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*I*NTERSECTIONALITY AND *C*HILDBIRTH: *H*OW *W*OMEN FROM *D*IFFERENT *S*OCIAL *L*OCATIONS *D*ISCUSS *E*PIDURAL *U*SE*

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Abstract: Analyzing unpublished primary data from two separate qualitative studies, the authors employ an intersectionality framework to compare the experiences of two different samples of birthing women. Examining commonalities and differences in how women perceive and decide about epidurals in the hospital setting, the authors argue that feminist critiques of the medicalization of childbirth should be expanded to address race, class, and age as structures of oppression and privilege that shape women's reproductive experiences. Findings are based on qualitative analyses of 19 interviews with predominantly White, middle- to upper-class women in a Mid-Atlantic state and 51 interviews with African American teens in a Southern state. Generally, Southern teens emphasized medical risks associated with the epidural and based decisions to forego the epidural on concerns about their wellbeing. Alternatively, Mid-Atlantic adults defined the epidural as a safe way to avoid the pain associated with childbirth and subsequently chose to use the epidural. The findings challenge many feminist critiques of medicalized childbirth, suggesting that conceptual approaches that focus only on gendered oppression and women in privileged locations fail to fully explain the birthing experiences of diverse groups of women. The authors conclude that understanding women's perceptions of and decisions about epidurals (as well as other aspects of childbirth) is only possible if we pay attention to commonalities and differences among birthing women. This article is an exercise in how to move beyond gender and compare diverse women's childbirth experiences.

Keywords: childbirth; epidural; intersectionality; social location; race; class; age; qualitative research

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Intersectionality approaches, approaches that focus on understanding the multiple and cross-cutting systems of oppression and privilege in social life, have steadily made their way into a number of social science disciplines, and have been applied to a number of theoretical and empirical issues. While we applaud these advances, we recognize that there is still much work to be done to expand the reach of this framework in order to better understand how all aspects of social life are structured by oppression and privilege. First, we believe that these approaches have not been applied fully in the study of health. Second, we believe that scholars have forgone ample opportunities to collaborate in intersections research and to analyze each others' data for similarities and differences; thus we suggest that there is much more room for scholars engaged in separate research projects to work together in creating intersections analyses. In this article, we present an empirically-based argument for the importance of a race, gender and class approach to understanding how women experience medicalized childbirth, based on unpublished data from qualitative interviews in two separate studies (one done by each author). We hope that this article serves as a reminder that intersections analyses can improve our understanding of women's health experiences and can allow scholars to go back to unpublished original data and look at it with a new, collaborative lens.

While feminist critiques of medicalization and qualitative studies of women's childbirth experiences have contributed enormously to our understanding

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of the patriarchal construction of childbirth as a gendered process, the continued focus within this area of scholarship is on middle class, White, female adults. The bulk of literature on childbirth still remains focused on a generic or uniform category "woman," and ignores how various social locations interact with gender to affect women's experiences. In agreement with many contemporary feminist scholars, we argue that we cannot fully understand gender (or any other social location or inequality, for that matter) until we analyze how gender experiences are simultaneously experienced with, filtered through, and influenced by race, class, age, sexuality, national origin, and other social locations (Baca Zinn & Dill, 1997; Weber, 2001; Collins, 1991; Ore, 2000; Andersen & Collins, 2004).

Not only do we know little about any birthing women besides those who are White, middle-class adults, but also we lack knowledge about how this group of women compares to any other. Most existing studies—even when they focus on groups other than middle class White women—focus only on one group of women; the rare exceptions include studies of the social class locations of childbearing women, and a comparison of African American versus Jewish motherhood (e.g., Nelson, 1986; Armstrong, 2000; Zadoroznjy, 1999; Litt, 2000). Little attempt is made within single research studies or across multiple research studies to compare and contrast varying types of childbirth experiences and types of birthing women to find differences and commonalities among those experiences. This article represents a unique attempt, in that we compare and contrast the birth experiences of two separate groups of childbearing women: one sample of lower income, African American teens in the South and one sample of middle class, White adults in the Mid-Atlantic States. In writing this article, we suggest that it is in the comparison of different groups' experiences and the acknowledgment of intersecting social locations that we truly begin to understand a gendered experience like childbirth. Essentially, we must employ intersectionality in our analyses in order to see gender more fully, as well as to begin to see how race, class, and age work in conjunction with gender in the birth setting.

CONCEPTUAL FRAMEWORKS

Many scholars have analyzed the medicalization of childbirth, the normalization of technological forms of childbirth, and the loss of control and choice women experience in the hospital birth setting. Because the feminist literature on medicalization guided both of our studies, and generally frames women's discussions of epidural use as the most commonly-discussed feature of medicalized childbirth, we discuss this scholarship as one of the conceptual frameworks guiding this analysis. Following this discussion, we highlight specific features of the intersections approach that are most relevant to our analysis and argument.

The Medicalization of Childbirth

Much of feminist scholarship has focused on the medicalization of

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women's bodies and their biological processes. The social construction of women's biological processes (and therefore labor and childbirth) is based on definitions of women as "different" from men, what Zita (1997:193) deems the "baseline problem" (Lorber, 1998; Riessman, 1983). Biology formed the basis for gender ideology, and "science" "proved" that women and men were "different" (Lorber, 1998). Over time, men's control of the practice of science, their development of technology and their establishment of modern medicine[1] caused women's ["healthy," "normal," "natural"] reproductive processes to be constructed as "pathological," "abnormal" and "unnatural," or at least in need of continual monitoring (Zita, 1997; Martin, 1992; Riessman, 1983; Woods, 1999).

Medicalization represents the core of the biomedical perspective of women's "difference." Riessman (1983:4) defines "medicalization" as the process by which behaviors or conditions take on medical meanings—"that is, defined in terms of health and illness" (see also Martin, 1992). It is a process in which "medical practice becomes a vehicle for eliminating or controlling problematic experiences that are defined as deviant, for the purpose of securing adherence to social norms" (Riessman, 1983:4).[2] Thus, pregnant and birthing women must consult "experts" to understand experiences that historically they understood better (Leavitt, 1986; Wertz & Wertz, 1977; Davis-Floyd, 1992; Oakley, 1984; Martin, 1992; Rothman, 1989).

Research on the medicalization of childbirth focuses on its effects on the nature of women's childbirth experiences, and how women lose control over the birth experience within the U.S. hospital setting (e.g., Leavitt, 1986; Davis-Floyd, 1992; Kahn, 1995; Wertz & Wertz, 1977; Eakins, 1986; Arney, 1982; Romalis, 1981; Oakley, 1984; Jordan, 1980; Martin, 1992; Riessman, 1983; Probyn, 1993). Many scholars have argued that childbirth has been co-opted and transformed by medicine through the normalization of hospital birth and the creation of technology that monitors the course of birth (Riessman, 1983; Davis-Floyd, 1992; Leavitt, 1986; Oakley, 1984; Martin, 1992; Wertz & Wertz, 1977; Kitzinger, 1988; Litoff, 1978; Romalis, 1981). Faced with readily available technology and health care providers who are trained in using this technology, women lack true choice over whether a procedure is used in the hospital birth setting (Probyn, 1993).

Feminist researchers have made important contributions to our understanding of ways in which the medicalization of childbirth has impacted women's experiences of hospital birth, yet only recently have they begun to present women's own views of medicalized childbirth (e.g., Davis-Floyd, 1992; Fox & Worts, 1999; Martin, 2003). Recent studies suggest that women often adhere closely to a medical model for birth and do not question the use of particular procedures in the hospital setting. For instance, although medicalized childbirth can involve a number of interventions, including fetal monitors, labor inducement (through Pitocin or a similar drug), episiotomies, cesarean sections, the administration of IVs (for pain-relief, inducement, hydration or other reason), and epidurals, many women seem to differentiate between natural and medicalized birth

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based on the absence or presence of analgesia or anesthesia (Davis-Floyd, 1992; Fox & Worts, 1999). Specifically, when women prepare for and experience childbirth, they focus their decision-making abilities on whether to avoid pain or pain-relief medications. Women often regard this decision as the only choice they have in the hospital birth setting (ibid.). This finding in itself illustrates the embeddedness of medicalized childbirth in U.S. culture, since women do not question the use of other technologies during birth.

While we are beginning to understand how embedded medicalized childbirth may be within lay culture, little research has been done on how women discuss specific technological procedures that may be used during labor and delivery. In light of the fact that women seem to focus on the choice for or against pain-relief medications, we need to explore exactly how they go about making the one choice that they feel they hold in the hospital birth setting. An examination of the meanings that childbearing women assign to specific pain relief medications—for instance, the epidural—can help us understand more deeply how the medicalization of childbirth affects women, and how certain groups of women may be affected differently than others based on their social locations.

Intersectionality

Although most readers are likely familiar with this conceptual framework, in this section we identify the particular features of the intersections approach that are most relevant to our argument for the need to apply this framework to research on women's experiences of medicalized childbirth.

The main argument proposed by the intersections conceptual framework is that individuals do not share equal opportunities or equal conditions of living (Garey & Hansen, 1998; Baca Zinn & Eitzen, 2002; Weber, 1998; 2001; Ruzek et al., 1997). Individuals' and/or groups' access to resources, opportunities and power are structured by their particular "social locations" defined by race/ethnicity, class, gender, sexuality, age, national origin, and other social structures of oppression and privilege. These structures occur simultaneously as they shape individual and group experiences (Weber, 1998; 2001; Collins, 1991; 1998; Andersen & Collins, 2004; Baca Zinn & Eitzen, 2002; Baca Zinn & Dill, 1997). Feminist critiques of medicalization that focus only on gender as a structure of oppression neglect the significance of racism, classism, and other forms of inequality.

Axes of inequality (e.g., gender, race, class) have not been defined in the same way throughout time and place but rather "have changed as part of larger economic, political and ideological processes, trends, and events" (Weber, 1998:16; see also Baca Zinn & Eitzen, 1999). Although this applies to all axes of inequality, a particularly salient example relevant to this article is the category of "age." The childbirth experience is defined very differently, both by the culture at large, and by mothers themselves, depending on the age of the mother, especially in the case of teen pregnancy. Based on current cultural norms around pregnancy in the U.S., where adult women are privileged by their age, teens are oppressed as they are

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viewed as deviant and denied access to resources on the basis of their age.

Systems of inequality operate simultaneously. In other words, most of us occupy both privileged and disadvantaged locations at the same time within different social structures. A person might be White, female, and poor or an individual may be male, Black and heterosexual at the same time. Thus, some opportunities may be available based on one of our locations, yet other opportunities may be limited based on another. Depending on the specific combination of our race, class, gender, age, and sexuality, our reproductive experiences can be both oppressive and an opportunity for resistance (Collins, 1991; Weber, 1998; Lopez, 1993; Witt, 1994-5; Hondagneu-Sotelo et al., 1997).

Finally, race, class, gender and other relations based on inequalities are "embedded and have meaning at the micro level of individuals' everyday lives as well as at the macro level of community and social institutions" (Weber, 1998:21; Baca Zinn & Eitzen, 1999). For example, an interaction between two individuals and a structural change in the availability of jobs can reinforce race, class, or gender hierarchies. Thus, macro- and micro-level sources of inequality work separately and also combine forces to perpetuate systematic differences in achievement and success among groups (Weber, 1998; Baca Zinn & Eitzen, 1999). Here we can see the possibility of looking at individual women's reproductive experiences as well as the larger structures that constrain them (e.g., the medicalization of birth in the hospital setting, as well as race, class, gender, and other systems of inequality), as well as the interconnections between experiences and structures.

In this article, we explore women's narratives about the epidural decision as one example of medicalized childbirth, and argue that in order to more fully understand women's experiences of medicalization, we must employ an intersections approach that addresses multiple axes of inequality including race, class and age, as well as gender. Comparing previously unpublished primary data from our two separate qualitative studies, we can begin to understand birthing women's decisions more fully when undergoing a race, class, age, and gender analysis of their decisions within the hospital setting, and we encourage other scholars to embark on similar, collaborative endeavors that push the boundaries of literature on health.

LITERATURE REVIEW

Intersectionality and Reproductive Experiences

In general, researchers employing intersections approaches have not studied childbirth, although many have examined other reproductive experiences. For instance, Loretta Ross (1993) focused on African American women's experiences with abortion (including her own), dispelling the myth that African American women have been strictly against or in favor of abortion throughout history. Scholarly work on infertility describes the enormous emotional burden and

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social stigma that infertile women *and men* have accepted in their reproductive lives and their interaction with a "fertile world" (Griel, 1991). Sue Fisher (1995) reported the unequal nature of doctor-patient communication in the hospital setting, interviewing diverse groups of women on how these interactions impacted their reproductive lives. Research by Iris Lopez (1993) detailed Puerto Rican women's experiences with forced sterilization in New York City yet also how these women sometimes used sterilization to their own advantage. Laura Gomez (1997) conversed with women who were convicted of exposing their fetuses to illegal drugs, such as crack cocaine, and studied how they were treated by a male-biased criminal justice system. According to bell hooks (1998), alliances with men of their same race are more important for African American women than alliances with other women around parenting issues (and many other issues for that matter). Discussing women's opportunities for "reproductive liberty" in a world defined by gender and racial injustices, Dorothy Roberts (1997) described contemporary efforts to block Black women's control of their own bodies, sexuality and reproduction.

While not specific to childbirth, many of these findings suggest that social location does indeed shape women's reproductive experiences in different ways through differential access to resources, specific historical circumstances, various cultural meanings, and other factors.

Experiences of Medicalized Childbirth by Social Location

Little research has explored the birth experiences of women from different social locations. We choose to concentrate on class, race, and age locations of birthing women in this article and therefore address the few studies that do exist on the effect that these social locations have on women's birth experiences in this section.

Social Class. In the past three decades, some studies have focused on unique groups of women giving birth, for instance working class versus middle class women. Nelson (1986), for example, argued that women's class locations influence their receipt of medical services during childbirth experiences. In other words, middle-class women were more likely than working-class women to receive the kind of birth and/or medical treatments they desired.[3]

In addition, Nelson's data showed that middle-class women inevitably have different expectations for their medical care. Whereas middle-class women reported looking forward to and enjoying parts of pregnancy and childbirth because they contributed to their "personal growth," working-class women were more likely to fear labor and delivery and think negatively about the bodily discomforts of pregnancy and childbirth (Nelson, 1986:154). Another difference cited by researchers among women from different social classes is the level of preparation for childbirth. For example, Nelson (1986), Armstrong (2000), and Zadoroznjy (1999) found that middle-class women were better "prepared" for pregnancy and birth experiences, due to higher enrollments in childbirth classes and higher

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educational levels than working-class women. No research, however, has been done on whether women from different class locations make different choices about medical interventions, or perceive the procedures themselves or the information about procedures differently. Further study of social class and childbirth is warranted.

Race and Ethnicity. There has been little research on race, ethnicity, and childbirth in the U.S. While some cross-cultural studies have discussed how women in the U.S. experienced more medicalized birth than women in other countries (who also happen to be women of color) (Jordan, 1980), direct attention to the impact of race or ethnicity on childbirth experiences is rare. Literature that does exist is likely to discuss women of color's access to hospital births and regular medical care over time, and discrimination towards birthing and postpartum women of color (Lopez, 1993; Clarke, 1984; Shapiro, 1985; Kreiger et al., 1993; Roberts, 1997).

Fraser (1998) suggests that African American women often have desired medicalized, hospital birth because it is a luxury within the context of an historical lack of access to formal medical care. On the other hand, Litt (2000) found that historically Jewish women were more likely than African American women to embrace medicalization based on the former's equation of equating medical knowledge with social status. Thus the scant literature that exists on race and childbirth suggests that experiences are different by race, due to varying experiences with and access to social institutions, yet this research is inconclusive. Much of this research is historical, and no attempts have been made to compare and contrast different racial-ethnic groups in the United States in terms of how they think back on particular aspects of childbirth experiences. No research has looked at how women from different race locations define or deal with medical interventions such as the epidural either. Commonalities across racial-ethnic categories have not been documented in childbirth literature at all; this may simply be due to a lack of research or an implicit assumption that all childbearing women have similar experiences and make similar decisions within/about the hospital setting. There is considerable room for more research on race, ethnicity, and childbirth.

Age. Age as a social location that might influence childbirth experience remains virtually unexplored as well. Both research on teen pregnancy and feminist research on childbirth largely ignore teens' birth experiences, although studies often talk around this issue. Although a few researchers have addressed either medical complications during teen births or teen birth outcomes (Luker, 1996; Tuimala et al., 1987) or teens' concerns about labor and delivery (Kilpatrick, 1989), teens' experiences with labor and delivery and decisions about medical interventions remain under-addressed.

Low (2001) specifically addressed childbirth experiences of predominantly white teens and compared those experiences to those of adult women. Teens in the

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study spent less time than adult women in other studies preparing or planning for childbirth through formal classes (Low, 2001; Low et al., 2003). Teens' main concern in preparation for childbirth was on impending motherhood. Like adult women in the study, however, many teens took pride in being able to give birth "naturally"—i.e., without pain relief medication. Low's work therefore suggests that there may be commonalities as well as differences among birthing women of different ages.

The overall absence of research on how diverse women define and experience childbirth makes research in this area necessary. We need to know more about commonalities and differences among groups of birthing women, how they approach and think about birth, as well as how they experience it. Women from different social locations may perceive, define, and ultimately make choices about medical interventions during childbirth in very different ways. And if women focus their energies on a single choice during hospital birth experiences, that of whether or not to receive pain relief medication, then research into this specific choice is needed as well. We begin to explore some of the ways in which diverse groups of women define, discuss, and deal with medical interventions during childbirth by concentrating on women's narratives about epidural use. Before moving to an analysis of women's discussion of epidural use, we outline the methods behind the two qualitative studies we completed.

METHODS

The data for this article derive from two separate research projects focused on childbirth experiences; that is each author completed her own study before these particular data were compared for commonalities and differences. While each author completed her own study, however, the two authors met while they were both conceptualizing their research projects.[4] Meeting when they did, the first and second author were able to consult about the kinds of interview questions each would ask and also were able to pinpoint exactly where their research questions and conceptual frameworks overlapped, long before engaging in this collaborative analysis. Thus, while the studies were conceived and completed separately, there was considerable analytic collaboration during the conceptualization, data collection, and data analysis phases of the two studies. The data we present in this article have not been analyzed previously in any formal way, so this article is based on primary data analysis. The "Southern" data are taken from a study of 51 African-American teens' experiences coming to terms with unintended pregnancy and consequent childbirth and motherhood, completed in 1997. The "Mid-Atlantic" data are taken from a study of 19, primarily White adult women's experiences with hospital births, completed in 1996.[5] Age and race information as well as other demographic characteristics for each sample are presented more fully in Table 1.

Not only do the two samples differ by participants' age and race locations, but also women in each sample come from very different social class locations.

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Because of the economic situations of participants in each study, we designate the Southern teens as lower-class and the Mid-Atlantic adults as middle-class. Of the teens, all but one were either enrolled in the state health care program (formally Medicaid), received WIC, or received free lunch at the time of the interview, suggesting that their families were at a low-income level. Twenty-three (44%) teens' family incomes were based at least partially on AFDC, also suggesting that teens and their families can be categorized as lower-class based on their reliance on public support. Alternatively, in the Mid-Atlantic sample, about two-thirds (13) had family incomes of $50,000 or more. The majority of Mid-Atlantic women also completed at least some college (see Table 1). Thus we consider the Mid-Atlantic women are middle class based on a combined measure of their education and income (Eitzen & Baca Zinn, 2000). This means that, while both samples include childbearing women, our two samples are different because of their age, race, and class locations.

Table 1: *Selected Demographic Characteristics*

Southern Sample	N=51 Teens	Mid-Atlantic Sample	N=19 Adults
Age Range		*Age Range*	
15-19 years of age		20-39 years of age	
Race		Race	
African American	51 (100%)	African American	1 (5%)
		Asian American	1 (5%)
		Non-Hispanic White	17 (90%)
Marital Status		*Marital Status*	
Never Married	51 (100%)	Never Married	1 (5%)
		Married	18 (95%)
Education		Education	
Some High School	51 (100%)	Some High School	1 (5%)
		Graduate High School	1 (5%)
		Some College	6 (31.5%)
		Graduated College	6 (31.5%)
		Post-Graduate Work	5 (26%)

In the Southern study, teens represented a convenience sample of students enrolled in a teen parenting program at a public city school. In the Mid-Atlantic study, a snowball sampling procedure was used to recruit participants. Contacts with Mid-Atlantic respondents were made through mothering/parenting organizations, breastfeeding support organizations, childcare centers, registered

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nurses, pediatricians, as well as the use of well-placed flyers and word of mouth. Both sets of interviews were limited to those women who volunteered to participate. All of the Southern teens were interviewed at the public city school in a small, private room adjacent to the main office. Most Mid-Atlantic respondents were interviewed in their homes, yet three women were interviewed in more neutral locations (e.g., a coffee shop). With the women's permission, all interviews in both studies were audio-taped (with hand-held tape recorders) and transcribed, in order to insure greater accuracy of the interview data. Per IRB regulations, all women in both studies signed informed consent forms and were assured that their interviews would remain confidential.

Data Collection and Analysis

Both studies utilized semi-structured interview guides in face-to-face interviews. The interview questions in both studies were posed in the form of a conversation, in order to make the respondents feel more at ease and offer a more interactive, less mechanical relationship between the researcher and the researched (Denzin, 1989; Oakley, 1981; Rubin & Rubin, 1995).[6] Oakley (1981:41) suggests that "the goal of finding out about people through interviewing is best achieved when the relationship of the interviewer and interviewee is non-hierarchical." Rubin and Rubin (1995) also state that interviews are most successful when the interviewee and interviewer are "conversational partners." Both researchers attempted to follow these non-hierarchical, conversational styles of interviewing. Additionally, a semi-structured or focused interview format utilized in each study permitted the collection of details on personal reactions, specific emotions, expectations, as well as other information about the issues and concepts under study. This interview style also allowed for probing into areas in which data appear to be lacking, and afforded the interviewers great leeway in the order and kinds of questions asked.

While the studies were completed separately, information on epidural use and perceptions of its use during childbirth was gathered through basic open-ended questions in each study. These questions, though developed separately, were extremely similar. Both authors initiated conversations about childbirth experiences and technological procedures by saying, "Tell me about your birth experience." When probing during women's discussions of their births, both authors asked similar follow-up questions about specific procedures (e.g., "Tell me about the experience of getting an epidural. Why did you decide for or against an epidural? How did you decide for or against an epidural? Did you expect to get an epidural? Where and from whom did you learn about epidurals?").

In both studies, interview transcripts were analyzed for themes (both themes predicted by previous literature and those that would emerge from the data). The findings we present in this article are based on major themes that emerged directly from our data on women's feelings and decisions about epidural use. In both studies, the researchers view women's narratives about their birth experiences as subjective and based on their own interpretations of available information

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provided by and interactions with medical providers. That is, in neither case did the researcher observe these encounters nor interview the providers with whom the women had interacted; analysis presented in this article, then, is limited to women's retrospective accounts of their experiences. Despite this significant limitation to our data and analysis, we suggest that a comparison of the themes that emerged out of the women's perceptions of their childbirth experiences is compelling enough to support an argument that women from multiple social locations experience and interpret medicalized childbirth in distinctly different ways.

At base, while the primary purposes of and the sample recruited for each study were distinct, parallels exist between the themes found in the interview transcripts in the two studies in relation to epidural decisions and epidural use. Because the interview questions each author utilized were so similar, we believe that the differences in findings across studies are substantially valid to report here. We hope that our comparison of data from the two studies will initiate efforts to study multiple groups of women within single studies about birth in the future.

FINDINGS

One of the initial commonalities we found among women in both samples was that they conceptualized their decision for or against epidural use as one of few choices (if not the only choice) they had once they entered the hospital setting. Women in both samples also perceived their control over the epidural decision as the difference between "natural" and "medicalized" birth. Interviewees' focus on the epidural decision as their only choice and as the key difference between "natural" and "medicalized" birth illustrates the embeddedness of the technocratic model of birth in interviewees' perceptions of childbirth that other feminist scholars have already documented (e.g., Davis-Floyd, 1992; Fox & Worts, 1999). Likewise, women in our samples did not question the use of IV-based pain relief medications (e.g., Demerol) or other medical procedures used during their births (e.g., fetal monitors, ultrasound, or use of Pitocin) as much as the epidural in their conversations. This lack of questioning of or debate over other pain-relief medications and procedures illustrates the same point.

These initial findings are important in that they show that diverse women may adhere to medical models for childbirth in similar ways, thus illustrating the gendered nature of medicalization as based on a shared social location. Yet because other scholars have discussed the primacy of the epidural decision in women's minds and its use/non-use as the determinant of "medicalized" versus "natural" birth, we move on to discuss our findings about how many women decided for the epidural and the varied ways in which women discussed the epidural.

Different Decisions about Epidurals

Whereas women in the Mid-Atlantic sample overwhelmingly chose to accept the use of the epidural in an effort to control the birth experience through the

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management of pain, almost one-half of the African American teens in the Southern sample defined the epidural negatively and were inclined to refuse its use based on their fears and concerns about its potential side effects. Specifically, in the Southern sample, 21 teens (41%) defined the epidural negatively and refuse its use during birth. Of the Mid-Atlantic women interviewed, only one Mid-Atlantic woman (5%) defined the epidural negatively and specifically refused its use during labor.

Because teens in the Southern sample appear to refuse epidurals at a higher rate than women in the Mid-Atlantic sample, we turn to examine the differences in the meanings women attributed to the epidural. We first discuss how teens in the Southern sample conceptualized epidural use as risky. Second, we discuss how Mid-Atlantic women concentrated more than teens on their fears of pain during birth. We then turn to a discussion of where and from whom women in our samples received information about epidurals, in an attempt to uncover why meanings of the epidural and ultimately decisions for the epidural differ between our two samples.

Different Meanings of Epidural Use

Teens Fear Side-Effects. Teens in the Southern sample focused on the side-effects or risks of epidural use. The potential side-effect of the epidural most often identified by teens was paralysis. Specifically, ten teens expressed concern that if they had the epidural, they might become paralyzed. In addition to these, three teens heard that the epidural could cause "back problems," and two that it would slow down the labor. Denise also heard that the epidural did not effectively alleviate labor pain. Interestingly, none of the teens mentioned headaches or decreased blood pressure, the risks identified by the birth video that they all viewed as part of birthing classes, as potential risks. Yet all teens focused on the risks for mothers, not babies, in their discussions of risk.

Some teens explained that they considered the risks while in labor, responding to the information provided by anesthesiologists or other medical professionals. For example, Evelyn describes her interpretation of the anesthesiologists' warning:

> Yeah, he (the Doctor) told me, . . .you know, you've got to sign some papers before they give it to you. And he had said, 'You know, you can get paralyzed if you move and jerk out [the needle]. Because the medicine, it's supposed to go directly to the bottom, but I'd get it all over and it would paralyze you.' Because you know once it's in you, once you lay back, you can't move, can't do this, can't do that, because you're gonna' move that medicine around. You've got to stay in the same spot.

Similarly, Clarissa recalled how she made the decision to have "natural" birth – that is, birth without an epidural—during her labor:

> No, not ahead of time but when I was in labor and having contractions and

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> stuff, then they asked me. It was hurting so bad, they asked me did I want one and I told them yeah. I thought about all the, you know, problems they said, what could happen and stuff. So the lady came down there and she was saying, explaining to me, she was saying 'It could paralyze you and then you can die.' That's what she said—'die and paralyze.' I said 'Forget it.'

Teens Fear the "Needle." Six additional teens indicated that their negative perceptions of the epidural were based on their fear of the needle, still concentrating on the risks to self. Although they did not always identify the source of information about the needle, Vernisa described having seen the procedure in the birth video shown in the school's parenting class.

> I wouldn't take [the epidural]. . . .[b]ecause I said I wasn't hurting bad enough for any epidural. . . .I heard a lot bad about it, but it wasn't what I heard, it was just the fact that I had seen the video where they poke like a little hole in somebody and threaded the needle. That scared me bad, and since my labor pains weren't that bad . . .

Evidently, despite the anesthesiologist's reassurances in the video about the needle were not sufficient for Vernisa to define the epidural as safe. Instead, she relied on her own interpretation of the appearance of the procedure to make her decision.

Unlike the teens, only three of the 19 Mid-Atlantic women who birthed in a hospital setting mentioned any risks or side effects of the epidural anesthesia. In fact, many women talked about how they had learned in their birthing classes that epidurals were better than other pain medications because, according to Valerie and Donna, epidurals "did not affect the baby as much" as other pain medications and allowed women to stay alert during the births of their babies. Two women mentioned briefly that the baby had to be monitored much more closely after the epidural was administered yet, overall, did not think this meant anything negative about the epidural itself. In these cases, Mid-Atlantic women focused on potential risks for the baby rather than risks to self and decided the risks were minimal. The most common worry for most Mid-Atlantic women, in fact, was not the risks or side effects about the epidural, but rather, how quickly its effects would be felt and whether the anesthesiologists would put it in correctly the first time they tried. Many women in the Mid-Atlantic sample had heard horror stories about how many times the needle had to be inserted before the medication began to work; according to Mid-Atlantic women, these stories came exclusively from informal sources, usually friends who had recently had babies or acquaintances within mothering organizations. And while they learned about the basic risks of the epidural procedure in childbirth classes, many women in this sample considered the benefits of the epidural procedure to outweigh the risks. Karen's discussion exemplifies how Mid-Atlantic women weighed their options.

> You know, it's so weird because, when you hear about the epidural in

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> birthing classes, it sounds like a really not very safe thing to have done, because they put it through your spine and into the, you have two spinal bones, and they put it in between the two bones and they say they can jab your spinal cord or whatever. . . .but both epidurals I had were great. You know, they come in and they administer it, and you feel it within five minutes, you're getting comfort. . . .I consider myself somewhat lucky that I [didn't have more pain], but to deliver naturally? I mean, I can't imagine that.

Thus, Mid-Atlantic women who mentioned risks also explained why they wanted those epidurals anyway – that is, to "get comfort" and avoid pain.

Privileged, Adult Women Fear Pain. All eighteen women (95%) in the Mid-Atlantic sample who received an epidural discussed fearing the pain of childbirth and reported considering epidural use because of these fears. Susan reflected on her dislike of pain and why she chose the epidural and decided against a "natural" birth:

> I'm not into pain, I wanted an epidural. I spent most of the time screaming, "I want an epidural; I'm not doing this, I'm going home!" I gave birth completely natural with no medication whatsoever, and I was hysterical. I did not want that. I don't like pain, and it hurts very bad, and I don't understand why any woman would want to birth naturally.

Carol spoke along the same lines:

> I've heard about people not getting any anesthesia and it being a really brutal, very painful experience. And I don't think that having children needs to be a painful experience. I mean, I understand that you're uncomfortable and you have pain, but it doesn't need to be devastating when you're pushing. . . .And I look back at the experience and I have a smile on my face, but I wouldn't want to look back and think, oh my god, it was the worst day of my life! You know, it's much nicer with the epidural.

Alleviating pain was the reason why Mid-Atlantic women said they chose the epidural. Many women had heard from friends and family members about how painful labor was, and so this was a prominent issue in their minds throughout their pregnancy, while they were preparing mentally for the birth experience. It was not clear whether women spoke specifically to their doctors about how much pain they would experience during labor, but a few women reported telling their doctors beforehand that they would prefer not feeling pain and planned ahead of time to get an epidural. Some discussion of how to deal with pain occurred within the birthing class setting as well and these discussions, according to the Mid-Atlantic sample, centered around the epidural as a safe, effective alternative to pain. Thus formal as well as informal sources confirmed their fears of pain and epidural use as an

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acceptable way to avoid this pain.

In addition, within the Mid-Atlantic sample, a wish to appear in control or disciplined during the birth experience paralleled their fear of pain. Martin (2003) and Zadoroznyj (1999) have also discussed this theme in their studies of similarly located women. Some Mid-Atlantic women wanted to be able to experience labor and delivery while at the same time maintaining their composure, and this meant needing to be free of pain/distress during birth. While we typically believe that women lose control over their bodies within a medical setting, women in this sample who opted for an epidural discussed a need to continue disciplining their bodies during labor and delivery so that they could act "normally"—that is, nice, kind, and composed (see also Martin, 2003). Carol's comment about wanting to be able to "smile" during her birth experience illustrates this desire. Likewise, Karen reported not wanting to be "hysterical" or "screaming" during birth and therefore opted for an epidural. Martin (2003) and Zadoroznyj (1999) both suggest that these desires may be caused by gender norms that pressure women to manage their emotions and maintain a particular demeanor in public (especially within a medicalized setting where they do not hold power). While we do not have data to explore further the impact of gender norms on women's desires or behaviors during childbirth experiences, Mid-Atlantic women's discussions of pain allowed a concern about outward appearances and control over one's physical body to surface. This theme did not appear in teens' discussions of pain.

Although the most common theme in teens' accounts of the epidural decision was fear of the risks of an epidural (making them different from Mid-Atlantic interviewees), the second major theme emphasized by teens in their accounts of childbirth was the fear of pain. Thus women in both samples reported being concerned about pain during childbirth. Sixteen teens (31%) commented that they were either afraid of the pain because they had been warned by others about the intense pain of labor. Thirteen of these teens reported that warnings about pain came from outside the medical establishment, from family and friends. Although not all of the teens indicated a direct causal relationship between others' warnings about pain or their own concerns about labor pain and their decision to have the epidural, such information seemed to shape the meanings some teens gave to the epidural. Specifically, eleven (69%) of the teens who discussed receiving information about pain from others defined the epidural as a useful intervention.

Even though both teens and adults received information about pain and/or worried about pain, more women in the Mid-Atlantic sample agreed to an epidural for pain reasons than women in the Southern sample. Two teens who worried about pain even decided that labor was not painful enough to have the epidural.

Medical Information Differs with Women's Social Locations?

Another commonality between the two samples was that Southern and Mid-Atlantic women both identified medical providers as the primary sources of information regarding the epidural, its potential benefits and its risks.[7] Most

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interviewees did not define the medical profession as controlling and imposing their beliefs and procedures on patients; that is, most women in both samples described having made the epidural decision by themselves. Yet the information that medical providers dispense to pregnant women also appeared to result in particular decisions, depending on interviewees' social locations. Specifically, according to our respondents, Southern teens reportedly heard more negative information about epidurals from medical sources and often refused the epidural, and Mid-Atlantic adults heard more positive information from the same sources and accepted the epidural. Again, while we can only rely on women's reports and perceptions in this analysis, our data suggest important differences in the types of information women receive about the epidural from providers.

In most cases, teens identified medical professionals as the source of negative meanings of the epidural.[8] In addition to providers, another source of medical information regarding the risks involved with the epidural was childbirth classes. Of the twelve teens who mentioned risks or side-effects associated with the epidural, nine had taken childbirth classes. Although 48 percent of the teens who did not take childbirth classes chose to have the epidural, only 29 percent of those who attended classes chose to have the epidural. According to a childbirth instructor interviewed for the Southern study, instructors typically discussed pain relief issues with the teens, including the potential risks of the epidural. She suggested that teens also sometimes choose to give birth naturally typically out of fear of the epidural. Among teens who chose to have an epidural out of fear of the pain, only one teen recalled a provider emphasizing pain in defining the epidural as an acceptable method. According to Carla, her doctor said, "I believe you're gonna' want it, because you don't like pain."

Consequently, using providers' words to support their conclusions, teens in the Southern sample seemed to believe that they were drawing on medical definitions of the epidural in giving meaning to their decisions to forego the procedure. These teens specifically attributed this interpretation of the epidural to medical professionals themselves. Thus they believed their decisions against epidural use were consistent with medical definitions of risk.

Similarly, most women in the Mid-Atlantic sample reported receiving most of their information about procedures and what to expect in the hospital setting from their prenatal care doctors and birthing classes. All 19 women in the Mid-Atlantic sample reported attending at least some birthing classes, although some were sponsored by hospitals and some were sponsored by private organizations. Jenna supposed, "Childbirth classes, if you think about it, are often OBGYN-recommended and that's why they tell you about what they do, they tell you about procedures, and they don't really go over other options [for example, forgoing the epidural or other interventions]." Susan, in describing her epidural as "that yummy thing, that wonderful, wonderful thing, if they do it right," also talked about birthing classes' role in constructing her choice, and how the instructors warn expectant mothers about when (rather than whether) to get their epidurals:

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> They won't give you an epidural after you're 5 centimeters [dilated]...and I know that's one of the first rules they teach you in birth class. 'Get it at 5 because at 5 it doesn't hurt bad enough to think you want it, but if you really think you might want it, get it at 5, because at 8 when you want it, it's too late. They teach you that.

Thus the Mid-Atlantic sample seemed to rely most heavily on the childbirth class setting for technical information about childbirth and their options in the hospital setting and, as a result, all but one woman opted for the epidural during labor. Some Mid-Atlantic women sensed, however, that doctors and instructors of birthing classes assumed that women would want epidurals and therefore concentrated on explaining the benefits and/or logistics of administering epidurals rather than the risks, or telling them when to get the anesthesia. Ann elaborated:

> Childbirth classes basically focus on the labor and they do teach breathing, but they also teach you about medication. They teach you about the epidural and Demerol, about a possible c-section, about all the other interventions they [i.e., providers] want to do.

All of these women also reported receiving positive rather than negative information about the epidural as a pain relief choice and as a medical procedure from doctors and class instructors, which runs contrary to the reports of Southern teens. That medical providers can or may dispense different types of information about epidurals to two different samples of women, according to our interviewees, means that women's social locations (regional location, age, race, or class, or a combination of these social locations) may play a part in how medical providers relate to them and/or what types of information they decide to give. And even if medical providers are providing similar information to different groups of women, women's social locations may play a part in how women interpret medical information about the risks and benefits of the epidural. We now move on to summarize and conclude about the major commonalities and differences between our two samples.

Discussion and Conclusion

A common theme among all women in the two studies, regardless of their race, class, or age locations, seems to be the construction of "natural" and "unnatural" childbirth as birth with or without an epidural. And the choice for or against the epidural seems to take on great importance in both groups' experiences, for their decision about this procedure will define (for them and others) what type of birth they really had. Thus they see this decision as a primary responsibility during pregnancy and early labor. That this common definition exists across two such different groups speaks to 1) the pervasive nature of medical definitions of birth, and 2) women's general lack of power within the hospital setting (in that they only see themselves as making one decision whereas doctors and other health

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professionals in the birth setting make many). From an intersections approach, we can view this commonality as illustrative of the shared social location of gender as a primary axis of inequality. Because of the macro-level medicalization of childbirth in the hospital setting, all women focus on one decision as their main "job" during labor.

A difference between the two groups of women is in whether they rejected or accepted the epidural and why. As we discuss in the above section, many Southern teens rejected the epidural because of their fear of side effects or the needle (i.e., the procedure itself); thus teens focused on the negative aspects of epidural use and concentrated on the risk to self. Many Mid-Atlantic women, however, accepted the epidural for the relief of pain and hardly ever mentioned side effects or risks of any sort; that is, they focused on the positive aspects of epidural use. If Mid-Atlantic women concentrated on risks at all, they concentrated on the epidural's impact on the speed of labor and the potential risks for the baby. Mid-Atlantic women were also much more likely than Southern teens to discuss their fear of pain and a related desire to maintain their composure during birth.

The importance of maintaining one's composure, and appearing in control and even "feminine" during birth, has been identified as a theme in White, middle-class women's birth accounts (Martin, 2003; Zadoroznyj, 1999). Low (2001) hints that this may not be the case for teens as they give birth. From an intersections approach, then, adult women privileged by race and class have a much greater ability to achieve the dominant cultural ideals of femininity that are defined by this group's experiences, making this particular meaning of the epidural choice more relevant to them than to women from disadvantaged race and class groups or teens.

While critics could suggest that women in the two samples are simply justifying their decisions, both groups attributed their decisions in part to information they received from medical sources. Because the two samples' characterizations of medical information are different, Southern teens and Mid-Atlantic adults are potentially receiving very different information from their health care providers, and this may be related to their social locations. Alternatively, even if the two samples of women received similar information about the epidural from medical sources, they interpreted this information very differently. Whether medical information itself or the impact of medical information differs depending on women's social locations should be explored further, as we are limited by our data on this topic.

Again, approaching these findings from an intersections perspective, we must consider how race, class and age inequality shape these women's experiences differently. Although both groups of women seemed to present their interpretations of the epidural decision as consistent with the meanings presented by medical professionals, the fact that each "heard" or emphasized different messages suggests a number of potential explanations. If they are receiving different information about epidurals from medical professionals, there may be structural explanations

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such as differential access to medical insurance, where costs of procedures impact the ways they are presented to patients. For example, if poor teens lack health insurance, providers may discourage them from using expensive procedures like epidurals. There may also be cultural and historical explanations, where, for example, African American teens have been taught by their families and communities to question medical intervention based on the historical mistreatment of African Americans by the medical profession.

Although the Mid-Atlantic sample is much smaller than the Southern sample, if the former women were refusing epidurals at the same rate, then approximately eight of the 19 women interviewed in the Mid-Atlantic state should have felt comfortable refusing an epidural. Yet this was not the case—only one Mid-Atlantic woman, Joan, refused the epidural. And, alternatively, if Southern teens were accepting epidurals at the same rate as Mid-Atlantic adults, then approximately 48 Southern teens should have accepted the epidural during their labors. While our data are drawn from two limited, qualitative studies and are inconclusive, there are potential differences in perceptions of and decisions about the epidural that are worthy of more exploration. The commonalities we found should also be re-examined.

In general, we found that Mid-Atlantic women's decisions align more closely to what Fox and Worts (1999) and Davis-Floyd (1992) found in their samples than Southern teens' decisions: in general, most Mid-Atlantic women fully accepted the technological, medical model of hospital birth. Southern teens often resisted this model in their discussions of the epidural. Most likely, the similarities between the Mid-Atlantic sample of women and previous literature are due to the similar racial and class backgrounds of the respondents, but the commonalities and differences across race, class, and age locations must be investigated more deeply. In addition, we cannot tell from our research whether race, class, age, or a combination of these social locations create the differences in perceptions and use in our samples. Perhaps residential locations of women in each study mattered as well, yet we cannot conclude about this social location either. Further research is needed to separate out the effects and intersections of these social locations within women's childbirth experiences.

Suggestions for Future Research

This study has expanded the pool of sociological knowledge dealing with medicalized childbirth by highlighting the connections between 1) women's "decisions" about whether or not to use epidurals; and 2) women's social locations. Studies such as this one, however, barely brush the surface of the complexity that surrounds childbirth experiences and experiences with a health care system. The importance of looking at the commonalities and differences by age, class, and race, as well as gender, is undeniable; in addition, we must begin looking at how residential location, sexuality, disability, national origin, and other axes of

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difference and inequality come into play in women's childbirth experiences. Unfortunately much of the information we currently have on childbirth essentially describes a White, middle class, adult experience of childbirth. We know little about how social locations affect birth experiences.

There are a number of potential questions we should explore, based on previous research as well as the findings we present in this article. For example, did the mothers in these two samples approach medicalized childbirth, in terms of their preparation and decisions regarding procedures, differently, based on their particular social and cultural experiences, as suggested by other researchers (Armstrong, 2000; Litt, 2000; Nelson, 1986, and Zadoroznjy, 1999)? Did doctors and birthing class instructors construct the meaning of epidurals differently, depending on what type of women they were informing? Why was maintaining composure and avoiding pain more important to White, middle-class women in the Mid-Atlantic sample than the teens in the Southern sample? Did the risks of the procedure just seem scarier to teens? Why did teens concentrate more on the risks to self while adults sometimes mentioned risks to babies? And, in general, do different groups of birthing women have different conceptions of medical "risk"?

We also should question the medical construction of "choice" for each group of birthing women. While we cannot be certain as to how (or even whether) the choice for an epidural was constructed for these separate groups, we could propose that choice construction might have been slightly different in each case, due to the race, class, and age differences that are readily apparent to doctors, hospital staff, and class instructors. Because "choice" is necessarily a product of power, we need to critically assess the focus on this aspect of medicalization in the context of privilege and oppression. Where for privileged women, choice and control may be resources they take for granted and expect, marginalized women have less access to these resources in their daily lives and may conceptualize and experience medicalized childbirth in terms of other factors. At face value, it appears that Southern teens knew a lot more about the risks and side effects than the Mid-Atlantic women—or at least the former group considered these risks more seriously than the latter. Although we acknowledge the limitations of the study in terms of its generalizability, we argue that the findings pose too many questions to simply discount them. We argue that we must ask why two different samples of women held such different meanings to the epidural choice, and investigate further the effects of social location on epidural use and perceptions of the epidural.

There are other avenues one could take in researching childbirth experiences as well. One area for research is the study of specific technological interventions, such as Pitocin or fetal monitors, in hospital births. How information on procedures is disseminated and to whom is also left to be explored. Although there has been a significant amount of research completed on the subject of childbirth, current literature does not cover the issues mentioned here. While we make our argument for an intersections approach to medicalized childbirth focusing exclusively on the epidural decision, we suggest that there are a number of

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additional aspects of medicalized childbirth to be explored from this perspective.

Because our two studies were completed separately, others may call into question the reliability and validity of our analyses; we do not deny the methodological problems in comparing data from two separate, qualitative studies. While we asked similar open-ended questions and probes, there was no attempt before data collection to standardize our interviewing strategies for the purposes of our research, even though we did discuss our similar approaches at various points along the way. The results we report may not be replicated in future research. Nonetheless, we present this article to illustrate the importance of comparing across social locations when studying childbirth experiences, and we urge other researchers to further explore some of the tentative findings we report in their own single studies. Other researchers may also find that their research is similar to their colleagues', and may benefit from the same comparative exercises that we have undertaken. Intersections scholars and other scholars of difference and inequality have taught us that multiple social locations impact every perception, event, experience, and decision that groups or individuals encounter or make (e.g., Baca Zinn & Dill, 1997). We have an obligation to explore this possibility within studies of women's childbirth experiences and other studies of health experiences.

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NOTES

[1] Here we refer to White men of considerable economic means, since no other men historically had access to this authority (Zita, 1997; hooks, 1984; Weber, 1998; Baca Zinn & Dill, 1997).

[2] Medicalization can be (1) conceptual, in that medical vocabulary is used to define a problem; (2) institutional, when providers legitimate a program or problem, and (3) interactional, at the level of doctor-patient encounters, when actual diagnosis and treatment of a problem occurs (Riessman, 1983). A consequence of medicalization is the "deskilling of the populace" as experts begin to "manage" and "mystify" human experiences (Riessman, 1983:4).

[3] Nelson (1986:143) suggests, however, that women rarely receive exactly the care they desire.

[4] The authors met in May 1996, as participants in a race, class, and gender "curriculum transformation" conference at the University of Memphis Center for Research on Women of Color and Southern Women.

[5] The full Mid-Atlantic study included 38 interviews, but 19 women gave birth in a freestanding birthing center; their experiences are not analyzed in this article.

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[6] The researcher in the Southern study acknowledges obstacles to this in her study, which required interviewing across social locations of race, class and age, and the potential impact on the data.

[7] Both groups, however, did highlight the fact that they did receive information from informal sources from time to time, especially about how painful labor and delivery can be; nonetheless, both groups placed more weight on the information they received from medical sources.

[8] Two teens indicated that informal advisers (e.g., friends, families, and teachers) provided them with negative definitions of the epidural. Sharonica's mother told her that the epidural could slow down the labor process, so she was hoping to avoid it. Cherie recalled "people" saying that the epidural could paralyze you and had decided not to have it. Otherwise, teens reported hearing positive information from informal sources and negative information from medical sources.

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