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"Reality" TV: Portrayals of Labor and Birth in a Mainstream Reality Series One Born Every Minute

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Running head: PORTRAYALS OF LABOR AND BIRTH IN "REALITY" TV

"Reality" TV: Portrayals of Labor and Birth in a Mainstream Reality Series *One Born Every Minute*

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Abstract

Today, the birthing process is predominantly medicalized in the United States. Compounding this phenomenon is the media, which has a strong influence on people's perceptions, attitudes, and behavior, and can serve to reinforce cultural norms—specifically, mainstream media disproportionately promotes medicalized birth. The media has a tendency to portray labor and birth as a dangerous affair, and as a result, may contribute to the culture of fear around labor and birth. In this feminist, qualitative media analysis, we examined several mothers' experiences giving birth on a popular reality television series called *One Born Every Minute*. We analyzed how these mothers' births are portrayed in four episodes, paying close attention to the frequency of perceived danger and who identifies as the decision maker. We asked two questions to guide our study: 1) How often is birth portrayed as dangerous in the reality television show *One Born Every Minute?*, and 2) Who are presented as decision makers during labor and birth? Our findings showed that labor and birth are more frequently portrayed as dangerous than not, and that women are most often the least empowered to make decisions during labor and birth, after their doctors and family members. This analysis reflects popular beliefs about labor and delivery and sheds light on the disempowerment of mothers in labor and birth.

Keywords: labor, delivery, childbirth, birth, dangerous, portrayal, reality TV, empowerment, intersectionality

"Reality" TV: Portrayals of Labor and Birth in a Mainstream Reality Series *One Born Every Minute*

Although, historically, midwives were responsible for childbirth, medicalization of birth has become normalized in the United States, causing labor and birth experiences for birth mothers to be fraught with medical interventions (Kline, 2010; Kukla & Wayne, 2015). Empowerment of birth mothers in their birthing experiences has declined due to the deeming of pregnancy and birth as a pathology: something that must be treated and managed by professionals, instead of a naturally occurring condition or process (Talbot, 2014; Song, West, Lundy, & Dahmen, 2012). The medicalization of birth is disproportionately promoted by reality television and, therefore, is subsequently normalized by it. Simultaneously, the lack of representation of non-medicalized birth within reality television may influence women's perceived risk and attitude toward the birthing process, as well as their awareness of other childbearing options (Young & Miller, 2015). The media has a tendency to portray labor and birth as a dangerous affair, and as a result, may contribute to the culture of fear around labor and birth. Additionally, Young and Miller (2015) state that women are more likely to accept medical intervention when they have negative expectations of labor and birth; this is despite evidence that absence of medical intervention in low-risk births is beneficial to mother and baby. Indeed, women's confidence in their own ability to give birth has deteriorated, and consequently, their empowerment in birth suffers (Uppal, Davies, Nuttal, & Knowles, 2016).

Few studies have examined the implications of reality television series that promote medicalized birth to the individuals that watch them. Reality television series *One Born Every Minute* is an example of mainstream birth in the media: it centers on women's birthing

experiences in a hospital setting. The current study explores how mainstream reality television represents labor and birth as dangerous through a feminist, qualitative media analysis of *One Born Every Minute*. We examine how often birth is portrayed as dangerous by focusing on medical interventions and observe who are presented as decision makers during the birthing process. For example, is the birth mother empowered to make the decisions, or are her medical staff and support system presented as the decision makers? How, if at all, is ethnicity a factor in depictions of power and decision making?

This research is feminist in nature due to the question of women's empowerment or disempowerment and addressing how women may become empowered in their birthing experiences. As a result of the study at hand, women may become more aware of the ways reality television impacts their ideas about birth. Women from all backgrounds may begin to make informed, educated decisions regarding maternal support and childbirthing options. Women can begin to seek agency and obtain knowledge on how they may be able to self-empower when making decisions about their birthing experience. Additionally, it is critical to address the ways in which women of color are further impacted in the birthing process and how they may also navigate their experiences. By incorporating intersectionality theory, we examine how ethnicity was shaped in One Born Every Minute and how ethnicity impacts empowerment of the women featured. Finally, we carefully exercise reflexivity in our research in order to reduce the impact our background and experiences may have in interpretation of our data.

Literature Review

This feminist research focuses on the way the media portrays women's birthing experiences and decision making during the birthing process. It is important to highlight the literature on the following topics: medicalization of birth, medical interventions, the shift from

midwives to the obstetricians, women's empowerment in birth, reality television, and birth in reality television.

Medicalization of Birth

There has been a lot of discussion and controversy over the increasing medicalization of birth in the United States occurring over the last century. Medicalization of birth is defined as a process that is supervised and managed by medical professionals in a hospital or clinical setting, by which medical interventions are frequently performed (Kukla & Wayne, 2015). This means that from conception to birth, pregnancy is monitored by medical professionals whose job is to treat illness; the mother becomes the patient and the baby becomes the pathology.

The dialogue surrounding the medicalization of birth centers on a range of concerns, such as whether or not the United States overemphasizes the benefits or necessity of medical interventions in birth or labor (Every Mother Counts, 2014). Today, the norm is to be overseen by medical professionals, such as an obstetrician, as opposed to midwives—an overwhelming 98.8% of births take place in a hospital with 86% of those births being attended to by physicians (Dekker, 2013). While maternal and infant mortality had decreased with the introduction of medical professionals into the birthing process, many argue that the skyrocketing rates of medical intervention performed by physicians today do nothing more to decrease those numbers (Johanson, Newburn, & Macfarlane, 2002). In fact, the high rates of medical intervention, specifically caesarean sections or other instrumental interventions, are linked to a number of postpartum maternal deaths (Johanson, Newburn, & Macfarlane, 2002).

Medical interventions in birth are not to be demonized; for women who require intervention in labor, it can be the difference between life or death for the mother, the baby, or

both. The controversy from many is that medicalized birth has become the norm in the United States, with low-risk to high-risk pregnancies and births sharing the same rates of medical intervention. Barbara Katz Rothman, a sociologist and professor in New York, points out that there is a language of danger about pregnancy and birth—that no pregnancy or birth is considered a healthy one, but one associated with risk (2014). She states, "…the best you can hope for is a low-risk pregnancy" (p. 2).

Medical Interventions

The United States have observed fewer maternal and infant deaths due to some necessary medical intervention; though, other medical interventions have become routine, such as fetal monitoring and placing IVs into the arms of the birth mothers, despite lack of empirical evidence showing that they provide any sort of benefit or risk (Kukla & Wayne, 2015). The rates of medical interventions are quite telling if one takes the time to look. In the United States, the rate for cesarean sections are 32.9%—that is over twice the amount the World Health Organization considers harmful and excessive (Every Mother Counts, 2014). Researchers Declercq, Sakala, Corry, Applebaum, and Herrlich (2013) found that, of mothers that responded to a national survey, 41% of women were induced by their caregivers, out of which 74% successfully began to labor. Many of the same women also indicated that the reasons for induction were for convenience sake, such as the baby already being full term or for timing purposes. Only 17% of mothers that responded to the survey abstained from pain medication, while 83% used some sort of pain relief (e.g. epidural) for labor. Additionally, mothers reported many other interventions they experienced; vaginal exams, IV fluids, catheters, synthetic oxytocin (Pitocin, to speed up labor), water breaking, and episiotomy (surgical cutting of the vagina), to name the most

prevalent interventions. Similarly to other reported rates of cesarean sections in the United States, responding women indicated a 31% cesarean rate. Two in five mothers delivered babies with assistance of forceps or vacuum suction. Only 73% of women attempted non-medical interventions in pain relief, such as breathing techniques or massages (which is not to say that these women had not already received pharmacological pain relief).

Shift from Midwife to Obstetrician

Heather Cahill (2000) points out that the decline of the midwife and rise of the obstetrician began in the 17th century, whereby medicine had transformed into a legal monopoly by the 18th century. She explains that those who practiced medicine organized themselves into an occupational group called 'doctors' and gave themselves the title of 'professional'. Consequently, all others that were unlicensed and without this title, including midwives, were actively and aggressively discredited by the medical community. Cahill posits that as the number of hospitals and doctors grew, so did the need for patients—in order to draw in business (i.e. patients), doctors needed to devalue midwifery and emphasize their 'knowledge' and 'expertise' in science and medicine while offering alternative, 'superior' methods in the childbirthing process.

Susanne Klausen (2013) further expands that the occupational group of 'doctors' continued to branch into specialties, out of which obstetrics was born. Obstetricians became an attractive option for pregnant women, she explains, if they could afford them—aggressive marketing by the physicians, as well as the number of women that were becoming increasingly aware of the perceived less painful and more efficient birth doctors could provide, made that a reality. Pregnant women by the 19th century were giving birth with the assistance of pain killers, cesarean sections, and tools utilized by the obstetricians managing their childbirth—Klausen

states that "in 1900, less than 5% of births nationwide were hospitalized" (pg. 1), but by 1955 that percentage rose to the rate we see today. So, expecting mothers were plucked from the supportive, experienced hands of their female support systems, such as mothers, friends, neighbors, and midwives, and placed into the arms of physicians who "heightened their fears about what lay ahead and rendered them all the more reliant upon their doctors for advice…" (pg. 1).

Women's Empowerment in Birth

Often women find birth to be extremely empowering: giving birth is a phenomenon that only women experience, and is an experience that traditionally has been navigated and assisted by other women. Midwives often consider childbirth to be a rite of passage that is certainly very transformative, but medicalized birth minimizes the control a woman has in her own labor and ultimately harms the way she experiences herself becoming a mother through the birthing process (Uppal et al., 2016). Indeed, Deborah Talbot (2014) states that there is a relationship between a mother's transition into motherhood and her experience in childbirth; that women's narratives of what constitutes a 'good birth' are births in which the mother feels dignified, respected, and free from medical trauma. Talbot explains that high levels of medical intervention increase the risk of mothers becoming depressed and experiencing post-traumatic stress disorder after birth—which she posits may be a result of a decreased sense of "motherhood" (p. 855).

Furthermore, Uppal et al., (2016) explain that medical intervention and the medicalization of birth is damaging to women's confidence in their ability to give birth. They state that our culture fears pregnancy and birth, and what may happen in labor. The two are related and by no coincidence—the normalization of medicalized birth informs women on how

they should feel about giving birth, i.e. fearful. However, women who resist the medical model of birth and its authority, and find agency in their own birthing process, are the women who are likely to feel extremely empowered. In the next section, we explain how reality television further complicates the medicalization of birth.

Reality Television

Sears and Godderis (2011) define reality TV as a genre that intends to portray the real, ordinary lives of people. They also explain Pecora's three categories of reality TV: crime oriented or emergency, intimacy or relationship oriented, and lifestyle surveillance of the day-to-day. Sears and Godderis state that reality television's importance is two fold. First, reality television reveals cultural norms and behaviors by reproducing them in its content. Second, it reinforces cultural norms and behaviors through its portrayals of individuals as well as their decisions and behaviors.

According to Sears and Godderis (2011), there are motivating factors for individuals that watch reality television. They explain that television portrays the lives of ordinary individuals allowing viewers to judge the lives of participants while also fantasizing about the possibility of the ordinary becoming a celebrity. Part of the thrill of watching reality television is that viewers are able to insert themselves into the lives of the participants through the surveillance space that reality television offers. The surveillance space, then, is a means for the viewer to experience thrill and enjoyment from watching the lives of the participants. Another motivating factor may be the fantasy element derived from ordinary viewers surveying the lives of the ordinary with celebrity status from being on television.

Reiss and Wiltz (2004) support Sears and Godderis's (2011) observation that the ordinary, fantasizing about becoming celebrity is a motivating factor for watching reality TV. A

study by Reiss and Wiltz (2004) indicates that personal interests may influence which, if any, reality television shows are watched. The study shows that viewers watch reality tv shows to help satisfy their basic desires. Reiss and Wiltz discuss the temporary nature in which basic desires are satisfied where quickly after a desire is satisfied, the desire is renewed and must be satisfied. Reality television may be easy way to continuously satisfy desires; viewers can watch reality television shows that align with their values as a way to meet their basic desires quickly and multiple times over. Reiss and Wiltz found that status and vengeance were the main basic desires that motivated reality television observance (2004).

It is important to question the authenticity of reality television as "reality." Based on Sears and Godderis's (2011) ideas about surveillance, we can question the legitimacy of reality television in its portrayal of reality. Sears and Godderis connect Focault's (1997) idea of the panopticon, or the circular prison where anonymous surveillance is used as a form of imprisonment or punishment, with ideas of surveillance through reality television, creating an idea of an electronic panopticon where the surveillance as imprisonment is electronically performed through the vehicle of reality television. The participants are aware of the cameras and therefore the anonymous gaze. Therefore, we know that reality TV can be constructed with the anonymous gaze of the viewer in mind. Sears and Godderis (2011) state:

> The very act of observing people, the presence of the television camera, and the editing process all effect what is actually viewed as an end product and, hence, what reality is being portrayed. Thus, scholars have argued that reality TV does not reflect reality but rather redefines reality into a narrative for programming purposes (p.182).

Birth in Reality Television

The media, while compounding the medicalization of birth, is one of the most popular resources consumed by women (Young & Miller, 2015). It is a concern, then, that reality TV disproportionately promotes medicalized birth with nearly no mention of alternative birthing methods while also endorsing ideas of birth as dangerous (Young & Miller, 2015; Uppal, Davies, & Knowles, 2016). In the case of reality television, birth is often portrayed as excruciatingly painful, frightening, and dangerous—mothers cry, scream, and appear exhausted during labor, even after the use of pain relieving measures, such as an epidural. In tandem, women's confidence in their ability to have a baby has declined (Uppal, Davies, & Knowles, 2016). Overall, reality television reinforces ideas of birth as dangerous while simultaneously reinforcing medical models of birth (Young & Miller, 2015; Uppal, Davies, & Knowles, 2016). Additionally, Young and Miller (2015) state that women are more likely to accept medical intervention when they have negative expectations of labor and birth despite evidence that absence of medical intervention in low-risk births is beneficial to mother and baby.

It is of importance to discuss the significance of reality television because it can serve to reinforce cultural norms, behaviors, and perceived risks and attitudes regarding birth (Uppal, Davies, & Knowles, 2016). We can utilize Sears and Godderis's (2011) ideas of the electronic panopticon to understand how reality television is constructed to shape these cultural norms, behaviors, and perceived risks and attitudes regarding birth. The purpose of this study is to examine how labor and birth are portrayed as dangerous on a mainstream reality television series called *One Born Every Minute*.

Method

Content

For this research, we conducted a feminist, qualitative media analysis of the reality television series *One Born Every Minute*. Our data collection included watching season one, of which the last four episodes of that season were analyzed. Selection of season one and analysis of the last four episodes was based upon ease of availability of episodes viewable online, as well as the consensus that analyzing the pilot season may ensure the most authentic content. All four episodes were 45 minutes in length and each episode featured labor and birthing experiences of three women.

Data Collection and Analysis

The four of us researchers individually watched all four episodes twice. After watching all four episodes individually, we cross-checked our data collection to ensure accuracy and consistency between all four researchers. When inconsistencies were found, all researchers watched the episode in question for a third time to ensure consensus among all four researchers.

The research questions posed for this research were: 1) How often is birth portrayed as dangerous in the reality TV show *One Born Every Minute*?, and 2) Who are presented as decision makers during labor and birth? Specifically, is it the birthmother making decisions in her birthing process, or her medical staff and support system? Additionally, because interpretation of danger is a matter of the viewer's perception in the media, the construct of danger proposed in this research was measured by the frequency of medical interventions and the music dramatization of those scenes in order to answer our first research question.

To analyze our data, we coded the number of medical interventions performed on each woman and recorded specifically what type of intervention was performed, focusing on both medicalized or non-medicalized interventions. Next, we recorded whether or not consent was shown for each intervention performed, paying close attention to who specifically gave the

consent. Dramatization of music during each intervention was recorded as either dramatic, somewhat dramatic, relaxing, silly, sad, no music, or other in order to gauge our perception of the level of danger as viewers and to explore which interventions might receive the most attention in terms of dramatic music (see Appendix). Recording dramatization of music as dramatic, somewhat dramatic, relaxing, silly, sad, no music, or other was based upon tempo and pitch and conclusively determined by unanimous consensus among all four researchers after analyzing each episode to ensure consistency. The categories for music dramatization were selected based on how we anticipated viewers may most often perceive the music played during interventions, and how that might affect which interventions receive the most attention.

Intersectionality Theory and Reflexivity

According to Kimberle Crenshaw (1991), intersectionality refers to an attempt to understand how different social categories of one's life, such as race, gender, sexuality, and class, work together independently and simultaneously to create a different experience from one individual to the next. We incorporated intersectionality theory into our study by exploring how ethnicity was shaped in *One Born Every Minute*. We recorded the ethnicity of the birthmothers to allow us to compare the use of medical interventions and consent between women of color and white women. By incorporating ethnicity into our data collection, we could analyze whether or not one group of women was more or less likely to be empowered or receive medical interventions than the other.

Reflexivity is the process of recognizing and understanding how each researcher's background and experiences can influence the study (Hesse-Biber, 2014) and each student researcher for this study were particularly careful to remain reflexive throughout the research

process. Each of us examined how our own experiences and ideas about motherhood, or lack thereof, might intersect with each other's to impact our questions, interpretation, and analysis.

Results

Medical Interventions

Given the fact birth is predominantly medicalized in the United States, it is no surprise that medical interventions were performed significantly more often than any nonmedical intervention in *One Born Every Minute*, although the higher numbers still raise concern. There were six types of medical interventions and five types of non-medical interventions observed, and subsequently measured, across all 12 women in the four episodes. The 12 women in the episodes experienced 38 total interventions combined across all four episodes (see Table 1).

Table 1:

Intervention Type and Frequency

Intervention Type (M = Medicalized, NM = Non-Medicalized)	**Frequency of Interventions**
IV (M)	12/12 birth mothers
Epidural (M)	6/12 birth mothers
Fetal Monitoring (M)	4/12 birth mothers
Cesarean Section (M)	4/12 birth mothers
Breaking of Water (M)	3/12 birth mothers
Oxygen (M)	2/12 birth mothers
Ted Socks (NM)	2/12 birth mothers
Ball (NM)	2/12 birth mothers

Shower (NM)	1/12 birth mothers
Massage (NM)	1/12 birth mothers
Sheet Pull (NM)	1/12 birth mothers

The number of medical interventions performed versus non-medical interventions is disconcerting. There was an average of 2.6 medical interventions per woman as opposed to an average of 0.58 non-medical interventions per woman, or an average of 3.2 interventions total.

Interestingly, ethnicity appeared to be a factor in the number of interventions performed; the number of interventions decreased among nonwhite women. Rather, there was an average of 3.4 interventions performed on white women compared to an average of three interventions performed on African American women, with the Hispanic woman having the least amount of interventions performed at an average of two (see Table 2).

Table 2

Relationship Between Ethnicity, Frequency of Medical Intervention, and Consent

White Women n=8	**African American n=3**	**Hispanic n=1**
27 medical interventions	9 medical interventions	2 medical interventions
10 instances of consent shown	4 instances of consent shown	0 instances of consent shown
37% of the time, consent was shown	44% of the time, consent was shown	0% of the time, consent was shown

Music Dramatization

Music dramatization during intervention scenes were highly variable and the meaning of this is not clear to us (see Figure 1).

Curiously, non-medical interventions were slightly more consistent in music dramatization. During non-medical interventions, music dramatization was almost always 50%-100% silly or relaxing.

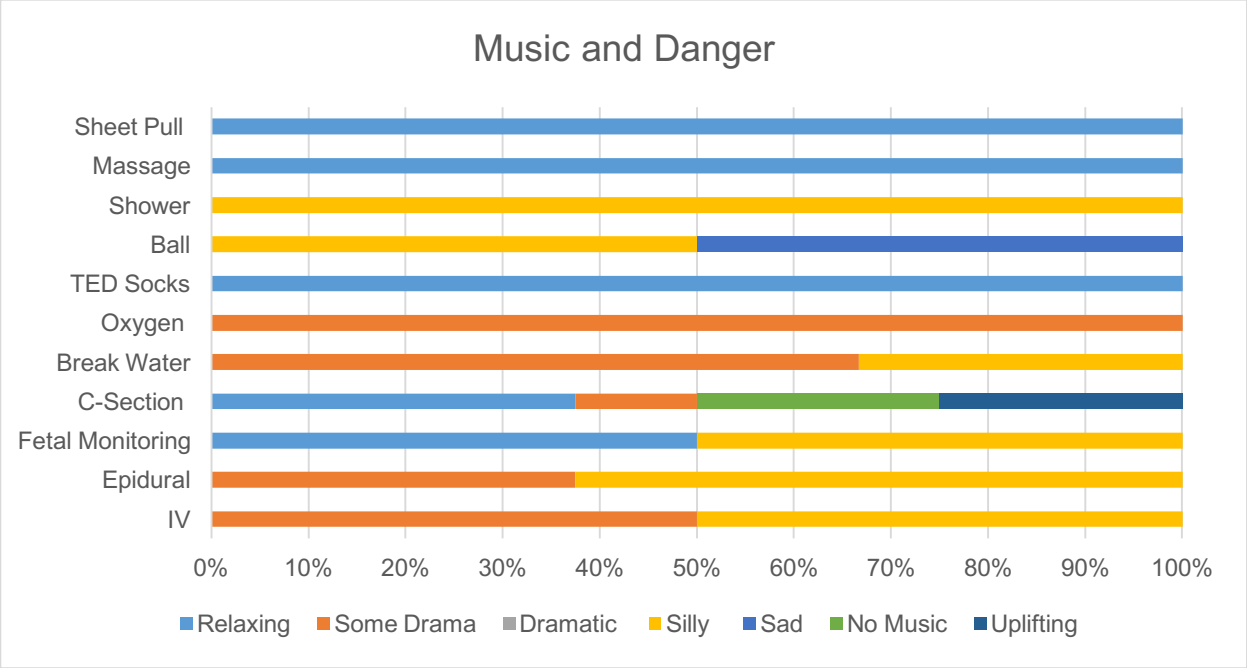

Figure 1. Music and danger. This figure illustrates the type of music dramatization during interventions that occurred.

Consent

There were 38 total interventions shown across the 12 women featured—a shocking number of those interventions were not preceded by consent. Of the 38 interventions shown, there were only 14 instances of consent shown which means that 37% of the time birthmothers were presented as decision makers. However, the other 24 instances out of the 38 interventions

shown were shown without consent which means that 63% of the time birthmothers *were not* presented as decision makers.

The numbers are more troubling as they are broken down; out of the eight white women, consent was shown ten times. Out of the three African American women, consent was shown four times. Lastly, the Hispanic woman was never shown to consent (see Table 2).

Discussion

Based on the results obtained from our research, we can see that the number of medical interventions shown versus the number of nonmedical interventions shown inform the viewer about *what type* of intervention reduces danger in birth. The television series *One Born Every Minute* presents birth as dangerous and suggests medical intervention is necessary for a safe delivery. Due to the average of 2.6 medical interventions and less than one non-medical intervention per woman in the episodes we analyzed, we can infer that the representation and prevalence of these interventions suggests that medical interventions are what effectively reduce danger in birth and that any additional non-medical interventions performed are merely options if the mother so chooses.

Considering ethnicity in relation to the number of interventions performed, we observed that the number of interventions decreased when the birth mother was a woman of color. Although the number of women of color was small in comparison to white women featured in the episodes, the subtle message remains that women of color are afforded less quality care. In a country that values and chooses medicalized birth for its convenience and perceived safety, one would believe that all women are offered the same interventions when necessary or appropriate. However, we need only look at the average number of interventions white women received compared to the average number women of color received to see that this is not the case. This is

an indication of one of the few disparities women of color face during the birthing process as compared to white women.

When women are only presented as the decision maker 37% of the time, we see that this show reinforces the disempowerment of women to make their own competent and informed decisions about their birth and during labor. At the same time, it informs the viewer that what is routine does not require consent. When women are not shown to give consent 63% of the time, the indirect message is that the consent did not matter because the intervention was considered necessary.

There was not a lot of diversity in terms of ethnicity featured in the episodes analyzed. There were four women of color across all four episodes—three African American women and one Hispanic woman. Lack of representation of women of color in the media is not a surprising finding, but this is problematic in terms of how viewers interpret the representation of birthmothers in the media. It is important to note, as well, that the number of times consent was given for the African American women featured on the show would have been drastically lower if it had not been for one of the African American birthmothers being extremely terrified of needles, therefore scenes shown for that mother emphasized her fear and her consent for her interventions. More inclusion of women of color in the media, and specifically this television series, must be addressed. Additional research must be done across more episodes in order to get a more thorough picture of any disparities women of color might face during childbirth and how women of color that may be viewing the media are informed during these representations.

Surprisingly, there were no intervention scenes in which dramatic music was perceived by any of the researchers conducting this research. The worst label any intervention scene was given was 'somewhat dramatic', which is something we did not expect given the nature of this

reality television series. In fact, many intervention scenes were characterized by what we perceived to be relaxing or silly music. The highly variable nature of music dramatization types that characterized the interventions left us with many questions. For example, sometimes cesarean section intervention scenes were highlighted with relaxing music, other times with somewhat dramatic music, and sometimes with uplifting music. Sometimes while the medical staff broke water, somewhat dramatic music played and sometimes silly music played. There is something to be said about what this means, however, there is not enough data to support any conclusions about music dramatization from the episodes analyzed for this research. More research must be done to address the implications of how types of music are perceived during specific interventions. An analysis focusing on music dramatization should include a larger selection of episodes or seasons to adequately capture the nuances of the music.

Lastly, we must consider that there were interventions likely performed that we could not measure because they were not explicitly shown. For example, Pitocin is a drug that speeds up contractions in labor and is frequently administered via IVs, and because the administration of IVs was not shown (except for one mother because of her extreme fear of needles), it is likely we missed many instances of this medical intervention. Episiotomies (a surgical incision at the vagina) are also performed quite frequently, but because of the censored nature of reality television and the focus being on the mother holding her newly born child after birth, we rarely even see the tiniest glimpse on camera of medical professionals working on the vagina after delivery and we never see the incision being made.

It is critical to understand that we do not choose the content we see on reality television. Someone had carefully cut and edited the scenes viewers consume on *One Born Every Minute*. Therefore, the implication of our findings is that the executive decision by the producers to

exclude some interventions and consent from being observed means the ones we are actually shown should be regarded as more important than the others. The scenes in which empowerment may be observed were not shown frequently, for example: scenes where birth mothers give firm consent or ask questions about risks or benefits of the interventions being performed were not depicted frequently in the episodes we analyzed. In terms of danger, it is clear that that the message we receive from the many scenes of medical interventions shown is that safe delivery is a result of the medical staff and availability of all the interventions they have at hand.

Limitations

When conducting a media content analysis there can be many limitations. The media content analysis relies heavily on what images are selected to be shown by the producer. This in turn limits the research that can be accurately conducted. For example, twelve women received an IV; however, the process of getting the IV placed was only shown for one mother and it could be assumed that the only reason it was shown was to emphasize the fear the mother had for needles. Scene cutting leaves the researcher and audience with limited information to interpret what really happened and how each mother is empowered when encountering medicalized procedures. The trends observed and analyzed in the media content analysis may not portray an accurate description of what happened before scenes were cut and spliced. Scene cutting suggests a storyline that fits the producer's objectives of a selected reality that is geared towards increasing the ratings. Dramatic events were emphasized whereas relaxing, peaceful moments may not have been, and vice versa.

The time available to conduct this study was a limitation. Our analysis was limited to four episodes of one reality television show and we watched episodes in only one of its seasons. We chose to analyze the last four episodes of the first season due to ease of access and availability of

viewing, and that in and of itself was a limitation. Perhaps analyzing a full season, multiple seasons, or multiple reality television shows would potentially have given us deeper insight into the disempowerment or empowerment of women, as well as the medicalization of birth, during the birthing process.

The interpretation of the data is also impacted by the individual researcher's personal exposure to birth and pregnancy and thus serves as another limitation. Naturally, researchers analyze and process information based on an individual standpoint. This is why reflexivity is important. The education and experience each researcher possesses limits the research. If all researchers were to have the same basic foundation of knowledge on the birthing experience or pregnancy, the data collected may have an even more unbiased approach. Personal experience or knowledge could potentially lead an observer to infer more often than those who have not had equal experience or knowledge.

Future Directions

This study provides several possibilities for future research. For example, researchers could examine how medical staff's interaction with birth mothers impacts the number of medical interventions performed on reality television. Language utilized by medical staff is a powerful tool. Verbal and nonverbal communication of medical staff directed towards a mother may reflect how language used by medical staff can impact or reinforce medicalization of the birthing experience for mothers in hospitals. An analysis of this language could provide insight regarding how language affects the number of medical interventions facilitated as well as the overall experience of the birthing process for the mother in relation to empowerment and consent.

Particularly interesting research could also be conducted on music dramatization during interventions and labor in the media. Including data on and analyzing music dramatization for the scope of this study was far more complicated than we had anticipated and is a considerable research project in and of itself. This future research could focus on the way women of color are characterized by certain types of music in the birthing process or expand further on the implications of presenting certain types of music for specific interventions and during labor. For example, women of color were presented with silly music much of the time in intervention scenes or while they were shown to be interacting with their families. Also, there were many scenes that allocated relaxing music to highly medicalized procedures such as cesarean sections and silly music to non-medical interventions. Research could be done to detangle the deeper meaning behind many of these subtleties and seemingly unimportant details.

In *One Born Every Minute*, scenes were selected to demonstrate the staff making light of their work day by minimizing the emotional experiences of the laboring mothers in the remarks they made away from them with other staff members, as well as gossiping about them and their families. Medical staff were repeatedly playing in the hallways, making jokes to one another, or gossiping about the mothers who were in labor. Portrayals such as this send a profound message to the viewer of what the level of professionalism is for medical staff as well as demonstrate what is deemed as acceptable behavior for a mother giving birth. In reality, no two birthing experiences are identical. For example, comments by medical staff shown about a mother or to a mother about her decision to omit the use of medication during the birthing process could subliminally send a message of either empowerment or disempowerment during labor and delivery. The portrayal of the medical staff mocking or making fun of this decision potentially sends a message of what the "norm" is in relation to medicated births.

Lastly, future research could focus on how male birth fathers are portrayed as a support system in the media. Historically, men have not always been a part of the birthing process. Today men are often invited into the experience of bringing a child into the world. During our analysis we noticed that the male birth fathers were often portrayed as absent, temporarily absent or shown to have strange behaviors while the mother was in labor. Future directions to explore this may include analyzing how the media shapes a masculine or father role during the birthing process.

Conclusion

Throughout our research we have observed how portrayals of birth in the reality television series *One Born Every Minute* represent childbirth in a highly medicalized, and dramatized, manner. It is clear that much more credit is given to medical interventions and their ability to provide a safe birth as portrayed by the media than non-medical interventions. Meanwhile, this research, in its focus on decision making and consent during reality television's portrayals of birth, contributes to the discussion surrounding empowerment during birthing experiences, or the lack thereof. We have recognized through our analysis that women are not presented as primary decision makers most of the time, and that women of color are even less likely to be shown as decision makers compared to white women. Neglecting to depict women as decision makers reinforces the patriarchal nature of the hegemonic model of medicalized childbirth, as well as the belief that medical intervention is necessary to have a safe delivery.

Activism

Since our analysis found that during the birthing process women are not shown as primary decision makers a significant amount of the time, it is important to incorporate ways to find empowerment during the birthing process. We would like to highlight a few methods of

activism that women can incorporate into their birthing experiences in order to increase the chance that empowerment will be observed in the process of giving birth.

A birth plan is a written document a woman discusses with her practitioner and medical staff presenting her desires and expectations for delivery. It is important to discuss these plans with medical personnel to make sure that it is a safe and reasonable plan. In the episodes watched, only one woman had a birth plan, and unfortunately she had forgotten it at home. For the remainder of the show, the medical staff were shown making jokes about her and the fact that she had left her birth plan at home, meaning that she could no longer control her birth as she had wanted. Had she not forgotten it and had it on hand at the hospital, perhaps she could have found more of a sense of control and empowerment in her delivery.

Another way to find empowerment during the birthing experience is hypnobirthing. Hypnobirthing is a relaxation method meant to empower the woman, partner, and medical personnel in any setting. Hypnobirthing teaches how to deal with the pain and stress of labor and delivery through breathing, relaxation, meditation, and visualization techniques (Hypnobirthing, 2016). This technique is taught in classes which can be practiced in any setting to allow for a more peaceful and relaxing birthing experience.

Looking for ways to empower oneself during labor and delivery is important, but so is advocating for policy, education, and resources for women and mothers. Mothers of Change is a non-profit agency in Canada that focuses on advocating for positive birthing experiences for both the mother and the baby. Founded in May 2010, Mothers of Change is a group primarily made of women and mothers that want to advocate for women's rights when it comes to their experiences, education of the process and options available, and resources to make options available to all mothers (Hennessey, 2010).

Creating and honoring a birth plan, hypnobirthing, and joining an advocacy group are ways women can increase the occurrence of empowerment during birth. We hope that this study contributes to the conversation surrounding women's empowerment during birth and helps to provide women with options for empowerment within their birthing experiences.

Appendix: Content Analyses of *One Born Every Minute*

Content Analysis Chart: One Born Every Minute	**Episode #**	**Date Watched**	**Episode Length**
Episode Name: Mission Impossible	5	3/2/16	42:56:00
Name of Birthmother:	Susan	Vanessa	Angela
Age of Birthmother:	38	22	35
Relationship status :	Married	Partner	Married
Assumed Ethnicity:	White	African American	White
Name of Birthfather:	Mark	Erin	Ben
Age of Birthfather:	40	27	36
Assumed Ethnicity of Birthfather:	White	African American	White
Name of Birthmother:	Susan	Vanessa	Angela
Birthmother's Medical Intervention 1	Planned C-sec	IV Line	Broke Water
Was consent of this intervention shown? Y or N	N	N	N
If yes, who gave consent?	N/A	N/A	N/A
Were risks shared? Y or N	N	N	N
Were benefits shared? Y or N	N	N	N
Was this used for pain management? Y or N	N	N	N
Was this used for induction? Y or N	N	N	Y
Did you observe persuasion? Y or N	N	N	N
Stage of Labor: (mark with an X)			
1-3cm Early Labor	N/A	X	X
3-7cm Active labor	N/A		
7-10 Transition	N/A		
Perceived level of danger: (mark with X)			
No perceived danger	X	X	X
Moderately dangerous			
High danger			
Music dramatization during this intervention level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3	X	X	
Silly =4			X

other =5 Describe in notes	X (uplifting)		
Name of Birthmother:	Susan	Vanessa	Angela
Birthmother's Medical Intervention 2	N/A	Broke water	Epidural
Was consent of this intervention shown? Y or N		N	Y
If yes, who gave consent? (Name)		N/A	Birthmother
Were risks and benefits shared? Y or N		N	N
Was this used for pain management? Y or N		N	Y
Was this used for induction? Y or N		Y	N
Did you observe persuasion? Y or N		N	N
Stage of Labor: (mark with X)			
1-3cm Early Labor			
3-7cm Active labor		X	X
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger			X
Moderately dangerous		X	
High danger			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2		X	
Relaxing =3			
Silly =4			X
other =5 Describe in notes			
Name of Birthmother:	Susan	Vanessa	Angela
Birthmother's Medical Intervention 3	N/A	Epidural	IV Line
Was consent of this intervention shown? Y or N		Y	N
If yes, who gave consent?		Birthmother	N/A
Were risks and benefits shared? Y or N		Y	N
Was this used for pain management? Y or N		N	Unknown
Was this used for induction? Y or N		Y	N
Did you observe persuasion? Y or N		N	N
Stage of Labor: (mark with X)			

1-3cm Early Labor			X
3-7cm Active labor		X	
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger			N/A
Moderately dangerous		X	N/A
High danger			N/A
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2		X	
Relaxing =3			
Silly =4		X	
other =5 Describe in notes			N/A
Name of Birthmother:	Susan	Vanessa	Angela
Birthmother's NON- Medicalized Intervention	TED Socks	N/A	Shower
Was consent of this intervention shown? Y or N	Y		Y
If yes, who gave consent? Y or N	Birthmother		Birthmother
Were risks and benefits shared? Y or N	Y		N
Was this used for pain management? Y or N	N		Y
Was this used for induction? Y or N	N		N
Did you observe persuasion? Y or N	N		N
Stage of Labor: (mark with X)			
1-3cm Early Labor	X		
3-7cm Active labor			X
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger =3	X		X
Moderately dangerous =2			
High danger =1			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2			

Relaxing =3	X		
Silly =4			X
other =5 Describe in notes			

Content Analysis Chart: One Born Every Minute	**Episode #**	**Date Watched**	**Episode Length**
Episode Name: Patience is the Name of the Game	6	3/2/16	42
Name of Birthmother:	Kim	Megan	Marcella
Age of Birthmother:	36	26	20
Relationship status :	Married	Single	Partner/boyfriend
Assumed Ethnicity:	White	White	Hispanic
Name of Birthfather:	Tom	N/A	Tim
Age of Birthfather:	41	N/A	22
Assumed Ethnicity of Birthfather:	White	N/A	African American
Name of Birthmother:	Kim	Megan	Marcella
Birthmother's Medical Intervention 1	IV line	IV line	IV line
Was consent of this intervention shown? Y or N	N	N	N
If yes, who gave consent?	N/A	N/A	N/A
Were risks shared? Y or N	N	N	N
Were benefits shared? Y or N	N	N	N
Was this used for pain management? Y or N	Unknown	Unknown	Unknown
Was this used for induction? Y or N	N	N	N
Did you observe persuasion? Y or N	N/A	N/A	N/A
Stage of Labor: (mark with an X)			
1-3cm Early Labor	X	X	X
3-7cm Active labor			
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger	X	X	X
Moderately dangerous			
High danger			
Music dramatization during this intervention level: (mark with X)			
Dramatic =1			
Some Drama=2			

Relaxing =3			
Silly =4			
other =5 Describe in notes	N/A	N/A	N/A
Name of Birthmother:	Kim	Megan	Marcella
Birthmother's Medical Intervention 2	Epidural	Epidural	N/A
Was consent of this intervention shown? Y or N	Y	Y-requested	
If yes, who gave consent? (Name)	Birthmother	Birthmother	
Were risks and benefits shared? Y or N	N	N	
Was this used for pain management? Y or N	Y	Y	
Was this used for induction? Y or N	N	N	
Did you observe persuasion? Y or N	N	N	
Stage of Labor: (mark with X)			
1-3cm Early Labor	X	X	
3-7cm Active labor			
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger	X	X	
Moderately dangerous			
High danger			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3			
Silly =4		X	
other =5 Describe in notes	N/A		
Name of Birthmother:	Kim	Megan	Marcella
Birthmother's Medical Intervention 3	Unplanned C-Sec	Fetal Monitor	Fetal Monitor
Was consent of this intervention shown? Y or N	Y	Y	N
If yes, who gave consent?	Birthmother	Birthmother	N/A
Were risks and benefits shared? Y or N	Y	N	N
Was this used for pain management? Y or N	N	N	N

Was this used for induction? Y or N	N	N	N
Did you observe persuasion? Y or N	Y	N	N
Stage of Labor: (mark with X)			
1-3cm Early Labor		X	X
3-7cm Active labor			
7-10 Transition	X		
Perceived level of danger: (mark with X)			
No perceived danger		X	X
Moderately dangerous	X		
High danger			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2	X		
Relaxing =3	X		
Silly =4		X	X
other =5 Describe in notes			
Name of Birthmother:	Kim	Megan	Marcella
Birthmother's NON- Medicalized Intervention	Sheet Pull	Bouncy Ball	N/A
Was consent of this intervention shown? Y or N	N	N	
If yes, who gave consent? Y or N	N/A	N/A	
Were risks and benefits shared? Y or N	N	N	
Was this used for pain management? Y or N	N	Unsure	
Was this used for induction? Y or N	N	N	
Did you observe persuasion? Y or N	N	N	
Stage of Labor: (mark with X)			
1-3cm Early Labor		X	
3-7cm Active labor			
7-10 Transition	X		
Perceived level of danger: (mark with X)			
No perceived danger =3	X	X	
Moderately dangerous =2			
High danger =1			
Music dramatization level: (mark with			

X)			
Dramatic =1			
Some Drama=2			
Relaxing =3	X		
Silly =4			
other =5 Describe in notes		X (sad)	

Content Analysis Chart: One Born Every Minute	**Episode #**	**Date Watched**	**Episode Length**
Episode Name: Fear is a Four Letter Word	7	3/4/16	42
Name of Birthmother:	Dionne	Felicia	Amber
Age of Birthmother:	33	22	33
Relationship status :	Married	Married	Married
Assumed Ethnicity:	White	African American	White
Name of Birthfather:	Ray	Larry	Ryan
Age of Birthfather:	39	21	36
Assumed Ethnicity of Birthfather:	White	African American	White
Name of Birthmother:	Dionne	Felicia	Amber
Birthmother's Medical Intervention 1	IV Line	IV Line	Planned C-section
Was consent of this intervention shown? Y or N	N	Y 5:44	N
If yes, who gave consent?	N/A	Birthmother	N/A
Were risks shared? Y or N	N	N	N
Were benefits shared? Y or N	N	N	N
Was this used for pain management? Y or N	Unknown	Unknown	N
Was this used for induction? Y or N	N	N	N
Did you observe persuasion? Y or N	N/A	N/A	N/A
Stage of Labor: (mark with an X)			
1-3cm Early Labor	X	X	X
3-7cm Active labor			
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger	X	X	
Moderately dangerous			X

High danger			
Music dramatization during this intervention level: (mark with X)			
Dramatic =1			
Some Drama=2		X	X
Relaxing =3			
Silly =4		X	
other =5 Describe in notes	N/A		
Name of Birthmother:	Dionne	Felisha	Amber
Birthmother's Medical Intervention 2	Epidural	Epidural	Fetal Monitors
Was consent of this intervention shown? Y or N	N	Y	N
If yes, who gave consent? (Name)	N/A	Birthmother	N/A
Were risks and benefits shared? Y or N	N	Y	N
Was this used for pain management? Y or N	Y	Y	N
Was this used for induction? Y or N	N	N	N
Did you observe persuasion? Y or N	N	Y 19:05- 19:40	N
Stage of Labor: (mark with X)			
1-3cm Early Labor	Unknown		X
3-7cm Active labor	Unknown	X	
7-10 Transition	Unknown		
Perceived level of danger: (mark with X)			
No perceived danger	X		X
Moderately dangerous		X	
High danger			
Music dramatization level: (mark with X)			
Dramatic =1	N/A		
Some Drama=2	N/A	X	
Relaxing =3	N/A		X
Silly =4	N/A		
other =5 Describe in notes	N/A		
Name of Birthmother:	Dionne	Felisha	Amber
Birthmother's Medical Intervention 3	Oxygen	N/A	IV (26:09)
Was consent of this intervention shown? Y or N	N		N
If yes, who gave consent?	N/A		N/A

Were risks and benefits shared? Y or N	N		N
Was this used for pain management? Y or N	N		Unknown
Was this used for induction? Y or N	N		N
Did you observe persuasion? Y or N	N		N
Stage of Labor: (mark with X)			
1-3cm Early Labor			X
3-7cm Active labor	X		
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger			N/A
Moderately dangerous	X		N/A
High danger			N/A
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2	X		
Relaxing =3			
Silly =4			
other =5 Describe in notes			N/A
Name of Birthmother:	Dionne	Felisha	Amber
Birthmother's NON- Medicalized Intervention	Massage	N/A	N/A
Was consent of this intervention shown? Y or N	N		
If yes, who gave consent? Y or N	N/A		
Were risks and benefits shared? Y or N	N		
Was this used for pain management? Y or N	Y		
Was this used for induction? Y or N	N		
Did you observe persuasion? Y or N	N		
Stage of Labor: (mark with X)			
1-3cm Early Labor			
3-7cm Active labor	X		
7-10 Transition			
Perceived level of danger: (mark with X)			

No perceived danger =3	X		
Moderately dangerous =2			
High danger =1			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3	X		
Silly =4			
other =5 Describe in notes			

Content Analysis Chart: One Born Every Minute	**Episode #**	**Date Watched**	**Episode Length**
Episode Name: Miracles Do Happen	8	3/4/16	42:56:00
Name of Birthmother:	Amanda	Tiana	Samantha
Age of Birthmother:	20	32	22
Relationship status :	Married	Married	Single
Assumed Ethnicity:	White	African American	White
Name of Birthfather:	Tim	Fola	N/A
Age of Birthfather:	21	36	N/A
Assumed Ethnicity of Birthfather:	White	Nigerian	N/A
Name of Birthmother:	Amanda	Tiana	Samantha
Birthmother's Medical Intervention 1	IV Line	IV Line	IV Line
Was consent of this intervention shown? Y or N	N	N	N
If yes, who gave consent?	N/A	N/A	N/A
Were risks shared? Y or N	N	N	N
Were benefits shared? Y or N	N	N	N
Was this used for pain management? Y or N	Unknown	Unknown	Unknown
Was this used for induction? Y or N	N	N	N
Did you observe persuasion? Y or N	N	N	N
Stage of Labor: (mark with an X)			
1-3cm Early Labor	X	X	X
3-7cm Active labor			
7-10 Transition			
Perceived level of danger: (mark with X)			

No perceived danger	X	X	X
Moderately dangerous			
High danger			
Music dramatization during this intervention level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3			
Silly =4			
other =5 Describe in notes	N/A	N/A	N/A
Name of Birthmother:	Amber	Tiana	Samantha
Birthmother's Medical Intervention 2	N/A	Oxygen	Broke Water
Was consent of this intervention shown? Y or N		Y	N
If yes, who gave consent? (Name)		Birthmother	N/A
Were risks and benefits shared? Y or N		N	N
Was this used for pain management? Y or N		N	N
Was this used for induction? Y or N		N	N
Did you observe persuasion? Y or N		N	N
Stage of Labor: (mark with X)			
1-3cm Early Labor			X
3-7cm Active labor			
7-10 Transition		X	
Perceived level of danger: (mark with X)			
No perceived danger		X	X
Moderately dangerous			
High danger			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2		X	X
Relaxing =3			
Silly =4			
other =5 Describe in notes			
Name of Birthmother:	Amanda	Tiana	Samantha
Birthmother's Medical Intervention 3	N/A	Fetal Monitoring	Planned C-Section

Was consent of this intervention shown? Y or N		N	N
If yes, who gave consent?		N/A	N/A
Were risks and benefits shared? Y or N		N	N
Was this used for pain management? Y or N		N	N
Was this used for induction? Y or N		N	N
Did you observe persuasion? Y or N		N	N
Stage of Labor: (mark with X)			
1-3cm Early Labor		X	N/A
3-7cm Active labor			
7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger		X	X
Moderately dangerous			
High danger			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3		X	X
Silly =4			
other =5 Describe in notes			
Name of Birthmother:	Amanda	Tiana	Samantha
Birthmother's NON- Medicalized Intervention	N/A	Birthing Ball	Ted socks
Was consent of this intervention shown? Y or N		N	N
If yes, who gave consent? Y or N		N/A	N/A
Were risks and benefits shared? Y or N		N	N
Was this used for pain management? Y or N		Y	N
Was this used for induction? Y or N		N	N
Did you observe persuasion? Y or N		N	N
Stage of Labor: (mark with X)			
1-3cm Early Labor			N/A
3-7cm Active labor		X	

7-10 Transition			
Perceived level of danger: (mark with X)			
No perceived danger =3		X	X
Moderately dangerous =2			
High danger =1			
Music dramatization level: (mark with X)			
Dramatic =1			
Some Drama=2			
Relaxing =3			X
Silly =4		X	
other =5 Describe in notes			

Appendix: Data collection charts each researcher used to gather data.

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