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Teen mothers' perceptions of medicalization and the patient/provider relationship

A thesis submitted in partial fulfillment of the requirements for the degree of Master of
Science at Virginia Commonwealth University.

by

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Abstract

TEEN MOTHERS' PERCEPTIONS OF MEDICALIZATION AND THE PATIENT/PROVIDER RELATIONSHIP

By Preston T. Martin-Lyon, B.A.

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Within the past twenty years, a great deal of research has addressed pregnancy and childbirth in the United States. Often, however, prior studies have focused on white middle-class women and have neglected the experiences of women of color and low-income women. Teen mothers have also been marginalized in past research. With few exceptions, the limited research that does exist on African American teen mothers is usually framed around the “teen pregnancy crisis” in the U.S; seldom are teens included in studies dealing with the overall issue of medicalization. In an effort to understand the extent to which the medical model of childbirth shapes teens’ understandings and experiences of prenatal care, this paper analyzes in-depth interviews with 40 pregnant or parenting African American adolescents attending a Teen Parenting Program. The

analysis focuses on teens' accounts of their experiences with the patient provider relationship and their interpretations of and responses to the medicalization of pregnancy and birth contextualized in teens' encounters with medical providers during pregnancy. Overall, the adolescents accepted the medical model of pregnancy and childbirth. There were, however, acts of resistance and defiance of medical authority.

Chapter 1. Introduction

This study examines the pregnancy and childbirth experiences of low-income, Black pregnant and parenting mothers within the formal health care system. Focusing on teens' descriptions of their experiences with and perceptions of prenatal care and childbirth, as well as their interactions with medical providers, this study adds to the growing body of feminist research that seeks to understand the intersections among age, race, class, and gender in specific social settings. The theoretical bases for the analysis are rooted in radical feminist theory, and more specifically, its attention to the male doctor/female patient relationship and the two opposing childbirth frameworks, as well as theories regarding race, class, and medicine.

This analysis focuses on both the acceptance of medicalization in pregnancy and childbirth and the patient/provider relationship. In general, the respondents in this study neither completely rejected nor completely accepted, although many did show resistance to medical authority. This resistance, however, differs from the resistance of middle class White women previously discussed by Davis-Floyd (1992), Martin (1992), and others. I also found that at least in these interviews, race, class, and gender did not play as obvious a role in the patient/provider relationship as seen in the literature.

The findings of this study also contribute to the existing body of knowledge on women's experiences in childbirth. Both adolescents and Black adult women tend to be neglected in sociological and feminist research on childbirth. By focusing on middle-class White women, sociologists marginalize the experiences of minority women and

mothers living below the poverty line. Subsequently, the views and opinions of minority women generally are left out of the American public and academic discourse on childbirth.

Public policy dealing with teen pregnancy may also profit from this study.

Previous research has tended to focus on adolescent pregnancy as a social dilemma, and few studies have looked at the formal support provided to new teenage mothers. It is my hope that by analyzing how teen mothers perceive their relationships with their doctors, my findings will be valuable in discovering new methods for communicating effectively with adolescent mothers, such as engaging them in decisions regarding their pregnancy.

Background and Statement of the Problem

In contemporary American society, childbirth is considered a rite of passage for women (Davis-Floyd 1992). While biologically, childbirth serves the function of procreation, within the social world, childbirth functions as a uniquely feminine liminal experience that transforms woman into mother. For adolescent mothers, however, childbirth may mark not just the beginning of their mother status, but also the end of their status as children. The meaning of pregnancy and childbirth experiences in the context of teen pregnancy poses a number of challenges to dominant views of reproduction.

This specific context of pregnancy experiences is important given that in 2002, there were a reported 425,493 births to women between the ages of fifteen and nineteen nationwide (National Campaign to Prevent Teen Pregnancy 2002). Twenty-four percent of teen mothers that year were Black.

Despite the numbers, the experiences of pregnant teens in general, and of teens of color in particular, have been largely neglected in popular discourse, as well as academic scholarship. For the past thirty years, feminist scholars and sociologists have reported on many aspects of childbirth. Until recently, however, the literature on childbirth was based primarily on the experiences of adult, White, middle-class, married women.

As exceptions to the overwhelming focus on White and/or middle-class women, some studies of women from marginalized groups have recently entered the literature. In her study of teen mothers and their educational experiences, Pillow (2004) notes that, typically, researchers have historically defined teen pregnancy as a social epidemic, despite the fact that teen pregnancy rates usually mimic national birthrates for all age groups. Within American society, the teen pregnancy crisis is generally thought to be a black problem (Luttrell 2003, Pillow 2004). Luttrell (2003) finds that

the 'pregnant teenager' is seen as a black, urban, poor female who is more than likely herself the daughter of a teenage mother. She is probably failing school, has low self-esteem, sees no future for herself, and now must deal with the untimely end of her youth and face the harsh realities and responsibilities of adulthood (4).

While pregnancy rates among Black adolescents have steadily declined within the past ten years, the birth rate for Black adolescents aged fifteen to nineteen in 2002 (sixty-eight per one thousand) was considerably higher than that of both White adolescents (twenty nine per one thousand) and the birth rate for all races (forty-three per one-thousand) (Martin et al. 2003).

I. Theoretical Frameworks

The research question for this study is guided by radical feminist theory in general, and by a focus on the patriarchal medicalization of women's reproduction in particular. In this section, I provide a general overview of radical feminist theory, identify and describe two specific areas of focus within men's domination of the formal medical system, specifically with respect to women's reproduction. Finally, I discuss class and race as interconnected realms of oppression that structure women's reproductive experiences.

A. Radical Feminist Theory

Radical feminism is a holistic women-centered theory that concerns itself with the origins of women's oppression. There are two components of radical feminism that are important to my analysis of the patient/provider relationship and modern medicalization of childbirth. The first is the idea of patriarchy and the patriarchal relationship between a typically male doctor and a pregnant woman. According to radical feminists, under patriarchy, a man's body is considered normal, while a woman's body is approached as an anomaly. Second is the patriarchal relationship between a doctor and his female patient.

There are two central themes in radical feminism. The first theme is the idea that radical feminists refuse to allow men to define equality; radical feminist theory is created by women, for women (Rowland and Klein 1996). Radical feminism is based on both the personal experiences of individual women and collective experiences of women as a group.

The second theme is the idea that “women as a social group are oppressed by men as a social group... [and] this oppression is the primary oppression for women” (Rowland and Klein 1996: 11). Thus, as a group, women are viewed as a social class. The systematic oppression of women by men is termed patriarchy. Radical feminists call for “a total revolution of the social structures and the elimination of the processes of patriarchy” (Rowland and Klein 1996: 11).

According to Rowland and Klein (1996), patriarchy is “a system of structures and institutions created by men in order to sustain and recreate male power and female subordination” (15). This subordination of women is sustained through men’s violence against women (i.e. rape, spousal abuse, murder) and the institutional exploitation of women (Lorber 2001). While patriarchy is enforced through the violent oppression of women, that violence need not be explicitly physical. Violent exploitation can come in the form of pornography, verbal harassment, or even fashion. At the institutional level, covert violence against women occurs in the workplace, the household, as well as in medicine.

There are two material bases to patriarchy. The first is economic systems that make women dependent on men. The second is the woman’s body which is objectified through the media and entertainment, owned under marriage, and controlled by men through reproductive laws and practices (Rowland and Klein 1996). Women’s reproduction is feared and envied by men, because it is controlled by women. In an effort to gain control over women’s reproductive power, men create laws that limit women’s

reproductive freedom by controlling abortion, contraception, childbirth, and reproductive technologies (Rowland and Klein 1996).

In patriarchal societies such as the United States, all major social institutions are structured through male dominance (Lorber 2001). In the formal institutionalized system of medicine, radical feminists argue, the male body is considered the norm. Women's bodies are typically viewed as abnormal. Normal functions of the female body, such as menstruation, pregnancy, and menopause, are commonly treated as illnesses by those in the medical profession (Lorber 2001; Davis-Floyd 1994).

While many critics of radical feminism have complained that this theory ignores the role race and class play in the oppression of women, Rowland and Klein (1996) assert that radical feminism acknowledges the diversity of women. Radical feminists argue that gender oppression is the most important kind of oppression, but recognize that race, class, sexuality, and age cause different groups of women to have encounters with oppression and to experience them differently (Rowland and Klein 1996).

In this study I will focus on two specific aspects of the patriarchal medicalization of childbirth: the male doctor/female patient relationship, and two contrasting models of childbirth.

Male Doctor/Female Patient Relationship

Patriarchal inequality is inherent in male doctor/female patient relationships. Doctors have an extreme amount of power over their patients for several reasons. According to Ratcliff (2002), "medical training and the culture of medicine have been physician-centered, teaching doctors that, regardless of the gender of their patients, they

should be in control” (33). Doctors control information that is critical to the lives of all women. When a patient comes in with a question about her health, the doctor acts as a gatekeeper of knowledge, determining what information he will give his patient, and what he will withhold. Furthermore, if a doctor has prejudices against certain groups of people (e.g. minorities, homosexuals, Medicaid recipients), his biases could affect his interaction with patients (Ratcliff 2002).

Many women prefer to see female obstetrician-gynecologists (Foster 1995). Unfortunately, the field of obstetrics-gynecology, like most medical specialties, remains dominated by males (Foster 1995; Scully 1994). In 1999, only thirty-seven percent of obstetricians and gynecologists were female (Plunkett et al. 2002). While women may prefer to see a female obstetrician, the fact remains that these doctors are socialized in the same manner as their male counterparts and may adhere to the same patriarchal methods and values (Scully 1994).

One barrier to good communication between doctors and female patients is “the emphasis on medicine as a science” within medical schools and subsequent training (Ratcliff 2002: 33). Within the field of obstetrics and gynecology, surgical technique is highly valued (Scully 1994). Evaluation of medical students is based more on their grasp of technical knowledge of the body than their interactions with patients. Their education emphasizes “knowledge of anatomy, physiology, pathology, and diseases” (Scully 1994: 103). Interviewing skills are virtually ignored within the classroom.

The male doctor/female patient relationship also mimics traditional gender interactions found within society. Ratcliff (2002) notes that female patients are more

likely to have their health complaints written off as psychosomatic, and are more likely to be given more simple, unscientific explanations of their conditions.

The relationship between male doctors and their female patients is particularly important in prenatal care. While prenatal care can consist of any “changes that a woman makes to her daily routine simply because she is pregnant,” receiving formal prenatal care is an important part of a healthy pregnancy (Daniels and Parrott 1996: 222-223). Encouraging women to obtain prenatal care is imperative, because women who receive little to no prenatal care are at risk for premature delivery and low birth weight (Parrott and Daniels 1996).

According to Parrott and Daniels (1996), there are two elements involved in whether women will seek prenatal care. First, “a woman must be convinced to seek care from a provider trained to perform such procedures” (Parrott and Daniels 1996: 212). Secondly, “a woman must be convinced to continue care when the tests may be physically uncomfortable, psychologically embarrassing, and financially costly” (Parrott and Daniels 1996: 212). While there are many personal variables that determine whether a woman will obtain prenatal care, her relationship with her doctor is also an influential factor. Communication incompetence (i.e. language or other communication barriers) and dissatisfaction with medical care can impact a woman’s decision to receive prenatal care (Parrot and Daniels 1996).

B. Childbirth Paradigms

Davis-Floyd (1992) distinguishes between two oppositional birthing paradigms in the United States: the holistic model and the technocratic model. According to

Zadoroznyj (1999), control during childbirth is the crucial idea in both of these frameworks; however, where the holistic model places control in the hands of the birthing woman, the technocratic model gives control to medical professionals.

The Holistic Model

The holistic or natural model of childbirth emphasizes a woman's natural ability to give birth. Under this model, women are seen as the most qualified people to make decisions regarding the management of their birthing experiences (Davis Floyd 1992). The ideal birth is one in which the woman actively participates, and "the process of giving birth is an end in itself" (Zadoroznyj 1999, 269). In general, a holistic birth is one that is done without prescription pain killers and requires no medical intervention (i.e. epidural, episiotomy, cesarean, etc.) (Davis-Floyd 1992).

The holistic model of childbirth is commonly embraced and practiced by midwives (Davis-Floyd 1994). Currently in the United States, midwifery is prohibited by law in seven states; not legally defined, but not prohibited in seven states; and legal with no licensure available in seven states (Citizens for Midwifery 2004). Because midwifery is illegal or unregulated in twenty-one states, a homebirth may require resources that are unavailable to low-income women. In states where it is illegal, homebirth may only be an option for women who have the means of finding a midwife (i.e. through friends or local pro-midwifery organizations). Additionally, of the twenty-nine states where midwifery is legal and regulated, only eight states offer Medicaid reimbursement for midwife-attended births (Citizens for Midwifery 2004). Because of these barriers, as well as culturally-specific issues discussed below, I would argue that the holistic model that

focuses on midwifery and homebirth is irrelevant to the lives of lower income women and thus does not provide a useful analytical framework for this study. This model is unlikely to be incorporated into teens' ways of thinking about reproductive issues.

The Technocratic Model

In contrast to the holistic model, the technocratic model of childbirth has its beginnings in traditional medicine, which is rooted in Cartesian thought. While the medicalization of health and illness affects both men and women, "women have been the main targets in the expansion of medicine" (Reissman 1998: 47). Descartes and the other Enlightenment thinkers, including Hobbes and Bacon, saw "the universe as mechanistic" (Davis-Floyd 1994: 44). Even before the Enlightenment split the world into the spiritual and the scientific, Western culture was already subscribing to Aristotle's definition of woman as the incomplete male. Since the thirteenth century, Western medicine has revolved around the assumption that the male body is normal, while the female body is an anomaly. When Cartesian and Aristotelian thoughts are combined, a woman becomes a defective machine, in constant need of adjustment and repair.

Because of woman's "flawed" nature, the technocratic model of birth holds that her participation in the birth is not essential. As technicians trained to repair the machine, doctors are seen as better equipped for delivery than women are for giving birth. Proponents of the holistic birth model criticize the technocratic model because of the lack of agency given to mothers, as well as control this perspective gives doctors over a woman's birth experience (Martin 2003, Davis-Floyd 1992).

Sterk (1996) finds three primary reasons why women give birth in hospitals: “the control of the American Medical Association over licensing and over practicing midwives, U.S. faith in the ‘expert,’ and women’s desire to do what they are told is right for their babies” (125). The latter two ideas are supported by American mass media, from television sitcoms to popular magazines. In media portrayals, alternatives to hospitals births are seen as “choices [that] are singular and therefore remarkable, but certainly not intended to be seen as reasonable or normal choices” (Sterk 1996: 126). Due to the one-sided popular discourse on the subject of childbirth, today hospitals are assumed to be the right place to give birth and doctors are seen as the proper people to deliver babies.

Although scholars generally emphasize the negative consequences of medicalization, Reissman (1998) notes that women are not passive victims of the medical model, and in fact, helped to create it. When doctors began promising easier, safer, painless births, upper- and middle-class women welcomed their interventions.

One outcome of the medicalization of childbirth has been the shift of attention from the mother to the fetus during pregnancy and childbirth. During birth, the woman becomes not just a machine, but an instrument of production – a baby factory. Davis-Floyd notes that “the most desirable end product of the birth process is the new social member, the baby; the new mother is a secondary by-product” (57). Thus, the baby is viewed as a separate entity and more valuable than the mother. Given the technological advancements in neonatal diagnosis and surgery in the past fifty years, women are encouraged by doctors to do everything they possibly can to ensure the safety of the fetus

(Casper 2002). Under this framework, a pregnant woman is defined by doctors “either as ‘the best heart-lung machine available’ to support the unborn patient, or as a flesh-and-blood barrier to be opened surgically in order to access the fetus” (Casper 2002: 251-252).

The rights of the fetus over the woman have made it possible for courts to declare certain lifestyles illegal for pregnant women. In cases where the courts find that a mother is found guilty of fetal abuse, judges can step in and order a woman to undergo medical treatments that she has already declined. Maternal supervision can even be court-ordered if a judge feels that a woman’s behavior is endangering the welfare of her fetus (Ratcliff 2002).

Women may also find their rights diminished if they reject medical care that health care professionals deem necessary for the well-being of the fetus. Low-income women of color are more likely to have medical procedures forced upon them for the assumed well being of the fetus (Foster 1995).

Recent research suggests that, despite feminist criticisms of the patriarchal technocratic model of childbirth, many women choose the technocratic model because it gives them a sense of control that they don’t feel they can achieve through natural birth (Davis-Floyd 1992). When women subscribe to the medicalization of childbirth, they come to rely on the knowledge of doctors, who as technicians, are seen as properly trained to deal with pregnancy.

Race, Gender, and Motherhood

Women of color in American society face oppression that is different from the oppression faced by White women. Both publicly and privately, Black women are confronted by sexism and racism on a daily basis. One area that is particularly subject to controlling oppressive images is the family. According to Ware (2000), Black families try to imitate White families, “but since blackness connotes ugliness and evil to Whites, black women have been despised as coarse and animal-like in sensuality. They have been despised by both Whites and by their own people” (98). Negative stereotypes of Black mothers are transmitted through powerful social institutions such as schools, mass media, and the government (Collins 2000).

Black institutions also convey degrading images of Black women. Within the Black community, the Black woman is supposed to be self-sacrificing and devoted to her community, and she should forsake her own needs for those of the community.

According to Collins (2000), this is because

Many Blacks regard the role of uniting all blacks to be the primary duty of the Black woman, one that should supersede all other roles that she might want to perform (86).

According to Black feminists, one problem faced by Black women in the United States is the concept of the “ideal American family.” The ideal family is “formed through a combination of marital and blood ties,... [and] consist[s] of heterosexual, racially homogenous couples who produce their own biological children” (Collins 2000: 47). Within this family, a father maintains the role of wage-earner, while a mother’s role

is within the confines of the home, as a wife and mother. This perfect household is seen as a private haven from the public sphere of everyday life.

For Black families, however, the standard of the ideal American family may be difficult, if not impossible, to live up to. Motherhood in the United States is defined by White culture and is based on White motherhood. The role of the White mother is to care for her children, her husband, and her home (Collins 1994). The ideal of a stay-at-home mother is not an option in many Black families who rely on the incomes of women. Historically, Black women have always worked, and in modern society it has become easier for Black women than their male counterparts to find well-paid work (Collins 2000; Roberts 1997).

Instead of the ideal American family, many Black women rely on community-based care for help with childrearing. Biological mothers, or bloodmothers, are expected to care for their children, but because this is not always possible, relatives, friends or neighbors—or othermothers—may assist them with mothering responsibilities (Collins 2000; James 1993). The concept of othermothering “reflects both a continuation of West African cultural values and functional adaptations to race and gender oppression” (Collins 2000: 119).

Black women are also condemned through their reproduction. According to Roberts (1997), in American society, White reproduction is viewed as desirable, while Black reproduction is unwanted. Black mothers “transmit inferior physical traits...damage their babies...through their bad habits during pregnancy...[and] impart a

deviant lifestyle to their children” (9). Black motherhood is believed to be the cause of Black poverty and marginality.

Collins (2000) points out that Black women serve as the “Other” in American society, and have been labeled many different stereotypes—mammy, matriarch, “hoochie,” and welfare queen to name a few. Of particular significance to the issue of Black women as mothers are the categorizations of mammy, Black matriarch, and welfare queen, because these stereotypes convey the different popular images of Black motherhood. Like the notion of the ideal American family, these myths are used to rationalize Black poverty.

Despite these negative images, Black women show a variety of responses to their oppression. Collins (2000) notes that Black writers resist these images, while at the same time creating “positive self-definitions” and denying negative ones (83).

While stereotypes describing Black mothers as inferior or unworthy abound, Black women continue to have “strong pronatalist values” (Collins 2000: 134). Motherhood is a rite of passage for young Black women that serves as a stepping stone to full adult status. Thus, the act of mothering remains an empowering experience for Black women, because “Black children affirm their mothers...in a society that denigrates Blackness and womanhood” (Collins 2000: 137).

C. Race, Class, and Medicine

One common critique of radical feminist thought is that it ignores the intersection of race, class, and gender as systems of oppression (Lorber 2001). This is particularly important with respect to health care since, according to Scully (1994), there are two

health care systems currently operating in the United States: one for the upper and middle class and one for everyone else.

In order to better understand the significance of race within medicine, specifically in childbirth, we must first look at the history of Black childbirth. As Fraser (1995) points out, there is a tendency among academics

to homogenize the history of reproductive health care so that it comes to have, in a sense, a creation story and then another with a happy ending as women rediscover their control over birthing and come to reassert the ‘natural’ processes of their bodies against the unnatural technologies of hospital-centered obstetrics (55).

Social scientists – particularly anthropologists—have recently begun documenting the history of Black childbirth, focusing on the antebellum Southern Black, or “granny”, midwife (Fraser 1998; Davis and Ingram 1993). In some areas of the South, midwives served as the only birthing attendants available to women of color from the eighteenth century to the 1940s (Davis and Ingram 1993). In recognizing the variation of experiences across the South, these histories tend to focus on particular states or regions. Fraser’s *Black midwifery in the South: Dialogues of birth, race, and memory* (1998), for example, provides the history of Black midwives in Virginia.

According to Davis and Ingram (1993), before doctors, pregnancy and childbirth were empowering experiences for both midwives and their female patients, because this area was outside patriarchy and racial tyranny. Because of their specialized knowledge, even as slaves, Black midwives “experienced high cultural autonomy and prestige” (Davis and Ingram 1993). When male doctors began serving as birth attendants, their patients were middle- and upper-class White women. Although more and more women

started choosing doctors over midwives beginning in the mid-nineteenth century, in many parts of the rural South, midwives were the only option available for poor White and Black women (Fraser 1998).

By the early twentieth century, doctors and public health officials began to become concerned with the high rates of maternal and infant mortality in the Black community (Fraser 1998; Davis and Ingram 1993; Marland and Rafferty 1997). Marland and Rafferty (1997) note that in the South, “there was a close correlation between maternal mortality rates and the proportion of deliveries attended by black midwives” (187). Rather than investigating the social problems attributing to these deaths, however Black mothers and midwives were blamed for the problem.

Midwifery education programs were developed in many states. The short-term goal of improving the infant and maternal mortality rates was achieved (Fraser 1998; Marland and Rafferty 1997). The long-term goal of many of these programs, however, was to phase out midwives and replace them with doctors (Fraser 1998).

Despite efforts to develop midwifery education programs, most institutionalized health care professionals viewed midwives as intellectually inferior to doctors and incapable of learning and improving their methods. Still, Southern doctors viewed Black midwives as a “necessary evil,” because these doctors were unwilling to treat the poor, rural populations that midwives attended to (Fraser 1998; Davis and Ingram 1993). By the 1920s, however, doctors began advertising to Black women. As a result, by the 1950s, most Black women went to hospitals to give birth.

Today, Black midwifery in the South is only a distant memory. In talking to Blacks who lived in the rural South when midwifery was still practiced there, Fraser (1998) found that “admitting to either having knowledge about midwives or having used their services was perceived as somewhat shameful” (145). For the people interviewed, admitting to using a midwife amounted to admitting you were poor, and implied that someone in your family relied on inferior care when better quality care was available. Davis and Ingram (1993) also note that today the Black midwives who successfully served their communities for over two hundred years are labeled as ignorant, superstitious, and unclean. While a young Black woman may see using a midwife as a return to her cultural heritage, older Black women see the use of midwives by their daughters as a betrayal of “the progress the family [has] achieved” (Fraser 1995: 51).

Within modern medicine Black women still face prejudice. Barbee and Little (1993) define reproductive freedom as

unrestrained access to the medical knowledge (information) available in one’s society that is necessary for the optimum maintenance of one’s reproductive health...[including] safe, effective, affordable forms of birth control, family planning, sexual education, freedom from forced sterilization..., the right of consenting adults to conduct their sex lives as they chose, reduction in African-American infant and maternal mortality rates, and affordable access to diagnosis and treatment of sexually transmitted diseases (191).

The concept of reproductive freedom remains elusive to many impoverished women of color. Poor women are more likely to have their pregnancies monitored by the government, because of their dependency on governmental services, as well as their inability to challenge government intrusion (Roberts 1998). Pregnant low-income and minority women are more likely to have their lifestyles questioned, more likely to have

their reproduction threatened by welfare laws, and less likely to be considered for infertility treatments.

As fetuses gain rights, mothers are prosecuted for lifestyles that society feels is threatening to their children. In cases of drug-addicted mothers', most of the offenders are poor Black women (Roberts 1997). Doctors are more likely to report Black mothers' drug use than White mothers, despite the fact that there is no statistically significant difference between drug use among White and Black pregnant women. In August, 1989, when the city of Charleston, South Carolina decided to test pregnant women and mothers who had just given birth for crack cocaine, it resulted "in the arrests of forty-two women...all but one of whom were Black" (Roberts 1997: 166). The women targeted by this particular policy were women attending the only hospital in town available to Medicaid recipients. Moreover, those patients attending the same clinic who had private health insurance were not subject to the non-consensual testing. Even when women seek treatment for drug addiction during pregnancy, they are more likely to be reported to the state and prosecuted (Roberts 1997).

As new reproductive technologies emerge, Blacks and the poor are less likely to be recipients of them. According to Roberts (1997), although White middle-class couples are more likely to take advantage of infertility treatments, infertility in the United States is most common among the "poor, Black, and poorly educated" (253). Treatments such as in vitro fertilization are unavailable to poor women who receive Medicaid and cannot afford their costs. Moreover, Black women may be guided away from infertility

treatments because doctors fail to give accurate diagnoses due to racial stereotypes regarding the causes of infertility (Roberts 1997).

Despite popular myth, the American welfare system discourages reproduction of its recipients. According to Roberts (1997), “the major goal of some welfare reformers is to reduce the number of children born to women receiving public assistance” (209).

Some of the strategies used to reach this objective include creating welfare family caps that deny payments to children born to welfare recipients and offering long-term contraceptives to women on Medicaid (which may be accompanied by a cash incentive).

Summary

These theoretical frameworks direct the focus of this study toward particular aspects of patriarchy in medicine that potentially shape the experiences of these teen mothers. Specifically, the theory points to gender inequality within doctor/patient interactions that places medical providers in positions of power over their patients. Because of the prevalence and enforcement of the technocratic model of reproduction, the literature should show that women subscribe to the medicalization of childbirth. Due to the historical oppression encountered by low-income women of color within the health care system, as well as within society in general, minority women’s encounters with medical providers should differ greatly from the experiences of their middle-class, White counterparts, but given limited research in this area, it remains to be seen how.

II. Literature Review

In this section, I review existing literature that addresses the following issues: women's perceptions of and experiences with the technocratic model of childbirth; childbirth experiences of women from diverse social backgrounds; and encounters with medical providers during childbirth and prenatal care.

A. Two Approaches to Childbirth

Consistent with feminist scholarship, research findings suggest that women conceptualize their childbirth experience and reproduction through two distinctive perspectives: the technocratic or medical model, and the holistic or natural model. Within the technocratic model, the doctor is viewed as the childbirth expert, whose decisions are followed, unquestioned by all other parties involved. In opposition to this model, the holistic model views childbirth as a natural process that may be facilitated by a midwife, but ultimately it is the birthing mother who has control (Davis Floyd 1992).

Some studies have shown that women identify primarily with the technocratic model of childbirth. While most of these studies focus on the actual birth experience rather than prenatal care, these studies support the view that most women do subscribe to the medical model of childbirth. For example, Davis-Floyd (1992) found that eighteen percent of White mothers completely identified with the statement "birth is not done by mothers but by doctors," and nine percent did not think their bodies were naturally made to have babies and welcomed the control offered by the technocratic model (189). The

majority of her respondents, however, did not wholly identify with the technocratic or holistic models, but some combination of the two.

More recently, the 2002 Listening to Mothers survey conducted by the Maternal Center Association found that although the majority of respondents identified with the holistic model of childbirth, their experiences were highly technocratic (Declercq 2002). Forty-five percent of those women surveyed thought that birth was a natural process and that any intervention should be medically necessary, while thirty-one percent disagreed with this approach. The majority, however, also reported having some kind of medical intervention during labor. For example, sixty-three percent reported receiving an epidural, fifty-five percent had their membranes ruptured, and ninety-three percent reported that an electronic fetal monitor was used (Declercq 2002). It is important to note, however, that this survey was mostly conducted over the Internet and, consequently, seventy-seven percent of the respondents were White and fifty-six percent had more than a high school education.

In a study of fifty working-class and middle-class Australian women whose race was omitted, Zadoroznyj (1999) observed that social class affects women's orientation toward control over the birth of their first child. Working-class women in this study tended to take a defeatist position towards childbirth. Middle-class women, on the other hand, were more likely to take an active role in the planning of their birth experience. Zadoroznyj attributes this to the fact that middle-class women had more resources available to them that gave them control over their experiences. The middle-class women

differed, however, on whether they subscribed to the natural or technocratic model of birth. Most subscribed to the natural model, while others chose the technocratic model.

Some researchers have focused on adolescent girls' perceptions of medicalization. For example, in a study of teen mothers within an educational program for parenting teens, Luttrell (2003) found that in improvised skits, Black and White teen mothers relied on "dominant medical metaphors." For example, the students depicted nurses as having power over patients and treating girls as being ignorant and young. Within the skits, the results of medical tests were unquestioned, "whereas women and men were understood to be either mistaken or deceitful" (117). In a content analysis of medical advice columns about menstruation in Finnish magazines, Oinas (1998) found that the medicalization of the body is something that both the medical profession and young women subscribe to. Olinas found that the young women who wrote the letters in her study seemed to wholeheartedly accept the advice of medical professionals. According to Olinas, medicalization of the body provides "a way whereby the young women construct themselves as they explore the boundaries of proper female gender behaviour [sic] and the 'normality' of the female body" (54). For this reason, doctors use medical advice columns to socialize adolescent girls to become compliant medical consumers. Unlike Oinas and Luttrell, however, in a study of mostly White teens attending an alternative school, Kane Low et al. (2003) observed that the majority of subjects did not embrace the medical model, but rather felt that "being able to 'get through' the birth experience naturally was described as an accomplishment that they could take pride in" (195).

Brubaker (1999) addressed “ways of giving meaning to teen pregnancy, examining both the meanings constructed publicly by researchers and politicians, as well as how teens themselves, through interactions with others, give their own meanings to pregnancy” with an emphasis on how social actors describe and make sense of their behavior (2). In doing this, she examined both the informal and formal care received by the mostly Black study participants through a focus on both moral (the social stigma of being a teen parent) and medical (the health problems experienced by pregnant adolescents) accounts of teen pregnancy. According to Brubaker (1999),

Analysis of teens’ accounts suggests that even when asked to describe these health-related aspects, teens do not always see pregnancy completely in terms of health issues as much medical research assumes. Rather, they derive their understandings and construct meanings of pregnancy through interactions with others, and the understandings that evolve sometimes conflict with medical accounts from health professionals. In interpreting their experiences, teens draw on and change, accept, embrace, ignore, and challenge medical and moral accounts of pregnancy (3).

Like Kane Low et al. (2003), Hill (1994) found that women do not always follow dominant medical models of health care. In a study of how thirty-two low-income Black mothers of children with sickle cell disease (SCD) dealt with their children’s diagnosis and managed their treatment, Hill (1994) found that many mothers rejected medical explanations of the disease. According to the medical model of SCD, the disease is caused by two people who carry the sickle cell trait having a child with SCD. This model assumes that people who carry the trait will alter their reproductive behavior in order to avoid spreading the disease. Hill found, however, that mothers whose children had SCD created their own meanings and explanations of SCD that were “consistent with their resources and values, and... reinforced by those in their support system” (155). Hill cites

medical mismanagement as one of the reasons why mothers rejected the medical model, because it creates mistrust of medical knowledge and practitioners. The few mothers who did subscribe to the medical model relied more on the medical establishment for direction on how to care for their children, and, thus, were not empowered by the medical model to manage care themselves.

B. Childbirth, Race, and Social Location

Until recently, research on women's childbirth experiences primarily has been limited to examining the birthing experiences of middle-class, White women. Scholars suggest that the focus on this particular demographic group to represent the struggles of all women was an inherent flaw of second wave feminism (e.g. Davis-Floyd 1992, Martin 1992). For example, Davis-Floyd analyzes the birth narratives of one hundred "well-educated mainstream middle-class White women who, given the realities of American life, could be expected to receive the best that the American obstetrical system has to offer" (1992: 4). Likewise, Martin (2003) relies on a sample of twenty-six mostly White, mostly married, middle-class, middle-aged heterosexual women. While this literature explains the experiences of one specific type of woman, studies like this have ignored the unique experiences of women living in poverty and women of color. The premise behind Davis-Floyd's work is to expose the gender inequalities present in the medical model of childbirth, but by ignoring minority women, even feminist researchers continue to marginalize the experiences of these women.

Previous studies have analyzed the relationship between the health care experiences of minority women and their utilization of prenatal care. In a study of the

satisfaction and use of prenatal care among Black women, Handler et al. (2003) found that satisfaction had little to do with prenatal care utilization. Specifically, they found that although women receiving Medicaid rated their prenatal care better than Non-Medicaid women, the women receiving Medicaid had fewer prenatal visits than the other group. In another study involving both Black and Mexican-American Medicaid recipients, Handler et al. (1998) found that several prenatal care characteristics increased satisfaction, including “having procedures explained by the provider, short waiting times at the prenatal care site, the availability of ancillary services, and reporting that the prenatal care practitioner was male” (679).

Oakley (1991) also found that disadvantaged women were more likely to be dissatisfied with their prenatal care. In a study of two hundred thirty-six women at high risk for low birth weight in Britain, Oakley reports that working class women (race was not reported), as well as women with less education, were more likely to spend more time in waiting rooms than their middle-class and more educated counterparts, and, subsequently, to be more dissatisfied with having to wait. Furthermore, in listing the people who were most helpful and least helpful to the respondents during their pregnancy, both hospital doctors and general practitioners ranked lowest on the helpful list and high on the least helpful list.

C. Encounters with Medical Providers

Research has also focused on the potential social support pregnant patients receive from their doctors which lends support to feminist criticisms of the technocratic model and men’s control over women’s health care. In a survey of 101 low-income

women of varying ethnic backgrounds who were receiving prenatal care, Schaffer and Lia-Hoagberg (1997) found that the women in their sample did not consider their health care providers to be sources of social support. Only thirteen percent of their sample identified a doctor or other health care provider as a source of social support. Similarly, in a study of the interaction between parenting teens and staff at an educational program, Horowitz (1995) noted that the ethnically diverse teens in her study were very conscious of society's disapproval of their pregnancy.

In looking at formal prenatal care, Brubaker (1999) finds that most teens thought medical care during pregnancy is important, and that the positive meanings the respondents gave to their medical care played a role in their self-transformations into motherhood. Seeking medical care was supported by friends and family members. Additionally, all of the teens felt they received adequate prenatal information and formal care, although the amount of prenatal care each young woman received varied greatly.

Many teens gave meaning to their formal prenatal care that showed two major themes: monitoring the pregnancy and the contribution prenatal care makes to the pregnancy outcome (Brubaker 1999). Monitoring consisted of both baby-centered and mother-centered monitoring. According to Brubaker (1999),

by giving medical meanings to prenatal care, emphasizing monitoring of the body and intervention in physical outcomes, teens were able to avoid drawing on negative self-concepts that often are associated with teen pregnancy. In this respect, drawing on the medical separation of body from self might have been appealing to many teens as a strategy of resistance (134).

Another study (Kane Low et al. 2003) found that pregnant teens desire positive, supportive relationships with their health care providers. Through interviews with

twenty-five parenting students, most of whom were White, the researchers concluded that, compared to adult women, adolescents have less self-confidence and rely more on others to provide validation and approval. But while most girls wanted supportive relationships with their doctors, some felt discriminated against because of their age. On the other hand, girls who felt they were treated positively by their doctors were more likely to ask questions and value the experience.

The relationship between women and their health care providers can be influenced by the race and social location of both. Scully (1994) found that medical residents she interviewed preferred educated middle-class patients. This was due to the fact that the doctors assumed that low-income patients “lacked middle-class values, were casual about health matters, failed to respond to medical authority, and did not exhibit appropriate deference to physicians” (Scully 1994: 92).

Schaffer and Lia-Hoagberg (1994) found that the forty ethnically diverse low-income women patients in their study had different reasons for obtaining prenatal care. All of the women in their sample listed their own health and the health of their baby as rewards they received from their prenatal care, and all but one said they felt they were being responsible by going to the doctor. Fifty-five percent said they could not afford prenatal care. While this sample did include seventeen adolescents between the ages of fifteen and nineteen, no analysis was done to see what role age played in determining the rewards and costs of prenatal care that adolescents perceived.

Race and gender can also affect the amount of trust and satisfaction patients have in their encounters with health care providers. For example, in a study designed to

measure adults' willingness to become organ or blood donors, Boulware et al. (2003) found that Blacks were less likely than Whites to trust physicians. Interestingly, the researchers also found that younger participants (aged eighteen to thirty) were less likely than older participants to trust their physicians.

In a study of mostly Black low-income prenatal and postpartum adult women, Sheppard et al. (2004) also found that the amount of trust the respondents had for their physicians was dependent on the several factors, including effective communication. They also found that women who did not trust their doctors were less likely to follow their doctors' advice.

Similarly, Copeland et al. (2003) found that the Black women who participated in focus groups listed several topics that were important within the doctor-patient relationship, including communication (such as listening and information giving), trust, and attitude toward patients. The researchers surmised that these women's distrust of formal medical care may be rooted in their historical encounters with managed care, including

the existence of racially segregated medical facilities through the middle of the 20th century and defacto segregated facilities after that time, as well as the widely publicized and egregious Tuskegee experiment that withheld treatment from Black men under the guise of research (Copeland et al. 2003).

The literature review suggests that both patriarchy and racist institutionalized practices and ideologies have an effect on women's experiences within formal health care systems during pregnancy and childbirth. The research shows that women generally subscribe to the technocratic model of childbirth to some extent. In general, low-income

women, women of color, and adolescents are more likely to comply with the medicalization of childbirth than middle-class, White adult women.

Some of the specific ways that women experience patriarchy and racism are through their perceptions of decisions regarding medical intervention and encounters with health care providers. Minority women are more likely to be dissatisfied with their health care and to rely less on their medical providers for social support.

Little research exists on similarities and differences in experiences among women from diverse backgrounds. It is the intention of this study to help fill that void by focusing specifically on low-income Black teen mothers' experiences and comparing the findings to those reported for other groups.

Chapter 2. Methods

Research question

Based on the literature and theoretical frameworks guiding this study, the general research question was: how do pregnant and parenting teens experience the formal health care system? Specifically, I was concerned with two areas: the acceptance or rejection of the medical model and the teens' relationships with their doctors. In concentrating on these two areas, I examined how much teens' perceptions of the importance of prenatal care were informed by the medical model of childbirth, as well as examining the medical model through their encounters with health care providers during prenatal care visits and childbirth.

Data

This study utilizes secondary analysis of data collected at a "Teen Parenting Program" (TPP) by Sarah Jane Brubaker. The data consist of transcribed semi-structured interviews with pregnant and parenting teens attending a city school located in a large metropolitan area, whose population is largely Black and low-income, in a mid-Southern state. Information on how and why the respondents became involved in the TPP were not available from the dataset, although such information would have been helpful to interpretation of the findings.

These data were originally collected by Brubaker for her dissertation, "Medical, moral, and local meanings: How teens make sense of pregnancy and create positive identities" (1999). Unlike my analysis, which is rooted in radical feminist theory,

Brubaker's analysis utilized symbolic interactionism. Brubaker examined not only the interactions between the women and their doctors, but also the relationships these women had with their families and peers.

Also unlike my analysis, Brubaker's (1999) original work relied not only on the accounts given by the respondents, but also on other sources. She was able to observe TPP classes and school activities, as well as conduct interviews with teen parenting teachers. Brubaker also interviewed medical personnel such as doctors, nurses, a childbirth instructor, and a midwife, all of whom worked with adolescents.

Although I used the same qualitative data collected and previously analyzed by Brubaker, there are several differences between our two approaches. First, and most important, is the difference in our theoretical approaches. Unlike Brubaker, who used symbolic interactionism as the basis for her analysis, my approach focuses on the feminist issues surrounding childbirth, and whether and how the medical model is internalized by adolescent girls through the medicalization of the birthing process. My concern is not with the liminality of the birthing experience but with the impact patriarchy has on childbirth experiences as described by adolescent girls. Secondly, although Brubaker does address the role of race, class, and gender, the nexus of these three concepts are of primary importance in my analysis. Third, my analysis primarily addresses the interactions between medical personnel and the respondents during prenatal care visits and birth. Finally, in examining the experiences of adolescent mothers, my analysis is concerned not with teen pregnancy as a social issue. Thus, I am not concerned with teens' interpretations of the moral issue of teen pregnancy.

Sample Description

A total of fifty-two face-to-face interviews were conducted from April to June of 1997. The students interviewed were Black, with the exception of one, who was White. The one White student has been omitted from the current analysis in order to maximize homogeneity. Because teen parenting classes were not taught during the summer program, the ten interviews with students who attended the summer session but did not attend the TPP during the normal school year have also been omitted. The current study reanalyzes a subset of forty students from the original sample.

For this study's sample, the ages of the students ranged from fourteen to nineteen, with a mean of seventeen. The mean age of the teens at first pregnancy was fifteen. Thirty-three of those interviewed had already given birth, five were pregnant with their first child, and two had given birth and were pregnant again at the time of the interview.

The majority of the students interviewed received reduced or free lunches and received WIC (Women's, Infants', and Children's Supplemental Nutrition Program). Fifty-six percent of the teens were from female-headed households and thirty-three percent were from two-parent households.

IRB Approval

The original research was approved through the University of Delaware's Institutional Review Board. For this study, the research proposal was resubmitted and approved for exemption by Virginia Commonwealth University's Institutional Review Board.

Analysis

The students were asked a series of open-ended questions dealing with their experiences during pregnancy and childbirth (for the complete Interview Schedule, please see Appendix A). Interviews were tape-recorded and transcribed. For this study, the original transcripts have been retyped in order to facilitate analysis using HyperRESEARCH 2.6 to find major themes around teens' responses to specific interview questions. The questions I used in my analysis are:

- Why do you think doctors think it's important to go to the doctor while you're pregnant?
- Why do you think it's important to go to the doctor while you're pregnant?
- How long after you found out you were pregnant did you first go to see a doctor for a checkup?
- Did you like going to the doctor's appointments?
- Did you follow all of the doctor's advice?
- Tell me what it was like when you gave birth to the baby.
- Who have you talked to about your pregnancy?
- Have you been to see a doctor or nurse since you've been pregnant? [If so]
How did you decide to go?
- How did you like going to the doctor?
- Do you think the visit was useful?
- Are you able to follow the doctors' and nurses' advice and instructions?

In addition to these questions, I analyzed the entire data set for relevant information regarding encounters with providers.¹

My analysis utilizes the grounded theory approach. According to Straus and Corbin (1990),

a grounded theory is one that is inductively derived from the study of phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon (23).

I coded the data based on the technique outlined by Strauss and Corbin (1990). Coding involves conceptualizing the data. The data was broken down into the individual questions that I examined and then coded. There are three coding stages to this technique: open, axial, and selective. Open coding involves taking apart each individual occurrence, breaking it down into separate pieces, and giving each discrete piece a code. To minimize the volume of concepts, codes were grouped into conceptual categories. Axial coding involves taking the codes and categories created through open coding and making connections between them. During axial coding, Strauss and Corbin (1990) suggest using a paradigm model that uses the conditions of a phenomenon to create subcategories for main categories. For every phenomenon, several subcategories can be identified: causal conditions, context, intervening conditions, action/interaction strategies, and consequences. Selective coding involves selecting a core category, and then relating all other categories and subcategories to it. This final step also includes scrutinizing the data and going back over previously created codes and refining them.

¹ Gender and race of the physicians was not asked in the interviews.

Limitations

There are a couple of limitations to the current study. First, the current study uses secondary data analysis limited to existing data. Secondly, this study will be limited to interviews conducted with only forty adolescents who attended the same Teen Parenting Program, thus the results are not generalizable, but are intended to provide rich descriptions of this particular group of mothers' perceptions of their health care experiences.

In addition to these limitations, the reliability of the data is also an issue. For many of the respondents a good amount of time had passed between their pregnancy and birth experiences and when the interviews were conducted, and it is possible that the girls' memories were not completely accurate. Also, the questions asked revolved around a series of events that were completely foreign to the respondents, involving places and experiences that were new to them, which could also have affected the accuracy of their reporting. It is important to remember that the respondents' reports of their experiences with health care providers are not accurate reports, but the girls' perceptions of what occurred.

Chapter 3. Medicalization

In this chapter I discuss the data in terms of primary focus in feminist literature on pregnancy and childbirth in the United States: that there are two competing frameworks of childbirth, medical and holistic models. In relating the interviews to these two models of childbirth, it became clear that the teen respondents relied more on technocratic or medical explanations of pregnancy and childbirth than on more natural, holistic approaches. Therefore in this chapter rather than framing the issue in terms of accepting the medical model or accepting the wholistic model, I focus on the framework more readily available to the teens and discuss the respondents' acceptance or rejection of the medicalization of childbirth.

Views towards medicalization emerged during the interviews in several different ways. Once the pregnancy was discovered, the respondents made their first choice in whether or not to accept medicalization in their decision to obtain prenatal care. Once beginning formal prenatal care, the respondents made choices regarding their acceptance of medical authority and knowledge. One direct way that the women reacted to medical authority was through their decision to follow or ignore physician advice. Then during the birthing process some respondents faced increased medicalization through interventions such as cesarean and labor induction. Finally, the acceptance or rejection of medicalization can be examined in the overall importance the respondents placed on prenatal care compared with their perceptions of the importance medical personnel place on it.

A second aspect of the feminist critique, the patient/provider relationship is discussed in Chapter 4.

A. Pregnancy discovery and prenatal care

Obtaining formal prenatal care is a clear sign that, at least initially, these adolescents accepted medicalization. Of those asked, twenty-three respondents sought prenatal care within one month of finding out they were pregnant, while only six waited longer than one month. It is interesting, however, to note that twenty respondents said that the clinic or doctor who told them they were pregnant either scheduled their first prenatal care visit or told them that they needed to make an appointment. Thus, it is possible that without the advice of medical professionals, some of these respondents may have waited longer to obtain prenatal care.

Another interesting issue is how the respondents found out they were pregnant. While ten respondents said that they knew they were pregnant without having a doctor tell them that they were (usually through a home pregnancy test), the majority of respondents relied on doctors to tell them they were pregnant. Twenty-three said that they thought they might be pregnant, and a doctor confirmed it. Fourteen said that they had no idea that they were pregnant, went to the doctor for some other reason, and were told that they were pregnant. Brubaker (2005) argues that teens' reliance on the medical establishment to "discover" their pregnancies reflects the social/cultural denial of important information to teens about their bodies, an issue that likely would not affect middle class adult women to the same extent.

B. Influences on teens' views of the formal medical system

In seeking prenatal care, the adolescents received outside influences from a number of different sources. During the interviews, respondents were asked about the influence and advice offered by other people regarding seeking prenatal care and following doctors' advice. In most instances, the adolescents were encouraged to accept the medical model by both their family and members of the medical establishment.

1. Familial influences

In several instances, respondents were encouraged by others to seek advice from medical professionals. In two cases, respondents reported that their mothers advocated relying on the expertise of doctors. The first, Davina,² said her mother thought going to the doctor was important "to make sure I take care of the baby and my self." The second, Latesha, reported that her mother instructed her to follow the doctor's orders.

In other cases family members who worked within the medical establishment promoted the medical model. For example, Harmoni's sister worked in a hospital. In another case, Denise reported that her aunt, who works in a drug treatment facility, often used her own experiences as an example of why seeking medical advice is important. According to Denise, her aunt said during labor "it's best to get cut by a doctor than let the baby split you" (i.e. to have an episiotomy), despite the fact that the aunt also said the procedure was very painful. This aunt's support of the medical model seems to be strengthened by her experiences as a pregnant drug addict. As a drug addict, Denise's aunt's ability to be a mother was questioned by medical professionals during her own

² The respondents names have been changed.

pregnancy. According to Denise, her aunt risked losing her baby once he was born if she used drugs during her pregnancy. As Denise explains,

My auntie said that uh her son had to get a shot cause see my auntie she used to smoke and uh like if the baby uh had some drugs in his system she was going to go to jail so the baby didn't have none in his system.

Given her experiences, it is understandable why Denise's aunt would be fearful of not following the doctor's orders. As stated earlier, doctors may have the ability to test mothers whom they suspect of having an addiction and then report them to the police (Roberts 1997). Faced with this kind of power, its no wonder that Denise's aunt put so much trust in medicalization. Denise's reliance on the knowledge of medical professionals may be influenced not only by her aunt's stories of her own experiences, but also by her own mother's crack addiction which was brought up in the interview.

2. Influence from medical providers

Besides familial influences, medical professionals also told respondents that they should trust their doctors. This is most obvious in situations where the clinics that administered pregnancy tests to the adolescents also made the first prenatal appointments for them, as was the case for the majority of respondents. In other instances, nurses supported the medical model more directly to their patients. For example, Angelique reported that while she was laboring in the hospital, a nurse told her,

Just do what the doctor say. She said, 'don't be trying to push it out.' She said, 'cause you will wreck something.' She said, 'if you strain too hard you will break some veins in your stomach.' And so she told me, she said, 'just do what the doctor say'...And she said, 'breathe hard.' She said, 'whenever he tells you to breathe, that's when you blow.' I said, 'ok.'

Despite some reluctance to obtain prenatal care, overall the teens were willing to seek medical care during pregnancy. This decision was influenced by the opinions of both family and medical professionals. That all of the respondents chose formalized medical prenatal care is not surprising, however, considering that at the time midwives were not legal in the state in which the respondents lived.³

I. Trust in medical authority

The acceptance of medicalization does not stop at the decision to obtain prenatal care, however. Throughout pregnancy, women continue to negotiate the medical model. They do this through the amount of trust they choose to place in medical authority. Throughout the interviews, respondents were asked a number of questions dealing with the medical aspects of pregnancy and childbirth. Just as Zadoroznyj (1999) found that working-class women take a defeatist position to childbirth, the teens interviewed here can be viewed as relinquishing control to their medical care providers. Given this context, in many of the teens' responses to the questions, it is apparent that most of them agreed with the medical model. One of the more obvious ways in which this occurred was in their compliance with medical advice, as well as their decision about whose advice to follow when choosing between formal medical advice and advice from informal sources.

A. Advice

One way in which respondents chose to trust medical authority was in their acceptance or rejection of the advice offered by health care professionals. Respondents

³ Certified Nurse Midwives have since become legal in that state, although their services are still not reimbursed by Medicaid.

reported on the dietary advice, as well as advice regarding prenatal vitamins, given to them by their physicians. Respondents were also asked whose advice they followed the most during their pregnancy and whether or not any advice they received from family members and friends conflicted with their physician's advice. The teens were also asked to discuss the various forms of influence in their lives that encouraged formal prenatal care.

In addition, for many respondents, the interview included the discussion of certain medical procedures that were performed during their childbirth experiences. These included cesareans and labor induction.

Advisors

Respondents were asked whose advice they followed the most during the course of their pregnancy. Fifteen teens said that they followed their doctor's advice the most, or that they followed the advice of their doctor and another person (usually a female family member). Clearly, these respondents placed a lot of trust in the knowledge of their health care providers.

But not all of the respondents named their doctor as the person whose advice they followed the most. Seventeen respondents named a relative or significant other; specifically, nine respondents named their mother, six named another family member, and two said the baby's father. Additionally, three respondents said they followed their own advice, while one respondent said she followed no one's advice. Still another respondent said she followed everyone's advice, but also said she followed "all the

advice that I think is helpful.” When asked how she decides what advice is helpful, she said, “I think about what makes sense and what doesn’t make sense.”

Physician Advice

Two forms of physician advice were discussed during the interviews that are relevant here. First, respondents were asked to identify dietary advice given by their doctor. Then respondents were whether or not they chose to follow this advice and how well they followed it. Through the course of these discussions, the respondents said that the physicians also told them to take prenatal vitamins.

When asked directly if they were following all of their doctor’s advice, ten respondents said yes they were. Another twelve respondents, however, said no when asked directly, although most of these adolescents did admit to following some form of advice when asked about a specific topic, such as vitamins. Of the respondents who said that they were not following all of the doctor’s advice, many admitted to not following the dietary advice prescribed by their physician. While several teens did realize that they needed to change their diet and incorporate more healthy food choices, they did not want to give up the foods that they loved. For example, when asked why she continued to eat greasy foods, which her doctor told her to stay away from, one respondent replied, “I love to eat out. So I ate out all the time.”

Almost none of the respondents stated that they did not follow any of the advice their doctors gave them. In one extreme case, however, when asked why she didn’t follow any of the doctor’s advice, one respondent said,

Because I was just greedy and I liked to eat food I wanted to eat and ate my own food. / *Did you think it was gonna hurt the baby at all, to eat*

*what you wanted to eat? / No, I didn't think that. / Did you tell the doctor you weren't doing what she told you? / No, I didn't tell her.*⁴

Some respondents found following physician advice regarding daily prenatal vitamins and iron pills to be difficult. There were fourteen respondents who said that yes, they were following their doctor's advice, but later explained that there were parts they either found difficult to follow or did not follow because they disagreed with the advice. Most of these cases involved prenatal vitamins and iron pills, which are large, and can be difficult for pregnant women to swallow. A number of respondents also said they would forget to take the vitamins every day. Some respondents said they started taking their vitamins when the doctor first prescribed them, but admitted they stopped later on in the pregnancy. When asked about the taste of the vitamins, one respondent, Keisha, admitted that she took them "on and off. I'd take them, like, a month and stop, month, stop. A couple of weeks. It was nasty." While these adolescents may have chosen to not take their prescription vitamins regularly because of the taste or size, this is still a form of resistance to medical authority.

Conflicting advice

Another question asked was if the advice from family members and friends conflicted with the doctor's advice. While the majority answered no, three respondents answered yes, the advice they received from other sources conflicted with what the doctor said. One of these respondents, whose doctor told her that the advice she had received to use lotion to avoid stretch marks was incorrect, agreed with her doctor and

⁴ Interviewer questions within quotations have been italicized.

ignored the other person's advice. In the other two cases, however, the adolescents appeared to agree with the advice given by individuals other than the doctor

The first of these respondents, Gayle, said the conflict occurred when her doctor told her not to exercise. According to Gayle, her mother said, "she [the doctor] didn't know what she was talking about." Her subsequent decision to follow her mother's advice and continue to exercise rather than following the doctor's instructions was also influenced by another conflict that occurred between what her mother told her and what her doctor said. It was her mother who told Gayle that she was toxemic, while her doctor was unable to say she was toxemic until the baby was born. Because of this, Gayle felt that her mother's advice about exercise was more credible than her doctor's.

Another respondent, Gwendolyn, was also told by her mother that the advice given by doctors may not be credible. "She would sometimes tell me the doctors don't know what they're talking about. Most of them don't have kids." In questioning her doctor's knowledge based on her mother's opinion, Gwendolyn's response is not consistent with the medical model. However, unlike Gayle, she could not remember a single instance when her mother's advice differed from that of the doctor.

While these two cases represent a minority within this sample, the messages they received from their mothers about doctors are significant. Like the subjects in previous research (Kane Low et al. 2003, Hill 1994, Copeland et al. 2003), clearly, the mothers of these respondents did not have blind faith in doctors. This could be due to the historically bad relationship that African Americans in general, and African American women specifically, have had with the modern American medical establishment

(Copeland et al. 2003). Their unwillingness to rely solely on their health care providers could also be influenced by their cultural assessments of knowledge and authority as African American women (Fraser 1998, Davis and Ingram 1993, Fraser 1995).

Two respondents also asked their doctor about the validity of the advice they received from others. Clarissa said that her grandmother had told her to stop eating spicy foods, because it would make her baby blind. Instead of following the advice, she asked her doctor about it. Her doctor told her, "I can eat any hot stuff I want as long as me and my baby can take it." Similarly, Evelyn's mother told her to not "reach up too high, you know, the umbilical cord go around your baby neck." She too asked her doctor about the advice, and he said that it wasn't true. Both Clarissa and Evelyn, unlike Gayle, chose to believe their doctors over the advice of others.

The data do not provide an explanation for why Clarissa and Evelyn chose to follow their doctors' advice, and Gayle chose not to, but it is important to note that in all three instances, the subjects seem to have chosen to trust advice that allowed them to continue to do what they wanted to do. By following her mother's advice over her doctor's, Gayle was able to continue exercising. Similarly, by choosing to believe the doctor when he said she could eat spicy food, Denise was able justify continuing to eat the food she loved, just as Evelyn did not have to worry about reaching too high because her doctor was able to discredit the advice given by her grandmother. The decision to follow advice or not advice may not have been motivated as much by trust, as by teens' desire to continue to do what they enjoyed doing.

II. Compliance

In exploring the data for common themes, it became clear that there were instances when respondents did not comply with medical authority. While the majority of respondents said that they obeyed with their doctors' decisions regarding prenatal care, there were instances where some of the adolescents expressed doubt in their doctors' knowledge and abilities.

Some respondents tried to avoid dealing with the medical establishment. At least four teens waited up to more than one month before going to the doctor for prenatal care. All four of these adolescents told family members and friends that they were pregnant but still waited to go to the doctor. Of the four, three were even told by a medical professional that they were pregnant. While this could be seen as a sign of resistance, it is also possible that these respondents delayed prenatal care out of fear of doctors and medical procedures – some respondents mentioned a fear of needles in the course of the interview. In either case, the hesitation reflects less than full acceptance of medical authority.

In one particular case, Cassandra said she was in labor for four days before she went to the hospital. The only reason she gave was that she did not want to go. Another respondent, Gayle, whose doctor had been unable to diagnosis her with toxemia, did not want to call her own doctor when she first felt contractions, because she did not like her doctor. Instead, she asked for another doctor to deliver her baby:

My mom, she was supposed to call her [the doctor], but I said don't call her. She'd probably say I wasn't in labor. / *So what did you do then?* / I had called this man doctor to come up and he delivered the baby. / *Did you like him ok?* / Yeah, he was nicer than her.

One criticism of the technocratic model of birth is that women are seen as inessential to the process of birth, and doctors are regarded as the technicians best qualified to deliver a baby (Davis-Floyd 1992, Martin 2003). This critique seems consistent with a few of the teens' narratives about their dissatisfaction with medical professionals' control. These respondents described ways in which the on-call medical personnel limited their own control over the birth of their child. For example, Niki described wanting to push during labor when the nurse told her not to:

And they said, 'don't push' because there wasn't a doctor in the room, wasn't a doctor in the hall. I said 'I can't help it.'...She [the baby] was really pushing herself, making her own way. So they had to get a doctor that wasn't even on call. He still had on his suit, and he had to run and get some gloves. It was a mess.

Another respondent, Kendra, also described not being able to push because the doctor was temporarily unavailable.

It hurt me, but I took the pain. But it hurt bad. Especially at the end, because you want to push, it was hard because they told me not to push because the doctor wasn't there. They kept telling me I wasn't ready when I was.

Niki also complained that she had asked her doctor for another drug besides an epidural, but the doctor told her that he preferred to administer the epidural,

I really didn't want one, because I was having back problems before I was pregnant, but I got one anyway. I asked was there any other kinds of medicine, but he preferred the epidural.

Another form of distrust occurred when several respondents felt they did not receive adequate prenatal care from their providers. Kanika's doctor told her that he could not test for sickle cell anemia during the pregnancy. She later found out from

another doctor that this was not true. As mentioned earlier, Gayle said her doctor told her there was no way of knowing she was toxemic until the baby was born, while her mother had warned her she was toxemic early on in the pregnancy.

According to Gayle, the relationship between herself and her doctor was not based on trust. Throughout her interview, she gave many examples of ways in which she was unable to fully trust her doctor. Copeland et al. (2003) reported that in their study, Black women listed communication, trust, and attitude toward patients as key factors in the good doctor-patient relationships. In Gayle's relationship with her doctor, these three features are virtually nonexistent. While some of the adolescents interviewed named their doctor as a support person, Gayle felt that her doctor was against her. For example, in describing how her doctor would treat her, Gayle stated,

My doctor would get smart [with me]...Talking about 'you're too young to be pregnant.' Talking about her and her husband. 'A mistake is a mistake.' / *What did she tell you about her and her husband?* / How they waited 12 years before they [had children]. I don't care.

Two respondents also reported not being able to find out the sex of their baby because of constraints placed on their prenatal care. The first was only allowed one ultrasound, and since the doctor could not determine the sex at that time, was unable to find out whether she was having a boy or a girl until the baby was born. Although in this case, the restriction of allowing only one ultrasound is likely caused by HMO or insurance providers rules, in the second case the respondent said it was her doctor's personal rule that prevented her from finding out the sex of her child. Interestingly, in the second case, while the teen was denied her request to know the sex for her first child, with her second child the same doctor told her the sex of the baby. The fact that both of

these adolescents were not allowed to know the sex of their child, whether because of a doctor's personal opinion or because of an official policy of insurance or practice, still reflects a structural level constraint on the individual woman's agency.

The issues of resistance brought up here seem to be very different from the kinds of resistance shown by White women in previous literature. Davis-Floyd (1992) and Martin (1992) found that their subjects' resistance to and rejection of medical authority was based more on a knowledge of alternatives to medicalization. The acts of resistance shown here, however, seem to be more about personal comfort and wanting to assert some kind of independence, rather than being fueled by any social or political motivation resources.

III. Control over procedures

Another aspect of medicalization during childbirth is the emphasis placed on invasive intervention during the birthing process. As noted in Chapter 1, a majority of women report receiving some type of medical intervention during the childbirth (Declercq 2002). During the interview process, respondents were not asked about specific medical interventions like episiotomies, electronic fetal monitors, and cesareans. Rather than relying on medical terminology, respondents were asked to describe their birthing experiences in their own words.⁵ Two medical procedures that many of the adolescents said they experienced were cesareans and having their labor induced.

Like the respondents of the 2002 Listening to Mothers survey (Declercq 2002), only ten respondents in this study said that they gave birth "naturally," that is without

⁵ In the original interview guide, there was only one question that specifically asked about medical intervention and that question dealt only with epidural.

having a cesarean, labor induction, or epidural. Only three adolescents who had given birth twice said they gave birth naturally, and all three only experienced a natural birth with one of their pregnancies. Of those ten who experienced natural births, four stated that they had originally wanted an epidural but were unable to obtain one because the labor progressed too rapidly or, as in one case, her mother did not sign the release form.

A. Cesarean

Davis-Floyd (1992) describes birth by cesarean as:

the most extreme manifestation of the cultural attempt to use birth to demonstrate the superiority and control of Male over Female, Technology over Nature (130).

In 1997, the cesarean-section rate among females under the age of twenty was fourteen percent. Similarly, of the forty births in this sample, only six (fifteen percent) were by cesarean. What is interesting, however, are the reasons the respondents gave for their cesareans.

Unlike participants in the Kane Low et al. (2003) study, giving birth naturally was not seen as a source of accomplishment for the adolescents who underwent cesareans in this study. In each case of cesarean, the respondents describe ways in which their body failed and medical intervention was necessary. For example, although she was still pregnant, Veronica said that her doctor told her that her body was too small to give birth vaginally, and was already planning on a cesarean.

Similarly, most of the adolescents who had already given birth by cesarean said that the procedure was necessary due to specific circumstances. Cassandra underwent a cesarean because she had not dilated the full ten inches and the baby was ready to come

out. Cherie had the same problem with her second child, and also had an emergency cesarean during the birth of her first child, because the baby's heart rate decreased.

While Gayle said that her cesarean was the result of a "dry labor," she also attributed the procedure to her own failures: "I was worried I wouldn't be able to push or do anything right. That's why I had a c-section. I could barely catch my breath." In the explanation of her failure to give birth vaginally and the subsequent medical intervention, Gayle supports the medicalized concept that women are not experts at giving birth and that doctors are the most qualified personnel to deliver a baby (Davis-Floyd 1992).

B. Induced labor

Twelve respondents, or thirty percent, reported having their labor induced by the doctor. This percentage is higher than the national percentage, which, according to the Center of Disease Control, was seventeen percent in 1996 (Ventura et al. 1998). An additional three said that they were scheduled for induction, but went into labor before their appointment. Of these fifteen, seven said that their labor was induced because of health risks (high blood pressure, toxemia, the baby was losing weight). Another respondent reported that she had gone into labor, went to the hospital, and later when her labor stopped she was induced. Seven reported that their labor was induced because they were past their due dates. While most respondents did not question their doctor's decision to induce, Monica indicated that there was some confusion about her due date:

He said he was going to induce my labor. / *Why was he going to induce?*
/ They were giving me different dates. They said I was supposed to have my baby on December the 3rd but then he said that they had the dates wrong so I was supposed to have her in November but he just told me to come in November 27th and he was going to induce my labor. My baby

didn't come till the next day. / *So did they end up inducing or not?* /
Yeah, they induced it.

Responses like these appear to favor the medical model of birth over the holistic model. Like the adolescents interviewed by Luttrell (2003), these respondents placed a great deal of trust on the knowledge of their medical providers. Although there is great debate over the safety and necessity of labor induction among scholars and researchers (Griffin 2001; Davis-Floyd 1992), none of the adolescents in this study questioned their doctors' decision to induce.

Through their responses to medical interventions like labor inducement and cesarean section, as well as their reliance on medical advice, the teens show an overall acceptance of the medical model in their trust in medical authority and interpretation of the necessity for medical intervention. While this is consistent with some of the previous literature on adolescents' relationships with medical providers (Olinas 1998; Luttrell 2003), it contradicts previous research that relied on middle class White women as subjects where women resisted medical authority (Davis-Floyd, Martin 1992). Teens' resistance to some aspects of formal medical care does suggest some limit to their acceptance of medical authority. As these pregnant and parenting teens demonstrate, the ideas and opinions expressed by middle class women are by no means universal.

IV. Focus on prenatal care

Another indicator of the respondents' general acceptance of medicalization was their perceptions of why medical care was important during pregnancy. Two questions were asked relating to the importance of prenatal care. The first question was "Why do you think doctors and nurses think its important go to the doctor?" In contrast, the

second question was “Why do you think it’s important to go to the doctor?” While these two questions were asked to compare the perceived opinions of doctors with the opinions of the adolescent mothers, very few differences were found between the answers to the two. Despite several respondents showing minimal resistance to the medical model during pregnancy, when it came to the issue of the importance of prenatal care, most respondents seemed to be in agreement with their physicians.

Another question that was asked relating to respondents’ perceptions of prenatal care was what they felt they got out of going to prenatal appointments. Like their overall perceptions of medicalized care, the adolescents expressed that the reassurances and knowledge they received during doctor’s visits were mostly positive.

A. Perceptions of importance providers place on prenatal care

When asked why doctors think it is important to go to the doctor, respondent answers focused either on the well-being of the mother or the well-being of the baby. Generally, respondents’ answers fell into one or the other category, but in a few cases responses were given involving both types. The majority of responses fell into the latter category, the well-being of the baby. While the holistic view of childbirth sees a healthy mother and baby as being most desirable, the medicalized view of childbirth sees a healthy baby as the desired end product. Teens’ responses that focused only on the well-being of the baby could possibly reflect a viewpoint that is in agreement with the medical model.

For those who saw the mother’s well-being as the top priority for health care providers, their answers revolved around two issues: those who thought a doctor’s

primary concern was the health of the mother, and those who felt their doctor was more concerned with educating pregnant adolescents.

Very few respondents saw the health of the mother as the reason doctors think it's important to obtain prenatal care. In most instances, this explanation was an afterthought—an add-on to the health of the baby explanation. Only one respondent listed education as the reason doctors think women should go the doctor when they're pregnant.

Responses dealing with the well being of the baby emphasized distinct issues or goals: to check the health of the baby, to insure the outcome of the pregnancy, identify problems with the pregnancy or baby, and to protect the baby from the mother. These categories all illustrate a central technocratic theme: that the baby is a product whose well-being takes precedence over the mother's needs.

The first group of respondents felt that doctors think prenatal care is necessary to ensure the overall health of the baby. As Keisha put it,

Because they really care about the baby that's being born and if you have any kind of sicknesses or health problems that's the most important thing they need to know before the baby is being born. For they'll know what condition the baby might be in or going to be in when the baby is born.

The second group of respondents said that doctors are concerned with the outcome of the pregnancy and ensuring a healthy baby. As Carla explained, doctors think that prenatal care is important so that they can

Find out if anything is going wrong with your baby before you have it. And to let you know if they need to do any tests or take any tests on you, you know, to find out if you and the baby are still healthy before you deliver the baby, before anything happens to the baby.

Some respondents said that the reason medical providers think that prenatal care is important is to identify any problems with the baby. Interestingly, these problems could be either correctable or not. Vernisa thought that doctors were interested in problems that could be remedied:

Because it's stuff they can prevent, and if you don't have enough and they give you the vitamins and iron you don't have enough vitamins and iron something could go wrong with the pregnancy and just to make sure the baby's alright.

Trina, on the other hand, thought that doctors were looking for any kind of problems that could plague a newborn, regardless of whether or not they were correctable:

Anything could be wrong with your baby. It could have a disease that you thought you might not have had. It could be born handicapped. Because I think they can detect if your baby is going to be born retarded or something. And they can detect it and I think every mother should know it if something is going to be wrong with their child when they're born.

In this case, while a problem may not be "fixed," Trina believes it is still important for a mother to know that this illness or defect exists in her child. Kendra echoed this idea:

You can see if the child has any kind of problems and they can try to stop them before it's too late. And just so they can know how serious, or you know if you have any problems, just so you can prepare and know what to do.

The final category involves protecting the child from the inexperience and ignorance and harmful behaviors of the mother. This kind of response represents an extreme for this sample, and only a few responses fell into this category. According to one respondent, Vanessa, doctors think that prenatal care is important,

So they can check up on the baby, make sure everything is ok and make sure you ok, make sure you're not doing anything you're not supposed to while you're pregnant. / *Like what kinds of things?* / Like drinking and smoking.

B. Personal views on the importance of seeking prenatal care

As a point of comparison to the question of why doctors think it's important to get prenatal care, respondents were also asked why *they* think it's important that women go to the doctor when they are pregnant. Eighteen respondents said that they thought prenatal care was important to check on the well-being and health of the baby. Three of the adolescents whose responses fit into this category mentioned the importance of making sure they were not passing a disease on to their child, e.g. AIDS or hepatitis, although none of the respondents disclosed having either disease. Likewise, another two respondents said that going to the doctor was important in order to make sure that they were doing what they should for their baby (i.e. eating the right foods, taking their vitamins). Another two said that they felt it was important to find out the sex of the baby. Given the controversial history of Black women and the institution of medicine, it is possible that the fear of giving a child a serious disease such as AIDS or a mother feeling that she must be monitored to make sure she does not hurt the baby are more of a concern placed on minority women living in poverty by the medical establishment than is the case for middle-class White women.

Twelve respondents said it was important to make sure that the mother was healthy, a contradiction of the medical model, which views the well-being of the baby to be the most important outcome.

Interestingly, twelve respondents answered that the reason they feel it is important to seek prenatal care is the same reason they feel doctors think it is important. While this could be a product of their dependence on the medical model of childbirth, there is a methodological issue that could also explain their answer. During the interviews, the question of why they think it is important to go to the doctor was usually asked immediately following the question of why doctors think it is important. Thus, sequence of questions could have influenced the fact that a respondent answer to the latter question did not waver from their answer to the former question.

C. What was gained through prenatal care

Respondents differed on what they felt they got out of going to the doctor during pregnancy. In their answers many of the respondents perceived medical supervision and intervention in a positive light. Nine respondents said their doctor helped keep them healthy and monitored their weight. Specifically, doctors made sure their patients were eating healthy foods and abstaining from behaviors that could put the baby in jeopardy. Similarly, three respondents said that their visits to the doctor's office were mainly educational. Ten respondents said that they got to know their babies during their office visits. This was accomplished through ultrasounds and hearing the baby's heartbeat. Another twelve respondents reported that what they got out of their doctor's visits was knowing that their baby was okay. Of course, the respondents might feel differently about formal prenatal care if something was wrong with the baby. Unlike respondents who felt that prenatal checkups were worthwhile, fourteen respondents felt that they gained nothing from their experience.

In contrast to these responses, there were other positive responses to going to the doctor that did not revolve around the pregnancy itself. Five respondents said that what they got out of going to the doctor was getting to miss school or getting to go somewhere that was not part of their daily routine. Another three said they enjoyed going to the doctor because they were given free things, such as food. Robin mentioned several items she received by going for prenatal care: “they would like give me packets like of lotion, and I got a baby bed in the mail from St. Francis. I got the bottle set. I got, like, four diaper bags with brushes and combs and footies and all types of things.” While it is easy to dismiss responses such as this one as immature and materialistic, it is important to remember that this sample is mostly low-income, and these incentives to obtaining prenatal care may include items that an impoverished adolescent mother cannot readily afford.

Another issue that may have impacted the teens’ positive responses to going to the doctor is the fact that, historically, African American women have felt excluded from modern medical care (Fraser 1998; Collins 1994; Roberts 1997). While White middle-class women may take medical prenatal care for granted, formal care is not necessarily assumed for the African American woman. Simply being a part of the medical model might be seen as a mark of privilege, and, therefore, an incentive to prenatal care (Brubaker 1999).

As previously illustrated by Davis-Floyd (1992), Martin (1992) and Zadoroznyj (1999), the acceptance or rejection of the medicalized childbirth is not clear-cut. Instead, adolescents like those interviewed here vary in the extent to which they agree and

internalize the medical model. Their views are informed not only by their health care providers, but also by the communities in which they live. As a result of these influences, the respondents also varied in the amount of time before they sought out prenatal care, as well as their reactions to medical interventions during labor and delivery.

Overall, medicalization was accepted or rejected by the teens in several different ways. First, the majority of respondents accepted medicalization by choosing to go to the doctor for prenatal care, regardless of how long after pregnancy discovery it took them to go. Once prenatal care had begun, the respondent chose to either follow or ignore the advice given to them by the doctor. In a few cases there was a choice between a doctor's advice and another source. Respondents also chose to accept or reject medical authority during labor and delivery. This includes the acceptance of any intrusive medical procedures that may have been performed. Finally, in the interviews the respondents accepted or rejected medicalization in their answers to the questions pertaining to the importance of formalized prenatal care, as well as what they felt they gained from the experience.

Chapter 4. Relationships with providers

Besides the dominance of the medical model in modern discourse, another important component to the feminist critique of American childbirth is the racist, patriarchal relationship that exists between women and their health care providers. As stated in Chapter 1, previous research has indicated that this unequal relationship is generally analyzed using the viewpoint of the patient regarding her interactions with health care providers. This chapter looks at the attitudes of the respondents about their dealings with doctors and nurses. Specifically, this chapter deals with the personal feelings the adolescents felt toward medical staff, as well as whom the teens relied on for support during pregnancy.

I. Attitudes toward health care providers

One indicator of the relationship between the respondent and her physician is her personal feelings towards her health care provider and the office visit. While the majority of respondents did personally like their doctors, a few did not. Similarly, while the majority did like going to the doctor, many respondents did not like certain aspects of the visit.

Many respondents said that they personally liked their doctor. Some reported they thought their doctor was nice. One respondent, who switched doctors during her pregnancy, said that although she liked her first doctor, who was a man, she liked her second doctor, a woman, more. Another respondent named her doctor as a support person during her pregnancy.

When asked whom they talked to about their pregnancy, nineteen adolescents said their doctor, in addition to family members, such as mothers and aunts, and friends. During these conversations, some respondents talked to their doctor about issues that worried them about the pregnancy or childbirth experience. For example, Harmoni reported that she expressed her fears to her doctor:

Was my baby going to live or was one of us going to die. Because I kept watching these TV shows, and this lady, you know, she was pregnant and she went in labor. Her baby lived but she died. / *Was that on ER?* / [inaudible] / *Did you talk to the doctor and stuff about that kind of thing?* / He sent me to counseling.

Other respondents said that they asked their doctors questions regarding their pregnancy or what would happen in the delivery room. Still others reported that doctors talked to them about how to take care of themselves.

While most of the adolescents said that they liked their doctor and got something out of their prenatal care appointments, there were a few respondents who reported that there were parts of the doctor's visits that they did not enjoy. For example, Gloria felt that the doctor withheld information from her during her pregnancy:

They wouldn't tell me why my baby was low, you know, he was low. They wouldn't give me all the information that I needed, wouldn't tell me why the baby was so small or why'd I have it so early.... / *Was there any other thing that they told you to do when you went? What you needed to do or not do while you were pregnant?* / Nope, they didn't tell me nothing.

Mashekia said that she did not like the way her doctor spoke to her about her pregnancy: "I think Dr. B- told me, 'you know having a baby so young, you might die.' I didn't like him. I only saw him about one or two times."

While most respondents did not have grievances as severe as Mashekia or Gloria, some did express that aspects of the visit were either uncomfortable or undesirable to them. Eleven respondents said they did not like pelvic examinations (most respondents referred to this as a pap smear, although these tests are usually only preformed during the first prenatal care visit). Seven respondents did not like other procedures conducted during prenatal care visits such as any test involving taking blood or using needles. Three reported that they did not like getting undressed for the examination. Another four respondents said they did not like getting up for early morning appointments or missing school, and seven said they did not like the long wait to see the doctor. These examples suggest a negative view of medicalization, at least in terms of how certain procedures facilitate the physicians' control and privilege that control mothers' comfort, which is consistent with feminist critiques.

Clearly, the respondents differed in their perceptions of the relationships they had with their health care providers, so that the issue of patient-doctor interaction provides limited support to any argument regarding its importance to teens' views of medicalization.

Chapter 5. Discussion and Conclusions

This analysis focuses on two distinct issues in childbirth and pregnancy: the medicalization of childbirth within the United States and the patriarchal doctor/patient relationship that manifests during prenatal care. Through this research, I am concerned with how these two issues affect Black adolescents, a group virtually ignored in by feminist scholars, except as a deviant group. In this chapter I discuss the findings related in the previous two chapters regarding these two issues, as well as offer suggestions regarding future research and policy.

In looking at the decisions these adolescents made regarding their pregnancies, it is important to remember that this was a convenience sample, and all of the respondents were enrolled in a program specifically for pregnant adolescents. At the time of interview, these were not adolescents who were expecting to terminate their pregnancy, nor did any put their children up for adoption. While not all of the teens would be raising the child by themselves, they all expected to have some responsibility for the child after birth.

Medicalization

The acceptance of a medicalized pregnancy and childbirth cannot be explained by a single decision, but a series of choices over the course of the pregnancy and the actual birth. Thus, a woman's response to medicalization is not necessarily static but evolutionary and can change over the course of the pregnancy. However, for those who fully subscribe to the medical model, whether consciously or not, the opportunity for

choice does not present itself as often. At some point these adolescents make a decision (or have it made for them) to rely on their doctors to make many of the important choices.

All women are involved in the first choice which occurs at the onset of pregnancy. With only a few exceptions, at the point in which these adolescents found out they were pregnant, most of the respondents chose to seek medical care fairly quickly. Not surprisingly – since midwifery was not an option – all of the respondents chose formal prenatal care administered by a physician. It seems that alternatives to medical prenatal care were not discussed with the adolescents in this study.

The issue remains, however, of whether or not this was a decision the pregnant adolescents were allowed to make for themselves. It may be that the first prenatal appointment after pregnancy discovery was set up automatically by the clinic staff, or their guardians may have made that decision for them. Indeed, a majority of respondents reported that the clinic where they found out they were pregnant either scheduled their first appointment or recommended that they do so.

Pregnant adolescents do not live in a vacuum. The outside influences that encouraged the seeking and maintaining of prenatal care was also a factor in any decision the teens may have made regarding medicalization. Many of the respondents reported having family members directly promote their following physician advice. Still others noted that medical professionals themselves supported trusting medical authority.

The external influences promoting medicalization also affected its acceptance throughout the pregnancy. Once the decision was made to obtain prenatal care, there were other opportunities for the adolescents to accept or reject medicalization. Overall,

however, the respondents accepted it. Most of the teens followed their physician's advice, or at least tried to. What's more, the few respondents who chose not to follow medical advice regarding vitamins and nutrition seem to have done so for purely hedonistic reasons that had nothing to do with the technocratic/holistic dichotomy. That is, the adolescents who resisted medical advice did so because it went against what they wanted to do. The fact remains, however, that they did resist.

In some areas, the respondents did show some resistance to medicalization. What is not clear, however, is whether their non-compliance with medical authority was really a sign of resistance to medicalization or a sign of something else entirely. For example, while a few respondents waited to obtain prenatal care, it is highly possible that this was caused by a fear of doctors in general rather than hesitation to accept a medicalized pregnancy and childbirth. At other times it is uncertain if respondents resisted medical authority because they did not agree with its control over their pregnancies and bodies or because of a personal dislike for the medical staff attending them.

Despite these remaining questions, it is possible that in many cases resistance to medical authority was related to the race and gender inequality most feminist scholars argue exists. There were respondents who did not trust their doctors and felt they did not receive all the information they should have. Within this sample, however, these respondents were few and far between. None of the respondents who expressed resistance specifically said that their defiance was caused by any perceived racial prejudice or patriarchal oppression, although it is important to recognize that teens' relative youth and immaturity may have prevented them from acknowledging and

articulating these issues. Also, it is important to note that while there were some examples of resistance, no resistance resulted in a respondent choosing to not go to the doctor.

On the issue of control over medical procedures within the delivery room, while most of the respondents who underwent cesareans or labor inductions did not choose those procedures, neither did they ask not to go through them. It is likely the case that these teens are not used to having any say in much of what happens to them, however. In addition, none of the adolescents who reported such procedures expressed that they had any say in the decision. Instead, it was the doctor who chose to perform them. Of course, in the case of an emergency cesarean, choice is not possible. It could be argued, however, that in some of the cases that were deemed “emergencies” by doctors there really was no need for such urgency (Davis-Floyd 1992). The same could be said for inducement, especially considering that of the fifteen respondents scheduled to have their labors induced, three reported that they went into labor naturally before the inducement.

Focus on the outcome

Another important aspect of medicalization, according to radical feminists, is the focus on a healthy baby as the end product of a successful pregnancy and delivery to the point where the mother’s comfort and safety may be jeopardized in order to ensure this outcome (Sterk 1996; Casper 2002). The respondents here clearly identified with this aspect of the medical model as outlined by radical feminist theory.

Within this sample, the production of a healthy child is clearly important to these adolescents as evidenced in their answers to questions regarding the importance of

prenatal care. When asked about their own perceptions of the importance of prenatal care, most respondents expressed that there was a need to know that the baby was alright, while very few listed their own health and wellbeing as a reason to go to the doctor. In fact, in some cases it seems that the respondents felt that part of the importance of prenatal care was to protect the baby from the mother, by making sure the mother was not compromising the health of the baby and not at risk for giving the baby any diseases. It's also important to note that many of the respondents were in complete agreement with the reasons why they thought doctors place importance on prenatal care.

Their responses regarding what was gained by going to the doctor are very similar to their reasoning of why prenatal care is important. Again, they listed the importance of medical surveillance of the pregnant woman's habits as something gained from the appointments. This finding provides an important challenge to notions of teen mothers as selfish and self-indulgent. Their notions of surveillance by medical professionals also suggests that teens might be viewed by providers as potentially causing harm to their babies.

There were responses, however, that included more positive reasons for going to the doctor. For example, some of the adolescents expressed that going to the doctor meant getting to see the baby via ultrasound or hearing the baby's heartbeat, signs that these adolescents saw prenatal care as a means of bonding with the fetus. Still others stated that their doctor educated them about pregnancy and childbirth during the appointments.

Relationships with Providers

In analyzing the respondents' relationships with their providers I initially hoped to look for clues as to whether race, class, and gender were a factor in these interactions. During analysis, however, I found there was not much data regarding the doctor/patient relationship to draw any strong conclusions about this issue. Despite this, I was able to find some indication of how these issues impacted the relationship by focusing on the attitudes respondents expressed about the medical personnel who attended them during pregnancy and childbirth.

While the literature suggests that race, class, and gender create a doctor/patient relationship that disenfranchises women and causes their distrust and discomfort with the medical system, for the majority of this sample, it seems this is not true. In fact, most of the respondents said they liked their doctor. Some even said they relied on their physicians for support during pregnancy, asking questions and expressing acceptance during their prenatal visits.

This satisfaction with health care providers was not universal, however. Despite generally liking their physicians, many said they did not like the invasive medical procedures they had to go through during a typical doctor's visit, like pelvic exams and tests that required them to give blood. But again these complaints seem to be more against medicalization, rather than dissatisfaction with their providers.

A few of the respondents did state that they did not like their doctors and did not feel comfortable with them. In these cases their may have been issues related to race, class, and gender that caused their dissatisfaction. There is also a chance that age played

a part, since a few respondents said that their doctors made blatant comments regarding the age at which these adolescents were having children. Other than age, however, any other areas of oppression were not discussed in or ascertainable from the interviews.

Comparing the sample with middle-class White women

Previous researchers like Davis-Floyd (1992) and Martin (1992) who have focused primarily on middle class White women in their analysis of American childbirth have shown that the women in their studies vary in their degree of acceptance of the medical model. These middle class women have something that is unavailable to the adolescent girls analyzed here, however. Unlike this sample, the samples addressed by previous women researching this subject have had the power to choose the type of birth they are most comfortable with.

There are many possible limitations that could impact the amount of choice given to adolescent girls during pregnancy and childbirth that are not issues for their adult, middle class counterparts. The first limitation, of course, is the lack of legal, affordable alternatives to formal prenatal care. Second is the issue of knowledge regarding choice. It is possible that many if not all of the respondents were unaware that they could make choices regarding what medical procedures they wanted done during pregnancy and how they wanted to give birth. Third, even if midwifery had been legal in their state and they had prior knowledge of alternatives, since a majority of them did not have private insurance, chances are their Medicaid would not have covered anything other than a hospital birth with an obstetrician. A fourth limitation is the amount of influence they

received from outside sources. These sources included parents, guardians, and medical providers – all authoritative figures in the life of an adolescent.

Additionally, many of the teens' apparent need for attention as well as other material "perks" provided by prenatal care suggest that the influences on their perceptions of the relative value of formalized health care are very different from those of more privileged women.

Suggestions

One of the goals of this study was to open up the feminist dialog on childbirth to adolescent girls of color, a group typically marginalized in the discussion. To this extent, this study has succeeded. There is a lot more research to be done in this area, however. Here I outline several suggestions for further research, as well as ideas for policy changes for the future.

As stated in Chapter 2, this study was limited by a number of factors. First, the relatively small size of the convenience sample, as well as the uniformity of the respondents hindered any generalizations that could be made from this research. Future research must involve a more diverse group of adolescent respondents. Secondly, the present study focuses on pregnant and parenting adolescents. Any true comparison of the perceptions of medicalization of adolescents and adult women must be done using a sample of both age groups. Similarly, this study was also limited by the racial homogeneity of the sample. Any study that really looks at the role race and class play in the medical/natural childbirth debate must include women of different races and social classes. Finally, this project was also limited by its use of secondary analysis of a prior

study. In future research, questionnaires should be more clearly directed to answer the research questions.

While this study may not be generalizable to a larger population, it does raise some policy questions regarding the treatment of pregnant adolescents. Presently, in the United States, teen pregnancy is viewed as a social problem, and pregnant and parenting teens are greatly stigmatized. Certainly, teen pregnancy should not be idolized or encouraged. But in seeing pregnant teens only as a problem, we may be failing to educate them about their own bodies and the rights they have in relationship to their bodies and their children. In denying them this knowledge, we as a society are further increasing their dependency on the medical system and decreasing their own agency to make decisions about their lives.

Conclusion

The purpose of this study was to gauge whether or not the respondents accepted the medical model of childbirth, as well as to see what impact race, class, and gender had on the patient/provider relationship. While there were instances of resistance, on the whole the sample favored acceptance and conformity to the medical model. This can be explained to a large extent by the outside influences that encouraged medicalization, as well as the lack of information about alternatives to a medicalized childbirth. It was also found that at least for this sample, the intersection of race, class, and gender did not appear to be an important issue in the doctor/patient relationship as perceived by the teens. Future research should focus on broadening the sample to include a more diverse group, designing more focused questions, and observing actual doctor-patient

interactions, so that generalizations can be made. That resistance was found and articulated, despite overwhelming support for the medical model, suggests significant potential for the acceptance of alternative approaches.

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APPENDIX A

Interview guide

1. Tell me about how you found out you were pregnant.
What made you think you might be pregnant? How far along were you when you found out for sure?
2. How did you feel when you found out you were pregnant?
Who else did you tell you were pregnant?
How did they react?
How have others reacted to your pregnancy?
What kinds of things did they say? why do you think they said this?
How did you feel about their reactions?
What kinds of things would you like them to have said?
Did anyone ever suggest that you not have or keep the baby?
If so, who, and how did you decide not to have an abortion or place the baby for adoption?
3. Who have you talked to about your pregnancy?
Family members, boyfriend, friends, teachers, social workers, church leaders, health care workers
What kinds of things have they told you?
Any stories, advice, etc.?
How do you feel about what they've told you?
What are the most helpful things they've told you? what are the least helpful things they've told you?
Why do you think they told you these things, treated you this way?
4. What do you think about most when you think about being pregnant?
What kinds of things are you worried about? excited about?
5. What kinds of things have you done differently since you've been pregnant?
Do you eat or avoid eating anything in particular?
Do or avoid doing any activities, like sports, fighting? are your relationships with people different? if so, how? do you wear different kinds of clothes?
6. Who would you say has been the most supportive of you during your pregnancy?
What kinds of things have they said or done?
Who would you say has been least supportive of you?

- What kinds of things have they said or done?
 Were there kinds of support that you expected and didn't get?
 Can you tell me about that?
 Were there kinds of support that you didn't expect, but did get?
 Can you tell me about that?
 Do you think you're getting all the support you need?
7. What are the best things about being pregnant?
 What are the hardest things about it?
 How has being pregnant changed your life?
 Do you think other people see you differently now that you're pregnant?
 If so, who, and how?
 Do you see yourself differently now?
 If so, how?
8. [For mothering adolescents:] Tell me what it was like when you gave birth to the baby.
 Was it different from what you thought? if so, how? what had other people told you to expect? who told you what to expect?
 [For pregnant adolescents:] Has anyone talked to you about what it's going to be like when you
 go into labor?
 If so, who, and what have they told you?
 If not, what do you think it's going to be like?
9. Have you been to see a doctor or nurse since you've been pregnant?
 [If so] How did you decide to go?
 Did somebody tell you to go? Did you know someone else who had gone?
 if so, who?
 Where did you go?
 What was the name of your insurance?
 What happened when you went there?
 Who talked to you? what kinds of things did they tell you? who did you see? what did they do?
 How did you like going?
 Do you think the visit was useful?
 Are you able to follow the doctors' and nurses' advice and instructions?
 What kinds of advice do you follow? What kinds don't you follow?
 Did you go more than once?
 If so, how many times have you been?
 If not, why not?
 Was there anything about going that you didn't like? Can you tell me about that?
 [If not] Can you think of any reason you might go?
10. Why do you think some people consider going to the doctor while you're pregnant so

important?

Do you agree with them?

Has anyone told you how often you need to go to the doctor while you're pregnant?

Do you think you'll go that often? Why or why not?

Are there reasons it may be hard to go so often, do you think you really need to go that many times?

Do you think you need to go for regular check-ups even if you're feeling OK, or should you go only if you're feeling sick?

When, during the pregnancy, do you think women need to go to the doctor?

At the beginning, in the middle, at the end?

11. Before you got pregnant, had anyone ever talked to you about trying not to get pregnant?

If so, who?

What kinds of this did they tell you?

Had you ever thought about, or talked to anyone about, what you might do if you became pregnant?

Were you doing anything to try to prevent getting pregnant?

If so, what?

12. How often did you go to the doctor's office or other medical facility before you were pregnant?

What kinds of things did you go for?

Who usually makes decisions about your health care?

You, your parents, someone else?

What kinds of things do they tell you about getting health care? How important do they think it is?

How do you feel about going to the doctor in general?

Do you like going? why or why not? how do the doctors, nurses, etc... usually treat you?

13. How old are you?

Are you single? If so, have you ever been married?

[To determine social class:]

Who do you live with?

What kind of job do they do?

How much education did they complete? Do they work part-time or full-time?

(If supporting themselves or living with husband/boyfriend/friend) What do you do?

What does your husband/boyfriend do?

Do you or your family receive any kind of government assistance? If so, what kind?

Vita

Preston T. Martin-Lyon was born on April 16, 1979, in Roanoke, Virginia and is an American citizen. She graduated from Patrick Henry High School, Roanoke, Virginia in 1997. She received her Bachelor of Arts in Sociology from Hollins University, Roanoke, Virginia in 2003. She was a teaching assistant in the Sociology Department at Virginia Commonwealth University for a year and a half. Preston has been a member of Alpha Kappa Delta since 2002.