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WHY TAKE THE RISK?

WOMEN’S INTERPRETIVE REPERTOIRES FOR CHOOSING HOME BIRTH

By

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The purpose of this project was to use a social constructivist approach to understand the perception of risk by mothers making the choice to give birth at home in Missoula, Montana. Social constructivism assumes that knowledge about risk is filtered through “social and cultural frameworks of understanding” (Lupton and Tulloch 2002, 321). The information gained from participants in this study was interpreted as a representation of the individual’s culture, including their beliefs, values and upbringing, as well as the influences of the individual’s social network which can include family members, spouses, friends, and community members. Various phenomena, elements or constructs in society are viewed as realities by social groups whether they exist as reality or not. Social constructs in the United States create a reality around the normalcy of hospital birth and tend to paint a picture of home birth mothers as “risk takers” (Craven 2005) (Davis-Floyd 1992). However, in developing this study, I predicted that home birth mothers would construct a different type of reality around risk in order to explain their decision to have a home birth. By examining the interpretive repertoires of home birth mothers in Missoula, Montana, one can begin to understand how women interpret their individual risk concerning birth and respond according to their determined level of vulnerability. First, the mothers confronted the dominant social norm that home birth is risky. In response to accusations of making a risky decision, these home birth mothers responded by emphasizing the risks that they see in hospital birth. For home birth mothers, the importance of having minimal medical interventions during the birth of their baby outweighed other potential risks associated with homebirth identified by medical authorities or published studies. Furthermore, many of the women in this study emphasized feeling very positively about their home birth experiences and felt that going through with this decision helped them gain feelings of confidence and empowerment.
Introduction

The purpose of this project was to use a social constructivist approach to understand the perception of risk by mothers making the choice to give birth at home in Missoula, Montana. Social constructivism assumes that knowledge about risk is filtered through “social and cultural frameworks of understanding” (Lupton and Tulloch 2002, 321). The information gained from participants in this study was interpreted as a representation of the individual’s culture, including their beliefs, values and upbringing, as well as the influences of the individual’s social network which can include family members, spouses, friends, and community members. Cultural anthropologists (Douglas 1990) have identified the language of risk as a key component to decision-making, keeping in mind, as noted by Davison et al. in their study of lay epidemiology, that “…individual behaviours are rooted in a cultural field, which in turn is strongly influenced by social differentiation” (1991, 3).

I identify the mothers in this study as a loosely constructed social group who share similar values about birth. The choice to have a home birth was the most obvious commonality between all of the women. Although the women interviewed had many differences, the women shared some recurring values which I identified from the interviews. Some of the most frequently shared values between the women included naturalistic approaches to health, a skeptical attitude towards medicine, feministic viewpoints, and an importance placed on the empowerment of women. Because of these shared values, the women can be viewed together as a loosely defined social group. Various phenomena, elements or constructs in society are viewed as realities by social
groups whether they exist as reality or not. Social constructs in the United States create a reality around the normalcy of hospital birth and tend to paint a picture of home birth mothers as “risk takers” (Craven 2005) (Davis-Floyd 1992). However, in developing this study, I predicted that home birth mothers would construct a different type of reality around risk in order to explain their decision to have a home birth.

The narratives of women discussing their choice to have a home birth offer a chance to understand how risk is filtered through women’s knowledge and experiences associated with this birth choice (Wilson 2005). I chose to focus my analysis on the interpretive repertoires that the mothers in the study used to explain their decisions. Interpretive repertoires are defined by Lupton and Chapman as “broad, recurrently used systems of terms that are employed to characterize and evaluate phenomena” (Lupton and Chapman 1995, 484). I utilized this definition which allows for a thematic analysis that focuses on the social uses of speech in constructing reality. I conducted semi-structured in-depth interviews with 16 women between the ages of 23 and 39, who had had home births. Two of the women, who were already experienced with giving birth at home, were pregnant at the time of the interview. A third woman was pregnant with her second child but was planning her first home birth. This paper explores how risk is constructed and politicized by social institutions to influence individuals who in turn process the information through social and cultural filters to create their own interpretive repertoires for explaining their decisions. As a result, the individual’s perception of risk is continually being challenged and reconstructed as the available information continues to change very quickly in the modern world.
Voices of Authority: The Use of Risk as a “Forensic Resource”

Sociocultural theorists have developed a variety of theories on risk in modern society. Cultural theorist and anthropologist, Mary Douglas, recognized the importance of studying risk in society: “The calculation of risk is deeply entrenched in science and manufacturing and as a theoretical base for decision making” (Douglas 1990, 2). From Douglas’s perspective, risk is a social and cultural construct with inherent political biases that has been a part of society throughout human evolution. In her 1990 Daedalus article, “Risk as a Forensic Resource,” Mary Douglas discusses how in modern society, rather than maintaining its original meaning of probability, risk has taken on the new meaning of danger. By referring to risk as a forensic resource, Douglas invokes the definition of ‘forensic’ similar to the one provided by the Merriam-Webster Online Dictionary as “belonging to, used in, or suitable to courts of judicature or to public discussion and debate.” According to Douglas, ‘risk’ is the preferred term over the use of ‘danger’ due to its implications of science and calculation. Risk as danger can be used to stigmatize groups that are not in line with the cultural norm, in an attempt to maintain homogeneity. Douglas theorizes that in an individualist culture, “Since it is inherently difficult to be aware of liminal groups in a society organized under the principles of competitive individualism, it is easier to write them off as human derelicts” (Douglas 1990, 14). Thus, groups that do not follow the cultural guidelines in a society based on competitive individualism are simply ignored or forgotten about. Douglas admits the difficulty that many have in identifying cultural norms: “The innocent view of culture is that we don’t have it at home; it is only abroad that people are culturally hidebound”, and suggests that one way to overcome ‘cultural blindness’ is to “be attentive to the way that claims of
authority and solidarity are being treated. In the regular ongoing cultural debate about justice and the world, some idea of danger is usually invoked” (Douglas 1990, 4). In other words, Douglas is suggesting that sociocultural constructs can be identified by paying attention to examples in society in which authority identifies danger. For instance, in present-day American culture one way that the medical institution defines risk is through public health messages that encourage certain behaviors or ways of living in order to prevent injury or disease. How these messages are received and translated by individuals can vary widely, yet, certain behaviors tend to carry weight as being culturally acceptable depending on where you are from or what social setting you are in. Some of the problems one may encounter for going against these norms may include moral judgments by others, an increase or decrease in physical or emotional health, and the potential of encountering greater difficulty when attempting to accomplish personal goals.

Ulrich Beck, a German sociologist, focused many of his theoretical studies on the modernization of society. Beck suggests that the breakdown of traditional social structures has left people to face modern-day problems individually. Beck believes that the increased attention to risk in modern times has led to the formation of a ‘risk society’ (Elliott 2002, 295). While Douglas’ theory sees risk as a modern sociocultural construct that has merely replaced our notion of ‘danger’, Beck contends that risk is a relatively new concept in society, which differs from that of danger, and has emerged along with concepts of rational control in decision-making. Beck’s theory argues that in addition to the process of modernization, a process of individualization will occur in which people will become even more responsible for their personal choices which may be fraught with
ethical and moral decision-making (Elliott 2002, 299). He argues that this process will eventually result in ‘reflexive modernization’ in which people will be forced to confront the consequences of risk: “…that is, the questioning of divisions between centres of political activity and the decision-making capacity of society itself” (Elliott 2002, 297). Beck contributes to the understanding of risk by suggesting how rational decision-making in modern society has led to a greater focus on risk in the present-day. Adding on to Douglas’ theories on moral risk, Beck suggests that the increased concern with risk will lead to individuals facing great moral and ethical dilemmas in modern society.

Much of the information that is constructed around risk in society is disseminated through various media sources. Lisbeth Sachs (1996), a Scandinavian anthropologist, has discussed how the public receives knowledge about risk. Sachs claims that people receive knowledge about risk through the media interpretation of preventative messages from science, technology, and major social institutions. However, the messages are translated by individuals and tend to vary widely in their translation. Discussions of risk often refer to the dangers that threaten a person’s idea of a healthy lifestyle, body, or environment. Although individuals in society are bombarded by information about risk from authoritative and epidemiologic sources, the person receiving the information must process it into meanings that translate to the feelings of vulnerability or being ‘at risk.’ Sach’s point is that although the message being shared with the public may seem very clear to those releasing the information, the interpretation of this information is not always so clear. Furthermore, research has shown that when media messages present controversial results or studies, the public has trouble trusting these sources’ validity, and
often defaults to personal belief systems that help them resolve the conflicting information (Lupton and Chapman 1995).

Not all risks seem to cause negative outcomes in the lives of individuals. In their 2002 article on risk epistemologies, Deborah Lupton and John Tulloch describe how individuals facing such social “risks” as unemployment and unstable relationships are prone to significant anxiety (Lupton and Tulloch 2002, 318). However, Lupton and Tulloch also noted that taking certain types of risk in life seemed to have a positive outcome on participant’s lives: “Engaging in risk is a means of extending the self, of seeking and meeting challenges and gaining knowledge of one’s self and the world” (Lupton and Tulloch 2002, 328). Engaging in a behavior considered “risky” by society at large means that mothers choosing home birth may develop their own interpretive repertoire to explain the reasons for making this decision for themselves and for those around them.

The theoretical contributions of Douglas, Beck, Sachs, Lupton and Tulloch and others have created a body of theory about the nature of risk as a sociocultural construct in society and how it is received and interpreted by individuals. Upholding the definitions of sociocultural constructs contributes to the maintenance of social structure and unity. Maintaining these constructs requires the belief in their essential reality by members of the social group. However, due to the dynamic nature of social constructivism, it is also important to examine areas where these constructs are challenged by different ways of thinking and decision-making. For instance, women who choose to have home births likely have reasons for making this choice that define who they are and why they are willing to take the risks associated with this decision, while
others are not. Analyzing home birth mothers’ interpretive repertoires offers a unique perspective on whether women who choose home birth translate the meaning of risk associated with home birth into feelings of danger and vulnerability.

**Risk and Home Birth**

Although modern hospital birthing arrangements have been attractive to many women in the United States for several decades, presently about one percent of American women choose to have their babies outside of the hospital, with approximately 65 percent of these occurring at a place of residence (Martin, et al. 2007). Women who choose to have a home-birth do so despite the dominant cultural norm for childbirth in a hospital. Women living in the modern world are subjected to a multitude of warnings about the possible complications that can occur during childbirth. In a nation where the rate of cesarean section has been climbing to nearly 30 percent, the possibility of complications during birth seems high (Martin, et al. 2007). Although women undoubtedly have other reasons for choosing to have their babies in the hospital, many American women feel that the safest place to be during child labor is in the hospital, close to life-saving equipment and technologies (Lazarus 1994).

The technological model of birth that exists in America today has been described by anthropologist Robbie Davis-Floyd as a rite of passage for women in America (Davis-Floyd 1987). According to Davis-Floyd, the ritualized act of hospital birth allows for society’s most important values to be impressed upon the mother and “map a technological view of reality onto the birthing woman’s orientation to her labor experience, thereby aligning her individual belief and value system with that of American
society” (Davis-Floyd 1987, 480). Davis-Floyd labels the current American birth system as the ‘technocratic model’ of birth, which she argues manages birth with the use of obstetric rituals which emphasize a dependence on technology and a fear of natural processes. The influence of this belief and value system by the medical institution places more accountability on the mother for conforming to these cultural norms.

Other anthropologists have examined how the language of reproduction is used to construct notions of risk around the female body. Emily Martin’s book, *The Woman in the Body* (1987), examines metaphors in the medical language of reproduction. A common metaphor evokes the image of the female body as a dysfunctional machine and the doctor as the technician who can fix it. Martin describes how:

In the development of obstetrics, the metaphor of the uterus as a machine combines with the use of actual mechanical devices (such as forceps), which played a part in the replacement of female midwives’ hands by male hands using tools…. the metaphor of the body as a machine continues to dominate medical practice in the twentieth century and both underlies and accounts for our willingness to apply technology to birth and to intervene in the process (Martin 1987, 54).

Technological birth reinforces this metaphor by treating the woman’s body as the source of potential complications in producing a healthy baby without acknowledging the interconnected identities of the mother and the fetus (Heriot 1996). As a result, many women may be led to think of their own bodies as a source of risk and look to the institution of science and medicine to guide their choices in birthing and thus reduce the risks they pose to themselves and their babies.

It is important to recognize that pregnancy risks are not always assessed or measured by the lay person with the same set of criteria such as those used by the physician or the medical institution in general. Trostle and Sommerfeld (1996) suggested
that collaboration between anthropology and epidemiology might help to understand human behaviors and the differences in the clinical language and lay perceptions of risk. This changing perspective on risk continues to evolve as new technologies, scientific studies, and qualitative research on the construction and perception of risk emerge. As discussed by Douglas, risk was originally defined as a statistical probability or predisposition of an individual to encounter potential problems. This definition shifts the focus of risk away from social and cultural elements that also contribute to risk and places the focus on individual biological risks (Chapman 2006, 493). Rachel R. Chapman examined the social significance of risk in pregnancy in her study of women’s pregnancy narratives in Central Mozambique. Chapman found that social risk is the number-one concern for pregnant women in Mozambique, and many women try to conceal the fact that they are pregnant because they believe that the social knowledge of pregnancy makes them more vulnerable to danger or harm. Women in Mozambique tend to relate the most serious pregnancy risks to personalistic causes such as witchcraft, sorcery, or spirits, rather than biological ones, and these explanatory models directly contribute to the women’s health-seeking behaviors (Chapman 2006, 488-9). Rather than the fear that something could go wrong physically or biologically in the birth process, Chapman’s subjects were more concerned about the harm that other members in their society may inflict on them during their pregnancy. Chapman suggests the anthropological use of the language, “maternal vulnerability” or “reproductive threats” versus the language of risk, as she believes this conveys a more accurate sense of how women actually perceive reproductive risk (Chapman 2006, 493).
Recent studies support the safety of home birth, but encounter difficulties with isolating the many social and cultural variables contributing to the relative risks involved with the place of birth. Johnson and Daviss’ (2005) prospective study of North American home births is one of the larger and more recent studies to attempt to prove the safety of home birth with a licensed attendant. Their results showed that of 5,418 low-risk women planning a home birth with a certified midwife, the intrapartum and neonatal mortality rate was 1.7 deaths per 1000, which is consistent with other low-risk pregnancies in the hospital setting (Johnson and Daviss 2005, 2). Despite this encouraging statistical analysis regarding the safety of home birth in North America, Johnson and Daviss comment on the social and cultural attributes that are not easily measurable when considering the relative risk of a home or hospital birth:

Regardless of methodology, residual confounding of comparisons between home and hospital births will always be a possibility. Women choosing home birth (or who would be willing to be randomized to birth site in a randomized trial) may differ for unmeasured variables from women choosing hospital birth. For example, women choosing home birth may have an advantageous enhanced belief in their ability to give birth safely with little medical intervention. On the other hand, women who choose hospital birth may have a psychological advantage in North America associated with not having to deal with the social pressure and fears of spouses, relatives, or friends from their choice of birth place (Johnson and Daviss 2005, 5).

In this passage, Johnson and Daviss acknowledge that a multitude of factors can affect the outcomes of women giving birth including psychological factors, such as their belief in their own ability to give birth with or without intervention, as well as social factors that may impact these beliefs depending on whether the woman’s social network is supportive of the woman’s choice in birth place.

Kirsi Viisainen (2000) studied the perceptions of risk in parents who chose home birth in Finland. Viisainen discusses how home birth parents usually hold a different
perception of risk than the perception of risk held by the medical community. Rather than viewing childbirth itself as being inherently risky, home-birth parents perceived the medicalized hospital version of birth with its technological interventions as more risky than home birth (Viisainen 2000, 793). As Viisainen states,

…This distinction perhaps focuses too narrowly on the perceived role of medical practice, and especially obstetrics, vis-à-vis the definition of risks rather than on the way both the medical view and the alternative view approach childbirth through its risks. Lane (1995) claimed that the issue in childbirth is not the questions of risk or no risk, but the way in which medical discourse assigns risk to pregnant bodies, largely ignoring structural and social conditions in risk production, and thereby realizes social control over women. The authoritative position that medical knowledge has in defining risks needs to be considered when analyzing the perceived risks in birth choices (Viisainen 2000, 793-4).

Viisainen goes on to discuss how the moral dangers of going against medical advice that are widely accepted by a large majority of society can create stigma and labeling of home-birth parents as risky or irresponsible. Viisainen classified home-birth parent’s perceptions of risk into three categories that they considered in their decision to have a home birth. These categories were medical risks, which included complications that can occur in any pregnancy regardless of birth place, iatrogenic risks, which referred to risks that are created or caused by medical intervention, and moral risks, which referred to the perception coming from others that home birth is risky. Interestingly, the parents in this study chose home birth despite their knowledge of the risks associated with pregnancy, including the knowledge of going against social and cultural norms; “The parents felt strongly that the moral danger (Douglas 1992) of having to go against authoritative knowledge limited others from making the same decision, and it also led them to conceal the home-birth plan from health authorities and even from friends” (Viisainen 2000, 810).

Similar to Viisainen’s research, I also examined the risks related to home birth, but rather
than trying to isolate the risks identified by the mothers, I focused on the main elements of the interpretive repertoires of women who chose home birth. In this way, I tried to piece together how the women constructed their reality around the risks of home birth. While Johnson and Daviss (2005) suggest reasons why it may be more advantageous for women to choose hospital birth in North America, this study focuses on women who, despite the potential social and cultural advantages of giving birth in the hospital, choose to give birth at home. Using qualitative analysis, I was able to consider social, cultural and psychological factors when analyzing women’s responses in the in-depth interviews.

In the United States, the cultural tendency to assign authority in risk-prevention to the realms of science and technology in risk-prevention leads many to believe that birthing outside of the hospital is simply too big of a risk to take. However, some women feel safer giving birth at home rather than in the hospital. My study examines how home birth mothers explain this behavior by interpreting the risk associated with birth. Home birth mothers’ interpretive repertoires emphasize the increased risks of hospital birth and ‘unnatural’ birthing techniques in contrast to the safety of the ‘natural’ techniques used in home birth. By redirecting the emphasis of risk to the hospital setting, home birth mothers confront the social norms of birth and answer to the moral challenge that having a home birth is a risky decision.

**Research Site**

This study took place in the state of Montana which, according to Montana Department of Public Health & Human Services (DPHHS) statistics from 2006, had 289 births or a 2.3 percent rate for births with ‘residence’ listed as the location of birth (Office of Vital
Statistics 2006, see Table 1). Table 1 shows the number of births that occurred in various settings in Montana in 2006. The numbers are also categorized by the type of practitioner who assisted at the birth. All interviews took place within Missoula County, which had a 3.9 percent rate of out of hospital births in 2006 (Office of Vital Statistics 2006).

Table 1. Frequency of Live Births by Location of Birth and Attendant at Birth Montana Occurrences, 2006

Provided by the Office of Vital Statistics, Montana DPHHS

<table>
<thead>
<tr>
<th>Mongolia Total</th>
<th>Total</th>
<th>Physician</th>
<th>Osteopath</th>
<th>CNM*</th>
<th>DEM**/Other Midwife</th>
<th>Other</th>
<th>Not Stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>12,488</td>
<td>10,386</td>
<td>95</td>
<td>993</td>
<td>205</td>
<td>800</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>12,102</td>
<td>10,374</td>
<td>95</td>
<td>911</td>
<td>5</td>
<td>713</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>4</td>
<td>-</td>
<td>49</td>
<td>23</td>
<td>12</td>
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<td>7</td>
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<td>-</td>
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<td></td>
</tr>
<tr>
<td>289</td>
<td>1</td>
<td>-</td>
<td>33</td>
<td>176</td>
<td>74</td>
<td>5</td>
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In 2006, Missoula had the highest rate of out-of-hospital live births at 3.6 percent for counties with over 1,000 live births with Flathead county following with a rate of 3.4 percent (Office of Vital Statistics 2006). Given the national rate of one percent out-of-hospital births per year, Missoula was an ideal site to examine how women choose to have a home birth and their perceptions of risk related to this choice because of its relatively higher out-of-hospital birth rate (Martin, et al. 2007). The Montana DPHHS listed the 2005 census-estimated population of Missoula County as 101,417 (Office of Vital Statistics 2006). Approximately a quarter of the Missoula County population is between the ages of 20 and 34 giving Missoula’s community a youth-dominated culture (Missoula Area Economic Development Corporation 2006). In addition, the University of Montana campus is located in Missoula, providing a center for education and culture.
in the community. According to information obtained from their web page, Community Medical Center is the only hospital that offers obstetric services in Missoula County; however, a recently opened facility, 'The Birth Center,' offers a home-like environment for birthing mothers without intervention or medications. Furthermore, in the state of Montana there are 20 licensed midwives, 7 of which reside in Missoula (Danison 2007).

**Methods & Research Population**

Prior to beginning any data collection, ethical clearance was obtained from the Institutional Review Board at the University of Montana. Women who had had or were planning to have a home birth were identified using a snowballing technique beginning with three separate contact references of women who had had home births. Three different contacts were selected to start snowballing from in order to prevent gathering data from women within the same network of friends or acquaintances; this method helps ensure a range of experiences. Women identified through snowball sampling were contacted and asked if they would be willing to participate in a study about home birth in Missoula. If they were willing, interviews were scheduled, usually at the participant’s home; however, some interviews took place in public parks or coffee shops. Prior to each interview, the research subjects read and signed informed consent forms. Following each interview, the women were asked if they knew of other women in the community who might be willing to participate in the research project. A total of 16 women were interviewed between June and September, 2007.

All participants were asked to fill out a brief demographic questionnaire at the end of the interview, which offers some quantitative characteristics of the population studied.
(see Appendix B and C). The home-birth interviews were semi-structured, but questions varied from person to person based on topics introduced by the individual (see Appendix A for sample interview questions). Interviews were audio recorded with participants’ consent, transferred to the researcher’s home computer and then deleted after transcription. Slightly over 16 hours of recorded conversation, with the average interview lasting 53 minutes, was transcribed word-for-word and imported into NVivo 2.0 for analysis. The average length of the transcribed interviews was 12 single-spaced pages.

The biggest difficulty encountered during the interview process was deciding whether to introduce myself to the participants as a nurse, an easily recognizable title in the community, or as a student, leaving out my role in the medical field. The prospect that informants might not feel comfortable talking about a decision that may be considered an alternative to a medical birth made me decide to leave this piece of information out of my introductions. Occasionally, I would discuss my occupation at the end of the interviews when the recorder was turned off. Most of the interviewees seemed somewhat surprised at first, although I did reassure them that my nursing experience lies outside of the realm of obstetrics.

I began the process of analysis by examining the transcribed interviews and coding them line-by-line for general concepts. Identification of over 100 initial codes in the interview content included topics such as 'influences in home birth choice,' 'social support,' 'birth story,' 'pain,' 'choosing a midwife,' 'risk perception,' 'preparation,' 'cost,' 'post-partum recovery,' and 'breastfeeding' to name a few. I organized codes and structured them around key concepts; for example, more specific codes such as 'risk of
medical complications' were placed under more general codes such as 'perception of risk.' After coding in this manner, and sometimes re-coding previous documents, themes were created from the data. Carol Bailey's description of thematic analysis states, "Simply put, themes are recurring patterns, topics, viewpoints, emotions, concepts, events, and so on. They may result from things that the researcher heard over and over. Often, themes are created during coding as similarities across cases are identified" (2007: 153). This analysis focuses on the most frequently coded themes that make up women’s interpretive repertoires regarding risk in the home birth choice. All of the women referred to as participants were given pseudonyms and will be referred to by these pseudonyms in order to protect their confidentiality. I made the effort to include quotations from the interviews in their complete and originally spoken form. Occasionally, small segments, superfluous words, or pauses in conversation were deleted. I encased any words I added to the quotations in brackets if needed to create more complete sentence structures.

**Description of Sample**

The average age of the participants in this study was 32, with ages ranging from 23 to 39, thus the sample was similar to the dominant population age group (ages 20 to 34) living in Missoula. Limitations of this population include limited ethnic diversity of participants, all of whom were either white or Hispanic, and the fact that half of the participants reported earning between $31-45,000 annual household income which is consistent with the median income reported for this age group by the U.S. Census Bureau (DeNavas-Walt, Proctor and Smith 2007). However, these limitations reflect the overall demographics of Missoula which is 94.4 percent White (2005) and had a median household income in 2004 of $37,172 (U.S. Census Bureau). By circumstance, some of
the women contacted who had been referred by others were pregnant at the time of the interview. Only one of the pregnant interviewees had not yet had a home-birth but was planning to have one. The other two pregnant women had had at least one child previously at home. Six of the women had experienced two home-births, while three women had one hospital birth and one home-birth. The remaining five women had one child who had been born at home. One interviewee had been transported to the hospital after attempting to have her first child at home, but after becoming pregnant again, delivered her second child at home. Another interviewee had had a Caesarean section for her first birth and then had a Vaginal Birth After Caesarean (VBAC) in her home for her second birth, and another had given birth at home but then had to be admitted into the hospital briefly to obtain assistance in removal of the placenta.

**Interview Analysis**

The following analysis builds from the body of theory on risk established by thinkers such as Mary Douglas, Ulrich Beck, Lisbeth Sachs, and Lupton and Tulloch as well as others. By looking through the lens of social constructivism, I was able to develop broad categories from the mothers’ interviews that make up their interpretive repertoires and construct a sociocultural reality for the home birth mothers as the social group of interest.

*Confronting Friends and Families Who Think That Home Birth is Risky*

According to anthropologist Robbie Davis-Floyd, dominant cultural norms in the United States support the normalcy of the hospital as the place of birth for the majority of American women. Likewise in my study, the societal perception of the choice to have a home-birth was considered to be a more risky decision than having a hospital birth. Friends and family members, representing the larger society, made several comments to
the participants in this study relaying their perception that home birth is risky. As Erin, 33, mother of 2 children born at home describes, telling her in-laws about the choice to give birth at home that she and her husband had made was rather difficult:

We told all of my family first and my family was kind of nervous but supportive and knew that I’m an adult and can make a decision. And [my husband’s] family was really kind of angry with us. They thought that we were being really selfish because of all the things that can go wrong. They live in New York and they’re very much like a fear-based culture and so they were quite taken aback. And I mean, they had never even heard of homebirth. Like, what was I thinking? Of course you go to the hospital. So we were really challenged by their thoughts and their kind of ideologies around birth but we just kind of held strong.

Erin and her husband were confronted by her husband’s family when they indicated their desire to have a homebirth. This decision was met with criticism and accusations of being selfish due to the perceived risks of having a home birth. Kathy, 39, mother of 2 children born at home also described how facing the dominant social norms was one of the hardest things about making the choice to have a home birth:

L: What do you think was hard about it?

K: I think the hardest part really is societal perception on what that means. Everybody has their own opinion about it, particularly if a woman and a couple has chosen to have it in their home. There's a lot of pressure, a lot of fear. There's a lot of fear-base from society in general, because it's just not the norm. So that's the hardest part to deal with, I found myself having to educate myself on my choices and the differences of hospital and homebirth and I felt like I was expected to educate everybody else on it. And I didn't want to do that. They needed to deal with their own fear about it and their own issues. And a lot of times people put those fears and issues, you know, they put them on me and it wasn't mine to deal with. So, figuring out how to deal with, you know, communicating with family members and friends on that was probably the hardest piece.

Some of the participants’ interpretive repertoires included explanations for why they thought family members were unsure of their decision to have a home-birth. For instance Beth, a 30-year-old mother of one child born at home stated, “I think my mother-in-law
was a little bit wary because she’s pretty much a hospital person. But we’re not that close
to them anyways, so that doesn't really affect me.” In Beth’s case, it seems like worry
from family members may have affected Beth and her husband more if they were
considered ‘close’ relatives.

Andrea, a 31-year-old mother of one child who was pregnant and planning to
have her first home birth discussed how the perception of risk varied in her social
network. Due to her profession as a nurse in a hospital Andrea had encountered the
perception of risk from acquaintances while at work:

L: Did you encounter any reactions from others that seemed disapproving or…?
A: Yeah, like at work it was pretty mixed and I was surprised that it was mixed.
That there were people that were supportive, because having talked about home
birth options with some of the nurses [I thought] that their sense was like, why
take the risk? A lot of people consider it risky. But people have been supportive
to me - but they’re people that I know that I’ve had that conversation with - I
know how they feel about it. Not that anyone said to me ….because I don’t think
anyone , but I do know that people feel pretty strongly about it. Several people
that I work with feel fairly strongly about that. That it’s a risk for the baby
mainly. That why would you take [the risk]?…and that was the one thing that I
had to come to terms with.

Andrea was surprised that several of her co-workers were supportive of her decision to
have a home birth, as she knew that it was not what most of them were used to hearing
about. Andrea recognized that many people felt she was compromising the safety of her
baby. She responded to this by assuring herself of the equipment that the midwives’
brought with them to the birth, “It wasn’t a life-threatening situation for me to get to the
hospital - and interventions and whatever - that would be fine I’m sure. But for a baby,
maybe not. So having the oxygen and suction and that sort of stuff at home made the
difference for me.”
The majority of participants did not feel that having a home birth was inherently risky, and in this respect, mothers choosing home-birth represent a viewpoint that is different from the societal norm reflected in the previous excerpts. For instance, Mandy, 32, a mother of two children born at home, described how her and her husband’s reputation among their social network of friends and family was helpful in assuring them of the safety of their decision:

L: So did you ever feel like you were challenged by some of the people? You said you were the only person that had had a homebirth - by others who maybe weren't familiar with that?

M: Did other people like, question my decisions and things? I guess it came up once or twice - not as much as I had anticipated that it would - for the most part, we have a lot of support. I felt very strongly that people who cared about us trusted that we were intelligent, thoughtful folks who were thrilled about starting a family and wanted to only make a decision that we thought was best for the baby. A couple of times that we were questioned I was more than willing to provide information for folks who were curious and not informed about home birth, and were - wow I've never heard about this! You know? Absolutely. So it felt to me and it turned out to be true that people who knew us would say well, I may not understand this, but I know Mandy and Greg, and this must be a good way to go, because Mandy and Greg wouldn't make a decision that was compromising safety.

Although Mary Douglas (1990) argues that groups of people who do not follow cultural norms in an individualist society tend to be pushed aside or forgotten about, the sense from the interviews that I conducted was that home birth mothers did not encounter too much difficulty in obtaining and maintaining social support from friends or relatives regarding their decision. However, this may be due, in part, to the fact that some mothers admitted to being selective in who they talked with openly about the decision to have a home birth. For instance, Leah was a 33-year-old mother of two children whose first child was born in a hospital birthing center and whose second was born at home. Since
Leah’s husband worked in the medical field, she was careful about who she discussed having a home birth with:

L: Oh really did you keep it [your decision to have a home birth] private…?

Le: I didn't keep it a secret. But like, for example, my husband's coworkers - like the doctor he worked for - we didn’t have to tell them that we were having a homebirth! Everyone assumed that we were having a hospital birth until after the fact. Like, ‘oh how long did you stay [at the hospital]…?’ Oh, we had him at home. Like, ‘oh!’ We just didn't advertise it because we don't want to deal with what other people's baggage around that was like. We don't need to hear it. It doesn't help us. It doesn't. That doesn't help shape your experience to hear other peoples’ like, ‘oooh.’ …I don't think we were being dishonest about it. I think we just sort of thought about who it was important that we talked to about this - particularly [with] the medical community.

The mothers in my study individually confronted the social perception of home birth as risky by constructing their own interpretive repertoire about why home-birth was a better option for them despite encountering challenging viewpoints from various members of society. These interpretive repertoires were found to contain some recurring elements, which I discuss below.

Redefining Risk: Hospital Births as Riskier or More Problematic than Homebirths

A majority of the participants reflected on the many problems with hospital-birth being the norm in the United States. In fact, most of the participants felt that having a baby in the hospital setting was a more dangerous or riskier choice than home-birth. To prove their point, women generally focused on certain types of problems that they viewed as negative in the hospital birth experience. For the home birth mothers, the perceived likelihood of these problems occurring in the hospital setting was more of a risk than the risks of having a home birth. For instance, several of the participants interviewed discussed how the time pressures in the hospital setting may jeopardize a woman's efforts
to have a natural birth without medical interventions. Lindsay, 34, mother of one child born at home, described how in the United States, the tendency to want things to happen efficiently in hospital births can increase the incidence of birth interventions:

L: Do you think that there are things missing from the current way we look at labor and birth in the medical system from your experience with homebirth midwifery?

Li: Um, I think there's just a raw human element that birth is nitty and gritty and hard but it's totally natural. And we live in a society where we want to rush things along and your kids grow up fast. Do everything fast, get it over with. I just feel like that's where the intervention comes along - just to mess with your labor in the hospital.

L: Hurry things along…

Li: Yeah or - oh, she's been pushing for 10 minutes, we'll just - [cut an] episiotomy.

Lindsay's sentiments were also reflected in other comments made by mothers who chose home-birth. Some women noted the midwives' use of various techniques such as oils, perineal massage, and positioning in order to aid in the birth process versus the more invasive surgical techniques employed by obstetricians in the hospital setting. For the home birth mothers, the use of 'unnatural' techniques for aiding in the birth process was considered a risk and undesirable. As Vera, 29, a mother of 2 children born at home described it:

…Another thing that my midwife did that I know doesn't usually happen at the hospital is that when he was crowning, she did like hot compresses with hot water and also she massaged with oil just to try to stretch the perineum. Just so that there is less of a chance for tearing and I mean, I tore anyways with [my first son]. I didn't with [my second], but I know that at the hospital they don't usually do that and I was wondering why because it's not a big... It's not hard to do or whatever and it can make a big difference.
Sonya, a 23-year-old mother of one child born at home who was pregnant and planning a second home-birth discussed her interpretation of the risk of hospital births and what she felt was being lost in the current system of obstetrics:

L: Do you think with our current medical system and obstetrics - do you think things are being lost?

S: Yeah, I don't think doctors… I mean, I think they’re really really knowledgeable in helping women with complications if the mom is about to die or if she's in real danger. But I think that it's a lot safer to have your body just do what it's going to do. If you want to be at a hospital fine. They have like a time-frame at the hospital where if your water breaks and 24 hours later, the baby's not born, you automatically have to have a C-section. If you're not dilating like 2 cm every two hours, you've got to get started on drugs. So you know, that's pushing it - but if your body doesn't do this for three hours and then the next two hours you [dilate] 5 cm… So it's not like labor has a schedule, you know?

For Sonya, conforming to the schedule set by hospital protocol was not worth the risk of being pressured to use drugs or surgical interventions to speed up the labor process.

Although Sonya verbally acknowledges the ability that doctors have to help women in ‘real danger,’ her interpretive repertoire stressed the importance of being able to allow her birth to happen at a natural rate was more important than risking having a Caesarean section if her birth was not progressing at the rate determined by hospital protocol.

Hospital Settings as Disempowering

In addition to the mother’s perceived risks of intervention in hospital birth, home birth mothers interviewed for this study also expressed concerns about the risk of losing control or being disempowered in the hospital setting. Many of the mothers spoke about their desire to have their babies without the use of medication or anesthesia. Some mothers described the risks to the health of the baby when drugs are used to aid in labor. Furthermore, taking pain-killers during labor was generally viewed as the first step that
starts the spiral into the use of more and more medical interventions during birth. Kari, 32, a new mother who had her first baby at home in November of 2006, described how the concept of having to write a detailed birth plan prior to having a hospital birth seemed indicative of a lack of control in that arena:

Yeah…it's just, everybody I know who was having a baby in the hospital was writing these extensive birth plans that were like 10 pages long. You know, ‘If I'm really in a lot of pain, please do this, please do that, please don't offer me this.’ It just seemed really - just scrounging to have some control over it. So it led me to believe - I've never had a hospital birth so I can't speak firsthand - that you don't have control.

Beth also discussed her feelings about how modern medicalized birth has taken away women's instinctual control over the natural birth process:

…I just think Western medicine is really sad in general, because it kind of strips away our natural instincts and our natural ability. I think that's one of the biggest things. It's like women are afraid of our natural ability to give birth. You know - their doctors feed them with fear. And when they start having pain, it seems like it's really common for doctors to be like, ‘oh we don't want you to be in pain let’s just give you an epidural,’ and it just feels like it deadens the natural ability to do what nature intended. And I think there's also something really special about the natural birth process without having to have any medication. Just that connection that I felt with [my baby] and the naturally euphoric high is really special.

Similarly, Erin’s interpretive repertoire discussed how women’s desire to be pain-free during birth led to a disconnect and loss of women’s empowerment in birth:

…We've become so disconnected from birth, like so much of American culture and cesarean rates and drug intervention, that we don't even want to feel birth anymore. We just want it to be done. We don't want to feel the pain. We don't want to risk anything going wrong so that connection to like what homebirth and what natural birth is, is receding from women’s lives. And it's just so interesting to think about how that path has evolved. Like in the beginning, we had no hospitals, and no interventions and midwifery and homebirth. And we grew into this culture where women were just knocked out and just given gas and they woke up and their babies were there - to this high cesarean rate right now. But [there's] a real push for women to do natural childbirth, and birth centers [are] opening and so it's just interesting to me. And I can't even believe that people schedule cesareans now - women - just because either they had one before, and they don't
think they could do a VBAC, but they just think it's easier to just have an operation and get your baby out [rather] than going through labor. And that to me is pretty sad that people don't want to be in touch with that. And I think, again it's like not knowing and being so out of touch with birth and the empowerment of birth, and how great of an experience it is.

Beth and Erin's concerns about vaginal birth becoming obsolete in the hospital setting represent a set of values and personal beliefs that contribute to their interpretive repertoires explaining their home birth choice. For them, the risks of hospital birth include a loss of control and the risk of women becoming disempowered from the embodied knowledge of natural birth. Erin also discussed her opinion that in our technological age with the prevalence of risk being used as a forensic resource in society, it is difficult to tell someone that they should have a home birth:

We’re given a lot of fear around birth -around everything you know? And I don't think anybody should be judged for that. You know what I'm saying? We've been taught yeah, a safe place to go is the hospital. They have the tools they have this and that and the machines. And we've been taught to trust that over other things. And we're so far that way in society, I mean we have air bags, every little thing is safety. Like, to trust technology is being safe - we equate it with safety and so once you've gone that far in society I think it's really tough to say oh, you should have your baby at home to somebody…. I'm certainly not going to look at anybody who chooses not to do that and try to convince them.

Several of the mothers recognized the reality of home-birth being perceived by others in society as risky, and as a result, many participants said they would never try to convince someone to have a home-birth unless they were genuinely interested.

*Home-birth as a risk worth taking*

In their article which re-assesses the use of fatalism as an appropriate category for describing health behaviors in the popular culture (1992), Davison, Frankel and Smith stated: “…individual ignorance of the main epidemiologically identified behavioral health risks is very rare. Rare also is the strong belief that health and illness lie totally
inside or outside the realm of individual ignorance” (Davison, Frankel and Smith, The limits of lifestyle: Re-assessing 'fatalism' in the popular culture of illness prevention 1992, 677).

Likewise, home-birth mothers in my study were not unaware of the inherent risks and potential complications of birth. Several of the mothers described how they or their husbands had researched the statistics of home-births. During her interview, Julie, a 39-year-old, a mother of two children born at home referred to her knowledge on the social perception of risks of home-birth:

I felt pretty educated and pretty confident about my education …. I feel like a lot of people get into you know, your baby could die if it's a homebirth or something. And that's really like, if you look at, which I don't know off the top of my head - but if you look at the rate of death in home births and things like that, it's very low. And so there's kind of a just a fear around that that people have and then there's reality.

Home-birth mothers used their knowledge of science and statistics to describe hospital birth in a negative light. Lindsay described how she knew that the percentage of home-births was much higher in other areas such as Europe:

…I think it's over 70% and then the amount of infant mortality is so much smaller in countries where they have homebirth versus hospital births…. It's like you never hear those statistics, they’re not mainstream statistics, like in a world based on fear when everyone depends on the medical world, and we think they can fix everything.”

As described by Lupton and Chapman (1995), people presented with conflicting information regarding risk often default to their own personal belief systems. After consulting the accessible studies, many mothers in my study concluded that risk had to be determined individually.
Instead of focusing on the potential risks of home-birth, women in this study expressed a confidence in their personal health and lifestyle, which they translated to a confidence in the outcome they expected for their pregnancy. As Emily said, “I didn't even have any fears it's almost like if you think too much about it, it scares you too much. So I just trusted my body, and that the pregnancy was healthy and that the baby was going to be fine.” Erin echoed this sentiment when she stated, “…I didn't do an ultrasound with the first pregnancy, and I don't know, I guess I just kind of had faith that I was healthy [and my husband] was healthy, and we lived in a fairly healthy environment, and you know, we wanted to have a baby.” Erin also described how she knew several people who had had false positives with pre-natal testing and this knowledge helped her to “just kind of put faith in that things would work out. Kind of the same way that you do by saying, I want to do a homebirth.”

Some of the home-birth mothers compared the choice of home-birth to a personal challenge like that of an adventurous sport. Similar to Lupton and Tulloch’s (2002) study, many of the women in this study described positive aspects of taking risks in life, as well as in birth. The experience of having a home birth made many of the women feel more confident in themselves and ready to encounter new challenges more easily. Leah discussed how her decision to have a home-birth was her ‘own personal marathon’ which helped her see herself differently:

It's a powerful experience. And I think on some level, not on a public level, not on like an egotistical level or anything, not on a level that I would share except for maybe talking to you or something, but it changes my perception of myself too….Like, I feel like I can push myself harder, like when I'm on a mountain bike ride, because I'm capable of so much more than I believed I was before….you've proven on a level, a much higher level of endurance than you ever thought you
could handle before. [I’m] a little less wimpy than I used to be. Maybe. Not that I thought I was a wimp before, but like oh yeah, I can handle it, I can handle it.

Leah felt more confidence by challenging herself to face her fears of having a home birth. Her confidence increased her belief in her ability to face other challenges in life which in turn, changed her perception of herself. Cora, a 33-year-old mother of one, also felt differently about herself after she gave birth at home. Her description of the feelings she had afterward admit the difficulty of the experience, as well as the intense feelings she had of being able to ‘do anything’:

L: And how was it for you afterword?

C: Oh god, I was appalled! First of all, my recovery physiologically was really hard there for the first week. I'm hoping that doesn't happen for the next one. But at first, I was just totally disturbed at how hard it was. And then a couple of weeks later that same exact thing starts to fade. And then a couple months later, you're like oh I could do that again. And then you just start to have this overwhelming - I think for me in daily life it’s like, you know, I did that - I can do anything. I just think it influenced my life more like that, because if you survive some crazy experience, in a way it makes you feel stronger. So that's kind of what it did for me. Although - I’m not necessarily looking forward to the painful part of it - but in the recovery, I'm shooting for a better recovery.

At the end of her interview, Monica, a 36-year old mother expecting her second child whom she planned to have at home, emphasized her feelings on why home birth was such an important choice for women to have.

M: …I think the only problem is again, as a feminist, I think it’s [homebirth] the final frontier. Or one of them, there might be more, but it’s one I see in front of me right now. You know - we do so much work to empower ourselves and to trust ourselves and to love our bodies. And this constant struggle we have in accepting ourselves as who we are and trusting ourselves and our strength. And knowing that we’re strong and knowing we’re capable and that we’re not inadequate.

Monica’s final word on the powerful effects that choosing home birth can have on the women making the choice underscores the positive aspects of risk-taking in the lives of
individuals. In contrast to her first baby being born by caesarean, Patty, a 30-year-old mother of two, emphasized the intensely positive experience that she had giving birth to her second baby at home.

L: How did it feel after that second birth, how did you feel?

P: Great, like I just had accomplished, you know, like it was the greatest feat of my life. Probably. I think it was also because the first time around, I felt like I was kind of robbed of something. I personally hadn't done it. Like, I just didn't feel like I had really accomplished what I wanted to accomplish. [The midwife] told me too, that there are a lot of cultures where a woman doesn't become a woman until she gives birth. Basically, like that's when she becomes a woman. She was like, ‘getting your period is easy,’ and I'm like yeah compared to pushing a giant baby out, it's quite a bit easier! But it really made me feel like I had done it. I felt amazing - just really strong.

Discussion

A large body of anthropological work examines cross-cultural comparisons of birth and reproduction, while contemporary studies have taken a closer look at current birth practices and technologies. Kirsi Viisainen’s (2000) study on home birth risks was unique in that it applied sociocultural theories on risk pioneered by thinkers such as Mary Douglas specifically to a qualitative analysis of home birth parents. My study expanded on Viisainen’s work by examining the interpretive repertoires of mothers who choose to have home births and how these repertoires address the topic of risk. The sociocultural constructs that surround the ideas of risk in birth in the United States were predicted by Mary Douglas (1990) in her discussion of risk as a forensic resource. The warnings of danger from social institutions, authority figures, public health messages, friends, family members, and coworkers make up the constructs of risk that home birth mothers face.
However, as this study indicates, home birth mother’s interpretive repertoires construct a reality with a different emphasis on the risks of birth.

The interpretive repertoires analyzed in this study offer a subtle level of understanding often missing from aggregate studies of birthing decisions and risks. My analysis of the interpretive repertoires of home birth mothers in Missoula, Montana paints a picture with several main elements. First, the mothers confronted the dominant social norm that home birth is risky. The women interviewed encountered some warnings of the danger of home birth from family members and people in their social networks. Still, the mothers I interviewed maintained that they had a strong base of social support, either by family members or spouses who were positive about the decision, friends who had had home births before, or from the midwives and birth assistants themselves.

Secondly, although the cultural norm seems to be that having a home birth is risky, women interviewed for this study tended to associate birth risk not with home birth but with having an overly medicalized birth in a hospital. Lisbeth Sachs (1996) described how people encounter risk messages from many sources in the media but interpret the messages in a variety of ways resulting in individual levels of vulnerability to these risks. Although many of the mothers I interviewed were aware of medical studies reporting the various risks and complications of child birth, this information did not seem to represent a level of vulnerability that could outweigh their personal belief systems regarding home birth. Many of them described how in the hospital, the pressures of time constraints, interventions, and medications were a risk to the possibility of having a natural birth. Mothers discussed how some of the midwifery techniques used to assist with natural birth may be disappearing in the realm of obstetrics. As theorized by Robbie Davis-Floyd
(1990), a technological birth can be interpreted as an important ritual in American culture that emphasizes the authority of science and technology. Women in this study did not desire to have a medicalized birth, which they viewed as risky or otherwise problematic, and placed greater emphasis on the importance of natural birth.

A final element of the home birth mother’s interpretive repertoires describes the positive effects that making this ‘risky’ decision had on their lives. Lupton and Tulloch (2002) described how for some people, risk can be a positive lifestyle factor by extending and challenging the self. Similarly, some of the women in this study reported feeling very positively about their home birth experiences citing feelings of confidence and empowerment. Interestingly, home birth mothers interviewed varied in their perspectives on having a baby in a medical facility. Despite their varied opinions on hospital birth, nearly all of the mothers agreed that having a home birth was a ‘personal choice’ and that they would never try to convince another person that they should do it.

By examining the interpretive repertoires of home birth mothers in Missoula, Montana, one can begin to understand how women interpret their individual risk concerning birth and respond according to their determined level of vulnerability. In response to accusations of making a risky decision, these home birth mothers responded by emphasizing the risks that they see in hospital birth. For home birth mothers, the importance of having minimal medical interventions during the birth of their baby outweighed other potential risks associated with homebirth identified by medical authorities or published studies. Home birth mothers were able to counteract these risks by doing their own research that reinforced the safety of home birth and gave them confidence that they were making the right moral choice.
Mary Douglas (1990) described how liminal groups in a competitive society are often ignored or forgotten about. Home birth mothers may be considered a liminal group within society due simply to the fact that they are so outnumbered by women in the U.S. who choose to give birth in medical facilities. Indeed, some of the women interviewed chose not to discuss their choice of birth place choice with a wide group of people until after the birth. Home birth mothers were able to conceal their plans with those who might disagree with them and tended to share their decisions with close family members or those who were supportive of their home birth. Similar to Viisainen’s (2000) study, this study shows that the home birth mothers in Missoula defined birth risk differently from the general social norm and the public health messages from the medical community.

Examining how risk is individualized is a useful factor to consider for those who seek to distribute messages warning of such risks. Levels of vulnerability and perceptions of morality and ethics involved in risk-taking choices are significantly associated with personality and lifestyle factors. The shared values around birth such as a naturalistic view of health, feminist values, and women’s empowerment were a significant factor for this group of home birth mothers in constructing their interpretive repertoires around the choice to have a home birth. In the future, studies consider asking women more specifically about lifestyle factors and which ones are most important to those who choose to have a home or hospital birth. Also, further studies might consider conducting a qualitative analysis on mothers who give birth in the hospital in order to examine their knowledge of home birth options and considerations of birth risk.
Bibliography


Danison, Sandhano, interview by Laura St. Clair. *In-Depth Interview* (August 8, 2007).


Appendix A

The following questions are examples from the interview guide I used which was intended to provide some structure to the interviews. Questions were often changed, left out, or added during the course of the data collection.

1. Can you describe what led you to make the decision to have a home birth?
   Probe: What or who were the main influences in your decision?
   Probe: Which was the most important influence?
   Probe: Was cost a factor in your decision to have a home birth?
   Probe: Who did you tell about your decision to have a home birth? How did they react? What did they say?
   Probe: Did you search for a birth attendant? What type? Why?

2. When you were preparing for your home birth, did you ever perceive or have any concerns about risk? (For you, for the baby, for your husband, friends...etc)
   Probe: What kind of knowledge did you have regarding risk in home birth?
   Probe: What were your personal beliefs concerning risk?
   Probe: How did you prepare yourself for the birth despite those concerns?
   Probe: Did anyone try to talk you out of having a home birth?
   Probe: Who was most concerned about risk? What were they most concerned about?
   Probe: Were there any other sources of information you encountered regarding risks or dangers of home birth?
   Probe: What was the biggest risk factor that you were concerned about?

3. Can you describe your home birth experience?
   Probe: What did you do first, who did you contact first?
   Probe: Who was present at the birth?
   Probe: Did any problems arise, if so how were they handled?
   Probe: How did you feel during the experience? After?
4. Do you feel the same about risk now after having gone through the home birth experience?
   Probe: Have your feelings about risk changed/stayed the same? Why/why not?
   Probe: What would you say to other women considering home birth as an option?
   Probe: Would you have any advice to offer them?

5. Are there any other important points about home birth that we haven’t already covered?

6. I am trying to contact other women in the community who might be willing to share their home birth experiences with me. Do you have any suggestions of others who might be willing to talk with me?

7. Do you have any questions you would like to ask of me?
Appendix B

Demographic Questionnaire

1. Age:_____________________

2. Highest level of education (check one): some high school
   high school diploma
   some college
   college degree
   some graduate education
   graduate degree or PhD

3. Marital status (check one): Single ☐
   Married ☐
   Cohabiting ☐

Approx. Annual Household Income
(check one): less than $15,000 ☐
$15-30,000 ☐
$31-45,000 ☐
$46-60,000 ☐
$61-75,000 ☐
$76-90,000 ☐
over $90,000 ☐

Ethnicity: _______________________

Current Occupation: _______________________

Spouse/Partner’s Current Occupation: _______________________

Religious Preference (if any): _______________________

38
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<th>Home or hospital birth?</th>
<th>Type of birth assistant (i.e., cert. nurse, midwife, physician, lay midwife)</th>
<th>Birth assistant licensed? (y/n) Type of license? (if known)</th>
<th>Type of health insurance coverage for birth (or none)</th>
<th>Did insurance cover home birth? (all, some, none)</th>
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Appendix C

Results of Specific Items from Demographic Questionnaire

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*Names have been changed to maintain confidentiality.