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ORIGINAL ARTICLE

Coping with the stigma of home birth: Strategies of engagement and disengagement

Rachael Kulick Bommarito[A,B,C,D,E,F,G]

Midwifery Education Accreditation Council, Minneapolis, United States

BACKGROUND
Home birth in most developed countries is stigmatised. Negative discourses frame women planning home births as risk mothers who put their desire for a particular birthing experience above the health and safety of their children. As a result, one of the primary challenges home-birthing women face during pregnancy is how to cope with this stigma.

PARTICIPANTS AND PROCEDURE
This study was conducted in the upper Midwest region of the United States with women who were planning home births with midwives. Eleven women participated in the study. Data included in-depth interviews, participant-observation field notes, and content from one participant's blog. Data were analysed using inductive content analysis.

RESULTS
Participants coped with home birth stigma in three ways: (1) avoidance, (2) engaging in an education campaign, and (3) focusing on a family tradition of home birth. These responses represent both disengagement and engagement approaches to coping. Nine participants exhibited one dominant coping strategy: three relied on avoidance, three on an education campaign, and three on family tradition. Two participants used more than one approach. Both of these participants used avoidance and family tradition.

CONCLUSIONS
Home birth stigma is a source of chronic stress for women who choose to give birth at home. Women cope with this stress in a number of ways. Interventions to increase women's coping resources and processes may be helpful. Changing the environment through efforts to destigmatise home birth may reduce the overall stress experienced by home-birthing women and improve their wellbeing.

KEY WORDS
qualitative research; stigma; midwifery; coping with stress; childbirth

CORRESPONDING AUTHOR – Rachael Kulick Bommarito, Ph.D., Midwifery Education Accreditation Council, 850 Mount Pleasant Avenue, 48103 Ann Arbor, United States, e-mail: rachael@umn.edu

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BACKGROUND

In most developed countries, birth takes place in hospitals, with the majority of prenatal, labour, and postpartum care overseen by midwives working under the supervision of obstetrician-gynaecologists. Rates of home birth range from less than one in a thousand births in Sweden (Hildingsson, Lindgren, Haglund, & Radestad, 2006) to 13.00% in the Netherlands (Perined, 2016). In most developed countries, the rate is between 1.00% and 3.00%.

The United States, where this study took place, is typical in that the vast majority of births take place in hospitals. In 2015, 98.50% of births were in hospitals and 1.50% took place in homes or freestanding birth centres (Martin, Hamilton, Osterman, Driscoll, & Mathews, 2017). It is different in that less than 10.00% of births are attended by midwives. In the mid-twentieth century, the United States virtually eliminated midwifery (Leavitt, 1986; Rooks, 1997; Wertz & Wertz, 1989), and by the 1970s, midwives attended less than one per cent of births (Martin et al., 2007). Over the past 40 years, midwifery has made a resurgence, but physicians remain the primary care providers for most pregnant women.

Across the developed world, with the exception of the Netherlands, home birth is neither culturally normative nor socially accepted. Researchers in Finland found that women who plan home births are labelled risk mothers (Wrede, 1997) and must "deal with the moral danger of labelling and stigma consequent to their 'irresponsible' behaviour" (Viisainen, 2000, p. 794). Longitudinal research conducted in England found that discourses of risk, blame, and responsibility constrain women's decision-making with respect to place of birth, and that even with national-level policy support for home births and freestanding midwifery units, few women choose to give birth outside of an obstetrical unit (Coxon, Sandall, & Fulop, 2014). In the United States, some influential obstetrician-gynaecologists assert that women "do not have the right to put their baby at risk" by choosing home birth (Chervenak et al., 2013, p. 35). Pervasive disapproval makes it difficult for midwives to consult with physicians, makes home-to-hospital transport treacherous, and potentially decreases the safety of home birth (Snowden et al., 2015).

Despite negative rhetoric, a small percentage of women choose home birth. Research from New Zealand (Grigg, Tracy, Schmeid, Daellenbach, & Kensington, 2015), Canada (Janssen, Henderson, & Vedam, 2009; Murray-Davis et al., 2012), Sweden (Hildingsson, Radestad, & Lindgren, 2010), and the United States (Boucher, Bennett, McFarlin, & Freeze, 2009) has found that home birthing women are motivated by a number of factors, including confidence in their midwife and their own ability to give birth, trust in the birth process and wanting to have more control over it, and a desire to avoid unnecessary medical interventions. Women who choose home birth see the high rates of medical intervention associated with hospital birth as an indicator of reduced safety (Boucher et al., 2009), and they invert the hegemonic risk discourse to argue that hospital birth, not home birth, is a risky choice (Fage-Butler, 2017).

STIGMA, COPING, AND THE SALUTOGENIC MODEL

Negative discourses surrounding home birth contribute to and are illustrative of the stigmatisation of the choice to birth at home. One way people experience stigma is as a chronic stressor (Miller & Kaiser, 2001). There are many ways of coping with stressors, and numerous taxonomies have been proposed to categorise coping responses, including problem versus emotion, approach versus avoidance, active versus passive, cognitive versus behavioural, and engagement versus disengagement (Skinner, Edge, Altman, & Sherwood, 2003).

According to the salutogenic model of health, how people cope with stress has a significant impact on their health (Antonovsky, 1979). The concept of salutogenesis and a focus on factors that promote health have long been used in public health research (Antonovsky, 1996; Lindström & Eriksson, 2005) and has recently been applied to the study of maternity care (e.g. Church et al., 2017; Ferguson, Davis, & Browne, 2013; Perez-Botella, Downe, Magistretti, Lindstrom, & Berg, 2015; Smith et al., 2014). This article contributes to the literature on salutogenesis and childbirth by examining how women cope with the stigma associated with planning a home birth.

RESEARCH QUESTIONS

This study began as a broad inquiry into women's experiences of home birth in the United States and the overarching question driving the project in its early stages was: What is it like for women to plan a home birth in a society in which this choice is stigmatised? To gain insight into this experience, the researcher conducted ethnographic fieldwork and interviews. During pre-birth interviews, the researcher explicitly inquired about how people were responding to the women's plans to birth at home. Participants' answers to these questions informed the specific research question that is addressed in this article: For women who experience stigma in relation to home birth, how do they cope with that stigma?

PARTICIPANTS AND PROCEDURE

PARTICIPANTS

Recruitment followed a two-step process. First, the researcher recruited midwifery practices via home birth support groups, midwifery training workshops, and professional organisation meetings. Four practices enrolled in the study. In the second stage, these practices informed their clients about the study and invited those who were interested to contact the researcher about potential involvement. Individuals from all four practices contacted the researcher expressing interest in participation. The only requirement for participation was that the pregnant woman be planning a home birth with a midwife and have a due date within the study period. All qualified women who expressed interest in the study were included. Notably, participants were not recruited on the basis of felt or experienced stigma, but all described having to cope with stigma during pregnancy.

Through this procedure, 10 participants joined the study. The researcher also participated in the study. She recorded field notes during her own pregnancy and was interviewed by a colleague, Dr. Vania Brightman Cox. Therefore, a total of 11 women made up the study group.

Participants completed a socio-demographic questionnaire, reporting their age, race/ethnicity, religion, education, marital status, family income, and number of children. In general, the sample reflects the typical demographics for home-birthing women in the United States: they are older, white, highly educated, and married (Johnson & Daviss, 2005; MacDorman, Declercq, & Menacker, 2011; MacDorman, Mathews, & Declercq, 2012). The literature also suggests that home births are more common among women with several previous children. In this study, however, nine of 11 participants had one or no previous children. Table 1 provides an overview of sample characteristics.

MEASURES

The study is based primarily on interviews conducted during pregnancy. Limited additional data come from other sources, including post-birth interviews, prenatal field notes, and blog material. Data sources, by participant, are detailed in Table 2.

Table 1

Participants' demographic characteristics

Participant	Age	Race/ ethnicity	Religion	Education	Marital status	Family income	#of children
Krista	37	White	None	Bachelor's degree	Married	Upper middle class	1
Sarah	32	White	None	Bachelor's degree, enrolled in master's program	Married	$95,000	1
Mona	32	White	None	Bachelor's degree, enrolled in a doctoral program	Married	$70,000	0
Michelle	31	White	None	Master's degree	Long-term cohabiting	$40,000	0
Jolene	26	White	Undecided	Bachelor's degree	Married	$22,000	0
Jessica	28	White	Christian	Some college	Married	$28,600	0
Faith	27	White	Christian	Bachelor's degree	Married	$50,000	3
Kelly	28	White	Independent Apostolic Lutheran	Bachelor's degree	Married	Not specified	4
Emma	27	White	Lutheran	Associate degree	Married	$35,000	1
Lauren	32	Black	None	Bachelor's degree, some professional training	Married	$63,000	1
Lisa	35	White	Unitarian	Two bachelor's degrees	Married	$62,000	0

Table 2
Data sources, by participant

Participant	Pre-birth data collection			Post-birth data collection
	Pre-birth interview	Fieldwork	Text	Post-birth interview
Krista	X			
Sarah		X		X
Mona	X	X		
Michelle	X			X
Jolene	X		X	
Jessica	X			
Faith	X			
Kelly	X	X		
Emma	X			
Lauren	X			
Lisa	X			

Interviews. The dataset includes ten pre-birth interviews and two post-birth interviews. Interviews were approximately 90 minutes long and consisted of open-ended questions. All interviews were recorded and transcribed.

The pre-birth interview protocol included a number of questions, three of which were designed to elicit feelings and experiences of stigma as well as descriptions of coping. These questions were: (1) How did you find out about home birth? (2) Why are you planning to give birth at home? (3) How are people in your life responding to your decision to birth at home? Participants' responses to these questions form the primary dataset for this study.

Two post-birth interviews were included in the dataset due to special circumstances. One participant joined the study at approximately 37 weeks of pregnancy and gave birth before the pre-birth interview could take place. Therefore, the researcher asked both the pre- and post-birth interview questions during the post-birth interview. A second participant completed a pre-birth interview in which she described how she dealt with people who were sceptical about her plan to birth at home. During the post-birth interview, her mother was present, and together they returned to this topic. Therefore, transcripts from both the pre- and post-birth interviews were included.

Participant-observation. The researcher accompanied women during prenatal appointments, which took place in women's homes or midwives' offices. She also attended participants' births, arriving at the start of active labour and leaving three to four hours after the birth of the baby. While in the field, the researcher recorded "jottings" (i.e. short notes and bits of dialogue), which were used to create field notes that included detailed observations of the physical environment, participants' behaviour, and verbal and nonverbal communication between pregnant women, their midwives, and their family members (Emerson, Fretz, & Shaw, 2011; Lofland & Lofland, 1995). Field notes were generally completed within 48 hours of a field experience.

The researcher also recorded auto-ethnographic field notes about her own pregnancy (Chang, 2016; Ellis, Adams, & Bochner, 2011). These field notes included thorough descriptions of events as well as self-observational data regarding behaviours, thoughts, and emotions. The researcher compared and contrasted her personal experience with the experiences of others as observed in the field and described in the literature.

Texts. One participant created a blog during her pregnancy. The blog was disseminated to friends and family members as a means to inform them about the couple's birth plan and educate them on the practice and safety of home birth. The participant referred to the blog during the pre-birth interview and gave the researcher permission to use it in the study.

ANALYSIS

Interview transcripts, field notes, and texts were analysed using inductive content analysis. This involved reading the documents generated by the research process, coding them, and writing memos about them (Emerson, Fretz, & Shaw, 2011; Lofland & Lofland, 1995). The researcher began by reading the pre-birth interview transcripts because this was where she explicitly inquired about stigma. She conducted high-level coding for passages that dealt with feelings or experiences of stigma during pregnancy and descriptions of coping. After the pre-birth interviews were coded

for "stigma" and "coping," the researcher examined other data collected during the course of the study to see whether they contained references to stigma or coping. The researcher found limited additional passages in prenatal field notes and post-birth interviews.

Once all the passages related to stigma or coping were located, the researcher re-read the material, this time making notes about themes, patterns, and links to the literature. These notes formed the basis for longer memos, in which the researcher examined relationships between the participants' descriptions of coping with stigma and the existing literature's categorisation of coping strategies. As the researcher cycled through the activities of reading, coding, and memo writing, a typology of coping responses emerged.

RESULTS

All 11 participants felt or experienced stigma during pregnancy. They coped in three ways: (1) avoidance, (2) engaging in an education campaign, and (3) focusing on a family tradition of home birth. Nine participants exhibited a single, dominant approach to coping: three relied on avoidance (27.00%), three engaged in an education campaign (27.00%), and three focused on a family tradition of home birth (27.00%). Two participants used both avoidance and family tradition strategies (18.00%). Coping responses are summarised in Table 3.

AVOIDANCE

Krista

During the pre-birth interview, Krista described how her neighbours reacted to her plan to birth at home. "It gets the same response as, 'I slaughtered a small puppy down the street for supper last night.'" She went on to describe the feeling that others viewed her as selfish. "That's my favourite part, that it's so selfish to have a home birth. That I'm being selfish in doing this outrageous thing and why would I risk the life of the baby."

Krista reported that as her pregnancy progressed, her sense of stigmatization increased, as did her anxiety about it. She recounted a time when she was "ambushed" on her way home from the mailbox. "This neighbour I hardly know said, 'So, you're getting close!' And she says, 'Where are you having the baby?' And she goes, 'Wow, I never even considered having my child anywhere but the hospital.' I was having contractions at the time, so it wasn't like I could run. I had to kind of wait it out, you know? So [laugh], I'm standing there and I'm getting (a) really angry and (b) really very hurt. And I can't escape. I can't leave at that moment. I'm kind of holding on and then she goes, 'two of my children needed help from my hospital. They could have, who knows what could have happened if I wasn't in the hospital.' So, finally, I'm like, 'Well, good to see you!' And I crossed the street and went back inside."

In the last weeks of pregnancy, Krista moved from avoidance to almost complete social withdrawal. She said, "I actually found myself wondering if I might have agoraphobia because I didn't want to go outside"

Sarah

Sarah gave birth to her first child by caesarean section. When she became pregnant with her second, she began researching vaginal birth after caesarean. Toward the end of her pregnancy, she decided to plan a home birth and she changed care providers from

Table 3
Coping responses of study participants

Participant	Avoidance	Education campaign	Family tradition
Krista	X		
Sarah	X		
Mona	X		
Michelle		X	
Jolene		X	
Jessica		X	
Faith			X
Kelly			X
Emma			X
Lauren	X		X
Lisa	X		X

an obstetrician to a midwife. Sarah and her husband, David, knew from their research and the stories of others that home birth after caesarean section was even more controversial than home birth without a history of surgical birth. Therefore, they tried to conceal the change in their birth plan. "We didn't tell anybody," Sarah said, and then added, "Well, we told a couple of people." The couple chose to tell David's mother, for instance, because she was going to watch their older child during the birth, but they did not tell David's father or their friends and neighbours. Sarah reflected, "Mostly we just didn't want to hear people's feedback. It took us a long time to get to this point." David added, "We didn't want to have to convince people." Sarah had done hundreds of hours of research and she "did not want to hear someone's off-the-cuff opinion about our decision."

One week after the birth, Sarah and David hosted a birthday party for their older child at their home. Approximately 50 friends, relatives, and neighbours attended. When they told their guests that the baby had been born at home, "They were like, 'Oh no, what happened?'" Sarah and David explained that it was a planned home birth and not an emergency. Once the baby was born and both mother and child were safe and healthy, they felt like they could finally come out of hiding and tell people about the baby's place of birth.

Mona

Mona[1] spent the first seven months of her pregnancy in the Netherlands, where home birth is part of the mainstream health care system. However, Mona was planning to return home to the United States to give birth. Because she was a home birth researcher, she knew that her friends and colleagues in the United States would assume that she was planning a home birth, if they found out she was pregnant. So, she decided not to tell them about the pregnancy. Not being able to share the news of her pregnancy with others for fear of stigma left her feeling isolated and alone.

When Mona returned to the United States, she experienced the typical culture shock of returning home after many months abroad, as well as the shock of leaving Dutch home birth culture and re-entering a society where home birth is stigmatised. Her husband noticed a difference in her mood and behaviour. She was depressed and withdrawn.

During the pre-birth interview, Mona talked about not wanting to participate in childbirth preparation activities. She explained, "It was a very conscious decision for me – to not do prenatal yoga, prenatal childbirth education classes, read a million books, watch a million videos. I didn't want to do any of that." She went on, "I didn't want to go to prenatal yoga class where you sit in the beginning and everybody goes around and says how many weeks pregnant they are and where they are having their baby. I didn't want to have to say, 'at home.' And have people say, 'Oh, that is so brave of you. I would love to do that, but I'm too afraid.' Or 'I could never do that.' That is what most people say to me, 'Oh, that is so brave' or 'Oh, that is so bold.' I don't like that kind of comment."

To Mona, being told that she was brave or bold implied that what she was doing was dangerous and outside the norm.

Mona further described her disengagement when she said, "Since I've been pregnant, I haven't been a part of groups, I haven't been on Listservs." The interviewer, asked, "Do you know why?" Initially, Mona could not explain. She replied, "I … I just … hmmm." The interviewer pressed, "I'm just wondering why wouldn't you seek community versus …" Mona responded, "I didn't want to have to answer people's questions. I had found even within home birth or [alternative] parenting communities that people were really ideological, not very flexible, and I didn't want to deal with anybody's commentary – even from groups that were supposedly, who would supposedly be supportive."

The interviewer summarised, "So, it has been a really individual, focused time. Not community. Trying to remove yourself." This comment struck Mona, as if she had not realised the degree to which she had isolated herself and cut herself off from potential sources of support. She seemed a little disoriented and then asked, "What was the question?"

EDUCATION CAMPAIGN

Michelle

When Michelle became pregnant with her first child, she began reading books about natural childbirth and came across the idea of home birth. She said, "I guess I never really realised that it was an option, and I think a lot of women probably feel the same way. It is sad [that] more women don't know about it. I think if people were more informed and educated that more people would definitely have home births."

When describing how people were responding to her decision to birth at home, Michelle said, "I'm not being secretive at all. When I tell people that I'm having a home birth, I immediately explain why and I give them the statistics on women that have home births – they're less likely to have problems, lower rates of episiotomies… So, I don't just say I'm having a home birth and leave it at that. I tell them why."

In addition to telling people that she was planning to birth at home and laying out her rationale, she also distributed copies of the documentary film *The Business of Being Born* (Epstein, 2008), which presents typical American childbirth as overly medicalised and advocates for less interventionist approaches, including midwife-attended birth at home or in birth cen-

tres. According to Michelle, "Giving people that movie is good. [My partner and I] got a few copies of it to give it to people. Somebody that my partner works with just thought it was the stupidest thing that I was doing home birth and so we gave it to him… I think people really don't know, really have no clue about home birth and what the statistics actually show."

Michelle's efforts paid off with key people in her life. Her mother, for instance, was initially sceptical, but found the film persuasive. She said, "When I saw *The Business of Being Born*, [Michelle's decision] made more sense." Through conversations with Michelle and watching the film, Michelle's mother moved from a fear of the unknown to a sense of being informed and she came to both understand and support her daughter's decision.

Jolene

During the pre-birth interview, Jolene described how people were responding her plan to birth at home. She said, "Most people have been pretty accepting." Then she qualified her response. "Uhm, not like, 'Oh that's great!' A few people have been like that, but, you know, mostly they're like, 'Okay, so how far do you live from the hospital?' That type of thing… People would bring up, you know, sanitation, which I thought was odd. We actually ended up writing this two-part home birth blog on our MySpace page just to clear it all up."

In her blog post, Jolene introduced readers to her plan to birth at home. "As all of you already know, around the sixth of May, using all the guts and gusto of my womanly body, I am expecting to deliver a tiny person (yet not so tiny for the likes of a vagina) into this world. What some of you might not know (although, if you know us very well at all, you won't be surprised) is that we will be bringing said tiny person not into a clean, white hospital, but into our dimly lit, gypsy-esque, iTuned, living room. Yes, a home birth, and if timing goes well, we are going to add 800 lbs of water to the mix in the form of our very own, internet-purchased birthing tub. For those of you who couldn't care less about birthing and babies and such, abandon this blog right now (if you haven't already)… For the rest of you, here is why."

Jolene was a college graduate who had done extensive reading and developed a critique of standard obstetrical practice in the United States. In her blog, she drew on numerous scientific studies to support her case. Her hope was that the use of scientific evidence would solidify the legitimacy of her decision and persuade her audience.

Jessica

Early in her pregnancy, Jessica and her husband "were encountering firm resistance" to their plan to birth at home. Over time, however, "People's mindsets have changed. They're much more accepting." When describing what brought about this change, Jessica talked about one-on-one conversations she had with friends and family members. One friend, who Jessica described as "very medical" with a "basic hospital approach," had shown a marked shift in views after talking with Jessica. The friend became "excited for my home birth and has been Googling midwives." According to Jessica, her perspective changed so dramatically that "she might have a home birth when she ever gets pregnant."

To illustrate the success of Jessica's education campaign, she described a family gathering in which her husband, Mike, overheard his father and two friends discussing the merits of home birth. Jessica recounted, "Mike said he was listening to them, and his dad is so for it and my friend Angie is, like, so for it. They've all changed their mindset about it now that they've heard the good things about it, and it's not such a radical idea to them."

Jessica coped with the stigma surrounding home birth by engaging in an education campaign targeted primarily at closely-bonded family members and friends. Her efforts at social change were modest, localised, and effective.

FAMILY TRADITION

Faith

Faith describes herself as a second-generation home birther. At the time of the study, she was pregnant with her third child. When asked about how she decided to birth at home, she said, "Home birth is all I really know." She continued, "My mother had her first home birth [with one of my siblings] in 1990. So, that's how I found out about it. It's kind of in the family, I guess."

Not everyone in Faith's family was as supportive as her mother was. Her parents were divorced and when her father and stepmother learned about her plan to birth at home with her first child they were worried. Faith's father "didn't have any clue about what it was about." He thought the midwife was "just lighting candles and weird stuff like that." After Faith safely gave birth to her first child, "they didn't have anything to say about it." Faith choosing home birth with her second pregnancy and, now, third, was a non-issue for her father and stepmother.

Faith primarily interacts with people she knows to be supportive. She once talked with a friend who said, "I really like the security of knowing all the high-tech equipment is around in the hospital." According to Faith, her friend "didn't get the point that I was trying to drive across to her that, yeah, it's nice to have that, but they also use it more than they really should." Since that conversation, Faith avoids talking

about home birth with this particular friend. Instead, she discusses it with her mother, her stepmother, or people she meets online through home birth or natural parenting websites and Listservs. In this way, Faith occasionally employs an avoidance approach, but it is not her dominant coping strategy.

Kelly

During her pre-birth interview Kelly said that home birth "has been kind of something that has run in my family." She went on to say, "My aunt has had a few home births. Uhm, actually, I had a couple aunts that had home births. I think for the most part my grandma had hospital births. She did not enjoy them. And back then, you know, they strapped you to the table and the husband couldn't come in the room and she was all by herself and she was trying to push by herself and just … it was an awful experience for her. And so, I think, as soon as she got done having kids, she realised the importance of these things. She got more into the more holistic things. It was around the time when I was born, she got into massage reflexology and she got a reflexology certification."

Kelly's grandmother is an important influence in her life. She even came to Kelly's home in early labour to perform reflexology on her feet. With her grandmother and aunts as models, Kelly has come to devalue Western allopathic medicine. In issues related to pregnancy and childbirth she favours healing practices based on "a more Eastern philosophy."

Kelly's personal biography is dominated by "being different." She grew up in a fundamentalist church and believes that her spiritual upbringing taught her to accept her difference and not place too much value on the beliefs and ideas of others. She said, "Maybe I'm preprogrammed to think unique and out of the box, because I realize that not everything that everybody says is fact, and that I don't have to accept or conform to other people's thoughts." Kelly has a sense of self that is not based on comparisons to mainstream culture. This helped her cope with the stigma associated with home birth.

Emma

Emma did not initially see herself as someone who would birth at home. Her mother, who she describes as a "very earthy" woman, "kind of opened [her] eyes to the idea." Describing how her mother introduced her to the idea of home birth, she said, "My mom sent me to one of the Birth Collective meetings. I didn't know what it would be and I felt totally out of place there. Everyone was in tie-dye and dreadlocks and you know, all this, and I had a Gap sweatshirt on and I'm like, 'I don't belong here. I totally don't belong here.' But everybody was so nice and they were talking about how great it was to do home births or have a doula."

After the meeting, Emma brought up the idea of a home birth with her husband. His initial reaction was, "No. Hell no. Absolutely not! We're not doing that." Nonetheless, he agreed to go to a Birth Collective meeting and, according to Emma, "By the end of the thing he was like, 'Yep, this is for us. I see why you want this now."

In addition to introducing Emma to the idea of home birth, her mother also played an important role at Emma's births. In fact, both of Emma's children were born at her mother's house. Part-way through Emma's pre-birth interview, her mother joined in and the two reminisced about the birth of Emma's first child. They went back and forth, laughing and revelling in their shared memory.

DIFFERENT CIRCUMSTANCES, DIFFERENT APPROACHES

Lauren

Lauren is a community organiser, a member of an attachment parenting group, a doula, and an aspiring midwife. Home birth and other natural parenting practices feel normal to her. Lauren's family members provide one source of support for her alternative beliefs and practices. When discussing how her family members responded to her decision to plan a home birth during her first pregnancy, she said, "My mom and my entire family completely supported it." She recounted, "My parents started out as hippies when they first got together. So, it was no big deal at all. They were like, 'Well of course that's what you are going to do' … Of course you nurse your baby, of course you use cloth diapers, of course you have your baby at home if you can. My mom and dad had had all-natural births with us. They were in hospitals, but very much not medicated – laboured at home, my dad caught me when I was born. My older brother has three kids and with his first kid his wife had an epidural. The second one they laboured at home and she went to the hospital, pushed the baby out, was there for an hour, and left. The third one was born at home. They are like totally attachment parenting, home birth, natural birth people."

Lauren developed complications in labour with her first child. She transferred from home to hospital and, ultimately, gave birth by caesarean section. When she became pregnant with her second child, she experienced more opposition to her decision to birth at home. In fact, she initially rejected the idea and planned a hospital birth. Part-way through her pregnancy, however, she realized that mainstream maternity care did not meet her needs. She found

herself distraught, angry, and crying after every prenatal appointment. When she switched to a home birth midwife, she felt more confident and at peace, but the decision came at a cost.

Because of the controversy in the United States surrounding vaginal birth after caesarean section, Lauren felt like she could not be as open about her home birth plan as she had been during her first pregnancy. She recalled, "Early on in pregnancy my mother-in-law said, 'You're not going to try for a vaginal birth, are you? Babies die. They drown in their blood.' … So, we just don't even talk about it with them. They think we're going to the hospital. We haven't told them that we are. We haven't told them that we aren't. They just asked us last week, 'So, when you go into labour, do you want us to come watch Zack?' I said, 'Oh, my mom's coming.' They don't need to know."

In response to this kind of negative feedback, Lauren employed a selective disclosure approach. She told her mother and her brother about her switch from a hospital- to home-based midwifery practice. "Otherwise," she said, "we haven't told a lot of people."

Lisa

Lisa did not know much about birth before becoming pregnant. Her mother had not talked about it while she was growing up. "Home birth," she told me, "definitely does not run in the family." She said, "I don't have any relatives that have done it or anything like that. My relatives all think I'm crazy [laugh]. They're right, I think, but we just don't talk about it much."

Lisa does not rely exclusively on an avoidance coping strategy, however. Connections she has made through decades-long involvement in alternative medicine and environmentalism provide significant support. Regarding her background in alternative healing, Lisa said, "In the last ten years or so I've been really interested in herbal medicine and self-healing. I've gone to alternative practitioners and have seen a naturopath … I had always done that kind of stuff. So, [choosing a home birth midwife when I became pregnant] wasn't a big jump for me."

Describing her involvement in environmental issues, she recalled, "[I've been involved] as long as I can remember. When I was in junior high school my parents sent me to – or even when I was younger – we went to this nature camp which I loved as a kid! Then, when I was a teenager, I was a volunteer. When I was in college, I went back and worked for a summer as an intern – teaching, doing environmental education kinds of things."

When Lisa became pregnant, the decision to work with midwives and birth at home felt consistent with the rest of her life. While she did not have a biological family history of home birth, she found that her pre-existing social networks around alternative medicine and environmentalism provided a kind of chosen family that supported her decision.

DISCUSSION

Participants in the study exhibit three coping strategies: (1) avoidance, (2) engaging in an education campaign, and (3) focusing on a family tradition of

Table 4

Coping responses categorised by disengagement or engagement

Participant	Disengagement coping	Engagement coping	
	Avoidance	Primary control	Secondary control
		Education campaign	Family tradition
Krista	X		
Sarah	X		
Mona	X		
Michelle		X	
Jolene		X	
Jessica		X	
Faith			X
Kelly			X
Emma			X
Lauren	X		X
Lisa	X		X

home birth. Of the various taxonomies used to categorise coping responses (e.g. problem versus emotion, active versus passive, and cognitive versus behavioural), the strategies utilised by participants in this study map most directly onto the disengagement versus engagement model described in the general coping literature (Compas, Connor-Smith, Saltzman, Thomsen, & Wadsworth, 2001; Connor-Smith, Compas, Wadsworth, Thomsen, & Saltzman, 2000) and adapted to stigma-related coping, in particular (Miller, 2006; Miller & Kaiser, 2001). Table 4 maps coping responses exhibited by participants onto the disengagement versus engagement theoretical model.

DISENGAGEMENT AND ENGAGEMENT COPING

Disengagement coping is oriented away from the source of stress and can be understood as an effort to protect oneself from threat. It may involve (a) avoidance of situations in which stigma may be a problem or social interactions with people one perceives to be prejudiced, (b) denial or minimisation of prejudice, or (c) wishful thinking. Participants who used disengagement coping did not deny or minimise prejudice or exhibit wishful thinking. Their disengagement primarily involved avoidance. Krista, for example, stayed in her home, to the point that she began to worry that she may be suffering from agoraphobia, as a way to avoid social interactions with neighbours. Mona avoided potentially stigmatising situations by not participating in childbirth- or parenting-related classes or groups. Sarah and Mona both tried to conceal their stigmatised status by not disclosing their plans to birth at home.

Engagement coping is oriented toward the stressor and can be further characterised by efforts to gain a sense of primary or secondary control over the situation or one's thoughts or feelings. Participants who mounted education campaigns illustrated primary control engagement coping by trying to change the situation. Jolene, Jessica, and Michelle used blogging, one-on-one conversations, and the distribution of an evidence-based, pro-home birth documentary to explain their rationale for choosing home birth and attempt to change minds. Through engagement, they hoped to not only reduce their individual experience of stigma and discrimination, but also to influence the larger culture by replacing fear and speculation about home birth with accurate information.

Secondary control engagement coping includes acceptance, positive thinking, seeking social support, devaluing domains in which one experiences stigma, and comparing oneself to people with similar beliefs, values, and traits. Participants who focused on a family tradition of home birth are illustrative of secondary control engagement coping. Faith sought social support by reaching out to her mother who had personal experience with home birth, her stepmother who had become an ally after Faith's previous births, and members of online home birth and natural parenting groups. Emma sought support from her mother and a local natural birth collective. Kelly described both a devaluing the biomedical domain in which her plan to birth at home was stigmatised and comparing herself to members of her in-group instead of mainstream culture.

While nine of 11 participants exhibited a dominant coping style, two participants regularly used more than one technique. Lauren and Lisa both utilised avoidance, a disengagement coping strategy, and family tradition, a form of secondary control engagement coping. Lauren used the disengagement coping techniques of avoidance and concealment when she chose not to tell her mother-in-law about her plan to birth at home and, later, not to correct her mother-in-law when she assumed that Lauren would be birthing in the hospital. She used secondary control engagement coping when she sought support from her mother and brother, compared herself to people in her alternative parenting group, and devalued typical American obstetric practice by working as a doula and studying to become a midwife. Lisa exercised avoidance when she chose not to talk about her birth plan with members of her biological family. She demonstrated secondary control engagement coping when she turned to her social network of environmentalists and alternative medicine practitioners for support and a point of reference for her decision.

There is a large body of literature on stigma management and coping in general, but little research has been conducted on how pregnant women cope with the specific stigma associated with planning a home birth. Miller's (2012) work on stigma management among women who choose unassisted birth is a notable exception. While discourses of risk and blame are relevant for women with low-risk pregnancies, who choose to give birth at home with a trained midwife, they may be even more salient for those who plan home births with higher-risk pregnancies (e.g. vaginal birth after caesarean, multiple gestation, or breech position) or who give birth without professional assistance (Holten & De Miranda, 2016; Lee, Ayers, & Holden, 2016). The participants in Miller's study deployed a variety of strategies to cope with stigma, which Miller categorised as either avoidant or proactive. Avoidant strategies included silence, failure to correct or passing, and selective disclosure. Miller described one proactive strategy, which she termed evangelism. All of the women in Miller's study deployed multiple coping strategies. In this way, the participants in Miller's study are different from the participants in this study, many of whom described one, primary coping strategy.

COPING, SALUTOGENESIS, AND INTERVENTION

The salutogenic model posits that how one copes with stress has a significant impact on health. A recent review of the literature examines mental and physical health outcomes of different coping responses and finds that, in general, engagement- and approach-oriented coping are associated with more positive mental and physical health while avoidance-oriented coping is associated with increased psychological distress and physical symptoms (Taylor & Stanton, 2007). In the current study, the researcher observed that participants who relied most heavily on disengagement coping exhibited higher levels of emotional distress during pregnancy than did participants who used engagement forms of coping.

The empirical literature on coping with stress suggests that while people have some control over how they cope and can increase their coping resources (e.g. social support) and improve their coping processes (e.g. engagement versus disengagement), many factors that affect coping are out of their control (Taylor & Stanton, 2007). Such factors include genetics and early life experiences. Research also suggests associations between coping responses and age, stressor severity, and personality (Carver & Connor-Smith, 2010). Therefore, people's coping responses are constrained. Further, even when people can exercise control over how they cope, the consequences are, in part, dependent on how others respond to the coping efforts (Swim & Thomas, 2006).

Midwives and mental health practitioners may want to examine screening tools or questionnaires that could help them identify women who are struggling with stigma and coping. They may also want to develop interventions to help home birthing women increase their coping resources and processes. Finally, efforts to change the environment and destigmatise home birth, including educating medical practitioners and the general public about home birth and the people who choose home birth, may reduce the overall stress experienced by pregnant women and improve maternal health and wellbeing.

LIMITATIONS AND FUTURE RESEARCH

This study has three primary limitations that suggest avenues for future research: geographic scope, sample size, and methodology. The study was conducted in one Midwestern state in the United States. Home birth rates vary by state as does the legal status of direct-entry midwives. This may mean that stigma severity, stigma consciousness, and coping demands vary by geographic location. A more nationally-representative sample could be informative, as could international comparisons.

The study included 11 women. Due to the small sample size, it is likely that not all experiences and coping responses were represented among the participants. Additional qualitative work would be helpful to uncover the various ways women cope with home birth stigma. Moreover, while all of the women who participated in the study felt or experienced some degree of stigma and described having to cope with the stress associated with that stigma during pregnancy, it is possible that not every person who chooses home birth feels or experiences stigma. A larger study group could help researchers determine what percentage of home birthing women struggle with stigma and to what degree it interferes with their lives.

The qualitative methods used in this study allowed the researcher to gain a deep understanding of the experiences and meanings of home birth for its participants in a natural setting. Future research using survey methods or a validated instrument such as the Responses to Stress Questionnaire (Connor-Smith et al., 2000), which was developed to assess disengagement, primary control engagement, and secondary control engagement coping, could provide additional insight into the coping responses of a larger group of respondents.

CONCLUSIONS

This study contributes to the literature on salutogenesis and childbirth by describing the experiences of a range of women planning home births. Stigma related to the choice to birth at home can be a significant source of chronic stress during pregnancy. Women deal with this stress in a number of ways, which can be categorised as either disengagement or engagement coping. Understanding women's coping responses to home birth stigma is an important precursor to finding ways to mitigate some of the stress and developing interventions to increase women's coping resources and processes. Ultimately, changing the environment through the destigmatisation of home birth is an important project in the overall reduction of stress experienced by pregnant women and the improvement of maternal wellbeing.

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Endnotes

1 Mona is a pseudonym for the researcher.

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