The BIRTH Oral History Archive: A Public Humanities Project

by
Eliza Wilson-Powers

Presented to the American Culture Faculty
at the University of Michigan-Flint
in partial fulfillment of the requirements for the
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Second Reader:
Jennifer Alvey, PhD

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And to my daughter Eva, where I fear, words fail.

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Abstract

The BIRTH Oral History Archive (BOHA) is a public humanities project designed to collect first-hand stories of childbirth and pregnancy loss, capturing how birth stories are remembered and integrated into comprehensive life narratives. Participant Narrators engage in a multi-step interview process allowing narrators to construct the shape of their story, define the scope of the narrative timeline, and identify key events independently, thus acknowledging and prioritizing their authoritative knowledge.

The medicalization of birth resulted in the marginalization of the embodied experience, leaving many birthing people without narrative authority over their own birth experience. The recollective process facilitates identity construction and allows individuals to continually integrate and evaluate the meaning of significant life events such as childbirth. Building on Annette Kuhn's concept of "memory work," the BOHA project and interview process prioritizes the (re)constructive meaning-making inherent in the act of retelling, allowing narrators to regain narrative authority. As a public humanities project, BOHA further positions participants within a meaningful continuum, reflecting the perpetual contemporary through community-driven priorities and values.

Through their Archive birth stories Participant Narrators articulate key power dynamics throughout their pregnancy and birth experiences, and the ways these experiences and acts of revisitation have influenced their sense of self and their position within broader life continuums as well as the socio-cultural landscape.

Keywords: Childbirth, Oral History, Public Humanities

Introduction and Review of Literature

The literature reviewed here serves as an introduction to the BIRTH Oral History Archive and provides a brief overview of the transition of birth to the medicalized space and the production of a concurrent knowledge system effectively marginalizing the embodied experience of the birthing person. This is followed by an exploration of the role of significant life events, such as childbirth, in the construction of life narratives and the personal meaning-making process. The collection of oral histories is examined as a valuable form of "memory work," utilizing the connection made between past and present through the act of recollection, to capture the lived experience and restore narrative authority. Finally, this review presents the benefits of positioning an oral history archive within the public humanities as a responsive, participant-driven instrument for the creation of meaningful social and cultural memory.

Early American Childbirth

In the early American setting childbirth was a semi-social affair largely regulated by women. Experience and expertise held by female members of the community directed both the form and the nature of care and practices surrounding pregnancy, labor, and the postpartum period (Cheyney et al. 180). While the risk of serious complication or death during childbirth was present, historians argue that revised figures of maternal mortality, and contemporaneous writings of women diarists in 18th- and 19th-century America demonstrate an approach to birth that was pragmatic and communally supported (Cheyney et al. 181; Schlissel 57). This horizontal system of

shared knowledge persisted in some communities, often those seen as less profitable or prestigious, however, various factors converged by the early 20th-century to effectively establish childbirth as a (white) male-led procedure undertaken primarily in a hospital setting (Bonaparte 25; Cheyney et al. 182; Jordan, “Authoritative Knowledge” 72; Fraser 148; Lupton; Schwartz 312).

The increased professionalization of medicine throughout the 1800s included the more concise articulation of obstetrics and gynecology as specialized medical fields. Standardization limited widespread access to recognized medical education while labeling and eliminating various forms of “alternative” care (Cheyney et al. 183; Stahnisch and Verhoef 1). Medical texts presenting the female body as “defective” and “unpredictable” undermined widely held confidence in physiologic labor and denigrated experience-based, woman-led birth support in the form of lay-midwives, supporting the gradual transition to male physicians and surgeons (Bonaparte 26; Cheyney et al. 181). As birth became increasingly seen as a pathology, it became increasingly framed as a threat requiring surveillance and management. (Cheyney et al. 174, 183; Lazarus 134). This perception facilitated the comprehensive move of childbirth in America to a hospital setting where the vast majority of births in the U.S. still take place today (National Academies of Sciences, Engineering, and Medicine 32).

Anthropology of Childbirth

Birth became a medicalized space in both practice and study. Pregnancy and the perinatal period were systematically categorized as biologic processes centered around

the physiologic act of childbirth and academic examination of pregnancy, labor, and the post-partum period was dominated by the medical sciences. Within the humanities and social science-based disciplines, reproduction and childbirth were largely subsumed under the study of ritual, kinship structure, or labor systems (Davis-Floyd and Sargent 2). Anthropological interest in childbirth was delayed by systemic limitations of both gender and class within the discipline and a general bias towards what was considered purely “social and cultural phenomena” (3). Thus, confounded by the biological aspects of birth, the investigation of childbirth and its supporting practices within a larger socio-cultural context didn’t emerge until the mid-20th century.

Early work by individual anthropologists in the 1960s and 70s provided necessary momentum culminating in the articulation by Brigitte Jordan of a bio-social framework addressing methodological hurdles and justifying anthropological focus on childbirth practices (Davis-Floyd and Sargent 2; Cheyney et al. 165). In *Birth in Four Cultures* (First Edition, 1978), and subsequent works, Jordan argues for the ecology of childbirth to be studied as a social structure, presenting with internal logic, and relevant and attendant behaviors and history that allow for the cross-cultural comparison central to the discipline of anthropology (Davis-Floyd and Sargent 3; Jordan, “Four Cultures” 8). Following this, anthropologic interest in the field of childbirth and reproduction expanded exponentially. Exploring the interplay between the biological and socio-cultural aspects of childbirth and reproduction, anthropologic examination worked to acknowledge the influences and effects of historically constituted ideologies of birth (Cheyney et al. 166; Davis-Floyd and Sargent 16; Lazarus 132).

Authoritative Knowledge in Childbirth

Authoritative knowledge, a key concept emerging from Jordan's work, argues the existence of an implicit hierarchy privileging forms of knowledge that organize the larger world more efficiently, and/or align with dominant power structures (Jordan, "Authoritative Knowledge" 56). Importantly, authoritative knowledge does not need to be "correct" to "count." It is "interactionally grounded" and collaboratively made visible ("Authoritative Knowledge" 58). Jointly enacted by actors within the domain, this hierarchy typically establishes one "legitimate" form of knowledge on which to base key decisions and actions ("Authoritative Knowledge" 56), simultaneously identifying and devaluing alternative forms of "knowing," and reproducing structural inequities (Browner and Press 114; Dixon et al. 38, 41; Jordan, "Authoritative Knowledge" 61). Jordan demonstrates how the knowledge/power dynamic creates reaffirming "truths," transforming the intrinsic power of legitimacy into the inherent power of a "natural order" governing all actors ("Authoritative Knowledge" 57).

In the American birth space, concurrent knowledge systems are negotiated and actively managed to create a "natural order" centralized around obstetricians and other medical personnel (Dixon 39, Jordan, "Authoritative Knowledge" 71). Continually constructed and reaffirmed in both instructive, and prescriptive settings, authoritative knowledge in the birth setting increasingly supports the medical/technological paradigm (Davis-Floyd 9, 13; Davis-Floyd and Davis 316; Dixon et al. 18, 37; 40; Jordan "Authoritative Knowledge" 57), moving practices away from the embodied knowledge of the birthing person (Cheyney et al. 196; Davis-Floyd and Sargent 16, Dixon 43).

Constructs of authoritative knowledge in the hospital setting have historically prioritized the “expertise” of physicians over the body and birth experience of the birthing person often replacing it with a version of “reality” better aligned with the medical perspective and reinforcing the role of a “good patient” (Jordan, “Authoritative Knowledge” 59, 67). Tokens of cultural value, such as being “good at labor,” or having a “good baby” incentivize the complicity of birthing people in delegitimating their own embodied forms of knowledge (“Authoritative Knowledge” 61, 64, 67; Lazarus 149) leaving many feeling responsible for medical procedures undertaken with minimal evidential imperative (Davis-Floyd 4), and over which they had limited influence (Lazarus 132).

Although the number of expectant people seeking to birth at home or in independent birth centers in the US has increased over the last twenty years, birth remains indisputably hospital based (Cheyney et al. 174; National Academies of Sciences, Engineering, and Medicine 32). While in recent years, gradual shifts to include more “humanistic” models with an increased focus on connected, responsive care (Davis-Floyd 16) are evident and supported by expanded access to nurse-midwives and labor support professionals such as doulas, modern birth in the U.S. birth setting continues to be experienced largely within the limiting constructs of medically-centered authoritative knowledge where the birthing person is neither subject, nor narrator of their own birth story.

The Creation/Integration of Personal Narratives in the Meaning-Making Process

Childbirth is a personal transition within a socio-cultural space. As a significant life transition, it presents opportunities for enhanced self-reflection and meaning-making. Interpretations of these events influence individual personality development and larger life trajectories (Bauer and McAdams 573). Transitions feature prominently in life stories which create narrative continuity across past and present experiences and future goals (McLean 683; McLean and Pratt, 715; Singer and Bluck 91; 93) and a "causal, temporal, and thematic coherence" within a personal sense of identity and self-understanding (Singer 438, 442). Revisiting highly affective sequential events or experiences in the life narrative enhances both meaning and application, effectively inferring causality and constructing "scripts" for future priorities, decision-making, and interaction (Singer and Bluck, quoting Dan McAdams 93; 94).

Active connections between events in an individual's life story and aspects of personality are made through the interpretive and evaluative process of autobiographical reasoning, drawing "remembering closer to the self" (Bluck and Habernas 137; Habermas 3). Combined with the recollective process, this active interpretation allows memory to function as a responsive construct both on the personal level, and within a broader social, and cultural landscape (Bluck and Habernas 137, 143; Kuhn "Memory Texts" 298; McLean and Pratt 715; Singer 445; Singer and Bluck 96). Through this dynamic, contextual elements of both the time of the event and the present influence the personal meaning-making process through revisitation or retelling, allowing the space/time between to be associated with positive or negative change and growth (Bluck and Habernas 137; Kuhn, "Memory Texts" 304; Özkul and Humphreys

351). Recollection of meaningful life events thus functions as an ongoing site of identity construction and negotiation of belonging.

Memory: Act and Artifact

Oral histories facilitate forms of intentional “remembering” through re-enactment or retelling. By initiating a “performance of memory” they can take the form of what Annette Kuhn calls “memory work,” an approach to recollection prioritizing meaning construction over the objective “truth” of the memories (“Journey Through Memory” 186). Taking “an inquiring attitude towards the past and the activity of its (re)construction through memory,” memory work foregrounds the production of narrative and meaning, acknowledging the deeply personal “truth” of the present retelling (Kuhn 186; Kuhn, “Memory Texts” 303). Memory is therefore not discrete and contained, but rather dynamic, responsive, and engaged in the world around it. Through interactional acts of revisitation memory is both the token and the act, personal and collective.

Lived experience finds further collective meaning through the cultural framework of the Humanities. As an academic discipline, the Humanities apply critical and comparative methodologies in the study of social and cultural expressions of the human experience. Through the examination of human social systems, forms of power and communication, and patterns of evolution and change, the humanities explore how individuals interpret and integrate both personal and communal experiences. Emerging in the 1970s and gaining further momentum throughout the 1990s (Smulyan 125), the Public Humanities are a collaborative application of the discipline, engaging non-academic audiences, connecting exploration with contemporary enaction, and prioritizing cultural relevance. Expanding recognized forms of knowledge production,

public humanities engage and respond to diverse publics, allowing the renegotiation of systemic power dynamics within institutionalized story-telling and research (Berkowitz and Gibson 68; Krmpotich 88; Woodward 111). Driven by participatory practices, public humanities projects locate participants within a process that is socially and culturally meaningful to them, offering contextually relevant benefits.

As a form of institutionalized remembrance, oral history collections provide a framework of commonality. Mobilized by public humanities practice, archives can create new “communities of remembering” through cross-communal recognition and a heightened sense of belonging (Krmpotich, Howard, and Knight 358; Kuhn, “Memory Texts” 298). Recognizing the centrality of narrative to social and cultural memory, Public Humanities practices allow oral history archives to position participants within a meaningful continuum, reflecting the perpetual contemporary through community-driven priorities and values.

Methods

Participant narrators for the BIRTH Oral History Archive (BOHA) are recruited through personal networks, community-based organizations and events, and via social media (see Appendix A). The recruitment process familiarizes potential participants with the BOHA project goals and interview process and confirms eligibility. The Archive collects only primary source data; inclusion criteria stipulate that participants contribute first-hand stories of pregnancy loss and/or birth in which they are the pregnant and/or birthing person. Interpreters may be arranged for participants contributing their story in languages other than English, and all participant narrators contributing stories during the thesis research period must be over the age of 18. Participants must agree to

contribute their story via the BOHA interview process and have their contribution documented via audio and/or video recording. Once enrolled, participant narrators review the BOHA consent form (see Appendix B) and sign via a secure online document signing platform (SignNow) or by hand. Each participant receives a copy of their consent, countersigned by the Researcher, via email, or US mail if requested. Digital copies of participant consent forms are stored in project files, separate from participant files, and not available to the public. Interviews are scheduled and confirmed via phone, email, and/or text communications.

BOHA participant narrators engage in a multi-step interview process including transcription, story-crafting, and the collection of photographic materials. The interview process includes two interviews: one open-ended, self-guided narrative and a second follow-up, semi-structured interview to provide opportunities for clarification and further expansion on key details. The first interview focuses on the participant sharing their pregnancy and/or birth story. To acknowledge and prioritize their authoritative knowledge, the BOHA process requires participant narrators to construct the shape of their story independently, defining the scope of the narrative timeline and key events without direction, and free from the influence of preconceived questions or prompts by the interviewer. To capture demographic data regarding the pregnancy, birth, and birth setting, a brief 9-item questionnaire is also completed during the first interview (see Appendix D). The second interview is scheduled at this time, and the optional inclusion of photographic material pertaining to the participant contribution is discussed.

In preparation for the second interview the BOHA interviewer listens to the first recorded interview as many times as necessary (minimum of one complete time) to situate themselves within the context of the participant narrative, identifying opportunities for further exploration in terms of experience, personal meaning-making, and the recollective process. The BOHA interviewer also highlights areas where the narrative may benefit from further detail or clarification. While this process provides a framework for the content explored through prompts by the interviewer during the second interview, participant narrators guide both interviews to ensure authenticity and adherence to their story and narrative voice. Participant narrators also use the second interview to share additional information or aspects of their story that may have been accidentally omitted or have occurred to them in the time following the first interview.

Interviews are audio and/or video recorded and may be photographically documented. Interviews are conducted in person, or virtually using video conferencing and recording software and all recordings are transcribed. During virtual interviews all participants are asked to keep their cameras on with updated screen names and preferred pronouns to facilitate connection, comfort, and transparency regardless of whether the interview-specific recording settings include video. The recruitment and enrollment process, which often includes multiple points of interaction via email or text, provides a strong foundation for the connection expanded by the nature of the BOHA interview process which prioritizes a conversational and constructive interpersonal dynamic.

In addition, each participant is offered the opportunity to contribute personal photographic material. Media releases are secured for publication of any contributions depicting the personal likeness of non-participants using contact name(s) and information provided by participant narrators and publicly available resources (see Appendix C). Identities are digitally obscured for non-participants who have not signed a media release form after three contact attempts by BOHA team members.

The archive is available to the public for scholarly and educational purposes; limitations to access are maintained in cases where exceptions were requested by the participant. Due to the personal and sensitive nature of the stories shared, exceptions may include, restricting access to parts or all of their statements or temporary or permanent confidentiality of their identity should they wish to contribute their story but not have their name searchable in the publicly available resources of the archive. As an oral history archive participant narrators have the option for the archive to retain only their voice recording and have no visual media attached to their contribution. Furthermore, participant narrators may augment or request exceptions at any time by submitting a request in writing.

Eight Participant Narrators were approached for and consented to inclusion in this thesis project. Their interviews were conducted via online audio/video conferencing software and completed between May and June of 2023.

Data Management Plan (DMP)

Archive data includes raw and edited video and audio recordings, digital image files (original and scanned materials), transcriptions, and project documentation. The full Data Management Plan is available as Appendix E.

Designated Archive

Original recordings, transcripts, edited stories/interviews, all photographic materials, and project documentation are archived by interview ID and securely stored in Deep Blue. A backup is kept in a HIPAA compliant Dropbox account, as well as on a dedicated external drive. Data will be retained for the life of the project.

Intellectual Property Rights

All project interviews are the intellectual property of the participant narrators. Through the consent process interviews have been licensed by the participant narrators under the Creative Commons Attribution-NonCommercial 4.0 International License, allowing researchers and members of the public to use, reproduce, digitize, and distribute the audio or video interview, contributed media materials, name, likeness, image, voice, and transcript in whole or in part non-commercially for educational purposes. They may also be used in books, radio, films, websites, exhibitions, presentations, or other media as long as credit for the original creation is duly cited.

By contributing interviews to the BIRTH Oral History Archive or depositing them in the repositories participant narrators do not transfer copyright but instead grant permission for dissemination activities as outlined, and any necessary transformation of

the data required to protect respondent confidentiality, improve usefulness and access, and facilitate preservation.

Ethics and Privacy

Each participant is assigned a sequential four-digit numerical study ID once they have been contacted for potential participation in the BIRTH Oral History Archive. Once their initial interview is scheduled, this number is associated with a unique interview ID in BOHA records. The interview ID will be used to identify all documents and recordings pertaining to a specific interview. Interview IDs are assigned on a sequential basis as participants consent to the study using the following format: YEARconducted_SequentialNumber (i.e., 2023_01). They are assigned to facilitate data tracking, storage, and search functions and allow participants confidentiality of identity should they wish to contribute their story but not have their name connected and searchable in the publicly available resources of the archive. This multi-ID system allows archive assets to be searchable through various data channels, such as participant or interview year, allowing contributions to retain their association with participant narrators, while also functioning as independent data assets.

Interview IDs are connected to identifying information of participant narrators through the Participant Log only. This documentation is stored in secure repositories, separately from participant files, and is not available to the public.

The BOHA project data management plan and procedures undergo periodic review to protect data integrity and access and the confidentiality of participant narrators, as well as regularly assess and manage disclosure risk.

Selection and Retention

The full dataset and BOHA project documentation will be retained for the long term with regular assessment to support the data through changing technologies, new media, and data formats.

Substantive metadata will be collected and maintained in compliance with the most relevant standards providing for the tagging of content, which facilitates preservation and enables access. These types of metadata will include, (a) Study-Level Metadata: a summary record created for searchability, and (b) Variable-Level Documentation: tagged information allowing users to identify relevant variables of interest, such as birth setting, type of care provider, and delivery method.

Interview data files are stored and may be made available in several widely used formats, including MP3 and WAV. Static documentation will be preserved as PDF for the life of the project. Ongoing project documentation is maintained in editable formats to allow updates as necessary, PDFs are exported and stored on a quarterly basis and retained for three (3) years, final versions are preserved as static documentation. Project data is stored in accordance with prevailing standards and practice.

Archiving and Preservation

The BIRTH Oral History Archive ensures the research data are migrated to new formats, platforms, and storage media as required by good practice in the digital preservation community. Good practice for digital preservation requires that an organization address succession planning for digital assets.

Storage and Backup

Research has shown that multiple locally and geographically distributed copies of digital files are required to keep information safe (Berez-Kroeker et al., 2022). Accordingly, master copies of original recordings, transcripts, edited stories/interviews, and all photographic materials are archived by interview ID and securely stored in the BIRTH Oral History Archive in Deep Blue, in a HIPAA compliant, secure Dropbox account, and on a dedicated external drive.

IRB Review

While oral history projects are not regulated as human subject research by the Internal Review Board (IRB) the BOHA project was submitted for review and determination by the University of Michigan IRB. The strict oral history categorization is complicated by the BOHA interview process which prioritizes the examination of contemporary personal narratives and meaning-making across time through the recollection of past, first-hand experiences and events. The development of individualized interview prompts and protocols in the context of, and in response to participant narratives pushes the project toward the type of “interactive and

interpersonal” engagement categorized as Human Subjects research by the IRB. The IRB approval process required the preparation and submission of a project summary outlining project goals, recruitment and enrollment protocols, and a comprehensive data management plan. Recruitment, informed consent, and media release documentation were also submitted for review and approval.

Based on these materials and process protocols, the University of Michigan IRB determined the BIRTH Oral History Archive exempt from ongoing review (see Appendix F).

Results

As an ongoing public humanities project, the BIRTH Oral History Archive seeks to actively engage diverse publics as collaborator and audience. The Archive provides a framework for preservation and access while prioritizing the narrative authority of contributors and the active construction of cultural memory through dynamic forms of knowledge production. As these priorities are best facilitated within a responsive, web-based context, the BIRTH Oral History Archive is publicly accessible via the BOHA website and the University of Michigan Deep Blue repository.

The Archive includes audio recordings and full transcriptions of interviews conducted with the Participant Narrators who contributed their stories as part of this thesis project, associated photographic material, and relevant project paperwork. The

website includes further demographic and geographic details as well as links to relevant BOHA administrative forms and literature.

Deep Blue DOI: 10.7302/21700

www.birtharchive.org

Findings/Conclusions

Analysis for findings shared here is limited to eight birth stories specifically contributed as part of the thesis process with the full consent of the Participant Narrators. Birth stories included here took place between the early 1990s and 2021 with the age of the Participant Narrator at the time ranging from 26-38 years. Seven of the births occurred in a hospital with one unfolding in a home setting. Six of the birthing people experienced medicated births while the homebirth and one hospital birth were unmedicated experiences. Two births were induced, two babies were delivered by cesarean section, and one baby was considered “premature,” arriving prior to 37 weeks of gestation. All but one story included here details the first live birth experience for the Narrator.

Presented below are observations and interpretations of emergent patterns within the eight interviews contributed to the Archive as part of this thesis project reflecting this fundamental shift in childbirth practices and the role of the embodied experience of the birthing person. While only a small number of interviews are analyzed here, they demonstrate the opportunity presented through narrative recollection and

reclamation to better understand the effects of increasing medicalization on the childbirth experience of the birthing person.

Medicalization and Authoritative Knowledge in Childbirth

The movement of childbirth into the medical space disrupted the largely horizontal power dynamic of traditional birth practices, wherein midwifery practices were informed by the embodied experience of birth and designed to preserve the autonomy of the birthing person. Removed from this supportive context, birth became an exercise in risk management requiring surveillance and expert intervention. No longer centered around the embodied experience, the medicalization of childbirth focused practices on augmenting pregnancy and birth towards predictable outcomes.

Experiencing what her doctors referred to as, “mystery infertility,” but Andrea described as an “onslaught of trying and not getting pregnant,” she and her husband sought the support and guidance of fertility specialists at a clinic in Michigan in 2019. They had experienced a first-trimester loss the year prior so felt confident pregnancy was possible, yet their infertility journey was discouraging and exhausting. Andrea was eager to supplement the hormonal process prescribed by the clinic with “natural” support such as nutrition regimens at home but was told by a consulting nurse there were “no studies to really support that and [they didn’t] want to stress [her] out.” This logic confused Andrea, as she put it, “I'm only putting this medication into my body and we're expecting an outcome. Like, what?” The implication was that only medically or scientifically achieved results were considered legitimate while more self-regulated

practices to support ovulation and pregnancy were considered negligible, ultimately causing more stress than benefit. In addition, excluding her from an active supportive role in the process resulted in a disembodied experience. For Andrea, this demonstrated a larger “disconnect between the whole person and what they're doing,” in her words, treating her “like a guinea pig” *they* were trying to get pregnant.

Andrea underwent three embryo transfers with her first fertility clinic, none of which resulted in a viable pregnancy. In retrospect, Andrea recognizes a profound shifting of blame during her experience with that clinic, primarily centered around positioning her body as fundamentally defective.

> “[I]f you don't fit within the box of [their] protocol…they make you feel like it's your fault, like, there's something wrong with you…‘if you don't respond to what we offer, that's, that's not a, an *us* problem. That's a *you* problem.’ And it, yeah, it felt very, um, I don't even know, I, I lack a word for it, um, but, shameful? Um, like, you know, already questioning why my body isn't doing what biologically it's set to do but also what I desire more than anything in the world.” [emphasis added].

Giving birth in a hospital in California in 2010, Liisa also noted the lack of support for self-guided methods of induction or labor stimulation. Liisa experienced an early release of the amniotic sac at 35 weeks. Before beginning a process of pharmacological induction through the administration of Pitocin (Pit), a synthetic form of oxytocin, the natural hormone responsible for stimulating uterine contractions during labor, Liisa and

her partner decided to try natural methods to bring on contractions in their hospital room.

> “I remember one of the, the one of the, um, like high-risk OBs coming in and being like, ‘None of this stuff you're doing is gonna start labor.’ Like, ‘you can't do it like this.’ And he pointed to the bag of, um, Pit on the IV. He's like, “this is what gets it going.”

Liisa goes on to articulate the precarious position of many first-time laboring people in hospital settings in her recollection of this brief interaction.

> “And I remember being like, ‘nice bedside manner,’ [from] this 75-year-old guy. It was just like, ‘how many babies have you had brah’?’ Like, I remember being annoyed with him, but I was also, oh God, I was so vulnerable.”

Annoyed by the dismissive manner of the male physician she internally challenges his expertise in comparison with her own embodied experience but outwardly supports his authority, chalking it up to “bedside manner.” In this way, his delivery is questioned, but not his prerogative. In this simple interaction a hierarchy of knowledge is established, privileging the medical perspective and personnel and devaluing alternative forms of knowledge and practice.

In recounting the story of her first birth Liisa is struck by how vulnerable she was to this dynamic, but also acknowledges how that changed across her birth experiences. As

she shared in her second interview, by the birth of her third child she was more comfortable asserting her knowledge of how her body births.

> “[T]hey always think I'm hemorrhaging and I'm always not. That's another, you just learn, you know what I mean? They're like, oh, I think we might have to do whatever the medicine [is], I don't remember what it is, but I was like, I was like, just gimme 10 minutes. Okay? Like it'll stop. It all comes out and then it stops. Like, just gimme a second. You know?...And it, it was fine.”

For Tamar, this dynamic was evident from the start, despite the unusual circumstances of her prenatal care. Becoming pregnant shortly before the onset of the Covid pandemic, she spent most of her pregnancy under some form of preventive lockdown. Tamar had almost no in-person appointments with her obstetrics team aside from a 10-week appointment to check for a heartbeat with a doppler and an ultrasound around 20 weeks gestation. She was provided with a blood pressure monitor and scale and instructed to take her own blood pressure and weight before each of her weekly virtual appointments with “random” obstetricians from her practice. Her appointments were brief, with her physicians relying on data from these basic medical assessments to determine if the pregnancy was progressing “normally.” As her estimated delivery date approached, Tamar was assured she did not need to prepare for labor, she would be instructed on what to do by the medical personnel present.

> “Like there were some virtual classes and so I remember asking my OB like, do I need to do anything? Like, do I need to know anything ahead of time? Or like, is somebody just gonna tell me what to do? And she's like,

> oh, the nurses will tell you what to do. And I was like, okay. So I didn't, I did not prepare at all."

This lack of support for education, or mental and physiologic preparation for labor combined with the minimal in-person visits, and absence of any hands-on examinations resulted in a highly medically circumscribed pregnancy and birth. Tamar described her approach as "following instructions," further mirroring the prevalent doctor-centered dynamic by sharing her view that birth is so natural to the birthing person that it can only be improved by laboring in hospitals with people "who have *delivered* children before" [emphasis added]. Here Tamar distinguishes between the person who is giving birth, and the person who is delivering the baby, imbuing the latter with crucial expertise.

In this way, Tamar positions medical expertise as a key facilitating factor to the "natural" process, while for Sarah B. it was the framework within which she connected to her own natural process as a birthing person. Pregnant with her second child in 2008, Sarah B. already had an 18-month-old at home who would be needing a second heart procedure close to her upcoming estimated delivery date. Balancing the needs of both children, as well as the demands of recovery for both her toddler and herself began to feel daunting without a clearer sense of how these events would overlap. Sarah B. remembers a crucial conversation with her midwife during this time:

> "[T]he midwife said like, do you need this baby to have a birthdate? And I was like, I do. And she goes, do you need permission to have a backup plan and to have [an elective] c-section? And I said, I think I need permission. And she said, I give you permission to have a c-section [if] that

would be like the healthiest thing for you and your family. And I was just, felt really like relieved that I had like, I don't know, I don't know exactly what the psychosis was behind needing permission, but it was very helpful that she gave that to me."

Later in the interview Sarah B. clarifies that she was seeking something more "holistic" than medical permission for the procedure: "I needed like the mama earth to say like, let's go ahead and embrace medical technology here." Interestingly, as the birthing person Sarah B. did not feel she could receive this permission from "mother nature" directly. Her needs as a birthing person were legitimated through the medical space, and her "permission" needed to have the voice of medical authority.

Supporting the predominant medical/technological paradigm is the socio-cultural narrative of the "good patient," which encourages behavior in line with established power hierarchies in return for increased social value. For Tamar, second stage pushing provided an valuable opportunity for praise and acknowledgement.

"So they were just like, okay, so you're gonna push. And I was like, okay. So just, just describe to me what that, what that is like and I can't remember what I, they gave like a specific, they were like, okay, it's kind of like you're trying to poop, but like, but not exactly…And so I was like, I was like, okay, I got this. And so I like listened to the instructions, I'm like, I'm gonna do this exactly. And so I, you know, started pushing and they were like, wow, you are really, really good at this…And I was like, oh, great!"

Tamar was eager to labor “correctly,” and felt pleased when she had done what was described, and what was needed for the labor to progress in the way the nurses expected. However, participant narrators also described feelings of failing to meet the expectations of this powerful narrative, drawing conclusions about their value and themselves during the vulnerable time of pregnancy and childbirth.

After Sarah H. gave birth in 1994, she was taken to the “dingy, dingy unit, old unit, the very last room on the floor” and dropped off. She did not see anyone again until they came to process her discharge a day and a half later.

> “[N]o one came in to do fundal checks, no one came in. I could have hemorrhaged to death in my room and no one would have known. There were no nurses. I think I took it as there's something deficient about me. Something odd, something not deserving of the attention.”

Sarah H. explained that midwives had just begun working as care providers within the local hospital system and midwifery patients were still rare. While she did not register a difference in treatment during the delivery, in retrospect, she attributes this “degradation” of care during her recovery to the fact that she had stepped outside of the OB-centered model of care as a “midwife patient,” forfeiting “good patient” status.

Andrea was clear about her dissatisfaction with the care and treatment she received at her first fertility clinic in 2019 describing it as “awful” and stating candidly she would “burn [it] to the ground.” However, when asked why she did not change clinics after two unsuccessful transfers and unresponsive protocols she highlighted her own need for validation. Feeling a sense of failure in not being able to become pregnant

spontaneously, she struggled with acknowledging her own value and asserting her right to support and assistance within the clinic setting.

> "[A]t that point in my own consciousness, I was still seeking, I was still outsourcing my power, so I was still looking for validation from the outside. I was still kind of in that patient-pleasing mode. Um, you know, who was I to question or to look outside of, you know, this clinic."

During childbirth this narrative can also take the form of being "good at labor" or having a "good baby." Both of these are illustrated in Andrea's descriptions of her labor, which began with a spontaneous release of waters and involved several medical interventions, eventually ending in delivery through cesarean section. In sharing that during "the pregnancy itself [baby] progressed beautifully," but "I continued to not progress" during the labor, Andrea locates failure within her own body, effectively labeling it as "bad" at pregnancy while simultaneously preserving baby's status as a "good baby."

Construction of Identity and the Life Narrative

Childbirth is a key transition within the life story. As the narrative providing coherence across the personal past, present, and future, the life story supports a functionally integrated sense of self, and this transition is a crucial point of personal meaning-making as well as recalibration within a wider socio-cultural context. Acts of revisitation subsequently activate past birth experiences as meaningful sites for the ongoing construction of self and adaptive conceptualization of future life trajectories.

Highlighted below are different ways the integration of this transition into a personal sense of self can be seen in contributions to the Archive. In addition, participant narrators articulate the negotiation of wider belonging and the ongoing application of meaning derived through their birth experience.

Of the group, two narrators shared the desire to have children at all was itself a significant shift in their sense of self. For Participant Narrator 7 (name redacted per request) who was not planning to have children with her husband, the decision to become pregnant, which began as a “maybe” and evolved into the birth of their child in 2001, involved exploration with a counselor of the fears they both held surrounding having a child. This explorative process allowed Participant Narrator 7 (PN7) to gradually integrate a conceptualization of herself as “mother” into her sense of identity, resulting in clarity and a strong commitment to mothering beginning early in her pregnancy.

> “And so, yeah, I remember talking, this was a year and a half probably we talked about this because at a point, certain point in time we decided to go ahead and try, and then a year later we're still not pregnant. And we're like, well, you know, maybe this isn't gonna happen. But in the meantime, we had kept talking about our fears. So, by the time I got pregnant, I was like committed. I was on those train tracks, and I was headed down that road…[a]nd I, I think that's the commitment you're hearing, is I was very focused on, on what I wanted for myself and for [baby]. And I, I worked at it, yeah, while he was in me.”

The transition for PN7 can be seen as a shift from *doing* (having a child) to *becoming* as PN7 embraced an expanded sense of self.

> “[T]hat mama bear comes in early. She comes in and when she does, *presence*. Wow. It just fills you. Right? It's like, I haven't known her before, where did she come from? I like this.” [emphasis added].

Like PN7, Tammy was not intending to become a parent, having “purposely planned not to have children.” After meeting her partner in her late twenties, she was surprised by a strong maternal instinct and desire to have children. About a year and half after getting married she decided to change her birth control method and became unexpectedly pregnant. While she and her then-husband had discussed having children at some point, they were both “pretty shocked” by the timing. However, her pregnancy was “easy,” and she felt “better than [she]’d felt in a long time,” it was a “happy place for [her] body.” For Tammy, the initial integration of this transition was largely body-led with desire and acceptance primarily experienced physically.

Pregnant in 1992, Tammy was planning to give birth at home in Cincinnati, with the help of lay midwives. The practice of lay midwifery, where practitioners receive training through apprenticeship rather than formal education, was largely illegal in Ohio at the time and Tammy understood that if she had to deliver in a hospital her midwife would not be able to accompany her. When Tammy’s waters released without the onset of contractions, heightened concerns at the time about Group B strep, a common bacterium that can pass from the birthing person to the fetus during labor, necessitated

a hospital transfer. Distressed by having to give birth in a hospital and with her labor disrupted by the transfer, Tammy describes her reaction when an obstetrician entered her room to check on her without acknowledging her presence, or her labor work, instead continuing a personal conversation with a colleague.

> "[H]e came in, he was talking to another attending physician or resident or something about golf scores and different sports things, and my mama lion woke up in a way I didn't even know it was in me, and I told him if he was gonna talk sports scores, to leave the room because I was having a baby…I sent him out of the room."

Here, Tammy has integrated her embodied transition into her sense of self, emerging in her mind as a "mama lion" who seeks acknowledgement from those witnessing and facilitating her transition through the physical work of childbirth.

Claire couldn't wait to be a mom. She married her high school boyfriend, moved to Michigan, and told him to let her know when he was ready for them to start a family. Her pregnancy was "perfect" and she described her birth as "the most like, beautiful and like, gentle entrance to motherhood" but it wasn't until several days later that she felt she "truly became a mom."

Claire gave birth in 2020 in a Michigan hospital where she also worked nightshift as a labor and delivery nurse. Various factors, including maternity leave regulations and Covid prevention policies regarding deliveries in the hospital influenced her decision to schedule an elective induction at 39 weeks. Claire's induction, labor, and delivery lasted

several days and involved both manual and pharmacological interventions with the baby eventually delivered vaginally. Leaving the hospital in a wheelchair, Claire's husband pushed her through the sliding doors into the summer heat.

> "[I]t was really hot outside and it just felt like almost being, like, birthed myself, into this really bright, sunny, summer world," and "[i]t almost felt like that moment was really the moment that I truly became a mom in my own like, power, and on my own."

Here Claire describes a rebirth, feeling her transition into motherhood as both a literal and figurative emergence. Leaving a space of negotiated power, she connects becoming a "mom" with her sense of personal autonomy and self-reliance. As she sits outside the hospital holding her new baby and waiting for her husband to bring the car around, she is effectually presented as a new mother to a wider "public." This framing, therefore, crucially aligns her personal transition to motherhood with a wider social recognition of belonging.

Some participant narrators felt this sense of wider belonging primarily through a perceived differentiation from the birthing experiences of those around them. Being told by a nurse that her birth was "one of those deliveries that like, you actually shouldn't tell people about, 'cause it was like, too easy, too textbook," provided Tamar a sense of belonging through a measure of power, privilege, and positive exception. While to Sarah H., the sounds she made during her labor made her seem like a "lunatic," leaving her feeling "deficient in comparison to women who have earthy longer low moans." Sarah H.

experienced what her midwife called a “train wreck delivery,” but she has since learned is referred to as precipitous labor.

> “[My body] just, it did what it was going to do, but it left me, the essence of me behind. And all I could do was concentrate on surviving. So, there was a separate me apart from the body that was laboring, and I wish it could have all been more holistic and cohesive…I am very, very jealous of women who have, like, even my sister who had such horrendously long labors, the way she talks about them, they were so powerful. And so meaningful for her. So I, yeah, I think I would feel differently about myself in the process.”

Here Sarah H. describes a fractured experience of labor resulting in a sense of disembodiment and deficiency. While associating this with a lack of belonging, or “wholeness” as a woman, she is careful to balance it with a strong assertion of her true belonging as a mother from which she gets a deeply meaningful sense of pride and empowerment. The connection she goes on to make between a “whole woman” and a “whole mother” highlights her ongoing negotiation of belonging almost 30 years after giving birth in 1994.

> “But it hasn't, the one thing that hasn't changed is I'm a fantastic mother. So, I always wonder does it impact some people's ability [to mother]? If I'm not a whole woman, then maybe I can't be a whole mother. I'm a fantastic mother. I was a fantastic breast feeder…I feel so competent and powerful”

As a key life transition, childbirth also allows birthing people to place themselves within a generational continuum, finding new ways of belonging in the familial context.

For Andrea, learning she was pregnant on Christmas Eve was “incredible,” not only in light of her fertility challenges, but because she knew that her mother found out about her own pregnancy with Andrea on that same date 34 years earlier. A similar connection was activated for PN7 when she vomited several hours into her labor. At the time she assumed it was from the pain but has since wondered if it was indicative of a deeper link between herself and her mother.

> “She did tell me she vomited too. And, and I wonder sometimes, [Interviewer Name], if I vomited - just because I do think there's a very strong, I don't know, what do you wanna call it? metaphysical, universal link, energy cord back to our mothers when we are delivering - and I often wonder if I vomited just because I was connected to her…Because, I had so many hours of labor after that that were so much more painful than it was in the morning and I didn't vomit again.”

The onset of labor was also a point of connection for Tammy. Woken by a “huge kick,” which surprised Tammy as her baby had not been very active in utero, she immediately slid off her bed.

> “I knew from my mother that, uh, women in my family's water often broke, uh, as the first sign of labor beginning. So, I very quickly slid off the bed, and it was a good thing I did because she had indeed broke the waters.”

For Tammy, childbirth provided a new way of belonging within the maternal line of her family that felt very active. Experiencing “memories of sexual abuse” in the months after giving birth, Tammy felt strongly they were not her own: as she explains in her interview,

“they've never come alive for me.” Conversations with her mother following the birth of her second child about three years later revealed sexual abuse and/or assault within her maternal line which moved Tammy towards the idea that birth allowed her to connect with inherited “violent memories…from [her] family of origin” during her immediate postpartum.

> “[T]his memory of abuse was it my mother's, my grandmother's, my great-grandmother's? How, how cellular is it?”

Thirty-one years later this connection remains very active for Tammy. In retrospect, having just returned from her first visit to Sicily before recording her interview, she frames her need to listen to ocean waves during her labor as almost instinctual, explaining the sound of the Ionian Sea is in her “Sicilian maternal genes.”

Restoring Narrative Authority through Oral Histories as Public Humanities

The ongoing meaning-making derived from the personal transition of childbirth is evident as participant narrators reframe key aspects and narrative events of their birth experience. As intentional recollection allows narrators to regain narrative authority of their birth story, they continue to renegotiate the far-reaching implications within their larger life story and their place in wider social and cultural contexts.

Recollecting her story in the present, Tammy positions herself as a key flexion point in a maternal family line that now continues through her to her own daughters, and any children they might have.

> “I don't know how far [up] the line abuse happen[ed], but I know, I know enough to not, to not be naïve; to know that many women don't choose pregnancy, whether they're married or not, and that I may be the first person in my maternal line to have chosen to be a mother and to chose, have chosen pregnancy, and to have enjoyed parenting…This is something I haven't shared with my daughters yet, but I want to. I know at least one of them is planning on having children in the near future, um, and I'd rather talk to her about it before she moves into the pregnancy stage.”

The implications feel more immediate for some narrators as they consider expanding their family to include more children. For Andrea, seeking fertility treatments were a form of “reclaiming some control.” In sharing her story now, she sees envy she felt at that time towards other women who looked like they were in control – although she “never put that language to it” before – as rooted in deeply held personal “life scripts” that she is working to disrupt.

> “[A]n old script for me, which, and this is like a super vulnerable thing to share is like, is that things come easily for other people and not for me and, and recognizing, um, the ways in which I was operating as though that was true.”

Revisiting that time now, she has “so much compassion and empathy for that person who had to go through that or who went through that, um, who went through month to month feeling so out of control,” sharing that a “takeaway for myself would be to give myself the room to have a different story” with subsequent pregnancies in the near future.

For some, the narrative shifts are subtle. The “trainwreck delivery” Sarah H.’s midwife described, is now for Sarah H., proof that her “uterus is so efficient at birthing;” for Liisa, who was not married to her baby’s father at the time of the birth, active recollection provides an opportunity to counter the narrative superimposed on her relationship by the hospital’s policy of assigning the baby the mother’s last name in the case of “single” mothers. For others, recollection provides an opportunity to reclaim deeply held ways of knowing that they were aware of at the time but may not have been acknowledged in meaningful ways within their birthing context.

Sarah H. is a nurse. She understands the conception process. She understands that viewing a professional presentation about breastfeeding in the fall of 1993 provided enough extra stimulation to the cascade of shifting hormones in her newly pregnant body to cause tingling sensations in her breasts, but she remembers the revelation that she was pregnant beginning when “electric bolts shot out of both of [her] breasts right through [her] nipples.” In going on to describe this as a “superpower,” Sarah H. takes ownership of a particular “way of knowing,” using narrative authority to supersede physiological processes. Although this pregnancy was confirmed in testing, her “breast alarm,” would become the “biggest sign” that she was pregnant in this pregnancy, and the one that followed.

Similarly, Tammy “discovered” she was pregnant before taking a pregnancy test.

> “I had a dream that I was pregnant, which was pretty amazing to have because I'd never had a, uh, a truth-telling dream that I was aware of in my past. Um, but I knew after this dream that I was pregnant. And so I woke up and I told my husband, um, and at this point we had been married less than two years, and he was still seven years younger than I, and not quite ready for this, and so he said, ‘No, you're not.’ And I said, ‘I am. I just had the dream. I know I am.’ Um, so, you know, we did all the [testing], and and confirmed that indeed I was pregnant.”

Unlike Sarah H., because Tammy and her partner were not trying to become pregnant at the time she was not primed for signs of pregnancy. In addition, as she shares above, she had never had a “truth-telling” dream before this experience, yet the depth of her “knowing” is clear, and though she asserts it in the moment, it is in offering it through recollection that she claims ownership. Finally, PN7 shared how she was “told” her labor was beginning in a “crystal clear voice.”

> “I'm trying to remember, did I wake up and have to pee or I don't remember if the voice woke me up. They were so simultaneous. I, I do remember coming as straight as a pregnant woman can up out of bed and maybe there was an internal knowing first, and then this voice, ‘I am coming.’ It's like, okay, I have to pee. But of course, then I peed, and my water broke, and things were moving.”

Asserting narrative authority, PN7 recalibrates the timeline of her birth, establishing the onset of her labor not at the release of waters, but with a moment of deep personal connection with her child.

The BIRTH Oral History Archive two-step interview process facilitates this restoration of narrative authority by prioritizing the (re)constructive meaning-making inherent in the act of retelling. Participant narrators define the scope of the narrative timeline, independently identifying key events through narrative emphasis and inclusion throughout the first “interview.” The self-guided structure of this interview opens the space for participant narrators to de/recontextualize past birth experiences, constructing narratives of the past that reflect deeply held present-day values and priorities. The dynamic engagement of these two points in time reveals a complex personal meaning-making process that is explored further in the second interview where the interviewer engages with the participant narrator as an active listener.

Having thoroughly reviewed the first recorded interview, the BOHA interviewer participates in the follow-up interview with the goal of facilitating further exploration and greater understanding by the narrator. The interviewer may suggest specific aspects and/or events of the birth story as shared in the first interview to revisit with the narrator, or the narrator may return to the second interview with new details, information, or memories they would like to include.

Liisa told the story of her unexpected pregnancy and eventual preterm induction of labor with levity and exuberance, describing it consistently as a “wild time” in her life throughout her first interview. During her second interview she added further emotional detail to her experience with her mention of postpartum depression (PPD), influenced by her return to work as a drama therapist at an inpatient psychiatric unit.

> “I was also in a pretty serious place, especially going back to work with, um, postpartum depression, possibly uncovering like kind of a chronic low-grade depression for most of my adult life that kind of exploded onto the scene, in particular with the breach of going back to work. I remember going back to work hurt me a lot. I didn't wanna do it…I remember pumping being really distressing. I would watch videos of [baby] to get my boobs going and pumping at work and I would be in my off-, my boss's office. And I remember it feeling, um, oh God, I remember it being very depressing. I felt very isolated and um, I didn't like it.”

Similarly, Tamar did not mention the depth of her anxiety during her pregnancy until the second interview sharing she “definitely was very nervous throughout the pregnancy,” overall feeling “kind of alone in [the] experience,” largely due to the Covid restrictions in place at the time that limited her access to in-person doctor check-ups.

While the second interview takes the form of a discussion, participant narrators guide both interviews, perpetually constructing the shape of their story. Some narrators acknowledge the value of having an active listener during the second interview as they process choices and events within their story that have been carried forward unresolved.

After giving birth to her baby at home over twenty years ago, PN7 was given a cloth to clean off the vernix, a natural moisturizer that protects baby’s skin in the uterus and

can remain on the skin after birth. Some vernix had crusted over the left eye of the baby preventing him from opening it but PN7 was hesitant to wipe firmly in such a delicate area so she left it for her doula to clean off, which she did, just a short time later.

> “And as I say it to you, it's not a big deal. But I have felt guilty, I'll be honest, I have felt guilty that I didn't get that eye cleaned off well enough so that he could see me through both of his eyes and so that I could see him because it's more of a complete connection. But I, I think it's okay. Um, at any rate, uh, it has come back to me in different ways ‘cause sometimes I look at his left eye, you know, how our left and our right eyes are different. Our left is so receptive, and our right is very often when you look at people and you just look at one eye, you can often see a very different person, a more outgoing, assertive, sometimes even angry or hurt outward right eye. And the left eye tends to be more tender and sometimes hurt too. It's where people tend to show their pain that they hold, they think they hold in – the left eye can be so revealing. And so, I didn't get to see that left eye right away. Um, but yeah, I think it's okay. I'm glad I said all that out loud. I don’t why that's been holding in in a more strong way than, than it feels like saying it out loud.”

In this way the two interviews work together to provide space and closure. With the shift to active listening in the second interview the BOHA interviewer is able to support the expansion of authentic narrative while acknowledging the narrator’s authoritative knowledge. Most importantly, the participant narrators control the process and the story,

and as one Archive narrator put it “[t]here is so much power in reclaiming the story from the lens of now.”

As a public humanities project, the BIRTH Oral History Archive does not seek to document the past so much as facilitate acts of personal revisitation in a public space, allowing for communal engagement in socially and culturally meaningful ways. In doing so, it also seeks to change the narrative about childbirth by returning these stories to their authentic narrators, providing a framework for commonality, and facilitating the negotiation of wider belonging. Driven by individual participant narrators and responsive to community-based priorities, the BIRTH Oral History Archive articulates a highly valuable, cross-generational, cross-cultural continuum of story-telling.

References

Bauer, Jack J., and Dan P. McAdams. "Personal growth in adults' stories of life transitions." *Journal of personality,* vol. 72, no. 3, 2004, pp. 573-602.

Berez-Kroeker, Andrea L., and Bradley James McDonnell. *The Open Handbook of Linguistic Data Management*. The MIT Press, 2021.

Berkowitz, Carin, and Matthew Gibson. "Reframing the Public Humanities: The Tensions, Challenges & Potentials of a More Expansive Endeavor." *Daedalus,* vol. 151, no. 3, 2022, pp. 68-81.

Bluck, Susan, and Tilmann Habermas. "Extending the study of autobiographical memory: Thinking back about life across the life span." *Review of General Psychology,* vol. 5, no. 2, 2001, pp. 135-147.

Bonaparte, Alicia D. "Regulating Childbirth: Physicians and Granny Midwives in South Carolina." In *Birthing Justice: Black Women, Pregnancy, and Childbirth,* edited by Julia Chinyere Oparah and Alicia D. Bonaparte, 24-34. London: Routledge, 2016.

Browner, Carole H. and Nancy Press. “The Production of Authoritative Knowledge in American Prenatal Care.” *Childbirth and Authoritative Knowledge*, 1st ed., edited by Robbie Davis-Floyd and Carolyn F. Sargent, University of California Press, 1997, pp.113-131

Cheyney, Melissa, et al. “Giving Birth in the United States and the Netherlands: Midwifery Care as Integrated Option or Contested Privilege?” *Birth in Eight Cultures: Brazil, Greece, Japan, Mexico, the Netherlands, New Zealand, Tanzania, United States*, edited by Robbie Davis-Floyd and Melissa Cheyney, Waveland Press, Inc., 2019, pp. 165–202.

Davis-Floyd, Robbie. "The technocratic, humanistic, and holistic paradigms of birth and health care." *Ways of knowing about birth: Mothers, midwives, medicine, and birth activism*. Waveland Press, Inc, 2018, pp. 3-44.

Davis-Floyd, Robbie E. and Elizabeth Davis. “Intuition as Authoritative Knowledge in Midwifery and Home Birth.” *Childbirth and Authoritative Knowledge*, 1st ed., edited by Robbie Davis-Floyd and Carolyn F. Sargent, University of California Press, 1997, pp. 315-349.

Davis-Floyd, Robbie E. and Carolyn F. Sargent. “Introduction: The Anthropology of Birth.” *Childbirth and Authoritative Knowledge*, 1st ed., edited by Robbie Davis-Floyd and Carolyn F. Sargent, University of California Press, 1997, pp.1-51.

f, Lydia Zacher, Vania Smith-Oka, and Mounia El Kotni. "Teaching about Childbirth in Mexico: Working across Birth Models." *Birth in Eight Cultures: Brazil, Greece, Japan,*

Mexico, the Netherlands, New Zealand, Tanzania, United States, edited by Robbie Davis-Floyd and Melissa Cheyney, Waveland Press, Inc., 2019, pp. 17-48.

Fraser, Gertrude Jacinta. *African American midwifery in the South: Dialogues of birth, race, and memory*. Harvard University Press, 1998

Habermas, Tilmann. “Autobiographical reasoning: arguing and narrating from a biographical perspective.” *New directions for child and adolescent development,* vol. 2011, no. 131, 2011, pp. 1-17.

Jordan, Brigitte. *Birth in four cultures: A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States*. Waveland Press, 1992.

Jordan, Brigitte. “Authoritative Knowledge and Its Construction.” *Childbirth and Authoritative Knowledge*, 1st ed., edited by Robbie Davis-Floyd and Carolyn F. Sargent, University of California Press, 1997, pp. 55-79.

Krmpotich, Cara. "Public humanities as third space: Memory, meaning-making and collections and the enunciation of “we” in research." *University of Toronto Quarterly,* vol. 85, no.4, 2016, pp. 82-92.

Krmpotich, Cara, Heather Howard, and Emma Knight. "From collection to community to collections again: Urban Indigenous women, material culture and belonging." *Journal of Material Culture,* vol. 21, no. 3, 2016, pp. 343-365.

Kuhn, Annette. "A journey through memory." *Memory and methodology*. Routledge, 2020. 179-196.

Kuhn, Annette. "Memory texts and memory work: Performances of memory in and with visual media." *Memory studies* vol 3, no. 4, 2010, pp. 298-313.

Lazarus, Ellen. “What Do Women Want?: Issues of Choice, Control, and Class in American Pregnancy and Childbirth.” *Childbirth and Authoritative Knowledge*, 1st ed., edited by Robbie Davis-Floyd and Carolyn F. Sargent, University of California Press, 1997, pp.132-158.

Lupton, Carroll. Interview. Conducted by Mary Murphy. 2 April 1980. Documenting the American South project at University Library of the University of North Carolina at Chapel Hill, Chapel Hill, NC.

McLean, Kate C. "Late adolescent identity development: narrative meaning making and memory telling." *Developmental psychology,* vol. 41, no. 4, 2005, pp. 683-691.

McLean, Kate C., and Michael W. Pratt. "Life's little (and big) lessons: identity statuses and meaning-making in the turning point narratives of emerging adults." *Developmental psychology,* vol. 42, no. 4, 2006, pp. 714-722.

National Academies of Sciences, Engineering, and Medicine. "Birth settings in America: Outcomes, quality, access, and choice." 2020.

Özkul, Didem, and Lee Humphreys. "Record and remember: Memory and meaning-making practices through mobile media." *Mobile Media & Communication,* vol. 3, no. 3, 2015, pp. 351-365.

Schlissel, Lillian. *Women's Diaries of the Westward Journey*. Schocken Books, 2004.

Schwartz, Marie Jenkins. *Birthing a Slave: Motherhood and Medicine in the Antebellum South*. Cambridge, MA: Harvard University Press, 2006.

Singer, Jefferson A. "Narrative identity and meaning making across the adult lifespan: An introduction." *Journal of personality,* vol. 72, no. 3, 2004, pp. 437-460.

Singer, Jefferson A., and Susan Bluck. "New perspectives on autobiographical memory: The integration of narrative processing and autobiographical reasoning." *Review of General Psychology,* vol. 5, no. 2, 2001, pp. 91-99.

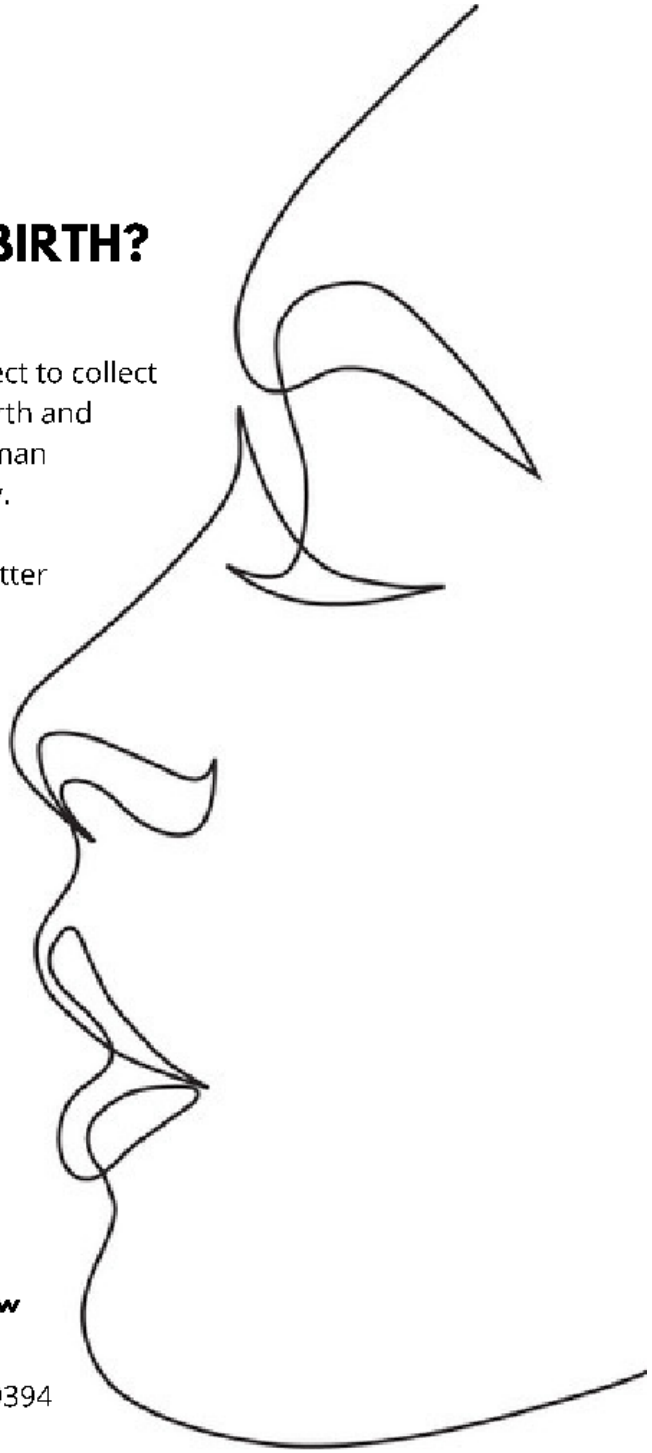
Smulyan, Susan. "Why Public Humanities?." *Daedalus,* vol. 151, no. 3, 2022, pp. 124-137.

Stahnisch, Frank W., and Marja Verhoef. "The Flexner Report of 1910 and its impact on complementary and alternative medicine and psychiatry in North America in the 20th century." *Evidence-based complementary and alternative medicine* 2012, 2012).

Woodward, Kathleen. "The future of the humanities-in the present & in public." *Daedalus,* vol. 138, no. 1, 2009, pp. 110-123.

Appendices

Appendix A: BIRTH Oral History Archive Recruitment Flyer



HAVE YOU BEEN PREGNANT OR GIVEN BIRTH?

The BIRTH Oral History Archive is a project to collect and preserve women's stories of childbirth and pregnancy loss, capturing how each woman remembers, relives, and retells her story.

Sharing your story will help to build a better understanding of the experience of pregnancy and birth, and the complex history of childbirth.

Our interview process includes two interviews that can be conducted in person or virtually, lasting about one hour each.

TELL US YOUR STORY.

BIRTH
ORAL HISTORY ARCHIVE

CONTACT US to schedule your interview

Eliza Wilson-Powers
ewpowers@umich.edu, or call 917-412-9394

Research supported by the Master of Arts in Liberal Studies in American Culture Program, University of Michigan-Flint; HUM0021 7596
Faculty Advisor: Vickie J. Larsen, Director, MLS program in American Studies

Appendix B: BIRTH Oral History Archive Informed Consent

BIRTH
ORAL HISTORY ARCHIVE

CONSENT TO PARTICIPATE AND LICENSE OF INFORMATION

BIRTH Oral History Archive
Study ID: HUM00217596

Principal Investigator: Eliza Wilson-Powers
Master of Liberal Studies in American Culture Program
Rackham Graduate School, University of Michigan Flint

Date of Interview: _____
Name(s) of person(s) interviewed:

_____

_____

Current Address: _____

_____

Email: _____

Telephone Number: _____

Age: _____ Place of Birth: _____

Purpose and Scope of Study

You have been invited to participate in an oral history of the pregnancy and childbirth experience. We will discuss your personal experience with pregnancy, childbirth, and the postpartum period. You will be asked to participate in two separate interviews for each childbirth and/or pregnancy discussed. These interviews will be recorded in audio and/or video, transcribed, and may be photographically documented. All materials may be made available to the public and for scholarly use. You will be asked for basic biographical information such as the place and date of your birth. We may discuss your perception and understanding of pregnancy and childbirth at different points in your life and key social and cultural influences. You will also be asked if you would like to contribute your own photograph(s) as part of the oral history project. We plan to use your interviews and materials to build a more comprehensive history of the experience of childbirth and to serve as an archive for future researchers.

Benefit, Risks, and Compensation
This research poses no risks to participants. You will receive a digital recording of your interviews but will not be compensated for your participation. Your generous act of sharing your story will help researchers and the public better understand the experience of pregnancy and birth, and the complex history of childbirth.

Confidentiality
To keep your personal information safe, the researcher(s) will safeguard all information in University of Michigan secure data repositories and password protected data drives. Your contact information is collected solely for the use of the research team and will not be shared or made public without acquiring your explicit consent. At any time you may: decline to answer any question, withdraw from the interview, restrict access to parts or all of your statements or provide a written request for temporary or permanent confidentiality of your identity. As a participant you will be assigned an interview ID number and may elect to be identified soley by this number in any and all publicly available BIRTH Oral History Archive collections and records at any time. A media release will be sought for each living person in any photograph for publication.

Consent and Release
The original recordings, transcripts, and all photographic materials will be archived at the University of Michigan as the BIRTH Oral History Archive. These materials will be archived by Interview ID, searchable by your name, and made available to the public for scholarly and educational purposes, unless you request exceptions as noted below.

Your interview is a piece of intellectual property of which you are the legal owner. By signing below, you license that material under the Creative Commons Attribution-NonCommercial 4.0 International License. This license allows researchers and members of the public to use, reproduce, digitize, and distribute your audio or video interview, contributed media materials, name, likeness, image, voice, and transcript in whole or in part non-commercially for educational purposes. Others may use your interview in books, radio, films, websites, exhibitions, presentations, or other media as long as they credit you for the original creation. Please list any exceptions or restrictions to these privileges you would like to place on your interviews below.

RESTRICTIONS:

_____

_____

_____

I have had a chance to discuss this project and the way my recorded interviews may be used with the research team and have received complete answers to all of my questions. I authorize the BIRTH Oral History Archive to share my recorded interviews with the public and to use my name, image, and voice, as well as my story in connection with the oral history project except for any restrictions noted above.

Name (please print):

Signature: _____

Date: _____

Researcher's Signature:

Date: _____

Contact Information
If you have any questions about this research, please contact:
Eliza Wilson-Powers
BIRTH Oral History Archive
917-412-9394
ewpowers@umich.edu

As part of their review, the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board (IRB) has determined that this study is no more than minimal risk and exempt from on-going IRB oversight.

Appendix C: BIRTH Oral History Archive Visual Media Release

BIRTH
ORAL HISTORY ARCHIVE

VISUAL MEDIA RELEASE

BIRTH Oral History Archive
Study ID: HUM00217596

Principal Investigator: Eliza Wilson-Powers
Master of Liberal Studies in American Culture Program
Rackham Graduate School, University of Michigan Flint

Date: _____

Name: _____

Current Address: _____

_____

Email: _____

Telephone Number: _____

Visual Media Description: _____

The BIRTH Oral History Archive (BOHA) documents, collects, and preserves first-hand experiences of pregnancy and childbirth. We believe these stories are crucial to a better understanding of the experience of pregnancy and birth, and its complex history. The BIRTH Oral History Archive is a publicly available resource.

As part of their contribution to the Archive, participant narrators are invited to voluntarily contribute photograph(s). Media depicting your personal likeness has been contributed to the archive.

Confidentiality
To keep your personal information safe, the researcher(s) will safeguard all information in University of Michigan secure data repositories and password protected data drives. Your contact information is collected solely for the use of the research team and will

not be shared or made public without acquiring your explicit consent. You will be assigned a study identifier and may elect to be identified solely by this number in any and all publicly available BIRTH Oral History Archive collections and records by submitting a written request at any time.

Original recordings, transcripts, and all photographic materials will be archived at the University of Michigan and with the BIRTH Oral History Archive. These materials will be made available to the public for scholarly and educational purposes.

I hereby grant BOHA permission to use my likeness in visual media in print and/or electronically. I hereby authorize BOHA to edit, copy, exhibit, publish, or distribute the media for scholarly and educational purposes. In addition, I waive my right to inspect or approve the finished product wherein my likeness appears. I release and discharge BOHA from any and all claims arising out of use of the media for the above purposes.

I have read and understand the above media release.

☐ I affirm that I am at least 18 years of age.

☐ I am under 18 years of age and have obtained the required consent of my parents/ guardians as evidenced by their signatures below.

Name (please print): _____

Signature: _____

Date: _____

If under 18, ALL LEGAL GUARDIANS MUST SIGN

Name: _____	Name: _____
Signature: _____	Signature: _____
Date:	Date:

Contact Information

If you have any questions about this research, please contact:
Eliza Wilson-Powers, BIRTH Oral History Archive
917-412-9394 / ewpowers@umich.edu

As part of their review, the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board (IRB) has determined that this study is no more than minimal risk and exempt from on-going IRB oversight.

Appendix D: BIRTH Oral History Archive Interview Information Sheet

BIRTH
ORAL HISTORY ARCHIVE

INTERVIEW 1 INFORMATION SHEET

BIRTH Oral History Archive
Study ID: HUM00217596

Date of Interview: _____

Interview ID: _____

Narrator Age at Contribution Birth: _____

Number of Children: _____ ☐ TWINS

Birth Order Position: _____ Birth Order Position: _____

Date/Year of Birth: _____ Date/Year of Birth: _____

Sex Assigned at Birth: _____ Sex Assigned at Birth: _____

Location of Birth: _____

Birth Setting: ☐ HOME ☐ HOSPITAL ☐ BIRTH CENTER ☐ OTHER

Birth Setting NOTES: _____

_____

Care Provider: ☐ NONE ☐ OB/GYN ☐ MIDWIFE ☐ OTHER

Care Provider NOTES: _____

NOTES

_____

_____

Date of Interview 2: _____ ☐ Scheduled ☐ NOT Scheduled ☐ DECLINE

Contributing Media Assets ☐ YES ☐ NO ☐ UNDECIDED; follow-up

Requested Anonymity ☐ YES ☐ NO

Appendix E: BIRTH Oral History Archive Data Management Plan

BIRTH
ORAL HISTORY ARCHIVE

DATA MANAGEMENT PLAN

BIRTH Oral History Archive
Study ID: HUM00217596

Principal Investigator: Eliza Wilson-Powers
Master of Liberal Studies in American Culture Program
Rackham Graduate School, University of Michigan Flint

Data Description

The BIRTH Oral History Archive will collect and preserve primary source data on the childbearing experience from women who have given birth and/or been pregnant. The interview process includes two interviews that will be audio and/or video recorded and may be photographically documented, recordings will be transcribed. In addition, each participant will be offered the opportunity to contribute personal photographic material. Data may include raw and edited video and audio recordings, digital image files (original and scanned materials), transcriptions, and project documentation.

Designated Archive

Original recordings, transcripts, edited stories/interviews, all photographic materials, and project documentation will be archived by interview ID, or participant name as determined by compliance with the confidentiality plan, and securely stored in Deep Blue. A backup will be kept on Dropbox, as well as a dedicated external drive. Data will be retained for the life of the project.

Access and Sharing

The archive will be made publically available for scholarly and educational purposes; limitations to these privileges will be maintained in cases where exceptions were requested by the participant. Exceptions may include, restricting access to parts or all of their statements or providing a written request for temporary or permanent confidentiality of their identity should they wish to contribute their story but not have

their name searchable in the publicly available resources of the archive. Media releases will be sought for dissemination of any contributions depicting the personal likeness of non-participants using contact name(s) and information provided by participant narrators and publicly available resources. Identities will be digitally obscured for non-participants who have not signed a media release form after three (3) attempts to contact by the researcher(s).

Intellectual Property Rights

All project interviews are the intellectual property of the participant narrators. Through the consent process interviews have been licensed by the participant narrators under the Creative Commons Attribution-NonCommercial 4.0 International License, allowing researchers and members of the public to use, reproduce, digitize, and distribute the audio or video interview, contributed media materials, name, likeness, image, voice, and transcript in whole or in part non-commercially for educational purposes. They may also be used in books, radio, films, websites, exhibitions, presentations, or other media as long as credit for the original creation is duly cited. By contributing interviews to the BIRTH Oral History Archive, or depositing them in the repositories outlined above, participant narrators do not transfer copyright but instead grant permission for dissemination activities as outlined, and any necessary transformation of the data required to protect respondent confidentiality, improve usefulness and access, and facilitate preservation.

Ethics and Privacy

Participant narrators are required to sign informed consent statements prior to participation in the interview process. The project consent form will be reviewed with each potential participant and signed via a secure online document signing platform (SignNow) or by hand. Each participant will receive a copy of their consent, countersigned by the Researcher, via email, or US mail if requested. Digital copies of participant consent forms will be stored in project files, separate from participant files, and not available to the public.

Contact information is collected solely for the use of the research team and will not be shared or made public without acquiring explicit consent. At any time participant narrators may: decline to answer any question, withdraw from the interview, restrict

access to parts or all of their statements or provide a written request for temporary or permanent confidentiality of their identity. A media release will be sought for each living person in any photograph for publication.

All participants will be assigned an interview ID number and may elect to be identified solely by this number in any and all publicly available BIRTH Oral History Archive collections and records at any time. Interview IDs are assigned on a sequential basis as participants consent to the study using the following format: YEARconducted_SequentialNumber. They are assigned to allow participants confidentiality of identity should they wish to contribute their story but not have their name connected and searchable in the publicly available resources of the archive. As an oral history archive participant narrators have the option for the archive to retain only their voice recording and have no visual media attached to their contribution.

Interview IDs will be connected to identifying information of participant narrators through the Participant Log and signed consent forms only, both of which will be stored in secure repositories, separately from participant files, and not available to the public.

The project data management plan and procedures will undergo periodic review to protect the confidentiality of individuals whose personal information may be part of archived data including regular assessment of disclosure risk and procedure review with project staff to manage disclosure risk.

Selection and Retention

The full dataset and project documentation will be retained for the long term, supporting the data through changing technologies, new media, and data formats.

Metadata

Substantive metadata will be created and maintained in compliance with the most relevant standards providing for the tagging of content, which facilitates preservation and enables access. These types of metadata will include, (a) Study-Level Metadata: a summary record created for searchability, and (b) Variable-Level Documentation: tagged information allowing users to identify relevant variables of interest.

Format

Interview data files will be made available in several widely used formats, including MP3 and WAV. Static documentation will be preserved as PDF for the life of the project. Ongoing project documentation will be maintained in editable formats to allow updates as necessary, PDFs will be exported and stored on a quarterly basis and retained for three (3) years, final versions will be preserved as static documentation. Project data will be stored in accordance with prevailing standards and practice.

Archiving and Preservation

The BIRTH Oral History Archive will ensure the research data are migrated to new formats, platforms, and storage media as required by good practice in the digital preservation community. Good practice for digital preservation requires that an organization address succession planning for digital assets.

Storage and Backup

Research has shown that multiple locally and geographically distributed copies of digital files are required to keep information safe. Accordingly, master copies of each digital file (i.e., research data files, documentation, and other related files) in the BIRTH Oral History Archive will be stored in Deep Blue, a secure Dropbox account and a dedicated external drive. This is in keeping with recommended data management plans.

Responsibility

The principal investigator will have overall responsibility for data management over the course of the research project and will monitor compliance with the plan.

As part of their review, the University of Michigan Health Sciences and Behavioral Sciences Institutional Review Board (IRB) has determined that this study is no more than minimal risk and exempt from on-going IRB oversight.

Appendix F: University of Michigan IRB Approval Letter

Health Sciences and Behavioral Sciences Institutional Review Board (IRB-HSBS) ▪ 2800 Plymouth Rd., Building 520, Room 1170, Ann Arbor, MI 48109-2800 ▪ phone (734) 936-0933 ▪ fax (734) 998-9171 ▪ irbhsbs@umich.edu

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To: Eliza Wilson-Powers

From:

Riann Palmieri-Smith
Thad Polk

Cc:

Vickie Larsen
Eliza Wilson-Powers

Subject: Notice of Exemption for [HUM00217596]

SUBMISSION INFORMATION:
Title: BIRTH
Full Study Title (if applicable): BIRTH Oral History Archive
Study eResearch ID: HUM00217596
Date of this Notification from IRB: 6/20/2022
Date of IRB Exempt Determination: 6/20/2022
UM Federalwide Assurance: FWA00004969 (For the current FWA expiration date, please visit the UM HRPP Webpage)
OHRP IRB Registration Number(s): IRB00000246

IRB EXEMPTION STATUS:
The IRB HSBS has reviewed the study referenced above and determined that, as currently described, it is exempt from ongoing IRB review, per the following federal exemption category:

> **EXEMPTION 2(i) and/or 2(ii) at 45 CFR 46.104(d):**
>
> **Research that only includes interactions** involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) **if at least one of the following criteria is met**:
>
> **(i)** The information obtained is recorded by the investigator in such a manner that **the identity of the human subjects cannot readily be ascertained**, directly or through identifiers linked to the subjects;
>
> **(ii)** Any disclosure of the **human subjects' responses** outside the research **would not reasonably place the subjects at risk** of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation

Note that the study is considered exempt as long as any changes to the use of human subjects (including their data) remain within the scope of the exemption category above. Any proposed changes that may exceed the scope of this category, or the approval conditions of any other non-IRB reviewing committees, must be submitted as an amendment through eResearch.

Although an exemption determination eliminates the need for ongoing IRB review and approval, you still have an obligation to understand and abide by generally accepted principles of responsible and ethical conduct of research. Examples of these principles can be found in the Belmont Report as well as in guidance from professional societies and scientific organizations.

SUBMITTING AMENDMENTS VIA eRESEARCH:
You can access the online forms for amendments in the eResearch workspace for this exempt study, referenced above.

ACCESSING EXEMPT STUDIES IN eRESEARCH:
Click the "Exempt and Not Regulated" tab in your eResearch home workspace to access this exempt study.

Riann Palmieri-Smith
Co-chair, IRB HSBS

Thad Polk
Co-chair, IRB HSBS