Contemporary Dilemmas in American Childbirth Education: Findings From a Comparative Ethnographic Study

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ABSTRACT

In this article, we examine key dilemmas childbirth educators experienced as they made crucial decisions about the content and format of their classes in the current U.S. maternity-care context. This ethnographic study demonstrates that childbirth education is a cultural phenomenon with deeply embedded values regarding the nature and importance of information, scientific evidence, and consumer choice. Articulating how culture shapes the presentation, content, and format of childbirth classes is an important step in understanding and increasing the relevance of this experience for birthing women.

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Since its inception in the 1950s, childbirth educators have endeavored to persuade pregnant women to view childbirth education as an essential and invaluable component of their preparation for labor and birth. In the beginning, the women who came to classes largely embraced this view, seeing education and preparation as a means to achieve their goals (to be "awake and aware" or to have their husbands present). However, in the past 45 years, childbirth education has undergone many changes in terms of numbers, organizational growth and diversification, degree of institutionalization, and respecification of childbirth goals and philosophies—for both educators and birthing women. We spoke with many experienced educators who said childbirth education is now at a crossroad: "The reasons women are coming to class are different today." In other words, women are no longer coming into classes strongly preferring unmedicated vaginal birth. *Listening to Mothers II* found that, in 2005, just 37% of women indicated that they attended class to learn more about natural birth (Declercq, Sakala, Corry, & Applebaum, 2006).

The social landscape of birth has gradually incorporated most of the early demands for family-centered practices, such as fathers being present or babies rooming-in. Over the past decade, technological and pharmaceutical interventions have been introduced into routine maternity care, and this has been accepted and even desired by a majority of American birthing women (Davis-Floyd, 1992). Today, birthing women experience

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Lamaze members can view the entire report of the Listening to Mothers II *survey by logging in to the Lamaze Web site (www.lamaze.org). Others can purchase the full report from the Childbirth Connection Web site (www.childbirthconnection.org), where the Executive Summary of the report is also available to the public.*

these interventions at historically high rates (Declercq et al., 2006). Given these changes, does a childbirth education curriculum placing normal, physiological birth at its center meet the needs of today's birthing women, only 14% of whom have had natural births[1] (Declercq et al., 2006)? The *Listening to Mothers* surveys (Declercq et al., 2006; Declercq, Sakala, Corry, Applebaum, & Risher, 2002) provided valuable information on women's desires, expectations, and experiences during pregnancy, childbirth, and the postpartum period. The most recent findings showed a dramatic drop in childbirth education attendance. We explore possible reasons for this by turning our lens not on pregnant women, but on childbirth educators and the various strategies, practices, and beliefs they present in their classrooms.

Childbirth education is its own microculture, and yet anthropologists and sociologists interested in birth practices have rarely explored childbirth educators' perspectives on their work (Monto, 1992; Sargent & Stark, 1989). Ethnographic research yields data showing what people *do*, not just what they *say* they do. Although we also rely on educators' *accounts* of their teaching practice, our participant observation allows us to see how they accomplish this in a naturally occurring setting (Pollner & Emerson, 2001). These data permit us to examine how and whether cultural factors influence class attendance and participant satisfaction and to specify linkages and disjunctures between educator perspectives and class experiences. The data permit comparative analysis of many phenomena, including educator teaching styles, presentation of topics, and amount of time devoted to coping methods for pain relief.

In this article, we focus on five key dilemmas that childbirth educators have encountered as they made crucial decisions about the content and format of their classes, whether they were affiliated with an organization or were independent. The extent to which these dilemmas were explicit and conscious for educators varied, but these dilemmas emerged in all classes, affecting structure, format, and content, and, as a result, how class participants experience childbirth education in the United States today.

[1] In this article, we define "natural birth" as unmedicated, vaginal birth.

METHODS

Several methods—including participant observation of childbirth classes; in-depth interviews with childbirth educators, birthing women, and key informants; review of printed materials; and an information-sources survey—were used to collect the data. Only the data from educator and key-informant interviews and from classroom observations are described in this article.

Two institutional review boards reviewed and approved all study protocols and materials. All individuals who participated in observed childbirth classes provided consent for the researcher to be present. Separate consent was obtained for in-depth interviews and the survey.

Sample and Recruitment

Data were collected from observations of 11 childbirth class series, of which eight were offered by larger organizations and three by independent educators. Class series included in the study were purposively selected to represent a range of formats (weekend mornings, weekday evenings, and weekend workshops), philosophical perspectives, and institutional affiliations. We identified 17 childbirth educators and/or key decision-makers (i.e., program administrators, public-health officials, and trainers) for ethnographic interviewing. Interviews were semistructured and explored experiences teaching childbirth classes, personal philosophies regarding birth, and thoughts about current trends in childbirth education.

Setting

The study was located in a large metropolitan area with a highly educated population. Of the eight hospitals in the county, three contracted out childbirth education, while the others hired childbirth educators directly into their programs. Home birth, birth-center birth, and midwifery care were available and covered by private and public health insurance. Public health programs covered childbirth education for women enrolled in the state's maternity-support-services program.

Data Collection

Overall, 11 childbirth class series were observed. Within the series, only classes on labor and birth were attended by observers. We also attended nine class reunions. A total of 160 hours of observation was logged. Altogether, the data set included observations of 65 individual class sessions. The

number of class sessions per series ranged from 2 to 10 sessions. These data were supplemented by ethnographic observations of two childbirth education trainings, photos of classrooms and teaching tools, hospital tours, review of printed and online program materials, and immersion in the childbirth education scene at conferences, community events, and social gatherings.

Data Analysis

Observations were recorded with handwritten field notes that were then transcribed by the observing investigator. Interviews were audiotaped and transcribed verbatim by a professional transcriptionist. The investigators met regularly during the data-collection phase to share insights and discuss findings. Both investigators read through the interview transcripts and typed field notes. These data were entered into qualitative-data-analysis software (Atlas.ti) and coded for key content and themes. The identified themes were examined for patterns across types of educators and organizational settings.

RESULTS: DILEMMAS IN AMERICAN CHILDBIRTH EDUCATION

Our analysis identified five dilemmas experienced by childbirth educators across organizational and independent affiliations. These dilemmas are summarized in the Table and each is examined in turn in the following paragraphs, with the educators' actual words indicated in italics. Some editing has been done for clarity and readability. Codes are used to identify the following:

- Type of participant – childbirth educator (CBE), key informant (KI), and class participants (P)
- Type of class – organization-associated (ORG) and independent (IND)
- Type of data – class observations (Field notes) and interviews (INT)

Although childbirth educators viewed classes as important and valuable sources of authoritative and credible information, they were aware that this vision was not equally shared by the public in general or pregnant women in particular.

Dilemma 1: Essential Rite of Passage Versus Extra Burden

Although childbirth educators viewed classes as important and valuable sources of authoritative and credible information, they were aware that this vision was not equally shared by the public in general or pregnant women in particular. *Listening to Mothers II* showed that only 11% of women viewed childbirth education as a routine part of pregnancy (Declercq et al., 2006). Educators related to us conversations with pregnant women who viewed childbirth education as an extra task or burden that they

TABLE
Five Key Dilemmas Experienced by U.S. Childbirth Educators

Dilemma	Explanation
1. Essential Rite of Passage Versus Extra Burden	Childbirth education is increasingly not seen as an assumed aspect of childbirth preparation for women. With the trend toward surgical and technological birth practices and the recent downward dip in childbirth class attendance, educators express concern over lower perceived relevance and, to a lesser extent, accessibility for all pregnant women to quality education.
2. Information Overload Versus the ''Necessary'' Information	Most Americans have more exposure to birth-related information, behavior, and attitudes via the Internet, books, and mass media. However, with shorter class times proving more popular, childbirth educators describe the challenges of debunking misinformation and providing all ''necessary'' information.
3. Building Community Versus Just the Facts	Educators desire community building, but find it challenging to implement due to shorter class durations, information agendas, and a perceived lack of interest among women.
4. Negotiating Evidence, Beliefs, and Experience Within the Framework of ''Unbiased Information'' and ''Choice''	In varying ways, childbirth educators balance evidence-based information with cultural beliefs and direct childbirth experiences. They describe their role as trying to provide unbiased information so that women can make choices that are best for them.
5. Empowerment Versus Birth Advocacy	Childbirth educators say their goal is to empower women to have a satisfying birth rather than to advocate a particular type of birth.

could forego with little consequence, much to the educators' shock and dismay.

> *They want quick, quick fixes. And not having enough time. . .people working two jobs and that kind of thing—they want a quick childbirth class. . . . The other thing is, they don't feel they need it. I think that's the big thing. I have tried for years in my descriptions of class—why would you want to take a childbirth class? It used to be, why wouldn't you? And now it's completely turned around as to, how do we get them to class?* (INT: KI: ORG)

Our observations and interviews revealed several insights into the problematic positioning of childbirth education in the lives of expectant women today. Two insights we discuss here include: (a) demographic differences between who is having babies and who is taking childbirth classes; and (b) the construction of childbirth education as a formal educational activity requiring a lengthy time commitment.

Attendance at childbirth classes has significantly dropped, lending a particular urgency to the childbirth educator's dilemma of how to effectively persuade more pregnant women to take classes. *Listening to Mothers II* found that just 56% of first-time mothers attended childbirth education classes in 2005 compared with 70% of first-time mothers in 2001–2002 (Declercq et al., 2006). The great majority of these women (82%) attended childbirth classes at a hospital site, while just 2% of women took classes in a home setting (Declercq et al., 2006). The data further support the picture of the typical woman attending childbirth classes as being White, partnered, over 25 years old, with some college, an above-average income, under an obstetrician's care, and covered by private insurance (Declercq et al. 2006).

Our ethnographic observations were congruent with these findings, in terms of both the estimated proportion of birthing women who took classes at area hospitals (about 50%) and the social characteristics of class participants. In the classes we observed, unmarried women and women of color were not well represented, despite earlier findings that unmarried women accounted for 36% of all births and women of color comprised 45% of all births in 2005 (Hamilton, Martin, & Ventura, 2006). Nationwide, women covered by Medicaid represented more than 40% of all births in 2002 (Matthews, 2005),[2] while administrators in our study estimated that only about 5–15% of women in their classes were Medicaid recipients. Classes targeted to low-income women and based in public-health, prenatal clinics have been dramatically cut in the past few years, resulting in fewer opportunities for childbirth education for this group of women (INT).

Low-income women often experience pregnancy in the midst of various life stressors. Recent research on women's pregnancy experience showed that many low-income women attending prenatal clinics did not attend classes because they felt they had no one to go with, were unable to coordinate it, or gave birth prematurely (Bessett, n.d). Low-income women were more likely than middle-class women to report television as their primary information source: "You see it all on TV anyway" (Bessett, n.d.). Echoing these observations, an educator who has taught in public-health clinics confirmed that low-income women attending prenatal clinics were often accompanied by young children and frequently interrupted during classes for exams and procedures. She acknowledged that many women often had more pressing needs than learning the stages of labor, for example. She related one case in which a woman requested her assistance in negotiating appropriate bureaucracies so the woman could get legally married (INT: CBE: ORG).

Educators identified several cultural factors driving the decline in childbirth education attendance among typical attendees (White, educated, partnered couples). They attributed this in part to the widespread availability of information about pregnancy and childbirth online, in print, and on television. They also observed that more women are working full-time and, in addition to having technologically mediated lifestyles, couples are increasingly overwhelmed by the demands of work and home. In one class, which voted not to have a reunion, half of the couples had recently moved or were in the midst of extensive remodeling projects (Field notes: ORG).

With the rise of the consumer spa culture, educators noted that women are exposed to alternative modalities for relaxation techniques—yoga, Pilates, massage sessions, and meditation or

[2] The total number of births to all U.S. pregnant women in 2002 was 4,019,280 (Centers for Disease Control and Prevention, 2003). Births covered by Medicaid totaled 1,661,320 (Matthews, 2005).

spiritual-awareness classes—and so may not see a need to turn to childbirth education for these skills. Educators also noted a shift in cultural orientation toward pain, with an increasing acceptance and even expectation that all pain—even the mildest—can and should be alleviated through the use of medications. Finally, childbirth educators reported that many women already committed to having an epidural saw little need to attend classes for information about pain-relief methods.

> *My presentation [at a prenatal clinic, to women not yet signed up for classes] is on the nonmedical ways to cope in labor. Okay. I am going to give them some tools so they will know how to cope in labor. Well, first thing I ask is, how many of you are planning to go natural? Well, you know. . .maybe two or three. How many are having an epidural? Oh, about 90%. Okay. . .what are you going to do before you get your epidural? "I don't know." They don't even know—they wouldn't think that way! They figure that they're not going to feel any pain!* (INT: KI: ORG)

Socioeconomic status and cultural factors influenced childbirth class attendance and the experience itself. Childbirth educators placed a high value on information, and nearly all taught in a "traditional-schoolroom" format—the teacher and authoritative visuals in the front of the room, with students sitting facing the front, either in rows or semicircles. The majority of participants in our sample were comfortable with the "classroom" experience. Most demonstrated their proficiency as students by attending regularly, complying with the educator's instructions, and displaying standard classroom behavior, such as raising a hand to ask questions. Furthermore, most seemed satisfied, as evidenced by their class evaluations and statements in reunions and the postpartum interviews.

Most educators closely matched the cultural and racial/ethnic characteristics of their core constituency—White, middle class, educated. Moving across these categories has its own challenges, as this educator noted:

> *[Laughter] Well, I hate to say—I'm not out to save the world, you know. . . .I think I'm pretty effective at teaching folks who look. . .a lot like me, you know, middle class. . .who basically have the same education I do. We can get down and talk. I'm not so good with the 16-year-old women. Not a lot of legitimacy there, you know? [Laughter].* (INT: KI: ORG)

The notion of legitimacy brings up how socioeconomic status, education, and age factor into the teacher's perceived effectiveness. It also highlights a strongly cultural meaning of legitimacy in terms of motherhood and of who is culturally considered a "good" or "legitimate" mother. As more cultural factors converge to differentiate educators from the pregnant women in their classes, childbirth education as a field must address cultural-relevance issues in terms of its curricula and its educators.

Childbirth educators expressed grave concerns about the declining relevance of traditional childbirth education among today's pregnant women and about their own ability to convey the value of such education, especially in contrast to how they experienced and viewed its worth. They also expressed concerns that alternatives to an information-rich, multiweek class experience were not adequate or optimal, in terms of time and information, in preparing couples for the major life change of becoming parents and having a newborn, let alone preparing them for labor and childbirth.

Dilemma 2: Information Overload Versus the "Necessary" Information

Today, birth-related information, behavior, and attitudes are widely available via the Internet, books, and mass media. Consequently, with shorter class times more popular among participants, childbirth educators described the challenges of debunking misinformation and providing all "necessary" information. Educators expressed frustration with having more information to share than could realistically be provided in the shorter classes preferred by expectant couples. Childbirth classes in the 1960s and early 1970s offered information that was otherwise relatively inaccessible for the average woman: physiology of normal labor, pain-coping methods, and films of live births.

Women access support networks during preconception or in early pregnancy, and they gain access through one or more of the multitude of pregnancy-chat and e-mail-list opportunities. Popular culture has turned an interested eye toward birth, with daily news about celebrities' reproductive practices. One educator shared her growing lack of patience with the need to debrief such "pop-culture stuff" in news reports of Tom Cruise and Scientology beliefs about silent birthing:

Whenever there's pop-culture stuff going on involving childbirth, that always tends to get debriefed. . .Who's giving you this information, and what is their motivation. . .? Oh. . .titillation and entertainment! Is it accurate? . . . So when you read the article, what was it telling you about silent birth? Oh, you don't want the baby to be born with a lot of people jabbering. Wait a minute—isn't that what everybody wants? Nobody wants extraneous words or cruelty behind the words. Everybody wants kindness. So. . . I don't know. I have so little patience right now—not for silent birth—but for somebody getting overwhelmed by what's in the popular media. (INT: CBE: ORG)

Although media and online resources at times created challenges for educators in terms of their authoritative value, these same resources were utilized heavily by educators for continuing education opportunities, online community support, and information exchange. Educators accessed current medical research through online resources such as PubMed and shared findings with each other via the many online communities (e.g., Yahoo! Groups). Childbirth educators contributed news items from around the world featuring cultural and political aspects of birth practices and provided information about local hospitals, care providers, and standard protocols. Many marketed their classes directly to the public through Web sites.

However, with the overwhelming amount of information now available, educators noted that students expected class presentations to be concise and educators to have culled the essential and omitted the extraneous information. Some childbirth education programs changed their format in response:

The people that come to Hospital A tend to be well educated. . . that generation of people who want things on PowerPoint. We purchased equipment so we can provide that, because that's what we see on the evaluations. Kind of that generation of "give it to me quick, the quickest way that you can get it to me," which is why so many people now do the one-day class as opposed to a 4- or 6-week class. So I would definitely say that is the majority of our population here. (INT: KI: ORG)

Compressing classes from 6–8 weeks down to 4 weeks (even when class hours remained constant) increased the sense of information overload. Educators then reported feeling pressured to keep the amount of information constant and, thus, devoted less time for participants to process information and develop skills in relaxation and comfort techniques. In terms of process, shorter classes meant that participants had less time to raise questions and share experiences over the span of the series, which had an impact on community building.

Dilemma 3: Building Community Versus Just the Facts

The compression of class sessions affected the amount of time people had to socialize and bond with one another, which was a central feature of early Lamaze classes. Founder Elisabeth Bing described community resulting from gathering together with other expectant parents who shared the same relative due month. She characterized the first meeting of couples interested in learning the "Lamaze Method" as full of "nervous anticipation in the air" and with "self-conscious husbands in a room of strangers" (Bing, 1967, p. 12). However, after eliciting their reasons for taking the class, Bing concluded:

Now we are no longer strangers to each other. We are all here together for the same purpose: to learn about the fabulous engineering feat of giving birth; to gain confidence, a sense of joyous anticipation, a thorough knowledge of how to handle emotional and physical difficulties—not passively, helpless and unconscious or pacing the hall outside, but as active participants. (Bing, 1967, p. 13)

Bing bound the group together through a shared experience and goal. Childbirth educators in our study agreed that community building was a vital aspect in the beginning:

When we started childbirth classes in the '70s, we'd have seven or eight prenatal classes and two or three postpartum classes. And. . .they wanted to keep coming. You know, that was their support group, they learned to love each other, they knew each other's names, they knew everything about them. . .they were a very cohesive group. Because we took time to develop them. (INT: KI: IND)

Today, childbirth administrators observed that couples want something very different:

They want to come in, you know, wham bam. . .a lot of information, the shortest amount of time.

And feeling personally involved with one another as birthing couples or that sort of thing is just really not on the menu. It's more interaction with data than it is with. . .with group learning. (INT: KI: ORG)

In our study, the extent to which educators saw community building as a goal of their classes, as well as their success at fostering community among participants, varied significantly. As one example, we observed how the snack represented a ritual for the class experience: a ''gift'' proffered by the educator at the first meeting, then organized so that every member had an equal chance to contribute. The snack facilitated a connection with others and was a way to demonstrate likes, dislikes, social status, and values. The ritual sharing of food brought the class together both physically (around a table or counter) and socially (opportunities to share personal information such as where one shops).

In some classes, the snack was not given a place of importance. In these classes, the researchers noted a lesser degree of social connection. In all but two of the class series observed, educators brought the snack on the first day, setting (and sending) a message of contribution, comfort, nutrition, and expectations for class participants' involvement in snack sign-ups for future classes. Snack interactions facilitated community in one class, when the educator requested a particular type of food for the next week:

CBE: Next week, we talk about whole grains. Do you have a specialty food?

P1: P2 makes a mean oatmeal cookie.

CBE: Bring some. Make them as wholesome as possible. Thanks for volunteering. (Field notes: IND)

The following week, the educator's offering of a ''mean oatmeal cookie'' was a big hit, with requests for seconds, and thirds, and the recipe. The partner's cookie-making skills were lauded. The snack became the basis for a positive, shared, collective, embodied experience; thus, community.

In contrast, another educator did not bring a snack on the first day, mentioned the existence of a sign-up sheet, and said, ''*If you are so moved, you are very welcome to bring a snack to share, but it's not necessary*'' (Field notes: ORG). The first snacks brought by these class participants the following week were store-bought chocolate-chip cookies. This class did not participate much in class discussion or interact during breaks.

The structure of the class (multiweek versus one-day) also impacted how much educators invested in the emotional work of facilitating community. One educator told us what she likes least about teaching one-day classes.

You know, I've been doing it a long time, and I can do it on automatic pilot . . . and so. . .telling the same joke for the 400th time—which is new and novel to them—but knowing it's not. . .instead of really engaging with the group. But often my investment with a group that I'm never going to see again after 5:00 is far different than if I do a 6-week. It's kind of giving up that community part of it and recognizing that's what I do in order to crank 'em out, because the numbers are there to sign up for [the one-days]. Sometimes it's kind of like I'm on automatic pilot. And it's kind of like, ehh. But that's okay. You know, it doesn't seem reflected in the evaluations. People get what they want, but. . . . (INT: CBE: ORG)

Her voice trailed off as she expressed her view that this was not her preferred way to teach. This feeling was shared by many of the educators in our study—they missed the community aspects, perhaps more than their students, who had no basis for comparison or who had different expectations.

Educators varied in how they encouraged or facilitated common connections between class participants, or they recommended additional types of support activities. Some educators set up electronic mailing lists[3] and encouraged participants to communicate with each other and share birth stories. The reunion was another setting where we observed social dynamics reflected in the overall tone and ease with which the educator facilitated and elaborated on participants' birth stories. Community building required conscious effort and facilitation by educators; for some, the loss of community was an unfortunate side effect of shorter classes.

Dilemma 4: A Fine Line—Negotiating Evidence, Beliefs, and Experience Within the Framework of "Unbiased Information" and "Choice"

Childbirth educators viewed evidence-based information as an authoritative source for determining

[3] An electronic mailing list, such as LISTSERV™, can be used as an e-mail-based discussion group in which members can ask questions or share information.

and evaluating maternity-care practices on the population level and also as the starting point for their own personal beliefs and choices. In class presentations, they typically referred to research findings within a larger framework incorporating cultural beliefs and individual experiences. Several educators told us their goal was to provide class participants with "*unbiased information so that women could choose what is best for them.*"

We found that "unbiased information" was operationalized in class presentations as containing equal measures of science (clinical research evidence), beliefs (individual preference and cultural practices), and experience (everyone is different). Educators invoked science and culture in their presentations on topics related to women making "informed choices." We explored the dilemma educators experienced as they discussed how to present scientifically accurate information that was culturally at variance with positions held by class participants and/or institutions and providers with whom they worked. Educators typically resolved these dilemmas by emphasizing the role of individual choice for women's birth experiences. Paradoxically, this shift to an emphasis on individual choice created dilemmas for educators when they tried to simultaneously present normal physiological birth, typical practices, and evidence-based research.

Goals and Desires of Participants Influenced Presentation of Information. Educators varied in terms of how they presented evidence, beliefs, and experiences based on their assumptions about and/or direct knowledge of the goals and desires of class participants. Independent educators who taught classes for women with an expressed preference for unmedicated, vaginal birth were more likely to acknowledge the health benefits of interventions, when necessary, and to critique the culture of mainstream obstetrics for not following evidence-based practice regarding intervention use. These educators assured class participants that, because of their prior choice of caregiver and their commitment to informed choice, any interventions they might receive would be medically necessary. For example, in a discussion about why and how often artificial rupture of membranes occurred, one educator noted that she did not witness the procedure a lot because she was not often in hospitals. She then drew upon research, as well as her own cultural assessment, in her response to why the procedure was practiced more commonly in a medical setting:

> *It's a cultural desire on the part of most OBs to want the information it gives you. . . .Also, most physicians are taught, if she's having stronger. . .more intense contractions, it means the baby comes out faster. One study says that is not true. I think we ignore that study. . .. Flip of cultures: We don't do this until it's really needed versus we just do this. . .. I believe it's a control thing. The culture is to control the process, which is otherwise mysterious. If you have the hammer in your hand, everything looks like a nail.* (Field notes: IND)

In another independent class, an educator who stressed the evidence-based advantages of waiting to go to the hospital in early labor told her class, with a confident, smiling tone,

> *Most of my clients skip triage. They come in clearly in labor. The nurses will assess how far you are, take blood pressure. None of you are going to be sent home, you'll all be at 7 centimeters, right?* (Field notes: IND)

In contrast, educators who taught in organization-based classes faced students with a variety of attitudes and expectations, caregivers, and birth places, and they could not assume shared views regarding medical interventions or methods of pain relief. In these cases, educators provided what they described as "unbiased information"—an equal combination of information comprising typical practice, research findings, and personal experiences:

> *Once the head is out, they typically put the baby on Mom, dry it off fast, and put nude baby skin-to-skin with Mom, which is fun. Most physicians cut the umbilical cord right away. I've always been on the fence about that. The Lamaze folks looked at the research, and there is some advantage in letting the cord pulsate a bit. They clamp it in two spots, dads usually cut it, it's tough, and there is a symbolism there. You are there at the beginning.* (Field notes: ORG)

In this short presentation of the cord-cutting procedure, the educator drew on many sources of information: her knowledge of typical practice (most physicians cut right away); her own position

(unsure); research findings (let cord pulsate); and, again, practice (they clamp and dads cut).

In another example, when a class participant suggested that perineal tears heal better than an episiotomy—information based on what she had read in the class textbook and heard from a friend—the educator responded:

> *It's a matter of philosophy. For a number of persons, though, that is a theory. But research does show we do okay to minimize it. Remember, if you do have one—I disagree with the book—it doesn't have to be severe. I did tear and I did have to be stitched up. It was moderate. Depends on what degree you had to get. And a woman with episiotomy didn't know she got it. You couldn't feel you got it.* (Field notes: ORG)

Again, this educator drew upon many sources of authoritative knowledge in her answer. She first evoked philosophy, suggesting it is a matter of opinion or an individual position. She referred to research but included her personal experience, because it was the basis for her disagreement with the class text.

Educators who taught classes with significant variation in goals and expectations explicitly framed their role as one that did not question, challenge, or judge women's choices regarding caregiver, birth setting, and/or pain-relief methods. They were highly sensitive to the possibility of inducing guilt or doubt in women. An education program administrator responsible for hiring and managing educators articulated the philosophy of her organization:

> *In a class, part of our role is to help women feel safe wherever they're birthing and whomever they're birthing with. And there are some things we might want to do in the early pregnancy to get them to choose the kind of caregiver we'd like. But when they're 4 weeks away from their due date is not a time to be criticizing their caregivers. It is a time to be supportive and be sure to give them the tools. . .to know how would you find out if that was the right thing, and how would you go about having more informed choice, but always continuing to imply that everyone involved in this birth has the best interests of you and your baby at heart.* (INT: KI: ORG)

Generally, educators told us their role was to support women and their partners and to help them feel safe with the choices they had already made. They described their role as giving women support and information on how to be a critical consumer of medical care and how to create and understand their experience.

Informed Choice as a Cultural Value. We found that some childbirth educators promoted informed choice by providing decision-making models and sharing advice on how to negotiate and interact with health-care providers. Educators assured class participants that this content would give them information and tools to help make decisions during labor, especially if things did not go as planned.

In 6 of the 11 class series we observed, the educators introduced some variation of the BRAIN (Benefits, Risks, Alternatives, Intuition, do Nothing) decision-making model. Alternative variations included BRAND (Benefits, Risks, Alternatives, do Nothing, Decision) and BRAN (Benefits, Risks, Alternatives, do Nothing). The BRAIN model and its variations were introduced as a tool to help couples think through any decisions they might have to make about interventions and to facilitate interaction with health-care providers.

One educator used several stories and examples to teach participants how they might advocate for themselves and negotiate with their care provider:

> *My second child also went postdates, and I was determined to take care of it myself. I negotiated. I went to my doctor and said what can I do. . .as long as I looked good and my baby looked good, it behooved them to keep me happy. . . . The world is not black and white—it's gray. You can usually negotiate with your care provider. . . . I'll give you an example. Informed consent is good but is way down the road from informed decision-making. . . . I had a client that really didn't like needles. When she went into labor, they wanted to put in an IV. We negotiated to allow them to put in a Hep-lock, but not hook it up.* (Field notes: ORG)

Although educators privately acknowledged that many "choices" are made in the absence of full information, they were careful about how and what they said in classes:

> *We do keep up with averages of C-section rates nationally, and that's another thing we have to deal with—do we talk about the hospital C-section rate? Yeah, we can talk about that in classes, some docs would prefer that not get out, so, do we then? So we keep up with it nationally as far as the*

trends, and that always opens up, of course, why is it going up? But we have decided. . .that it was better to send people back to ask their providers, because some hospital rates are skewed a bit—because they're a high-risk hospital or something like that. Whereas, it's more telling to have your particular provider's C-section rate or intervention rate or whatever. (INT: KI: IND)

Additionally, educators rarely or never mentioned or referred to other types of evidence, which has highlighted the role of extramedical factors in clinical decision-making (e.g., shift changes, variability in providers' practice) or intervention rates by care provider, hospital, and region (Block, 2007; Wagner, 2006).

In a number of ways, educators established authority and credibility through their use of evidence-based research, cultural analysis, and models of informed decision-making. However, to resolve the epistemological gap between what they considered "best" in terms of evidence and their concern with women's subjective experience, childbirth educators ultimately placed the highest value on women's "choices":

When. . .you watch people's raw. . .raw emotions, raw physical ability, really, you respect the process. However that person manages their birth, you have to respect it. You have to respect that individual effort. . .and the way they make choices. And I think, if you constantly kind of bathe yourself in that, then you will kind of wear that cloak into the classroom, you know, being respectful of the process and really have respect for those individuals. Ach! There are no wrong answers. As long as that person was thoughtful about how they made their choices. (INT: CBE: ORG)

Childbirth educators negotiated a fine line in their presentation of topics. Anxious not to be seen as "biased," educators then relied on equal parts of evidence, beliefs, and experience. This left them able to affirm any choice a woman made as right for her, as a result of her conscious, thoughtful decision-making process. Processes or factors outside the woman's control, yet directly impacting her experiences, were not typically identified.

Dilemma 5: Empowerment Versus Birth Advocacy

The last dilemma concerns the changing goals of childbirth educators, perhaps in response to the changing desires of birthing women. Many educators say that, in contrast to when they started, their goal today is to empower women to have a satisfying birth rather than advocate a particular type of birth (i.e., unmedicated, vaginal birth).

Over the past two decades, childbirth education has moved away from advocating unmedicated births, drawing on research findings indicating that women's long-term birth satisfaction is not based on the number or type of interventions but on their perception of support and involvement in the process, both during labor and birth and during postpartum (Fox & Worts, 1999; Simkin, 1991).

Many childbirth educators and organizations now emphasize the critical importance of the woman's *own* emotional response to her labor and birth, with the goal being that she remembers it as a satisfying experience.[4] The following statement was typical in terms of this perspective:

My philosophy of teaching is that everybody comes from a different place and has their own baggage and their own hang-ups and has their own traumas to deal with, and so it's not my role as a childbirth educator to tell people that they need to have an unmedicated birth or an out-of-hospital birth or a planned C-section. (INT: CBE: IND)

Even in a class for women who strongly desired unmedicated, vaginal births, the educator referred to the class textbook and read from Chapter 1, ending with her statement, "*The goal is not a specific outcome but a satisfying birth experience*" (Field notes: IND). Likewise, in another class, the educator eschewed an outcome-based agenda, reworking her curricula to include experiential skills and tools. She noted,

I have a core belief that we will create an experience based on what we believe. And it's not about outcome—if my role as an educator were to be very concerned about someone's outcome, class would look really different. My focus and intent is process. Process is not about outcome. . . .And so I think of the class as a training ground, and we tell them that. (INT: CBE: ORG)

[4] One major exception is the Bradley Method, which continues to unequivocally advocate unmedicated childbirth (www.bradleybirth.com).

Due to the primacy placed on women's subjective experience of their birth, educators embedded consumer-health or patient-advocacy messages within their curricula as matters of "individual" or "consumer" choice. They attributed this approach to their underlying philosophy of birth:

> *I do not have religion over a certain methodology. I am not a natural-birth advocate. I'm not! I think it's the best for most people or most situations. But I'm not going to burn my bra over it. I will burn my bra over choice—and making sure that women have whatever choices they want to have a satisfying childbirth. And if that means choosing X number of interventions, knock yourself out. I think where I really. . .you know, in terms of impact and in terms of really making sure women have a choice, they have to be informed.* (INT: CBE: ORG)

They also attributed this approach to maturing as a childbirth educator:

> *Well. . .so many of the messages we talk about—birthing and empowerment and how this can be such an emotionally satisfying and transformative experience—that's different for every person, and that's different for every woman, and that's different for every couple. And it's not my job to proselytize how they should be giving birth, but to try to make sure that the choices that they make are—at least they have some grounded information in which to do that.* (INT: CBE: ORG)

In another class, the educator listed the guiding principles of the class on the white board. These principles included, "*Knowledge decreases fear, tension, and pain; increases skill confidence and satisfaction. . .Satisfying birth experience. . .Involvement in decision-making along the way*" (Field notes: ORG). The educator explained that having a satisfying birth means doing it "your way" and not someone else's way. She then elicited responses to the question of what all the different "ways" might have in common. When the class responded with "healthy baby," the educator told a story of a couple who was satisfied with their birth experience despite the disability the baby incurred as a (possible) result of the birth's management:

> *We know lots of people who have healthy babies who don't feel they have had a satisfying birth. Other people don't have a healthy baby but feel good about the birth experience. When they talk about the birth, they say,* "We *did this, then* we *decided.*" (Field notes: ORG)

The educator constructed a satisfying birth as desirable and attainable—when couples take responsibility for making decisions. Furthermore, by using a story about a friend's experience, she called into question the idea that a "healthy baby" is the only desirable outcome. She clearly distinguished the couple's feelings about the birth process from the baby's outcome.

Educators noted that helping women achieve satisfying births includes not only disseminating information but also encouraging women to accept the responsibility to make "active choices." The reasons behind this shift in focus from unmedicated vaginal birth as the assumed first goal of birthing women to one that emphasizes women's emotional satisfaction are complex and require further analysis.

DISCUSSION: CULTURALLY EMBEDDED ASSUMPTIONS AND VALUES IN CHILDBIRTH EDUCATION

Childbirth educators today are at a crossroad, caught in the midst of social and cultural forces they cannot control, but which constrain and affect their roles and practices in the childbirth classroom. Both educators and class participants are making choices in circumstances not of their own making. Many observers of modern childbirth have elaborated on these forces (e.g., Block, 2007; Wagner, 2006), and the effects of these forces can be seen in the *Listening to Mothers II* (Declercq et al., 2006) survey findings in terms of the interventions experienced by laboring women.

These trends have resulted in a spiraling set of dilemmas that raise questions about the future of childbirth education in terms of attendance and client base, the amount and type of information presented, and the ultimate goal of birth. Underlying these dilemmas are some very difficult questions that warrant further examination.

The first question involves addressing to what extent childbirth education is inseparable from middle-class values that place a premium on formal education, science, and personal (consumer)

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choice. As the middle class shrinks, because its members are having fewer babies, childbirth education will need to find ways to become more accessible and relevant to a wider cultural range of expectant mothers or, instead, be satisfied with being a niche market that caters to a relatively small proportion of the birthing public. Related to this is the need for evaluation and research on childbirth education in order to understand the relationship between cultural views of information, science, and conscious decision-making and the perceived relevance of childbirth education for all pregnant women today.

For more information on Lamaze International's updated Six Care Practices That Support Normal Birth, *log on to the Lamaze Web site (www.lamaze.org).*

Another important question that emerged in examining these dilemmas concerns investigating what might constitute ''informed choice'' in childbirth. Does informed choice lead to a satisfying birth (and how would we measure this characteristic?) or does it place an undue burden of responsibility on couples and/or women for creating their own satisfaction? Furthermore, in today's maternity-care system, how much choice do couples really have in large institutional settings? If informed choice is the key to a satisfying birth experience, are there other tools and information that might empower people to make choices that benefit them? How well does the value of informed choice translate for people who do not come from a White, middle-class background?

As educators respond to changing maternity-care practices and to consumer demands, they need to make crucial decisions regarding how they are going to adapt. Key among these changes is the rise in cesarean sections and the consumer's desire for shorter classes. What is the role of childbirth education in influencing and changing consumer demands and attitudes? Is ''giving the consumers what they want'' the most effective approach? Or is there a role to be played in broader education and advocacy regarding the medicalization of birth and the need for patient advocacy? How can and should childbirth educators working in large, for-profit, health-care organizations advocate or present normal birth as an ideal when maternity-care practices at these institutions do not follow the *Six Care Practices That Support Normal Birth* (Lamaze International, 2007)?

Childbirth education is a cultural phenomenon, with deeply embedded values held by childbirth educators regarding the nature and importance of information, scientific evidence, and consumer choice.

CONCLUSION

Returning to the question raised at the beginning of this article: Given these changes in the U.S. maternity-care climate, does a childbirth education curriculum placing normal, physiological birth at the center meet the needs of today's birthing women? Our study demonstrated that childbirth education is a cultural phenomenon, with deeply embedded values held by childbirth educators regarding the nature and importance of information, scientific evidence, and consumer choice. These values shape whether, how, and what type of information childbirth educators provide. Although normal, physiological birth *is* a central feature of the curriculum, it is placed within a larger cultural framework of individual consumer choice, as well as in the beliefs and goals of childbirth educators. Within this cultural framework, childbirth educators described the information presented as ''unbiased.'' However, our observations and analyses consider what information and tools were *not* provided—especially information and tools that would not support an individual, consumer-based, decision-making framework. Articulating how culture shapes the presentation, content, and format of childbirth classes is an important step in understanding and advancing the place and relevance of this experience for all birthing women.

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