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The Role of Male Partners in Childbirth Decision Making: A Qualitative Exploration with First-Time Parenting Couples

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The Role of Male Partners in Childbirth Decision Making:
A Qualitative Exploration with First-Time Parenting Couples

by

Sharon Bernecki DeJoy

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
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Dedication

I dedicate this dissertation in memory of my brother, Thomas F. Bernecki, Ph.D.

I would also like to thank my husband, Conrad, and children, Joseph, Anna and Alexander for all their love and support.

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Abstract

Fathers' attendance at childbirth is almost universal in the United States, but few researchers have addressed the role that males play in childbirth decision making. The number of technological interventions available to birthing women is increasing, as is the utilization of those interventions. The degree to which women choose or agree to these interventions plays a major role in individual and societal health outcomes. Therefore, health care policy makers and educators must find ways to help childbearing couples navigate the complex maze of decisions related to childbirth. However, policies and programs to increase shared decision making may not function as intended if they do not consider the role that fathers play in making decisions about their children's birth.

This study used qualitative methods to explore the perspectives of 15 couples prior to and after the delivery of their first child. Findings identified values and beliefs held by men that influenced their input into decisions, as well as the roles they fulfilled in decision making. Results of this study can help policy makers, health care providers and health educator identify ways to encourage effective, empowered joint decisions on the part of childbearing couples.

Chapter One: Introduction

“In her journey to motherhood, a pregnant woman lives her life in the midst of many relationships: with the fetus, her doctor, midwife, partner, family, friends, and society as a whole. These relationships influence and inform her sense of self, and her experience as an expectant mother. Helpful or hindering, they will also influence the decisions she makes regarding her plan of parturient care. While not all women have a well-developed plan of care or actively participate in decisions regarding their care, this too may reflect how they situate themselves in their broader context. Yet despite this, much of mainstream clinical practice and bioethical theory does not explicitly account for the social situatedness of the individual.” (Thachuck, 2007)

Background of the Problem

History of Fathers at Birth. In the early 19th century, most women gave birth at home, but by 1940, the majority of births in the United States had moved to the hospital (Leavitt, 2003; Walker, Visger, & Rossie, 2009). Until the movement of childbirth into the hospital setting, women viewed birth as a normal part of life, and they were supported in pregnancy and birth by other women, usually their female relatives. Childbirth education classes were not available, probably because few saw a need for formal education for a normal life event (Walker et al., 2009).

However, once childbirth moved into the hospital, women no longer had the labor support of female friends or family members (Walker et al., 2009). Until the late 1960s, most hospitals excluded fathers from the delivery room, and often from labor wards as well.

Women were often alone and isolated from support persons and attended primarily by nursing and medical personnel. During this most vulnerable time, women were often ill-prepared for hospital routines and procedures, which led to increased fear and anxiety about the birth process” (Walker et al., 2009, p.469).

In the 1960s and 1970s, childbirth education became popular to help couples reduce their anxiety and understand their options for childbirth (Leavitt, 2003). In addition, the natural childbirth movement sought to humanize birth by making it a family-centered experience, and more fathers began to attend their children’s birth. However, men’s attendance at childbirth was not without controversy. Obstetricians worried erroneously that fathers’ presence might increase the risk of infection and malpractice liability, infringe on the privacy of other patients, or lead to mishaps, conflicts or diversions that would compromise care. By the 1980s, however, after years of pressure from consumer advocacy groups, most hospitals allowed, if not actively encouraged, fathers to accompany their partners during labor and delivery.

As part of fathers’ early forays into the delivery room, many hospitals required them to attend childbirth education classes with their wives; these classes are no longer required (Morton & Hsu, 2007). As men’s attendance at birth has risen over the past couple of decades, women’s (and couples) attendance at childbirth classes has been declining. Seventy percent of first-time mothers attended childbirth education classes in

2001–2002, while only 56% of first-time mothers attended in 2005 (Declerq, Sakala, Corry, Applebaum & Risher, 2006). Researchers attribute this decline to an increasing divergence between the culture of contemporary childbearing couples and the culture of childbirth education (Morton & Hsu, 2007). Whereas childbirth education once provided couples with support networks, education and skills to advocate for an unmedicated birth experience, this tradition is a poor fit with busy working couples who embrace contemporary technology and expect an intervention-intensive birth experience. As a result, couples increasingly obtain information about childbirth from the Internet and mass media (Declerq et al., 2006); those who attend classes prefer condensed formats (Morton & Hsu, 2007). Some childbirth educators believe that “alternatives to an information-rich, multiweek class experience [are] not adequate or optimal, in terms of time and information, in preparing couples for the major life change of becoming parents and having a newborn, let alone preparing them for labor and childbirth” (Morton & Hsu, 2007, p. 29).

Contemporary childbearing couples may be less prepared to make informed decisions related to childbirth at a time when the maternity care system offers a greater number of choices and higher exposure to interventions than ever before. More than 90% of mothers have a birth experience that includes medical interventions (Declerq et al., 2006), and more than 30% experience a cesarean delivery (Martin, Hamilton, Sutton, Ventura, & Mathews Osterman, 2010). In this environment, male partners may be particularly ill-equipped to participate in the informed decision-making process, particularly since childbirth education classes are often structured to meet the needs of

the expectant woman more explicitly than those of her male partner (Draper, 1997; Friedwald, 2007).

Nevertheless, findings from the literature, along with anecdotal evidence from childbirth attendants, suggest that fathers often play a pivotal role in a woman's childbirth experience (Ip, 2000). Despite a recent increase in research into men's roles in other reproductive health decisions (Blanc, 2001), there is a comparative lack of inquiry into men's role in childbirth decision-making. A recent interest in the role of fatherhood in maternal child health across Western countries has led to initiatives that involve fathers in every aspect of maternity care (Longworth & Kingdon, 2010). Now that childbirth truly has become a couple-centered event, more research is needed on couples' joint decision making processes and their effects on labor and birth.

Childbirth Decisions and Their Impact. When a woman becomes pregnant, she may, for the first time in her adult life, be faced with making major decisions about her health care (Galotti, Pierce, Reimer, & Luckner, 2000). The patient empowerment and feminist movements have encouraged women to become empowered decision-makers in this process.

Depending on where she lives and her insurance coverage, a healthy pregnant woman in the United States can choose to have a home birth in her bathtub or schedule an elective cesarean delivery in a tertiary care facility, or create a customized experience somewhere in-between. The decisions that she makes can have a significant influence on birth outcomes, as well as family satisfaction with the birth experience and adjustment to parenthood (Ip, 2000). In the aggregate, individual women's childbirth decisions influence the cost and utilization of maternity care in local communities, states, and

nationally. In 2006, 4.3 million childbirth-related hospitalizations accounted for \$14.8 billion in healthcare costs. Approximately half of those costs were billed to private insurance (\$7.5 billion), while 42 percent, or \$6.3 billion, were billed to Medicaid (Russo, Weir & Steiner, 2009). The vast majority of American women will give birth at least once in their lifetime, and the average woman will have two children (National Organization for Women, 2010).

Some critical choices women may make related to childbirth are attendant (midwife or physician), location (home, birth center, or hospital), requesting or accepting labor induction, method of pain relief (non-pharmacological methods, narcotics or epidural), and method of delivery (vaginal birth or cesarean delivery). This section will review each of these options and their implications for maternal and child health.

Types of Birth Attendant. The majority of women who choose a provider for prenatal care will have that specific person, or the same type of professional, attend their births (Howell-White, 1997). However, some women do switch to a different type of provider during pregnancy, or medical complications may arise that require a woman to be referred to a more specialized provider.

In the United States, two main types of providers provide prenatal care and attend births: physicians and midwives. Physicians may be further categorized as obstetricians (who perform the majority of deliveries) and family practitioners (Martin et al., 2010), although both types attend births almost exclusively in hospitals. Two types of midwives practice in the United States: certified nurse-midwives and certified midwives (CNMs/CMs) and direct-entry midwives (DEMs) who are not CMs. Direct-entry midwives include Certified Professional Midwives (CPMs) who are credentialed by the

North American Registry of Midwives and other midwives without formal training credentials (Myers-Ciecko, 1999). CNMs are educated in both nursing and midwifery, while CMs and DEMs focus their educational and professional preparation on midwifery alone. Most DEMs specialize in out-of-hospital births in homes or birth centers; most CNMs/CMs attend births in hospitals, although some attend births in birth centers or at home as well. CNMs/CMs have prescriptive privileges and can offer their clients pharmacological pain relief in labor in a hospital setting; most direct-entry midwives do not.

Because of differences in regulation and practice patterns, a woman's choice of provider is often a *de facto* choice of birth location, and may limit the interventions among which she can choose. For example, choosing a physician as a birth attendant almost universally ensures that a woman will give birth at a hospital. Choosing a home birth with a midwife reduces a woman's access to pharmacological pain relief. Since different types of providers have distinctive philosophies and practice patterns that result in differential intervention use (Rosenblatt et al., 1997), a woman's choice of provider early in pregnancy can play an important role in her childbirth experience.

Several studies suggest that midwifery care confers health benefits on both mothers and infants. For example, CNMs spend more time with their clients than physicians, and provide more counseling and education about behavioral risk factors such as smoking and diet (Oakley et al., 1996). CNMs also use fewer resources and medical procedures than physicians during labor and delivery, and have lower c-section rates, which may translate into lower costs (Rosenblatt et al., 1997). For comparable populations of women, CNMs have lower low birth weight and newborn death rates than

physicians (MacDorman & Singh, 1998; Visintainer et al., 2000). A study of homebirths attended by CPMs found similar rates of intrapartum and neonatal mortality between participants and low-risk mothers having hospital births; however, medical intervention rates were lower: epidural (less than five percent of participants), episiotomy (just over two percent), forceps (one percent), vacuum extraction (less than one percent), and caesarean section (less than four percent) (Johnson & Daviss, 2005). A recent Cochrane review of midwife-led care concluded, “All women should be offered midwife-led models of care and women should be encouraged to ask for this option” (Hatem, Sandall, Devane, Soltani, & Gates, 2008).

Use of a doula. A doula is not a birth attendant per se; doulas do not provide clinical care. Instead, a doula is “a trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth; or who provides emotional and practical support during the postpartum period” (DONA International[DONA], 2005). In hospital settings, continuous labor support, either in the form of a doula, midwife, nurse or other supportive person, has been associated with shorter labors, higher rates of spontaneous vaginal delivery and lower rates of both anesthesia use and negative perceptions of the birth experience (Hodnett, Gates, Hofmeyr, Sakala & Weston, 2011). Because of the clear efficacy and lack of harm associated with doula care, Hodnett and colleagues (2011) encourage policy makers to provide coverage for these services. Because many insurance companies currently do not cover private doula services, which can be several hundred dollars, the costs are borne by childbearing families. Some hospital- and community-based doula programs are available for high-risk, low-income women on a limited geographic basis

(DONA, 2005). However, the choice to use a doula is generally restricted to women who are educated about this option and have the means to pay for it.

Birth Location. A woman's choice of provider during pregnancy often determines where she will have her baby and to which interventions she will be exposed. Similarly, her choice of birth setting often constrains the type of provider who will attend her birth. Few physicians attend births in out-of-hospital settings. DEMs rarely have hospital privileges, and by necessity and philosophy attend births at home or freestanding birth centers (Meyers-Ceiko, 1999).

Hospitals provide immediate or relatively quick access to interventions that are not available in other settings, including epidurals and other forms of pharmacological pain relief, continuous electronic fetal monitoring, and emergency cesarean delivery (American College of Obstetricians and Gynecologists [ACOG], 2008). In a home or freestanding birth center birth, a woman who wants or needs any of these interventions would need to gather her belongings, have the midwife make transfer arrangements, go to the hospital, and be admitted and triaged before interventions could be administered. Many physicians argue that rapid access to emergency care makes hospitals the only safe place for childbirth, since the rare catastrophic complication would be better handled in the hospital (American College of Obstetricians and Gynecologists [ACOG], 2008). By contrast, home birth and birth center advocates argue that for healthy, low-risk women, the risk of a rare catastrophic outcome does not support universal hospitalization for childbirth. These advocates argue that many interventions, initially designed for high-risk women, have been applied to well women indiscriminately, creating the risk of iatrogenic harm that increases morbidity and mortality (Leslie & Romano, 2007).

The National Birth Center Study (Rooks et al., 1989) found that birth centers were a safe alternative to hospitals for women at low risk of birth outcomes, and used fewer resources than hospitals did. A systematic review of midwife-led birth centers reached the same conclusion (Walsh & Downe, 2004). More recently, an Australian study of more than 1,000,000 births found a slightly lower perinatal death rate for birth center clients than for hospital patients (Tracy et al., 2007), further supporting the safety of birth center care. However, the generalizability of the safety of birth center births in countries with national health systems and national standards for midwifery education may not be applicable to the United States.

The safety of home birth is a discussion that deserves, and has been, the focus of entire dissertation research projects (see Schlenzka, 1999). Because this study focuses on the process of couples' negotiation about birth, this document will not restate the clinical debate over the safety of home birth, or whether women have a right to choose it. In brief, women's use of homebirth is controversial; studies of varying quality and methodological rigor have identified conflicting findings about the safety of home birth (McLachlin & Foster, 2009). As McLachlin and Foster document, no randomized controlled trial of home birth has been completed, which means current clinical knowledge on this topic is incomplete.

Twenty-five states regulate direct-entry midwifery practice through licensure, certification, registration or permit; ten states allow Medicaid reimbursement for these services (Midwives Alliance of North America [MANA], 2010). Women who reside where direct-entry midwifery is legal may choose to give birth at home using the services of a CPM or a midwife with a state-recognized credential. Women in states where DEM

practice is illegal or not legislatively defined may also choose home birth, but generally with no guarantee of the practitioner's credentials, without possibility of insurance reimbursement, and with the knowledge they are complicit in commission of a crime. In illegal or "alegal" states, "DEMs are vulnerable to charges ranging from practicing medicine, nursing, or nurse-midwifery without a license to manslaughter, child endangerment, and possession or use of controlled substances" (Prown, 2004, para 1).

Medical Interventions: After choosing a provider and birth site, women are still faced with many decisions immediately preceding or during childbirth: whether to accept pain medication and, if so, which pain medication to accept; and whether to request or agree to an induction of labor or cesarean delivery, among others. Each of these decisions and resulting interventions has potential risk and benefits, as well as both intended and unintended consequences. Further, many interventions are associated with or require other interventions— what many natural childbirth advocates call a "cascade of interventions," where one unnecessary medical intervention has unintended consequences, leading to the need for another medical intervention, until the labor culminates in an operative delivery (Childbirth Connection, 2011).

Childbirth is an intervention-intensive process in the United States. Mothers who gave birth in 2005 reported experiencing the following interventions during labor and delivery: electronic fetal monitoring (94% of mothers), intravenous drip (83%), epidural or spinal analgesia (76%), one or more vaginal exams (75%), urinary catheter (56%), membranes broken after labor began (47%), and synthetic oxytocin (Pitocin®) to speed up labor (47%) (Declerq et al., 2006). In 2006, more than half of childbirth-related

hospitalizations involved medical induction, manually assisted delivery, and other procedures to assist delivery (Russo et al., 2009).

A recent population-based study in Australia found an increased rate of operative birth in association with *each* of the interventions offered during the labor process, with particularly strong associations for first-time mothers (Tracy, Sullivan, Wang, Black & Tracy, 2007). The study demonstrated an association between declines in rates of unassisted vaginal birth and an increasing rate of labor interventions, particularly among low-risk first-time mothers. The benefits and side effects of these labor interventions are discussed below.

Pharmacological pain relief. Epidural anesthesia (regional pain killers injected into the epidural region of the spinal cord) is the most common form of pharmaceutical pain relief in labor (Mayberry, Clemmens, & Anindya, 2002). According to Mayberry and colleagues (2002), side effects of epidurals such as itching, nausea, and hypotension during labor are common, but usually mild. Life-threatening complications, such as severe low blood pressure, respiratory or cardiac arrest, convulsions, and severe allergic reaction, while extremely rare, may occur. Additional interventions are required to monitor or treat the potential side effects of epidurals, including electronic fetal monitoring (EFM), intravenous (IV) fluids, frequent blood pressure monitoring, labor augmentation, and bladder catheterization. Each of these interventions is associated with a need for other interventions and potential side effects.

Epidural analgesia has been associated with an increased risk of labor augmentation, prolonged second stage of labor, and instrumental delivery (Anim-Somuah, Smyth, & Howell, 2005); a potential causal mechanism is malpresentation of

the fetal head, the risk of which is increased with epidurals (Lieberman, Davidson, Lee-Parritz, & Shearer, 2005). According to a Cochrane review, there was no statistically elevated risk of cesarean delivery among women receiving epidurals as compared to women with alternate forms of pain relief or no analgesia; however, there was a 42% increased risk of cesarean delivery for fetal distress, which approached statistical significance (Anim-Soumah et al., 2005). Since that systematic review was published, a later study found that epidural doubles the risk of a c-section for nulliparous women (Nyugen et al., 2010)

Epidural analgesia is associated with more frequent oxytocin augmentation, hypotension, and maternal fever (particularly among women who shiver) (Lieberman & O'Donoghue, 2002). In turn, maternal fever is associated with newborn infection work-ups and intravenous infusion of antibiotics for suspected infection. Further, epidurals are associated with an increased risk of jaundice, fever and seizures in the newborn, complications which require additional diagnosis and potential treatment for the infant.

Narcotics and sedatives, such as meperidine (Demerol™), Butorphanol (Stadol™), and fentanyl, while not as widely-used as epidurals, are another popular form of pharmaceutical pain relief (Cunningham et al., 2010). However, they can cause nausea and depress respiration in mothers (Bricker & Lavender, 2000). In addition, narcotics cross the placenta and can depress early newborn breathing, socialization and breastfeeding. Narcotics use by laboring mothers has been associated with addictive behaviors in the exposed infant later in life (Bricker & Lavender, 2000).

Electronic fetal monitoring. Electronic fetal monitoring (EFM) measures fetal heart rate, an indicator of fetal wellbeing, using a variety of technologies. External fetal

monitoring uses ultrasound technology to trace fetal heart rate via transducers applied to the abdomen of the laboring woman. Internal EFM uses electrodes attached to the fetal scalp; it is considered more accurate but more intrusive (Cunningham et al., 2010).

Most hospitals and hospital-based providers use continuous external electronic fetal monitoring (Cunningham et al., 2010). However, mothers having their baby at home or in a birth center typically have intermittent monitoring with a portable fetal Doppler (ultrasound) monitor, which has been associated with equivalent birth outcomes and fewer false positives for ischemia than EFM (Larma et al., 2007). Therefore, a mother's choice of provider and birth site will influence her exposure to different types of fetal monitoring.

As noted in the Listening to Mothers II study, 94% of mothers receive continuous electronic fetal monitoring (EFM) (DeClerq et al., 2006). EFM was introduced in the 1960's as a screening tool to reduce the incidence of childhood neurological injury due to intrapartum hypoxia (Larma et al, 2007). In the nearly five decades since then, researchers have discovered that the incidence of intrapartum hypoxia is considerably lower than expected. Further, EFM has a low predictive value for cerebral palsy.

As early as the late seventies, researchers warned that EFM would introduce higher costs into the maternity care system without significant benefits (Banta & Thacker, 1978). A meta-analysis in the mid-1990's suggested that EFM was associated with a halving of the perinatal mortality specifically due to hypoxia (Vintzileos et al., 1995). However, a recent study found EFM is not an exact method for the identification of metabolic acidosis or HIE [hypoxic-ischemic encephalopathy] (Larma et al., 2007). Because EFM has a high false positive rates, cesarean deliveries sometimes are

performed unnecessarily to rescue healthy babies from potential brain damage. “The use of [electronic fetal monitoring or EFM] is almost ubiquitous in the developed world, where it has almost certainly accelerated the rise in delivery by caesarean section” (Steer, 2008, p.2).

Continuous external fetal monitoring requires the laboring woman to be attached to the monitor at all times, which can limit her mobility and ability to assume different position throughout labor. Upright position and ambulation during the first stage of labor may reduce the duration of labor and decrease discomfort (Souza, Miquelutti, Cecatti, & Makuch, 2006).

Labor Induction: Labor induction is the “stimulation of contractions before the spontaneous onset of labor, with or without ruptured membranes” (Cunningham et al., 2009 p. 500). Most labor is induced via intravenous administration of synthetic oxytocin (brand name Pitocin®) (Cunningham et al., 2009).

Induction of labor is increasing in the United States—rising to more than 23% of all births in 2008 (Martin et al., 2010) . Of all types of induction, the incidence of elective induction of labor (induction without an immediate medical indication) appears to be increasing the fastest (Lydon-Rochelle, Cárdenas, Nelson, Holt, Gardella, Easterling, 2007). Accepted medical indications for labor induction include maternal health issues (e.g., diabetes mellitus, unstable cardiac disease, hypertensive disease of pregnancy) or fetal complications (e.g. postdates or nonreassuring results on antenatal testing) (Caughey et al, 2009).

Motives for labor induction vary, and are often determined by provider or patient preferences (Caughey et al, 2009). Pregnant women may wish to end their pregnancy

early because of physical discomfort, distance from the hospital, or scheduling issues (e.g. related to family visits or their work schedule) (Rayburn and Zhang, 2002). In addition to acceding to these patient preferences, providers may also want to limit their clients' exposure to potential poor outcomes that may worsen as labor lengthens. Scheduling elective inductions can also increase clinicians' profits and simplify their schedule (Caughey et al, 2009).

Elective induction can lead to preterm birth, prolonged labor, cesarean birth, and maternal and neonatal morbidity (Clark et al, 2009; Luthy, Malmgren, & Zingheim, 2004; Raju, Higgins, Stark, & Leveno, 2006). Labor induction is a risk factor for amniotic fluid embolism (Knight et al, 2010). These risks apply to all women having the procedure; however, for nulliparous women with an unfavorable cervix, the main risk is cesarean birth after unsuccessful labor induction (Clark et al, 2009; Luthy et al. 2004; Raju et al, 2006, Wilson, 2010). In addition, "there is a cascade of interventions associated with elective induction such as an intravenous line, continuous electronic fetal monitoring, confinement to bed, amniotomy, pharmacologic labor stimulating agents, parental pain medications, and regional anesthesia, each with their own set of potential complications and risk of iatrogenic harm" (Simpson, 2010).

Cesarean delivery. Cesarean delivery (commonly referred to as a c-section) is the birth of an infant via surgical incisions through the abdominal and uterine walls (Cunningham et al., 2010, p.544). Physicians perform c-sections for a variety of maternal or fetal indications where clinical judgment suggests operative delivery is safer for mother and/or infant than vaginal delivery. Current indications for cesarean delivery

include previous cesarean delivery, breech presentation, dystocia (protraction or arrest of labor), and fetal distress.

Although a cesarean delivery can be a lifesaving procedure for high-risk women and infants, or women who develop a complication during labor and delivery, this procedure is performed increasingly often on women with no risk factors (National Institutes of Health [NIH], 2006). In 2006, C-sections were the most commonly performed operating room procedures in U.S. hospitals (Russo et al., 2009). It is difficult to distinguish among emergency, elective and planned cesareans, because definitions can be ambiguous, vary among providers and researchers, and shift over time (MacDorman, Declercq, Menacker & Malloy, 2006). With that caveat, a study using a strict definition of “maternal request” cesarean delivery (i.e., a cesarean requested by a mother prior to labor) found such procedures are rare. On the contrary, many women felt pressured into agreeing to a cesarean (Declercq et al, 2006). However, whether requested or merely acquiesced to by the mother, cesarean deliveries with no indicted medical risk do occur.

In 2008, Florida’s cesarean rate was the second highest in the nation, at 38.2%, with wide geographic variation; the highest cesarean delivery rates occur in South Florida (Florida Department of Health [DOH], 2011). Nationally, the cesarean delivery rate rose to 32.3% of all births in 2008, another record high. (Martin et al., 2010).

Widespread cesarean deliveries may increase healthcare costs, both directly and through increased morbidity. In 2004, the total cost for cesarean deliveries in Florida was approximately \$1 billion (Florida AHCA, 2006). For low-risk first-time mothers, an Australian study found that an epidural raises the base cost of a delivery by 32%; a cesarean by more than 50% (Tracy & Tracy, 2003). Florida hospital birth charges for a

vaginal delivery were \$7,533 in 2004; comparable charges for a cesarean were nearly twice as much: \$14,458 (Florida AHCA, 2006).

A Canadian study of first-time mothers with singleton pregnancies found an increased risk of postpartum cardiac arrest, incision hematoma, hysterectomy, major puerperal infection, anesthetic complications, venous thromboembolism, and hemorrhage requiring hysterectomy in patients who had a planned primary cesarean delivery versus a planned vaginal delivery (Liu et al., 2007).

Women who undergo surgical delivery have an increased risk of rehospitalization for uterine infections, wound complications, cardiopulmonary problems, and thromboembolic disease over women with a vaginal delivery (Lydon-Rochelle, Holt, Easterling, & Martin, 2001). Obese women are at increased risk for a c-section, yet they have more postpartum complications from surgery than overweight or normal-weight women (Baron et al. 2010). After a primary cesarean delivery, in the next pregnancy women face a highly increased risk of placenta accreta and an increased risk of placenta previa and fetal malpresentation (Kennare, Tucker, Heard, & Chan, 2007). One study found that not only does the risk of placenta previa increase, but the outcomes for women with placenta previa also become worse with each successive prior cesarean delivery. Multiple measures of maternal morbidity (eg, coagulopathy, hysterectomy, pulmonary edema) increased in frequency as the number of prior cesarean deliveries rose. Even one prior cesarean delivery was sufficient to increase the risk of an adverse maternal outcome from 15% to 23% (Grobman et al., 2007). These include pain and surgical adhesions, as well as a possible increased risk for infertility or sub-fertility and perinatal complications in subsequent pregnancies (Silver, 2010).

Cesarean deliveries also raise the risk of poor outcomes for infants, including increased risk of breathing difficulties and NICU admission for the target infant (Kolas, Saugstad, Daltveit, Nilsen & Oian, 2006). “Cesarean delivery might be associated with a greater risk of asthma, caused perhaps by altered gut colonization, increased risk of neonatal respiratory disease, decreased gestational age at birth or decreased likelihood of breastfeeding” (O’Shea, Klebanoff, & Signore, 2010). There are also risks for subsequent pregnancies, including preterm birth and stillbirth in the next pregnancy (Kennare et al, 2007). This increased risk of stillbirth still applies even when the prior surgery had no indicated risk that would signify an underlying maternal or fetal complication (Kolas et al., 2006).

Currently, the average length of pregnancy in the United States is 39 weeks, which is associated with induction of labor and cesarean deliveries (Davidoff et al., 2006). Two-thirds of Florida’s increase in prematurity among singletons between 1995 and 2003 was associated with the increasing number of cesarean deliveries (Goodman, 2007). These late-term preterm infants have an increased risk of infant mortality and morbidity.

Significance of the Study

Due to the potential negative consequences of unnecessary medical interventions in low-risk childbearing women, policymakers and clinicians have debated the appropriateness of current trends in their use. The National Institutes of Health have called for more research to identify factors that increase the likelihood of successful vaginal birth, particularly in the first pregnancy, and decrease maternal and neonatal complications (NIH, 2006). Healthy People 2020 goals include reducing cesarean

sections and increasing breastfeeding initiation (U.S. Department of Health and Human Services, 2011). Encouraging healthy birth outcomes and promoting safe motherhood and infant health are two important public health strategies that support CDC's goal of Healthy People at Every Stage of Life (Centers for Disease Control and Prevention [CDC], 2006).

Whether a woman actively chooses a provider or intervention, or agrees to an intervention suggested by her provider, that choice may have significant downstream effects on the health of the mother/infant dyad. Understanding the process by which mothers/couples make these decisions may allow clinicians and health educators to design educational strategies that reduce morbidity in childbirth and enhance the transition to parenthood.

Currently, national advocacy groups, including the American College of Nurse-Midwives, International Cesarean Awareness Network, Coalition for Improving Maternity Services, Childbirth Connection, The March of Dimes, and the Midwives Alliance of North America, among others, have launched educational campaigns aimed at reducing women's use of birth interventions that may negatively affect birth outcomes. For these campaigns to be effective, however, health educators must understand the decision-making processes that women follow when choosing among childbirth options, as well as the factors that influence or constrain their decisions. Father may play an active role in medical decision making that affects their partners and children, but their influence has not been well explored.

Purpose of the Study

Childbirth is a family event, yet most current educational campaigns and childbirth education classes are aimed at mothers without knowledge of how fathers/male partners figure into the decision-making process. By understanding male partners' concerns, priorities, needs, and level of influence in childbirth decisions, health educators and providers can identify ways to help families have a satisfying birth experience and make informed decisions. This study addressed this critical goal by exploring the role males partners play in women's birth choices. Because of the paucity of research in this area, the proposed study was exploratory in nature.

Research Questions

The major research questions addressed by this study were as follows:

1. What beliefs, concerns and priorities characterize men's' involvement in childbirth decision-making?
 - a. Does childbirth preparation and birth setting affect these beliefs, concerns and priorities?
2. How do men and women negotiate decisions about childbirth?
3. What roles do men play in negotiating these decisions?
 - a. To what extent and in which areas do men influence women's decisions in childbirth?

Childbirth Education Models

To appreciate the role of childbirth preparation as a context for decision making, it is critical that readers understand the various childbirth education models that are

available to childbearing couples. A brief overview of these models is provided here for the reader's reference.

The Lamaze Method. French obstetrician Fernand Lamaze introduced the Lamaze Method in 1951 (Walker et al., 2009). As originally developed, the method consisted of childbirth education, relaxation, and breathing techniques. Lamaze advocated for more emotional support and involvement from the father of the baby. In the mid-twentieth century, the Lamaze Method became the most well-known childbirth education model, famous for its breathing and progressive relaxation techniques. Today, however, the focus of Lamaze International is less about specific methods than the overall goal of promoting normal birth. “The mission of Lamaze International is to promote, support and protect natural, safe and healthy birth through education and advocacy through the dedicated efforts of professional childbirth educators, providers and parents” (Lamaze International, 2010.)

The Bradley Method®. “The Bradley Method® teaches natural childbirth and views birth as a natural process... most women with proper education, preparation, and the help of a loving and supportive coach can be taught to give birth naturally. The Bradley Method® is a system of natural labor techniques in which a woman and her coach play an active part” (American Academy of Husband-Coached Childbirth®, 2011). The model was developed by Robert A. Bradley, an obstetrician/gynecologist who grew up on a farm watching animals give birth naturally (Walker et al., 2009). Husbands play a critical role in The Bradley Method®, serving as the major support person for the laboring woman. The model teaches couples to take an active role in decision-making and avoid interventions, especially medications. Men are expected to “act as

environmental stewards, thereby freeing the woman to labor without concerns for her comfort” birth (American Academy of Husband-Coached Childbirth®, 2011).

HypnoBirthing – The Mongan Method. Hypnobirthing is a relatively recent entry in the catalog of childbirth models, founded in 1990 (Walker et al., 2009).

HypnoBirthing helps mothers and their companions view birth in a positive manner, substituting positive, empowering terms for medical terms, e.g., “rushes” instead of “contractions”. Courses focus on anatomy and physiology, self-hypnosis, deep relaxation, visualization, and breathing techniques to create a pain-free birth experience. Its founders describe the method as follows:

“HypnoBirthing® - The Mongan Method is as much a philosophy as it is a technique. The concept of HypnoBirthing® is not new, but rather a "rebirth" of the philosophy of birthing as it existed thousands of years ago and as it was recaptured in the work of Dr. Grantly Dick-Read, an English obstetrician, who, in the 1920s, was one of the first to forward the concept of natural birthing. The method teaches you that, in the absence of fear and tension, or special medical circumstances, severe pain does not have to be an accompaniment of labor” (Hypnobirthing Institute, 2009)

Birthing From Within. Birthing From Within focuses on an emotionally healthy birth experience for parents and providers (Walker et al., 2009). According to its mission statement,

“Birthing from Within exists to inspire and teach expecting and new parents, and those who work with them, to... co-create holistic prenatal care that is informative, transformative, and builds a foundation for birthing in awareness in

our birth culture, whatever the birth location or outcome or events of the birth [and] prevent or minimize emotionally difficult births (for parents and professionals) through compassionate, honest preparation” (Birthing from Within, undated).

This model encourages prospective parents to investigate childbirth from a variety of perspectives: the mother's, father's, baby's, and providers point of view (Walker et al., 2009). Then, mothers are encouraged to engage in deep self-reflection to understand their needs and release their fears about birth.

Overview of the Study

This study used qualitative methodology to explore the decision making processes, context and outcomes for first-time parents related to childbirth. The primary researcher interviewed couples twice: once prenatally to identify their plans for their birth, and again after the birth to identify the decisions they actually made, the circumstances surrounding each decision, and the process by which couples arrived at decisions. After transcription and quality control, the author and a second coder analyzed the narratives using an inductive process to identify major themes and concepts. A related analysis using actor interaction models clarified and enriched the thematic analysis. Findings included insight into the values and beliefs held by men about childbirth, as well as the various roles they played in decision-making.

Delimitations and Limitations

The main strength of the study is its treatment of a little-studied phenomenon that may have significant impact on the utilization of health care services in the United States. Childbirth is the most common reason for hospitalization in the United States, and one of

the greatest costs to our medical system (Russo et al., 2009). This study addressed a major public health issue that is of timely and critical importance, and can provide valuable information to health educators and policy makers about the best ways to encourage women and their families to use childbirth interventions appropriately.

The qualitative nature of the research project captured the richness and diversity of the childbirth experience and generated preliminary theory about men's roles in childbirth. This research methodology enabled the exploration of subtle nuances of beliefs and experience that parents bring to the childbirth experience and the processes by which they negotiate their roles in decision-making.

However, no study is without limitations. Because this study focused on the role of male partners in childbirth decision making, it necessarily excluded key perspectives on this issue. Most important, the study did not address the influence that women have on other women in birth, a perspective that excluded lesbian mothers and non-partnered heterosexual mothers. As Annandale and Clark note, "If we conceive of power as a fundamentally male preserve we are led to gloss over ways in which women may exert power over others" (1996). Evidence suggests that female relatives can wield power over mothers, even in abusive ways (see Raj et al., 2011; Clark et al. 2008). In the case of single mothers, mothers in same-sex couples, and indeed all mothers, it would be instructive to explore how birth attendants other than male partners, particularly female relatives (i.e., mothers, sisters, grandmothers, etc.), influence childbirth decision-making.

In addition, the study focused on couples with common birth scenarios: couples intending on having a vaginal birth at home or in a birth center or hospital with a trained physician or midwife attending. It did not enroll any couples who chose to give birth

without trained professional assistance, or those who requested an elective cesarean delivery.

Most of the individuals who consented to participate in this study were white (of both Hispanic and non-Hispanic ethnicity), married, with at least a college degree. While this study did incorporate the perspectives of African-Americans, working class couples and unmarried couples, further research with each of these groups may yield a richer understanding of how the constructs of race, class and marital status influence men's beliefs and behaviors in childbirth.

Organization of the Dissertation

Chapter Two presents a review of theoretical perspectives relevant to the study, including background on decision making theory, social support, gender and power, and relational autonomy. It also provides a review of the literature on men's involvement in reproductive decision-making and attendance at childbirth. The following chapter, Chapter 3, provides a justification of the methods used in the study. Chapter Four provides the findings of the study, while Chapter Five discusses the implications of the study on health education and maternity care, as well as suggestions for further research.

Chapter Two: Review of the Literature

“Decision making begins by understanding one’s options, then proceeds to understanding oneself—and the tradeoffs one wishes to make. With many medical choices, both tasks can be challenging. The situation can be unfamiliar, uncertain, and complex, forcing one to identify, then master the relevant facts. The tradeoffs can be wrenching, forcing one to identify, then integrate relevant personal values. Those tradeoffs might be between certain pain now and possibly reduced pain later, between money and ... relief ... or between burdens borne by oneself and one’s family.”(John & Fischhoff, 2010)

Theoretical Perspectives

Decision Making Theory. Expected utility theory is one of the dominant theories researchers have used to understand patient decision-making behavior (Pierce & Hicks, 2001). Expected utility theory dates back to the 18th century as a way of predicting behavior. It describes decision makers as rational gamblers who can assess the probability of certain outcomes and their valuation of each outcome and then select the option with the best combination of likely and desired results—the one with the greatest expected utility.

A later refinement of this perspective, prospect theory, describes how people make choices in situations where they have to decide between alternatives that involve risk (Kahnemann and Tversky, 1979). This theory adds an editing stage prior to the calculation of expected utility, wherein people facing a decision prioritize potential outcomes before calculating their expected utility. In the case of childbirth, for example, a woman who feels cesarean delivery is highly likely and who does not value natural birth over cesarean delivery may be more likely to request or acquiesce to a cesarean delivery than a mother who believes she can achieve a natural birth and prefers to do so.

However, some researchers argue that expected utility theory is an inadequate model for the average person making decisions in real-world situations. Beach & Mitchell (1987 as cited in Pierce and Hicks, 2001) argue theoretical models are often too simplistic to capture the nuances of decision made in naturalistic settings, where complex options, emotions, and beliefs intersect with changing contexts. Medical decision-making adds an additional layer of complexity to decisions. “Highly uncertain and often risky decisions are often made under extraordinary physical and emotional stress and time constraints, placing a high cognitive demandHumans have limited attention and working memories in complex environments” (Peirce & Hicks, 2001, p.267).

Galotti (2009) argues that most existing research on decision making involves either professionals making decisions in their domain of expertise or lay people in laboratory situations working on hypothetical problems, and therefore does not adequately predict or explain the behavior of patients trying to navigate complex real-world medical issues. Even in laboratory settings, “research has repeatedly shown that people too often stop thinking too early, ignore evidence, integrate information in ways

that favor their initial biases, fail to fully consider likely consequences, and avoid using available decision aids” (Galotti, 2009, p.5). These processing problems, at odds with the “rational human calculator” approach of expected utility theory, suggest that real-world decision making is influenced by complex emotional and social factors.

Weinstein (2003) notes that people believe they are significantly more likely to experience positive events or consequences than their peers and significantly less likely to experience negative ones. This *optimistic bias* causes most people to estimate the probability of an outcome incorrectly. For example, in the case of childbirth, when a couple who hopes to avoid a cesarean delivery chooses to give birth at a hospital with a 60% c-section rate, this choice implies an optimist belief that the odds do not apply to them. Since expected utility theory assumes that people can determine probabilities rationally and with accuracy, this widespread inability to assess the likelihood of outcomes makes the predictive value of this theory problematic.

Assessing the desirability of various outcomes is also essential for good decision making. Choosing wisely among options is impossible if one’s evaluation of an option is inaccurate or incomplete (Arkes, 2003). Even in laboratory settings, subjects cannot make accurate judgments about the value of certain outcomes because they privilege their current experience (e.g., a gambler during a winning streak is likely to be more positive about his/her chances of continued winning than statistical probabilities warrant). Therefore, decisions are made more on the basis of “experienced utility,” than “expected utility.”

For this reason, it is difficult for most people to evaluate all possible outcomes of a decision, especially when they have never experienced a particular outcome before.

For example, a woman who is experiencing intense pain during labor may welcome a cesarean delivery because it shortens the duration of her pain. Never having experienced recovery from surgery before, it may be difficult for her to weigh the utility of a painless delivery now with a potentially longer and painful recovery later. First-time mothers, in particular, who have never cared for their own infant before, may not appreciate the impact of certain decisions on their newborn or their transition to motherhood (e.g., learning to care for a newborn while recovering from abdominal surgery).

Even when patients can anticipate the outcome of their choices, those outcomes are weighed by each individual in the context of her personal values and social context. In other words, human beings are not rational computers, but social creatures who assign deep personal meaning to experiences:

The probability of various possible outcomes from vaginal or cesarean births, such as future fertility, duration of recovery, or subsequent incontinence, can be measured scientifically, but probabilities alone will not tell us how individual women value these outcomes. ...slow recovery from abdominal surgery may represent a crisis for a single mother with several other children at home and little or no paid maternity leave, or a relatively minor discomfort for a first-time mother with a supportive and available spouse...there is just no answer to how risky an approach to delivery is on the basis of statistics alone; women's perspectives necessarily play a role in measuring risk in the first place (Kukla et al., 2009).

Other theorists add further important contextual dimensions to decision science. Loewenstein (1996 as cited in Arkes, 2003) asserted that "drive states", including hunger, pain and other visceral influences, can have a significant impact on decision-making

behavior. Because they are primal biological needs, drive states have a powerful impact on behavior that can be stronger than rationality. Hence, a woman who has been in labor for 24 hours, and is hungry, thirsty, fearful, and in pain, cannot be expected to make decisions based on a purely rational weighing of options. Loewenstein (as cited in Arkes, 2003) also noted that patients underestimate the role visceral influences can play when making decisions behavior. Based on this hypothesis, a first-time mother who has never experienced the pain of labor but plans to have a natural childbirth may be underestimating the effect of the physical sensations of labor on her ability to cope when she is actually in labor.

To further complicate decision-making, the probability and utility of potential outcomes can be “framed” in a way that biases the understanding of the problem and the way it is processed (Arkes, 2003). Because people are not rational computers, they cannot offer information in a purely objective way.

The act of offering a choice does not merely transparently convey information. Rather, it is a substantive communicative act, and as such it can have important performative effects; in particular, it can shift values and preferences at the same time as it makes room for acting on these values and preferences (Kukla et al., 2009).

In obstetric care, women may not be given informed consent or allowed to make choices because the consent process in obstetrics varies based on the individual that provides the information, the information that is shared, and how that information is presented to a pregnant woman (Amnesty International, 2010) As Zeidenstein notes, “In a typically paternalistic physician-patient relationship, the physician might present only

information on risks and benefits of a procedure that he or she thinks will lead the patient to making the right (i.e., the physician-supported) decision regarding care” (2005).

Further, when presented with similar scenarios, people find a potential loss more disturbing than they find a similar gain satisfying (Arkes, 2003). In the context of childbirth, for example, an intervention that is perceived as lifesaving for mother and/or child may be framed in a way to make it highly desirable (e.g., a doctor or nurse saying, “Sure you can have a natural birth experience, but why not do everything possible to make sure your baby doesn’t die?”)

Patients also judge their decisions in a social context. When making decisions, people evaluate potential outcomes in reference to decisions they believe others would make when faced with a similar decision (Kahneman & Tversky, 1979 as cited in Arkes, 2003). Arkes suggests that “more regret accompanies a poor outcome that follows an atypical course of action (‘Why couldn’t I just do what the doctor suggested?’) as opposed to typical (‘I did what everyone else does in that situation, so my decision cannot be faulted’)” (2003). The idea that avoiding regret may be a powerful motivator for decisions may explain why few women choose non-mainstream options such as midwifery and home birth. If a poor outcome were to occur in this scenario, then the woman may feel more at fault than if a similar poor outcome occurred in a situation perceived as normal (e.g., a physician-attended hospital birth).

Some recent decision theorists argue that utility may be irrelevant altogether in some decision-making situations. For example, in affect-based decisions, people choose mainly on the basis of affective reactions (i.e, conditioned responses) to certain conditions (Loewenstein, Weber, Hsee, & Welch, 2001). In this case, a mother who

believes the hospital is the safest place for birth but is extremely needle-phobic or distrustful of the medical system might still opt for a home birth. Here, deep-seated fear trumps the rational decision-making process.

Role-based decisions do not require the calculation of expected utility because the person's motivation is to behave in a way congruent with one's expected role (March, 1994), not with one's own preferences. For example, if a woman believes her appropriate gender role is to be compliant and non-confrontational, she may acquiesce to suggestions of her partner or provider even when they are rationally not in her best interest. Conversely, her husband may feel a need to play a masculine role by taking charge of decision-making during labor.

Decision making become even more complex when more than one person is involved. Whitney (2008) identifies two key steps in dyadic medical decision making- decisional priority and decisional authority. Decisional priority occurs when one person first identifies one choice as probably best. Decisional authority occurs when one person make the final decision. Although this two-step process has been used to describe how physicians and patients make decisions, it can also be applied to the process by which male and female partners negotiate childbirth choices.

Social Support Theory. Social support is information from others that tells a person he or she is cared for, loved, esteemed, and part of a network of social obligations (Cobb, 1976). Uchino (2004) defines four social support functions: emotional, informational, tangible and belonging. Emotional support includes expressions of caring and concerns. Informational support is the provision of guidance or advice; it can also carry a powerful emotional message. Tangible support is the provision of material aid such as food,

clothing and shelter. Belonging support includes social activities or the availability of others for shared activities. Although defined separately in theory, these functions of social support are associated with each other and not easily divisible in daily life.

Social support can be measured in at least two ways: structural measures focus on the organization of social networks (e.g., number of close friends or amount of time spent in contact with family), while functional measures address the activities performed by social network members (Cohen & Wills, 1985). Another way of measuring social support is its perceived availability (available support) versus the actual support provided to the recipient (received support) (Uchino, 2004). The association between these two measures is not always straightforward; further, some studies have found perceived availability of support to be more highly correlated with successful coping than the actual support received, which seems counter-intuitive.

This dichotomy between the value of received support and available support may explain variation in studies of the effects of social support during pregnancy. Intervention studies of programs that provided social support to high-risk women showed no significant effect on birth weight, but correlation studies have shown that perceived available social support may be associated with better outcomes (Hodnett & Fredericks, 2007).

Uchino (2004) suggests several reasons why received support may not be as useful for coping as perceived report. One of the most important is the quality of the support that is received; while the supporter genuinely may be trying to help, the support is perceived as unhelpful, or even annoying. This scenario may occur in particularly

stressful situations, when the support person feels uncomfortable or unsure about how to provide support that meets the needs of the person undergoing stress.

Childbirth is a stressful situation that may be particularly vulnerable to the dichotomy between the intention behind supportive behavior and how it is received. A study of first-time fathers found generally positive feelings about being present during childbirth, although 41% of fathers reported negative feelings (Nichols, 1993). Common themes found in explorations of men's' feelings during childbirth include helplessness, frustration, anxiety and fear, with young fathers and first-time fathers feeling more discomfort than older, experienced fathers (Berry, 1988; Chapman, 2000; Vehvilainen-Julkunen & Liukkonen, 1998). These unpleasant feelings often intensified along with the labor (Chapman, 2000).

Received support from male partners in labor is not associated consistently with improved birth outcomes, although most studies show mothers greatly value their husbands' presence at birth (i.e., available support) (Ip, 2000). A meta-analysis found fathers' presence at birth was associated with reduced levels of perceived pain, and less need for pain relief (Enkin Keirse, Renfrew & Neilson, 2000.). However, several studies have found that, despite fathers' widespread attendance at birth, the clinical benefits of the presence are not conclusive (Draper, 1997; Gungor & Beji, 2007; Ip, 2000).

In a Turkish study, women whose partners were present had a more positive experience of the birth. However, there was no difference in duration of labor or rates of interventions (Gungor & Beji, 2007). A study conducted in Finland found most women did not expect great things from men; they only wanted the men to be there as partners and to listen to them (Bondas-Salonen, 1998). Some participants recognized that their

husbands needed care, but needed themselves to be the center of attention and did not have the strength to meet their partners' needs. Even when the partner insulted the woman in front of staff, the woman tried to excuse his behavior, and later said it was helpful to have him there. A British study that examined expectations during birth found that where men exceeded their partners' expectations were the areas of "just being there," holding hands, and offering moral support (Singh & Newburn, 2000). Where they did not meet mothers' expectation was in comfort measures, understanding what was going on and decision making.

In a Chinese study, 77.8% of women rated their husband's psychological support as "a great deal" helpful, while only 51% rated their husband's practical support as helpful (Ip, 2000). Fathers' practical support was associated positively with length of labor and dosage of pain relief in the first stage; that is, the *greater* the husband's practical support, the *longer* the labor and the *higher* the dosage of the drug. The researchers suggested that mothers' increased use of pharmaceutical pain relief may be related to her husband's discomfort in seeing her pain. "The result that practical support was strongly related to the amount of pethidine [meperidine (USAN), commonly referred to as Demerol®] used during labour may explain why there was insufficient practical support from fathers perceived by mothers; if the fathers help mainly consists of requesting anesthesia, this may not fulfill the labouring women's other practical needs" (Ip, p. 270).

By contrast, continuous support during labor from a doula, a female labor support person, is associated with a need for reduce pain relief, cesarean and instrumental delivery, reduction in the length of labor, and higher APGAR scores (Hodnett et al.,

2011). However, “the doula effect” seems restricted to women. A recent randomized controlled trial compared the effects of father alone to presence of doula plus father. The presence of a doula reduced epidural and c-section rates, while the presence of the father alone did not (McGrath, & Kennell, 2008). The authors conclude that, while most fathers want to be in the delivery room, and most mothers want them there, they should not be the only, or the primary, support person for the laboring woman.

One explanation for the difference between doula support and father support is that fathers may be too emotionally involved in the birth, and may add to their wives’ anxiety rather than alleviate it (Dellman, 2004). “Giving support to a laboring woman often requires extreme patience and a “let it happen” attitude. A husband made anxious by his wife’s pain and distress may want to assume a more active role and thus be less effective as a supportive companion” (McGrath, & Kennell, 2008, p.96). Chapman (2000) found that as the pain and intensity of labor increases, women turn inwards in what appears to partners to be a turning away from them and their relationship as a couple. This uncharacteristic behavior and related feelings of discomfort on the part of fathers may lead them to encourage the use of epidurals and other pain-relievers, which normalize the laboring woman’s behavior.

Theory of Gender and Power. “In any social situation the possibility exists for alternative definitions of the situation, alternative social realities. Which version is accepted and acted upon is a reflection of the power of the participants” (Katz Rothman, 1978, p.127). Power is a complex concept that has been defined in varying ways by social scientists. One definition particularly applicable to joint decision-making was offered by Max Weber as “the probability that the actor within a social relationship will be in a

position to carry out his [sic] own will despite resistance” (1978, p. 53). Bases of power in relationships include resources (money, skills, status, knowledge, etc.), power processes (interactions such as persuasion, assertiveness, problem-solving), and power outcomes (who gets their way) (Cromwell & Olsen, 1975 as cited in Harvey, Beckman, Browner & Sherman, 2002). Differential access to, and usage of, these resources and processes can influence how couples make important decisions.

Because gender can influence the accumulation of resources, interaction styles, and negotiation outcomes, it can play an important role in the dynamics of decision-making in heterosexual couples (Annandale & Clark, 1996). Gender can be defined as “a complex web of performative ‘rules’ about what can be said and done, by whom, and in what context, in relation to sexual difference “(Connell, 2002 as cited in Eriksson, Westman, & Hamberg, 2006)

Blanc (2001) postulated that gender-based power in relationships can have a direct effect on health by altering the ability of partners to make health-related decisions and to take action to protect or improve their health or the health of their children. And, in fact, some studies have found that women expect to exert power and control over their labor in various ways, but the degree of control they report after birth is often less than they anticipated (Baker, Choi, Henshaw, & Tree, 2005; Lally, Murtagh, Macphail, & Thomson, 2008). Even when women feel in control, their ability to make decisions may be constrained. Men often speak of women’s reproductive decision-making as “letting” women make decisions or “giving her the authority” to make decisions. “Such delegated decision-making authority can lead to the illusion of power for women, suggesting that

women may feel powerful even though they do not have the final decision-making authority” (Harvey, Beckman, Browner & Sherman, 2002, p.287).

The Theory of Gender and Power provides a framework for understanding how a woman’s health-related decisions that affect childbirth may be influenced by gender roles and related power dynamics within her relationship with her partner. This theory states that gendered relationships between men and women influence the extent to which women can exercise power (Connell, 1987). Wingood and DiClemente adapted the Theory of Gender and Power to women’s health, stating that inequities and disparities based in gender create different exposures and risk factors that influence women’s risk for disease (2002). It attributes women’s differential power to three social structures: the sexual division of labor, the sexual division of power, and cathexis (social norms and relationships). These three structures exist at both societal and institutional levels, where they are linked with and reinforce each other:

“Power has multiple sources and forms in both the individual and the social context, and...these are in no way independent. Personality traits, institutional roles, and cultural statuses may affect the balance of power in face-to-face relationships by interacting in complex ways” (Jenkins, 2000, p.475).

In a biological sense, the *sexual division of labor* has a clear influence on childbirth: only persons with functional female reproductive organs can give birth. However, given that biological reality, childbirth occurs in a social and political context (Katz Rothman, 1978). Although most have not used the Theory of Gender and Power explicitly, researchers in the areas of anthropology and sociology have explored how the

sexual division of power and *social norms* affect women's childbirth decisions and experiences.

Cultural anthropologist Robbie Davis-Floyd argues the sexual division of power is deeply engrained in American society at the level of its medical system, reflecting “technocratic” values that privilege technology, science, and patriarchy in the form of technologically-assisted birth (2001). Some sociologists explain the rising rate of cesarean deliveries by focusing on the influence of social belief systems that intersect with gender ideologies in ways that encourage women's acceptance of birth technology (Behague, 2002; Bryant, Port, Tracy & Sullivan, 2007). For example, if cultural norms dictate that women maintain their bodies in ways to enhance male desire, then choosing a cesarean delivery to avoid a “stretched-out” vagina becomes a legitimate option.

The modern paradigm of physician-attended hospital birth, some critics have contended, is not only unjustified by scientific evidence, but also serves social, political and economic agendas unrelated to the best interests of mother and child. These critics of the medicalized model of birth have claimed that medical institutions and the technologies they employ disempower women by controlling and regulating their childbirth experiences (Katz Rothman, 1982; Martin, 1992). Further, they have argued that the medical system co-opts male partners to maintain its power over the childbirth process, since many forms of childbirth education, including The Bradley Method® (also known as Husband-Coached Childbirth) and Lamaze employ the husband in a directive role in the process (Katz Rothman, 1978).

A few studies of childbirth in industrialized countries have focused on the impact of *caregivers within the medical system* on women's decision-making. One study found

that women's perceived inability to control their birth experience, along with negative attitudes from hospital staff, was associated with feelings of fear, anger, disappointment, distress, guilt, and inadequacy (Baker et al., 2005). Another study found that women who changed their birth preferences related to medication (i.e., wanted an unmedicated birth but accepted pain medication) did so partly in response to lack of support from nurses. Additionally, the study found that the birthing context, including the availability of technology, may have had a significant effect on decision-making behaviors related to the birthing process (Carlton, Callister & Stoneman, 2005). A Dutch study investigated the role of mothers and caregivers in childbirth decision-making; however, the researchers did not ask questions about fathers/partners (Van der Hulst et al., 2007). The study found that women had the most level of influence in requests for pharmaceutical pain relief, but midwives had the most influence in deciding to consult or refer to a physician, while obstetricians had the most influence on inducing or augmenting labor or deciding on an assisted delivery (e.g., vacuum extraction or cesarean delivery) In a Swedish study of women's decision-making during childbirth, control between women and caregivers varied from unilateral to shared (VandeVusse, 1999). Laboring women's methods of decision-making included refusal, adaptation, agreement, and making direct requests. The role of fathers was not examined. Draper (1997) suggested that gender and power dynamics between obstetricians, midwives, male partners and women giving birth affect everyone in the relationship, and calls for further study of these dynamics on the process and outcomes of childbirth.

On the *family* level, one study found that some the strongest influences on women's attitudes towards medication during labor are friends and relatives (Sargent &

Stark, 1989). However, little research has been conducted on the specific role of fathers/male partners in decision-making in childbirth.

Feminist Relational Bioethics Theory. Relational autonomy theory applies the theory of gender and power to the traditional bioethical construct of autonomy. Most theories of autonomy identify two concepts inherent in this construct: liberty (independence from controlling influence) and agency (the capacity to act with intention) (Beauchamp & Childress, 2008). “Respect for the autonomy of the patient would, in common parlance, mean that the patient has the capacity to act intentionally, with understanding, and without controlling influences that would mitigate against a free and voluntary act” (McCormick, 1998). However, Kukla and colleagues argue:

This [mainstream bioethical] conception of autonomy does not seem adequate to capture concerns and intuitions that have a strong grip outside this discourse. A proper ethical analysis of birth practices, then, cannot begin by trying to ‘balance’ autonomy and welfare protection, but must (among other things) first provide a more richly textured understanding of autonomy in the context of birth (2009, p.2).

Feminist bioethicist Susan Sherwin and colleagues argue for a stronger standard for truly autonomous action. Sherwin et al. define their concept of relational autonomy as “emphasizing the political dimensions of the multiple relationships that structure an individual’s selfhood” (1998, p. 19). In her discussion of relational autonomy, Sherwin identifies four conditions for autonomy: 1.) The patient is competent (rational) to make the decisions, 2.) The patient makes a reasonable choice from a set of available options; 3.) The patient has adequate information and understanding about her options and 4.) She

is free from coercion in making her decision (Sherwin et al., 1998, p. 26). Sherwin also notes that freedom from coercion is elusive in oppressed groups, especially when it involves arenas (like reproductive health or other gender-based issues) related to the grounds for their oppression (Sherwin et al., 1998).

It is likely that women from different socioeconomic, cultural, and educational backgrounds vary in their access to information about delivery options, their confidence in their own ability to digest this information and make informed judgments about their preferences, and, importantly, their sense of entitlement when it comes to making requests of their providers. Hence if providers opt to discuss a delivery option only after a patient has spontaneously expressed an interest in pursuing it, they risk creating or intensifying systematic inequalities in women's access to this option (Kukla et al., 2009, p.6).

Thachuck (2007) applies the possibility of oppression by male partners through the example of abortion. A woman in an abusive relationship may choose to have an abortion to avoid further contact with her abuser. If the woman is informed, is competent to make the decision, and has not been coerced, then her decision falls under the traditional bioethical notion of autonomy. However, Sherwin would not call this decision wholly autonomous because the woman's decision is constrained by the oppressive nature of her relationship. If she were not in an abusive relationship, for example, she might not choose to abort the fetus (Thachuck, 2007).

In the same way, not all women's decisions during pregnancy or childbirth may be autonomous. "The development of self-trust is an essential component of autonomous decision-making. For those whose selfhood has been continually undermined, in overt or

subtle ways, acquiescing to another's suggestions may appear to be the only option" (Thachuck, 2007). Thus, women who have experienced gender-based discrimination may lack the capacity to act with intention to make their own choices. An example from childbirth is a woman who desires a home birth but "chooses" a hospital birth if her husband expresses his disapproval. Even if he does not coerce her to agree to his plans for the birth, her choices may be constrained if she perceives the future marital conflict, disapproval and stress are not worth advocating for her preference. In this case, the woman has exerted her agency to make a choice, but it is not a fully autonomous one.

Decision-Making Regarding Childbirth

Women's Childbirth Decisions. Women's decisions about childbirth have been the subject of significant research, particularly on topics deemed to be controversial, such as provider and birth place (i.e, midwife-attended home birth) (Galotti et al, 2000; McLachlin & Foster, 2009) and patient-initiated elective cesarean deliveries (Behague, 2002; Lundgren, 2010; Munro, 2009; Thachuck, 2004).

Regarding choice of birth attendant, research suggests that most women do not engage in active research and decision-making (Hoerger and Howard , 1995). Less than a quarter of the women in Heorger and Howard's study considered more than two potential birth attendants, and fewer than 60% of those women took the next step of actually interviewing their alternate choice. Regardless of the type of provider, once a woman chose her provider, in many cases she did not act as an autonomous decision maker, but instead acquiesced to the recommendations of her providers (Galotti et. al, 2000). These findings reinforce the assertion that "there is a sizeable body of qualitative empirical literature demonstrating that often, patients do not particularly want to be

offered more choices concerning their own medical care, nor do they experience such expanded choice as an enhancement of their autonomy” (Kukla et al., 2009).

For those women who actively sought out a maternity care provider, the process involved finding a “fit” with a provider, which included both rational and emotional components (Callister, 1993). Finding a fit included the following steps: (1) making an initial choice by consulting female friends or childbirth educators; (2) confirming the choice by checking out the caregiver, then feeling comfortable or making a change. After birth, women reconciled their prenatal expectations with reality and then re-evaluated their fit with their caregiver. Women who were dissatisfied began the process again.

“The decision making process was framed by access issues, including financial constraints such as health insurance coverage and nonfinancial constraints such as the availability of caregiver specialty, availability of a certain caregiver, and the desire for a caregiver of a specific gender” (Callister, 1993).

Other factors that affect women’s decisions about maternity care provider included race, ethnicity, education, decision-making style, locus of control, health status, previous pregnancy experience, and philosophy of birth (Galotti et al, 2000).

Galotti and colleagues (2000) identified several factors associated with the minority of women who chose midwives for their care: they felt more knowledgeable about birth attendants, more satisfied about their childbirth decisions, more in control of and satisfied with pain medication decisions, more autonomous in their pregnancy decision making, and more in agreement with “alternative birth” philosophies than women who chose physicians. Relevant to the current study, women who chose midwives also reported more approval from spouse/partner and friends, were more likely

to use “gut instinct” and previous experience to make pregnancy decisions, and felt more prepared to make these decisions than women who had not selected a midwife as their primary birth attendant

Another decision made by a minority of women, an elective cesarean delivery, is receiving research interest. Primary drivers of women’s’ decisions for planned cesarean birth include birth stories from women in their social network and cultural narratives from media. However, spouse’s experiences with these issues (e.g., discomfort at watching birth films) also influenced some women’s decisions (Munro, 2009).

Men’s Influence in Childbirth. Although there is a substantial body of literature about men’s role in reproductive decisions, and their role in attending childbirth, few researchers have investigated the decisional influence of men at childbirth.

Background on Men’s Role in Reproductive Health Decisions. The World Health Organization defines reproductive health care as

the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted infections (1998).

Common components of reproductive health include sexual behavior, sexually transmitted diseases, family planning and abortion, pregnancy, childbirth and postpartum care, breastfeeding and maternal and infant nutrition, and infertility (Becker, 1996).

Historically, family planning and other reproductive health programs have focused on women to the exclusion of men. However, in the 1990’s, researchers began to

incorporate men into studies of reproductive health, recognizing that “most sexual, family planning, and childbearing decisions are made or may potentially (and perhaps ideally) be made by both partners of a couple” (Becker, 1996). Since the 1994 International Conference on Population and Development in Cairo, researchers have placed increased emphasis on the effect of gender-based power dynamics on women’s reproductive health (Blanc, 2001).

Male partners have played an important role in women’s decision-making related to family planning and STI prevention (Ali, Rizwan & Ushijima, 2004; Blanc & Wolff, 2002; Chapagain, 2005; Harvey & Bird, 2004; Harvey, Henderson & Casillas, 2006; Orji, Ojofeitimi & Olanrewaju, 2007; Spear, 2004; Speizer, Whittle, & Carter, 2005) and abortion (Alex & Hammarstrom, 2004; Elkstrand, Tyden, Darj, & Larsson, 2007; Holmberg & Wahlberg, 2000).

Locock and Alexander (2006) drew parallels between men’s attendance at childbirth and men’s presence during fetal screening and diagnosis, since both are emotionally challenging experiences for men that require them to be supportive to their partner. In their qualitative study of antenatal screening in the UK, they found men influenced women’s decision-making (i.e. whether or not to abort a fetus diagnosed with a genetic disorder) by playing the roles of “gatherers and guardians of fact,” and “deciders and enforcers,” in addition to more passive roles as parents, bystanders and protectors/supporters.

In the time surrounding birth and immediately afterwards, male partners can have an effect on infant health by influencing breastfeeding attitudes (Kloeblen-Tarver,

Rempel & Rempel, 2004), initiation (Rempel & Rempel, 2004) and duration (Arora, McJunkin, Wehrer & Kuhn, 2000; Rempel & Rempel, 2004).

Despite the inclusion of birth in reproductive health, this area has been comparatively less well-studied than areas such as abortion, family planning and HIV transmission. Most research on the role of males in childbirth decision-making has been conducted in developing countries, with a specific focus reducing maternal mortality. The most important life-saving intervention for pregnant women is access to functioning emergency obstetrical care. Because husbands and family members are often gatekeepers to pregnant women's access to the healthcare system, understanding their role is critical in developing strategies for reducing infant and maternal mortality in developing countries (Dudgeon & Inhorn, 2004). For example, a study of decision-making in childbirth in Ghana found that older female relatives, who are seen as the experts in childbirth, generally make the decision to ask for medical care when a labor does not proceed normally (Jansen, 2006). By contrast, a study in Benin found that encouragement of biomedical care during pregnancy reduces women's decision-making ability, because the cost of these services were greater than traditional care, requiring input from the husband as financial decision-maker (Sargent, 1989). A later study in Guatemala also found that males control access to emergency care during childbirth because the associated costs fall under financial management of the household (Carter, 2002). Another Guatemalan study found that shared decision-making about prenatal care and emergency obstetrical care was more prevalent among couples where both were educated and worked for pay than in couples where the wife was not educated and did not work for pay (Becker, Fonseca-Becker & Schenck-Yglesias, 2006). By contrast, a study in rural

China found that women's power and autonomy were not associated with the training of the birth attendant; however, receipt of prenatal care and delivery under aseptic conditions were associated with the degree to which husbands shared in household chores (Li, 2004).

More research on the role of fathers in decision making has recently been conducted in Europe, particularly Great Britain, where the National Health Service is encouraging women to explore and make informed choices about maternity care (United Kingdom Department of Health, 2007). A qualitative study of men's input into birth place found that most men assumed their partners would give birth in a hospital and, indeed, most women did give birth there with little to no discussion of that choice with their partner (Bedwell, Houghton, Richens & Lavender, 2011). When asked about the possibility of home birth, fathers stated they would disapprove of that choice and would blame their partner if something went wrong, although ultimately it was the woman's decision. A similar study conducted in Sweden found that, among couples who chose home birth, fathers characterized their decision making process as "she leads, I follow" (Lindgren & Erlandsson, 2010).

In the United States, Howell-White (1997) found support from the baby's father played a role in a mother's choice of childbirth attendant. Women who perceived more support for alternative birth options from the baby's father were more likely to select a certified nurse-midwife for their childbirth attendant. Conversely, less support was associated with choosing an obstetrician. Two women who were offered a choice of either a CNM or obstetrician cited their husband as the main reason for choosing the doctor, either because their husbands were more comfortable with the physician or they

thought he/she was more professional. Partner's preferences also extend to birth place; a husband's "unwillingness to have a home birth can lead to a hospital birth even if that is not what the woman prefers. Hesitation and negotiation can lead to a late decision" (Lundgren, 2010) that can preclude a woman from having a home birth.

Although not specifically focused on the role of fathers in birth, one study found fathers had a powerful influence on the course of labor. Using a theoretical framework of internalized gender identities, Martin (2003) explored how everyday gendered interactions affect the ease or difficulty of birth for the woman in labor. Although the sample was small and homogenous (i.e., white, middle-class), the study identified findings that should be explored through further research. Specifically, Martin found that most women feel pressured to conform to social norms about gender during labor. In what she called "the tyranny of nice and kind" (2003, p.61) she found laboring women felt a need to be selfless and reluctant to impose on their husbands, sometimes to the point of placing their partner's needs above their own.

One woman waited until she was in excessive pain before asking her husband for support because she did not want to wake him. Another woman stated that watching her husband cry made her feel more uncomfortable during her labor. LoCicero (1993, p. 1266) suggested this pattern of behavior when she wrote, "Given the centrality of gender in [birth], one might anticipate that a woman giving birth would be expected to act in accordance with the feminine stereotype..." Further, she argues these stereotypes are disadvantageous to the process of labor and birth, stating, "Few situations require women to be stronger, more active, less weak, or, arguably, less submissive, mild or charming, than giving birth!"(p. 1266).

Martin also found “the part of this internalized technology of gender that is “selfless” and relational also often led these women to look to their male partners to describe, define and decide about their experiences during labor, even their bodily ones” (2003, p.63). Almost half went to the hospital when their husbands thought it was time to go. Several women decided to have epidurals based on their husbands’ opinion.

These findings are supported by studies that have shown male partners feel less anxiety during childbirth when the laboring woman received an epidural (Capogna, Camorcia, & Stirparo, 2007; Williams & Umberson, 1999). In some studies (Chandler & Field, 1997; Chapman, 2000), men were able to cope with early labor, but the intensity of later labor, and their wives’ response to it, felt alien and uncomfortable. Some participants felt an epidural promoted a more normal, social atmosphere in the labor room that improved their interactions with caregivers and their wives. The epidural enabled them to reconnect with their wives and exert more control in the decision-making process, in the words of one father:

“I felt like she would respond to me [after the epidural]. She listened to me. If I told her to breathe or told her to relax, that I was getting through to her. Where prior to that [epidural] I felt like she was so focused on what was going on with her and concentrating on the pain and the contractions that she was in her own little space and nothing we could say or do was going to interfere with her train of thought.” (Chapman, 2000, p.133).

Electronic fetal monitors also increased father’s perceptions of engagement in, and control, over the childbirth process (Williams & Umberson, 1999). However, most

women in that study felt that their husband's and doctor's reliance on information from the electronic fetal monitor was useless or annoying:

Well, I couldn't see [the EFM]. That's the only problem. They had them set in sort of a recess in a cupboard so I couldn't see it, but [my husband] was fascinated. [He] was looking at it and he says, "You're getting another contraction." And I'm lying there going, "Don't worry, I can feel it. I don't have to see it on the screen." And then he was looking at all the different peaks and everything and he was like, "Wow! That looks like a big one." I'm like, "Thank you, I know." The only time I would get a little annoyed was when he would tell me, "Oh, that wasn't so bad." And I'm like, "Thank you very much. Let me be the judge of that." (p.160)

When asked what increased his feelings of control during childbirth, one father stated: "Probably the monitor...being able to look at that monitor and know that at any point I could just jump up and go say, "Emergency C-section," or whatever" (p. 159).

These quotations underscore an important subtheme in Williams and Umberson's analysis: by providing a window into the physiology of pregnancy and birth, technology enables men to exert power over the process. Technology is a double-edge tool that can provide expectant fathers with a sense of control over the labor and delivery process while it undermines women's autonomy and gives them the sense of being secondary to the birth process (Eriksson, Salender & Hamberg, 2007). As Martin concludes,

"Culturally, birth has become more real for those with this outsider gaze than those with the lived bodily experience of it... If the "real" perspective on what is

happening or has happened is located in another, not in one's own body, then one is likely to let the other(s) decide how to proceed" (2003, p. 64-65)

Most interesting, however, is that not all women in Martin's (2003) and William's & Umberson's (1999) studies deferred to their husbands' judgment; many who did found assistance from their husbands to be empowering and helpful, which is the purported goal of partner participation in childbirth. These results suggest that the processes of decision making in a dyadic relationship are complex, diverse, and potentially context-sensitive. Findings such as these are consistent with anecdotal evidence from childbirth attendants who report great diversity in the level of involvement of male partners during birth, the content and quality of that involvement, its perceived value to the laboring woman, and its influence on her decisions.

Background on the Role of Men in Labor. Men attend the birth of their children because of expectations or pressure from their partners, to grow closer to their partners by sharing a meaningful experience, and to bond with the child (Backstron et al, 2009; Palkovitz, 1987). However, the most common reason provided by men for attending childbirth is to support their partners (Palkovitz, 1987).

Chapman (1991) identified three main roles fathers play during labor: coach, teammate and witness. Coaches were the most directive of the roles; they felt a strong need to be in control of themselves and the labor. Teammates tended to be followers rather than leaders; they responded to their partners' requests for physical and emotional support. Witnesses were passive observers; they were there primarily to provide moral support and to witness their baby being born. They looked to others to take charge of the situation. Later, Beadshaw (2001) added the role of the advocate, someone who is well-

informed about the couple's rights and advocates for their wishes. Kainz (2010) found five subtypes of men's childbirth role: "the child's father was present, he did not abandon the mother; the child's father pleaded the mother's cause; the child's father inspired the mother to have strength and courage; the child's father and mother—a team; and the child's father and mother become parents."

In a study of how providers perceived fathers during labor and delivery, the researchers identified the following roles men played in becoming a father: bystander, supporter of spouse, partner, and head of the family (Kaila-Behm & Vehvilainen-Julkunen 2000).

Background on Father's Feelings about Birth. Some researchers have studied the effect of labor attendance on men, with an emphasis on how the experience affects men's transition to fatherhood. A study of first-time fathers found generally positive feelings about being present during childbirth, although 41% of fathers reported negative feelings (Nichols, 1993). Common themes found in explorations of men's' feelings during childbirth include helplessness, frustration, anxiety and fear, with young fathers and first-time fathers feeling more discomfort than older, experienced fathers (Berry, 1988; Chapman, 2000; Vehvilainen-Julkunen & Liukkonen, 1998). These unpleasant feelings often intensified along with the labor (Chapman, 2000).

Stress levels were particularly high amongst men who felt they did not fulfill their role expectation, or they perceived pressure to be present at the birth....There appears to be some confusion as to the nature and purpose of men's presence at childbirth. Expectant fathers may not anticipate the psychological and emotional realities of childbirth...(Ericsson et al., 2007)

Ericsson and colleagues (2007) noted that some fathers attempted to control their fears via controlling behaviors; i.e, suggesting an elective c-section. Although the researchers described potential coercive behavior on the part of fathers, this behavior was not fully explored in this study. As noted in the literature on gender and power, however, it seems plausible that gender norms encourage some men to deal with fears and anxieties by invoking power in their sexual relationships.

Contributions of the Proposed Study to the Literature

Based on a review of the literature, as well as anecdotal stories from birth attendants, it is reasonable to assume that fathers play a role in constraining or supporting the choices women make, ultimately affecting their childbirth experience and outcomes. As shown by the previous literature review, however, there are few studies of the fathers' role in clinical decision-making during childbirth in the United States. A search of Medline, PsychInfo, Social Sciences and Dissertation Abstracts databases using the search terms of "fathers" or "males" or "partners" *and* "clinical decision-making" or "decision" *and* "childbirth" did not produce any studies that with a primary focus on the role of fathers in clinical decision-making during childbirth in the United States. The paucity of research in this area is surprising, given the fact that childbirth is the most common reason for hospitalization in the United States, and one of its greatest costs (Russo et al., 2009). "More qualitative research is needed...to include men as major part of women's social environment in both pre- and post-natal health" (Dudgeon & Inhorn, 2004). The proposed study addresses this gap in research by exploring decision-making processes among couples during pregnancy and childbirth.

Chapter Three: Methods

“A human being is the instrument of qualitative methods.”

Patton, 2002, p. 64

Purpose of the Study

This research project was an exploratory study using qualitative methods. The purpose of this study was to identify in which areas of decision-making first-time fathers influenced their partners' choices regarding maternity care. Further, the study sought to elucidate the processes by which couples negotiated childbirth decisions. It also examined the priorities, beliefs and concerns fathers brought to decision making, as well as the roles they fulfilled during the process. To explore these issues, in-depth interviews were conducted with first-time fathers and their female partners before and after the birth of their first child.

Research Questions

The major research questions addressed by this study are as follows:

1. What beliefs, concerns and priorities characterize men's' involvement in childbirth decision-making?
 - a. Does childbirth preparation and birth setting affect these beliefs, concerns and priorities?
2. How do men and women negotiate decisions about childbirth?

3. What roles do men play in negotiating these decisions?
 - a. To what extent and in which areas do men influence women's decisions in childbirth?

To address these research objectives, the author selected the qualitative research paradigm, conducted in-depth interviews with first-time parents as data sources, adopted a pragmatic "craft" interpretivist and feminist stance towards data analysis, and used triangulation of methods and researchers to deepen understanding of relevant issues and optimize the credibility of the study. This chapter will describe and justify the methodological choices that were made to maximize the credibility, transferability, dependability, and confirmability of the results.

Justification for the Qualitative Paradigm

A single, unified definition of qualitative research is elusive, because the term is used to describe a broad range of approaches and methods across different disciplines (Snape & Spencer, 2003). Denzin and Lincoln propose the following definition: "qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (2000, p.3).

Snape and Spencer (2003) offer the following characteristics as being common to all qualitative research: a focus on providing in-depth understandings of the social world of research participants; small samples and purposive selection; interactive data collection methods that enable a relationship between the researcher and participants;

data that are rich, detailed and extensive; analysis that is open to emergent themes; and outputs that interpret and share the social world of participants.

Although “no rigid rules can prescribe what data to gather to investigate a particular interest or problem” (Patton, 2002, p.12), qualitative methods are better suited to some research questions than others. Snape and Spencer (2003) identify four types of research where qualitative methods are particularly useful: contextual, or describing an existing phenomena; explanatory, examining the reasons why something exists; evaluative, appraising the effectiveness of a program or strategy; and generative, developing theories, actions or strategies. Specifically, qualitative methods are particularly appropriate to explore phenomena that are not well understood, deeply rooted in persons’ experience beliefs and feelings, or reflect complex cognitive processes such as decision-making. These latter characteristics are particularly relevant to the research questions of this study.

When studying reproductive decision-making, quantitative research by itself has limited value in understanding the shared process of reproductive decision-making the clients themselves consider important...aspects of couples’ decision-making are inherently phenomenological and are discernible only to the research participants” (Becker, 1996).

Because this study was contextual and explanatory (i.e., it sought to describe reproductive decision-making behavior and the beliefs and concerns that underlie that behavior), it was well-suited to the qualitative research paradigm.

Justification of the Interpretivist Feminist Approach to Qualitative Research

As noted by Patton, “understanding the divergent theoretical and philosophical traditions that have influenced qualitative inquiry is especially important in the design stage when the focus of fieldwork and interviewing is determined” (2002 p. 78).

Therefore, in designing this study, the author read various qualitative research textbooks to determine the theoretical and philosophical traditions that would frame the project.

Because qualitative methods have been developed across disciplines, multiple theoretical, ontological and epistemological perspectives can guide qualitative researchers in their work. Snape and Spencer (2003) identify two major epistemological stances: positivism and interpretivism. The stance of positivism states that phenomena of interest exist outside of, and unaffected by, the researcher; objective inquiry is possible; and the methods of natural science are appropriate for the study of human behavior, which follows predictable laws. By contrast, in interpretivism, the researcher is part of, and interacts with the social world; all research is influenced to some degree by the researcher’s values; and the methods of science that work in laboratory settings do not apply to complex, naturalistic settings. Further, Snape and Spencer (2003) further define six ontological stances, ranging from realism, where an external reality exists outside our understanding of it, to relativism, where there is no single shared social reality, only multiple local social constructions.

Cutting through the complex forest of ontology and epistemology, Patton distinguishes among theoretical perspectives by their foundational questions, a useful approach in searching for a theoretical framework for this study. The foundational questions of the social construction and constructivism paradigm include the following: “How have people in this setting constructed reality? What are their reported perceptions,

“truths,” explanations, beliefs and worldview? What are the consequences for their behaviors and for those with whom they interact?” (Patton, 2002, p 96). These foundational questions apply clearly to the research aims of this project. A major focus of the research study is to understand how expectant mothers and fathers construct their roles during pregnancy and childbirth, the perceptions and beliefs that drive their decision-making behavior, and the consequences of these processes on downstream decisions and birth outcomes.

Social constructionism assumes the lack of a single truth that corresponds with an objective reality; the notion that phenomena are local, and therefore conclusions about them are not generalizable, and findings from studies guided by social constructionism are merely one of an almost infinite number of realities, and therefore carry no special status or weight (Guba & Lincoln, 1989 as cited in Patton, 2002).

Several of these assumptions were problematic for the aims of this study. Clearly, events that are the focus of this research exist in an objective way. An epidural is inserted or it is not; a baby is delivered via C-section or vaginally. Further, the aim of exploring men’s roles in decision-making is not just to understand the lived reality of one particular group of men, but to identify findings that can be applied to other first-time parents.

Therefore, social constructionism in its purest form was not the ideal fit for this study.

An alternative to the social constructionist paradigm is positivist realism, which “posits a real world of objects apart from a human knower who can use language and symbols to accurately describe and explain the truth of this objective reality” (Angen, 2000, p.380). Knowledge is developed by accumulating facts through objective inquiry and based on observable phenomena (Snape & Spencer, 2003). The practical implication

of this stance means that researchers should use the assumptions of mainstream empirical science in designing, conducting, analyzing, and judging the quality of qualitative studies.

The positivist approach to qualitative research offers benefits for the researcher in public health, particularly its acceptability to the health science community.

In a community that values biomedical bench research, sees the randomized controlled trial as a reference standard, holds a belief in an objective reality, and values research that is reliable, valid, and generalizable (typically positivist ideals), it is not surprising that realist views with regard to qualitative research have found favor (Cohen & Crabtree, 2008, p.336).

However, Patton (2002) asserts that positivism has been rejected by most social scientists as a basis for understanding the social world. “It is now generally conceded that neutrality and impartiality are impossible standards to attain and that all knowing is perspectival knowing and therefore partial and open to reinterpretation” (Angen, 2000).

Patton (2002) and Lincoln and Guba (2000) offer postpositivism as a compromise between the unattainable neutrality and absolute truth of positivism and the relativism of constructionism. This falls under the interpretivist paradigm, which Angen (2000) offers as a pragmatic way to address ontological and epistemological challenges for the qualitative researcher. She argues that interpretivism does not necessarily equate to relativism, and that a researcher’s engagement with the research actually enriches understanding:

For the interpretivist, the midpoint between solipsistic relativism and hard-nosed realism lies in the lifeworld. The world of our lived experience, the lifeworld, is

the very ground from which all understanding grows; what we know is always negotiated within the culturally informed relationships and experiences, the talk and text, of our everyday lives. An interpretivist approach is attuned to the dialogical context of human understanding, arguing that we cannot step outside of our intersubjective involvement with the lifeworld and into some mythical, all-knowing, and neutral standpoint (Angen, 2000, p.384)

Ulin and colleagues (2005, p.18) characterize the interpretivist paradigm as a holistic approach that explores and links subjective perceptions, objective behaviors, and social, cultural and physical context. This holistic, middle ground interpretivist approach seemed the best approach to this type of study, which focused on parental perceptions and behaviors in social context.

As a complement to the interpretivist approach, this study also included the feminist perspective in study methods. “Feminist research frameworks are concerned with the gender and power dimensions of social phenomena that shape people’s lives” (Ulin et al., 2005, p. 21). Because this study focused on the role that men played in women’s childbirth decisions, it is possible that gendered power relationships played into this process. Therefore, a feminist approach seemed appropriate. However, feminist research is not just about women; feminist theorists have been instrumental in highlighting the absence of men from discourses about women’s sexual and reproductive health (Ulin et al, 2005). A review of the literature suggests that men’s voices have been conspicuously absent in the debate about women’s childbirth decisions, and therefore more research is necessary on the male perspective. Navigating these gender and power dynamics required a sensitivity to gender that is a strength of the feminist perspective.

Approach and Methodology as “Craft”

Lincoln and Guba (2000) stated that each qualitative research paradigm is associated with a specific methodology. Further, they argue a researcher’s preferred paradigm often drives his or her research aims, quality criteria, ethics and voice, among other methodological choices. However, other researchers argue that qualitative research methods do not have to be linked explicitly to particular philosophical or paradigm positions (Seale, 1999). Patton asserts that the paradigms debate is now “withering;” in qualitative research; “methodological tolerance, flexibility, eclecticism and concern for appropriateness rather than orthodoxy now characterize the practice...”(Patton, 2002, p. 585).

Seale (1999) suggested that social research is an art or craft, best learned through apprenticeship to a variety of ontological and methodological traditions, rather than adherence to strict methodological rules. He encourages social researchers “to develop research skills taken from a number of genres (quantitative as well as qualitative, in fact), in much the same way as artists learn how to paint, draw, or sculpt in a number of different styles (1999, p.476).” Angen (2000) also considers interpretive inquiry to be a craft best learned through deep reflection, study and practice.

In interpretive inquiry, there is no choice but to be responsible for choosing, and much of the craft of the inquiry process lies on the shoulders of the person conducting the investigation. As investigators, we are responsible for choosing topics that have practical value; our research should be both relevant and beneficial to those concerned. The complexity of human experience and our

shared humanity must figure in to our questions, our investigative processes, and, ultimately, our answers (Angen, 2000, p. 392).

Rather than attempt to fit this particular study artificially into one particular methodological frame, the author chose to follow the craft interpretivist approach, and selected each component of the methodology based on its fitness for the particular research question.

Study Population

Sample. The proposed research study used a purposeful sampling methodology, where information-rich data sources are selected to illuminate the research question (Patton, 2002, p.46). Participants were recruited using maximum variation sampling because a demographically heterogeneous sample allows researchers to both identify different perspectives on complex phenomenon and identify common themes that emerge despite other differences (Ulin et al., 2005, p.73). Therefore, the sampling method sought to include couples of varying races and ethnicities and birth plans who fit the study's inclusion criteria.

Sampling began with an a priori sample of 15 adult couples, with both partners over the age of 18, selected to represent diversity in race, ethnicity and marital status. This sample size was selected partly on the basis of previous studies, which suggest theoretical saturation is likely to be reached with 12 interviews, with main themes emerging after 6 interviews (Guest & Bunce, 2003)

As data collection and analysis proceeded, the researcher made sampling additions and modifications as necessary until the point of theoretical saturation had been reached (Ulin, Robinson, & Tolley, 2005, p. 54). Several key themes began to emerge

after the first six to eight interviews; however, data collection until 15 couples were interviewed both prenatally and postpartum. One couple completed the prenatal interview but was lost to follow up for the postpartum interview. Therefore, an additional couple was recruited to fill the quota of 15 prenatal interviews and 15 postpartum interviews.

Inclusion Criteria: Participating couples were first-time expectant parents with an involved male partner, where the target pregnancy was the first birth experience for both partners. Male involvement during pregnancy has been categorized as participation in antenatal care and childbirth classes (Ekeus & Christensson, 2003). To ensure that partners were sufficiently engaged in the pregnancy to influence decision-making, couples must have been married, living together as married, or have been involved in a committed relationship for at least one year prior to the birth. Furthermore, to ensure that partners could comment on their comfort level with the planned childbirth attendant, the male partner must have attended at least one prenatal appointment with his significant other.

Exclusion Criteria: The sample was restricted to first-time parents because decision-making among first-time parents and more experienced parents may vary. Prior birth experience on the part of one partner may imbue that person with more knowledge, and thus more power over decision-making. In addition, prior experience with childbirth and a long-standing relationship with a provider may strongly influence couples' decisions in a current pregnancy, restricting the amount of decisions they feel compelled to make. Limiting the sample to first-time couples enabled the fullest exploration of decision-making and reduces the influence of prior childbirth experience on the resulting findings.

Evidence suggests that gender roles and decision-making power vary by culture (Uchino, 2004). Because the focus is on decision-making in the United States, study participation was restricted to couples where both partners were native-born United States citizens. Because the primary researcher was not fluent in any other language, all study participants were required to be fluent English speakers.

Diversity of Birth Plans: The sampling design called for at least two couple planning their birth with a midwife. This is an overrepresentation of midwife-attended births compared to the general population (Martin et al., 2010); however, the process by which women and their partners become aware of, consider, research and accept or decline midwifery care is of particular interest in this study for several reasons.

First, analysis of “extreme cases” may provide key insights into differing perspectives on the same phenomenon and increase the credibility of the data (Patton, 2002; Ulin et al., 2005). Because midwife-attended births, particularly in out-of-hospital settings, are a small minority of all births (Martin et al., 2010) they represent an important deviation from the dominant paradigm of maternity care.

Although analysis may seek common ground or consensus across different individuals or groups, it is equally important to understand how and why individuals or groups differ with respect to issues under study. Identifying and tracking exceptions may yield important insights and lead to a better understanding of the research problem (Ulin et al., 2005, p. 141).

Second, choosing midwifery care may require a more complex and rich negotiation process between partners. “Unlike the usual unreflexive ‘choice’ to subscribe to the medical model, the move to a midwifery model of maternal care requires an active

commitment to the ideology and concomitant practices of midwifery...” (Kline, 2007, p. 27). This active commitment may be more subject to the influence of male partners than the commonplace choice made by most mothers, and therefore provides a fruitful source of data about the role of fathers in childbirth decision-making.

Third, Martin (2003) found that women who were less likely to acquiesce to their husbands’ wishes during childbirth were also more likely to have a midwife-attended home birth, and suggested further research to explore this phenomenon.

Fourth, Williams and Umberson (1999) suggested that medical technology enhances the level of male influence in childbirth: “Medical involvement appears to result for many expectant mothers in the transference of some level of control and ownership of the process, not only to the medical profession, but to their husbands” (p. 165). By contrast, Dellman (2004) suggests that male partners may have *less* control over childbirth in high-technology setting. In a hospital, caregivers may play conflicting roles, enforcing hospital policies that may conflict with the couple’s birth plan. Husbands may need to be more of an advocate for the couple’s decisions in hospital settings, but may not feel comfortable challenging the authority of doctors and obstetrical policies. Perhaps the interaction of male autonomy and technology occurs differently depending on the gender dynamics of the couple and the context of the birth. A key principle of qualitative research is attention to the social context in which phenomena occur (Ulin et al., 2005). Including both technology-intensive settings and non-medicalized settings illustrated how birth context and provider-father interactions influenced the couple’s decision-making process. Therefore, the research was designed to include couples who planned to have their babies in hospitals, birth centers and at home.

The researcher was unable to obtain a full spectrum of childbirth experiences in the study, which is detailed in the limitations section. Although the author was contacted by a couple who selected an elective cesarean, they would not consent to participate in the study. In the same way, the study did not reach any “freebirthers”, those who give birth at home unassisted by any medically trained personnel, most likely because recruitment occurred through providers.

Location and Setting of the Study: Interviews were conducted in three main locations: Miami, Florida; metropolitan Tampa, Florida; and northern New York State. These study locales enabled the researcher to draw from urban, suburban and rural populations, reflecting diversity in availability of maternity care providers, both in numbers and types as regulated by the state. During the years that data were collected, 2009 and 2010, the cesarean delivery rate in Miami-Dade County was 49.3% (Florida Department of Health [DOH], 2011). This high cesarean delivery rate describes the likelihood of couples in Miami to have a cesarean delivery and provides context for decision-making among couples who wished to avoid a cesarean delivery. Miami-Dade County is a major metropolitan area that offers a variety of providers and settings for birth, ranging from home birth with licensed midwives to university-affiliated tertiary care centers. The Tampa Bay region of Florida encompasses both urban and suburban settings, along with some rural areas, also with diversity of birth providers and settings. Northern New York is primarily a rural area spanning several rural counties with the majority of providers being physicians in hospital settings.

Participants were invited to participate in face-to-face interviews, although phone interviews were arranged as needed. The primary researcher offered to schedule

interviews in a location convenient to the couple, either in their home or a restaurant, park, library, or other location. All of the couples chose to conduct the interviews in their homes or via phone rather than in a public place. Mothers and fathers were interviewed separately, to reduce censoring of responses that might occur due to unequal power dynamics in the relationship or the desire to present a unified, consistent story. Separate interviews encouraged women to be frank and protected them from potential harm or conflict if they disclosed anything that would upset their husbands if said in their presence. In the postpartum interview, the author arranged separate interviews by asking one parent to take the newborn into another part of the house while the other partner was interviewed. interviews were conducted in one visit, with one interview immediately following another, so partners were not be able to consolidate their birth narratives prior to the interviews.

The primary researcher had moved out of state of Florida after completing the initial interview with three Florida resident couples; in other cases, two participants moved after the first interview. One couple lived in a remote rural area and preferred conducting both prenatal and postnatal interviews via phone. Therefore, one prenatal interview and six postpartum follow-up interviews were conducted by phone; the remaining interviews were conducted in person.

Recruitment. Participants were recruited initially through maternity care providers (midwives and physicians) in the targeted regions. Providers from the author's professional network, supplemented by providers randomly drawn from the phone directory, received a cover letter describing the survey and copies of recruitment flyers to distribute to their clients (see appendix). One hundred fifty recruitment flyers were

distributed. Interested participants called the toll-free number on the flyer and were screened for eligibility by the primary researcher. If the couple was eligible, the first interview was scheduled. In addition, after an initial difficulty recruiting African-American couples into the study, the researcher conducted an additional outreach mailing to providers of color. After noting an initial low response from physician practices, the researcher also expanded the recruitment to include childbirth educators. To ensure sufficient time to conduct the first interview before the birth, participating couples were recruited before 36 weeks of pregnancy.

Data Collection Procedures

Timing of Interviews. The first interview was scheduled at 32-37 weeks of pregnancy and elicited plans for labor and delivery, and the influence of the male partner in decisions made to date. The second interview captured the birth experience and the decision-making processes that occurred during labor. All couples participated in the prenatal interview between 32 and 41 weeks of pregnancy. All postpartum interviews were conducted within three months of the birth, with 14 out of the 15 conducted within the first six weeks postpartum.

The researcher asked women and their partners similar questions about their plans for labor and delivery, their interactions as a dyad, and their decision-making processes as a couple both prior to and during delivery. Using this approach generated rich descriptions of each partners' perceptions of their dyadic experiences, and of the shift in beliefs, intentions and couple dynamics over time and across contexts.

Each interview took 20-60 minutes per person (i.e., ninety minutes per couple at both of the interview points) for a total of approximately three hours total interview time.

Demographic Data. Demographic questions related to participants' age, race/ethnicity, marital status and education were asked prior to beginning the formal interview and recorded on the interview guide. The data were then entered into a Microsoft Excel spreadsheet, along with contact information for each participant.

Individual Semi-Structured Interviews. Interviews followed a semi-structured format, using a topic guide, as recommended by Ulin and colleagues (2005, p. 102). See the appendix for a copy of the topic guide. An initial interview guide was developed based on the literature review and study objectives, pilot tested with three couples, and then finalized with feedback from dissertation committee members. The pilot test focused on whether participants understood the questions and terms used, whether any questions were judgmental or made participants uncomfortable, and the degree to which questions elicited information-rich responses.

The interview guide included two major categories: descriptive and probing questions. Descriptive questions asked participants about their planned birth experience (in the first interview) and their actual birth experience (in the second interview). Probing questions were then asked to elicit deeper responses to previously asked questions (Ulin et al., 2005). Careful listening and probing allowed opportunities for the interviewees to lead the discussion and/or for the interviewer to introduce new questions, depending on the participants' lived experience (Reinharz, 1992, p. 21). Interviewing techniques balanced the need to engage and empower participants while covering the required topics.

To establish rapport with participants (Patton, 2002), prior to the prenatal interview, the researcher congratulated couples on their pregnancy and explained the

purpose of the research and confidentiality procedures. The researcher concluded the prenatal interview by wishing couples a safe birth, healthy outcome for mother and baby, and the birth experience they preferred. Prior to the second interview, the researcher confirmed that the family was healthy and doing well and congratulated the couple of their new baby prior to beginning the formal interview. The second interview was concluded by wishing the new family well.

After obtaining consent but prior to conducting the first interview, the researcher asked for permission to audiotape the discussion and reiterated confidentiality procedures. None of the participants objected to being recorded. The primary researcher recorded the interviews on a digital recorder while simultaneously taking handwritten field notes on a hard copy of the participant's interview guide. Field notes included interview context; participant demeanor, facial expressions and body language; the researcher's subjective perception of individual emotional states and the quality of couple interaction, and a summary of the researcher's thoughts about the interview.

Technical Research Procedures

Transcription Quality. Interviews were transcribed verbatim by a research assistant who had completed human subjects training. This research assistant was a community health undergraduate student and Registered Nurse with medical transcription experience. The research assistant was trained to follow Poland's instructions (2002) for notation systems and strategies for ensuring high quality tape recording, including recording pauses, laughing, comments, interruptions, flagging garbled speech and noting what the guessed correct phrase is, and using uppercase letters for emphasis (because formatting is sometimes lost upon import into qualitative analysis systems).

At the Interview

1. Check batteries regularly and bring along extras to the interviews.
 2. Choose an interview site that is quiet and free from interruptions.
 3. Place microphone close to respondent.
 4. Test the recording system.
 5. Speak clearly and slowly to act as an example for the respondent.
-

After the interview

1. Listen to the tape and makes notes that will facilitate transcription while the interview is fresh in your mind.
 2. Make backup copies of recording before handing them over to the transcriber
 3. Label each recording with pre-identified pseudonym for the participant; add recording file number and time code to participant records.
-

Figure 1. Strategies for Ensuring High Quality Tape Recording (adapted from Poland (2002) and Patton (2002))

The research assistant flagged areas of the transcription where sound quality was poor (i.e, a loudly-crying baby in the next room) or an unknown term was used. The primary researcher then listened to each interview and checked the transcript for accuracy, paying particular attention to areas flagged during transcription. Since the transcriptionist was not a midwife, most areas of confusion related to midwifery terms, particularly names of homeopathic and herbal remedies used by home birth midwives. Omissions were corrected in the final transcripts prior to uploading into qualitative analysis software. For example, in one instance the original transcription read, “I had a cervical lip so [midwife’s name] applied [?] to reduce the swelling.” After reviewing the

original digital audio file, the primary researcher corrected the statement to read as follows: “I had a cervical lip, so [midwife’s name] applied Arnica to reduce the swelling.” (Arnica is a homeopathic remedy often used by midwives and is applied in gel form to the cervix of a woman who is almost fully dilated, but with some anterior cervix remaining.)

Confidentiality. Electronic files were kept in password-protected files on a secure server, and the digital audio recorder and hard copies of transcripts and field notes/interview guides were kept in a locked file cabinet.

Protection of Human Subjects. Prior to conducting the research, the primary researcher obtained approval from the Social and Behavioral Sciences Institutional Review Board (IRB) at the University of South Florida. Informed consent was obtained using processes and forms consistent with university policies and approved by the IRB. At the end of the second interview, couples received a \$25 retail gift card for their participation, which was a reasonable incentive for participation, but not large enough to be coercive.

One of the women had planned a home birth that included a lengthy labor at home, transfer to the hospital, and then a cesarean delivery. She spoke for approximately 90 minutes at her postpartum interview. The length of her labor, the number of decision points within it, and her reflections on her experience all contributed to the length of the interview. During the interview, she expressed conflicting feelings about her partner and the providers involved in her care, and became visibly emotional. Concerned about the possibility of postpartum depression, as well as the possibility of the study inadvertently inflicting psychological harm, the primary researcher encouraged her to contact a mental

health provider for counseling. This participant stated that it had been “therapeutic” for her to speak with someone who was knowledgeable about childbirth, specifically home birth and midwifery, but not involved with her care, so she could vent her feelings and frustrations.

Data Analysis

Modified Inductive Analytical Approach. Although various theoretical perspectives guided the development of the research questions, analysis followed a modified inductive process of thematic analysis. The goal of the analysis was to generate new knowledge about the role of male partners in childbirth decision-making. Inductive analysis is appropriate to analyze transcripts of decision-making interviews to identify the social and contextual factors that influence decisions (Pierce & Hicks, 2001). Areas where researchers have explored the effect of couple dynamics and decision-making processes on pregnancy include smoking cessation during pregnancy (Botoroff et al., 2006), disposition of frozen embryos (Lyerly, et. al 2006), and prenatal testing (McCoyd, 2008). These studies share a similar inductive analysis process. This study drew on these works and followed the in-depth, iterative and inductive process outlined by Ulin and colleagues (2005, p. 144): immersion, coding (broad labels related to study questions, followed by continuous content-driven coding), data reduction (identification of themes and subthemes), and interpretation.

However, the coding, data reduction and interpretation processes were iterative and included deductive as well as inductive components, because,

“understanding of human behavior emerges slowly and nonlinearly. As in design and implementation, qualitative analysis typically follows an iterative path. A

flexible and integrated approach is therefore essential if the researcher is to understand complex issues from the participants' perspectives. It may, in fact, take numerous rounds of questioning, reflecting, rephrasing, analyzing, theorizing, and verifying" (Ulin et al, 2005, p. 144).

Coding Procedures. Prior to coding, the researcher organized narratives in the following order to complete a case study for each couple: male prenatal, female prenatal, male postpartum, and female postpartum. A modified constant comparative or continuous analysis method was used to analyze the data. Coding each interview after it is completed provides many advantages, including the ability to identify gaps or biases early in data collection, when it is still possible to refine data collection and sampling methods and gather more data (Ulin et al., p.152). However, the primary researcher coded interviews in groups of two or three at a time, due to practical limitations of the researcher's and transcriptionist's work schedules.

After immersion in the data, the primary researcher used ATLAS.ti to assign initial open codes, create coding/analytical memos and flag quotations representative of each code. Particularly for the first research question—beliefs, concerns and priorities of male partners—coding prioritized the male narratives while finding confirming or disconfirming codes in female narratives. The researcher then used the ATLAS.ti *families* feature in data reduction, building a second level of themes representing concepts from the data that shared common features. In this fashion, 46 preliminary codes were collapsed into 21 second-level themes. The author then developed 15 final themes connecting and consolidating all of the second-level themes without loss of any key concepts.

By contrast, a second coder and peer reviewer conducted coding manually at the end of data collection, resulting in triangulation of coding methods (constant comparative versus *post hoc*, and manual paper-based coding via software-assisted coding). The two coders reconciled disparities in codes and themes via discussion and negotiation, although those discrepancies were minimal. More information about this triangulation process is provided in the section on study trustworthiness.

Themes were reviewed by the expert panel of reviewers on the doctoral committee, who encouraged another level of deductive analysis vis-à-vis the research questions. The initial themes were modified slightly and confirmed with the second researcher/peer reviewer in a second consensus process.

Iterative Coding with Actor Interaction Models. The primary analytical technique for this study was thematic analysis. However, to understand the points of convergence and divergence within each couple's individual narratives, it was helpful to create a coherent case study for each couple that focused on key decision points (see Botoroff et al., 2006; Lyerly, et. al 2006; and McCoyd, 2008). The principal researcher selected the approach of actor interaction models, a method of building conceptual models of decisions (Bernard & Ryan, 2009, p 130.). This framework calls for analyzing the internal (beliefs, emotions) and external (physical, social) environments that inform interactions between two individuals. The primary researcher read through the interviews and developed a decision matrix using paraphrases or quotes from participants, along with initial codes. This analysis produced a list of contextual factors, thoughts, emotions and quotes surrounding common decision points. Using this technique required the researcher to ask more in-depth questions about feelings and thought processes at key

decision points, which improved the quality of probing questions and enhanced the depth of the interviews.

The results of this analysis were used in developing and refining codes and themes. Together, the two methods of data analysis provided a synergy of results. Examples of complete actor interaction matrices are provided in the appendix. The samples were selected to represent a variety of birth settings, including hospital, out-of-hospital, and home-to-hospital transfer.

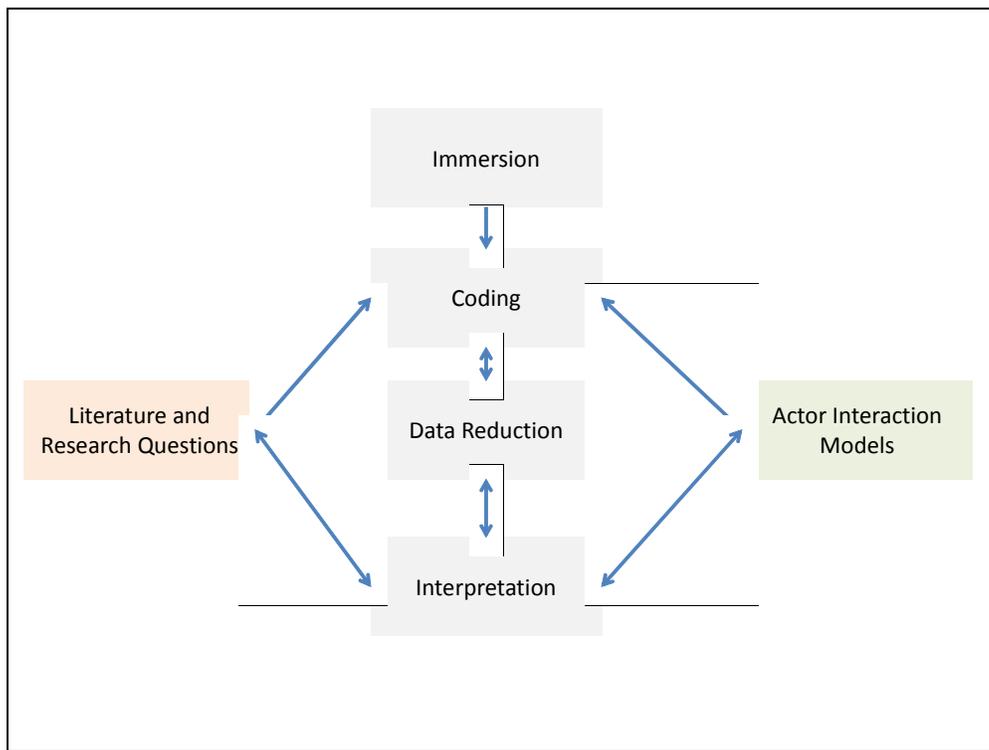


Figure 2. Modified Inductive Analysis Process. Adapted from Ulin et al, 2005 and Patton, 2002.

Data Interpretation. Because extensive literature review may bias the researcher towards existing theories (Patton, 2002), the author limited the initial literature review to ensure that themes that emerged would truly arise from the data, and not recollection of prior work. After identifying initial themes inductively, the primary researcher followed a deductive confirmatory process to verify the robustness of the analysis (Patton, 2002, p.454). As part of this confirmatory process, the researcher conducted an expanded literature review in the area of clinical decision-making, which enabled more robust theory and confirming of finding findings with previous research.

Research Question 1. For this question, the deductive confirmatory step focused on patient decision-making literature. For example, one of the themes that emerged from the data was a belief among first-time couples that their labor would be shorter and less painful than the norm. During the expanded literature review, the author identified a body of work on optimistic bias, a psychological construct that describes the human cognitive bias towards overconfidence in their own abilities (Weinstein, 2003). As a result, the author was able to use the term optimistic bias to concisely convey this concept in the discussion of results and to confirm the accuracy of the theory developed during analysis.

Research Question 2. Data reduction and interpretation of the thematic analysis included a deductive process of corroboration with Whitney's (2008) two-step process of shared medical decision making. In the first-step, decisional priority, one person suggests one option that appears the best of all the possibilities. In the second step, decisional authority, one person makes the final decision. Decision making processes were then discussed in terms of whether or not there was intrapersonal negotiation and, if so, which partner asserted priority and which asserted authority.

Research Question 3. To identify names for each of the roles identified through thematic analysis, the primary researcher reviewed studies that explored men's roles in reproductive decision making. Theory developed in the study was corroborating by finding similar roles in these findings with previous research. In addition, where names of existing roles described a role also identified in this study, that name was adopted to ensure continuity with the literature.

Presentation of Results. After writing an initial report of findings, the author shared results with the second coder/reviewer and held a discussion focused on the content of the analysis and the potential for bias. Comments resulting from this discussion were incorporated into the dissertation manuscript. The peer reviewer also asked permission to share the results with their obstetrical nursing faculty at his institution for additional feedback, which was also incorporated into the final draft.

In addition, the author shared the results with the student intern who had transcribed the majority of the comments; the transcriptionist was also a nurse and mother of five, having experienced a range of childbirth experiences from natural childbirth through cesarean delivery. We met in person to discuss inconsistencies between raw data and findings, as well as to look for potential sources of bias based on the pre-analysis bracketing interview. No inconsistencies or biases were noted.

After the first round of review, the primary author shared the manuscript with the expert panel on the dissertation committee who suggested changes to the thematic structure. After making these changes, the author shared the revised manuscript with the second coder/peer reviewer and a second consensus-building process occurred prior to submission of the final manuscript.

Use of Pseudonyms. The author promised confidentiality to participants in this study and to the Institution Review Board that reviewed the research project. Therefore, quotes from participants are presented using pseudonyms instead of their real names. The use of pseudonyms to present data from participants is ubiquitous in qualitative research and is rarely discussed in the literature (Guenther, 2009). However, heeding Angen's admonition that qualitative researchers are always "responsible for choosing" (2002), the primary researcher explored this methodological choice. Gunether (2009) argues that "because names are powerful, choosing to use – or to alter – them is also an act of power," and that there are some compelling reasons to use real names, including the argument that readers can sometimes decode the pseudonyms and that participants may want their actual voices to be heard. However, given the focus in this study on gender and power dynamics, as well as the fact that one couple was complicit in a felony by having a home birth attended by a direct-entry midwife in a state where that was prohibited, the author remained confident in the decision to use pseudonyms.

Quality Criteria in Qualitative Research

In designing the study, the author planned ahead to verify results, recognizing that "reliability and validity should not be evaluated at the end of the project, but should be goals that shape the entire research process, influencing study design, data collection, and analysis choices" (Cohen & Crabtree, 2008). However, like methodology, quality in qualitative research often becomes entangled in larger discourses of ontology and epistemology (Pope & Mays, 2006, p 90). Like many other aspects of qualitative research, the proper way to verify results is subject to controversy and grounded in entrenched philosophy.

Mays and Pope (2000) suggest two main schools of thought for qualitative research in health care. The first one states that validity and reliability, as defined by the realist paradigm, are important criteria for evaluating qualitative research; without them, qualitative research risks being seen as unscientific and inexact. The second states that applying empirical standards of validity and reliability to qualitative research is inappropriate, and therefore qualitative researchers must define their own standards for quality.

Cohen and Crabtree (2008) argue the first approach is common in health care qualitative research because it “assimilate[s] the values, beliefs, and criteria for rigorous research that emerge from the positivist paradigm.” Among these values are validity, reliability, and generalizability; “the holy trinity of natural science research” (Angen, 2000, p. 382). Validity is the degree to which the research represents an external underlying truth; reliability, the extent to which results can be verified through replication of study methods; and generalizability, the extent to which results can be applied (Mays and Pope, 2000). Qualitative research that purports to identify a valid, reliable and generalizable truth, like that supposedly attained from biomedical research, has greater cache in the health care community, and is more likely to be supported through research funding and publication (Angen, 2000; Cohen & Crabtree, 2008).

However, some qualitative researchers argue that validity, reliability, and generalizability cannot be determined in qualitative research using methods developed in quantitative research (Angen 2000; Seale, 1999). Silverman (1993) proposed that qualitative researchers adopt alternative validation methods to approximate as closely as

possible the goals of validity, reliability and generalizability, and therefore retain the ability to claim an objective truth about the phenomenon under study.

Cohen and Crabtree (2008) note these alternative validation techniques “may foster the appearance of validity and reliability, but can be problematic if inappropriately applied.” They note that alternate criteria (1) cannot be applied to all qualitative studies in a prescribed manner (2) do not necessarily lead to higher-quality research, particularly in the hands of inept researchers; and (3) foster an belief among evaluators of research that use of these techniques guarantees higher quality, thereby reducing their motivation to question the research methods and conclusions of studies using these methods. Others (Angen 2000) reject alternative methods because they posit an external truth against which study findings can be compared. Nielsen (1995) argues that the adoption of positivist criteria such as those described above is “in danger of making qualitative research into bad quantitative research” (p. 8. as cited in Angen, 2000).

Therefore, a third approach to rigor and quality suggests the search for a unified set of evaluative criteria for qualitative research is misguided.

The hotly contested debate about whether quality criteria should be applied to qualitative research, together with the differences of view between ‘experts’, about which criteria are appropriate and how they should be assessed, should warn again unthinking reliance on any one set of criteria” (Mays & Pope, 2000, p. 98)

Instead, researchers need to recognize each study is unique in its theoretical positioning and approach, and different evaluative criteria are needed to evaluate its quality.

“Because the use of specific procedures is no longer viewed as a guarantee against the taint of subjective bias, interpretive reformulations of validity are less about normative methodological criteria and abstract procedural rules and more about broad principles that must be carefully considered in each specific instance” (Haraway, 1988).

Lincoln and Guba (1985) argue that these principles should address the central question of: "How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of?" (p. 301 as cited in Patton, 2002). Criteria for trustworthiness for interpretivist researchers include credibility, transferability, dependability, and confirmability (Patton 2002; Ulin et al., 2005).

Credibility. Credibility is the analogue of validity in the natural sciences and refers to the ability to generate interpretations of qualitative data that are consistent with the data and have truth value to readers (Ulin et al, p.25) Patton (2002, p. 552-553) argues that credibility results from three components of inquiry: rigorous methods, a credible researcher, and a commitment to the value of qualitative research. Researchers enhance the credibility of their research when they document consideration of negative cases and alternative hypotheses, analyze inconsistencies from triangulation of methods or researchers (Ulin et al., 2005; Patton 2002) and demonstrate self-reflection about potential biases (Patton, 2002). The primary author considered each of these points in developing the findings of this study.

Dependability. Just as validity has its analogue in credibility, reliability has its analogue in dependability (Ulin et al, 2005 p.25). Studies that are dependable have the

ability to be reconstructed or replicated by others. Therefore, qualitative researchers should carefully document each step of their studies to ensure that other researchers could conduct a similar study in a similar context. Triangulation of researchers can also help increase dependability by demonstrating consistency of findings across data analysts. This study used both documentation and triangulation to ensure dependability.

Confirmability. Confirmability refers to the degree to which the results of the study are as free as possible from distortion from the researcher's biases, demonstrating that "even as a co-participant in the inquiry, the researcher has maintained the distinction between personal values and those of study participants" (Ulin et al, 2005, p. 26) While the interpretivist paradigm rejects the concept of an objective researcher (Angen, 2000) it values the concepts of balance and fairness (Patton, 2002, p.575). Therefore, self-reflexivity plays a role in confirmability, as does an audit trail of procedures and outside inspection and verification of results (Ulin et al, 2005, p 168). Self-reflexivity and outside inspection of results contributed to the confirmability of results.

Transferability. In quantitative research, scientists assess generalizability; in qualitative research, the corollary concept is transferability (Ulin et al, 2005). While the concept of generalizability in the traditional sense is not applicable to interpretive research, it is important to know whether the conclusions of a study have utility outside of the small sample with which it was collected. Ulin and colleagues suggest a middle ground, where "lessons learned from qualitative studies can be applied to other contexts if samples have been carefully selected to represent viewpoints and experiences that reflect key issues" (2005, p.27). Patton (2002, p. 584) uses the term extrapolation to describe how researchers can make thoughtful and problem-oriented connections

between study conditions and similar situations. The primary researcher selected a diverse sample to promote extrapolation of results to the larger population of childbearing couples.

Justification of Methods to Ensure Trustworthiness

Just as a pragmatic craft approach was used to design the study, a similar process was used to develop a plan for ensuring the rigor of the analysis. The principal researcher considered each quality criterion and then identified methods to ensure the rigor of the study based on its particular research aims and context. To enhance the credibility of the study, the author selected triangulation of researchers and method, and also conducted self-reflexive exercises to reduce bias in interpretation. Triangulation of researchers and self-reflexivity also contributed to the confirmability of the study, as did sharing results with stakeholders both internal and external to the study. To enhance the dependability of the study, the author documented each step of the research process, as well as the considerations that framed decisions about method. Finally, to enhance transferability, the author selected a sample with diversity of race/ethnicity, marital status, birth attendants, and birth settings, to identify patterns in the data that could be extrapolated to the larger population of childbearing couples in the United States.

Triangulation. Triangulation refers to comparing data from two different collection methods or sources, and was named after the technique in surveying where surveyors converge on a point using measurements from three different angles (Pope and Mays, 2000). “The assumption in research is that multiple methods, investigators, and/or data sources will result in convergent meanings about the topic under inquiry”(Angen, 2000). This strategy is problematic for interpretive research because it assumes an

underlying truth to be converged upon (Angen, 2000; Cohen & Crabtree, 2008). Because “all knowing is perspectival knowing,” (Angen, 2000) triangulation of researchers is as likely to result in inconsistent or contradictory evidence as in convergent findings (Seale, 1999). Rather than using triangulation to converge on a singular truth, some view it as an opportunity to increase the comprehensiveness of an analysis. “Triangulation is less a strategy for validating results and procedures than an alternative to validation . . . which increases scope, depth and consistency” (Seale, 1999, p. 230). By incorporating multiple viewpoints, researchers can ensure that important perspectives are not overlooked. To increase the scope, depth and consistency of the analysis, the principal researcher elected to use triangulation of data sources, methods and researchers, as described below.

Triangulation of Data Sources. The research objectives of this study focused on the roles that men played in women’s childbirth decisions. Therefore, it was important to examine men’s and women’s perspectives and identify where partners’ narratives either converged or diverged. This approach required collecting data from both males and female members of the couple individually.

Triangulation of Methods. To understand the points of convergence and divergence within each couple’s individual narratives, it was helpful to create a coherent case study for each couple that focused on key decision points. The principal researcher selected the approach of actor interaction models, a method of building conceptual models of decisions (Bernard & Ryan, 2009, p 130.). The author used this approach to triangulate data analysis by examining each couple’s narrative through the behaviors, thoughts, emotions, and environment around each decision. Both female and male partners’ prenatal and postnatal narratives were read closely, and then inputted into an

actor interaction model that highlighted key decisions (i.e, choice of provider, choice of pain relief, etc.). Using an iterative process, the researcher coded participant narratives and then used representative quotes and summaries to complete an actor interaction model for each couple. In turn, insights from the modeling grids were used in data reduction, creating a synergistic interpretation of the data.

Triangulation of Researchers/Peer Review. To enhance the credibility of the study, the principal researcher sought a second researcher to code transcripts of couple's interviews. The second coder was sought not to restrict the analysis to areas of agreement, but to expand the analysis to be as comprehensive and rigorous as possible.

The greatest potential of multiple coding lies in its capacity to furnish alternative interpretations and thereby to act as the "devil's advocate" ... in alerting researchers to all potentially competing explanations. Such exercises encourage thoroughness, both in interrogating the data at hand and in providing an account of how an analysis was developed (Barbour, 2001, p. 1117).

The principal researcher sought recommendations from two faculty members who were experts in qualitative research. They suggested that a married, heterosexual male with qualitative research experience would be the best choice to bring the perspective of that gendered social identity to the research. While working on another project, the author encountered a male nurse with a doctoral degree, chair of the nursing department at a local college, who also happened to be a husband and father and was interested in this topic. Not only was this second researcher able to bring the perspective of a father to the research, he was also able to incorporate the perspective of the mainstream medical system, having worked as a hospital-based nurse for many years, which helped balance

the perspective of the principal researcher, who is a midwife who has worked primarily outside of the hospital setting.

The second coder/ peer reviewer was provided with a copy of the complete original transcript of all 30 interviews and an initial codebook for his independent analysis. Final themes were established through a consensus process, although disagreements were minimal. After the author wrote the results section of this manuscript, it was shared with the second coder/peer reviewer. The researchers held a face-to-face meeting to finalize the content of the analysis and the potential for bias.

Although the principal researcher elected to share study data and results with a second analyst and peer review team, results were not shared with study participants. In *member checking*, data, analytic categories, interpretations, and conclusions are tested with members of those groups from whom the data were originally obtained (Cohen and Crabtree, 2008). This can be done both formally and informally, as opportunities for member checks may arise during the normal course of observation and conversation.

Member checking has been advocated as a method to increase quality and make the research more participatory (Cohen and Crabtree, 2008). However, there are several valid criticisms of this technique. First, study participants may not recall what they said (Cohen and Crabtree, 2008). New experiences, including the process of interviewing itself, or events occurring after the study, may change beliefs recorded in the interviews (Angen, 2000). Further, “the purpose of data analysis is to organize individual statements into themes that produce new, higher-order insights. Individual contributions may not be recognizable to participants, and higher-order insights might not make sense” (Cohen and Crabtree, 2008, p. 335). Even when results do make sense, respondents may disagree

with the researcher's interpretation, creating a conflict between the researcher and participants (Angen, 2000). For all these reasons, the researcher elected not to conduct peer analysis/member checking with respondents. In addition, this analysis focuses the communication and power dynamics within couples' relationships. Not all couples may appreciate having an outsider comment on their relationship in this fashion, and revealing one partner's thoughts to another may violate confidentiality. Therefore, to protect human subjects and prevent conflict in the relationships of participants, member checking was not used.

Self-Reflexivity. Interpretive researchers often consider the issue of self-reflexivity to be a misguided attempt to obtain a false objective distance between the self and the work being undertaken (Angen, 2000). According to Angen, even if researchers identify and discuss their own biases, there is no guarantee they are self-aware enough to realize the nature and extent of those biases. However, qualitative research that emphasizes the perspective of the researcher lacks credibility and therefore undermines the aim of qualitative methods to understand the lifeworld of participants (Mays & Pope, 2000). Therefore, qualitative researchers must remain acutely sensitive to the ways in which the researcher and the process have affected the data, including the researcher's prior experience and knowledge, sex, gender, age, and profession.

In designing this study, the principal researcher tried to remain cognizant of Patton's statement that "the researcher is the instrument" (2002, p. 64). Although recognizing that all knowing is "perspectival knowing," (Angen, 2000) the researcher approached the study intent on ensuring that her subjectivity as a midwife and mother did not jeopardize the trustworthiness of the study.

To reduce the potential for bias, the author used the technique of *bracketing* from phenomenological research. In this method, the researcher participates in an interview and the results are then compared to the final themes identified (Bernard & Ryan, 2009). Prior to data analysis, the student intern research conducted an interview with the author about her first childbirth experience using the female partner's interview guide. The principal researcher and intern then jointly analyzed and discussed the themes that emerged from that narrative; the main themes identified were "not having found my voice" and "not knowing any better." These themes were highlighted as potential biases and set aside or "bracketed" for special consideration if identified in participants' comments. However, because the author answered the question based on two births and twenty years of life experience after the event of interest, there were few similarities between her narrative and those of first-time parents around the time of birth.

In developing this manuscript, the author also heeded Patton's admonition to "report any personal and professional information that may have affected data collection, analysis and interpretation" (Patton, 2002, p. 566). Patton identified four ways that the presence of an outside observer can affect the findings of qualitative research (p. 567) reactivity of the participants to the researcher, changes in the fieldworker/interviewer, and predispositions, selective perceptions and/or biases of the inquirer, and researcher incompetence.

Reactivity. An interview is a two-way interaction, and the behavior and interviewing choices of the researcher can influence how participants react. Traditionally, qualitative researchers have been urged to limit self-disclosure on the grounds that research is about the participants, and not about the researchers. However, many

interpretivist researchers have rejected this position, particularly feminist researchers who believe it constructs a hierarchical relationship between researcher and participant, and therefore perpetuates unequal power structures among women (Reinharz & Chase, 2002). Further, attempting to create an objective distance between researcher and interviewee represents the values of realism rather than the interpretivism that underlies much qualitative work (Angen, 2002). However, Reinhartz and Chase (2002) acknowledge that researcher self-disclosure can have an impact on the interview process, although this relationship has not been well-studied or understood. Therefore, they urge researchers to think strategically about “whether, when and how much disclosure makes sense in the context of particular research projects and with specific participants” p (228).

In general, self-disclosure about the author was limited to discussing the project in the context of dissertation research, particularly in the first prenatal interview. In one case, however, the author purposely divulged her identity as a home birth midwife to a participating couple. This particular couple had been referred to the study from a licensed midwife in Florida, and then prior to the birth had moved to another state where direct-entry midwifery was illegal. Although the couple had willingly answered the prenatal questions (prior to the move), the female partner seemed reticent in answering questions about her new provider and her birth experience during the postpartum interview. The author realized that, by talking about her home birth experience, the interviewee was describing a felony offense committed by her midwife. Once the author divulged her identity as a midwife who had attended birth in out-of-hospital settings, and reiterated the confidential nature of the study, the participant’s demeanor and responsiveness became more open and positive, and the remainder of the interview proceeded without incident.

Changes in the fieldworker/interviewer. The primary researcher conducted all of the interviews personally, so interviewer variation did not affect the study.

Predispositions, selective perceptions and/or biases of the inquirer. Aspects of the primary researcher's identity include mother, wife, feminist, homebirth midwife, educator, researcher, and maternal child health advocate. The author's personal birth experiences include both technology-intensive hospital-based births with a physician and intervention-free births with midwives. During the conduct of this study, the primary researcher attempted to submerge all of these identities and perspectives under that of researcher to conduct a credible study.

The objective of this study was to explore couples' decisions, and not to influence them in any way. Therefore, when conducting interviews, the author adopted the stance Patton (2002) calls "empathic neutrality". During the interviews, the primary researcher was careful not to comment on the clinical aspects of the case, or to make comments about couples' choices that could be construed as judgmental. An effort was made to keep facial expressions and body language neutral. During quality control of the transcription, a review was conducted of the interviewer's side of the dialogue to see whether any inappropriate comments had been made and, if so, whether they had influenced the course of the interview. None of the peer reviewers who read the transcripts noted any biased comments that influenced participants' narratives.

Research incompetence. Prior to conducting this study, the primary researcher's experience in qualitative interviewing was limited to on-the-job-training and work experience conducting focus groups for a consulting firm. To ensure that the primary researcher's relative lack of experience as a qualitative researcher did not unduly

influence the credibility of this study, an extensive study of qualitative interviewing literature was undertaken. The author then pilot-tested the interview guide with three pregnant and postpartum couples, taking notes on techniques that facilitated couples' open and complete responses. Pre-testing the interview guide helped the researcher improve the depth of information gathered in the 30 interviews conducted for the study.

Special Considerations of Gender-Based Research

Selection of Interviewers. Race, ethnicity, gender, and age are important embodied perspectives that affect how interviewees present themselves to researchers (Warren, 2002). Some reproductive health researchers have suggested that male researchers should conduct interviews with men about sensitive issues (Becker, 1996), while women interview women (Reinharz & Chase, 2002) to encourage full disclosure. The primary researcher's options for selecting interviewers were 1.) To conduct all the interviews individually. 2. Ask a male researcher to interview the male subjects. 3. Team with a male researcher to interview all subjects.

Ultimately, the first option was selected. In the author's judgment, the questions in this study were not sensitive enough to cause men discomfort if asked by a woman. In the United States, birth stories appear on television and on the Internet, and are the subject of conversation among casual acquaintances. Further, having a male interviewer interview the male participants would prevent the primary researcher from comparing the men's stories with the women's stories except via transcript, removing the nuances of body language and facial expressions. Asking a male interviewer to conduct all the interviews jointly with the primary researcher might have intimidated individual

participants by making them feel outnumbered and could have weakened the rapport between participants and the interviewer.

Further, Schwalbe & Wolkomir (2002) argue against a “one size fits all” approach to interviewing. Although researchers must be cognizant of the special challenges inherent in interviewing special groups, they must also recognize that multiple identities within groups prohibit generalizations about the population. For example, while an African-American male executive and a white male factory worker may both fall under the gender category of men, their different races/ethnicities and socioeconomic statuses argue against the assumption that the researcher can use the same interviewing approach with both. Therefore, the primary researcher attempted to approach each interview with an appreciation of both the commonalities of male gender identity and the diversity of perspectives brought to the research by each participant. In the interpretivist paradigm, reality is co-created by the interviewers and the participants; therefore a different researcher may have elicited different responses from the participants.

Techniques for Eliciting Male Narratives. Warren asserts that women interviewing men provides a special challenge, because the dominant form of masculine self-identity requires men to dominate women in conversation (2002). Schwalbe and Wolkomir (2002) agree that, in interviews, men often perform masculine identities that involve such concepts as control, autonomy, rationality, risk taking and heterosexual conquest. They also state that men are prone to exaggerate rationality, autonomy and control in their narratives, particularly in relation to decision-making. Therefore, men may be more likely to claim that they were the primary decision makers in many cases, or that they made decisions without consulting others. Schwalbe and Wolkomir (2002, p.

212) suggest asking men directly with whom they conferred when making a decision. This suggestion was incorporated into the interview technique.

Another problem in interviewing men is minimization, where the participant is taciturn and appears unemotional. To overcome minimization, Schwalbe and Wolkomir (2002) suggest letting the interview proceed with short answers and then circling back to key questions, presenting an air of uncertainty to let the informant feel more in control of the interview. Another technique is setting aside the notepad during the interview because it signifies the interviewer's power.

One of the participants, Manny, fit into this mold. His initial responses to questions were quite short and unemotional, although his girlfriend described him as expressing intense emotions during the labor and birth, including having a shouting match with a physician. His reserve did not seem to be an attempt at controlling the interview or interviewer, but rather the expression of an introverted and easygoing personality. Nevertheless, after completing the interview, the researcher put aside the interview guide but left the recorder on and asked a general, informal question about the birth experience, which produced a much richer narrative than the formal interview.

Justification for Individual Interviews. Triadic relationships (male partner, female partner and interviewer) pose a special challenge for interviewers. When interviewed together, couples can take varied and inconsistent positions in the interview, including trying to keep secrets, or to portray loyalty to the spouse (Warren, 2002, p 94). Further, "spousal presence during an interview leads to greater agreement between husbands and wives" (Zipp & Toth, 2002). Zipp and colleagues (2004) cited the "invisible power of men," in noting that wives were much more likely than husbands to

agree with their spouses' known answers. However, Seale and colleagues (2008) claim that in joint interviews about health issues, gender differences are reduced and women's perspectives are more prominent, so researchers wanting to find out about men's experiences concerning health-related topics such as those associated with fatherhood may find out more in one-to-one interviews with men.

Reinharz (1992) suggests that interviewing women separately from their male partners may yield richer, more authentic responses. Woman-to-woman talk is different from discussion in mixed sex groups; women may tend to talk more freely about their feelings, particularly regarding relationships, when men are not present. However, it is important to interview men as well, to triangulate their perspectives with those of their wives and girlfriends (Reinharz, 1992, p.23-24).

There are other important reasons to triangulate male and female perspectives in understanding men's experience of phenomena.

“Including women's indirect accounts is important—firstly because they have a valuable and intimate perspective on what their partners have been through... Given cultural assumptions about emotional work being women's work, women may be able to give voice to feelings that their partners have discussed with them in private but would not be willing to express in an interview. ... Secondly, women's accounts are important because men's roles are played out in a dynamic relationship with their partners. Women contribute to creating roles for men and their expectations may encourage or constrain men to behave in particular ways (Locock and Alexander, 2006).

Lastly, since concerns about privacy are critical to qualitative research, it is standard practice for interviewers to question respondents alone, especially on sensitive attitudes and behaviors (Zipp and Toth, 2002). For all reasons noted above, the principal researcher opted to interview male and female participants separately.

Chapter Four: Results

The greatest obstacle ... is not ignorance; it is the illusion of knowledge.

Daniel Boorstin

This chapter is divided into three major sections. The first section describes demographics of participants in the study. The second section provides brief descriptive case studies of the childbirth-related decisions of each couple. The third and longest section discusses the findings associated with each research question.

Participant Demographics

The sampling method attempted to maximize the diversity of the sample. Overall, however, the majority of participants in this study were married, white and well-educated. Among the 15 female participants, fourteen described themselves as white, while one described herself as Black/African-Caribbean. Thirteen of the male participants identified as white, one as Black/African-American, and one as Asian. Five of the male participants (one third) described themselves as Hispanic/Latino, with four women categorizing themselves as Hispanic/Latina. This sample of first-time couples was well-educated, with most participants holding at least a four-year college degree. Because the focus of this study was on male partners, the table below shows the demographics of the male participants in the study. The mean age of men in this study was 30.8 years. All the

couples were age concordant; that is, neither one of the partners was more than 5 years older or younger than the other.

Table 1. Demographic Characteristics of Male Participants

Demographic Characteristics	N
Age	
Mean= 30.8 (range 21-42)	
Race:	
African-American	1
Asian	1
White	13
Ethnicity:	
Hispanic	5
Non-Hispanic	10
Education:	
High School Diploma	2
Associate's Degree	1
Bachelor's Degree	9
Graduate Degree	3
Relationship status:	
Married	11
Cohabiting	3
Engaged; not cohabiting	1
Childbirth education	
None	4
Independent Lamaze	1
Bradley	4
Birthing from Within	1
Hypnobirthing	1
Class sponsored by birth facility	4
Couples who mentioned <i>The Business of Being Born</i> unprompted	3
Planned place of birth	
Hospital	10
Birth Center	2
Home	3
Actual place of birth	
Hospital	11
Birth Center	2
Home	2
Planned birth attendant:	

MD/DO	7
CNM	3
LM/CPM	5
Actual birth attendant:	
MD/DO	11
CNM	0
LM/CPM	4

Case Study of Couples and Childbirth Decisions

To assist the reader in understanding the context of quotations and themes presented in this chapter, this section provides a description of each couple and a summary of their birth plan and their actual birth experience.

Alex and Theresa. Alex and Theresa were a married, white Hispanic couple in their mid-20s living in Miami, Florida. Theresa planned a natural, vaginal birth in a hospital, which Alex supported. To prepare for a natural birth, the couple attended an independent Lamaze childbirth class and selected a certified nurse midwifery practice as caregivers. However, late in pregnancy, it was determined their baby was in breech position, so their midwife transferred care to an OB/GYN for a cesarean delivery. Both partners expressed dissatisfaction with their birth experience and stated a preference for a home VBAC (vaginal birth after cesarean) for their next child.

Alonso and Sheena. Alonso and Sheena were a married couple in their early 30's living in Miami, FL. He described his racial/ethnic background as white Hispanic, while she described herself as White Non-Hispanic. Sheena's initial birth plan was to have a home birth attended by a Florida licensed midwife. However, after interviewing several midwives, the couple elected to have a physician-attended birth in a hospital instead. They attended Bradley® childbirth classes. Sheena was induced at 40 weeks' gestation

for suspected macrosomia, a failed non-stress test and to avoid giving birth during the week her doctor was on vacation. She had a vaginal birth with epidural anesthesia, despite a strong preference prenatally to avoid pharmaceutical pain relief. Sheena expressed high levels of satisfaction with the birth experience, her physician and her partner, but Alonso expressed disappointment in both the physician and himself.

Brad and Nancy. Brad and Nancy were a white, non-Hispanic married couple in their early 30s who were living in Tampa, FL at the time of the first interview and then moved out of state. After the move, Nancy transferred care from a Florida licensed midwife to a CPM practicing illegally in their state. Initially, Brad was uncomfortable with Nancy's choice, but agreed after interviewing her midwife. Nancy had an uneventful water birth at home using Hypnobirthing™ techniques, with no intervention other than AROM (artificial rupture of the membranes; breaking the bag of waters surrounding the infant.)

Brennan and Patricia. Brennan and Patricia were a white, non-Hispanic married couple in their mid 30's in upstate New York. Patricia was enlisted in the armed forces and the couple lived in a rural area close to the Army base. Their only option for maternity care under their military insurance was the OB/CNM practice that served the base. They did not complete any formal childbirth education. Patricia and Brennan planned a vaginal birth with an epidural. Patricia received narcotics early in labor, and then an epidural that did not provide complete pain relief. Their baby was born via C-section after Patricia pushed for four hours with little progress. The couple expressed regret that the cesarean did not occur earlier. They stated that they looked forward to a scheduled cesarean delivery for their next child.

Caleb and Laurel. Caleb and Laurel were a white, non-Hispanic married couple in their mid 30's living in Tampa, Florida. Although Laurel stated she "hated" hospitals, doctors and needles, the couple chose to have their baby in a hospital with a physician because of their experience with two of Caleb's relatives who sustained disabling birth injuries, one in a hospital and one at home. Initially, Caleb was not supportive of Laurel's choice of an unmedicated birth. However, after attending Bradley classes with her, he became supportive. Laurel was induced at 41 weeks of gestation. They had hired a doula to assist with the birth, but the doula spent most of the labor with Laura's mother, who was anxious. Caleb functioned as Laurel's only support person. Although she asked for an epidural, her husband refused, and she had an unmedicated vaginal birth. Both participants were highly satisfied with their birth experience.

Chas and Jordan. Chas and Jordan were a white, married couple in their late 20's living in the Tampa Bay region. They planned a natural birth, attended Bradley® classes, and selected a birth center with Florida Licensed Midwife as the primary birth attendant. After a long labor, Jordan had an uneventful water birth at the birth center, with no intervention other than AROM. Both participants expressed high levels of satisfaction with their experience.

Greg and Suzanne. Greg and Suzanne were an engaged couple (not cohabitating) in their early 20's who lived in Miami, FL. Both were full-time students with part-time jobs. Greg was African-American and Suzanne described herself as both Black and Hispanic. Neither attended any formal childbirth classes. They selected a physician-attended hospital birth with epidural anesthesia. Suzanne went into late preterm labor at 36 weeks gestation, arrived at the hospital in active labor, and had a relatively short labor.

She experienced a vaginal delivery with an epidural and had a healthy baby. Both partners were highly satisfied with their birth experience.

Isaiah and Krista. Isaiah and Krista were a white, married couple in their early 30's living in rural central Florida. They selected a home water birth with a Florida Licensed Midwife because the nearest hospital was an hour away and they did not like the facility's reputation. To prepare for a natural birth, Krista studied Hypnobirthing. After a relatively short labor, Krista had an uneventful vaginal birth at home (although she did not give birth in the birth tub). Both Isaiah and Krista expressed high levels of satisfaction with their experience.

Jeff and Erica. Jeff and Erica were a white, non-Hispanic married couple living in Tampa, Florida. They attended Bradley classes. Erica had been born at home, so she planned a home birth initially. Jeff was uncomfortable with that decision, and refused to let Erica give birth at home. As a compromise, they selected a CNM who attended birth in the hospital. However, two weeks before their due date, their midwife lost her malpractice insurance and referred them another practice. The midwife on call, whom they had never met, attended their birth. Erica gave birth via cesarean with a diagnosis of pregnancy-induced hypertension, failure to progress and fetal distress. Both Jeff and Erica were highly dissatisfied with their birth experience and expressed a preference for a home VBAC for their next child.

Joe and Nadia. Joe and Nadia were a white, Hispanic cohabitating couple in their early 30's living in Miami. They did not complete any formal childbirth education, stating it did not fit into their schedules. For Nadia's maternity care, they selected a practice with both OB/GYNs and CNM's. Nadia developed gestational diabetes and her

care was managed by a physician. Nadia planned to, and did, use epidural anesthesia during labor. Nadia was induced for gestational diabetes and suspected macrosomia prior to her due date and gave birth via cesarean due to failure to progress. Both couples expressed satisfaction with their birth experience.

John and Kathy. John and Kathy were a white, cohabitating couple in their early 30's in upstate New York. They did not attend childbirth education classes for financial reasons. Kathy expressed a strong preference for an epidural, but no preference for either vaginal or cesarean delivery. Kathy remained with her regular OB/GYN as her caregiver during pregnancy. Kathy also consulted with two orthopedists due to back injuries she sustained during a previous car accident; her physicians were concerned that the anesthesiologist would not be able to place an epidural correctly. Kathy was hospitalized for pregnancy-induced hypertension at 36 weeks and then induced a few days later. Attempts to place an epidural failed. Kathy did not make adequate progress on Pitocin. Concerned about the risks of performing a cesarean under general anesthesia, the attending physician manually dilated her cervix using a Foley balloon catheter. Kathy sustained extensive tearing to her cervix and vagina, but gave birth vaginally to a healthy baby. Both partners were highly dissatisfied with their birth experience. Kathy stated she was told not to get pregnant again for at least two years, if at all, but would pick another hospital and physician and an elective cesarean delivery if she decided to have a second child.

Jonas and Diana. Jonas and Diana were a white, married couple in their mid 30's living in Tampa, FL. Initially, they had planned their birth at the nearest hospital. However, they decided they did not like the hospital atmosphere and selected a birth

center with both a CNM and LM on staff, based on the recommendation of a friend. They prepared for their birth by taking childbirth classes sponsored by the birth center, reading numerous books, and hiring a doula. After two trips to birth center for “false alarms” in early labor, Diana was admitted to the birth center in active labor and gave birth to a healthy baby girl 10 hours later with no medications or interventions. Both partners expressed high levels of satisfaction with their birth experience.

Manny and Jennifer. Manny and Jennifer were a white, Hispanic couple in their late 20’s cohabitating in Miami. Jennifer planned a home birth with a Florida Licensed Midwife and her partner was supportive. She prepared for labor using the Birthing from Within techniques. In attendance at her labor was her partner, her best friend, her parents and two midwives. Jennifer experienced a long labor, which arrested at seven centimeters of dilation. Eventually, Jennifer requested transfer to the hospital but her request was ignored by her partner and the attending midwives for several hours. Upon transfer to the hospital, her partner attempted to delay the cesarean delivery recommended by the physician on call and got into a shouting match with him. Jennifer received narcotics prior to her surgery and became incoherent. She gave birth to a healthy baby via cesarean. Jennifer expressed multiple, conflicting feelings about her experience and her partner, but ultimately described the labor and birth as so traumatic that she experienced psychosomatic symptoms when speaking about it. Her partner did not express any dissatisfaction with the experience.

Peter and Anna. Peter and Anna were a professional, married couple in their early 40’s living in Miami, FL. Peter was Asian and Anna white, non-Hispanic. They did not complete formal childbirth education classes, citing scheduling conflicts. Anna

recalled strong pressure from a friend to give birth in a birth center staffed by LMs, but did not seriously consider that option, particularly since her husband was not supportive. She remained under the care of the OB/GYN who did her annual well-woman visits. Anna expressed a strong preference for an epidural, but did not express a preference for either a vaginal or cesarean delivery. She scheduled an induction for a date that fit with the couple's work schedules. Anna received her epidural and then gave birth via cesarean due to fetal distress. Both partners were highly satisfied with the birth experience.

Tom and Sarah. Tom and Sarah were a white, non-Hispanic married couple in their mid-20s living in upstate New York. Sarah planned a natural, vaginal birth in a hospital. They did not interview potential providers, but remained under the care of her regular OB/GYN. The couple attended the childbirth class sponsored by the hospital at which they planned to deliver. Sarah came from a large religious family; her mother had given birth naturally and easily and Sarah assumed she would follow in her mother's footsteps. Sarah experienced pre-term premature rupture of the membranes at 36 weeks gestation and was admitted to the hospital with weak contractions and no cervical dilation. Her labor was induced/augmented with Pitocin and she requested and received an epidural, despite a strong preference for natural childbirth. At 4 cm dilation she was scheduled for a cesarean for failure to progress. Upon the next vaginal exam, she was found to be fully dilated and gave birth to a healthy baby a few minutes later. Sarah expressed dissatisfaction with the experience, but Tom did not.

Research question 1: What beliefs, concerns and priorities characterize men's' involvement in childbirth decision-making?

Thematic analysis of men’s comments revealed twenty-one subthemes in initial coding that were collapsed into sixteen themes in secondary coding without loss of any key concepts. These subthemes were then organized into three broad themes based on the research questions: beliefs, concerns and priorities.

Table 2: Priorities, Concerns and Beliefs of First-Time Fathers

Priorities	
Theme #1	Healthy Mother and Baby
Theme #2	Safety
Theme #3	Minimization of Pain
Theme #4	Control
Theme #5	An “Unaffected” Birth
Theme #6	A Peaceful Birth
Concerns	
Theme #7	Complications
Theme #8	Having to Catch the Baby
Theme #9	Messiness of birth
Beliefs	
Theme #10	Reliability of intuition
Theme #11	Expertise of providers
Theme #12	Ease of labor
Theme #13	Sufficiency of Preparation
Theme #15	Birth as personal, not profitable
Theme #16	Men as outsiders

To assist the reader in identifying the prevalence of each theme, the following guide is provided: “a few” references three or four participants/couples; “some” or “several” refers to five to seven participants/couples, and “many” or “most” refers to eight or more participants or couples.

Priorities. For men in this study, key concerns related to the outcome of childbirth, with the majority of men hoping for mother and baby to be healthy and emerge from the experience safely. Some men also hoped their partners would be able to

avoid severe pain during labor. A few also hoped for a natural and/or peaceful birth and expected to exert control over the birth experience.

Theme 1: Healthy Mother and Baby. When asked how they envisioned their best possible birth, most men in this study expressed a wish for the outcome of a healthy mother and baby. Many participants emphasized that the health of both mother and baby was important to them. Representative comments from three men are given below:

A healthy baby and also a healthy wife after the birth. I guess whatever needs to happen to make it end up that way is the ideal birth.

I hope she'll just get through it and everyone will be happy and healthy. No problems.

The health of my wife and child would be the top of my list. There really's not much else, as well as no complications and that everything works out, you know, without any problems.

Theme 2: Safety. Another important, and related, emergent theme was a concern for safety. For men, safety included choosing a safe setting for the birth and having a competent, professional birth attendant. How men defined these concerns about safety, competency and professionalism influenced their participation in decision-making.

Safety was the main concern for partners who resisted their partners' preference for midwife-attended or home birth. For example, Alonso recalled how he and his wife changed their birth plan from a homebirth to a hospital-based physician-attended birth:

If we ended up going with midwives we would have ended up going with somebody who we felt was probably not qualified to handle certain emergencies, and just their personalities did not give us confidence. So it would have been a

major compromise to go with a midwife... Going with a doctor is a compromise as well, because we would be in a hospital setting where we would be losing control. Sheena and I had a lot of conversations to try and get it straight in our mind, which compromise would we be able to live with, and we decided the doctor is one we could live with.

Implicit in Alonso's statement is the belief that childbirth is inherently risky. If a serious complication were to occur, Alonso and Sheena wanted to be with a provider and in a setting that could save the life of mother and baby immediately; any other possibility was not one they could live with.

By contrast, Brad and his wife planned a home birth with a midwife. At first, Brad was concerned about the safety of the home birth, particularly since they were planning a birth in a state where their midwife was practicing in an unregulated capacity. However, he equated safety with the provider's extensive experience in attending childbirth, as well the ability to protect his wife from what he perceived to be the dangers of an unnecessary C-section. He recalled,

She [my wife] took me down to a home birth open house the midwives were having. I still tell people, [when they ask] well why did you do it [have a home birth], well because, this woman we went with was so straightforward and honest, you know. I asked her, like, what her cesarean rate was. She was like, "I have about a two percent cesarean rate," and that's just the way it is. ...She's been doing this for over 20 years, I believe, and she had delivered hundreds and hundreds and hundreds of births.... She's just on top of it and she gives us security.

Some men equated safety to giving birth in a setting and with a provider with access to technology. For example, when asked if he and his wife had considered any providers other than the one they ultimately chose, Price replied,

Anna mentioned one of her co-workers had a baby in a birth center with a midwife, but, no, that's just not---That doesn't seem the safest way. I'm a scientist and I want to know that my wife's care is governed by the best available evidence and technology.

Concerns about the safety of mother and baby were the main reason fathers acquiesced to interventions on which they had not originally planned. Caleb, who had two family members who were permanently disabled due to birth injuries, held safety as a high priority. Although his wife strongly desired a natural labor, at his urging, the couple agreed to an induction for the safety of the baby. In recalling his insistence on the labor induction, despite his wife being "terrified," of it, he stated,

It's standard medical practice to do it [induction] after one week [after the due date] because of the risks of...any kind of risks increase after one week... but really, that was why, to be safe. We didn't want any issues.

Manuel had been supportive of his girlfriend's plan for a home birth. He also played an active role in resisting a transfer to the hospital and a C-section. However, when his girlfriend became incoherent after Demerol, he consented to the C-section. Although he cited numerous reasons for his decision, safety of mother and baby was a primary concern: "We weren't sure really at this point, was she gambling with time? With two lives, you get a little scared and you wonder if you do wait, what could happen?"

Theme 3: An “Unaffected” Birth. For some men, the goal of labor was not just a healthy mother and baby, but also attaining a “natural” birth. In describing his preference for a birth as free of interventions as possible, Jonas called this optimal outcome “an unaffected birth.” The principal researcher used this phrase in in vivo coding of the data because it captures the sense of an unaffected birth as both “not affected, acted upon, or influenced” and as “simple; sincere; natural” (Random House Dictionary, 2011). Jonas envisioned an optimal labor as one where his wife was

able to labor through it without any medications or interventions other than water birth. I know we’re hoping to do that. Other than the help of the midwife, me, and the people at the birth center, an unaffected birth; the least amount of medical intervention as possible. If medical interventions are required outside of the natural birth, as little as possible, that’s what we are hoping for.

Several men, regardless of chosen birth place or attendant, expressed a natural or unaffected birth as an important priority sought by themselves and their partner. In his prenatal interview, Alonso explained that he and his wife selected their birth attendant by asking friends for recommendations and then planning to interview candidates (although they only interviewed one.) He stated that he felt an instant connection to the provider they selected because the physician represented himself as minimally interventive:

We still wanted a doctor that was going to be as natural as possible, and be on board with us and to help us with as little intervention as possible. We found [Dr.’s Name]. One of the first things he told us when we asked him his philosophy, right off the bat he said that he worked with doulas. His philosophy is that women have been having babies before hospitals for thousands of years, and

the less he gets involved the better. Those were his own words without us asking anything, so we were pretty sold onto this guy.

However, as pregnancy progressed, Alonso's definition of a natural birth changed from no intervention at all to whatever interventions were needed to facilitate vaginal birth. At the time of their interview, the C-section rate was nearly 50% in Miami and nearly 70% at their delivery hospital; therefore, avoiding a cesarean delivery became their top priority. Late in pregnancy, their physician asked them to select a due date from a three possibilities; they picked the earliest one.

At that point my concern was that we really wanted to stick to the plan of having a natural birth. By talking to the doctor, it seemed like if we went earlier as opposed to later, that it would be more possible because he would be less heavy as baby and a smaller baby would be easier to deliver. So Sheena went to have a non stress test on the due date that we chose... We chose the earliest one because of that reason; we thought that a smaller baby would be easier to deliver.

Theme 4: Minimization of Pain. For some men, their main concern was their partner's comfort; specifically, men expressed a wish for their partners to avoid pain during labor, or have a small amount of pain that was easily manageable. Both men whose partners planned for pharmacological pain relief and those who chose natural birth expressed a desire for a painless birth. For example, Chas envisioned their optimal birth as, "completely natural, drug free, no pain for my wife or little pain for my wife," despite choosing an out-of-hospital birth with no access to pharmacological pain relief. Chas was a strong advocate for a water birth, although his wife had concerns about its safety. Chas

explained, “I know she is a little apprehensive about maybe doing a water birth but I ... just think it would be a lot more painless.”

On the other hand, Caleb required extensive research and negotiation with his partner before he would support her plan for a drug-free birth. As his wife Laura explained,

I’ve always wanted a natural birth, and he at first was like, ‘no you have to have an epidural, because you don’t handle pain well and I don’t want you to pass out during labor.’ Just out of concern, he just didn’t want me to go through this horrible pain that childbirth is portrayed as.”

Men who supported their partner’s choice of an epidural frequently cited avoidance of pain as the main benefit. Greg, like several men in this study, was vocal in his appreciation for pain relief in labor when he said, “I mean, they have that stuff now, so women don’t have to suffer like in the old days. That’s a good thing. I’m like, whatever she wants, man. Whatever gets her through it.”

Several men supported their partner’s choice to avoid an epidural, and even planned to deny their partners an epidural if they requested one. However, some of these men acquiesced to the epidural because they could not bear to see their partners in pain. Tom described the scenario in which he and his wife agreed to an epidural despite her strong earlier preference for natural labor.

She went into this, like, super labor. She has an extremely high pain tolerance, and this just wiped her out. The nurses suggested an epidural. And she agreed..
...Sarah was in excruciating pain. I wanted her to do whatever she needed.

In general, men's hope and belief that pain could be minimized in labor helped frame the decisions that couples made prior to birth. However, the experience of birth, particularly a painful birth, strengthened some men's belief in the postpartum period that pain should be avoided. Three of the men in the sample, whose partners had long difficult labors, expressed a preference for a cesarean delivery for their second child. John expressed his frustration after seeing his partner, Kathy, experience an induced labor, failure of an epidural, and manual cervical dilatation:

Now, you know, I'm really pissed off. For a while there, they said she was going to have a C-section. Then they changed their mind and made her go through all that suffering and it was hell, you know. Well, why couldn't they just have knocked her out and taken the baby? She's been through enough. I think they treated her like a goddamn lab rat. ... It was a nightmare for everybody, Kathy most of all. But we all hurt for her, seeing her like that. But Kathy, she kind of feels like she went through hell and survived.

Manny supported his girlfriend through a long labor, with a planned home birth that resulted in a transfer to the hospital and ultimately a C-section. After the birth, he seemed puzzled why his girlfriend planned and endured a long, painful labor, expressing this sentiment: "I was surprised how quick the C-section was and kind of understand why people schedule C-sections."

Theme 5: A Peaceful Birth. Several men in the study visualized the birth of their child as a time for bonding with their new family, requiring intimacy and a minimum of disturbance. Although this priority was common among many couples, it was especially prevalent among couples planning home births. Isaiah explained that the birth of his first

child, as an important family event, was deserving of privacy and minimal outside disruption.

We'd prefer to have a few people here as possible. It kind of goes along with the way we got married. We got married in Scotland and it was just her and myself, the father [minister], and our wedding coordinator so, we generally tend to do important things in a more intimate kind of way, not as big a show. So people [will be] here that are very critical to the process of— very important to the child's birth— the baby's Godmother is going to be here... ..I don't want any phone calls coming in or people checking in. I've already told people all the phones in the house are going to be turned off except for my Blackberry and that's going to be set so that it doesn't ring. If people want updates they can text message me but they are NOT talking to Krista.

The desire for intimacy was related to couples' decision to use a doula and their experience with the doula. Two out of the fifteen couples in this sample hired a doula. Among couples who expressed a preference for an unaffected birth but gave birth in a hospital, one chose the services of a doula. Although they hired the doula to assist them during childbirth, ultimately she spent her time comforting the woman's mother, who was distressed watching her daughter experience natural childbirth. Two other couples had considered a doula, but opted not to use one because they thought they would be uncomfortable with a stranger attending their birth. For example, when asked if they had considered a doula, Alonso replied,

We thought about it a lot... We thought about with our child birth teacher, because she is a doula. The biggest part of it is how much we invested in our OB, and the

other part of it is that I think we might be more comfortable with just the two of us.

Although some men preferred to keep the birth free of external disturbance, others were concerned that the peaceful birth environment would be disrupted by their partners. In visualizing his optimal birth experience, Greg echoed the concerns of some men, “I just hope she don’t start screaming and yelling and stuff. Sometime you hear stories about girls freaking out in labor.” Similarly, when asked about his optimal birth experience, Manny recalled, “There was one video where the lady just quietly had the child. Peaceful and quiet...”

For some men, a wish for a peaceful birth predated the birth experience. Other men gained a greater appreciation for a peaceful birth after experiencing labor with their partners. In the postpartum interview, Jeff attributed his wife’s C-section, and the blood pressure problems that contributed to it, partly to giving birth in a hospital (which his wife had resisted) with a strange birth attendant and numerous strangers in the room:

We had no relationship with the midwife that ended up being on call for our birth. We had never met her; that was the first time we had ever met her and so, you know, we had no relationship with her, and so it was very, very difficult. And we didn’t feel very comfortable in the hospital and you know, there was a lot of doctors coming in and she had blood pressure issues and it ended up bad.

Theme 6: Control. Another theme that emerged from men’s narrative was a desire for control over the childbirth experience. In a typical response, Chas described his satisfaction with Bradley™ classes because they prepared him to take charge of birth

decisions, “what I love about the classes that we are taking is that they are basically preparing me to be the ‘go to’ person.”

Some men were concerned about their partners giving birth in the hospital, because they feared hospital protocols would influence their labor. Alonso, who encouraged a physician-attended hospital birth for safety reasons, nevertheless worried about the potential loss of control in the hospital, stating,

Ideally we would like the doctor there for a few hours, and we would like for the nurses and the staff of the hospital to not be pushy, and to allow us to be in control of what we want, not to impose on us like drugs or other methods that we are not comfortable with, that if we say that we are uncomfortable with something and we want to try something different, that they’re going to be responsive to that and allow us to try something that we think would be good. ...That’s our biggest fear... I’m afraid that we aren’t going to have as much control as we would like. If they’re pushy, I know that we can be pushy right back and get what we want ultimately, but it would have to be a negotiation during a very difficult time, obviously. When you’re trying to have a baby you don’t want to be arguing at that point, you hope that everyone’s on board. I think that we would have total control as long as everything is going well, but if something did not go well, I think our control would start losing power.

Later, Alonso’s fears would prove to be well-founded, and his inability to control decisions during parts of his wife’s labor led to his feelings of dissatisfaction with the birth experience.

By contrast, Jeff recalled initially being pleased with the choice of a hospital birth because he felt in control of the situation. He described the doctors and nurses as consulting him throughout his wife's labor, enabling him to decide the course of events.

... in the hospital I actually felt like I had a lot of control. A lot of it was I had knowledge about the things we did want and didn't want. Like, we didn't want the vitamin K shot, we didn't want circumcision for our boy. ... You know, I was kind of able to make those, to call the shots, you know. They are always coming to you about this or about that.

After the birth, Jeff, like some men in the study, re-defined the importance of control in labor. While he felt comfortable wielding power over the hospital staff, he experienced regret for wielding power over his partner. He described the hospital environment as coercing him into convincing his wife to have a C-section. Since earlier in the pregnancy he had ruled out the home birth his wife wanted, he felt regret for contributing to the birth outcome his wife had tried to avoid. In his post-partum interview, Jeff stated that laboring women, not their partners, should have control over the birth experience, describing this realization:

A big thing that I realized (and this is what I say to people all the time now when they are going to go into their pregnancies) you know it's [the decision is] really not what I am comfortable with ... because I am not having the child. So I kind of have to fit myself into what she needs.... If that means I have to be out of the room so I can't voice my opinion, [then] I have to be out of the room.

Although thematic analysis focused on interviews with male partners, confirmation of the theme of control was found in women's interviews. A few women articulated a strong

need for control over the birth experience. Women who expressed a desire for control were the most forceful and successful in negotiating with their partners about an out-of-hospital birth. For example, Diana described how she switched from a hospital to a birth center when she felt that the hospital limited her birth options.

I thought that when I went there [the hospital where she initially planned to give birth] they would explain to me my options, and when we went in for my first appointment I found out that's not how it works. At our first appointment, she [the nurse] went down her checklist about my health history, and that was it. I asked her, 'When do you tell me about my options?' And she said "No, no, this is how we do it here, you have a doctor here, and you go to this place for an ultrasound.' It's pretty standard. I asked, 'What if I want a midwife or a water birth or if I wanted to learn a little bit more?' The nurse said if I wanted to go that route I shouldn't have come there in the first place. She said it was too late and I should have already started that path. When we met with the doctor, I asked him a bunch of questions like, 'Am I going to be able to move around or am I going to be strapped to the bed and is he going to be the one at the birth?' His answers were vague, and he said he would not be the one at the birth, it's whoever is on call, and they may or may not let me out of the bed, it depends on who's there and who is more familiar with a natural birth. It was just all the answers I didn't want to hear.

Similarly, Jordan chose a birth center because she preferred a natural birth and was concerned that she would cave in to pressure from hospital staff to accept an epidural, or even give in to the temptation of pain relief because it was available.

I knew all along that I wanted to have a natural birth. At first it was for reasons that I just wanted to prove that I could do it. My mother had had a natural birth with me. And then as I did more research about a medicated birth and then even a C-section and I found there were actually a lot more reasons why I wanted to make sure that I did not have those things, options not even available so that I was not even tempted to maybe want an epidural when I was actually in the midst of the pain or half way talked into something that I didn't even want. So that's when we started thinking about looking into other options. And then a friend of mine had talked to us about her experience with the birth center and that when you're there that everything is all natural and you don't have to worry about having an epidural or stuff forced on you.

Concerns. Given the priorities of safety, a healthy mother and baby, and a natural birth, some men feared that complications might interfere with achieving those goals. However, none of the men specifically mentioned a fear that their partner or child would die as a result of complications. Other men were concerned about the possibility of having to catch the baby and were disturbed by the potential messiness of birth.

Theme 7: Complications. As noted earlier, most men in this study sought the outcome of a healthy mother and baby. Several men expressed concerns with the possibility of complications occurring during labor or delivery that might jeopardize the health of their partner and/or child. In describing their optimal birth experience, a few men echoed the sentiments of Tom:

Well, I just really hope nothing goes wrong. I mean, they talked about complications during the childbirth class we're taking. But Sarah and I haven't

really talked about them, you know, if something happens, I'm sure the doctors and nurses will take care of it. That's what they're there for.

A small number of men who expressed a strong interest in an unaffected birth expressed the concern that complications might not only cause health problems, they could also derail the couple's natural birth plan. As Alonso noted in his optimal birth scenario, "no complications with the way the baby is facing or anything like that, so the baby can come out vaginally."

A few men focused their birth planning research on complications, not so they could avoid them, but so they could better prepare for what could go wrong and to understand the decisions made by providers. As Price described his research, "I've been talking with some colleagues about complications that can occur during labor. So I think I have a good grasp on why certain decisions might have to be made."

A few fathers who wanted to exert control over the birth process focused on understanding complications so they could make informed decisions. As Chas said,

Actually I 'm learning about all the complications she has that maybe eight, nine months ago, that I had no idea—I had no idea about half these things that were going on with her body and that could go on with the baby and now, I do feel that I am prepared to go ahead and make those decisions.

A few other men, particularly those who participated in Bradley™ childbirth classes, like Jonas, went a bit farther and developed detailed plans to deal with potential complications:

We've tried to educate ourselves as much as possible about the different kind of interventions and the types of things that could happen. We've put a little bit of

thought into what extent we would go based upon the circumstances. I know you can't answer those questions until you're in the situation, but we both kind have an idea of that there is a possibility of complications going into it. If they were to arise exactly how would we handle it? We know a lot of it is an 'in the moment' sort of thing, but we have put some thought into it.

Concerns about complications were one of the main reasons men cited a preference for a hospital birth. Caleb stated that he would never consider an out of hospital birth, but might have agreed to "a midwife, maybe, if they were in a hospital setting in case anything goes wrong." His wife elaborated:

I work in a hospital and I don't like them, but my husband has two family members that have had complications with births; one [who was born] at home who has permanent disabilities because of it, so it's never really been anything that we've considered. I think that if we hadn't had those experiences with family then we would have considered it [an out-of-hospital birth], but we just realized how complicated birth can be.

However, some men stated that complications could arise from specific interventions and used this knowledge to justify refusing those interventions. Although Caleb originally urged his wife to plan for an epidural during pregnancy, he ultimately changed his mind:

I wasn't really aware of what an epidural was. It just seems like it was a shot you get to kill the pain. I guess the more I've learned about it, the more I've realized that there are complications associated with it, and it's usually not just an

epidural; there are other things that go along with it. So I guess that's where my concern has been ...so I think it's not necessary. May as well try it without.

Theme 8. Having to catch the baby. During the prenatal interview, most men anticipated a labor no longer than 10-12 hours. Also, perhaps because men hoped for and expected a short birth, and wanted a competent professional to attend the birth, a few men expressed a fear of having to catch the baby. This fear expressed itself in men feeling the need to call the midwife or drive their partner to the birth center or hospital fairly early in labor.

When asked about his optimal birth scenario, the first thing Jonas said was, "In a perfect world we would make it to the birth center in time, to actually have the baby with the midwives, we're only about 2 1/2 miles from here, but I have heard of having a baby quicker than that. Yeah, make it there in plenty of time." Jonas drove his wife to the birth center twice before finally being admitted for active labor at their third visit.

Isaiah recalled his panic when his wife's contractions did not come at the regular intervals described in the childbirth class, but instead varied widely, with some coming quite close together:

I wanted to call the midwife and let her know, like hey, you need to get over here. So it was probably around 11:00 when I couldn't get accurate contraction information out of her [my wife] I was like, yeah, we better go ahead and call the professional 'cause I am NOT capable of delivering this baby on my own.

In his prenatal interview, Greg stated, "I'm studying to be an EMT, but I've never seen a birth. The books make it sound a little scary. So I'm, like, thank God someone else will have to deal with that mess." He received a call from his fiancé while out on a

training run on the ambulance. He was able to use the lights and sirens on the ambulance to get back to the station and pick up his fiancé to take her to hospital. Interestingly, the phenomenon of being afraid of having to catch the baby may not be limited to men. Greg's fiancé, Suzanne, was home with her mother when her membranes ruptured in early labor, which caused her mother to want to rush to the hospital so she would not have to deliver the baby. Suzanne recalled,

I told my mom [my water had broken], and she started kicking up a fuss and packing a bag and just generally acting crazy. So I called Greg, and he was on a run halfway across town. So I sat down with my bag in my lap and said I wasn't going to the hospital until Greg came, and that made my mom act crazier.

Theme 9: Messiness of birth. Several men in the study expressed squeamishness about the potential mess involved with birth. As noted in the previous section, Greg, who had read about births from his textbooks and had talked to other EMT's, was concerned about what he termed the "mess" of birth. As a result, he was happy to delegate decision-making authority to the doctor and his partner, viewing his role as simply to be present.

Kathy and John planned for his limited involvement in decision making---and even social support during labor, because of his squeamishness about birth. In describing how she envisioned her partner's role in labor, she stated, "He faints at the sight of blood. [Laughter]. Big guy like that, and he's a real [hesitation] well, pussy, when it comes to needles and blood and things like that. I figure he'll be in the waiting room for most of it." During the labor, John did leave his wife's hospital room during all medical procedures, delegating most of his support responsibilities to Kathy's parents.

Men who were vocal about their squeamishness prior to birth tended to plan a hospital birth. However, most men in the study did not voice any prenatal concerns about bodily fluids or the birth process. In the postpartum interview, a few men recalled strong reactions to the physical aspects of birth, suggesting that such experiences may influence their behavior in later births.

Tom was so uncomfortable with his wife's long labor he actually left the hospital briefly, although he returned in time to witness the birth, recalling unpleasant, vivid memories of his wife vomiting, the doctor cutting an episiotomy, and his son's birth:

She was crying, saying, I can't believe this. I can't believe how much this hurts. She was really trying to tough it out. I tried to help her breathe, like in class, but that didn't get anywhere. And then she started throwing up. Like that movie, the Exorcist, throwing up, you know what I mean? (Laughter). She was having contractions and puking and she couldn't get a break. Just constant misery.... So then the doctor came in, and got suited up, and told Sarah she could push. So I watched her push and it was, like (laughter) really weird. He [my son] looked like an alien coming out. His head was all squishy. And then the doctor pulled out these scissors...and I looked away.

Similarly, when asked if anything surprised him about the birth, Brad immediately recalled the midwife rupturing his wife's membranes:

Our midwife kind of felt that that helped her [my wife] out a lot, it relieved a lot of pressure because it was pushing on the area, you know, on her cervix and they felt that it was preventing her from dilating properly. So she broke her bag of

water in the birthing pool. I didn't even know. Hello! I thought it was Nancy pooping. It wasn't really pretty.

Beliefs. Themes that emerged from the interviews centered on the following beliefs: reliability of intuition, expertise of providers, ease of labor, sufficiency of preparation, birth as personal, not profitable, and men as outsiders.

Theme 10: Reliability of intuition. Another theme that emerged was trust in “gut instinct” or first impressions in selecting the woman’s healthcare provider. Some couples researched and/or interviewed several providers before selecting their birth attendant. However, none claimed their decision was based on a rational consideration of practice statistics, experience, or credentials. Even complimentary birth philosophies were not sufficient in some cases. In fact, of the few couples who said they chose among several providers, nearly all said they did so on the basis of “gelling” with the provider, being “in synch,” knowing that provider was “the one” and generally selecting the provider intuitively rather than logically. Although studies suggest that men portray themselves as rational decision makers in qualitative interviews (Schwalbe & Wolkomir, 2002), a few of the men in this study stated they selected a particular provider based on a positive first impression. Men often portrayed themselves as using data to help select a generic *type* of provider and birth place. However, when it came to selecting an individual provider, the fit between couple and provider held the most sway.

Alonso described the couple’s provider selection process as follows: “We were interested in hiring a midwife, because we wanted to have a natural birth, and we interviewed several midwives, but we noticed that most of the midwives we encountered we just didn’t gel with them.” Alonso and Sheena then obtained recommendations for

physician from their friends. Although they planned to interview them all, Alonso stated the one they chose “was the only one; pretty much as soon as we met him we felt comfortable with him and his approach.”

Although Brad and Nancy chose a home birth, he described their selection of midwife in a similar fashion:

So to go to this particular midwife... we had asked some people who had had home births who they used, then when we met with the midwife, we really didn't look into anybody else... we felt very comfortable with her after meeting with her and so, and she was available, so there really wasn't a lot of decision making.

Theme 11: Expertise of Providers. Several of the couples in this study perceived doctors or midwives to be the experts on childbirth, and did not vocalize any thoughts of questioning their judgment at any point. Price, who had researched birth complications and had no preference for his wife to have either a vaginal or cesarean delivery, recalled that his wife's emergency C-section did not involve any decision-making.

It was clearly an emergency. Everything happened so fast ... Anyway, the doctor took the time to explain that the baby was in danger. So we just went along.

Because clearly he's the expert in the room. Looking back, we knew something could go wrong, and we were open to the very real possibility of a C-section.

Similarly, when asked if he would be involved in any decision-making related to his fiancé's medical care, Greg expressed puzzlement:

Do you mean, would I question him [the doctor]? No, I'm just an EMT in training. I know a little, probably just enough to be dangerous. He's the expert,

man. Unless he said something totally crazy, like...uh, I don't know, I can't really think of anything.

Doctors were not the only focus of couples' complete trust. Although Manny and his girlfriend selected a Licensed Midwife to attend their home birth, Manny expressed implicit confidence in the midwife. In the prenatal interview, Manny stated, "Honestly, I wouldn't make any decision except a decision to support the midwife or Jennifer... Because I don't know much about vital signs and things like that, I would have to trust the midwife to tell me it's time to transfer." The postpartum interviews revealed that Manny had adhered to this position; he followed the midwife's advice to stay at home despite his partner's repeated statements that she wanted to be transferred to the hospital: "A couple of times throughout, she was like, 'All right, I'm ready to go to the hospital,' but because she was all right we decided not to, as long as [the midwife] said she was cool, we would say you can do it."

Because they trusted their partners' providers, men in this study took statements from their partners' providers at face value. In making decisions, couples assumed that their personal test results (like ultrasound estimates of weight) and other data (like due dates) were accurate, with little margin of error. They also assumed that providers' recommendations based on these data were objective and respectful of the couple's birth plan.

A few of the couples, particularly those who had attended independent childbirth classes and planned a natural birth, verbalized an expectation that doctors and hospitals *in general* might be hostile towards their birth plan or might try to coerce them into accepting interventions they did not want. In discussing their relationship with their

personal maternity care provider, however, all of these couples expressed complete trust in this individual and the clinical data he or she provided.

For example, a well-informed couple would state that they knew that an ultrasound estimate of weight performed late in pregnancy could be inaccurate by one full pound in either direction, and that induction for macrosomia under those circumstances was not clinically indicated. However, they believed that their ultrasound was correct and their provider would never give advice at odds with clinical guidelines or their birth plan. One example of this phenomenon in this study occurred with Sheena and Alonso, who had taken Bradley™ classes. Their doctor estimated their baby weighed 7.5 pounds at 36 weeks, with an estimated birth weight of 9.5 pounds. The baby was born at 40 weeks gestation weighing 7 pounds, 12 ounces. The diagnosis of macrosomia contributed to the choice of a due date and an induction on that date.

In addition to a belief in the accuracy of weights via ultrasound, another common belief among men in this study was the accuracy of due dates. In general, men believed their partner's due date was an immutable deadline, rather than an estimate of gestational age. All of the couples who were told to have an induction at 40-41 weeks agreed, although some couples negotiated with their doctor for a few extra days before having the induction performed. Until he and his wife were asked to pick which due date they preferred, Alonso, like a few men in the study, believed that due dates were definitive:

About picking a due date? I guess I was kind of confused about how that works. I was confused about how you get a due date and how accurate it was. I thought that we had a due date. I guess a few days before that date or right around that time is when I realized that it wasn't official, that they basically just estimate

based on the ultrasound and the measurements; that's one method, and the other method is by the last period or whatever. So I never understood until that last visit to the doctor that is was just estimates, and that one estimate would differ from the other depending on which method you were using...

In a few other cases, couples who had planned to avoid pain relief accepted it when doctors or nurses told them the women were still in early labor and would be in labor for hours. In other words, they generally did not believe labor would be long until they received an estimate from providers. An interesting pattern that emerged from this study: of the four couples that delivered in a hospital and had wanted to avoid an epidural, all four experienced a labor induced or augmented with Pitocin, and all four requested or considered an epidural relatively early in labor (4-6 cm dilation). The three that delivered vaginally did so within a relatively short time (generally an hour) after being pronounced at 4-6 cm dilation. In his postpartum interview, Tom explained what happened after the administration of the epidural at 4 centimeters dilation, "Sarah just started to relax. Then the nurse decided to check her. She got a funny look on her face and said to the other nurse, 'Call [doctor's first name]'. And the other nurse was like, 'what's wrong?' And the first nurse was like, 'the baby's coming' "

After experiencing birth, a couple of men who had wanted a natural birth but did not achieve it expressed regret for trusting in their provider. In reflecting on his son's birth and the imprecision of due dates, Alonso expressed suspicions about the doctor's motivation for his wife's induction. A Bradley® father, Alonso was a strong defender of the couple's natural birth plan, which is why he was troubled that the induction was scheduled at the only appointment he was unable to attend.

I wish I was there [for the non-stress test]. The doctor did it and he said that... I guess that Sheena told me they were going to go ahead and induce, because the baby didn't pass one of the ten findings or whatever. I just hope they feel bad. How accurate was that or how important was that he didn't pass that one thing? He's just a very calm baby and he probably was just not agitated. I don't think there was anything wrong. Hindsight is 20/20 but I know if we would have just allowed the birthing process to start on its own, then we probably could have avoided a lot of the things...

Theme 12: Ease of Labor. Male participants, as well their partners, expressed a belief that their child's birth would not fit the mold of a typical or statistically average first labor. The most common area where couples felt the norm did not apply was in the length of labor. Men, particularly those who had attended natural childbirth classes, specifically acknowledged that first-time labors that are not induced or augmented could take 24 hours or longer. However, that piece of empirical knowledge did not translate into their personal expectations. Several men expressed a wish for a quick birth and an expectation that labor would last no longer than 10 hours, in general. Men (and women) also expressed a preference for avoiding pain during labor, and planned to have a labor free of pain or with a minimum of pain for the laboring woman.

When asked to describe his optimal birth experience, Chas echoed the sentiments of many men, "Completely natural, drug free, no pain for my wife or little pain for my wife. Obviously, no issues for the baby. You know, as far as time process goes kind of speedy, we're not there for twenty hours or so, you know, maybe in and out [of the birth center] in a couple hours."

In discussing decisions about pain relief, Alex's response was typical of men who minimized the impact of pain, "I guess we expect some pain but through the classes we plan to be able to handle those through relaxation exercises and some other things that we've practiced, so I guess I just expect— I'm envisioning kind of a very happy occasion."

Jonas was typical of a few first-time fathers who were surprised that labor had taken much longer than they had anticipated:

I think that the first surprise was that we got sent home twice from [the birth center] [laughter], because both times we thought, 'oh this is it, this is great.'

Well, the first time not so much, but the second time we thought, 'oh, she has got to be close' and she was still probably 18 hours away. But during the actual labor there, during the last visit, I don't think there were any major surprises other than it just taking so LONG.

Theme 13: Sufficiency of preparation. Men's preparation for childbirth ranged from no formal preparation (e.g., talking to friends, visiting websites) to the full 12-part series of Bradley® method classes focused on Husband-Coached Childbirth®.

Regardless of the childbirth preparation method in which they participated, men in this study unanimously felt prepared to handle the task of attending the birth of their child.

Generally, men with less preparation expressed the belief that little preparation was needed, either because childbirth is a natural process, or because they placed it in the hands of trained experts. Jeff, speaking after the birth of his baby about his beliefs prenatally, said, "You know, I just felt like, 'It's birth. Whatever.' [Shrugging] We've got this down pretty well as a society."

Men who participated in Bradley® method classes tended to take the opposite view; they saw themselves as directors and guardians of the birth experience who were expected to challenge medical advice that went against the couple's natural birth plan. Bradley® participants felt the classes had prepared them for the many potential complications and variations of childbirth, and they often had complex mental, if not written, plans to address each situation. Isaiah summarized the plan he and his partner had developed.

We have a couple of notebooks that we have put together with birthing plans in case we have to have a hospital transfer if she is incapacitate, if she is unable to make decisions. We have a number of notes inside of what's going on, most of which I have tried to commit to memory. If she is unable to have the baby immediately, no antibiotic in the eyes, the baby is not to be given formula. I am to stay with the baby at all times whereas the Godmother or whomever will stay with Krista. Holding off on certain vaccines until, holding off on any shots or anything like that.... We've got a number of bits of information in there. We've already contacted friends who are breast feeding to say if there's a reason that Krista can't provide breast milk that they're ready to go and provide breast milk.

Theme 14: Birth as personal, not profitable. A few men did not want themselves or their partners to be “just another number” or “just part of a day's work” to the provider; they wanted their care to be driven by concern for the couple's unique needs, and not by a desire for profit. Jonas, who was a self-described skeptic of the health care system in the United States, recalled his feelings after touring the local hospital:

The hospital wasn't very informative; it felt very mechanical and very much like a business. They really didn't care about you; it was 'here are your numbers, here are your statistics, we'll see you in two weeks'. It was just very unattractive to us. We wanted something that cared more about Diana, and a little bit less about the check we were writing them at the end of the day. I feel we've gotten that at the birthing center; it has been a much better experience.

Chas expressed similar needs when reflecting on the couple's choice of a birth center, "We really loved the facility and we loved the caretakers. We liked the fact that it didn't seem like it was just a business. It seemed more like a uh ---hard to say. It just felt more caring and it seemed like the environment that we wanted to bring our baby into."

Theme 15: *Men are outsiders to pregnancy and birth.* At some point during one of the interviews, most men commented that they could never share their partner's embodied experience of being pregnant or feeling the pain of childbirth. For some men, this essential gap between the sexes precluded them from taking any role in childbirth decision making prior to labor.

Tom epitomized this belief during the prenatal interview when asked about his role in decision-making. He stated, "Sarah would make them [decisions]. I mean, she's really smart. I trust her to make decisions in general, you know. And it's her body. I can't put myself in her place; I can't know what it's like. Labor, you know. So, as far as I'm concerned, it's not really my place to make decisions for her."

Suzanne epitomized the female viewpoint on this issue when asked what role her partner had played in her plans to get an epidural. She replied, laughing, "When he's the one having the baby, he can have an opinion!"

A few other men, particularly those who had been involved significantly in prenatal birth planning, did not express this belief until the postpartum interview. For some men, moving from a theoretical understanding of childbirth to the reality of lived experience changed their perspective. Prior to their birth experience, both Sheena and Alonso expected him to refuse an epidural if she requested one. However, seeing his wife in pain caused Alonso to feel that he could not make decisions based on the perceptions of another person. “It’s hard for me to... I don’t know how much pain she was in, so for me to say she couldn’t have it [the epidural] wouldn’t be right.”

Research Question 1a. Does childbirth preparation and birth setting affect these beliefs, concerns and priorities?

Four couples stated they had not completed any preparation for childbirth; their reasons for avoiding childbirth classes centered on out-of-pocket costs and scheduling conflicts. Most couples mentioned gathering information from friends, the Internet, and popular childbirth books, either in lieu of traditional childbirth education or as a supplement to it. A few couples attended classes at the facility where they intended to give birth. Seven couples attended independent childbirth classes, and most of these couples planned an unaffected birth.

This was not a quantitative study; therefore, no assertions can be made about the statistical association between preparation and/or birth setting and men’s priorities in birth. However, it was instructive to review the priorities expressed by men in couples with different types of childbirth preparation. Coded case studies were sorted into three groups: no childbirth classes, facility-based classes and independent classes, to see if any themes were present or absent from any particular group. Overall, most themes were

present across all three groups, with a few exceptions. Three themes were found solely among men who had attended some type of formal childbirth education class: *control, an unaffected birth*, and *birth as personal, not profitable*.

None of the men in couples who had declined childbirth education classes expressed an interest in controlling aspects of their partner's care. In addition, none of these men stated a desire for a natural birth. In reviewing the narratives, the researcher found that all of the narratives with the theme of *birth as personal, not profitable* mentioned viewing *The Business of Being Born*, a documentary about the American maternity care system. According to the director, the film explores "the infuriating way medical traditions and institutions – hospitals and insurance companies – actually discourage choice and even infringe on parents' intimate rites, ultimately obstructing the powerful natural connection between mother and newborn child" (see <http://www.thebusinessofbeingborn.com>). The film argues that birth in America has become a big business that is not concerned with the best interests of mothers and babies. Since some participants credited the film with changing their philosophy of childbirth, it is not surprising that their priorities reflect the language and viewpoint of the documentary.

Although the minimization of pain was a theme that emerged from many couples in the sample, all of the couples who had declined childbirth classes planned for an epidural with little or no discussion. The women (and their partners) who planned for epidural anesthesia did not express any concerns about its potential risks, had not attended childbirth classes, and had not considered seriously a natural labor. Therefore,

none of the partners of women who chose epidural expressed concerns about this choice prior to labor.

In summary, couples who did not attend childbirth classes appeared to have little desire for a natural birth or shared decision making. Those who attended childbirth education classes planned to exert more control over their childbirth experience. However, without further study, it is unclear what the direction of the relationship is between childbirth class attendance and a desire for control and a natural birth. It is plausible that childbirth education classes stimulated discussion and critical thinking about childbirth options and awakened couples' interest in shared decision-making and natural birth. Or perhaps couples who were more invested in a natural birth and control over the birth experience opted to attend classes. As with most behaviors, multiple explanatory factors were probably at work. Further research in this area is necessary.

Research Question 2: How do men and women negotiate decisions about childbirth?

In terms of the process that couples followed to make decisions, six major dynamics were identified. Some couples displayed no negotiation during childbirth, which included three dynamics: unknown options, limited choices, and silent decisions. Other couples did engage in negotiation, which incorporated the dynamics of female priority and authority; female priority, male authority, and male priority, female authority.

Table 3. Couple Dynamics in Decision Making

Lack of Negotiation

Dynamic #1	Unknown Options
Dynamic #2	Limited Choices
Dynamic #3	Silent Decisions
Negotiation	
Dynamic #4	Female Priority and Authority
Dynamic #5	Female Priority, Male Authority
Dynamic #6	Male Priority, Female Authority

Dynamic 1: Unknown Options. Two key points emerged from this analysis. To make decisions: 1) couples had to view childbirth as an area where they could or should exercise choice; and 2.) couples could only choose options with which they were familiar. The narratives of several couples suggested that they did not see themselves as consumers of health care, but rather as patients who were expected to follow medical advice unquestioningly. A few couples who saw themselves as decision-makers had limited knowledge of the options available to them.

Specifically, the interview guide asked participants how they had chosen their particular provider. Joe echoed the sentiments of several men---and women--- when he looked puzzled and replied, “She [my partner] just went with the practice that does her normal OB/GYN stuff.” When asked how they felt about their partner’s provider, several men seemed surprised by the question, and responded with answers such as “he’s OK, I guess,” or “she’s alright; I don’t have any problems with her.” These statements suggest that many some men and women do not conceptualize a need for extensive decision-making related to maternity care.

For some participants, the only decision they considered as such was the choice of provider. Some couples were unaware of alternatives to physician-attended hospital birth and therefore did not—in fact, could not—in consider these options. For these couples, one of the few critical decisions they made related to childbirth was choosing one physician over another. And most of these couples did not actually interview potential candidates and choose amongst them; they simply remained with their current gynecologist. As for interventions during labor, some couples felt they had no choice; the doctor was the expert in the room, and if the doctor had recommended it, they would do as instructed.

In addition, the interview guide included probing questions to explore whether couples had considered other options than the ones they ultimately chose. For example, both men and women were asked if they had ever considered a different kind of maternity care provider (i.e., a midwife if they had chosen a physician, or vice versa.) When asked if he had heard of midwives or had ever considered midwifery care, Greg replied. “Uh, actually I know there’s a midwife training program at school [where he attends]. But [hesitation] I don’t know. I don’t know how that works. Don’t most people go to doctors?” Similarly, when asked if they had heard the term doula before, a few couples stated that they did not know what a doula was. In the case of midwifery care or doulas, some couples could not make decisions about these options because they did not know they were available. All of the couples who selected midwives had heard of physicians, and knew physicians attended most births, but articulated specific reasons for choosing midwifery care.

Dynamic 2: Limited Choices. Some couples saw themselves as informed consumers who could make decisions about childbirth. However, their choices were constrained by legal regulation, insurance coverage, or professional practice guidelines.

Patricia, who was enlisted in the Army, lived in a rural area. The only maternity care provider that her military insurance would cover was the one practice that served the base. She described the process of finding a maternity care provider in this way, “We’re in the military, so we kind of get told who we see.” Although Patricia preferred one of the providers in that practice, she knew she would not have a choice about which one attended her birth:

I’ve heard a lot about using a midwife over an OB/GYN, so I’ve been trying to schedule my appointments with a midwife, but sometimes you can’t help that ... And then I’m at that point right now where I’m I guess I might as well get to know everybody in the clinic because whoever’s on call is going to be the one that delivers the baby.

In other cases, professional protocols and institutional policies limited couples’ choices. For example, Manny recalled his partners’ transfer to the hospital after a failed home birth; he had hoped to keep the birth as natural as possible, but was unable to negotiate with the OB/GYN on call to support the couple’s natural birth plan:

When we got there the surgeon took a look at her and looked at the charts that said she hadn’t dilated, he said, in like ten hours or so. She hadn’t dilated any more. The way he saw it that it was a C-section and that’s what he thinks should be done, and that’s all he would do. Basically we were talking that if we could wait a little longer and see what happens... That went to: we had already waited

too long, her blood pressure had gone up, as far as he was concerned he would only do a C-section, he would not deliver the baby naturally. ...He was basically, since it was arrested labor, if somebody wanted to deliver that baby naturally he was like, fine, but he's not going to do it and he's not going to a C-section afterwards, because it was already too late.

Isaiah and his partner found that insurance coverage was a potential barrier to having a home birth. He described how financial considerations played into the couple's negotiation about the home birth:

The only point where it got a little dicey with the home birth is that I work for a very large global company and our insurance plan was like, 'oh yeah we cover home birth' and then we got a thing back saying that we deny this and you're going to have to pay like \$5000.00 out of pocket. And at that point I was like, I really know you want a home birth but we really can't afford \$5000.00. You know, if we do a hospital birth they're going to cover like everything ... thankfully though, the midwife did a really good job of appealing that decision on our behalf to the insurance company and we got a letter back saying that we reversed the decision and we're going to cover it like a hospital birth. So, I would say that of the things that, that we might have really gotten tangled up in, that would have been the money issue...

A few other couples assumed that having their provider of choice would ensure the birth of their dreams. However, they did not realize that practice guidelines might derail their birth plan. Theresa, who had wanted a natural birth, assumed that selecting a

midwife would ensure that outcome. After her cesarean, she regretted not having searched for a provider who would have attempted a vaginal breech delivery:

My daughter was breech... and even though we had midwives, they could not legally attend me at that point, so I was referred to an obstetrician, which was an automatic C-section. We did not know at the time that we had another choice. We were unbelievably disappointed, but I just did not know that I had choices. We thought we had taken our choices; we had midwives, what other choices were there?

Similarly, Jeff recalled that the midwife they had chosen was not able to attend their birth because she had lost her legally-required collaborative agreement with her supervising physician:

The midwife we had chosen lost her back-up doctor ... they dropped her as a client ... because, like I said, liability insurance and malpractice insurance. So she knew they were going to go away but she thought they were going to go away later, after our birth. But...I would say about two weeks before she [my wife] was due, she told us she could not be our provider anymore. She lost all of it and she had not transitioned into a new a practice, which is the practice we ended up going with.

Dynamic 3: Silent Decisions. Some couples reported a lack of discussion about key decisions and instead described a seamless and silent unity with their partner. Diana expressed this concept when she characterized her intuitive harmony with her partner as a “flow.” When asked to describe how they made decisions during labor, Diana said, “He didn’t tell me to do anything and I didn’t, like, really ask him to do anything. We just

kind of did what we did, and I don't really know, like, I don't really know, it didn't feel like decisions, it felt more like a flow."

Others recalled silent decisions during labor because their needs were self-evident. For example, a couple choosing a birth center assumed that each partner and provider would facilitate a natural birth.. In describing the birth of their child at a birth center, Chas and Jordan described few decision points and no discussion between themselves or with their midwives. Chas noted that they had discussed their wishes extensively with the birth center staff during pregnancy, and there was no further need to discuss it in labor, stating, "they (the midwives) were really awesome about that. We talked about it up front and there was really nothing to make a decision about during the process."

Similarly, Sheena and Alonso described trust in their provider and extensive discussion about their birth plan throughout pregnancy. When their physician recommended an induction, Sheena did not question this recommendation, saying,

The actual induction when I was at the non-stress test--- there really wasn't any conversation to be had. It's almost like we made the decision in his office on the 12th, because that was a possibility with doing the non-stress test on the new date, but I don't think anybody, even my doctor, expected us not to pass it.

Dynamic 4: Female Priority and Authority. In a few couples, the female partner controlled decisions related to childbirth; she was responsible for both suggesting an option (asserting priority) and making the final decision about that option (asserting authority). Through this process, some women became the sole decision-makers in terms

of their birth attendant. When asked how his partner's maternity care provider had been selected, Greg stated:

Suzanne decided. And I'm just going along, because it doesn't really matter if I like him or not. He's not taking care of me. OK, I mean, he's taking care of my girl and my baby, yeah, so I want him to be good. But he seems to know what he's doing. I feel confident.

Women were also likely to assert authority over the decision to have an epidural. In fact, some of those women felt the male had no right to decide whether or not she should feel the pain of childbirth. As Patricia related, "I think he kind of left it up to me to decide. I'm going to be the one enduring the pain. I guess I never really asked him if he was okay with it (the epidural) [Laughter] But I don't think he minds that I'm doing it."

In one case, a mother asserted authority over the mode of birth, requesting a C-section from her physician without consulting her husband. Brennan recalled,

Pat actually demanded the C-section. She had been pushing for hours, and she was exhausted. The doctor kept telling her that the baby was fine, and she could push as long as she wanted to. And there came a point where she said she didn't want to push any more [laughter]. Actually, she said she WOULD not push anymore and they couldn't make her. She was done, and they could cut her right now.

A few couples in this study allowed the woman to be the primary decision-maker in all childbirth decisions, with the man abdicating any responsibility for these decisions or the woman refusing to allow him any control. For example, when asked about her

partner's role in decision making, Jennifer replied, "I would have to be out of it for him to be primary decision maker, just in a sense that he feels like it's my work to do and my consequences to deal with". Her partner, Manny, when asked a similar question, responded, "I leave it up to her, because she is the one going through it. I mean I'm going through it, too, but she's the one really. It was her decision and I was all right with it....she may have made a birth plan, if she did she hasn't told me."

Sarah took a similar approach her to birth experience. When discussing the role her partner played in decision-making, Sarah seemed to realize that she had not considered his input to-date:

I don't think my partner really has an opinion. I think he is just nervous and scared and wants to do whatever I think is best. ...Honestly, I don't [hesitation] I haven't really thought about it much. As I think about it, I'm the main decision-maker. He is there to give support and not to give any input whatsoever. It's my decision.

Dynamic 5: Female Priority, Male Authority. Another theme that emerged from the interviews was the male partner placing a stamp of approval on the female partner's decisions. In some couples, women suggested a preferred option for key decision points, leaving it up to the male partner to approve or deny her choice.

For example, Isaiah recalled that his wife was adamant about certain decisions, such as having a home birth and refusing circumcision if they had a boy. He described their decision making process in this fashion: "this is what Krista wanted. I followed up with research saying okay, can I either live with or agree with, or am completely behind what she wants and thankfully most of the decisions lined up that way."

Price stated that his partner did not want to go ahead with the induction scheduled by her physician until she checked with him:

Anna had pretty much decided that the induction was a good idea before she left the doctor's office. But, you could say, she wanted to run it by me and get my opinion. Really, the question was when. We didn't want to do it too early if the baby wasn't ready, but we didn't want to wait too long, in case the baby got too big or the placenta started to degrade or something.

Isaiah recounted that the process by which he and his partner selected their midwife was similar to the decision-making process they used throughout the pregnancy; one where she asserted priority and he asserted authority:

When we decided on the midwife and what have you, the idea was that if she liked the person and then if we both liked her we would continue to use her, but the majority of the primary research was done by Krista with me, you know, coming in from behind saying that, yep, this is a good decision, I like this, let's go ahead with that, so....There really hasn't been a decision that I've felt I've been forced into. So much of that was giving options that she liked, the ability to state how I felt about it and we both came to the conclusion that these were the right decisions to make. Not based on her just wanting it or me just giving in, but by me researching it and saying okay, this is a good decision, we can do it this way, I'm behind this, so it worked out well that way.

Dynamic 7: Male Priority, Female Authority. Another pattern of decision-making that emerged from the data was one where the male suggests an option for the female partner's approval. In the case of Alonso and Sheena, he was the one who

preferred a physician over a midwife and helped select the specific OB/GYN who attended their birth. He recalled, “there was a moment when [name] left the office for a minute and we talked briefly, and I remember I asked her, ‘I think he’s the one, what do you think?’”

In the case of Chas and Jordan, the man advocated a water birth to reduce his wife’s pain during childbirth. At the time of the prenatal interview, she had not reached a decision on his suggestion, stating, “I had considered a water birth and I don’t know yet if I want one or not. I know that he is more, very much agreed on it at this point and I’m more on the fence about it and I don’t know, that might be something that would change.”

In a few couples, men were responsible for calling the midwife or deciding when to leave for the hospital. Brennan, like several fathers, was concerned that his wife’s labor might be short and feared he might have to catch the baby. He described how they decided to leave for the hospital,

Well, you know we live in [town.] That’s about 25 miles from the hospital. That’s a good 40 minutes in good weather, and since it was kind of snowing a little, as soon as her contractions were five minutes apart, I was, like, we’re out of here because, you know, I don’t want to be stuck on the road with the baby coming. And Pat, she didn’t have any problem with that because she wanted to get the epidural as soon as possible.

Research Question 3: Roles Men Play Related to Childbirth Decision Making.

An examination of themes from the interviews and interaction matrices revealed six distinct roles that men play in childbirth decision-making: bystander, protector, interpreter, researcher, limiter/ boundary setter, and leader.

Table 4. Roles Men Played in Decision Making

Role #1	Bystander
Role #2	Researcher
Role #3	Interpreter
Role #4	Leader/Decider
Role #5	Limiter/Boundary Setter
Role #6	Protector

Role 1: Bystander. Several men in this study acted as bystanders in the decision-making process related to childbirth. In specific circumstances (or, in the case of some men, all decisions), they did not provide any input into the decision.

As noted earlier, several men were bystanders in the selection of a provider. Generally, when the woman interviewed providers, the men attended the interviews; however, when she stayed with her usual well-woman care provider, the male partner did not see any role for himself in that decision. In addition, when a woman planned for an epidural prior to labor, the male partner generally had no input into that decision.

Depending on the situation, men may have removed themselves from the decision making, or the women may have excluded them. Regardless of who sought the exclusion, men often found themselves not only removed from negotiation, but also physically distant from the birth.

Nancy held a strong preference for a home birth. Her partner Brad, described himself as a nervous person who contributed to his wife’s stress in difficult times. After

the birth, he stated, “I’m a worrier and I was just terribly worried the whole time.” Both partners agreed that, to reduce conflict, Brad should be involved with the birth process as little as possible. Brad characterized his feelings this way in the prenatal interview:

For me, you know, ideally I wish we could go back to the 1950’s where I would wait in another room and you would come grab me and take me in [laughter].

Does that sound realistic? So, I mean I don’t really think that way in general, but in some ways it’s just like, “can we just get it all over with then come get me?”

Krista was another determined woman who strongly preferred a home birth. She was concerned that her husband, who had a structured and detail-oriented personality, would interfere with the intuitive, natural birth she had planned. When asked how he contributed to the decision-making process during labor, Krista replied, “As labor went, he stayed, you know, I think 15 feet away at all times, out of the line of fire... That was my choice, he needed to stay away. Women only.” Isaiah concurred that his role was primarily physical support, not decisional support:

I stayed back in the kitchen and had basically had a “to go” counter of the things that the midwife might need, so we had warm washcloths on low in the Crockpot, I had cold washcloths in an ice bath, and whenever they needed something I would just hand it over the breakfast bar to them.

Jordan also planned an out-of-hospital birth, and chose to exclude her husband from early labor, calling him home only when it was time to go the birth center.

My husband still went to work that day. I just stayed at home; I didn’t have work. ...I had my mom come over. We hung out, we went for a walk and had lunch, you know, just did, just tried to have a normal day ‘cause they [the contractions]

weren't really intense for most of the day. And then it wasn't until later that evening it started to get real intense that I called the midwife and let her know that we would probably be coming in soon. He actually had a meeting that night and my contractions were still you know, anywhere, from 6-8 minutes apart. So I told him to go ahead and go to the meeting. ...

Men also filled the bystander role in the hospital; however, there they were more likely to exclude themselves than be excluded by their partners. For example, Tom recalled that his partner's labor was augmented by Pitocin; the augmentation/induction did not appear to work for several hours. He described his partner as angry, fearful, and irritable while they waited for active labor; "she was miserable. I needed a break. And nothing was happening; she wasn't in any pain. So I called some friends and went out for a beer."

In her prenatal interview, Kathy characterized her partner John and phobic about needles and blood. For this reason, she said "he was kind of in and out. John was out of the room when they gave me the IV and the epidural," and had no input into decision making.

Role 2: Researcher. For some men in this study, the primary role they played was researcher, or what Locock & Alexander (2006) called "guardian and gatherers of facts." In this role, the man focused on research which would enable him to validate or reject his partner's choices. For this reason, most men who filled this role operated in the "female priority, male authority" approach to decision-making. These men let their partners take the lead in decision making, but positioned themselves as the rational evaluator of the safety of different approaches, often using Internet research. Men in this role also

collected data to monitor their wives' condition, often using technology such as smartphone applications, and then used that data in the decision-making process.

For example, Isaiah, a self-described "computer geek", agreed to his wife's home birth plans once he had the opportunity to do research on the topic:

When we first found out Krista was pregnant, I did a couple of things. I'm more of a technical person, so I ordered a book called baby manual, which is written basically for geeks on how to tend for a baby ... I also installed an application on my iPhone to track the baby's growth and what Krista should be looking for, and it would give me all the warnings and what have you. ... Once Krista decided she wanted to do a home birth. I read a couple of studies from the WHO about home births in the Netherlands and other countries to see what the safety of that was ...

A scientist and professor, Price fulfilled the researcher role by consulting with colleagues at the medical school at his university. As his partner Anna described his contributions to decision-making during the prenatal interview:

He's talked with some of the doctors on faculty at [university], and he's learning about complications, about some of the things that can go wrong during labor and how the doctors will monitor me for those things. I think he would be very involved [if a complication occurred]... I think he'll be talking with the doctors, talking about the scientific end of things, looking at the probability of certain things happening, or the anatomy, or whatever.

When asked how her partner contributed to decision-making in labor, Laurel emphasized his role in gathering and evaluating data:

My husband was very proactive because I had to have intervention, Pitocin intervention. He did a lot of research. He talked to his uncle who is a child lawyer [birth injury malpractice attorney] and discussed all the complications and got all the information he needed on how much Pitocin should be administered and when. My husband was keeping track of everything on his phone and keeping track of how long the contractions were lasting. And the [electronic fetal] monitor wasn't working because I was allowed---they were letting me stand up and he was counting everything. And every time they would come in to try to administer more [Pitocin], he's like, "I don't think she needs any more at this time, her contractions are already two minutes apart and they're coming regular."

Role 3: Interpreter. In the interpreter role, men acted as intermediaries between providers and women. Usually men stepped into this role during labor, when women's discomfort or need to focus on their labor prevented them from interacting directly with midwives, doctors and nurses. The function of this role was to identify the woman's needs and convey them to providers, while listening to the advice of providers and communicating it in a way his partner could understand.

Diana recalled laboring in a state of altered consciousness, only able to focus on the sensations in her body and her partner's familiar voice. Her partner explained how the midwives and doulas at the birth center were able to guide Diana through her labor:

She claims I was the only person she was really listening to in the room. Yeah, so while everybody was saying this, saying that, I was repeating a lot of what everybody was saying; it was my voice that she kept focusing in on. So if I hadn't

been there. I am not exactly [hesitation] I'm sure things would have turned out ok, but things may have been different.

By contrast, Sheena relied on her partner to communicate her needs to others in the room:

I found out that when I had a contraction I needed quiet, to be able to tell people not to talk. I needed to be able to tell people without worrying about offending anyone. Having him there was best for that, plus when I needed to tell people to leave the room so we could have quiet time and he was able to be my advocate for that

Comments like Sheena's reinforced other studies where women filled traditionally more passive roles during birth while expecting their partners to be more assertive (LoCicero, 1993; Martin, 2003).

A key component to successful interpretation was both partners knowing what the woman wanted at a certain point in time. This was a particularly tricky task, because it sometimes required men to understand what the woman truly desired versus what she said she wanted in the throes of labor pain. Several men in this study pointed out that childbirth classes taught them that women will ask for pain relief at the height of labor pain even though she "doesn't really want it." Couples also learned that the height of labor pain occurs close to delivery, so waiting out the pain for a short time can get women past the impulse for pain relief. Some fathers were confronted with a dilemma when their partners requested an epidural after having previously tried to avoid one. How the couples negotiated in this scenario depended partly on the man's knowledge of his partner and his ability to assess her state of mind. As Alonso said,

I think at that point it was my role to just kind of discern whether she meant that she really wanted it [the epidural] or not, just by me knowing her. Not that I wasn't going to tell her not to do it; I just wanted to see from her attitude and general condition, if she really meant that she really needed it, and I could tell that she really did.

His wife had the epidural and stated it was the “best thing that happened” to ensure she had a vaginal delivery.

Maternal dissatisfaction occurred when women that their partners did not fulfill their interpretive role properly. This perceived failure on the part of men could occur if a man was unable to understand or convey his wife's wishes, or if he placed the advice of the provider above his partner's needs. As a result, some women perceived their partner's actions as coercive or insensitive, expressing anger after the birth that caused their partners to reconsider their actions. These men felt they were acting with the best of intentions but then later expressed regret for their actions and resolved to act differently at the next birth, should there be one.

For example, Jeff recalled with guilt the sense of importance and control he felt at the birth of his son in the hospital. Having completed the Bradley™ method course, Jeff was prepared to be the primary decision-maker for the couple. When the physician diagnosed fetal distress, Erica, Jeff's wife was resistant to an immediate C-section. The physician enlisted Jeff to convince Erica to agree to the surgery. After the baby was born with no signs of compromise, and after it took nearly an hour to arrange the “emergency” cesarean, Jeff began to doubt the necessity of the cesarean delivery and to regret his role in encouraging it:

They pulled me out [of the room] and said, they said you know this is what we want to do, this is why we want to do it. So I just went in and talked to her.... the C-section decision was pushed heavily by the doctor. They kind of alarmed me, you know, the baby was having decelerations. You know, once we looked at all the data it looked like maybe they pushed a little too soon.

In another case, Jennifer and Manuel had planned a home birth with a Florida licensed midwife. After a day of false labor and then active labor that arrested at seven centimeters' dilation, Jennifer was ready to transfer to the hospital for pain relief and a cesarean if necessary:

At that point I was looking at Manny and said I'm done, you've got to take me to a hospital and cut me. I don't care, I'm done....I just kept saying it, but nothing was happening. I kept saying it and I was having trouble trying to be articulate. I wasn't saying it to complain, I was saying it because something needed to change and I really needed it. There has got to be something else because this isn't working. It was sad to say, but I was talking to him [hesitation and tears]. I needed help and I said, I'm to the point I don't care what happens to her [the baby]. Whatever it takes, I need this to stop. THEN they started listening to me.

Manuel, under the direction of the attending midwives, played a key role in convincing Jennifer to wait to transfer to the hospital and then, once at the hospital, to delay having a cesarean delivery:

She kind of wanted the C- Section. She had mentioned it early on, or she mentioned maybe she might not be able to take this if it's supposed to get worse. A couple of times throughout, she was like, all right, I'm ready to go to the

hospital, but because she was all right we decided not to, as long as [the midwife] said she was cool, we would say you can do it.

Both Erica in the first case and Jennifer in the second expressed anger at their partners and providers for being in collusion, one for encouraging interventions she did not want, and one for withholding interventions she ultimately decided she did want. Jeff, Erica's partner, came to regret the way he fulfilled his role as an interpreter, while Manny did not express any remorse.

One potential explanation for this phenomenon may be the strength of the couple's relationship and their communication skills. Erica and Jeff were a married couple whose narratives suggested a history of effective communication. By contrast, Jennifer and Manny were a recently cohabiting couple who moved in together after Jennifer discovered she was pregnant. Although Jennifer revealed her frustrations with her birth experience to the researcher, it was unclear whether she had shared her anger with her partner. His postpartum interview did not reveal an awareness of the depth of the unresolved emotions Jennifer held about the birth. Perhaps she did not confide in him, and therefore he had no context in which to judge his actions.

Role 4: Leader. Prior to birth, several couples stated that the male partner would only take the lead in decision-making if a serious deviation from the birth plan was required and if the female partner was unconscious or incapacitated in some way. The following quotes exemplify this role:

I think if it came to the point that I had to change my plan that I wouldn't be in the right state of mind [laughter] to make decisions and I completely trust what he

would decide so I'd probably just tell him whatever he thinks needs to happen, we'll do. (Laurel).

I figure I'll be so out of it Brad makes these primary decisions. You know in these kinds of situations I am sure, if like the plans change, who makes those decisions you know? But you know, I guess it depends how out of it or into it I am to be involved. (Nancy).

[In case of complications or a transfer to the hospital] I think I'm going to be prepared for everything, but I think my role is going to be to execute things that were talked about while she is unable to do so. (Isaiah)

I think in the heat of the delivery process, you know, I'd let her as long as she is capable of making the decision herself. You know I am pretty comfortable with anything she--- she's pretty capable of making any decision that would be necessary. If I was required to, I would feel comfortable doing that as well. I think I would defer to her on most things that would have to do with her body, I guess (Brennan).

Despite the fact that most couples prepared a contingency plan in case the woman was too incapacitated by drugs or unconsciousness to make decisions, in only one case did this occur. During Jennifer's labor, she was offered and accepted Demerol. Jennifer, a nurse, claimed,

Demerol was the end of everything, Demerol did not take away my pain; it made me a lunatic, like a stroke patient, because I knew I was thinking right. I had clear coherent thoughts, but what I would speak was not what I was thinking... The Demerol was horrible. I felt like it was a chemical restraint. I felt like it took all my power away.

Although her partner, Manny, was placed into a leadership role in this scenario, it is not clear how much volition he felt he had in the decision to have a C-section. He agreed to the cesarean only after the OB/GYN on call told him that he refused to consider any other options but a C-section:

I don't feel like we were forced into a C-section. I felt like we might have been explained that it was the best choice; it did kind of seem that way. I didn't know where else to where to turn. At that point we had transferred care from [our midwife] to them, so if they're not going to deliver the baby, what are we going to do? So we kind of had to go along, so we chose to go along. If that makes any sense...

A review of postpartum narratives revealed that cases of men being the sole decider were rare, and were generally limited to deciding when to call the midwife or go to the birth facility. As noted earlier, Isaiah was responsible for calling the midwife,

I wanted to call the midwife and let her know, like hey, you need to get over here. So it was probably around 11:00 when I couldn't get accurate contraction information out of her [my wife] I was like, yeah, we better go ahead and call the professional 'cause I am NOT capable of delivering this baby on my own.

Role 5: Limiter/Boundary Setter. Another role was that of the limiter or boundary setter, where men delimited areas within which women could make decisions. Most often, these boundaries took the form of forbidding a controversial decision but then being open to negotiation on everything else. The most common example of this role was a man who forbade his wife or partner from having a home birth due to safety concerns, but was open to any other decision she made within the context of those limitations. As Jeff recalled his negotiations with his partner about their birth plan:

... we found out she was pregnant and we were trying to compromise between her, and what she and I think. She knew then that she wanted a home birth. And I think she tried with me, part of the compromise with marriage...She said, "I didn't want to [have the baby in the hospital]. I wanted a midwife." I was like, that's [a midwife is] fine. I really wanted to have it in the hospital because my sister had had at that point four children in a hospital with really relatively no problems.

In other cases, the male partner could be adamant about choosing one particular provider among those the couple had considered; once he was comfortable with the provider selected, he left the woman free to make the remaining decisions about childbirth. Brad, who was initially uncomfortable with a home birth, recalled setting limits on how his wife could conduct that birth, "my only stipulation was that I wanted us to have the same midwife that interviewed. That was the only thing, I feel comfortable with her, she feels comfortable with her and that's a good feeling for both of us."

Alex described his input into his partner's choice of midwife in a similar fashion:

I knew she wanted a midwife. But it was really important to me that I felt, you know, confident in whoever was providing her care. The midwife we chose --- we passed by, we interviewed a few. But the one we picked, she talked a lot about how she worked with a doctor. To me, well, it was important that there---that she had that arrangement. I wanted to feel confident that there was someone who could step in in case of emergency. So I told her [my partner], that if she wanted a midwife, she should go with that one.

Unlike men who excluded themselves from decision-making, limiters viewed mothers and babies as having different and perhaps competing agendas. A woman's desire for a particular birth experience was not allowed to trump the baby's right to safety or the father's right to protect his family from harm. While these men expressed noble intentions to safeguard the health of their partners and children, their behavior clearly constrained their partners' childbirth options in several cases.

Role 6: Protector. Some couples, particularly those who planned a natural childbirth, cast the male partner in the role of protector and defender. In this role, the man was expected to protect the women from unwanted interference and to defend the integrity of the natural birth plan. As Isaiah explained prenatally,

My job is very much to execute the birth plan and try not to let doctors or nurses apply fear tactics. To say, 'hey, listen; this is the plan, these are the decisions we made...when we were clear headed. So please don't try to change these plans.

Similarly, Brad described his anticipated role in decision-making this way, "I do feel like if we went to a hospital, because she is so uncomfortable with it, I would have to

step up my role and try and protect her as much as I could and have them do as little intervention as possible."

Another component in this role was the man's willingness to confront those who needed to be confronted. Couple who planned "an unaffected birth" in the hospital often anticipated the need to advocate strongly for their birth plan, describing their anticipated birth experience as a fight or battle against the nurses (not their physician). When a caregiver proposed an intervention, the male partner was expected to be assertive and confrontational. This arrangement reduced the role the women had to play in the three-way negotiation between mother, father and provider, presumably to safeguard her from having to make decisions during episodes of pain and distress. And, as Martin (2003) notes, having the man serve as the confrontational partner in the negotiation allowed both partners to maintain traditional gender roles, wherein women are supposed to be accommodating while men are supposed to be assertive. As Sheena described her birth plan, "If I can have a totally natural childbirth I'll be happy, without having to argue or getting too angry with people. That's Alonso's job, not mine."

Similarly, after Jennifer's transfer to the hospital, Manny got into a shouting match with the OB/GYN on call and literally asked him to "take it outside:" "It was kind of a loud discussion, so I asked him to kind of come out side and I had to explain to him that we were trying to have a natural birth here."

In some cases, the couple expected the man to confront the laboring woman during labor and forcefully remind her of her original birth preferences. For example, although during pregnancy Caleb urged his partner to have an epidural, after taking

Bradley classes, Caleb embraced the role of protector. He described that his decision to refuse his wife's request for an epidural was simply a defense of their original birth plan:

The decision [to avoid an epidural] was made well before that point, and from what I've heard it's very common for a woman to demand an epidural at that point. I knew she didn't want it. I just said... 'just wait a little while, you're almost there'. Not really knowing where we were...

In the postpartum interview, his wife became visibly emotional and expressed gratitude for his strength in the face of her demands, which allowed her to experience the natural birth she desired:

Little did we know, within 45 minutes, I went from four centimeters to complete. It was really intense labor for 45 minutes and I was begging my husband for an epidural and he wouldn't give in. And I was really surprised, 'cause I thought for sure he wouldn't be able to see me like that, but he was so sure that I could do it. He was like, 'no you don't need it,' and he stood behind me the entire time just touching my back because it hurt for him to rub and he just stood behind me the whole time... [Tears] I couldn't have done it without him.

Role Fluidity: Describing these roles as separate and distinct does not imply that men were locked into one role during pregnancy and labor. Instead, men could and did move between roles during pregnancy, labor and the postpartum period. For example, Caleb acted as a boundary setter in refusing a home birth, then as a researcher and interpreter throughout much of his partner's labor. Alonso acted as a boundary setter when he rejected his wife's desire for a home birth, then became an interpreter and protector in labor, and ultimately a bystander in the decision-making about the epidural.

In the case of some couples in this study, as the couple approached the time of birth, the more real and less theoretical labor became, creating uncertainty in their prenatal plans and the roles they had planned to fulfill before labor started.

Research Question 3a: To what extent and in which areas do men influence women's decisions in childbirth?

The areas of greatest controversy between expecting couples were attendant and place of birth. These two decisions were highly associated with each other, since direct-entry midwives generally attend out-of-hospital births. Other areas of male influence were pain relief, when to make “the call,” the decision for a cesarean delivery, and induction.

Area 1: Birth Setting. Choosing a birth site was one of the most highly contested decisions among some childbearing couples. In all cases, the desire for a planned out-of-hospital birth was initiated by the female partner. A few of the women had expressed a preference for a home birth; in some cases, the husbands were not comfortable with a home birth and took a strong stance against it, whereupon the couple opted for a hospital birth instead. These men expressed safety and health outcomes as important priorities and tended to fulfill the limiter/boundary setter role in this decision. Men who acted as researchers and were persuaded by their partners to research home birth inevitably agreed to their partner's choice. In only one case did the male partner independently advocate for a home birth, after he and his partner had ruled out a hospital. His partner expressed ambivalence about that idea and selected a birth center instead.

Area 2: Provider. Decisions about providers were difficult to disentangle from decisions about birth site, since the two are so closely related. Just as women initiated

discussion of an out-of-hospital birth, they also initiated discussions about using midwives. In general, men who ruled out a home birth also ruled out the possibility of using a DEM, since these types of midwives attend more home births. Men who forbade home birth did not seem to differentiate between different midwifery credentials, although Alonso did note that the homebirth midwives he met were “too hippy” for his taste.

Men who expressed a strong preference for a particular provider generally were able to convince their partners to choose that physician or midwife. After his wife took him to a home birth open house, Brennan felt an immediate sense of security from the midwife; “this woman we went with was so straightforward and honest... after we went to that open house I was like, you know if we’re going to have a home birth, I think we should have her as our person, she really has a great style.”

Area 3: Pain Relief. Another area of contention was pain relief. None of the women who planned for an epidural mentioned any conflict about that decision with their partners, nor did the partners’ interviews reveal any concerns. In the case of a few couples, the male partner initially opposed the woman’s preference for an unmedicated birth, and changing the partner’s mind generally involved education and negotiation. Couples who planned an unmedicated birth did not uniformly achieve it; where they did, the male partner was willing to confront the providers and the woman herself to advocate for the natural birth. Where they did not, the male partner generally excluded himself from the decision because he felt he could not put himself in the woman’s place.

Area 4: Making “the Call”. As illustrated by several quotes in earlier sections, men were more likely than their partners to suggest calling the doctor or midwife at a particular time, and were anxious to leave for the birthing facility as soon as possible.

Area 5. Induction. Fathers’ involvement in induction was variable. Some husbands fell into the bystander role when an induction was scheduled. As John described his partner’s induction, “I guess they were worried about her blood pressure. Then on the 4th of July, they decided her blood pressure was getting dangerous. It was safer for the baby to be out than in. So they decided to induce her.” When asked if he had any input into this decision, John, looking puzzled, replied, “The doctors decided to induce. They needed to do it for the baby’s health.”

Alonso might have tried to negotiate the timing of his partner’s induction, but he was not at the non-stress test when the induction was scheduled. Prior to birth, Sheena stated that the couple would be willing to agree to an induction if it could help them avoid a cesarean delivery. However, during the induction, Alonso was involved in controlling the dosage:

They started really, really low with the Pitocin like one drip an hour or something like that. We were ok with that. That was like a compromise, because we didn’t want that from the beginning, but when we saw that nothing was progressing, I think we had to do it. Then they started increasing the Pitocin every hour, just like one drip an hour or something like that. In the morning I got really upset, there was a change of shifts and this one nurse came in and she like doubled the Pitocin. And before that all the nurses were telling us we’re increasing your Pitocin one more drop, we were being communicated with, but that one nurse

didn't introduce herself as the new shift nurse and didn't say anything about what she was doing, she just fiddled with the machine and left.

By contrast, Caleb actively encouraged his wife to acquiesce with the induction promoted by her doctor. When asked how the decision to schedule the induction was made, Laurel replied, "my husband has a couple of cousins that actually have permanent disabilities because of problems during birth and he's really sensitive in doing what the doctors say."

Area 6: Cesarean delivery. Some couples who planned an unmedicated birth tried to anticipate what they would do if the provider recommended a cesarean delivery. However, most fathers whose partners did have a cesarean delivery reported little actual negotiation at the time of the decision. As Joe recalled his partner's labor and delivery, there was no negotiation or even thought of negotiation on his part:

It was the doctor's decision. They tried everything, and she just didn't dilate. It just wasn't working. And it had been long enough that they were starting to worry about the safety of the baby. Plus, you know, she's a good size baby, and they were worried about that, too. I mean, was she too big to come out vaginally and was that why nothing was happening?

Fathers who did negotiate with the provider, like Manny and Jeff, reported that their convictions about the importance of natural childbirth crumbled in the face of their belief in the physician's superior expertise and their hesitance to risk the mother's and baby's health upon a lay person's suspicion that the cesarean was unnecessary. As Jeff recalled,

They started saying things like, you know, it's been a while since her water broke, now we've got to do an antibiotic, you know, it's been this long. They kept telling me that the baby's heart rate was descending and that she [my partner] wasn't dilating, all these things. And you know, out of exhaustion and tired and scared and—VERY scared—and we caved in and ended up having a C-section.

Chapter Five: Discussion

Discussion of this study focuses on the following five sections: 1) Summary of Research Findings 2. Synthesis of Research Findings; 3) Strengths and Limitations; 4. Implications for Research, Policy and Practice and Education and 5) Conclusion. The first section provides a summary of the findings for the three major research questions; the synthesis of research findings identifies cross-cutting themes. The strengths and limitation section discusses areas of strength and weakness. The Implications for Research, Policy and Practice suggests applications of the findings of this study and possible future direction for exploration and growth. The Conclusion summarizes the utility of the study and addresses next steps.

Summary of Findings

Research Question 1: What beliefs, concerns and priorities characterize men's involvement in childbirth decision-making? Numerous values and expectations characterized men's involvement in childbirth decision-making, centering on three major themes: priorities, concerns and beliefs. Many men sought the outcome of a safe birth with a healthy mother and baby, with some desiring a natural or unaffected birth. Male partners wanted their partner's birth experience to be pain-free, peaceful, intimate, and quick. They wanted to maintain control over the experience while avoiding mess or having to deliver the baby.

Regardless of childbirth preparation, most fathers felt prepared for childbirth and believed labor would be relatively short and painless. They trusted in their intuitive selection of birth attendants and trusted those attendants to uphold their birth plans. Emerging from their childbirth experience, however, many of the study participants expressed the hindsight of lived experience. Some men noted in their postpartum interviews that they had not been prepared enough for the challenges of childbirth; this was as true of men who could be considered among the best prepared (i.e., who had taken an extended childbirth class with their partners) as for those who had hardly any preparation at all.

Research Question 2: How do men and women negotiate decisions about childbirth? This study suggested that not all decisions about childbirth are negotiated; in fact, many are not conceptualized as decisions by either men or women. These findings confirm the “sizeable body of qualitative empirical literature” that shows “patients do not particularly want to be offered more choices concerning their own medical care, nor do they experience such expanded choice as an enhancement of their autonomy” (Kukla et al., 2009).

When decisions were negotiated, no clear pattern of decisional authority emerged. In some cases, women both proposed and made final choices with their husband’s research input, similar to the “she leads, I follow” dynamic identified by Lindgren & Erlandsson (2010). In others, they allowed their husbands to have the final word on their decisions. In still others, men proposed options that women approved. Episodes of men taking charge unilaterally of decision-making (i.e., asserting both priority and authority) were rare in this study. However, some men used their power to restrict women’s

decisions related to birth place and provider. It is unclear whether a different population of men may have expressed more dominance over the decision-making process. It is also possible that social desirability bias (Crano and Brewer, 2002, p. 293), motivated couples in this sample to present themselves as more equal partners than they actually were.

Research Question 3: What roles do men play in negotiating these decisions?

In this study, men played a variety of roles in the process of making decisions about childbirth, ranging from significant dominance (generally in minor decisions) to complete submission to the mother's or provider's wishes. Further, men often fulfilled different roles during pregnancy and labor, depending on the context and the nature of the decision.

Roles identified in this study include the bystander, protector, interpreter, researcher, limiter/boundary setter, and leader/decider. These roles share similarities with roles identified by previous researchers investigating male influence on reproductive decision-making. Specifically, these roles overlap with five roles identified by Locock and Alexander (2006) in prenatal testing decisions: parents, bystanders, protectors/supporters, gatherers and guardians of fact, and deciders or enforcers.

Because childbirth is a different phenomenon from prenatal testing, some of these roles necessarily differed. In this study, the priority of safety led some men into a limiting, boundary setting role. This role was conceptualized as forbidding certain decisions rather than taking an active role in making them, which deserved a role of its own. The interpreter role reflects acknowledgment on the part of pregnant couples that childbirth presents a unique situation where a woman's decision-making capacity may be

diminished by pain or drugs; therefore this role is present here where it may not be explicit in other areas of reproductive health.

Synergy of Findings

An inductive analysis of the major themes for each research question was undertaken to identify cross-cutting themes that characterized the data. Six meta-themes were identified.

Lack of Consumer Awareness: The lack of decision making found in the bystander role and non-negotiation dynamics suggest that some men (and women) do not see themselves as empowered consumers of maternity care. It is not clear whether these beliefs extend to other areas of health care, since that was not the focus of this study.

Some couples did not see any reason to “shop around” for a maternity care provider. Often, these couples focused on the medical aspects of labor and delivery, which could be managed by any competent, reputable obstetrician. Many of these couples did not question the authority of the expert they had chosen or feel a need to advocate for a particular birth experience. While a few couples were aware of childbirth alternatives—such as midwives and doulas—and rejected those options, some were unaware that these options existed. A few couples who made limited decisions related to childbirth expressed satisfaction with their birth experience. However, a few others expressed regret in their postpartum interviews that they had not learned about or explored other options.

According to the Agency for Healthcare Research and Quality (2011), consumer involvement in decision-making can improve patient satisfaction and health outcomes and may lead to lower demand for health care resources. Therefore, the results of this study suggest a need for increased shared decision-making in maternity care for those

patients who desire this option. Specific recommendations to achieve this goal will be provided in the implications section.

A Safe Passage. This theme incorporates the priorities of safety and healthy outcomes, the concern about complications and having to catch the baby, and roles such as the limiter/boundary setter and decider, where men act to safeguard the mother and infant.

In this study, men unanimously expressed a safe birth outcome for mother and baby as a major priority. Where men participated in decision making related to childbirth, safety was often their driving concern. These results suggest that mothers with involved partners should take their concerns about safety into consideration when negotiating decisions. In addition, maternity care providers should involve fathers in discussions about the safety of various childbirth options.

Family-Centered Care: The themes of control, peaceful birth, unaffected birth, and birth as personal, not profitable suggests that some men see childbirth as a special family event that deserves respectful, customized care. Several couples in this study wanted a birth that was peaceful, with a minimum of interruptions and distractions. A few wanted a birth with limited medical intervention, and felt a strong need to advocate for their personal birth plan. Others rejected the idea that something as special as the birth of their child could be a routine event to a hospital. To increase patient satisfaction, maternity care providers should assess the degree to which patients want a family-centered experience and then identify ways to provide that experience within the realm of safe practice.

Optimistic Bias. Optimistic bias was revealed in the themes of minimization of pain, reliability of intuition, expertise of providers, ease of labor, and sufficiency of preparation. That is, fathers-to-be anticipated that labor would be relatively short and painless. They believed that “gut instinct” was sufficient for selecting a provider, and that the provider they chose would follow their birth plan. As a result, they believed they were adequately prepared for labor support.

Often despite childbirth education, couples believed their birth experience would follow their birth expectations closely. Even couples who were highly informed about the probability of certain childbirth interventions seemed to underestimate their risks of experiencing them. Unrealistic expectations colored men’s beliefs about their prospective childbirth experiences as well as the level of preparation required for those experiences. Couples who chose a hospital birth but planned a birth free of interventions believed their preparation and birth plan would prevent them from receiving unwanted interventions. However, none of these couples were able to experience a birth free of interventions such as induction, epidural anesthesia or cesarean delivery, although one was able to complete labor without pharmacological pain relief.

In general, men believed labor would be less challenging for their partners than the normal first time labor. Men hoped or believed their partners’ labor would be short, even though many were able to verbalize correctly the average length of a first-time labor. Men also vocalized a desire or expectation for a labor that would be less painful than average. Chas exemplified this belief when he described the couple’s optimal birth as, “ completely natural, drug free, no pain for my wife or little pain for my wife, um, obviously, no issues for the baby, you know, as far as time process goes, kind of speedy;

maybe in and out in a couple hours.” Most of the couples who planned a natural childbirth were surprised at the intensity of labor. Two couples who planned for an epidural were surprised and left without a backup comfort measures plan when the epidural did not work as intended.

Negotiating the Boundaries. Themes related to messiness of birth, men as outsiders, and the interpreter role suggested that men struggled with the tension between the intimate physical connection among mother, father and fetus and their separate, sometimes competing, desires.

Male involvement in childbirth decision-making took the form of six different roles, ranging from complete *laissez-faire* to dominance in some issues, particularly related to safety; men could and did morph into one or more roles during pregnancy and childbearing. However, men’s level of involvement seemed to fall into two broad categories: men who felt they had a right or an obligation to participate in decisions about the birth of their child, and those who did not. None of the men in this study articulated their involvement in childbirth decision making explicitly in terms of pregnant women’s autonomy versus fetal rights. Nevertheless, these concepts, while not explicitly invoked, influenced the type of role men played in childbirth decision making. According to Draper (2003)

Pregnancy, birth and breast feeding challenge our concepts of both individuality and ownership... the concept of two people being within one body challenges notions of self, as boundaries between self and Other become indistinct. Thus the mother’s autonomous ‘self’ is called into question by the presence of the fetus

and, similarly, the ‘self’ of the child remains elusive, lodged deep within the mother’s body.

In such an ambiguous space, “ownership” of the fetus can become contested, leading to disagreements about who has the right to make decisions about the pregnant or laboring body. This embodied nature of childbirth was a significant challenge for some couples in negotiating childbirth decisions. Either throughout the pregnancy, or at some time during labor, some male participants withdrew from the decision-making process or became confused about their role due their inability to experience labor and hence empathize with their laboring partners.

Martin (2003) claimed that, “culturally, birth has become more real for those with [an] outsider gaze than those with the lived bodily experience of it.” However, in this study, the lived experience of childbirth demonstrated to a few fathers that the outsider position was less “real” than the experience of the woman in labor. As Jeff noted in his postpartum interview,

A big thing that I realized (and this is what I say to people all the time now when they are going to go into their pregnancies) you know it’s [the decision is] really not what I am comfortable with ... because I am not having the child. So I kind of have to fit myself into what she needs.... If that means I have to be out of the room so I can’t voice my opinion, [then] I have to be out of the room.

Confusion about bodily boundaries may also be related to some fathers’ distaste for the physical “mess” of childbirth. Since Biblical times, emissions from women’s bodies have been seen as polluting. “Within both historical and contemporary cultures women’s bodies are constructed as far more dangerous than men’s because of their

greater propensity for the ‘natural’ breaking of body boundaries and the subsequent potential for dirt” (Draper, 2003). Across time and cultures, rituals exist to remove potentially polluting females from the public sphere and make their emissions invisible (Draper, 2003). Pregnant women are more threatening than others because “their bodies are often considered to constantly threaten to expel matter from inside –they may vomit, cry, need to urinate more frequently, produce colostrums which may leak from their breasts, have a “show” appear, have their waters break” (Longhurst 2001, p. 84 as cited in DeMaeyer, 2010). At the time of birth, the leaky female body collides with societal norms to sanitize it and with gendered expectations of men to be clean and controlled (Draper, 2003). Therefore, it is not surprising that men were anxious about literally “getting their hands dirty” and sought to avoid this experience.

In this study, one of the ways men dealt with their fears of having to catch the baby was to go to the birthing facility or call the midwife early in labor. Although this decision may seem relatively minor compared to, say, urging a woman to have a cesarean delivery, it may have downstream consequences. ACOG recommends that women go to the hospital when labor is well-established (ACOG, 2009), and many childbirth educators suggest that couples, particularly those desiring an unaffected birth, go to the hospital in active labor to avoid medical interventions. Indeed, hospital admission prior to active labor has been associated with a lower vaginal delivery rate (Jackson, Lang, Ecker, Swartz & Heeren, 2003; Holmes, Oppenheimer & Wu Wen, 2001). Therefore, first-time fathers who, in their excitement and fear, hurry their partners to the hospital may unwittingly be encouraging interventions.

Control: The theme of power and control permeated negotiation processes, the priority of control, and the protector, limiter/boundary setter and leader roles.

DeMaeyer (2010) argues that contested ownership of the fetus due to confusion about bodily boundaries plays an important role in the gender dynamics of reproductive decision making. Specifically, the intertwined nature of maternal and fetal bodies enables fathers to use their biological connection to the fetus to impose their preferences on women. Further, it allows men to use the guise of beneficence towards the fetus as an excuse to exert dominance over their female partner.

In this study, most male participants stated that the safe delivery of the infant was their main priority. In a few cases, the mother's desires for a particular type of birth were set aside for the health of the child. Particularly in the case of cesarean deliveries, the mother's bodily integrity was secondary to a healthy baby, even when both partners were not completely convinced the cesarean was necessary. For this subset of men, their main role in the birth was to protect the fetus, and the priority of safety took precedence over all others. While a healthy outcome for the fetus was critical to all participants of the study, and is certainly an important outcome in public health, it is clear that the priority of safety was wielded by some men to overrule their partner's wishes. From the perspective of feminist relational bioethics (Sherwin et al., 1998), not all women in this study were able to make fully autonomous decisions.

Limitations

Several limitations inherent in the study design may constrain the utility of its findings

First, the results of this study may not completely represent the phenomena of interest because they are based on self-reported data. Findings were generated from participants' narratives, and may have been subject to recall bias (e.g. forgetting how events occurred) (Crano and Brewer 2002, p. 228). However, unique events with long-term impact (like the birth of one's child) are more likely to be recalled with fidelity than more mundane events (Crano and Brewer 2002, p. 228).

The second and related limitation is the possibility of social desirability bias among study participants. According Crano and Brewer (2002, p. 293), social desirability bias occurs when participants modify their responses to portray themselves in a positive fashion or to conform to accepted social norms. It can also result from a respondent's lack of self-awareness about his/her cognitive processes. Participating couples may have portrayed the male partner as conforming to accepted male gender norms such as assertiveness (e.g., the protector role) or rationality (i.e, the researcher role). On the other hand, it is also likely that the men's behavior itself conformed to these gendered roles, and therefore the roles were an accurate representation of reality.

Gender also relates to a potential third limitation of the study: gender discordance between the female interviewer and male interviewees. Because the researcher was female, male research participants may not have been forthcoming as they might have with a male interviewer. Specifically, they may have portrayed themselves as more supportive of their wives and of the female viewpoint in general. A similar study conducted by a man may have generated different results.

Fourth, it is possible that the researcher may have unwittingly compromised the trustworthiness of the data. Patton identified four effects that an outside observer can

have on findings: reactivity of the participants to the researcher, changes in the fieldworker/interviewer, and predispositions, selective perceptions and/or biases of the inquirer, and researcher incompetence. Chapter three further discusses in detail how researcher bias was controlled in this study using techniques of researcher triangulation/peer review, preparation and field testing, and bracketing interviews.

Fifth, this study focused on couples experiencing their first labor, with a specific emphasis on the decision-making processes of couples new to childbirth. As a result of this focus, the results of the study are not applicable to experienced parents planning for their second or later child.

Sixth, this sample was not representative of the demographics of first-time parents Florida or the United States (Martin et al. 2010). Overall, the participants in this study were likely to be white, married and well-educated. The sample was representative of Hispanic/Latino couples, but not those of African-American race. Although the researcher made a specific outreach effort to providers in African-American neighborhoods, only one African-American couple consented to the study. Therefore, the findings of this study may not apply to this population. Unmarried couples of low socioeconomic status may have different beliefs, attitudes, and priorities for childbirth than those identified here. In addition, given that only 56% of first-time mothers attended childbirth classes in 2005 (Declerq et al 2006), the sample probably included an over-representation of couples attending childbirth classes and planning a natural birth. However, those couples tended to have the most complex narratives and were more articulate about their choices and their negotiation processes. Chapter 3 details the

importance of including unusual cases and a diverse sample to enhance the credibility and breadth of the study.

The results of this study suggest that a woman's satisfaction with her birth experience and the father's role influences her plans for the next birth. In particular, a few women who wanted an unaffected birth but did not achieve it looked forward to having another baby so they could "do it right next time". A few couples who wanted to minimize pain but were unable to do so with an epidural expressed an interest in a cesarean for their next birth. However, no infant or maternal deaths or serious injuries occurred in this study; had these events occurred, they might have caused couples to reconsider the choices they believed led to this outcome. Therefore, study results most likely would have been different in a population of women who experienced neonatal mortality or morbidity.

Two perspectives on childbirth decisions were missing from this study: those of "freebirthers" (couples who chose to give birth at home unassisted) and couples who choose elective cesarean delivery. Because participants were recruited through medical providers, it would be difficult to recruit freebirthers through the recruitment strategy used in this study. A fraction of a percent of births occur at home unassisted (Martin et al, 2010), and it is unknown what percentage of these are planned; therefore, these births represent a small proportion of first-time couples in the United States. Although one couple planning an elective cesarean delivery was contacted several times by the researcher, they did not return any calls.

With patients who expressed a desire for an epidural in the prenatal interview, the primary researcher did not ask about the preferred timing of the epidural. During

negotiation of themes, the primary researcher and peer reviewer recalled that in the 1990s, childbirth educators encouraged women to wait to receive an epidural until well into active labor. As a result, the author re-read the narratives and noted that none of the couples who expressed a prenatal preference for an epidural mentioned deferring administration or expressed a concern about medication slowing labor progress. In fact, most expressed a desire to have an epidural as soon as possible and did not display knowledge of the potential side effects of epidurals. In addition, most of the couples who expressed a strong desire for an epidural had not taken an independent childbirth class. No claims can be made about how the male partner may influence the timing of medication administration in couples that plan for medication at a specific time.

This study emphasized the role that male partners play in decision making around childbirth, with a focus on gendered power relationships. Therefore, this study does not provide insight into the decision-making processes of same-sex couples, or in couples using surrogate mothers where a third person (or more) enters into the decision-making process. This study did not address the interactions among various players at the birth, including family members, particularly female family members. All of these decision making dynamics would benefit from their own studies.

Strengths of the Study

First, this study fills a significant gap in the literature by exploring the perspectives of male partners on childbirth decision making and the roles and negotiation processes they follow in influencing their partners' decisions. Few studies have been conducted in the United States on this topic.

Second, this research study focused on a public health topic—childbirth—that affects millions of people each year and is the single greatest contributor to hospitalization costs in the United States (Russo, Weir & Steiner, 2009). Understanding how and why couples utilize specific health care services can help policymakers develop strategies to encourage appropriate use of resources.

Third, the use of qualitative methods enabled the researcher to develop a rich understanding of the priorities, beliefs, and concerns of fathers, as well as the interpersonal dynamics that occurred in childbirth decision making. It also enabled the identification of roles that men fulfill during childbirth decision-making.

Fourth, various forms of triangulation used in this study contributed to its trustworthiness. Triangulation of researchers and data analysis techniques increased the depth of the findings, while triangulation of participants (males and females) enabled the researcher to confirm and expand results from male interviews.

Fifth, conducting interviews both before and after the birth of the target child allowed the researcher to not only identify men's priorities, beliefs and concerns during pregnancy, but to explore how those beliefs changed over time and context. Understanding how a couple's first birth influences their decisions about later births can provide important strategies for educating first-time parents.

Implications for Public Health Education and Practice

Encouraging healthy birth outcomes and promoting safe motherhood and infant health are two important public health strategies that support CDC's goal of Healthy People at Every Stage of Life (CDC, 2006). Therefore, this study has several implications

for public health education and practice. This section discusses implications for health care providers and childbirth educators.

Implications for Health Care Providers. Physicians, midwives and birthing facilities should recognize that fathers prioritize the safety and health of their partners and infants. In this study, many fathers' strongest beliefs and actions were motivated by their need to keep their loved ones safe. To meet the informational need of childbearing couples, providers should involve both mothers and father-to-be in discussions about safety. The results of this study suggest that many men define safety as reducing the potential for harm from the inherent dangers of childbirth, while some define it as protecting their family from iatrogenic complications. Couples may be appreciative of childbirth attendants who help them define what safety means to them and then provide them with data to help them make appropriate decisions. Conversations about birth options should include both members of the couple (if the father is involved) and focus not only medical factors, but also on social context (e., level of support at home and plans for more children), personal values, and cultural norms and pressures (Kukla et al., 2009).

While safety was an important outcome for participants in this study, many couples expressed a preference for a particular type of birth experience, and a few desired a natural birth as an important outcome in its own right. Providers may increase patient satisfaction and reduce conflict within couples and among couples and clinicians by identifying couples' preferences prior to labor and then striving to provide those experiences within the bounds of safety (as defined by the couple) and the limits of their professions and institutions. In some cases, providing this type of patient-centered care may require birth facilities to examine and change current guidelines to include the

psychosocial as well as the medical aspects of labor and delivery. It may also require professional groups to develop new services and practice patterns to meet the diverse needs of childbearing consumers. For example, some couples in this study felt torn between their need for safety and a particular (i.e., natural) birth experience. More collaboration among physicians and midwives could encourage the integration of both “high tech” and “high touch” maternity care that offers a broader range of customizable childbirth options.

Implications for Childbirth Education. Findings of this study suggest several strategies for improving the effectiveness of childbirth education in American couples.

First, childbirth decision making varied significantly across couples, suggesting a need for more customization of childbirth education. For some couples, childbirth decisions were non-decisions; for others, they sprang from a complex, emotionally-charged process. This study found there is no one role that men follow and no single negotiation model that fits every couple. Therefore, it follows that childbirth educators should be more flexible and less dogmatic about the father’s role. Childbirth educators should, if they have not already done so, reconsider the role of male partners at birth as a labor “coach.” A coach is “someone who instructs or trains, especially a sports performance” (Random House Dictionary, 2011). To further the sports metaphor, The Bradley Method® website tells pregnant couples, “birth is not a spectator sport” (American Academy of Husband-Coached Childbirth, 2011).

One can see how the concept of “coach” can be appealing to men searching for a way to describe their role in labor. However, observing the birth may be more than sufficient for some fathers. Studies have found that men experience maximal stress at the

time of birth, and greatest stress is felt by who perceive pressure to be present at the birth or believe they have failed to fulfill the correct role (Johnson, 2002). It may be unfair to expect a man to become a coach when he has never played and (barring future technological advances or gender reassignment surgery) can *never* play the “game” of childbirth.

Lamaze International has taken steps away from this “coaching” model of childbirth, noting in a recent position paper,

Lamaze classes emphasize the importance of continuous emotional and physical support in labor, but the “coach” who takes charge of the birth, calling the plays and instructing the mother, has been retired. Research suggests that when trained in class to take on the role of coach, few men actually do so. More importantly, women know how to give birth; therefore encouragement and support, rather than “coaching,” is required (Lamaze International, 2001)

Some fathers in this study felt comfortable providing physical support to their partners during labor, but not participating in decision-making. A portion of fathers entered into labor believing it was not their place to interfere in the mother’s decision-making process. Those who exerted control over the experience and experienced self-recrimination and/or blame from their partner for encouraging unwanted interventions expressed a strong commitment to noninterference in the next birth. A couple of women (whose relationships seemed to exhibit equity and partnership in all other respects—at least to the extent that could be determined from two interviews) relegated men to the fringes of the birth experience, feeling strongly that birth is “women’s business.”

By contrast, a few women were deeply grateful for their partner's influence in decision-making. One recalled her unmedicated labor as occurring in an altered state of consciousness, where the only sensory input she could process was her husband's voice and touch. She surrendered her control over the process (something she felt necessary to birthing naturally) by trusting his advice and doing what he said without question. Another woman gratefully recalled her husband's refusal of an epidural, although frustrating at the time, as evidence of his commitment to their vision for an unaffected birth and his understanding of her unvoiced needs.

Rather than a one-size fits all approach to fathers' attendance and decision-making at birth, childbirth educators and maternity care providers should encourage couples to design the role that best meets the couples' needs. Such a discussion could include clarifying couples' priorities for the birth and identifying under what circumstances male partners should assert decisional authority. Instead of, or in addition to developing a birth plan for the birth attendant, since these plans may be disregarded or forgotten, first time-couples could focus on developing a birth agreement spelling out expectations, rights and responsibilities for each partner.

Secondly, childbirth education should consider developing new learning strategies to enhance the effectiveness of childbirth education. Although most couples in this study could cite statistics about birth, few actually believed those statistics applied to their situation. After experiencing birth, some couples regretted certain decisions and expressed the importance of hindsight. Therefore, childbirth educators could supplement data and factual knowledge with dramatized testimonies from experienced couples. "Fictionalized accounts of important social issues can influence the ways people make

sense of and make choices with regard to their health. (Kline, 2007); therefore, birth stories with fictionalized or first-person accounts of labor and delivery could make childbirth options less abstract and more meaningful. Carefully-screened experienced fathers could be invited to childbirth classes as guest speakers or mentors to share their stories. Special male-only classes may help (Friedwald, 2007).

For those couples who do not have the time or inclination for group classes, as well as for those that value technology, educators could develop fun, interactive decision-aids. For example, InJoy Productions offers an option of an eClass for childbirth education, complete with birth stories (InJoy Productions, Inc., 2011). Childbirth Connection has partnered with the Foundation for Informed Medical Decision Making to launch a new online maternity care decision aid (Childbirth Connection, 2011). Couples could use such tools to explore birth options by clicking on different types of birth stories; they could then select from videos of medical experts discussing the risks and benefits of each option and of couples sharing their personal experiences and advice. Since several men in this study reported using portable electronic devices to research birth option and/or monitor contractions at the births, it is conceivable there would be a market for a free or low-cost childbirth decision aid “app” for first-time fathers optimized for the iPad or other tablet devices. Such programs would tap into the need of some men to fulfill the Researcher role in childbirth decision making.

Childbirth education should also focus on an important, but little-addressed issue: the process of decision-making itself. Most couples in this study conceptualized their birth plans as static and decisions as “right” if they led to a desired outcome and “wrong” if they led to an undesired one. Couples who felt they made the “wrong” decision and

blamed the father, at least in part, for those decisions, sometimes reported relationship conflict. It may be beneficial for couples to learn about decision theory, to gain a cursory understanding of how complex decision making can be. Perhaps if more mothers and their male partners understood how significantly decisions can be influenced by context, drive states (fear, exhaustion, etc.) and emotionality, fewer would blame themselves (or their partners) for accepting an intervention during a complicated, painful or prolonged labor.

Implications for Policy

The most recent data available indicates that numbers of cesarean deliveries have increased in recent years (Martin et al.2010) contributing to increased health care costs (Russo et al., 2009) and mortality and morbidity (see Grobman et al., 2007 and Kolas et al., 2006). In this environment, encouraging effective decision making among both members of a childbearing couples is critical. However, as identified in this study, education is not accessible for some families, and for others, it is not effective as possible in generating desired results (e.g., avoiding a cesarean delivery). Policy changes are required to ensure that more couples can access and act on effective education.

First, this study found that not all couples were aware of the possibility to be involved in shared decision about their care. Some couples were not cognizant of the full array of childbirth options available to them. Therefore, government and non-profit agencies could conduct media campaigns to raise awareness of shared decision making in maternity care and the importance of male involvement.

Second, there should be an expansion of effective childbirth education; i.e, independent childbirth classes that encouraged shared decision-making. Insurance

companies could increase funding for childbirth education in a variety of settings and invest in development of new media channels for delivery. Funding agencies could expand training opportunities for childbirth educators and conduct media campaigns to raise awareness about the importance of childbirth education.

Third, payors, governmental agencies and nonprofit organizations should develop interactive, technology-based decision aids such as those discussed in the previous section. These tools would enable providers to explore childbirth options with their clients. Further, incentives could be put in place to reward providers who use those tools to encourage informed choice with their pregnant clients.

Implications for Future Research

This study focused on couples experiencing their first labor, with a specific emphasis on the decision-making processes of couples new to childbirth. As a result of this focus, the results of the study are not applicable to experienced parents planning for their second or later child. Several of the participants in the study reflected on how their first birth experience would influence the decisions they made for their next birth. Thus, a natural extension of this study would be an exploration of how a couple's first childbirth experience influences their decision-making process in their second or later pregnancy.

Second, this study found that couples' narratives about childbirth reflect an optimistic bias about the duration and intensity of childbirth, as well as their ability to control the experience in hospital settings. However, a review of the literature did not reveal any studies measuring optimistic bias in pregnancy or childbirth. Understanding the extent to which optimistic bias plays a role in couples' childbirth decisions could help childbirth educators develop new curricula and tools to assist couples in their birth

planning. A next step for this field is developing and testing an optimistic bias measure for pregnant women and their partners.

Third, additional research is needed to refine and test the roles identified in this study and then link those roles with birth outcomes. A key goal of this study was to define the roles that male partners play during childbirth. A natural next step would be to develop a quantitative scale to measure men's alignment with these roles. The development of such a scale would enable researchers to measure the impact of these roles on birth outcomes and couples' satisfaction with the birth experience. Further, such a scale would allow researchers to determine whether male partners choose specific childbirth education programs because of a fit with their pregnancy role, or whether participation in childbirth education classes encourages fulfillment of a particular role (i.e. Bradley™ husband-coached childbirth classes encourage more active male partner participation). Although this study was qualitative in nature and did not use statistical measures of association, participation in childbirth classes and extensive personal research tended to cluster with preferences for out-of-hospital birth and unaffected birth, control over the birth experience, and joint decision-making. Further study in this area would enable childbirth educators to determine the extent to which male partner roles lead to, or are influenced by, specific childbirth education modalities.

Fourth, further research on the role of gender in childbirth decision making should be extended to include same-sex couples. This study focuses exclusively on the experiences of heterosexual couples who comprise the majority of childbearing couples. This perspective excludes the experiences of lesbian couples, gay couples, and couples of

all types using a gestational surrogate, where relationship dynamics differ from those of the male/female dyad. This study should be replicated with those populations.

Fifth, this study found intriguing hints of roles that other women may play in women's childbirth decisions. For example, several couples cited anxious grandmothers (i.e, the female partner's mother) as playing a role in mothers considering or accepting intervention. However, the author did not explore these themes in depth because they were not the focus of this inquiry. This may be a fruitful area of research in maternity care decision making.

Conclusion

Millions of women and their partners become first-time parents each year. Their interactions with the health care system as consumers of maternity care can affect utilization and cost of services. Therefore, helping couples become informed consumers is an important public health activity.

Further, some couples see the birth of their child as a family event that affects the couples' emotional health. Negotiating how the new family will be formed; that is, how their child will be born is, influences their relationship and quality of life in the postpartum period. Understanding and responding to the needs of both men and women in this process is crucial for optimal family wellness.

All men in this study expressed a strong desire to support their partners, and several wanted to be active participants in decisions about in labor and delivery. Some men believed it was their duty to intervene in decisions to protect their partners and infants from harm. Others believed that women should have the final authority in determining what happens to their bodies during labor. However, some men shared core

beliefs, priorities and concerns about birth. Most men were optimistic about obtaining the birth outcome and experience they desired and felt their preparation was sufficient to make them an effective partner in that experience. After the birth, several men realized they had not received sufficient preparation for childbirth decision making. Overall, this study suggested that couples should be educated about the complexities of childbirth decision making and be provided with tools to make informed health care decisions within a supportive health care system.

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Appendix A: Sample Recruitment Flyer



Be part of an important study about childbirth...

Are you and your partner (boyfriend or husband) having a baby?

Have you been with your partner for at least one year?

Is your partner involved with your pregnancy?

If you answered YES to these questions, you and your partner may be eligible to participate in a research study. The purpose of this research study is to understand how couples make decisions about childbirth. There are no medical tests involved; we just want to ask you some questions about your plans for your birth.

You will receive a gift card to thank you for your time.

English-speaking couples aged 18 and older who have conceived naturally (i.e. did not have fertility treatments) are eligible to participate.

Interviews will be held at a location convenient to you or via phone.

The study is being conducted by Sharon DeJoy, MPH, a doctoral student at the University of South Florida. Please call 877-252-8859 for more information.

Appendix B: Pilot Study Questions

1. Overall, what did you think about the interview?
2. Are there any questions you think I should eliminate?
4. What other questions do you think I should ask?
5. Did anything about the interview confuse you? Why?
6. Did anything about the interview make you feel uncomfortable?
7. Do you have any other questions or comments about the interview?

Appendix C: Screening and Demographic Information Form

Inclusion/Exclusion Criteria: (to be screened over the phone)

Is this the first child for both partners? Yes No

Was the pregnancy conceived via ART? Yes No

Were both partners born in the United States? Yes No

Do both partners speak English fluently? Yes No

Has the couple been together for at least one year? Yes No

Has the father met the provider and attended at least one prenatal visit?

Yes No

If the answer to any of these questions is “no”; thank the couple for their time and explain they are not eligible for the study.

If the answer is “yes” to all, collect the demographic information below:

Appendix C: Screening and Demographic Information Form (continued)

Mother's Last Name: _____ First Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Age: _____

Race: American Indian or Alaskan Asian Black or African American

Pacific Islander White Other, please specify:

Ethnicity: Hispanic Non-Hispanic

Highest Level of Education Completed:

Less than high school HSD/GED AA/Some College

Four-year degree Graduate degree

Provider: OB/GYN: _____ Midwife: _____

Intended Birth Site: Hospital: _____ Birth Center : _____ Home

Date of 1st Interview: _____ WGA: _____

Date of 2nd Interview: _____ Weeks postpartum _____

Appendix C: Screening and Demographic Information Form (continued)

Father's Last Name: _____ **First Name:** _____

Address: Lives with MOB

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Age: _____

Race: American Indian or Alaskan Asian Black or African American
 Pacific Islander White Other, please specify:

Ethnicity: Hispanic Non-Hispanic

Highest Level of Education Completed:

Less than high school HSD/GED AA/Some College
 Four-year degree Graduate degree

Notes:

Appendix D. Final Interview Guide

<u>PRENATAL TOPIC GUIDE</u>	
Mothers' Questions:	Notes:
Please tell me about any preparation you made have made for childbirth, like taking a childbirth class, reading books, or visiting Internet sites....	
How did you choose your provider? (Prompt about decision-making process)	
How do you feel about that choice?	
<i>If the partner had a differing opinion:</i> Continue prompting about the decision-making process.	
How do you envision the birth of your child? (In the most ideal situation).	
Do you have a birth plan? <i>[If yes, ask her to describe.]</i>	
<i>If not brought up in the previous discussion:</i> Where do you plan to have your baby? What types of comfort measures do you plan to use during labor?	
How was the decision made to....?. <i>[i.e., have a birth center birth, plan an elective cesarean, etc.]</i>	
<i>If the woman indicates the partners had differing opinions about a decision:</i> Continue prompting about the decision-making process.	
Sometimes birth doesn't go according to plan, and you need to make changes to your birth plan or make new decisions during labor. What role do you see your husband (boyfriend) playing in decision-making during labor?	
Is there anything you would plan to do differently at the birth if you were the sole decision maker?	
<i>If yes:</i> What would you do differently, and why?	
Fathers' Questions:	
Please tell me about any preparation you made have made for childbirth, like taking a childbirth class, reading books, or visiting Internet sites?	
How was the decision made to choose your wife's (girlfriend's) provider?	
How do you feel about that choice?	
<i>If the partner had a differing opinion:</i> Continue prompting about the decision-making process.	

Appendix D. Final Interview Guide (continued)

How do you envision the birth of your child going? (In the most ideal situation).	
Do you and your wife (girlfriend) have a birth plan? <i>[If yes, ask him to describe.]</i>	
<i>If not brought up in the previous discussion:</i> Where do you and your wife (girlfriend) plan to have your baby? What types of comfort measures does your wife (girlfriend) plan to use during labor?	
How was the decision made to....?. <i>[i.e, have a birth center birth, plan an elective cesarean, etc.]</i>	
<i>If the father indicates the partners had differing opinions about an issue:</i> Continue prompting about the decision making process.	
Sometimes birth doesn't go according to plan, and you need to change your birth plan or make decisions during labor. How do you see your role in decision-making during labor?	
Is there anything you would plan to do differently at the birth if you were the sole decision maker?	
<i>If yes:</i> What would you do differently, and why?	
<u>POSTPARTUM TOPIC GUIDE</u>	
Mothers' Questions:	Notes:
Tell me about your birth...	
When did you realize you were in labor? How was the decision made to <i>[go to the hospital or birth center/call the midwife]</i> ?	
And what happened next? <i>[Prompt as needed]</i>	
Did anything happen that you didn't plan for? Please tell me about it... <i>[Listen for potential decision points: induction/augmentation, medication/epidural, cesarean delivery, or transfer to hospital.]</i>	

Appendix D. Final Interview Guide (continued)

<p>It sounds like, during labor, there was a decision made to ... How was that decision made?</p> <p align="center"><i>[Repeat as needed depending on the number of decisions made during labor]</i></p>	
<p>If your partner had not been there, would you have made different decisions, or would things have happened differently?</p>	
<p align="center">Father's Questions:</p>	
<p>Tell me about the birth....</p>	
<p>When did you realize your [wife/partner] were in labor? How was the decision made to [<i>go to the hospital or birth center/call the midwife</i>]?</p>	
<p>And what happened next...?</p>	
<p>Did anything happen that you didn't plan for? Please tell me about it...</p> <p align="center"><i>[Listen for potential decision points: induction/augmentation, medication/epidural, cesarean delivery, or transfer to hospital [if at home or birth center.]</i></p>	
<p>It sounds like, during labor, there was a decision made to...? How was that decision made?</p>	
<p>If you had not been there, do you think things would have happened differently, or your wife (girlfriend) would have made different decisions?</p>	

Appendix E: Sample Actor Interaction Model Matrices

Table E1. Sheena and Alonso: Planned Natural Birth in Hospital; Induction and Vaginal Birth

Decision #1: Provider	Actor #1: Sheena			Actor #2: Alonso		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Believes a midwife-attended home birth would be the best chance of attaining a natural birth. Interviews LMs, which are rejected by husband.	Agrees with husband's assessment that "this one is it."	Satisfaction with provider.	Initially agrees with wife's decision and interviews midwives. Decides midwives are "too hippie" and suggests interviewing physicians.	Feels the provider's philosophy is in alignment with theirs.	Satisfaction with provider.
Context: Physiologic, Social and/or Environmental	Has taken a Bradley class and watched "Business of Being Born". Knows people who have had out-of-hospital births. Has knowledge of maternal child health issues.	Makes decision while in physician's office.	Provider is solo practitioner OB/GYN.	Has taken a Bradley class and watched "Business of Being Born"	Makes decision while in physician's office.	
Outcome:	Couple selects an OB/GYN who delivers in a hospital.					

Appendix E: Sample Actor Interaction Model Matrices (continued)

Decision #2: “Picking a Due Date”	Actor #1: Sheena			Actor #2: Alonso		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Believes that she will go into labor naturally around her due date.	Discusses provider’s vacation plans. Is concerned that picking a later due date may cause them to deliver with the physician on call, whom they do not know.	Believes they should have picked the latest due date.	Assumes there is one accurate and unchangeable due date.	Feels that picking an earlier due date will result in a smaller baby, which will help them avoid a c-section.	Believes they should have ignored the due date and allowed labor to begin on its own.
Context: Physiologic, Social and/or Environmental	Attends regular 39-week appointment	Solo practitioner is about to go on vacation.		Attends regular 39-week appointment with wife.		
Outcome	Couple selects the earliest of all possible due dates; Sheena agrees to a non-stress test on that due date (the following day). NST is nonreactive and physician schedules immediate induction.					
Decision #3: Induction	Actor #1: Sheena			Actor #2: Alonso		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision

Appendix E: Sample Actor Interaction Model Matrices (continued)

State of Mind: Thoughts/Beliefs and Emotions	Assumes the baby will pass the NST without any problems.	Agrees to NST; does not feel she can make a decision in this situation because the health of the baby is at stake.	Believes the baby was just “sleepy” and induction was not needed.	Assumes the baby will pass the NST without any problems.	Not present for decision.	Regret for not being present; suspicious of provider for “trying something” when Alonso was not present
Context: Physiologic, Social and/or Environmental	NST is nonreactive.	Already at the hospital.	Attempts to follow the natural birth plan.			Advocates for birth plan. Has a verbal altercation with the nurse.
Outcome	Coupe negotiates with provider to start induction by rupturing membranes. When that is ineffective, they progress to a slow oxytocin induction.					
Decision #4: Epidural	Actor #1: Sheena			Actor #2: Alonso		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Assumes she can handle the pain of labor and Alonso will not let her receive an epidural.	Cannot take the pain anymore; is at the end of her endurance.	“Best decision I made.”	Assumes Sheena has a high pain tolerance and will not need the epidural.	“Heartbroken.”	Believes the epidural was necessary under the circumstances, but the circumstances were not necessary.

Appendix E: Sample Actor Interaction Model Matrices (continued)

Context: Physiologic, Social and/or Environmental	States that nurses offered pain medication regularly but were not “too pushy”.	5.5 centimeters dilation, tired, can’t get comfortable, acid reflux, vomiting, sore tailbone	Is able to sleep; dilates quickly.	Is trying to preserve the natural birth plan	Negotiates with Sheena; believes she is asking for pain relief because she truly needs it.	
Decision:	Vaginal delivery.					

Table E2. Jennifer and Manny: Planned Home Birth, Hospital Transfer, Cesarean Delivery

Decision #1: Provider	Actor #1: Jennifer			Actor #2: Manny		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Was unsure whether she wanted a physician or midwife. After first meeting with the physician, it was “obvious” this model of care would not work for her.	Feels instant connection to the midwife she ultimately chooses.	Complex emotions, ambiguity, satisfaction mixed with anger at times.	Assumes they will have their baby in a hospital with a physician.	Defers to girlfriend’s wishes.	Pleasantly surprised with the amount of time and education provided by the midwife.

Appendix E: Sample Actor Interaction Model Matrices (continued)

Context: Physiologic, Social and/or Environmental	Jennifer is an RN who is familiar with hospitals and the medical system. Sought recommendations from her friends, but did not “gel” with the recommended providers. Selected a midwife from the Internet.			Manny has interviewed his friends whose girlfriends or wives have had babies. Based on those conversations, he has decided to let Jennifer make the decisions.		
Outcome:	Couple selects an LM who attends birth at home.					
Decision #2: Calling the Midwife	Actor #1: Jennifer			Actor #2: Manny		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Wants to labor at home alone for most of labor. Is relaxed and at peace.	Calls midwife when she feels like, “Where the hell is the midwife?”	Relieved; falls asleep.		Defers to girlfriend’s wishes.	

Appendix E: Sample Actor Interaction Model Matrices (continued)

Context: Physiologic, Social and/or Environmental	Has not been sleeping well; becomes physically tired when prodromal labor lasts 24 hours. Understands that discomfort is not pain, and plans to call the midwife and her best friend when she needs help coping with contractions.	Family stops by; encourages her to time contractions and call midwife. Family “sets up camp” in her house waiting for the baby to come.	Best friend is providing doula support; rubbing her back, etc.	Supports his girlfriend by walking with her, rubbing her back, “calling colors of the rainbow.”	Defers to girlfriend’s wishes.	
Outcome:	Jennifer calls the midwife when she is about 5 cm.					
Decision #3: Transfer to the hospital	Actor #1: Jennifer			Actor #2: Manny		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision

Appendix E: Sample Actor Interaction Model Matrices (continued)

<p>State of Mind: Thoughts/Beliefs and Emotions</p>	<p>Exhausted and in pain. Feels she cannot continue. Expresses the feeling that she doesn't care what happens to the baby any more, as long as she gets pain relief.</p>	<p>Jennifer decides to transfer to the hospital several hours before the transfer actually occurs. Is "pissed off" because she perceives that her boyfriend, best friend and two attending midwives ignore her wishes.</p>	<p>Initially excited that "something is going to change." Then has strong contractions in the car and wishes she has not left home. Gets to the hospital and feels the situation is out of her control; she cannot get comfortable and staff are rude.</p>	<p>Believes that Jennifer can do it at home. Believes it is his role to defer to the experts.</p>	<p>As labor goes on, worries what might happen.</p>	<p>Relieved.</p>
<p>Context: Physiologic, Social and/or Environmental</p>	<p>Midwives offer Jennifer herbal remedies to help relax her. Her pain does not diminish..</p>	<p>Baby is malpositioned for birth. Jennifer's blood pressure is increasing to unsafe levels. Midwives decide transfer is necessary.</p>	<p>Hospital experience exacerbates Jennifer's pain and distress.</p>	<p>Does not consider transferring unless the midwives say it is medically necessary.</p>	<p>Defers to midwives' decision.</p>	

Appendix E: Sample Actor Interaction Model Matrices (continued)

Outcome:	Midwives decide to transfers to the hospital when Jennifer’s blood pressure increases. Manny agrees. Labor is arrested at 7 cm.					
Decision #4: Pain Relief	Actor #1: Jennifer			Actor #2: Manny		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Jennifer transfers to the hospital planning to have an epidural. She does not want to discuss any birth options until she has pain relief.	Desperate for pain relief.	Feel disoriented and high. Cannot speak coherently.			
Context: Physiologic, Social and/or Environmental	Hospital staff say it will be at least an hour before the anesthesiologist can come administer the epidural.	Staff offers Demerol	Best friend, tells the couple that if they end up having a c-section, having an epidural first will increase the post-operative pain.		Supports her decision.	Tries to speak for Jennifer, since she cannot speak for herself.
Outcome:	Jennifer and Manny agree to Demerol while she is waiting for an epidural.					
Decision #5: Cesarean delivery	Actor #1: Jennifer			Actor #2: Manny		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision

Appendix E: Sample Actor Interaction Model Matrices (continued)

<p>State of Mind: Thoughts/Beliefs and Emotions</p>	<p>Disoriented by Demerol. Irritable.</p>	<p>Exhausted. Ready for the pregnancy to be over.</p>	<p>Conflicted; feels guilty; blames herself and her family for not having a natural birth. Also blames husband and midwife for not having the c-section sooner. Angry with hospital, CNM and staff.</p>	<p>Believes that it is his role to protect Jennifer from a c-section.</p>	<p>Scared; feels he is “gambling with two lives.”</p>	<p>States that he did not feel coerced into a c-section. Understands why people would select a c-section because it is so quick. Believes the course of the labor was determined by “God (him/her/it)/the universe/fate”</p>
<p>Context: Physiologic, Social and/or Environmental</p>	<p>CNM has suggested an epidural and Pitocin®. Jennifer denies lunch so, if she needs a c-section, she can have it quicker.</p>	<p>OB/GYN on call and husband have “loud discussion” over her bed when physician refuses to wait any longer to perform a – section.</p>	<p>Jennifer’s recovery is fairly easy. She is put on anti-hypertensive drugs; talking about the birth is stressful.</p>	<p>Midwife asks him to be an advocate for more time. Delays c-section by stating that Jennifer did eat lunch.</p>	<p>OB/GYN on call refuses to allow vaginal delivery. States he will perform a c-section or he will walk off the case.</p>	
<p>Outcome:</p>	<p>Jennifer and Manny agree to a c-section rather than Pitocin and epidural.</p>					

Appendix E: Sample Actor Interaction Model Matrices (continued)

Table E3. Krista and Isaiah: Planned Natural Vaginal Waterbirth at Home

Decision #1: Provider	Actor #1: Krista			Actor #2: Isaiah		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Prefers a natural birth.	Feels instant comfort with midwife.	Satisfaction with provider. Believes that Isaiah is too analytical and structured to be helpful in birth, which needs to be unstructured and organic. Wants “women only” in the room.	Litmus test of any decision Krista makes is, “Can I live with this?” Feels his role is to conduct research on safety of her decisions.	Likes the midwife, so agrees with Krista’s choice.	States the only decision on which they disagree is circumcision. Has planned to be the spokesperson in case of emergency. Has made notes about possible complications and committed them to memory.
Context: Physiologic, Social and/or Environmental	Has done Hypno-babies, read <i>Ina May’s Guide to Childbirth</i> , watched “Business of Being Born.”			Self-described “geek”; works in the computer industry.		Insurance company denies coverage for the homebirth, then relents.
Outcome:	Couple selects a Florida licensed midwife who attends birth at home.					

Appendix E: Sample Actor Interaction Model Matrices (continued)

Decision #2: Calling the Midwife	Actor #1: Krista			Actor #2: Isaiah		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Hopes for a quick labor but realistically plans for a long, slow early labor. Feels festive; wants to bake a cake to have a birthday party for the baby.	“Angry” at the amount of pain. Disappointed that there was no slow build up and no time to enjoy early labor.	“It hurt like a bitch,” but it was worth it.	Excited.	Fearful that labor is progressing so quickly he may have to deliver the baby.	Feels it is his duty to provide support to the midwives.
Context: Physiologic, Social and/or Environmental	Sends Isaiah to the store for birthday party supplies at 8:00 am. By 9:00 am, feels the need to get into the birth pool to cope with contractions.	Agrees with Isaiah’s decision to call the midwife.		Takes grocery list and goes to the store. Returns to find Krista in the birth tub. Tries to time contractions and has difficulty because they are coming one after another.	Decides to call the midwife so she will arrive in time.	Stays in the kitchen with an assembly line of everything needed for the birth.
Outcome:	Krista has a healthy baby girl before 4:00 pm.					

Appendix E: Sample Actor Interaction Model Matrices (continued)

Table E4. Patricia and Brennan: Planned Hospital Birth; Cesarean Delivery

Decision #1: Provider	Actor #1: Patricia			Actor #2: Brennan		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Feels she has no choice but to see the provider who serves their military base.	Feels she has no choice but to see the provider who serves their military base.	Prefers the CNM, but know she has no choice over who will deliver her baby.	Feels Patricia has no choice but to see the provider on base.	Likes the midwife and is glad they have her as a possibility.	
Context: Physiologic, Social and/or Environmental	Went to babycenter.com and a few other internet sites to prepare for birth. Has read “Your Baby Week by Week.” Is in the military, and does not have a choice of provider. Attends a MD/CNM practice with rotating call.			Has read “Your Baby Week by Week” and interviewed friends.		
Outcome:	Couple selects the provider that serves their military base.					

Appendix E: Sample Actor Interaction Model Matrices (continued)

Decision #2: Epidural	Actor #1: Patricia			Actor #2: Brennan		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Believes childbirth is painful and pain should be avoided. Wants to avoid a c-section.	Decides she wants an epidural as soon as she finds out she is pregnant.	“Life is grand” until the epidural catheter dislodges. Experience confirms her belief that childbirth is the most excruciating pain one can imagine.	Feels that the decision is Patricia’s to make, since he will never experience that kind of pain.	Feels helpless; wants them to do anything to ease her pain.	
Context: Physiologic, Social and/or Environmental	Asks friends to share their birth stories and advice. Does not attend childbirth classes or make a birth plan.		Goes to hospital when water breaks.. Put on Pitocin® and given narcotics can get her epidural. Epidural catheter is dislodged before pushing.	Has read “Your Baby Week by Week” and interviewed friends.		

Appendix E: Sample Actor Interaction Model Matrices (continued)

Outcome:	Patricia decides on an epidural as soon as she knows she is pregnant.					
Decision #3: C-section	Actor #1: Patricia			Actor #2: Brennan		
	Before Decision	At Point of Decision	After Decision	Before Decision	At Point of Decision	After Decision
State of Mind: Thoughts/Beliefs and Emotions	Exhausted from pushing for 3+ hours.	Crying. “Hostile”. Frustrated that pushing is taking so long.	Relief. Surprised at how painless the c-section is.	Anxious for the baby to be born.	Relief; felt a sense of resolution.	
Context: Physiologic, Social and/or Environmental	Baby is malpositioned. Doctor discusses a c-section after two-hours of pushing, but encourages Patricia to keep pushing for two more hours (with breaks)	Exhausted. Declares that she is going to stop pushing because it is futile. Demands a c-section.		Exhausted from staying up late painting the night before.		
Outcome:	Patricia has a c-section after 4 hours of pushing.					

About the Author

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