

“Even More Scared”:

The Effects of Childbirth Reality Shows on Young Women’s Perceptions of Birth

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DEDICATION

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ABSTRACT

In contemporary U.S. society, it is rare for a woman to be present at a birth before she gives birth herself. The representation of childbirth on television has greatly increased in recent years, and media portrayals may provide the only opportunity to witness childbirth outside of women giving birth themselves. Childbirth reality television shows present birth through a dramatized media lens, leading to questions about the impact such shows has on the women who watch them. This study analyzes the effects childbirth reality shows have on young women's perceptions of childbirth. College women (n = 78) participated in a viewing experiment followed by a focus group to measure the effects of the show *One Born Every Minute*, the most recent childbirth reality show to premiere on television. Findings reveal that portrayals of high-risk birth on reality television shows significantly increase women's anxiety toward future childbirth and decrease perceived agency in the birth process. These effects may have public health implications. To the extent that these effects are combined with portrayals of invasive procedures such as Caesarean section as the norm, expectant women may be more limited in their potential to envision a wide range of childbirth options.

Chapter I: Introduction

Nurses hear a loud scream from down the hall as a woman pushes during the final stage of her labor with her fourth child. The scene is intense, with dramatic music pulsing in the background and a worried husband looking helpless by his struggling wife's side. The woman wails, "GET IT OUT!" at the top of her lungs, which startles the nurses down the hall, as she pushes while the obstetrician waits for progress. The narrator reminds the audience that all this woman wants is a healthy baby. The mom screams and screams in agony as the show fades to commercial break.

Minutes later, one more successful birth – a relatively easy, uncomplicated one – goes down in the history of the show *One Born Every Minute*. The new Lifetime reality show documents the drama in the maternity ward of Riverside Methodist Hospital in Ohio, where the show has installed 40 cameras to catch every moment of every labor and delivery. Each episode follows three moms-to-be and their families on their final step toward welcoming a new baby into their lives. However, viewers of the show quickly gather that giving birth is no easy feat. In fact, the show presents birth in an edge-of-your-seat, gripping manner, provoking anxiety about every birth that takes place.

Over ninety-nine percent of births in the United States take place in hospitals like the births on *One Born Every Minute* (National Vital Statistic Report, CDC, 2009). Coupled with this nearly universal use of hospital birth is a cesarean section rate over double that which is recommended by the World Health Organization and some of the poorest maternal and infant mortality rates in the developed world (CDC, 2009). These less-than-optimal birth outcomes can be rather shocking, since the US treats birth as a medical event through widely used technological interventions and medically-controlled birthing experiences. The belief in the

power of medicine in American culture is largely unchallenged, especially in childbirth, because of the notion that doctors – not birthing women – know best when it comes to women’s bodies. Placing birth in doctors’ hands takes power away from women over their own bodies and their experiences of childbirth.

In recent years, it seems as if media interest in childbirth, especially medicalized childbirth, has increased. Examples of this proliferation include television shows such as *A Baby Story*, *16 and Pregnant*, and *I Didn’t Know I Was Pregnant* as well as the release of feature films such as *Knocked Up*, *Juno*, and *Due Date*. The American media overwhelmingly shows birth as a medicalized event. However, birthing in a professional medical center is a culturally specific construct. Although birth is a common human phenomenon, the experience of birth is not constant across societies (Jordan, 1997). Birth is a culturally specific phenomenon imbued with specific underlying messages, power relations, and cultural beliefs, all of which are portrayed via the media. Shows about pregnancy and birth are part of larger social discourses in which they take place. Thus, the way childbirth is presented in the American media may be a reflection of the way birth is thought of in the United States. Childbirth-themed media and real birth outcomes are inextricably linked within the cultural structures that make birth what it is in the US – a heavily medicalized, technology-reliant, fear-inducing event.

In this project, I hypothesize that typical media representations of birth increase anxiety about the process among young female viewers. Television shows are designed to entertain, not simply inform, and so they present birth in a highly dramatized, attention-grabbing manner. The media may indeed present birth as much more dangerous than it is in reality. Female viewers of childbirth-themed reality shows are vulnerable to becoming anxious about childbirth as presented through a dramatized lens, especially if they are planning on experiencing birth in their

future and use the shows to learn about birth. Fear about childbirth may lead women to rely more on medical technology to ensure a positive birth outcome, such as contributing to maternal demand for cesarean section (NIH, 2006). In this research, I hypothesize that the media promotes the medicalization of birth and increases women's fear about childbirth, which ultimately decreases the autonomy women have in their experiences of childbirth.

Childbirth-themed reality television shows are those whose main focus and theme is birth itself. These shows tend to be broadcast during the daytime on networks targeted for women. Childbirth-themed reality shows portray real women's experiences of giving birth. These shows include *One Born Every Minute*, *A Baby Story*, *Birth Day*, *Deliver Me*, and *I Didn't Know I Was Pregnant*. This category does not include shows like *16 and Pregnant*, *Teen Mom*, and *Bringing Home Baby*, which focus on the social experience of being pregnant and/or of being a new mother rather than the birth itself. The reality television shows I am interested in fall under the drama genre.

As an exemplar of childbirth-themed reality television, I chose the show *One Born Every Minute*. The show is new, with only one season broadcast so far (and a second on the way), and it has not yet been examined. Its portrayal of birth is typical of other shows in the same genre. Furthermore, the show portrays the birthing experiences of a diverse selection of women from multiple racial identities, ages, family structures, and sexual orientations. Previous childbirth-themed reality shows have tended to show less variety in identities (Morris & McInerney, 2010). I am interested in the construct of anxiety toward childbirth, especially after viewing childbirth television reality shows. I define anxiety toward childbirth as fear about the future experience of birth. I am focusing on anxiety about birth from women who have never experienced giving birth before.

The focus of my thesis is this intersection between childbirth-themed media and women's perceptions of childbirth. This study will critically examine how childbirth-themed reality television shows, in particular the new Lifetime show *One Born Every Minute*, affect college women's ideas about childbirth, and how the show may have an impact on women's future intentions of childbirth. It attends to the lack of effects-based research on this topic. By combining both qualitative and quantitative measures, this study addresses the question of potential mechanisms through which childbirth-themed media might impact women's intentions for future experiences of birth. Ultimately, the goal of my research is to identify ways in which the media contributes to positive or negative experiences and outcomes of childbirth.

LITERATURE REVIEW

Power and Control over Women's Bodies in Childbirth

Feminist scholarship suggests that although childbirth is a physical process, it takes on cultural meaning as a result of power relations and gender roles in society. The act of childbirth is a shared human experience, but the specific beliefs, practices, and traditions around the event in a given society reveal a great deal about that culture (Jordan, 1997; Davis-Floyd, 2003). In Western cultures, childbirth practices are heavily influenced by the privileged status of medicine. The medical system's control over childbirth, and the concomitant devaluation of women's own experiences of giving birth, has been a topic of feminist scholarship (Campo, 2010). This phenomenon is referred to as obstetric hegemony, in which systematic power relations rely on consent from the birthing woman to be under the authority of physicians rather than their own direction, and this power dynamic is sustained by the ideological power of medicine (Campo, 2010).

Is the medically controlled norm of birth problematic for women? Davis-Floyd (2003) refers to this as the "technocratic model" of birth, in which birth is seen as a disease for medicine to cure, mandating that it take place in hospitals under the jurisdiction of physicians. As with a disease, the institution of medicine views birth as having cures that are "based on science, effected by technology, and carried out in institutions founded on principles of patriarchy and the supremacy of the institution over the individual" (p. 46). Thus, authority over birth is taken away from birthing women and put into the hands of physicians who control it through the supremacy of the medical institution. Women's bodies are viewed as instruments for producing children that are inherently in need of medical regulation to successfully generate this desired product. Women's bodies are not trusted to handle birth without the regulation of medicine,

technology, and doctors' complete guidance. The medicalization of childbirth, therefore, draws agency away from women during one of the most intimate, personal experiences in their lives.

Jordan (1997) discusses this approach of childbirth in terms of authoritative knowledge, which she defines as the universally understood status quo, which becomes so engrained in a society's consciousness that it comes to be seen as the way things have always been and ought to be. Authoritative knowledge is culturally specific. Jordan demonstrates this fact by presenting the culture of childbirth in four drastically different societies. The American model of birth (in-hospital, physician-controlled, intervention-reliant) is not universal, nor can it be proven to be the "best" way of doing birth, especially considering the U.S.'s relatively high maternal and infant mortality rates (World Health Organization) – it is simply the way birth "ought" to be according to the authoritative knowledge of American culture. The media reflects such authoritative knowledge over birth through how it depicts the event. By promoting the medicalized model of birth almost exclusively, childbirth shows are embedded with the cultural belief that technology is superior to women's autonomy during birth. They promote the idea that childbirth requires medical and technological regulation. This is a culturally specific belief, not an inherent truth.

The shift from of birth in the US "from a normal biological event to a medical management issue" stems from gender issues (Richards 1992, p. 27). Because childbirth is an inherently female experience, patriarchal structures feel the need to control and manipulate it in order to be involved in birth at all. This results in women being devalued in favor of patriarchal control over their bodies, in spite of the fact that birth belongs to women's bodies (Davis Floyd 2003). Women can be affected by doubts that their bodies would be capable of giving birth without medical regulation, perpetuating fear about childbirth. Women are not encouraged to

think about themselves during childbirth but rather about the birth outcome according to decisions made by attending physicians, which results in a worrisome lack of women's agency.

Wildner (2008) provides a useful metaphor for medical control over childbirth through the "branding" of birth. Just as objects such as "Kleenex" and "band-aids" have been associated with a particular brand, so has birth. Childbirth is overwhelmingly automatically associated with hospitals, doctors, medication, and interventions in the United States, branding birth as a medicalized event. Fear of childbirth maintains the link between childbirth and medicine. Women are taken out of the equation of what is most immediately associated with birth.

Representation of Childbirth in the US Media

The intersection of childbirth and reality television may seem to be an unlikely pairing; reality television's primary purpose is entertainment, while childbirth is usually not considered an entertaining phenomenon, but rather a private act. Bringing childbirth out of the private realm into widely broadcast cable television poses an interesting question for producers of how to portray it in a way that entertains audiences.

Studies have shown that childbirth reality shows do not always realistically depict childbirth. Morris and McInerney (2010) analyzed the way in which childbirth is presented on reality-based television shows in their thorough case study of The Learning Channel's *A Baby Story* and Discovery Health's *Birth Day*. The two shows depicted the standard medicalized model of birth: women pushing while lying on their backs, opting to use pain medication and technologies such as epidurals, being constantly monitored with electronic fetal monitors, receiving rewarding responses to quick labors, and having other people regulate their pushing. Additionally, these shows depict a higher proportion of cesarean section surgeries than the

national rate. The shows illustrate unmedicated women as out-of-control and stubborn, and they present natural birthing methods as inferior to highly regulated medicalized birth. The authors found that the two shows present birth as unpredictable and dangerous, reinforcing the idea of women's bodies as unreliable and incapable of birth. The shows present birth as a standardized process that detracts from women's autonomy and control, exemplifying the technocratic model of birth. The study concludes, "the discipline and control of the female body are exaggerated and normalized through media representations" (p. 135); in childbirth shows the female body becomes the medium through which cultural understandings of gender are presented. Morris and McInerney believe that "the shows slanted the reality of the situations to create happy endings and warm feelings" that are typical of "good" television (p. 138). Because television must captivate audiences through dramatic hooks, depictions of childbirth in the mass media are unlikely to provide realistic tools for women to learn about birth. The study concludes that reality-based birth television shows do not give women accurate portrayals of women's typical experiences giving birth in the United States. However, the study does not explore the impact of these birth portrayals at all on viewers, leaving the effects of childbirth themed media unknown.

A more recent analysis of *A Baby Story* found that the show acts as surveillance and discipline over women's bodies (Sears & Godderis, 2010). As a reality show, the study identified four main discourses present in the representation of birth: the birthing woman, the birthing story, the role of medicine, and agency and resistance. The authors found that the show was highly unrepresentative of birthing women, portraying mostly white, heterosexual, married women. Furthermore, the show reinforced medicalization as the best choice for birthing method and that medicine plays a fundamental role in birth according to the show. Finally, the show supported the "right kind of femininity" (p. 190) being performed in the show, where women are

kept as quiet, passive actors in their own birthing experiences. Medical interventions are depicted as a requirement, not a choice. This study is particularly interesting in that it sees that “the very nature of reality TV programming presents the audience with the opportunity to judge the actions of those who are being watched and encourages these audience members to take up the position of surveillant” (p. 183), recognizing an active position of the audience while viewing the show.

VandeVusse and VandeVusse (2008) think of the media as important outlets through which women learn about childbirth. In particular, they consider reality television shows that depict experiences of childbirth to be particularly important sources of information about birth for women. In their content analysis of contemporary childbirth reality shows, VandeVusse and VandeVusse found that the majority of births on such shows are in-hospital and physician attended, reinforcing the medicalized, intervention-heavy model of birth as normative. They also found that childbirth reality shows portray midwife-attended births as special cases chosen only by particularly well-informed women, indicating a socioeconomic dimension to childbirth choices. For these reasons, the authors conclude that these shows are non-neutral sources of information about childbirth options for women.

While non-medicalized models of childbirth are available to women, they are not depicted in mainstream media. Despite the imperfections of the medical model, very few women even consider alternatives such as homebirths, birthing centers, and midwife-attended births. This could be a result of misconceptions about these safe alternatives learned from the media. To understand the way non-medicalized birth was being portrayed in the media, Kline (2007) analyzed representations of midwife-attended birth in prime-time television. In the few examples portraying midwives, midwifery-attended births were represented as irrational choices.

Prime-time shows such as *Gilmore Girls*, *Girlfriends*, and *Dharma & Greg* depicted midwives as controlling and irrational when it came to their involvement in birth. Such depictions misrepresent the midwifery model of obstetric care and ultimately affirm the need for the dominant medical model of birth. These media portrayals present midwives as inadequate compared to obstetricians. Obstetricians generally follow a medical model, however, so this “good” choice is linked with using technology to produce good birthing outcomes rather than using more natural, agency-promoting methods generally used by midwives.

Kline’s 2010 elaboration on her earlier survey of prime-time television shows explains that midwives are not only represented comically, but that they are shown through a form of comedic entertainment in which transgressors (in this case midwives) are portrayed as villains whose behavior (attending non-medicalized births) is so disconcerting that it warrants comedic laughter. Kline establishes this analysis through Burke’s (1966) frame of representation of stigmatized and/or minority groups; the prime-time portrayal of midwifery falls into Burke’s frame of rejection, meaning that the way midwives are depicted implies that they occupy a role that is stigmatized and looked down upon in society and therefore they should be rejected by society as viable caregivers for women. While representation of midwifery care on television may open up meaningful dialogue about different options available to women, the way in which midwives are represented tends to limit opportunities for such dialogue. As a result, media representations of midwifery discourage potential for cultural change away from the nearly universal dominance of birth by the medical field, thereby reinforcing the dominant medicalized model of childbirth.

Birth portrayals have expanded into new media outlets. For instance, the development of social media has created new spaces for childbirth portrayals and discourses to take place.

Longhurst (2009) explored YouTube, as an additional space for visual representations of birth; users are increasingly uploading videos of their own birthing experiences onto the public site for others to view. Longhurst found that user-created videos of birth on YouTube simultaneously increase the availability of exposure to birth while reinforcing cultural beliefs about correct childbirth and maternity. She found that a narrow range of birth experiences was represented on YouTube, most being from the United States; according to the author, a “particular kind of birth space, a ‘modern’ space, an Anglo space, and American space is being (re)produced online” (p. 56). A particularly interesting finding from Longhurst’s study is that not all videos are available to minors. Longhurst identified that “natural” vaginal births are far more likely than cesarean births to be censored by the website, implying that birth done through surgery is far more accepted in society for a range of audiences than biological deliveries. The author concludes that YouTube, like television, acts as a space that is contextualized within gendered social systems that imbues women’s bodies with power relations overwhelmingly in favor of the technological and medical over the natural.

What have been left out of analyses of childbirth-themed media are the effects that this media has on women. Previous research has neglected to analyze the impact that childbirth-themed media, especially reality shows, has on the women who consume it. Scholarship on childbirth reality shows has involved primarily content analyses, and this study will test the effects of the hypotheses posited by this previous research, looking for links between the way birth is portrayed to changes in attitudes about birth.

Learning about Childbirth through the Media

Previous research has shown that women draw upon media sources such as television, videos, books, and the Internet to learn about childbirth. Pregnant women and young mothers have been classified as “high information seekers” (Bernhardt and Felter, 2003). Participants in Bernhardt and Felter’s study preferred advice and information from clinical professionals as well as information online shared by other parents over other sources such as parenting magazines and word-of-mouth information. Television shows that portray mothers’ experiences of pregnancy and childbirth may have a similar effect as information online in that the shows center on real women’s experiences, which may serve as outlets of advice from other parents for information-seeking women.

Handfield et. al (2006) found that women increasingly rely on the media, particularly the Internet, as an influential source about health, underscoring Barnhardt and Felter’s findings. The study recommended that obstetricians become more aware of the outlets through which women learn about childbirth to accurately address their concerns, fears, and any erroneous information they may pick up through the media. This study only applied to obstetrician-attended birthing experiences, ignoring the connection between women seeking out information in the media about childbirth with midwifery care and non-medicalized birth.

Childbirth Connection found that two-thirds of pregnant women sampled had viewed television shows created to depict birth (Listening to Mothers II, 2006). The most common show viewed was *A Baby Story*. Women reported feeling excited about giving birth themselves, understanding of what giving birth would be like, and feeling worried about giving birth after viewing these reality childbirth shows. Women included in this study were already pregnant, however, so feelings of impending birth experiences likely influenced these women’s experience

of viewing more heavily than women who are not pregnant or facing childbirth in the near future.

How much can the media influence women's understandings of childbirth? Research from communication studies and psychology has established that television can, in fact, be a primary source that women draw upon to learn about major life events such as childbirth. One theory, referred to as uses and gratifications, sees audiences as "variably active communicators" who actively seek out media to gratify individual needs (Rubin 2002, p. 527). The theory explains that the media serve a specific role in individuals' lives that is "goal-directed, purposive, and motivated" (p. 527). Applying Bernhardt and Felter's finding that pregnant women are high information seekers, it is logical to posit that pregnant women are likely to actively turn to the media as a source of information about their upcoming experiences of childbirth. Thus, according to uses and gratifications, childbirth television shows may serve to satisfy the needs of pregnant women who seek them out with the motivation of learning more about childbirth and relating to other women experiencing similar things.

Another theory that helps explain women's perceptions of birth as an effect of television shows is cultivation theory, which was introduced by Gerbner (1976). According to this theory, viewers form a worldview over time that is based on exposure to the world portrayed on television (Potter, 1994). Applied to childbirth, cultivation theory predicts that heavy viewers of childbirth-themed programs on television would formulate ideas about childbirth that reflect birth on television. Previous conclusions show that childbirth reality show portray birth as requiring normalized technological interventions under a physician's authority as well as deeming women's bodies as incapable of giving birth sufficiently on their own (Morris and McInerney, 2010). Therefore, cultivation theory would posit that heavy viewers of childbirth-

themed reality shows would disproportionately view childbirth as an event requiring medical intervention and regulation. In addition, viewers would doubt women's ability to give birth without such intervention because of its overrepresentation according to this model on television.

Media portrayals of birth may have negative consequences for views about healthy birthing strategies. According to Koné and Mullet (1994), the media have strong effects on one's social perceptions of risk. The researchers recognized that perception of risk varies considerably across location. Their study, which looked at news media coverage of risk-oriented disaster situations in two different countries, found that despite dramatic differences in actual risk levels, participants in both countries rated their level of risk approximately the same. The amount of risk perceived by inhabitants of both countries correlated with the amount and content of the media available in each. Therefore, the authors concluded that there is a direct correlation between media portrayals and risk perception in a given location. Given the high amount of risk associated with birth portrayed on childbirth television shows (Morris & McInerney, 2010), women who view reality-based shows about birth are likely to think about birth as a riskier, more dangerous event than it is in reality. It is crucial to understand the effects that childbirth reality shows have on women in order to draw connections with what they learn about childbirth through such shows; such effects likely have implications for the way women view and approach their own birthing decisions.

Previous Research on Perceptions of Birth in the US

Previous research about perceptions of childbirth has supported the finding that young adults tend to support medicalized childbirth. Cleeton's (2001) study of beliefs about childbirth among college students found that most participants viewed physician-attended in-hospital birth

as universal and safe, while associating childbirth with fear and pain. In this study, students viewed a video of a homebirth attended by a midwife and a doula and were then asked to complete a survey inquiring their opinions about childbirth. While classifying childbirth as a miraculous event, students assumed that childbirth is inherently dangerous and must be handled by doctors. The study also showed that college students are interested in learning more about childbirth; these young adults were comfortable turning to the media for information. Although the study did not ask students how they feel they could learn about childbirth, it is likely that college students like these participants could turn to easily accessible television shows about childbirth, such as *One Born Every Minute*, to learn more.

DeJoy's (2010) findings support those of Cleeton in that college students associated childbirth with fear as well as concerns about out-of-hospital birth. DeJoy specifically looked at students' perceptions of midwife-attended birth and concluded that despite being given accurate information that supports the safety of midwifery care, students drew on larger social discourses to conclude that childbirth is inherently dangerous and unpredictable; thus, students expressed that childbirth requires medical control. DeJoy credits young adults' lack of support for midwifery care to knowledge deficits about the safety of non-medicalized birth. Given the negative portrayal of midwives and alternative birthing methods on television (Klike, 2007; Kline, 2010; VandeVusse & VandeVusse, 2008), knowledge deficits about any kind of birth other than in-hospital physician-attended are likely to persist.

Lampman and Phelps (1997) found evidence of society's acceptance of childbirth as a medical event through college students' acceptance of cesarean section deliveries. The researchers revealed that students were hardly aware of the risks associated with cesarean section and the negative effects the surgery may have on women. Rather, students viewed c-sections as

a rather benign procedure. Some did express concern over the high rate of c-sections in the US, but very few viewed the surgery as a negative experience. Furthermore, students viewed cesareans as having an operation rather than giving birth. The authors partially credit these results to the lack of visibility of cesarean section surgeries shown in television, movies, and books.

While much research on childbirth-themed media has articulated the way childbirth is portrayed in the media as well as the way that young people and women learn about childbirth, the effects of this media genre has yet to be examined. The hypotheses that many have proposed previously regarding childbirth reality shows have yet to be tested. This study aims to draw connections between the media that are being produced and the potential effects they have on the women who consume the media, specifically through the analysis of the impact of *One Born Every Minute* on viewer's perceptions of childbirth.

SIGNIFICANCE OF WORK

The statistics on birthing outcomes in the USA are some of the worst among developed countries. The US ranked 30th worldwide in 2005 in infant mortality rate (Center for Disease Control, 2009). The connection between a nearly universal practice of birth in a medicalized context and less than ideal birth outcomes is ironic at best; the highest quality medical care in the world accompanies an unexpectedly poor rate of birth success for both mothers and babies. My study hopes to address the precursors of how childbirth-themed reality television shows may eventually affect women's experiences of childbirth. If the portrayal of birth on television shows help perpetuate medicalization of childbirth while not addressing adverse birth outcomes, perhaps there is a better approach that should be taken toward such shows. It is imperative to

look at the underlying messages from shows like *One Born Every Minute* from a public health standpoint to critically analyze the positive and negative impacts these shows are having on real women and families. The births in the show always have positive outcomes, but births in the USA do not always end on such a positive note. The show, therefore, give a false impression of the realities of birth while likely creating anxiety among viewers.

Birth on *One Born Every Minute* always ends with positive outcomes for both mom and baby, despite the fact that not all births in the United States are so positive. Some might argue that such consistently positive endings may relieve the anxiety-inducing drama by reassuring women that birth will end positively. This hypothesis is unlikely, though, because while women expect good birth outcomes in the US, few are exposed to the realities of childbirth before giving birth themselves. This exposure through the lens of reality television may create anxiety toward childbirth. Thus, the show's happy endings do not act as a coping mechanism for viewers. Rather, the exposure to high-drama birth may cause anxiety-inducing effects that would likely overrule any conflicting effects that may result from happy-endings reassurance.

The effects of childbirth-themed reality shows have not yet been studied. The research presented above describes what is known about the way childbirth is portrayed in the media as well as how college students think about childbirth, but there is yet to be causal evidence about the interaction between childbirth-themed media and students' intentions about childbirth in the future. Understanding this relationship is crucial in order to understand how the media may or may not impact real birth outcomes. Furthermore, since many curious expecting women draw on childbirth-themed television shows for information, the creators and producers of childbirth reality shows must understand the impact that the shows have on their viewers. Fear-based shows may have a very different effect on women than shows that promote women's natural

ability to give birth. What type of show is produced should correlate with evidence-based best practices during childbirth that have the most positive outcomes for mothers and babies.

Given the evidence that women do, in fact, turn to the media for information about childbirth, critically analyzing the way birth is presented on television is crucial to the greater understanding of how women think about childbirth. If women think of childbirth as a fearful and dangerous event, they may set themselves up for negative experiences. Excess medicalization during childbirth may expose women to increased risks from often unnecessary interventions such as pain medication, episiotomies, and unnecessary cesarean section procedures that can leave long-term damage for both moms and babies. Although childbirth interventions are convenient and sometimes life saving, they do not always have a positive effect, especially when they are unnecessary. According to a study by Roberts, Tracy, and Peats (2000), “high rates of instrumental deliveries are not associated with improved perinatal outcomes but are associated with increased risks for mothers.” In their study examining epidurals, induction of labor, episiotomies, and births by forceps, vacuum, or caesarean section, this research did not show improvements among babies who were born with these interventions compared with babies born without them. Any instrument, drug, or procedure used during birth poses extra risk to mothers at any risk level and may cause more problems without necessarily improving birth outcomes. For example, women who undergo episiotomies so that the obstetrician may have an easier time delivering the baby and to reduce natural tearing, yet episiotomies are associated with a high risk of infection and future tearing, among many other complications (Gorti, Hudelist, & Mastoroudes, 2008). Shows like *One Born Every Minute* that promote a medicalized version of childbirth may increase women’s reliance on such technologies.

One Born Every Minute is a show in its infancy. Lifetime premiered the show on January 31, 2011. Because the show is so new, this study is relevant to discourses about childbirth being broadcast at the current moment. Studying a television show while it is being broadcast has the added advantage of allowing the researcher to capture audience members while they have the opportunity to view the show in their current lives. My research captures accurate, up-to-date information from the audience. Furthermore, as this show develops throughout time, producers have the opportunity to take feedback to understand how their show affects viewers and change the components that lead to negative effects.

One Born Every Minute is different than other shows that have preceded it. While other shows such as *A Baby Story* and *Birth Day* have shown a narrow range of birthing women (Morris & McInerney, 2010), *One Born Every Minute* has shown a much wider range of births, including a same-sex couple, a surrogate mother, an interracial couple, a single mom, a non-medicated birth, and several cesarean sections, in its first six episodes alone. The increased representation on the show may have an impact on the range of audience members it draws. Because it shows a much wider range of women and families, more viewers may feel that they can relate to the show and identify with more of the birthing women shown, which may in turn impact the results the show has on viewers and future birthing women.

HYPOTHESES

This study analyzes how the Lifetime reality show *One Born Every Minute* affects undergraduate women's perceptions of childbirth. I am particularly interested in how the event of childbirth itself is portrayed on *One Born Every Minute*, and I have studied how this portrayal

may or may not affect its young female viewers' attitudes about childbirth in the future. I hypothesized that viewing the show increases women's anxiety toward childbirth, which is something they will likely face in the future. As a result of increased birth anxiety, I believe that two further consequences result.

First, increased birth anxiety leads to decreased agency regarding birth. Drawing on Morris and McInerney's (2010) idea that the media normalizes medical control over women's bodies, I examined the amount of autonomy female participants feel they have in childbirth. The show presents birth from a fear-inducing angle in order to create dramatic entertainment that draws in audience members' attention. However, this portrayal of birth as a scary, dangerous, unpredictable event might have a negative effect on women, causing them to rely more heavily on the institution of medicine and technological interventions rather than trusting in their own bodies to give birth successfully and safely.

Second, I hypothesized that viewing the show increases young women's support of the medicalized model of birth. This addresses future actions of participants as a result of viewing childbirth-themed reality shows; specifically, I am interested in how the show *One Born Every Minute* may have an impact on the future choices women make regarding birth when they are experiencing it themselves. Future intentions regarding childbirth include whether or not participants are planning to bear children in the future, where they would like to give birth, whether or not they would like to use medication, who they would like their birth attendant to be, and if they have an idea of when they would like to have children, if at all. I collected data on future intentions because the experience of viewing the dramatized experiences of other women may encourage participants who have never experienced birth themselves to think about their own childbearing future and what they envision for themselves. Whether or not the show affects

future intentions, we must understand how young women think about childbirth. Their choices will impact birthing trends and cultural childbirth norms for the generations that follow.

DESCRIPTION OF STUDY

Methodology

In order to explore the dimensional aspects of the experience of childbirth on television, a combination of both qualitative and quantitative measures was required. My study took a mixed-method approach, involving an experiment to measure the causal effects of exposure to childbirth media on women's attitudes about childbirth followed by a qualitative focus group to further understand women's perceptions of and feelings toward birth. From the focus group, I gained a deeper insight into what college women's dialogues about childbirth are like as well as a foundation with which to understand my experimental results.

The study began with an experiment to measure the effects that *One Born Every Minute* may have on college women. Seventy-eight participants were randomly assigned into three conditions. Two groups were experimental groups, and the third was a control group. The two experimental groups each viewed a different segment of the episode "Expect the Unexpected" from the first season of *One Born Every Minute*. The first experimental condition (n = 27) viewed one low-risk narrative from this episode of that shows an uncomplicated vaginal birth. The second experimental group (n = 26) viewed a different clip from the same episode that shows a more complicated, high-risk birth from the show. The control condition (n = 25) watched a segment of an episode of *Say Yes to the Dress*. This show was selected because it is a popular reality television show of the same genre as *One Born Every Minute* that is not about

childbirth but does have a life-changing event focus (getting married) that may happen to participants in the future. The control episode has similarities in characteristics of the characters featured on the selected experimental episode of *One Born Every Minute*. Both shows always end on a positive outcome, and format is relatively similar. The control show is of the same reality genre in order to maintain as much control as possible.

The experiment took place at the University of Michigan in a research computer lab. Groups or in-depth interviews of 1-9 people were run at a time. All conditions followed the same format, which I conducted. Participants entered the computer lab and sat wherever they choose. I first welcomed participants to the study, thanked them for participating, offered them consent forms to sign, and then briefly explained the study procedure. Students who did not wish to participate were given the opportunity to leave before the screening began, and two participants did leave after the survey, thus declining focus group participation. Participants took a pre-viewing survey on Qualtrics before watching their assigned clip privately on a computer. After the clip run in entirety, participants completed a post-viewing survey on Qualtrics, measuring attitudes toward childbirth and the show, future childbirth intentions, and self-efficacy regarding birth. All conditions took the same surveys.

Once participants had completed the posttest, participants in experimental groups who had consented gathered their chairs to the middle of the room where they could see one another and interact. I addressed participants as a group and asked them open-ended questions about the clip they viewed and how they feel about it to gain an understanding of the way college-age women think about childbirth, followed by a debriefing. I conducted the focus groups and asked the questions. Participants were asked open-ended questions about their thoughts on childbirth

and the clip they viewed, reactions to the show, and questions about attitude and beliefs about birth.

With pre- and post-test questionnaires, participants responded to questions about multiple aspects about childbirth. Using this form of measurement, responses were coded and statistically analyzed to look for significant relationships between exposure to the different television clips and outcomes of interest. I asked participants open-ended questions in addition to the survey design to get deeper insight into how young women feel about childbirth. Childbearing can be an emotional, personal, and complex experience, and many aspects about how women perceive birth may be more difficult to capture through survey questions. A group format is most appropriate to use in this setting because it simulates a conversation about birth among women.

Surveys quantified concepts of interest to this study. Key variables were measured using Likert scales. Measurement scales included media exposure and use, Positive and Negative Affect Scale (PANAS) to measure empathy, fear of birth, medicalization support, birthing intentions, ability to relate to show characters, and mood. Participants were asked if they have ever seen childbirth shows before, and they answered a few questions measuring knowledge about childbirth in the U.S. Finally, participants indicated where they learn about childbirth. Focus group questions measured feelings and beliefs toward childbirth as well as feelings and reactions toward the show participants view.

Population

The study was conducted with female undergraduate students at the University of Michigan in Ann Arbor, Michigan. This study focuses exclusively on women because women physically experience childbirth, and it is a phenomenon most associated with being a woman.

Birthing women are at the essence of birth because the childbirth process is contingent upon women's bodies above all else. However, it is also important to recognize that men are also involved with childbirth and could be impacted as well from childbirth shows such as *One Born Every Minute*, but the show's effect on men is out of scope for this study. The population being sampled was chosen out of convenience and age compatibility. Many women ages 18-22 may be thinking about their reproductive futures and engaging in family planning while planning their careers after college. Conversations about childbirth and future children are not foreign to undergraduate women, so they may feel somewhat comfortable discussing issues of childbirth in the media.

An important criterion was that participants could not have given birth before. Because I am ultimately interested in how childbirth-themed reality shows may affect women's future experiences of birth, it is crucial to study women's ideas about birth before they experience it. The experience of having given birth before is likely to have a much larger effect on women's ideas about childbirth and might outweigh effects of the importance of media on childbirth beliefs. Furthermore, the show is likely to have a different impact on women who have given birth before, which is out of scope for this study. Thus, only women who had not previously given birth are included in the current sample.

There is considerable bias using my chosen population. All participants will be undergraduate students at the University of Michigan. This population is far from representative of women in this age category. Because the undergraduate population has a higher proportion of middle- and upper-class students as well as an unrepresentative racial makeup among its undergraduate student body than in the general US population, my results may not be generalizable to all undergraduate-age women in the country. Results will nevertheless be

important using this biased population because the reactions this population has to the show are not likely to be significantly different than other women's reactions to the show. If anything, my results could be a conservative measure of effects because the population being studied may be more knowledgeable about childbirth as a result of higher education level, and other direct experiences not seen by the lack of diversity in this sample may temper the effects of the show.

Chapter II: A Closer Look at One Born Every Minute

“‘One Born Every Minute’ takes an in-depth look at life inside the maternity ward at Riverside Methodist Hospital in Columbus, Ohio, as expectant mothers enter their final stage of pregnancy. From the delivery room, to the operating room, to the front desk, to the nurses’ station, 40 cameras roll 24 hours a day, 7 days a week to capture the high drama, humor and overwhelming emotion of childbirth as new lives begin and others change forever.

- Lifetime

This chapter will serve as a critical reading of *One Born Every Minute* as a media text, providing a more comprehensive background for the hypotheses that have been posited and establishing its implications on viewers as an important topic of study.

One Born Every Minute is the most recent childbirth reality show to premier on television. It is a reality show that portrays the birthing experiences at Riverside Methodist Hospital, which claims to have one of the busiest maternal wards in the country, according to the show. *Lifetime* aired the first season’s eight episodes between February 1 and March 29, 2011. The show indicated its success when it began recruiting and filming births for its second season at Riverside between April and June of 2011, and the second season premiered on November 29, 2011. Women featured in the show agree to participate, and as compensation they receive a personalized DVD of their birth.

One Born Every Minute is a reality show that follows the birth narratives of three different families per episode. In the introductory segment of the show, viewers are informed that cameras have been installed on the ceiling throughout the ward to capture every moment of every birth. Each episode starts with fade-in screams of birthing women and flashing images of medical environments. In the opening segment, the audience is introduced to the three birthing narratives they are about to view. Throughout the show, actress Jamie Lee Curtis provides voiceover narration, keeping the audience informed on what is happening and cues the emotional moments that take place. Birthing women, often accompanied by their partners, have small

segments of direct mode of address to the camera, telling of their journey to getting to this point. Most of the show, however, takes place directly inside hospital rooms in the maternity ward. The birthing women and their families are shown as they enter the ward or shortly after they arrive in their rooms, and they are followed through all phases of labor, delivery, and post-birth bonding time. There are a variety of interventions used, including at least one epidural and a cesarean section in every episode of the first season, but each and every birth has a positive outcome for mom, baby, and family.

One Born Every Minute emphasizes drama and suspense in its portrayal of childbirth. The show promotes itself as catching every moment of drama and emotion, but the degree to which drama is developed in production is unknown. In the show's construction, techniques are used to promote drama and to keep the audience at the "edge of their seat" – the main purpose of reality television shows such as *One Born Every Minute* is entertainment, and childbirth is thus turned into an attention-grabbing, rousing event to attract and keep

audiences. Dramatic music is cued before commercial breaks to keep the audience engaged and unsure about whether the birth will be successful. Medical conditions or traumatic past birthing experiences the women may have are emphasized to the audience, creating suspense.

The dramatization of *One Born Every Minute* leads to speculation about how such sensationalized portrayals of birth are interpreted by audiences. In particular, women who have never experienced birth before are likely unfamiliar with the reality of birthing experiences.



Image 1 - A print ad

On blogs about the show, viewers have been vocal about how the show does not depict the reality of birth. One viewer commented,

If there are any expectant moms out there watching please change the channel! This show succeeds in [its] aim to perpetuate a lot of fear inducing myths (not to mention questionable clinical practices). All of these moms are flat on their backs, stuck in bed and shown in agony if they don't have an epidural. This is not what childbirth has to be like. Please do your research and learn about your options.

- User "mamaniq", Lifetime comment board

This viewer is not alone in her speculation. Many other women have warned future mothers about the unrealistic drama present in the show, reassuring that birth isn't really the way this show makes it seem. Such dramatization of birth motivates this study's hypothesis that *One Born Every Minute* increases women's fear about childbirth through its portrayal of birth.

Primary Discourses within *One Born Every Minute*

Sears and Godderis' (2010) content analysis of the constructions of women and birth in the TLC show *A Baby Story* identifies four main discourses within the show – the birthing woman, the birthing story, the role of medicine, and agency and resistance. They find that *A Baby Story* presents these discourses through surveillance and discipline of women's bodies, reinforcing norms of gender and motherhood that devalue women's agency within the birthing process. This section will apply this framework to *One Born Every Minute*. Sears and Godderis' four discourse framework is useful to this analysis in that it highlights ways in which the Lifetime show fits into the established context of childbirth media portrayal it entered.

❖ *The Birthing Woman*

Previous studies about childbirth reality shows have found that one dominant type of woman has typically been portrayed, specifically that the vast majority of women featured on other shows such as *A Baby Story* have been white, heterosexual, married, younger, and not

shown to have mental or physical disabilities (Morris & McInerney, 2010; Sears & Godderis, 2010). *One Born Every Minute* is different from this homogenous portrayal of birthing women, which will be discussed in more depth. However, it does portray only women who are non-disabled and young (between 16 and 40), and most women on the show are partnered. In *One Born Every Minute*, there is a dominant expectation of birthing women, though. Birthing women are expected to be compliant on the show, accepting whatever medical interventions they are faced with and following all directions from medical staff, which is congruent with previous childbirth shows.

❖ *The Birthing Story*

Sears and Godderis examine the framing of the birthing narrative in *A Baby Story*, critiquing that the “life unscripted” motto of its network does not hold up to the carefully framed, predefined structure of each narrative. The same is true of *One Born Every Minute*, in which every episode narrates through three different births. Each narrative follows the same format, where within 15 minutes the birthing woman and often her partner is introduced, a story around the woman’s situation, family, previous birth, and/or birth fears develops, nurses’ personalities and presence is established, and the woman labors and delivers her baby through either vaginal delivery or C-section. Each narrative ends in a happy family and perfect birth outcomes. The scriptedness of each narrative is required by show length limits and format standards, but this comes at the expense of most of the birth being excluded from the show; thus, each birth story follows the same structure, when in reality every birth is unique.

❖ *The Role of Medicine*

Sears and Godderis claim that “*A Baby Story* reinforces cultural beliefs about the fundamental role of medicine in childbirth,” which is likewise true of *One Born Every Minute* (p.

189). Their analysis found that hospitals were favored over other birthing settings; in *One Born Every Minute*, every birth takes place in a hospital, rendering invisible alternative settings for birth. Furthermore, the Lifetime show emphasizes nurses as the main birthing assistants who spend the most time with birthing women, but delivery is limited to obstetricians. Birthing attendants including midwives and doulas are present in only one narrative within one episode of the first season, and they are framed in a way that the midwife and doula unwarrantedly take control over the birth away from the nurse. Thus, the medical model of birth is normalized by *One Born Every Minute*. Furthermore, the show elicits “the feeling that medicine was an essential part of successful birthing experiences” (Sears & Godderis, 2010, p. 190), as with findings on other shows of the same genre. Every episode includes medical interventions, including epidurals, Pitocin, fetal monitors, and cesarean section procedures, and some episodes show less frequently talked about interventions such as vacuums and forceps. In fact, a cesarean section is shown in every single episode of the first season.

❖ *Agency and Resistance*

Contrary to previous shows (Sears & Godderis, 2010; Morris & McInerney, 2010), *One Born Every Minute* incorporates a great deal of screaming, complaining, and general agony from the birthing women. However, it is consistent with its genre in that birthing women are not



Image 1 - A positive outcome for new mom Rochelle and her twins, Season 1 Episode 2

asked to evaluate different options or interventions regarding their birth; rather, women seem not to make birthing decisions at all. The medical model of birth in the show is thus represented as a requirement. This is not to say that birthing women who participate in the show

are passive; rather, the show chooses to leave out scenes of birthing women making decisions about their birth, thereby portraying them as having less agency in their birthing experiences.

Always a Happy Ending

Every birth in the first season of *One Born Every Minute* has a healthy, happy outcome for both birthing woman and baby/babies. Stress from the high-drama portrayal of birth is relieved by the conclusion of each episode. Birth in the show is portrayed, as in other childbirth reality shows, as always ending positively; previous childbirth reality show findings have shown that “as is typical of ‘good’ television, the shows slanted the reality of the situations to create happy endings and warm feelings” (Morris & McInerney, 2010, p 138). *One Born Every Minute*’s first episode includes no birthing narratives that involve newborns being taken to the neonatal intensive care unit, birth defects, or birthing conditions for neither mom nor baby.

A potential consequence of always having a happy ending is that the reality of birth outcomes in the United States gets masked by a false illusion that every outcome is positive. Unfortunately, such positive outcomes are not universally the case. About 10 to 15 percent of newborns are admitted into the NICU each year (Stanford Children’s Hospital). In 2008, 8.2% of all infants were born with low birth weight, and this rate increased to almost 14% for African American infants, and 12.3% are born preterm (Center for Disease Control, 2010). The United States has an infant mortality rate of 6.06 deaths per 1000 live births; its maternal mortality rate is 24 deaths per 100,000 live births (Central Intelligence Agency, 2010). These negative birth outcomes are not part of the reality portrayed on *One Born Every Minute*. Furthermore, happy endings reinforce the idea that the medical model is responsible for positive birth outcomes. The

show's emphasis on happy endings makes it highly unlikely to become a space to raise awareness about birth risks associated with technological interventions

The happy-endings phenomenon presents an interesting conundrum in the context of evaluating viewing effects. While the show embellishes birth in a way that is likely to produce anxiety among pre-childbearing women, its neglect to show negative birthing outcomes may serve to reinforce women's trust in the medical system and reduce anxiety about birthing outcomes. These are mixed and potentially conflicting effects whose evaluation may be beyond the scope of this study; however, it is a compelling lens through which to understand the complexity of media effects and reality television and is important to consider in results analysis.

Through the Lens of Reality Television

What childbirth reality shows such as *One Born Every Minute* offer to viewers is the opportunity to witness childbirth, an event that is kept tightly behind closed doors in contemporary American culture. Most women are not present for childbirth until they are giving birth themselves, creating an aura of mystery around what it's really like. Birth is a huge event in women's lives, and desire to know what to expect is a natural feeling. Shows such as *One Born Every Minute* provide an outlet to fill this void by granting viewers access into the hospital rooms of real women really giving birth. Portrayals of factual births are perhaps the closest most women today can get to experiencing birth and learning about it in preparation for their own future childbearing.

However, how "real" the reality of birth is as portrayed on the show creates questions. Logistically, producers are required to take each birth featured, lasting for hours upon hours, and reduce it down to an approximately 15-minute cut. This involves active and deliberate selection

of which few scenes, emotions, and moments to include, rendering the majority of births unseen by the audience. Most of vaginal birth is latent rather than active: birthing women spend hours waiting while birth progresses, experiencing frequent contractions; the pushing phase is shorter, but pushing and crowning of birth are portrayed disproportionately high in these 15-minute versions of birth. On the other hand, if the woman is having a cesarean section delivery, the show emphasizes pre-surgery time and spends a mere minutes on surgery footage, which is disproportionately lower than the hour the procedure approximately requires in reality. Such misleading timing is one important way *One Born Every Minute* fails to deliver the true reality of birth in its “real” portrayals.

Furthermore, the dramatization of birth in *One Born Every Minute* leads to speculation about how such sensationalized portrayals of birth are interpreted by audiences. *One Born Every Minute* emphasizes drama and suspense in its portrayal of childbirth. The show promotes itself as catching every moment of drama and emotion, but the degree to which drama is developed in production is unknown. In the show’s construction, techniques are used to emote drama and to keep the audience at the edge of their seat; the main purpose of reality television shows such as *One Born Every Minute* is entertainment, after all, and childbirth is thus turned into an attention-grabbing, rousing event to attract and engage audiences.

Audiences are aware that reality television shows are not purely factual; reality shows are created for entertainment, and audiences are "distrustful of the authenticity of various reality formats precisely because these real people's stories are presented in an entertaining manner" (Hill, 2005, p. 59). *One Born Every Minute* promotes its entertainment value is by emphasizing dramatic family dynamics and relationships within each birthing narrative, and viewers are clearly aware that each family dynamic is distinctive and that their experience of family during

birth will be unique to them. Interactions and emotional moments, both positive and negative, between family members are included in the show, taking up a large portion of each birthing narrative. Furthermore, dramatic music is cued before commercial breaks to keep the audience engaged and unsure whether the birth will be successful. Medical conditions or traumatic past birthing experiences the women may have are emphasized to the audience, creating suspense and doubt about the outcome of each birth. Such tactics increase the dramatic nature of the reality show for entertainment purposes, and such cues are likely to be picked up by audience members as altering the reality of birth as seen through the show.

How “real” the show is or is not perceived to be likely depends on the viewership. The perception of how real childbirth is in *One Born Every Minute* is likely to be very unclear for the female viewership who has never given birth before. Since most women do not have the opportunity to witness live birth in person, their perception of the reality birth may be based entirely on media representations such as this show. So while viewers may be aware that the show likely does not portray the true reality of birthing experiences, they may not know in which ways in which it is similar to or different from what viewers may experience themselves in the future.

Furthermore, a large conundrum about reality shows, as noted by Hill, is that "audiences are more likely to trust the information they receive in dramatized reconstructions of real people's stories in reality programmes than documentaries" (2005, p. 60). Applied to *One Born Every Minute*, this implies that viewers may be more likely to accept the birthing narratives of reality television as real than documentaries about childbirth they view in health class at school. Because the show is so new, how its audience receives it remains unknown. But because women increasingly draw upon the media to learn about childbirth (Handfield et al, 2006) it is

important to analyze what effects it may be having on its audience, as childbirth does not always have positive outcomes in the culture that the show is contextualized within.

What Makes *One Born Every Minute* Different

Unlike childbirth reality shows before it that “consistently erased signs of diversity and difference” (Sears & Godderis, 2010, p. 188), *One Born Every Minute* has been focused on showing a wider range of birthing women, families, and experiences than what has been showed in the past. In its first season, the show featured 24 birthing narratives in eight episodes. Because each episode has multiple narratives compared with the one-birth narrative typical of previous shows such as *A Baby Story* and *Birth Day*, *One Born Every Minute* has more space to feature more birthing experiences than other shows; whose birthing experiences are portrayed, however, involves intentionally made decisions made in the production of the show.

The representation within *One Born Every Minute* is wider than any other show in its genre. Of the 24 birthing women in the first season, the average age was 29.5 with a range from 17 to 40 years old. About 71% of the women were married, which is a significant decrease from Sears & Godderis’s find of a 100% marriage rate in *A Baby Story*, and about 8% of women were not partnered. A summary table of demographic and narrative information for each episode of season one is included in Appendix I. One narrative featured a same-sex African American female couple who gave birth to twins. In two narratives, birthing women chose not to keep their infants, one opting for adoption and the other due to the fact that she was a surrogate.

Riverside Methodist Hospital, where *One Born Every Minute* is filmed, is located in Columbus, Ohio. According to the 2010 U.S. Census, 28% of Columbus residents are African American, which is very similar to the 29% of African American birthing women in the first

season of the show. Sears & Godderis found that in *A Baby Story*, 75% of birthing women were Caucasian; in *One Born Every Minute*, less than 70% of birthing women were Caucasian, which is comfortably between the Columbus rate of 61% and the Ohio rate of 82%. Furthermore, one couple in the first episode is interracial. The statistics of *One Born Every Minute* mirror actual demographics much more closely than previous childbirth reality shows. This increased diversity than prior shows may lead to increased viewing effects because a more inclusive range of women will be able to relate to the women they see in the show.

What the show portrays about birthing women involves active decisions made by producers and editors. The decision about which women to show involves careful planning and consideration. The choice to include narratives such as a same-sex couple, a surrogate mother, a teenage couple, and a single mother were intentional choices that had been unprecedented. Because different identities are openly accepted and represented by the show, a wider range of viewers can find people who seem like them more in this show than any other childbirth reality television show. This is crucial to this analysis of effects in that “one of the most basic principles of interpersonal communication is that source-receiver similarity (homophily) increases the likelihood of communication attempts and promotes communication effectiveness” (McCroskey, 1975, p. 323). Therefore, increased character similarity and ability to relate to characters in the show is likely to amplify the effects of viewing for the audience; furthermore, these effects, if existent, are likely to be different than effects of other childbirth-themed reality shows, especially for women who do not fall into the specific prototype featured on other childbirth shows.

Another aspect about *One Born Every Minute* that sets it apart is that the show is portrayed through the eyes of primarily the nurses. The nurses are the medical attendants who

spend the most time with women during their labor and delivery. In the show, nurses are often interviewed to talk about a particular birth they are attending, medical terms and scenarios, and often what it is like to be a nurse in the maternity ward. Furthermore, the nurses are the only characters who appear in multiple episodes, thus becoming a consistent core theme among episodes. In this way, the nurses become a protagonist of the show, thereby telling the birthing narratives through a medicalized view.

One Born Every Minute is a show that is largely focused on medicalization. The show shifts focus away from birth as a natural occurrence, emphasizing the hospital and what it can do for birthing women instead of highlighting their natural aptitude for birthing. Every single episode of the first season featured one cesarean section operation, matching the national rate of 33%. Of these, 50% were performed on African American women, leading to an over-representation of black women in the medicalized procedure compared to their proportionate representation in the show overall. There is no discussion in the show about the risks associated with c-sections or the potential effects the procedure has on both mom and baby. This contributes to the normalization of c-sections as a routine way to deliver a baby, rather than a last-resort emergency option that is drastically overused in the United States.

Every woman in the show encounters some kind of medical intervention during her labor and delivery. Most women opt for epidurals, and a third of them deliver by c-section. Furthermore, Pitocin is mentioned regarding several births, and some births utilize forceps or vacuums. Only one narrative in the first episode of the first season used a certified nurse midwife and doula as birthing attendants. In this particular birth, the couple wanted to have a medication-free natural birth, but the nurse was not accustomed to a couple who wanted things a very specific, nonmedicalized way and felt that her authority had been diminished in the show

because of the couple's wishes. In the end, the woman received a dose of Pitocin after laboring for more than 23 hours; the narrator explained that the woman "has *finally* agreed to a little medical assistance to help things get going," as if it was only a matter of time. Neither midwives nor doulas were present in any other narratives throughout the rest of the season.

Surveillance

In addition to understanding what makes *One Born Every Minute* unique, the theme of surveillance of birthing women is central to this analytical reading of the show. *One Born Every Minute* is a lifestyle surveillance show, which is defined as a show whose purpose is "to document ordinary day-to-day experiences and conventional life transitions that "real people" encounter, such as becoming a parent" (Sears & Godderis, 2010, p. 181). This documentation becomes surveillance over life events, watching the transformative experience and inspecting the behavior, emotions, and involvement of those present. Birthing women are of utmost surveillance in childbirth reality television shows. This show is filmed from a fly-on-the-wall perspective, with 40 cameras installed around the maternity ward to constantly capture every moment of birth. The cameras supposedly do not require an additional person to be in the room, although it is unknown from viewing whether or not a cameraperson was present during births. The purpose of this camera surveillance is to catch every moment of birth and to get the "real" version of what happens, although what is portrayed may not be the entire reality of what was experienced by those present at Riverside Hospital for each birth, as will be discussed in more depth later.

This degree of surveillance of birthing women is unlike any other childbirth reality show. Birthing women cannot ask the cameras to turn off because there is no one physically filming

them; in this way, they have no agency over their surveillance, and are thus subjects of what Foucault refers to as the panopticon (1977). According to this theory, those under surveillance are as prisoners in cells situated circularly that are visible to a central inspector; the inspector's gaze can scan all cells from his central watch point simultaneously. The constant gaze of the cameras in *One Born Every Minute* transforms birthing women into spectacles being observed from all sides, powerless to the constant surveillance surrounding them.

Under the medicalized model of childbirth, women's bodies are put under the authority of physicians (David-Floyd, 2003; Jordan, 1997). Birthing women in reality shows such as *One Born Every Minute* thus experience a two-fold surveillance; they are under surveillance from both the medical authority of physicians and nurses and also the surveillance of the viewing audience. Such compounded surveillance leaves very little room for women's demonstration of authority and agency within the birthing space. Birthing women, on one side, are not shown to be given options or risk information through the perspective of the show, and on the other side of the camera lens, viewers expect mothers to do whatever it takes, as defined by the medical professionals, to deliver a healthy baby. Audiences bear witness to the women's experiences and actions, enabled through the surveillance of constant camera gaze.

Television creates witnesses out of millions of people in that those who consume television observe the events shown by television, and they are thus able to make judgments about what they see. This space of judgment creates a platform for audience surveillance of what is produced by television. And because in contemporary American society few women actually witness a live birth until they give birth themselves, childbirth reality shows provide a space for women to witness birth in a way that might not be possible otherwise. The opportunity to view a birth through the show allows young women to have exposure to a major life event

they will likely experience in their future. And as a result, viewers who become witnesses of birth are thus able to learn about childbirth from viewing and make judgments about both birth and birthing women on television. The potential effects of this witnessing are what motivate this study.

Chapter III: Quantitative Results

Methods

PROCEDURE

Participants (n=78) were randomly assigned into three experimental conditions: high-risk birth viewers (n = 27), low-risk birth viewers (n = 26), and a control group that saw a show involving a different major life event (marriage; n = 25). Participants completed a pretest questionnaire in which they reported anxiety related to childbirth (referred to in this study as “childbirth anxiety”), agency toward birth, and support for medicalized birth (Appendix III). They then viewed their randomly assigned clip and completed a posttest questionnaire measuring birthing attitudes regarding anxiety, agency, and medicalization support (Appendix IV). Subjects in the high-risk and low-risk birth clip conditions then participated in a focus group or in-depth interview depending on the number of participants available during time slots once everyone in their group had finished the survey (Appendix V). Participant interviews/groups ranged from 1 to 9 women. Themes from individual interviews versus focus groups did not substantially vary. Control group participants did not participate in focus groups or interviews because they did not view a childbirth video, and thus the questions were not relevant to their experimental experience. Survey data were collected electronically, and the focus group data was audio recorded and transcribed. Focus group results will be discussed in the following chapter.

THE STIMULI

Participants in both experimental conditions viewed clips from the same episode of the show *One Born Every Minute*, a reality television show portraying birthing experiences in an

Ohio hospital. The clips were taken from episode 2, “Expect the Unexpected”, from the first season. Three birthing narratives are shown in each episode. The episode from which stimuli were drawn features a heterosexual married couple with a normal labor, a heterosexual engaged couple whose birth becomes high-risk, and a same-sex female couple delivering twins via scheduled cesarean section. The first two narratives were chosen because they were similar in several ways: Both were vaginal births, both couples were heterosexual and in committed relationships (one married and one engaged), both women are their 30s and expecting their first child, both women had epidurals, and neither woman had pregnancy complications or expected an abnormal delivery before going into labor. The only difference between the clips was the birth trajectory; specifically, that the high-risk birth’s length was significantly longer and became much riskier than the low-risk birth.

In the full episode, the three narratives are interwoven. To maintain experimental control, the episode was reordered to exclude all but the narrative of interest in each clip. The high-risk clip was 15:15 in length, and the low-risk clip was 15:31. Both clips included the show’s introduction, which opens with sirens and women’s screams, then moves into a series of birth clips that introduce the hospital; there is a voiceover that introduces the show and provides narration throughout the episode. The conclusion was also included in both clips, in which the baby’s name is revealed and the conclusive statement “As long as the babies are healthy, the job never gets old” ends the episode. Similar in-between footage of the nurses present in the episode was included in the clips, showing down-time that is typical in the maternal ward; nurses are shown talking and joking with each other.



Image 1: High-Risk mom Courtney after delivery



Image 2: Low-Risk mom Michelle after delivery

The high-risk clip (Image 1) features parents Courtney, 33, and Rich, 35, who are engaged and expecting their first child. The show begins 10 hours into Courtney's labor, where her progress has stalled. She is given oxygen and Pitocin to speed up her contractions, and while she pushes for two hours there is still no progress. Because the baby is going back up the birth canal after she pushes, the doctors begin to worry about a shoulder dystocia where the baby's shoulders don't fit properly through the mother's pelvis. The neonatal intensive care unit is called for backup, and many extra nurses are in the high-stress hospital room. There is a lot of yelling from the family and moaning from Courtney, and intense background music adds to the stressfulness of the narrative. The baby girl is finally delivered, but she is immediately taken to the other side of the room to be checked by the nurses, where a shoulder dystocia has been confirmed. It takes an uncomfortably long time before the baby's crying is heard, while in the meantime the new parents and family are extremely worried about her health. In the end, baby Emma and mom Courtney are both confirmed to be of good health, and the couple is shown to be relieved, smiling, and calm as Courtney gets to hold her new daughter for the first time.

The low-risk clip (Image 2) shows Michelle, 33, and Andrew, 33, first-time parents who have been married for five years. They both claim to be high-energy, type-A personalities from the start. Michelle requests an epidural right away. Andrew is constantly antsy and excited, and the narrator jokes that Michelle will be taking care of two children after the baby is born. Her

labor is smooth and normal, but long (more than one nurse shift, although hours are never specified). Mid-way through the labor, the fetal monitor detects a change in the baby's heart rate, causing anxiety among the parents; the nurse reassures them that this is normal, however. Michelle experiences shaking from the epidural for a short period and some vomiting during pushing, both of which are very normal during birth, and her pushing is normal and progressive. Only the obstetrician and nurse are in the room for the birth. The baby boy, Anderson, is delivered with positive spirits from the family and doctor. The narrative ends with a smiling, content Michelle watching her happy husband hold their new son.



Image 3: Control – bride shows her family a wedding dress.

A narrative from *Say Yes to the Dress*, a TLC reality show about brides choosing their wedding dresses at a bridal salon in New York City, was chosen to be the control clip (Image 3). This show was chosen because it has no reference to childbirth but features on another future life event, a wedding. Similar to birth, the narrative focuses on the woman's experience, and her family is present at the salon with her; furthermore, salon sales staff acts as support and guidance for the woman's experience, as the nurses do in *One Born Every Minute*. The woman in the show was also similar to the women in the birthing clips in that she is in her late 20s and in a committed heterosexual relationship. This show is similar in structure, showing three brides per episode and interweaving their experiences. Because *Say Yes to the Dress* is shorter than *One Born Every Minute*, the clip was also shorter at 6:14, and as with the experimental clips, it includes the introduction and conclusion of the episode. The introduction features a melodic pop

tune with an animated reel of wedding dresses against a sparkling fuchsia background, and the conclusion ends the show with a narrated, positively-toned statement, “It’s not always easy working in bridal, but it’s always interesting”. In the episode, bride Lauren brings a large group of family members to help her decide which wedding dress she will choose. In the clip, she tries on three dresses and ends up torn between the first and third dresses. She has a difficult time choosing between them and is shown to be very conflicted. In the end, the show climaxes with the big reveal of her choice, dress three. The emotional cues of this show are very similar to the control clip. The bride began expecting a normal experience, had to work through the process of finding a dress, faced an emotional climax as she faced the stressful push to her final decision, and was happy with the outcome at the end of the narrative, sharing her satisfaction and accomplishment with her family.

Results

PARTICIPANTS

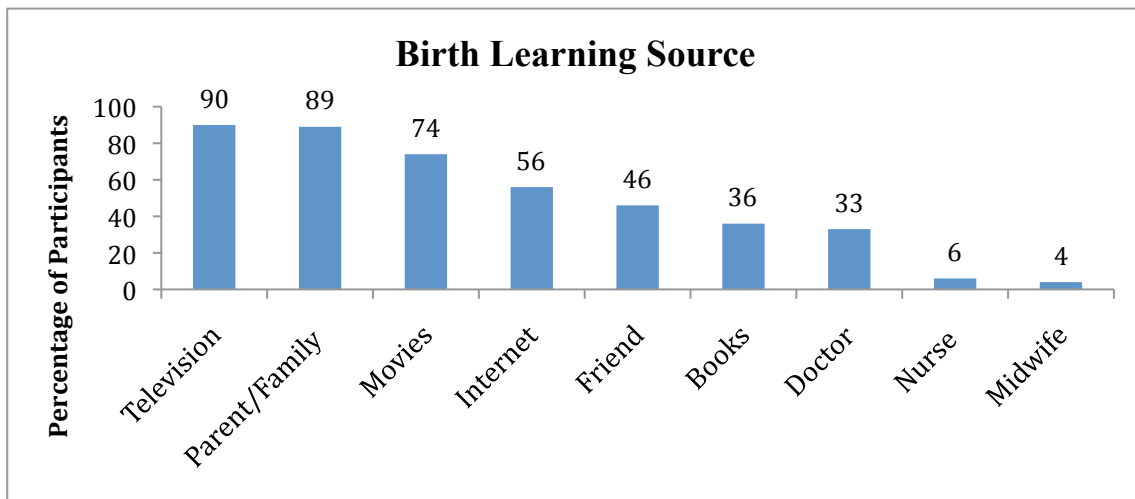
Participants ($n = 78$) were drawn from the undergraduate subject pool in the Communications department of the University of Michigan and received credit toward an introductory communications course for their participation.

Demographics were provided by all but three participants. Subjects were all women and ranged from age 18 to 21. A majority of participants (72%) identified as white, 15% identified as Asian, 8% as African American, 3% as South Asian or Indian, 1% as Latina, and 1% as mixed race. Of the subjects who disclosed their demographic information, 100% identified as heterosexual. On average, participants reported that they watch 5.7 hours of television per week ($SD = 5.81$) and 1.8 hours of reality television per week ($SD = 2.66$). No participants had ever

seen *One Born Every Minute* before participating in this study. Most control group participants (76%) had seen *Say Yes to the Dress* before.

PREVIOUS KNOWLEDGE OF CHILDBIRTH

A majority of women reported that they draw heavily on the media and family members' experiences to learn about birth. The most popular source of birth information is television (90%), followed by parents or family members (89%), movies (77%), and the internet (56%). This heavy reliance on the media as an information source highlights the importance and relevance of the following results.



Subjects were asked five questions in the posttest questionnaire to test their factual knowledge of childbirth in the United States. Of the five questions, the majority of responses were incorrect for three of them, indicating that pre-birthing women are not well informed about the realities of childbirth. Seventy-one percent incorrectly replied that the United States does follow the C-section rate that the World Health Organization recommends. In reality, the C-section rate in the US is double the rate that is recommended. About half of participants selected that 90% of births in the United States occur in a hospital; only 3 participants correctly chose that

over 99% of births take place in a hospital. Most respondents (78%) believed it to be false that the United States has the poorest maternal mortality rate of developed countries. The two majority correct answers were likely due to priming because both had only one childbirth-related response; there were no differences between groups. A large majority (78%) of participants correctly answered that cesarean sections are the most common surgical procedure performed on women in America, and 68% correctly replied that postpartum depression rates are higher for women who give birth at home is false. These incorrect notions about the realities of childbirth in the United States are likely linked to the fact that childbirth is not something young women think about.

PERCEPTIONS OF THE STIMULI

The high-risk and low-risk birth groups were not significantly different in their agreement that the childbirth clips they viewed are realistic portrayals of birth ($M_{hr}= 2.26$, $SD_{hr}= 0.944$; $M_{lr}= 2.08$, $SD_{lr}= 0.935$; $t(51)=.706$, $p = .48$). This is an expected finding because both birthing narratives were indeed real births, although the degree to which either was dramatized by production is unknown; this suggests that findings are not influenced by varying perceptions of the realism of stimuli. Participants in the three groups did report significantly different enjoyment levels of the clips they viewed, where the control group enjoyed their clip the most and the high-risk group enjoyed their clip the least ($M_c=4.04$, $SD_c=.79$; $M_{lr}=3.50$, $SD_{lr}=1.17$; $M_{hr}=2.85$, $SD_{hr}=1.26$; $F(2, 75) = 7.61$, $p=0.001$). The three groups were similar in their mild support that childbirth is a miracle ($M_{hr}=2.19$, $SD_{hr}=1.0$; $M_{lr}=2.04$, $SD_{lr}=1.08$; $M_c=2.12$, $SD_c=.78$; $F(2, 75) =.154$, $p=0.86$).

At posttest, a large majority (73%) plans on giving birth in the future, while 10% are neutral or unsure at the present time; pretest data was not collected on future plans to give birth. Seventeen percent do not intend to give birth someday. The show did not affect intentions to give birth. The three groups were similar in their posttest future intention to give birth ($M_{hr}=1.78, SD_{hr}=1.01; M_{lr}=1.73, SD_{lr}=.67; M_c=1.48, SD_c=.71; F(2, 75) = .983, p=0.38$). Detail about posttest childbirth intention by condition can be viewed in Table 1.

Table 1: Posttest Intention to give birth in the future, by condition

	Intend to give birth in the future	Neutral/Unsure	Do not intend to give birth in the future
High Risk	78%	18%	4%
Low Risk	88%	12%	0%
Control	96%	0%	4%

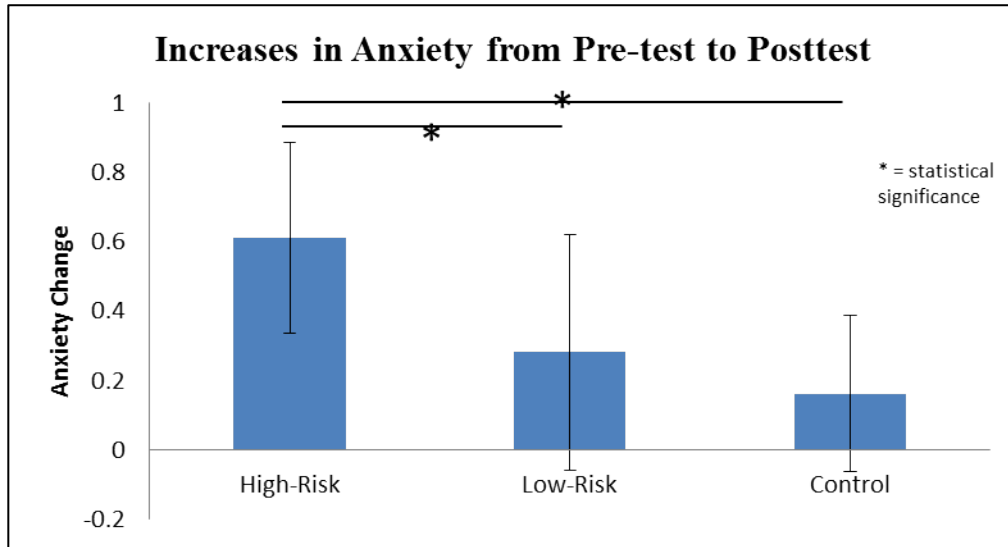
TESTS OF MAIN HYPOTHESES

I created three scales to measure the main hypotheses that viewing *One Born Every Minute* increases women’s fear toward childbirth and support for medicalized birth while decreasing their perceived agency regarding birth. Reliability within scales was measured using Cronbach’s alpha. The anxiety scale ($M= -.36, SD=.53$) measures participants’ fear of giving birth in the future and anxiety toward childbirth. An example item from this scale is “I am scared of giving birth someday” (2 item, pretest $\alpha = .60$, posttest $\alpha = .64$). The agency scale ($M=2.98, SD=.66$) measures posttest self-efficacy around the birthing process, examples of which include “If I give birth someday, I will have control over the situation” and “I can take charge of my own birthing experience” (8 item, post-test only, $\alpha = .80$). The medicalization scale ($M= -.09, SD=.47$) evaluates participants’ support of the medicalized model of childbirth, including the hospital setting, authority of doctors, and use of medication. It includes items such

as “Birth should take place in a hospital” (5 item, pretest $\alpha = .68$, posttest $\alpha = .80$) Analysis of variance tests were run to test for differences between groups in posttest-pretest change in the anxiety and medicalization scales. For the agency scale, posttest scores were analyzed for differences between groups; pretest-posttest changes were not analyzed for the agency scale to avoid control group priming contamination and lack of pretest agency items. Scale items as well as means and standard deviations by group can be found in Appendix II.

ANXIETY SCALE

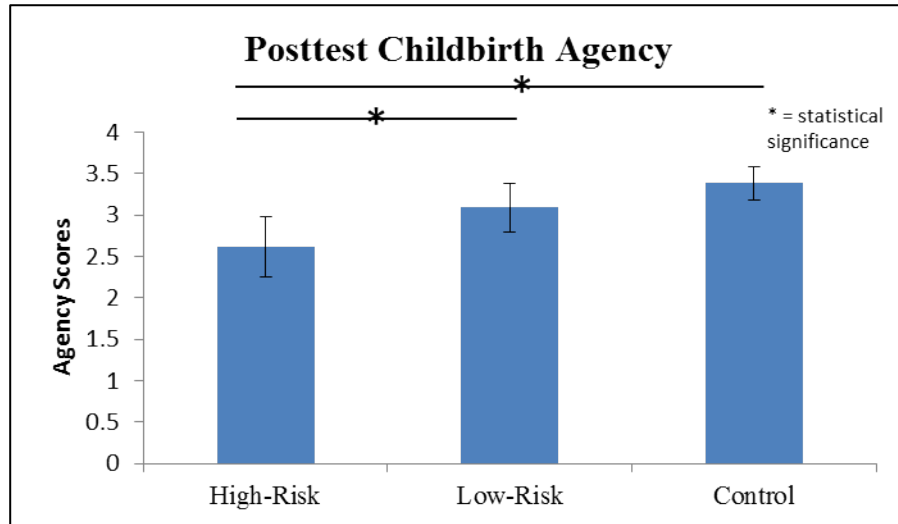
A randomization check suggested that the three conditions were not significantly different in pretest anxiety scores, ($M_{hr}=3.33, SD_{hr}=.85; M_{lr}=3.24, SD_{lr}=.75; M_c=3.12, SD_c=.95$); $F(2, 73) = .38, p = .69$). After viewing their randomly assigned clips, the groups differed on anxiety with the high risk group showing greatest increase in anxiety followed by the low risk and control groups, consistent with the hypothesis that media portrayals of birth can affect women’s anxiety toward childbirth; specifically, that high-risk clip viewers’ anxiety is significantly increased ($M_{hr}=.61, SD_{hr}=.55; M_{lr}=.28, SD_{lr}=.68; M_c=.16, SD_c=1.0$; $F(2, 73)=4.42, p=.015$). Planned custom contrasts suggested that the high-risk group increased anxiety significantly more than the control group ($F(1, 73)=8.19, p=.005$), whereas this was not the case for the low risk group compared to the control group ($F(1, 73)=.56, p=.46$). A third planned contrast suggested that the high-risk clip also resulted in a higher anxiety level than the low risk clip ($F(1,73)=4.44, p=.038$). The pattern of means follows that the high-risk group shows the highest birth anxiety, followed by the low-risk group, and finally the control group, which shows the least anxiety.



$F(2, 73)=4.42, p=.015$

AGENCY SCALE

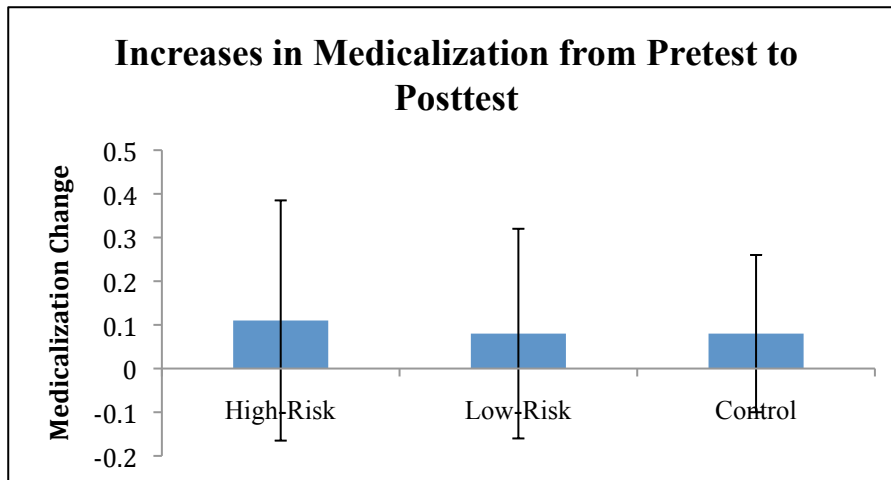
Randomization checks suggested no significant difference in pretest agency across groups ($M_{hr}=2.85, SD_{hr}=1.22; M_{lr}=2.68, SD_{lr}=1.14; M_c=2.64, SD_c=.86; F(2, 73) = .26, p=0.77$). A single item assessed agency before exposure to stimuli (“Birthing women can’t make decisions while in labor”). Posttest scores on the 8-item agency scale after viewing randomly assigned clips assessed agency attributable to viewing the clips. The high-risk group reported the lowest posttest agency score ($M_{hr}=2.62, SD_{hr}=.73; M_{lr}=3.09, SD_{lr}=.58; M_c=3.38, SD_c=.39$). Custom contrasts demonstrated that the high-risk group showed a significantly lower agency score ($F(2, 73) = 10.80, p < .001$), where significance was identified between high-risk and control groups ($F(1, 75)=21.11, p<.001$) as well as high-risk and low-risk groups ($F(1, 75)=8.05, p=.006$). The low-risk and control groups did not differ on posttest agency after viewing clips ($F(1, 75)=3.13, p=.08$). This supports the hypothesis that high-risk depictions of birth in *One Born Every Minute* decreases women’s agency toward future childbirth.



$F(2, 73) = 10.80, p < .001$

MEDICALIZATION SCALE

A randomization check showed that the three groups did not differ in pretest endorsement of medicalized birth ($M_{hr}=3.86, SD_{hr}=.66; M_{lr}=3.63, SD_{lr}=.66; M_c=3.62, SD_c=.55; F(2, 73)=1.20, p=0.31$). Groups also did not differ on change in medicalization support ($M_{hr}=.11, SD_{hr}=.55; M_{lr}=.08, SD_{lr}=.48; M_c=.08, SD_c=.36; F(2, 73) = .029, p = .97$). The data do not support the hypothesis that viewing childbirth reality television shows increases women's support of medicalized childbirth.



$F(2, 73) = .029, p = .97$

RELATIONSHIPS BETWEEN SCALES

Posttest medicalization support scores were strongly negatively correlated with posttest agency scores ($r(76) = -.47, p < .001$), indicating that low agency scores are associated with higher support for medicalized childbirth. Correlation was not found between anxiety and medicalization posttest scores ($r(78) = -.03, p = .78$) or anxiety and agency posttest scores ($r(78) = -.21, p = .06$). This suggests that anxiety and agency are independently affected by the stimuli rather than being causally related.

Discussion

The data reported suggest that viewing high-risk births from the reality show *One Born Every Minute* leads to increased anxiety about childbirth and decreased agency regarding future childbirth. The experimental groups showed significantly different levels of agency regarding childbirth, and agency is negatively correlated with medicalization support. These findings support the main hypotheses posited by this study and have implications about the effects of viewing childbirth as portrayed on *One Born Every Minute*.

CHILDBIRTH ANXIETY

The main hypothesis – viewing *One Born Every Minute* increases young women’s anxiety toward childbirth – was affirmed. The data showed that viewing high-risk clips significantly increases anxiety compared to no exposure to childbirth.

The high-risk birth involved a shoulder dystotia in which the baby’s shoulders get caught in the birth canal, which poses a risk to the baby. This birth frightened participants, most of whom probably did not know that such a risk existed. The dramatic framing of the birth only added to the uncertainty. Women who foresee themselves giving birth someday, which in this sample is the vast majority of participants, would naturally be frightened by exposure to a risky childbirth.

The low-risk birth, on the other hand, did not lead to higher anxiety. This condition viewed a birth that was free of complications. The mother did elect to receive an epidural, but she did not face other medical interventions or circumstances that would put either her or her baby’s health at risk. This narrative focused on the relationship between the birthing woman and her antsy husband while her birth progressed normally.

Both birthing outcomes were positive, meaning that both the mother and the baby in each respective birthing narrative were healthy after the delivery. That the high-risk group showed a higher anxiety level regardless helps to address the happy ending paradox pointed out in chapter 2; always showing positive birthing outcomes that don’t necessarily reflect real birthing outcomes does not likely make women feel more assured about childbirth. This evidence shows us that the type of birthing narrative has a larger effect on birthing perception than the birth outcome when the birth is high-risk.

Because most women are not exposed to the realities of childbirth, including the risks posed by medical intervention and poor birthing outcomes, they are likely to expect that the baby and mother will always be okay at the end of the process; therefore, having a “happy ending” is not what they are inherently worried about. Rather, the drama and the realness of the birth shown is not what pre-birthing women are used to, which is why it is so anxiety-inducing for them.

WOMEN’S AGENCY TOWARD CHILDBIRTH

Both low-risk and high-risk groups differed from the control group on their birth agency score post-test. The difference between post and pretest scores showed, on average, decreased childbirth agency. Therefore, as hypothesized, we can conclude that viewing the childbirth clips from the show *One Born Every Minute* led to decreased agency regarding birth, compared to the control clip.

The fact that women reported lower agency after viewing childbirth clips from the reality show is an important finding. Decreases in confidence about one’s ability to give birth are a negative consequence that could impact when these women go through the birthing process. Viewing the show may cultivate negative attitudes about childbirth, including women’s agency and anxiety toward birth.

Agency regarding childbirth is critical factor to consider when analyzing the way in which young women think about childbirth. The amount of self-efficacy young women have going into birth is likely to influence the decisions women will make in the future about pregnancy and childbirth care. Although support for medicalization did not increase after viewing the clips, the data show a negative correlation between posttest medicalization support

and posttest agency. This suggests that women who score lower on agency also score higher on medicalization support. Women who score low on agency may then feel a greater need to depend on medicalized birth, including the use of pain medication, physician authority, and hospital settings.

SUPPORT FOR MEDICALIZATION

Medicalization support did not increase after viewing the show; support for medicalization, however, was relatively strong to begin with. This finding is consistent with previous studies analyzing college students' perceptions of childbirth finding that students consider in-hospital birth to be universal and safe (Cleeton, 2001), that birth requires medical control (DeJoy, 2010), and lack of knowledge about cesarean section risks and rates (Lampman & Phelps, 1997). Indeed, the childbirth clips from *One Born Every Minute* only showed a medicalized model of childbirth, and the episode used in the experiment did not address questions about alternate models of birth or risks associated with medical interventions. As discussed in chapter 2, the medical model of childbirth overwhelmingly adopted in the United States is exclusively portrayed in the show *One Born Every Minute*, and viewers are not likely to critically think about this model of birth by viewing a show that does not question medicalized birth.

Limitations

This study was limited by several factors. This study did not draw upon a representative sample of all college-age women. Participants were drawn from an undergraduate subject pool, and in exchange for participating they receive credit for an introductory Communications Studies

course, and therefore only draw from the Communications department. Furthermore, college students are not representative of all young people of similar age and demographic background. Therefore, the results may not be generalizable to the entire population of college-age women who have not given birth before. The effect is likely to increase in a representative sample that does not exclusively include women of the same high education level or knowledge of media effects through Communication Studies courses. As such, the effects may be stronger among women without the same media analysis skills that would be included in a representative sample.

Procedural limitations also impacted this study. Participants did not view the clip they were randomly assigned to in a setting they normally would for several reasons. First, the clips were edited to show only one narrative out of a single episode so that effects could be observed in a clearer way. Women who watch *One Born Every Minute* see three intertwined narratives per episode, so the effects of viewing will not be as condensed as they were in this study. Rather, women are likely to have mixed viewing effects from exposure to different types of birthing narratives within a single viewing experience. It is difficult to say what effect a full episode may have on results of this study. On one hand, viewing both high-risk and low-risk clips as well as a third narrative would likely dilute the emotional, dramatic nature of the show, weakening some effects. On the other, being exposed to multiple narratives at once may increase similar effects observed by both high-risk and low-risk groups, such as decreased agency. Therefore, a combination of increased and decreased effects would most likely be observed among women who view an entire unedited episode.

Second, participants viewed the clip at a computer in a university research facility. They expected to come in for a study and were exposed to the material and research objectives through informed consent and survey questions. Typical viewers of the show would not have the same

procedure to follow in the context of viewing. Viewing the show in a natural setting without the added pressure of survey taking would likely increase the size of the effect because women would not be required to immediately respond to questions about the clip and their experience, providing less interruption between the viewing experience and effects. Future studies could repeat the procedure in women's natural setting with the clip or episode on each participant's preferred viewing device, whether that is on a television, mobile device, or computer screen.

The episode participants viewed was chosen based on availability at the time of the study rather than for randomness or generalizability to other episodes of the first season. The episode used, "Expect the Unexpected", was the only episode available to view on DVD, and I was not able to get different episodes for participants to view. Clips from different episodes may have provided more similarities among the birthing women and thus offered more control; however, since the two experimental clips were highly similar in key indicators, the effect would probably not change with a different selection of narrative from the show.

Chapter IV: Qualitative Results

The quantitative findings of this study statistically supported several of my hypotheses regarding the effects of *One Born Every Minute* on young women. The qualitative data from the focus groups support the previous findings within the same constructs of childbirth anxiety, agency, and medicalization support. Focus groups were conducted in order to expand the findings of this study beyond the confines of survey data collection. It was important to access the personal experiences and intimate feelings many women have regarding childbirth in order to better understand the way young women think about childbirth. A major advantage of focus group data is observing engagement in interaction (Morgan & Spanish, 1984), which enabled me to observe how young women would talk about childbirth with each other and which viewpoints gained group consensus. This triangulation of data from both methods strengthens my findings.

Methods

Subjects from groups who viewed birthing episodes were asked to participate in focus groups. Those who consented waited until everyone in the group was finished taking surveys and then gathered on one side of the room; only 2 participants did not consent to participate in focus groups and left after completing the pre- and post-test portion, likely due to not wanting to stay at the study more than the minimum time required to receive participation credit. I facilitated the focus groups and audio-recorded participants' responses, which were then transcribed verbatim. I was aware of which conditions participants were in when conducting the focus groups, but biases from this were limited by facilitating all groups in the same way and answering the same questions. Not all participants answered every question; in a few cases, one or two participants would take the lead and answer most questions, while others answered some

or none at all. When looking across all of the groups, no unique differences were noted as a result of the varied group dynamics. The women were allowed to respond to each other's statements and engage with each other in a conversational format, which parallels the way women would normally talk about issues such as childbirth. Focus group sessions lasted about five to ten minutes, with larger groups tending to last a few minutes longer than shorter groups because there were more participants responding to questions. Responses were not linked with specific participants to maintain an anonymous environment. Instead, quotes are identified by the group type of high-risk birth or low-risk birth.

Focus groups were asked the following questions:

- How did you feel about childbirth before viewing the show?
- How did you feel about childbirth after viewing?
- What stood out to you most about the show?
- Do you think women use television shows to learn about birth? Would you?
- What factors are needed for a safe birth?
- How did you feel about the hospital setting of the show?
- Do you think the show portrayed birth realistically?
- What is the amount of risk you associate with childbirth?
- How do you think most women would react to this show?
- If you intend to give birth someday, where do you intend to give birth? Will you want to use medication? Who would you choose to be your birth attendant?

Responses were analyzed by identifying key statements that highlight observed themes.

Themes were identified by question rather than in the overall data so that it was clear what participants were responding to. A coded content analysis was not incorporated into analysis of this data due to time limitations, but could be in future analysis. Thematic analysis was used to identify common elements across participants (Riessman, 2003). I found that the qualitative

responses support the hypotheses and highlight the key statistical findings of significance from the quantitative results.

Results and Discussion

PREVIOUS NEGATIVE NOTIONS OF CHILDBIRTH

Before participating in the study, subjects did not seem to think about childbirth much. Furthermore, participants did not bring a positive view of birth into the study. Most women viewed birth as scary and something they did not like to think about. There did not appear to be significant differences between high-risk and low-risk groups in pre-study attitudes about birth, as consistent with statistical findings.

“Tried not to think about it.” (*High-Risk*)

“I know... one day I’ll have a kid, but I tried not to think about it.” (*High-Risk*)

Many participants shared that they held a neutral notion of childbirth previously, expressing it was not something they thought much about.

“Just something that you do when you have a baby.” (*Low-Risk*)

“I was kind of neutral on it, like I guess I’ve kind of planned on it but I don’t really think about it that much. So it was just kind of there, it’s kind of whatever.” (*Low-Risk*)

“I kind of have the opinion that, like, it happens every day so it’s not really... one in a million chance or something, like, off to happen, so not too nervous about it.” (*High-Risk*)

Others expressed notions that childbirth is dangerous and/or scary.

“I’m not too keen on the idea, it’s pretty scary, to be quite honest.” (*High-Risk*)

“I was terrified of childbirth before I watched that ... like I’ve always been terrified of childbirth, and like you always hear stories of like all the terrible things that can happen” (*High-Risk*)

“Before coming in, it makes me kind of nervous. I can’t handle anything medical so it grosses me out, to be completely honest with you... So yeah, before coming in, I just think it’s kind of scary and gross, to be honest.” (*Low-Risk*)

Childbirth does not seem something that is thought about much within this population of college women, and when they do think about it, it is in a range from neutral to unfavorable, with high-risk participants emitting more negative thoughts toward birth. Participants as a whole did not express positive views of future childbirth. Many had cultivated a view that it is scary and dangerous before being exposed to childbirth stimuli. This suggests that when childbirth is talked about, if at all, among college women, it is often in a negative way that invokes fear. The lack of childbirth discourse is accompanied by a knowledge deficit about the realities of childbirth in the United States, which are demonstrated in the previous chapter. The incorrect notions held by these young women about the realities of childbirth in the United States are likely linked to the fact that childbirth is not something they think about.

Some exceptions regarding prior notions of birth were identified, indicating that a very small number of women have thought about childbirth. One participant brought up her potential desire for a home birth when asked what she thought about birth before:

“I knew that I wanted to have a child, and I knew that I wanted to have a natural childbirth, possibly at home.” (*Low-Risk*)

Another participant in that group also spoke about future birth intention:

“I knew it’s like really dangerous but still something I want to do, and I was also... considering a natural childbirth.” (*Low-Risk*)

These participants thought about birth in a future-oriented way and also had an awareness of the type of birth they wanted. Both showed a potential desire for non-medicalized birth and an indication that experiencing childbirth was something they wanted to do. These were the only

two out of 53 participants who expressed non-medicalized birth-supporting, highlighting most participants' support for medicalized birth.

NOTIONS OF CHILDBIRTH AFTER VIEWING

Reactions to childbirth generally did not become more positive after viewing childbirth stimuli, especially for high-risk group participants. Participants were asked the question, "How do you feel about childbirth after viewing the clip?" High-risk group reactions to the show ranged from unaltered prior attitudes to extreme anxiety and fear and/or disgust. Some participants seemed influenced to depend on medication and medicalization in the future. No high-risk reactions were positive. High-risk condition sentiments gave voice to the statistical finding that viewing a high-risk clip significantly increases anxiety toward childbirth.

"My view [about birth] hasn't necessarily changed, um, because I obviously knew that things could go wrong and it just kind of like, I didn't know like the shoulder something. I didn't know about that, but it didn't really change that much." (*High-Risk*)

"I guess it's just a scary thing before, and watching something that can go horribly wrong is still scary." (*High-Risk*)

"It made me, like, more scared of childbirth because she looked like she was in a lot of pain and I don't really have a high pain tolerance." (*High-Risk*)

"I didn't think much about it before, but just, that was crazy. It was just, what the hell is going on." (*High-Risk*)

"I didn't think it was as risky as that was." (*High-Risk*)

"It's always made me feel sick to my stomach, and, um, watching that made me literally feel like I was gonna throw up, I don't know why I physically feel pain when I see anything or like I think of childbirth I just think of like the worst pain you could possibly have, and then seeing that just makes me wanna like literally get sick." (*High-Risk*)

The low-risk groups' reactions ranged from calmer than what they expected to similar repulsion as what was observed among high-risk groups.

“This one looks much more calmer than what I've expected.” (*Low-Risk*)

“I guess a little less [scared] because like hers went smoothly, and I feel like sometimes watching, that everything is going to be really dramatic.” (*Low-Risk*)

“It kind of grossed me out a little bit, not gonna lie, I kind of felt a little bit uneasy about it, like not sure just about the whole process of it all.” (*Low-Risk*)

“After I felt even more grossed out because all the blood and everything, it just made it really real, and I think in movies they portray it as not as real as they did in the TV show. And it made me feel even more scared after watching the TV show.” (*Low-Risk*)

Low-risk groups did not generally look upon birth favorably before, using descriptors including “nervous”, “disgusting”, “painful”, “gross”, and “scary”, although participants gave more mixed reactions than those in the high-risk group. High-risk focus groups did not report a positive outlook on birth either, echoing the comments of the low-risk group but far more consistently across the condition. They expressed that they felt “stressed out” and “scared”, and that the clip was “gross” and “terrifying”. Reactions were stronger overall from the high-risk group than the low-risk group, indicating that the high-risk group perceived birth more negatively than did the low-risk group after viewing their condition-specific clip.

Some participants in the high-risk condition brought up their intentions regarding birth when asked about how they felt about birth, some unchanging and some negative.

“More dangerous [than I thought before], but like it still didn't really change my opinion on it that much, like I'm still gonna have a child” (*High-Risk*)

“I wasn't as scared before, now I'm more scared but I'm... still... going to have kids.” (*High-Risk*)

“I was scared going into [the study], now that solidifies my decision, so err... kids are iffy.” (*High-Risk*)

Most participants are confident that they will experience childbirth in the future, despite negative sentiments regarding birth after viewing *One Born Every Minute*, suggesting that the show does not impact birth intention. Participants' attitudes toward birth were significantly different after viewing, however. High-risk group viewers generally reported increased anxiety after viewing, from being "even more scared" to being taken aback by learning new risk factors involved with birth ("I didn't know...the shoulder something", "that was crazy"). Low-risk viewers who give birth in the future may approach it with less anxiety ("much... calmer than what I've expected") or higher-anxiety ("it made me feel even more scared"), not following as clear of an increasing anxiety pattern as high-risk viewers. The overall higher anxiety expressed by participants reinforces the statistically higher anxiety level previously found.

The responses to childbirth attitudes post-stimuli suggest that *One Born Every Minute* increases anxiety toward birth, as the data in the previous chapter also shows. That the show creates such negative feelings toward birth may have profound effects on the way women approach their own experiences of childbirth in the future, as some participants indicated that the show influenced them to use medication in the future ("definitely persuades me even more to use medication"). This is concerning because these attitude changes are based on media portrayals of birth rather than evidence-based knowledge about birth

USING CHILDBIRTH SHOWS TO LEARN ABOUT BIRTH

Most participants agreed that other women (but not themselves) would indeed turn to reality shows such as *One Born Every Minute* to learn about childbirth, despite their negative reactions to the show.

"I can see a lot of people actually like learning about it through TV 'cause it's like actual experiences, you know they didn't like make that up, and I don't know how

else you would learn about it besides like going to an actual hospital and watching one. Like for me, I don't know how else, I mean I know you can like watch videos on YouTube, but that's a little weird." (*High-Risk*)

"I think they probably could, especially if you were, like, want to have a baby in the near future you might be more inclined to watch more of these shows, so you feel like you have a lot of, like, broad knowledge of what's going on." (*Low-Risk*)

"Yeah I feel like women who, like, want a baby or are already pregnant would be more inclined to watch these shows." (*Low-Risk*)

A few participants, to the contrary, did not think other women would use these shows. These participants seemed to be outliers from the rest of the sample, with no systematic patterns regarding their responses.

"I don't think it really teaches you about it. I think it just like shows you how scary it is." (*High-Risk*)

"I don't think it's like the first source that they would go to, maybe yeah just more of like an entertainment thin than like a learning." (*High-Risk*)

Participants were then asked the question of whether they would use the show to learn about childbirth, after most had replied that they think other women would use the shows to as a learning tool. Most respondents quickly and simply replied "no". A large third-person effect (Davidson, 1983) was observed among participants' belief that other women would use childbirth reality shows to learn about birth, but they themselves would not. According to Davidson's hypothesis, participants thereby overestimate the effect that the stimuli have on others while underestimating the effect it has on themselves.

"I think I would see something like this and maybe form an opinion, but I, if I were personally going to, you know, go, if I were, you know going into labor I would, you know, be talking to a doctor more, like family members more, who have been through childbirth rather than a show like this." (*Low-Risk*)

"I feel like if I was pregnant I would, like, keep away from shows like these 'cause they would just totally freak me out." (*High-Risk*)

"It would be just something to watch, but I don't think I would learn anything from it." (*Low-Risk*)

“I probably wouldn’t [use this show to learn about birth] I’d probably read something more just because I think reading something is more reliable than a TV show, especially this being a reality TV show, but I mean I did learn a little but, but I wouldn’t rely on it fully.” (*Low-Risk*)

“I don’t think I would use TV necessarily to learn about it because I know that TV’s always more dramatic because, I mean it’s more interesting to watch the more dramatic things I think. If I was learning about childbirth I would read a book about it, but I don’t know I think you can learn from television.” (*High-Risk*)

As exemplified by the quotes above, high-risk participants tended to express a desire to avoid childbirth reality shows more than the low-risk group. Participants from both groups indicated that it is a source to “form an opinion”, or develop attitudes, regarding birth, as hypothesized. A few low-risk group participants, however, were particularly more open to the idea of learning from the show.

“I definitely did learn from it.” (*Low-Risk*)

“[I would use it] like a supplemental thing.” (*Low-Risk*)

“Not as a primary source of information, but like to validate what you learn.” (*Low-Risk*)

“I think so [that women would learn about birth from this show], yeah. I mean... I honestly don’t know that much about it, and I think I learned a little bit.” (*Low-Risk*)

That these participants learned about childbirth through the stimuli indicates that others likely learned from the show as well, but most indicated a strong disassociation from the show or from learning from it themselves because they disliked it.

One high-risk group agreed with each other that while they think other women would use this show to learn about birth, they would not due to the fact that it is reality television.

“Probably not because, like, there’s, um, reality TV there’s like some unrealistic process...” (*High-Risk*)

“I mean they totally dramatized it, so like what happened in like the episode like probably, I mean it might not happen like that often, and like, they kind of made it seem like it happens more.” (*High-Risk*)

“Yeah and especially because they said that the cameras have been there for a while, so you don’t know if people are staging, like, their conversations, ‘oh we’re all just going to be chill’ and like you were saying, like, play with their hair... you know like, does that actually go on or just because there’s camera’s there now, throughout the entire hospital.” (*High-Risk*)

These participants picked up on the fact that the portrayal of birth on the show is highly dramatized and that it is a representation by television, which is inherently different from being present for a live birth in person. It is notable that the participants in this study are students taking a Communication Studies course, in which they learn about media effects and critically analyze media texts such as television; therefore, the potential effects of learning from the show are likely to increase among non-communication students. This unique population who participated in the focus groups is not representative of the general student population on campus who may not employ a critical analysis approach to the effects of media presentations. However, the degree to which the show is dramatized through production is unknown, which was noted by some focus group participants.

Survey results revealed that these women actually do learn about birth through television, with 90% reporting that they had learned about birth this way; this finding is contradictory to the majority of focus group responses which indicated that they would not use childbirth reality shows to learn about birth. The third-person effect seen in focus group responses happened in a group format several minutes after survey responses were collected, which makes the discrepancy in response likely attributable to group agreement and a tendency to follow group agreement. Because most had given negative reactions to the show in the focus group setting prior to this question, saying that they would turn to these shows to learn about birth may have

seemed to participants at odds with what they had already responded. The prevalence of media as childbirth learning sources as well as the continued success of reality-based childbirth television shows like *One Born Every Minute* indicate that women do learn about birth from television, thus strengthening the importance of the results.

A REALISTIC PORTRAYAL?

Participants gave mixed responses when asked whether the clip they viewed is a realistic portrayal of birth. Some believed with certainty that the clips are realistic, while others conclusively decided that it was not realistic. Most were more skeptical to accept what they viewed as the reality of birth, especially since it is a reality television portrayal.

Some women in both conditions found the birth clip to be realistic. These feelings were not in the majority, however, indicating that perceiving the show as completely realistic is an anomaly.

“Yeah [it is realistic]... It showed how long it took & when the contractions were bothering her, and it showed stuff like when she’s, didn’t know about the heart rate or whatever” (*Low-Risk*)

“I think so [that is a realistic portrayal], because they showed that it wasn’t just like completely perfect, like, childbirth, that there were problems and stuff, which is realistic.” (*High-Risk*)

“It came off... as realistic. Like, it was, it didn’t seem like it was fake, you know; sometimes reality TV shows like seem like they’re scripted and stuff, but this one seemed like it was all good.” (*High-Risk*)

A few participants denied realistic aspects of this show.

“No [it’s not realistic]. I mean, I think there are like some realistic aspects, but I don’t think – like, it was really dramatic, and like, and with it being like what, did they say like 17 hours? Is that normal?” (*High-Risk*)

“I don’t think any reality TV is realistic.” (*High-Risk*)

There were participants in both conditions who were skeptical about how realistic the birth they viewed really is, but in different ways. High-risk reality skeptics seemed to think that this birth might have been too dramatic to be realistic.

“Some births I think are like that but not all of them. It didn’t show any of the ones that were easy. They kind of picked a dramatic one, so, I guess yes and no” (*High-Risk*)

“I feel like any birth isn’t going to be, like, easy, but it won’t be like that.” (*High-Risk*)

“Maybe [realistic], but not, like, truly like that. I feel like they dramatized that a lot.” (*High-Risk*)

On the other hand, skeptical low-risk condition participants thought the birth they viewed was too easy to be realistic.

“Not wholly, because I think, um, this show specifically is just kind of a, okay we’re going to start the birth, and oh here’s the baby and everything went smoothly, but I know realistically that doesn’t always happen. For this particular birth, I think it could have been realistic, like for this particular one, but I’m sure there’s more that happened that wasn’t shown as well.” (*Low-Risk*)

“There could be a lot more pain. Like she was like really calm, and I don’t, they could have, like, taken out, like, could have edited, like, any of the discomfort out but she really didn’t seem bad at all.” (*Low-Risk*)

“I think that that depends for every person. Like, everyone’s like not gonna have a really painful childbirth, like my aunt has had a bunch of kids and like on some of her younger kids she said it was completely fine, like it didn’t really hurt that bad, and like she, [Michelle] was shown, like, shaking a lot and she seemed, like, you know, like she was vomiting, but like I don’t think every pregnancy has to be like screaming, really traumatic experience.” (*Low-Risk*)

The statistical findings of this study revealed that subjects across both high-risk and low-risk group reported a relatively strong agreement that the show is a realistic portrayal of birth ($M=2.16$, an average response of “agree”), which is incongruent with some of the dialogue observed in the focus groups that seemed to be more condition-specific, in which many low-risk group participants found the clip to be easier than what they perceived to be reality and many

high-risk participants perceived their show as over-risky compared to the reality of birth. This is likely because participants had processed the show more by engaging in focus group dialogue than they had in the survey which they took immediately post viewing. The negative responses to the show gathered at the beginning of focus groups likely lead to participants' altered perception of its reality. Furthermore, group consensus that the show is not realistic among some focus group sessions may have over-perceived the strength of participants' reactions who did not give open-ended responses. However, 90% of participants reported in the posttest survey that they have learned about childbirth from television, more than any other source. Most participants in this study were skeptical that the show portrays birth completely realistically. But as Communication Studies students, these participants are more educated about and critical media and reality television than the average young woman, indicating that this sample is probably less likely to accept the show as reality than a representative sample. Previous findings that representations of reality are likely to be trusted by audiences (Hill, 2005) indicate that the show's level of reality accepted by participants as well as their reliance on television as a birth information source would lead to their trust in the accuracy of childbirth portrayed, thus enabling learning through the show.

HOSPITAL SETTING OF THE SHOW

Most participants indicated that they felt neutral about the setting of the show, aligning with the support for hospitals as part of the medicalized model of birth found in the quantitative results. The researcher did not observe differences between groups regarding attitudes toward the hospital setting. Both experimental clips were filmed at the same hospital in Ohio.

“I thought it seemed really nice, and very like welcoming and seemed like, you know, a safe place” (*Low-Risk*)

“They [the nurses] seemed... really experienced” (*High-Risk*)

“I thought it was fine, I thought it was realistic.” (*Low-Risk*)

“It seemed legit.” (*High-Risk*)

The question “How did you feel about the setting of the show?” was asked to see if any participants critically thought about hospitals as the location, compared with an alternative location. No participants mentioned the hospital setting in the context of childbirth, suggesting that young women do not think critically about or question the hospital settings for childbirth or what that means on the way birth is contextualized in the United States. Few participants are likely, then, to be aware of other options for childbirth and to make informed decisions about what the best option may be for them in the future. However, the group setting may have contributed to participants not bringing up alternative birth settings if they felt no one else would feel the same way, thus promoting group consensus.

Some participants mentioned the relaxed atmosphere of the hospital, as if this was something contrary to what they would have expected of a hospital.

“I thought it was very relaxed, and at first I was kinda like these people are way too chill for their job, but I mean they ended up doing a good job and kind of keeping the family very calm so in the end it was actually beneficial.” (*High-Risk*)

“I mean it was nothing like any of the hospitals by my house, so like it was weird, like, it was like pretty dark and like quiet, whereas like I’ve always, or like even like if I watch a TV show, like, the hospitals are not that quiet.” (*Low-Risk*)

“I feel most hospitals seem busier.” (*Low-Risk*)

“I think it’s different because it’s in, like, the maternal ward, um, so I thought that [the calmness] seemed pretty normal, because like, other hospitals that I’ve been in, people aren’t, like, giving birth.” (*Low-Risk*)

“It seemed a little laid back, like almost a little bit too laid back, but at the same time I guess the relaxed environment’s better than a high-tense situation.” (*High-Risk*)

These participants were speaking to scenes where the nurses were shown during downtime, chatting and joking with each other. Such downtime is typical for labor and delivery units (personal correspondence with nurse midwives). Participants' expectation of a tenser maternal ward environment in hospitals is likely linked to an additional expectation that birth is an inherently risky event.

RISK ASSOCIATED WITH CHILDBIRTH

Participants were asked how much risk they associate with childbirth. Risk as a term was not defined so that researchers could get an idea of what exactly participants think childbirth risk is. The amount of risk women reported to associate with birth during focus group sessions aligns well with the quantitative data results. Women who viewed the high-risk clip tended to express a greater perception of risk being associated with birth. Women in the low-risk condition had a larger range of risk association, where some women felt it was not that risky while others associated a high amount of risk with birth, despite the normal progression of birth and positive outcome.

High-risk birth viewers estimated a high amount of risk, congruent with the level they witnessed in the clip of *One Born Every Minute* they were randomly assigned to view. They included the following sentiments:

“A lot [of risk]. I don't know, I've always been terrified of it though, like just like, I don't even know, your bone breaking back there and just like all the ripping, oh my god, it just disgusts me.” (*High-Risk*)

“For me I associate a lot of risk because, like, with my family stuff, but in general for other people I still kind of feel like it's dangerous. Especially when there's like complications, and there's always potential for that, so I still feel like it's pretty high-risk.” (*High-Risk*)

“I'd say like a 6 or a 7 [out of 10].” (*High-Risk*)

“Probably 8 or 9 out of 10.” (*High-Risk*)

“Pretty high, ‘cause I mean you never know if something’s going to happen to the mom, or, like, in this case to the baby. Like, you just don’t know what’s going to happen.” (*High-Risk*)

“A lot [of risk]. To the mother and to the baby.” (*High-Risk*)

“I kind of think of it being higher now after watching what I did, than like if you were to ask me before I watched.” (*High-Risk*)

Low-risk birth viewers shared the following comments, indicating a wider range of risk estimations than what was shared by the high-risk groups.

“Um, not much [risk], really, maybe just a little bit with complications, but I think overall I, you know, associate it as being pretty, um, pretty safe, not, you know, not a whole lot of bad things that are going to happen.” (*Low-Risk*)

“I feel like more of the risk I associate with like the child and not with the actual, like, mother giving birth because nowadays it seems like the mom isn’t the one who would end up, like, suffering after. It would be like the baby would have birth defects or like end up dying.” (*Low-Risk*)

“I think there’s significant risks that a lot of people don’t think of, like I want to have a baby, it will be so cute, but childbirth is very dangerous.” (*Low-Risk*)

“High risk.” (*Low-Risk*)

The amount of estimated risk is related to the amount of risk viewed by each condition. In a full episode, however, risk level is mixed between each of the three narratives, so risk estimation after viewing a full episode is likely to be different than what was reported in this study.

Some participants in both conditions thought that the amount of childbirth risk varies by woman and context.

“I think it’s different for every birth. Like, my mom’s told me mine was very different from my sister’s and I would assume that was true woman to woman, child to child.” (*High-Risk*)

“It depends on like how old the woman giving birth is, like the older you are the more risky the birth is, so...” (*Low-Risk*)

“I think it depends on where, what country, and where you’re giving birth. So, in the United States, if... Or if you had somewhere else, like to another country, third world country, then I think it’s more, so...” (*Low-Risk*)

“I think it depends on the health of the person giving birth, more so than anything, and the health of the baby.” (*Low-Risk*)

These perspectives relate to truths about childbirth, such as that the United States has lower maternal mortality than developing countries and that risk increases with age. Furthermore, personal history and narrative plays a large role in risk perception. Women reported that one of the primary sources from which they learn about birth is family and friends; these personal narratives are highly influential in women’s perception of birth risk. According to Savage, “to formulate a foundation for the acquisition of knowledge that women possess surrounding the uniquely gendered perspective of giving birth, concepts are derived from experiential knowledge that are transferred from narratives (e.g. birth stories), social interaction, and culture” (2006, p. 11). Savage found that other mothers’ narratives, especially from their own mothers, were one of women’s most important and emotional childbirth learning sources. Therefore, women who have heard birth stories from family members are likely to develop a risk perception based on these narratives. The relationship between perceptions of risk from reality television compared to personal narrative is unanswered by this study, but provides a compelling basis for future investigation.

The theme of medicalization in relation to risk level was observed in some comments from participants in both groups.

“Not that risky, if you’re in a hospital.” (*Low-Risk*)

“I feel like it’s more of a halfway point in the hospital, but like if you’re, I feel like you’re at more risk if you give birth at home, without like medical attention.” (*High-Risk*)

“Now, since technology and doctors are so much more experienced than they were back then, I am confident in what I plan to give birth one day, I feel confident in their ability so I think there’s not much risk.” (*Low-Risk*)

These participants show a strong belief that the medicalized model of childbirth brings a much lower amount of risk compared to non-medicalized birth. This view directly echoes previous research showing that college students believe birth is inherently dangerous and must be handled by physicians to be safe (Cleeton, 2001).

One hypothesis is that participants would overestimate the amount of risk associated with childbirth. While risk is never quantified in this setting, most participants did consider birth to be high risk overall, which would suggest that risk overestimation is likely to happen among *One Born Every Minute* viewers. Participants may believe that emergencies and complications during birth happen more frequently than they do in reality; this makes normal, complication-free birth not the perceived norm. This is especially the case regarding high-risk childbirth narratives, where the level of risk is indeed higher than in a normal birth. Birthing women who are classified as having high-risk pregnancies do perceive a higher amount of birth risk than women with normal or low-risk pregnancies (Gupton, Heaman, & Cheung, 2001).

An underestimating effect may be likely to occur regarding risk surrounding medical interventions. Childbirth reality shows often neglect to show discussion of risk involved with specific medical intervention used during childbirth. These risks are not something participants in any focus group brought up, and given their low amount of childbirth knowledge in general, they are unlikely to know about the specifics of types of interventions. There is risk involved with every birth intervention such as epidurals, C-sections, and inducing labor, which are frequently used in the United States. The risks associated with the medicalized technological

interventions commonly used in birth may very well be underestimated, then, as a result of the lack of discourse around these interventions.

PARTICIPANTS' PERCEPTIONS OF THE SHOW

Several themes were recognized from the question of what stood out most to participants about the show. First, many low-risk condition participants noted the relationship between the couple, especially the annoying nature of the husband.

“Um, I thought it was really interesting how they portrayed the husband in the process, kind of like he was um, he was just kind of there in the background being obnoxious, and it was, you know, it's supposed to be more about the woman.”
(*Low-Risk*)

“The relationship between Michelle and Andrew stood out to me the most... He was bouncing off the walls, I would be so annoyed.” (*Low-Risk*)

How annoying participants found Andrew, the husband in the low-risk condition clip, to be is a weakness of this study. The couple's dynamics may have distracted low-risk condition viewers away from the birth, thereby reducing viewing effects. Much of the birthing narrative focused on the anxious, energetic nature of the husband as compared to the calm, tired demeanor of his laboring wife, and participants noted this. Stimuli selection was limited to one episode of the show due to availability by the network, and the two clips chosen were the two that controlled for the most factors. Having access to a different low-risk clip that showed a more similar relationship between the expecting couple would strengthen study results. Nevertheless, participants still did report being affected by the clip, and so it is likely that the effects observed would be as strong as or stronger with a better-controlled low-risk clip.

Alternatively, the dynamics of the couple shown during labor and birth may be a benefit to the depiction of the reality of birth. Family dynamics and relationships are a central aspect of

childbearing. By showing the social dynamics surrounding birth, the show facilitates a more holistic picture of its realities. This enables viewers to think about birth from an interpersonal point of view; those who will face birth in the future will inevitably face social and family factors that accompany it.

A second main theme was that the realities of childbirth stood out to participants.

“I think the actual childbirth scene stood out to me most just because it was so real and I haven’t seen real childbirth before” (*Low-Risk*)

“I think, like, the blood on the baby, I know that sounds weird but like the blood and like all, I don’t know, like the actuality of like watching it.” (*High-Risk*)

That the realities of childbirth stand out so strongly to participants is due to the fact that birth is not something they are exposed to or think about. Only one participant reported to have been present for a live birth before this study. Because so few women are present for a birth until it is their own, they are unexposed to the realities of birth, including what the baby looks like immediately after birth and the bodily fluids involved. Other media sources, especially movies, tend to show birth as a completely un-messy event, showing an unrealistic newborn with no fluid or blood on it and neglecting to show the placenta, amniotic fluid, or blood at all. Considering this unrealistic birth portrayal that is so pervasive in popular media, it is understandable that these realities would be strongly noted when seen for the first time.

It is important to note, however, that some of these factors are not shown in *One Born Every Minute*, either. The newborn is shown immediately after birth before it has been cleaned, but the placenta and fluids that many would consider “gross” are not shown. Many of the realities of birth are, therefore, censored, creating an interesting question of what is acceptable to show and what is not acceptable to show about birth on television.

A third theme identified as standing out most to participants was the previously pointed out concept of the relaxed nature of nurses' downtime.

“I thought like the leisure time that all the nurses had, like it would just cut to them like playing with their hair and like making jokes and then once the, like the risky thing happened they were all like frantic and stuff.” (*High-Risk*)

This point echoes the earlier finding that participants are not aware of the inconsistent activity, likely because of their perception that birth is highly risky and dangerous, requiring constant medical intervention. Downtime is a reality in labor and delivery units.

One participant brought up how much of an invasion of privacy she considered the show to be.

“The only thing I could think [about] was how much of an invasion of privacy that was, and I would never want that. I'm sure they were reimbursed and they definitely had consent forms and stuff like that, but, um, it seemed like a very private event to be showing.” (*Low-Risk*)

Birth is a very private event in the United States, and it was surprising that only one participant brought up privacy issues in the show. The women in the show consent to participation and receive a personalized birth video as compensation, but the high amount of surveillance that it requires is not common of childbirth in the US.

REACTIONS FROM OTHER WOMEN

Two opposing views were identified when women were asked how they think other women would react to the clip of *One Born Every Minute* they viewed. First, many participants, especially those in high-risk viewing focus groups, believed that most women would react in a negative way to this show.

“I think they'd be nauseous after watching that.” (*High-Risk*)

“Probably make them not want to have kids, if they were skeptical before.”
(*High-Risk*)

“Like really scared.” (*High-Risk*)

“It would, like, turn them away from, at least like temporarily away from having, like it makes me not want to have kids, I’ll be honest.” (*Low-Risk*)

“It makes me just want to get a C-section.” (*Low-Risk*)

Some participants in the high-risk groups seemed appalled that this show was on the air at all.

“I just don’t know how people could find that entertaining.” (*High-Risk*)

“I can’t imagine someone, like, watching that show every day, like what are you doing.” (*High-Risk*)

These are strong negative reactions to the show. Most women in the focus groups believed that other women would not enjoy the show, some even sharing that it would dissuade women from wanting to give birth. Participants showed the strongest negativity toward the show in the high-risk condition groups, indicating that high-risk birthing narratives trigger the stronger adverse reactions. This is expected because the high-risk condition also showed the highest birth anxiety and lowest birthing agency, and high-risk group participants reported the lowest level of enjoyment of the clip they viewed. The show *One Born Every Minute* has gone onto a second season, however, demonstrating that it does have an audience that enjoys it. But these women, who were not previously much exposed to the realities of childbirth, found that hard to believe.

Not all participants thought other women would react negatively to the show, however.

A few women in both groups thought that women would have more emotional, positive reactions to this show due to its women-related subject matter.

“I think it’s like an emotional thing for women, um, where if men saw it they’d probably be like grossed out, they’d like not really care, but for women since...we’re the ones that give birth I think it’s like more of an emotional thing, rather than like entertaining” (*High-Risk*)

“They’d probably like it, ‘cause women have babies, they like babies” (*Low-Risk*)

Because the show is about birth, the smaller group of participants believed other women would react positively to this show as women who have given or will give birth. One notable reaction was that a couple participants saw the show as a way to connect women through the common experience of childbirth.

“Empathetically. We’re all going to go through that one day so we can feel for her.” (*Low-Risk*)

“I thought it was kind of empowering, and...I think it might make a lot of women, um, feel connected to other women, and like, empathetic...because childbirth is something that a lot of us go through, so I think it’s like a connecting factor.” (*Low-Risk*)

These positive reactions attribute the show as being designed for women because childbirth is a shared, exclusive experience of womanhood. This perspective strongly contrasts the majority perspective that women would react negatively to the show; it is probable that such reactions would be observed in women viewers of the show depending on whether or not they have given birth and/or whether or not they have a positive view of birth. Because most women reported a negative perspective of childbirth, it makes sense that they reacted negatively to the show and though other women would react the same way. But other women saw the show as an opportunity to share a common experience and relate to one another as women.

FACTORS NEEDED FOR A SAFE BIRTH AND FUTURE BIRTH INTENTIONS

Overwhelmingly, the women in this study believed that medical factors were the most important for a safe birth. The two most common responses to the question “What factors are needed for a safe birth?” were a doctor and a hospital. Medication was also highly noted as being important for a safe delivery, and one high-risk participant also noted “all the machines” as

important. Some or all of these factors were mentioned in every focus group, indicating that for young women, safety in childbirth means medicalized birth.

Knowledge about the process of childbirth, in addition to medical support, was also recognized as an important factor for a safe birth.

“I think you need a really good doctor, and you need to be in a hospital, and you also need to be informed as well. You can’t just go in blind not knowing anything about what you’re getting yourself into. So you need to be knowledgeable, you need to go to a good hospital, and have good doctors surrounding you.” (*Low-Risk*)

Regarding their own birthing intentions in the future, most women indicated that they want to be in a hospital, with a doctor, under medication. Some expressed a desire to try birth without medication.

“I would do it in a hospital, but I would try without medication first. But then, worse comes to worst I would use it.” (*High-Risk*)

On the other hand, some were highly demanding of medication.

“I want to be knocked out, personally.” (*Low-Risk*)

“I want to be drugged.” (*Low-Risk*)

DeJoy (2010) found similar findings to what was reported by women in this study; she found that college students highly associate childbirth with fear and unpredictability, thus believing that it requires medical control. She credited lack of support for midwifery and non-medicalized birth approaches to knowledge deficits about the safety of non-medicalized birth in the United States, which was apparent in this sample as well. Unlike in DeJoy’s findings, several participants in both conditions of this study did give the notion that a birth attendant or “some sort of assistant” (*Low-Risk*) other than a doctor would be a safe choice for birth; many, however, were unclear of whom that would be, demonstrating similar knowledge deficits shown in previous studies.

“I’d say a doctor, or someone who knows what they’re doing.” (*High-Risk*)

“Like a trained midwife or whatever.” (*High-Risk*)

“I would want it in a hospital, and like I’ve always thought about a doctor but I don’t really know what a midwife is so I can’t really answer that question, but I would want to be medicated.” (*High-Risk*)

These women are aware that different options for childbirth exist, but they express some uncertainty about what exactly those choices are. Some of these participants specifically mentioned midwives, but seemed to be unsure of what exactly a midwife is or does. Women who expressed awareness of non-doctor birthing attendant options may be more inclined to learn about their attendant choices when facing birth in the future.

Overall, thematic findings from focus groups support the statistical findings from the previous chapter. A majority of subjects show intentions for medicalized birth, associate a high amount of risk with childbirth, and demonstrate negative reactions to the show *One Born Every Minute*. These and experimental findings reveal important foresight into women’s future childbirth intentions and public health implications of the effects of childbirth reality television shows.

Chapter 5: Conclusion

The most recent childbirth reality show to premier on television, Lifetime's *One Born Every Minute*, presents birth in a highly dramatized way. This study has demonstrated the effects that the show's portrayal of birth has on young women who have yet to experience childbirth. I confirmed the hypothesis that the portrayals of birth on *One Born Every Minute* increase young women's anxiety toward future childbirth, causing them to be "even more scared" of childbirth than they were before viewing birth narratives; in addition, the stimuli was shown to decrease women's sense of agency surrounding birth. The high-risk birth portrayal was found to have more significant effects than the low-risk birth portrayal. Women shared a lack of discourse about childbirth and showed strong support for the medicalized model of birth, demonstrating a lack of knowledge about birthing options and realities of birth.

The hypotheses in this study were tested on women who have not experienced childbirth before in order to see how they intend to approach birth in the future as a result of watching *One Born Every Minute*. Most participants intend to give birth, and the sample showed a strong preference for in-hospital, medicated birth attended by physicians. Furthermore, most participants showed negative reactions to both high-risk and low-risk birthing narratives while believing other women would react negatively as well. These reactions indicate that college-age women are not likely to be the intended audience for the show, whose popularity spurred on a second season. In fact, according to OhioHealth (the health system that hosts the show in its maternal facilities), the target audience of the show is women age 20 to 40 who are or hope to become mothers (2011); for many of the women in this study, becoming a mother was not in their near future. The effects observed in this study may be more relevant to populations of women who are indeed facing childbirth and engaging in active learning about birth.

FUTURE RESEARCH

To help address this topic more thoroughly, subsequent research should be done on the childbirth reality shows. First, the second season of *One Born Every Minute* premiered during the time this study was conducted. Similar methods should be conducted to analyze changes in the season's presentation of birth and its effects to note potential differences from the first season; noting changing trends in birth media is important to understand how women's perceptions of birth may change along with the media. Furthermore, similar procedures could be done using other childbirth reality shows, including *Birth Day* and *Deliver Me* as well as the more frequently studied *A Baby Story*.

Second, the same procedure of this study can be repeated using a full episode of the show (three birthing narratives intertwined together) rather than showing an isolated clip of one sequential birthing narrative within an episode, as was used in this study. The effects of the show were demonstrated more clearly by manipulating the level of risk between each narrative. In a full episode, three narratives are intertwined. Because viewers watch the show as a whole episode on television, knowing the effects of the episode as a whole would help answer questions about the impact of mixed clips.

PUBLIC HEALTH IMPLICATIONS

Childbirth in the United States is complex. This study revealed negative effects resulting from the current state of childbirth reality shows. While increasing women's anxiety and decreasing agency toward childbirth are not desirable outcomes of viewing television shows, I do not wish to argue that it would be better to avoid showing higher risk births on television. Rather, it is important to demonstrate the complexities of childbirth in the United

States so that women have opportunities to educate themselves about birth and hopefully increase their agency in childbirth.

The question of the ideal way to show birth on television is also complex. The goal of networks should not be to promote only one type of birth, but rather to show a range of childbirth models and experiences. The risks of promoting the medicalized model of birth as demonstrated in this study include increased anxiety, decreased agency, and a neglect of the risks and side effects associated with technological interventions. Promoting the opposite, however, of only natural, non-medicalized birth would not necessarily be ideal either. Natural birth, argues Jones (2011), is not necessarily “natural” in that normative ideals about nature are inherently imbued by cultural meaning, as is medicalized birth. She argues that “the idealization of ‘natural’ birth functions ideologically to impose a prescriptive normativity on women’s childbearing in a manner that deprives them of agency, inflates their expectations, and opens them to social stigmatization and a profound sense of shame if they fail to enact the ideal” (p. 108). Thus, women who pursue “natural” birth are subject to significant woman-blaming and shame if they do end up suffering complications or having emergency C-sections. Would promoting natural birth be better for women, then, if such adverse effects would arise?

The conflict between birth models brings back the question of how childbirth reality shows should approach birth portrayals. An ideal representation would not ignore tensions and opposing views on birth. Women do have birthing options, and they are at risk of experiencing a wide range of outcomes and emotions regardless of the approach they take. But reality television constructs a contrived reality of birth as it currently stands, customizing birth to fit its criteria for entertainment success and predominantly promoting only one model of birth. This approach to birth media does not have women’s best interests in mind, especially in light of the negative

outcomes that result from such birth portrayals. What is best for women is not up to the media to decide; it is up to women themselves. What should be of paramount importance in childbirth-themed media is the “agency of the mother with respect to the decision about how to give birth that is foregrounded as the crucial determinant of outcome” (Jones, 2011, p. 102). This includes showing the full range of birthing experiences and outcomes – including both medicalized and non-medicalized approaches – and dealing with all types of birthing outcomes, social factors, and risks.

The critique to showing a wider range of birth, of course, is that it might create *more* fear and anxiety among women for future childbearing. Increasing childbirth anxiety is absolutely a concern, but so is protecting women from birth realities and opportunities to learn about childbirth in light of a culture that otherwise keeps childbirth incredibly private. Giving mothers the decision about how to give birth is of paramount importance for agency and optimal birth outcomes. That includes giving mothers the choice of medication, C-sections, and natural birth alike; it also includes showing them this range through the media. But in order to achieve optimal agency and promote the best birthing experiences and outcomes possible, women need to be well informed to make these decisions, which is currently not the case among young women in this study.

One Born Every Minute's effects on women's perceptions of birth have implications for women's preparation for childbirth in the future. The show fails to address risks of common medical interventions, such as epidurals and cesarean sections. Multiple women in this study expressed desire for these interventions with little to no knowledge of the risks and side effects associated with them. The National Institute of Health (2006) has identified psychological factors including fear and feelings of inadequacy as factor that influences women to request C-

sections. Women may very well be influenced to seek out these technologies as a result of media exposure, increasing the normativity of the medicalized model of birth.

The high maternal and infant mortality rates in the United States affect the population disproportionately. Women of color and of lower socioeconomic status experience these negative birth outcomes significantly more than white women and women of higher socioeconomic status. Social factors that create health disparities such as birth mortality are rarely, if ever, addressed in the mainstream media. And as demonstrated by the women in this study, these realities are not well known among young women, who are entering their childbearing years and will face the reality of birth relatively soon. Childbirth reality shows neglect health care disparities among American women, thereby perpetuating the invisibility of negative outcomes that could have a severe impact on their health and their lives.

Reduced agency and increased anxiety have been shown to result from viewing *One Born Every Minute*, despite always showing a positive outcome for both mom and baby. These effects discourage women from becoming active participants in their pregnancy care. Through the normalization of medical interventions, women are more inclined to trust medical management of their birth over their own ability to give birth; this further internalizes the American cultural belief that the medical system is superior to women's autonomy. Childbirth reality shows, including *One Born Every Minute*, should strive to empower women to take charge over their birthing experience, rather than encouraging women to resign their autonomy to one singular model that has historically devalued them.

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APPENDIX I

SUMMARY OF BIRTHING WOMAN, *ONE BORN EVERY MINUTE* SEASON 1

Summary of Birthing Women – One Born Every Minute, Season 1							
Name/ Episode	Age	Married	Race	Vaginal/ C- section	Kept Baby?	Associated Risk	Notes
Tasha, 1	26	No	Black	C-section	Yes		
Melissa, 1	40	Yes	White	Vaginal	Yes		
Susan, 1	31	Yes	White	Vaginal	Yes		CNM & Doula
Michelle, 2	33	Yes	White	Vaginal	Yes		
Courtney, 2	33	No - engaged	Unsure – White?	Vaginal	Yes	Shoulder Dystocia	
Rochelle, 2	30	No - partnered	Black	C-section	Yes	Scheduled Cesarean	Same-Sex Couple
Carisa, 3	29	Yes	White	Vaginal	Yes		
Afyia, 3	33	Yes	Black	C-section	Yes	Scheduled Cesarean	
Jenna, 3	17	No – engaged	White	Vaginal	Yes		
Christian, 4	33	Yes	White	Vaginal	Yes		
Nicole, 4	34	Yes	Black	C-section	Yes		
Kara, 4	31	Yes	White	Vaginal	Yes		
Susan, 5	38	Yes	White	C-section	No	Scheduled C-section	Surrogate
Vanessa, 5	22	Yes	Black	Vaginal	Yes		
Angela, 5	35	Yes	White	Vaginal	Yes		
Marcella, 6	20	No-partnered	White	Vaginal	Yes		Interracial couple
Kim, 6	36	Yes	White	C-section	Yes	Scheduled C-section	
Megan, 6	26	No	White	Vaginal	Yes		
Felicia, 7	22	Yes	Black	Vaginal	Yes		
Amber, 7	33	Yes	White	C-section	Yes	Scheduled C-section	
Dionne, 7	33	Yes	White	Vaginal	Yes		
Amanda, 8	20	Yes	White	Vaginal	Yes		
Tiana, 8	32	Yes	Black	Vaginal	Yes	Fibroid, use forceps	
Samantha, 8	22	No	White	C-section	No	Scheduled C-section	
Summary	Average Age: 29.5	70.8% married		33% Cesarean	8.3% Not Kept		

APPENDIX II

SCALE ITEMS

Table 1: Means and Standard Deviations by Main Scales

	ANXIETY SCALE			MEDICALIZATION SCALE			AGENCY SCALE
	<i>Pretest</i>	<i>Posttest</i>	<i>Post-Pre Change</i>	<i>Pretest</i>	<i>Posttest</i>	<i>Post-Pre Change</i>	<i>Posttest</i>
High Risk	<i>M = 3.33</i> <i>SD = .85</i>	<i>M = 3.91</i> <i>SD = .73</i>	<i>M = .61</i> <i>SD = .55</i>	<i>M = 3.86</i> <i>SD = .66</i>	<i>M = 4.00</i> <i>SD = .74</i>	<i>M = .11</i> <i>SD = .55</i>	<i>M = 2.62</i> <i>SD = .73</i>
Low Risk	<i>M = 3.24</i> <i>SD = .75</i>	<i>M = 3.54</i> <i>SD = .76</i>	<i>M = .28</i> <i>SD = .68</i>	<i>M = 3.63</i> <i>SD = .66</i>	<i>M = 3.72</i> <i>SD = .59</i>	<i>M = .08</i> <i>SD = .48</i>	<i>M = 3.09</i> <i>SD = .58</i>
Control	<i>M = 3.12</i> <i>SD = .95</i>	<i>M = 3.28</i> <i>SD = 1.0</i>	<i>M = .16</i> <i>SD = .45</i>	<i>M = 3.62</i> <i>SD = .55</i>	<i>M = 3.70</i> <i>SD = .59</i>	<i>M = .08</i> <i>SD = .36</i>	<i>M = 3.38</i> <i>SD = .39</i>

Anxiety Scale

- Childbirth is dangerous.
- I am scared of giving birth someday.

Medicalization Scale

- Birth should take place in a hospital.
- Midwives aren't as dependable as obstetricians for safe delivery.
- Medication is usually necessary for childbirth.
- Women need the help of a doctor to give birth.
- Home birth is just as safe as hospital birth. (reverse)

Agency Scale

- If I give birth someday, I will have control over the situation.
- If I give birth someday, my opinion will be the most important when making decisions.
- If I give birth someday, the birth attendant's opinion will be the most important when making decisions. (reverse).
- I can give childbirth without medication.
- I could tell what's going on with my own body in childbirth.
- I can take charge of my own birth experience.
- I can call the shots when I give birth.
- I can prepare fully to give birth.

APPENDIX III

PRE-EXPOSURE SURVEY

What is your age? _____

What is your class level?

First Year Sophomore Junior Senior 5th+ year

What is your race?

What is your sexual orientation?

What is your major(s)?

On average, how many hours per week do you spend watching television?

On average, how many hours per week do you spend watching reality shows?

I choose to watch TV shows that are similar to my experiences and/or daily life.

Strongly Agree Agree Neutral/Unsure Disagree
Strongly Disagree

I often relate to characters I see on television.

Strongly Agree Agree Neutral/Unsure Disagree
Strongly Disagree

I watch TV shows that are not like my life.

Strongly Agree Agree Neutral/Unsure Disagree
Strongly Disagree

I can learn about different experiences and lifestyles than my own from TV shows.

Strongly Agree Agree Neutral/Unsure Disagree
Strongly Disagree

Please circle the closest response to how you feel about each of the following statements.

ANSWER SCALE:

A	B	C	D	E
DOES NOT				DESCRIBES ME
DESCRIBE ME				VERY
WELL				WELL

I daydream and fantasize, with some regularity, about things that might happen to me.

I often have tender, concerned feelings for people less fortunate than me.

I sometimes find it difficult to see things from the "other guy's" point of view.

Sometimes I don't feel very sorry for other people when they are having problems.

I really get involved with the feelings of the characters in a novel.

In emergency situations, I feel apprehensive and ill-at-ease.

I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

I try to look at everybody's side of a disagreement before I make a decision.

When I see someone being taken advantage of, I feel kind of protective towards them.

I sometimes feel helpless when I am in the middle of a very emotional situation.

I sometimes try to understand my friends better by imagining how things look from their perspective.

Becoming extremely involved in a good book or movie is somewhat rare for me.

When I see someone get hurt, I tend to remain calm.

Other people's misfortunes do not usually disturb me a great deal.

If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

After seeing a play or movie, I have felt as though I were one of the characters.

Being in a tense emotional situation scares me.

When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

I am usually pretty effective in dealing with emergencies.

I am often quite touched by things that I see happen.

I believe that there are two sides to every question and try to look at them both.

I would describe myself as a pretty soft-hearted person.

When I watch a good movie, I can very easily put myself in the place of a leading character.

I tend to lose control during emergencies.

When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

When I see someone who badly needs help in an emergency, I go to pieces.

Before criticizing somebody, I try to imagine how I would feel if I were in their place.

Have you ever seen a live birth before? Yes / No

If so, what was the context?

Have you ever given birth before? Yes / No

Please select one response for each of the following questions:

Strongly Agree Agree Neutral/Unsure Disagree Strongly Disagree

I think often about my future.

I would like to have a family of my own someday.

I plan on having a wedding someday.

I plan on giving birth in the future.

Getting married is risky.

Childbirth is dangerous.

I have a good idea of when I would like to get married.

I have a good idea of when I would like to have kids.

Childbirth is a miracle.

I am scared of giving birth someday.

Home birth is a good option for other people.

I wouldn't mind if I had to have a cesarean section (C-section) someday.

Birth should take place in a hospital.

I plan to use pain medication during childbirth.

I think home birth is a good option for me.

Midwives aren't as dependable as obstetricians for safe delivery.

I plan to give birth in a hospital.

Medication is usually necessary for childbirth.

I plan to get married before having children.

Women need the help of a doctor to give birth.

Birthing women can't make childbirth decisions while they are in labor.

If I have children in the future, I am planning on having a career when I become a mother.

Home birth is just as safe as hospital birth.

Have you seen any of the following television shows? If so, please indicate how familiar you are with the show.

0 – Never heard of it

1 – Heard of it but never seen it

2 – Have seen it once or twice

3 – Have watched occasionally, a few times a year

4 – Watch often, monthly or a few times a month

5 – Extremely familiar and watch multiple times a week

A Baby Story

Birth Day

Deliver Me

I Didn't Know I Was Pregnant

One Born Every Minute

16 and Pregnant

Teen Mom

Say Yes to the Dress

STIMULI

High-Risk: http://www.youtube.com/watch?v=_l3sqRUf8-o

Low-Risk: <http://www.youtube.com/watch?v=IMtD83rgCM0>

Control: <http://www.youtube.com/watch?v=JGwnYK7QMRQ>

APPENDIX IV

POST-EXPOSURE SURVEY

Instructions: This scale consists of a number of words that describe different feelings and emotions. Read each item and then enter the number on the scale below that corresponds to the way you **currently feel**.

<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
not at all extremely	a little	moderately	quite a bit	
___ interested				___ irritable
___ excited				___ alert
___ frustrated				___ disappointed
___ upset				___ content
___ strong				___ ashamed
___ happy				___ inspired
___ relieved				___ nervous
___ distressed				___ troubled
___ guilty				___ joyful
___ miserable				___ determined
___ scared				___ attentive
___ hostile				___ jittery
___ enthusiastic				___ active
___ pleased				___ unhappy
___ proud				___ afraid

Please select one response for each of the following questions:

Strongly Agree Agree Neutral/Unsure Disagree Strongly Disagree

Please choose the closest response to how you feel about each of the following statements.

This character was likeable.

I would like to be friends with this character.

While viewing One Born Every Minute, I felt as if I was part of the action.

While viewing One Born Every Minute, I forgot myself and was fully absorbed.

I was able to understand the events in the program in a manner similar to that in which {character name} understood them.

I think I have a good understanding of [character name].

I tend to understand the reasons why [character name] does what he or she does.

While viewing the show I could feel the emotions [character name] portrayed.

During viewing, I felt I could really get inside [character name]'s head.

At key moments in the show, I felt I knew exactly what [character name] was going through.

While viewing the program, I wanted [character name] to succeed in achieving her goals.

When [character name] succeeded I felt joy, but when he or she failed, I was sad.

I enjoyed the show I viewed.

The clip I viewed portrays childbirth realistically.

Childbirth is a miracle.

I plan on giving birth in the future.

Childbirth is dangerous.

I am scared of giving birth someday.

Birth should take place in a hospital.

Birth can safely take place outside of a hospital.

Childbirth is risky.

Midwives are as dependable as obstetricians for safe delivery.

Medication is usually necessary for childbirth.

Women need the help of a doctor to give birth.

Birthing women can't make childbirth decisions while they are in labor.

Home birth is just as safe as hospital birth.

I believe I have the ability to give birth without medication.

If I give birth someday, I will have control over the situation.

If I give birth someday, my opinion will be the most important when making decisions.

If I give birth someday, the birth attendant's opinion will be the most important when making decisions.

I can give childbirth without medication.

I could tell what's going on with my own body in childbirth.

I can take charge of my own birth experience.

I can call the shots when I give birth.

I can prepare fully to give birth.

Please answer the following questions to the best of your ability:

What is the most common surgical procedure performed on women in the United States?

- a. Hysterectomy
- b. Cesarean Section (C-section)
- c. Heart surgery
- d. Plastic surgery

The United States achieves the rate of cesarean sections (C-sections) as recommended by the World Health Organization.

- a. True
- b. False

What percent of women give birth in a hospital in the United States?

- a. 80%
- b. 90%
- c. 95%
- d. over 99%

The United States has the poorest maternal mortality rate of developed countries.

- a. True
- b. False

Women who give birth at home are more likely to experience postpartum depression than women who give birth in hospitals.

- a. True
- b. False

Where have you learned about childbirth? Circle all that apply.

Parent/family member

Friend

Doctor

Midwife

Television

Books

Nurse

Movies

Internet

Other:

APPENDIX V

OPEN ENDED FOCUS GROUP QUESTIONS

1. How did you feel about childbirth before viewing the show? How did you feel about childbirth after viewing?
2. What stood out to you most about the show?
3. Do you think women use television shows to learn about birth? Would you?
4. What factors are needed for a safe birth?
5. How did you feel about the hospital setting of the show?
6. Do you think the show portrayed birth realistically?
7. What is the amount of risk you associate with childbirth?
8. How do you think most women would react to this show?
9. If you intend to have birth someday, where do you intend to give birth? Will you want to use medication? Who would you choose to be your birth attendant?