curiosity, some are there to help the birthing woman, or because family members (a mother, aunt, or grandmother) thought that their presence would be helpful or appropriate. Clear, simple explanations as care is being provided could help those present in the birthing space (including the birthing woman) understand the rationale for various interventions. Providing this information during birth will help the laboring woman to evaluate and adjust her constructions about birth and motherhood during the postpartum period (Henriksen et al., 2017). Attendance at a childbirth preparation class can assist pregnant women and any companions to learn about the range of options available to help women navigate birth. Prenatal and early labor conversations can help those providing care to tailor their information during birth more appropriately, and providers should be educated about this need.

Finally, nulliparous women are commonly assumed to have little or no personal experience with birth, unless they are involved in a health-care profession. This idea may not be correct—and some nulliparous women can carry traumatic experiences from observing an unexpected outcome during a birth. It is concerning that some of these young women either had considered or were still considering not having children after seeing a birth, particularly since some of the observed births had occurred over 10 years prior to the interviews. Fear or anxiety related to these experiences could create negative ideas, add to a perceived lack of control, or increase the risk of other negative outcomes. Asking a nulliparous woman about her personal experience with birth, her experiences viewing online sources such as vlogs on YouTube, and the extent of her prior knowledge can give her permission to address any concerns which she may have. Frank and open discussions can correct misconceptions and misinformation, reduce prenatal fear and stress, promote trust, and assist in empowering the birthing woman.

NOTE

1. All names are pseudonyms.

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