

DISSERTATION

INFLUENTIAL FACTORS FOR FIRST-TIME MOTHERS IN THEIR DECISION
MAKING PROCESSES IN PLANNING HOME BIRTHS

Submitted by

Mary Katherine “Katie” Godfrey

School of Education

In partial fulfillment of the requirements
for the degree of Doctor of Philosophy

Colorado State University

Fort Collins, Colorado

Summer 2010

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COLORADO STATE UNIVERSITY

May 13, 2010

WE HEREBY RECOMMEND THAT THIS DISSERTATION PREPARED UNDER OUR SUPERVISION BY MARY KATHERINE GODFREY ENTITLED INFLUENTIAL FACTORS FOR FIRST-TIME MOTHERS IN THEIR DECISION MAKING PROCESSES IN PLANNING HOME BIRTHS BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

Committee on Graduate Work

Cindy Griffin

Nathalie Kees

Advisor: James Banning

Co-Advisor: Shelley Haddock

Interim Director: Carole Makela

ABSTRACT OF DISSERTATION

INFLUENTIAL FACTORS FOR FIRST-TIME MOTHERS IN THEIR DECISION MAKING PROCESSES IN PLANNING HOME BIRTHS

While the vast majority of pregnant women give birth in the hospital, the number of women planning to birth at home is currently growing (MacDorman & Menacker, 2010). While home birth can be a safe and satisfying option for women, little is known about what influences a woman to make the decision to plan a home birth.

A phenomenological analysis was conducted with first time mothers who were planning a home birth with a care provider. Three women who were pregnant wrote in journals about their decision making process. Six women who had planned a home birth for their first child were interviewed. An analysis of these journals and interviews was conducted to identify influential themes common to these first time mothers. Overall, a feminist lens was used to analyze data and Ecological Systems Theory was used as a way of organizing themes.

Findings indicate that influential factors for these first time mothers included the desire for a natural childbirth experience, apprehensions regarding the medical model of pregnancy and childbirth, wanting to have power and control over their birth experience, the guiding function of intuition, and the influence of their partners. In addition, the women provided suggestions for other mothers and shared lessons they learned from their

experience of planning a home birth. Results from this study are consistent with the literature calling for feminist based research on women's birth experiences.

Mary Katherine Godfrey
School of Education
Colorado State University
Fort Collins, CO 80523
Summer 2010

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CHAPTER 1: INTRODUCTION

A century ago, nearly all women gave birth at home. In 1940, that portion dropped to 50% (Committee on Assessing Alternative Birth Settings, 1982). Currently it is estimated that fewer than 1% of women give birth at home (Martin, et al., 2007), although there was an increase in the number of home births in the United States in 2005 and 2006 (MacDorman & Menacker, 2010). In one century, place of birth for women has completely reversed. However, with cesarean rates skyrocketing in the United States, and with women having normal, healthy pregnancies being subjugated to unnecessary, invasive procedures, it may not be surprising that a small percentage of women are choosing to give birth at home. With hospital birth being considered the norm in the United States, what factors influence women to plan a home birth?

Context of the Study

Many women in the United States do not believe they have a choice in where to give birth. They believe that the hospital is the only place to do so. In reality, there are choices in the area of maternity care. Women may choose to give birth at a hospital, a birthing center, or at home. Women and their partners may choose to use a direct-entry midwife, a certified nurse-midwife, a family practitioner, or an OB-GYN for prenatal care and for labor and delivery. They may also choose a planned cesarean section, to use

pharmaceutical pain relief, or to give birth naturally. According to National Vital Statistic Reports, while 99% women choose to have their babies in a hospital, 1% choose to give birth outside of the hospital. Of this 1%, 65.4% chose to give birth at home, and 27.3% gave birth in freestanding birth centers (Martin et. al., 2007). While these numbers may be underreported (Rooks, 1997), they have remained fairly stable for the past few decades. Women choosing to give birth outside of a hospital are actively choosing a different option. This study focuses on women choosing to give birth in their residence and seeks to find out more about the decision making process women use when choosing to plan a home birth.

Research Questions

The overarching research question guiding this study is what factors influence first-time mothers in making the decision to plan a home birth with a midwife? Decision making is a complex process. When making a big decision, people usually go through many steps and ask themselves many questions along the way. Various scholars have described the decision making process (Hammond, Keeney, & Raiffa, 1999; Hanks, 1993; Hill, Glaser, & Harden, 1998; Lamanna & Riedmann, 2009). This study utilizes a combination of the Hill, et al. feminist decision making model and the Hammond, et al. Smart Choices model, and is also influenced by Bronfenbrenner's (1979) Ecological Systems Theory. Specifically, this study will answer how do first-time mothers describe the influential factors in their decision making process to plan a home birth from their initial consideration to its implementation?

Rationale

I have personal, professional, and academic reasons for pursuing this course of research. Personally, as a woman who planned a home birth and gave birth at home, I am curious about other women's experiences of this phenomena. Professionally, I anticipate that this study will be the basis for my professional research agenda on maternity issues.

Academically, this study was designed as a way of learning more about women's decision making process around home birth. Home birth is a topic that has not been studied in the academic world to any great extent. When it has been studied, it is typically from a medical perspective or around issues of safety. There also appears to be more research done on home birth in countries other than the United States of America. Therefore, we know little about the women's experiences in deciding to plan a home birth.

Additionally, there are some myths about home birth that are important to dispel. For example, it is often assumed that home birth is not safe or that only fundamental religious women or hippy women pursue home birth. Another misconception is that midwifery and home birth are for low-income women who cannot afford a physician (Rooks, 1997). These (and other) myths will be explored in the review of literature.

My goal is that the findings from this study can be used in numerous ways. Accurate and positive information regarding home birth should be included in childbirth education classes for women to understand that they have a choice in their prenatal care, labor, delivery, and post-labor care. Information about women choosing home birth could be included in human development and family studies coursework as well as women's studies coursework. Popular press articles and scholarly journal publications

are also an important way of providing information. Finally, in order to reach more non-collegiate women, information could be dispersed through workshops and presentations with local non-profit organizations such as The Family Journey, a group of activists, birth professionals, care providers, and community members interested in issues facing childbearing women (www.thefamilyjourney.org).

Definition of terms

Doula: Doulas serve to advocate and support a mother before, during, and after labor. They are generally not medically trained caregivers.

Home birth: Where a woman gives birth at home. While this study focuses on home birth as a planned event with a medically trained attendant/caregiver present, some women give birth at home due to circumstances beyond their control. There are also some women who intentionally give birth at home without a caregiver present. Much of the research on home birth attempts to include only births with trained care providers; however, some in studies on safety, women who give birth at home unassisted are inadvertently included into the sample.

Midwife: In the literature, the term midwife is used in various ways. I will provide definitions of the more commonly usages this word. It may refer to a Certified Nurse Midwife (CNM), one who primarily practices in a hospital or sometimes a birthing center. CNMs are generally registered nurses who have taken additional coursework in midwifery, typically at the Master's level. Alternatively, other midwives are known as direct-entry or lay midwives. These midwives practice home birth and their education and experience vary. Many direct-entry midwives are certified by the North American

Registry of Midwives (www.narm.org) and are titled Certified Professional Midwives (CPM) (Rooks, 1997).

Multipara: a woman who has given birth to more than one child.

Natural childbirth: a birth free of pharmaceuticals and with minimal medical interventions in which the mother generally practices alternatives to pain relief such as breathing and relaxation (*The American Heritage College Dictionary*, 1997).

Primipara: a woman who has given birth to one child.

Singleton: a newborn who is not a twin or other multiple birth.

Delimitations

The participants include eight to ten women from the Northern Colorado area. All of the women will either be in the process of planning a home birth or have had a planned home birth within the past three years. While some of the women may have also birthed other children in a hospital or birthing center in a subsequent birth, the data collection interviews will center around their home birth plans and experiences. Additionally, all women had to have planned a home birth for their first child. Women will be interviewed and/or journal from April through September 2009. Interviews and journaling center around how and why women made the decision to pursue home birth, how others such as family members and authority figures influenced this decision, and issues of power and control in maternity care.

Methodology

This is a qualitative study using data obtained from interviewing and journaling. All post-partum participants will be interviewed either in their homes or in a private office in Fort Collins, CO. Interviews will last approximately two hours. All pregnant

women will complete journal entries over the course of their pregnancy. Data was analyzed from a phenomenal, feminist perspective utilizing Willig's (2001) suggestions. Additionally, data was analyzed using Bronfenbrenner's (1979) Ecological Systems Theory. Responses from participants in this study were given freely and honestly. All of the participants fit the parameters stated above.

Researcher Perspective

Hammersley and Gomm (2000) discuss bias based on our life experiences and encourage researchers to be transparent about potential biases. In an effort to be transparent about my biases, I include this section in which I discuss relevant aspects about my background as well as my personal experience with birthing at home.

The majority of my education and work experience has centered around women's studies and feminist issues. My Bachelor's of Arts degree is in English with a minor in Women's Studies from Appalachian State University in North Carolina. After completing my undergraduate education, I worked as a women's advocate at a battered women's safe house. In this position I endeavored to offer counseling, advocacy, and assistance to women and their children who were in abusive relationships.

While working at the shelter I earned a Graduate Certificate in Women's Studies from Colorado State University (CSU). Following my work at the safe house, I returned to CSU to obtain a Master's of Science in Human Development and Family Studies with a concentration in Marriage and Family Therapy. I intentionally chose this particular graduate program because of their focus on gender and diversity. Upon graduating, I opened a private psychotherapy practice where I specialize in feminist individual, couple, family, and group therapy. I work with clients around a variety of areas including

domestic violence, sexual assault, sexual orientation issues, relationship issues, pregnancy, childbirth and postpartum issues, and personal growth.

Presently, in addition to being a graduate student and therapist, I am an instructor in the Women's Studies Program and in the department of Human Development and Family Studies at CSU. I have been teaching undergraduate classes including Introduction to Human Development, Marriage and Family Relationships, Family Studies, Adolescent and Emerging Adulthood Development, and Introduction to Women's Studies for the past five years.

On a more personal side, I am a 36-year-old white woman, a mother to a pre-school girl, and have been with my partner for 6 years. When my partner and I decided we wanted to have a baby we researched various options for pre-natal care. Some people recommended we explore the option of home birth, while others recommended using nurse-midwives in the hospital. Most people, though, made the assumption we would opt for the more commonly used Obstetrician-Gynecologist (OB-GYN). It was widely assumed that I, like the majority of pregnant women, would give birth in the hospital. In fact, I only had one person specifically ask me otherwise. We knew that because I was likely to have a normal, healthy pregnancy that we did not want to do our prenatal care with an OB-GYN and risk being subjected to unnecessary tests and interventions. After interviewing a nurse-midwife and a Certified Professional Midwife, we chose to obtain prenatal care from the Certified Professional Midwife and plan a home birth. This is an option that worked very well for us and I since became increasingly interested in this option as a choice women may make.

As a developmentalist and a Women's Studies scholar, I recognize the importance of the childbearing years in women's lives. Because of that, I decided to pursue women's perceptions around decision making in the area of childbirth, specifically home birth, for my dissertation research.

CHAPTER 2: REVIEW OF THE LITERATURE

To orient the reader to the contribution of this project to the literature, I will review seven topics. First, I will examine the history of maternity care in the United States. Second, the reemergence of the field of midwifery will be addressed. Third, philosophical differences between the medical and midwifery models will be considered. Fourth, women's satisfaction with their birth experiences will be explored. Fifth, decision making, including specific decision making models, will be reviewed. Sixth, I will overview Ecological Systems Theory. Last, I will address how this project serves as an integration between decision making and the home birth literature.

History of Maternity Care in the United States

Birth attendants have the potential to yield considerable power over the experience of a birthing mother and her child. Historically and currently, this power has been abused by some in the medical profession. This section will cover the history of maternity care primarily in the United States of America. Addressed in this section will be how research has been used to gain power and control over the practice of midwifery and over women in the maternity industry.

Colonial Days

Historically, caring for women during pregnancy and birth has been a woman's responsibility. Women have cared for other women during labor for as long as we have written history, although it is speculated that during primitive and ancient times women may have birthed alone or with a male mate. In the 1600s, European midwives in the country were well respected. They were often times referred to as good mothers, wise women, wise mothers, or mother midwives (Brodsky, 2008).

The United States has always had midwives in our history, including granny midwives in the southeast, "Native American midwives serving other members of their tribes, *parteras* serving Latino women in Texas and the Southwest, and informally prepared midwives serving women in communities throughout the country during most of our history" (Rooks, 1997, p. 8). In the 1600s and 1700s, midwives in Colonial New England typically came over from England and were respected members of the community. Often times they were given a home rent free on the condition that they would care for laboring women. Midwives with the Dutch West India Company who settled New Amsterdam (present day New York, Connecticut, Delaware, and New Jersey) were salaried and sometimes given homes on the condition that they tend to the poor. In Louisiana, the French colony paid their midwives. In the south, midwives were typically slaves who attended both black and white women (Wertz & Wertz, 1989). In the 1800s, women on the frontier felt fortunate to utilize the services of a midwife, who were often kept quite busy (King, 1996).

In early colonial days in the United States, women cared for their friends, kin, and neighbors during and after childbirth. Women did seek the care of a midwife if one was

available. Wertz and Wertz (1989) describe Colonial childbirth as social childbirth because it gave women the opportunity to take a break from everyday chores and household tasks and be with one another. Family and friends would assist with the laboring woman's chores and other children during birth and during a laying in period of several weeks following the birth. While there was a social aspect to this help, it was also a necessity for some women. Because of the amount of work these women did, and sometimes limited access to food and nutrition, women who were not permitted this laying in period of time prior to and following the birth often times did not have the strength to endure labor and childbirth, and subsequently died.

Training of Midwives and Physicians in the United States' Early Years

The United States, unlike many other countries where training traditions and programs for midwives existed, has a different history of midwifery. Because the United States is made up of immigrants, midwives historically had varying experiences and degrees of training. Some midwives had pursued education in their country of origin, but many were midwives simply because there was no one else around and they were therefore pressed into service. Others were trained in an apprentice mode, and learned from an older, more experienced woman (Rooks, 1997).

As a result of the varying degrees of training, safety issues and mortality rates for mothers and infants also varied. This was true of the few doctors who may have been attending births as well. Medical doctors in Colonial times were scarce, and their training also varied greatly. Some did not have any training, but passed themselves off as doctors anyway. In terms of attending a woman during childbirth, most women preferred to labor with only women present because of Puritan beliefs about modesty (Rooks, 1997).

In the mid-1700s, male doctors began training under a new midwifery model at schools in Great Britain. At the schools medical doctors were learning new techniques and interventions, such as the use of forceps. This model was one of shared knowledge and power between midwives and medical doctors, where midwives were handling routine deliveries and medical doctors were being called in for any complications in order to use interventions (Wertz & Wertz, 1989).

Some of these doctors brought these techniques to the United States with the intention of replicating this model of shared knowledge and power and they offered classes to midwives and doctors. However, very few female midwives chose to come to these classes, and soon the classes were limited to “man-midwives”. Wertz and Wertz (1989) contemplate that women did not attend classes because they “were uninterested in studying what they thought they already knew and, moreover, studying it under the tutelage of men” (45). Rooks (1997) adds that most women during this time were illiterate, could not afford schooling, and that women were not encourage to obtain formal education under Puritan philosophy. As a result of this education being inaccessible to women and only men attending these classes, the shared model never happened in the United States.

The Disappearance of Midwives

During the 1800s women began disappearing from the practice of midwifery. This happened for several reasons. Because of their access to education, male medical doctors were becoming more trained in the use of interventions, and began to rely on this technology more so than trusting in nature and women’s bodies as female midwives had been doing for centuries. According to Wertz and Wertz (1989), “this view let to the

conviction that a certain mastery was needed, which women were assumed to be unable to achieve” (47). As Bogdan (1993) said:

At first, physicians were called only as a last resort when a childbirth seemed hopeless, then “just in case” it became difficult, and then gradually in the 19th century, physicians handled all births, replacing the midwife as chief attendant. Called in because they were male, because they claimed to be able to “do something” when women and midwives could not, men-midwives proceeded to redefine childbirth as disease, a pathology that called for medical attention and intervention. (p. 70)

It is important to note that while medical doctors did have access to various instruments, these were typically not as helpful as people were led to believe. Indeed, these instruments sometimes did more harm than good, physically harming or even killing the infant and/or the mother. (Scully, 1993)

In addition to approaching labor and delivery differently by using more and more interventions, these male medical doctors also changed the previously mentioned social aspect of birth by removing everyone from the delivery room except one person, usually a nurse or a friend. This person was expected to obey the doctor’s orders and was not necessarily there for emotional or social support to the mother. Wertz and Wertz (1989) speculate that this happened in the nineteenth-century because the doctors probably felt “ill at ease under the watchful eyes of many women” (p. 5).

With the advent of obstetrics, medical doctors began to take over the field of childbirth. By 1900, physicians in the United States were attending nearly all of the births of middle- and upper-class women, accounting for nearly half of the births. Midwives were taking care of other, primarily lower-class, women. It was during this time that births began moving from the home and into the hospitals and physicians began a campaign to abolish the profession of midwifery (Rooks, 1997). Physicians began what

has been called a “vicious, racist, sexist, and classist campaign” against midwives (Ratcliff, 2002, p. 210). Physicians began promoting themselves as safer than the midwives, touting their levels of education and access to instruments. However, the reality was that physicians lost as many women as midwives did and their infant mortality rates were also quite high. Furthermore, physicians began publishing articles against the midwives, describing them as “hopelessly dirty, ignorant, and incompetent” (Edgar, 1911, p. 882, cited in Scully, 1993).

The Shift of Birth From Home to Hospital

The United States experienced a large shift from home births to hospital births, with the most significant movement occurring in the 1930s. Declercq, Devries, Viisainen, Salvesen, and Wrede (2001) cite four reasons for this shift. First, there was a large movement during this time in the medical field to move many medical practices from the home into the more centralized location of the hospital. The move of birth from home to hospital had a huge affect on eliminating the field of midwifery because midwives did not attend hospital births in the 1930s. Second, in the second half of the 19th century hospitals had been reformed from dangerous places where sick people were safer at home to places which were actually helpful to sick people. Third, prior to the 1900s, birth was seen as a natural, normal practice. With the advent of hospitals and obstetrics, birth was redefined as an “illness” which needed to be treated with anesthesia, more easily available in hospitals. The popular press also assisted in this elimination by “portraying birth as unnatural and dangerous for mother and baby” (p. 12) and that the solution as to have the baby in a hospital with all of its new technology. Lastly:

The movement of birth to the hospital served the campaign of physicians to undercut the status of midwives. Physician groups saw midwives as a threat to their status, especially in those countries [such as the United States] where an attempt was being made to develop obstetrics as a specialty. This professional clash took alternative forms in different countries, but in all cases the hospitalization of birth served the purpose of physicians. (p. 9)

However, this move to the hospital did not necessarily serve in the best interest of women. For example, because hospitals were open to the poor, physicians were supplied with pregnant women “who could be used for clinical observation, experimentation, and instruction” (Scully, 1993, p. 296), thus advancing the field of obstetrics and further eliminating the field of midwifery.

Another aspect that is part of the equation of moving birth from the home and into the hospital setting was the use of Twilight Sleep, led by feminists during the early 1900s. Twilight sleep was a combination of morphine injected at the beginning of labor and scopolamine, which caused mothers to forget the birthing experience. It was touted as a way to make childbirth painless and was credited with making mothers and their babies healthier. Feminist women and society ladies began demanding Twilight Sleep in order to experience painless births. Twilight Sleep was only available in hospitals, thus luring women away from home birth. Hospitals began using it with nearly all births, and some used it for all births (Wertz, 1993).

The reality of Twilight Sleep was vastly different from the propaganda. Hospital births became routine and impersonal. Nurses sometimes ignored women because they would not remember anything anyway. Birth was not a peaceful, painless experience for

these women. Rather, it was painful and women were not in control of their bodies or actions. Women were frequently tied down or kept in beds with sides and a canvas top in order to control their thrashing. The morphine regimen was discontinued after women began dying from it. The scopolamine was a hallucinogenic for some women, resulting in “nightmare memories of the birth” (Wertz, 1993, p. 404). All in all, Twilight Sleep was a way of controlling women and childbirth that resulted in demoralizing and frightening experiences for mothers.

The Alternative Birth Movement

During the 1950s the Alternative Birth Movement started when women began to feel dissatisfied and victimized by the field of obstetrics. Twilight Sleep was losing popularity as women wanted consciousness and control over their birth experience (Wertz, 1993). Women reported feeling isolated, alone, and frightened while in the hospital. The *Ladies' Home Journal* received a letter from an obstetrician nurse in 1957 asking for an investigation into the “cruelty in maternity wards” (Wertz & Wertz, 1989). Following the printing of this letter, the *Ladies' Home Journal* received many letters from woman complaining that they were tied down during labor and left all alone for hours.

Many women probably believed that they did not have a lot of choice in terms of place of birth in the mid-1900s. Declercq, et al. (2001) note that women would have been going against the advice of the family physician, would have had difficulty finding a midwife, and would have been ignoring her husband’s health insurance plan, if she were married, in order to pursue a birth outside of the hospital. Nonetheless, midwives were

continuing to practice secretly, primarily in rural and poor parts of the country, and some women were utilizing their services (Steiger, 1993).

It is important to note that midwifery care has evolved through time in all countries and a balance of power between midwives and physicians has been achieved. The United States, though, is the only country in the world where midwifery actually failed to survive and where physicians did achieve their goal of eradicating the practice, at least for several decades of our history. Ironically, physicians did so without any indication that they could tend to women and their newborns safely or respectfully. “Midwifery almost ceased to exist in this country, and for the first time in history, an entire society of women was attended in childbirth by men” (Rothman, 2007, “Laboring Then”, p. 15).

The Alternative Birth Movement grew during the 1960s and 1970s. Practices such as Twilight Sleep were rarely used, and had become “the antithesis of everything that feminists desired in birth” (Wertz, 1993, p. 404). In 1970, birthing in hospitals reached an all-time high of 99.4 percent. By 1977, the out-of-hospital birth rate had doubled, from 0.6 percent in 1970 to 1.5 percent in 1977 (Institute of Medicine, cited in Rooks, 1997). This small but significant shift was because a small percentage of women were pursuing planned home births. These births were attended by physicians, Certified Nurse Midwives (CNMs), and lay midwives (Rooks). By 1978, 1 percent of hospital births were being attended by CNMs, who had not been attending any births in hospitals previously (Declercq, Devries, Viisainen, Salvesen, & Wrede, 2001).

Reemergence of the Field of Midwifery

The field of midwifery began making a come-back in the 1970s, and from 1990 to 2004 there was a gradual decline in out-of-hospital births, followed by an increase in 2005 and 2006 (MacDorman & Menacker, 2010). In 2006, home birth comprised 65% of all out-of-hospital births, with other out-of-hospital births primarily taking place in birth centers.

The United States currently has two fields of midwifery: Certified Nurse-Midwives (CNMs) and Certified Professional Midwives (CPM), which include lay midwives and direct midwives. During the 1970s direct-entry midwifery became more recognized. Today, lay midwives or direct-entry are experientially trained through self-study, academic coursework, and apprenticeship. Many direct-entry midwives are certified by the North American Registry of Midwives (NARM). CPMs primarily attend home births. Generally the term direct-entry midwife is used in the literature and will be used to describe any midwife who is not a CNM.

Certified Nurse Midwives

The field of nurse-midwifery actually began in 1925 as a reaction against the physician's movement to "disgrace and eliminate midwives of all kinds" (Rooks, 1997, p. 8). CNMs are trained in more of a medical model than direct-entry midwives. Because of the negative reaction to midwifery by the medical community, CNMs made a point of emphasizing their nursing training and education. Today, most hold a master's degree, usually in nursing. In addition to their master's degree, CNMs have education in midwifery, have passed a national certification examination, and met other criteria by the

American College of Nurse-Midwives. They practice primarily, but not exclusively, in hospitals (Rooks).

Direct-entry Midwifery Legalities

While CNMs are legal in every state, laws around direct-entry midwifery vary state-to-state. A state-by-state index of the status of midwifery can be found on the Citizens for Midwifery website: <http://cfmidwifery.org/states/index.aspx>. In the state of Colorado, for example, direct-entry midwifery was illegal until 1993. Now direct-entry midwives are regulated. They must acquire the appropriate academic qualifications, gain the appropriate amount of clinical experience, apply to the state of Colorado, and pass the NARM exam in order to practice as a Registered Midwife (Colorado Midwives Association, nd). The Colorado Statute can be read in its entirety at http://mana.org/laws/laws_co.htm.

In the neighboring state of Wyoming, direct-entry midwifery is not regulated, and the practice of midwifery is considered practicing medicine, making it illegal for a direct-entry midwife to provide pre-natal care to a pregnant woman (Citizens for Midwifery). Thus far one direct-entry midwife, Susan Merrill, has been charged with manslaughter and practicing medicine without a license (Dynes, 2007). Merrill practiced the profession of midwifery for 20 years, delivering 403 babies, including six of her grandchildren (Snyder, 2008). In 2006 the baby of a woman she was caring for died. Merrill was sentenced to one year probation on a reduced charge of criminally negligent homicide (Snyder).

The non-regulation of midwifery has proven to be a disservice to women in Wyoming as well as other states who do not offer legalization. Women who do not

choose to give birth in the hospital are left with few options. These include working with an unregulated midwife if they can find one, giving birth alone, or traveling to a neighboring state in order to give birth, usually in a hotel room or in someone else's home. As Merrill stated after her trial, "now these women don't have a choice. They'll go to Colorado for midwives" (Snyder, 2008).

Safety and Research

With direct-entry midwives attending births in women's homes, the issue of safety became an issue for those in the medical profession. Once again, obstetricians began questioning the safety of women giving birth in the home as a way of undermining midwives. Midwives and activists responded to this by researching and publishing articles regarding the issue of safety in birthing at home. When the research was questioned (Committee on Assessing Alternative Birth Settings, 1982; Campbell & MacFarlane, 1986), midwives and activists produced still more research addressing safety issues. Many of these studies, completed in the United States and abroad, have proven time and again that for healthy women with normal pregnancies, giving birth at home is as safe as giving birth in the hospital (Anderson & Murphy, 1995; Durand, 1992; Johnson & Daviss, 2005).

An example of the medical community questioning the safety issues is an article published by Pang, Heffelfinger, Huang, Benedetti, and Weiss (2002) on the outcomes of planned home births in Washington State from 1989-1996. This article concludes that "infants of planned home deliveries were at increased risk of neonatal death" and that "planned home births in Washington State during 1989-1996 had greater infant and maternal risks than did hospital births" (p. 253). Commentaries have been written on the

Pang et al. article critiquing it as flawed research. Goer (n.d.) published commentary on the Lamaze International website. Goer critiques the Pang et al. article on the following points:

- The study included unplanned home births
- The study includes planned home births with unqualified attendants
- The study includes preterm births from 34-37 weeks gestation
- The study does not investigate whether the choice to birth at home was at fault in neonatal deaths
- The study groups are not truly comparable
- The researchers should have matched women planning birth at home with women using hospitals in the same local area
- The investigators “cherry pick” their outcomes, failing to report all relevant outcomes while reporting some irrelevant ones

Goer concludes that “the Pang et al. study alarmingly concludes that planned home birth confers twice the neonatal death rate of planned hospital birth, but, in fact, the absolute difference amounts to 1 in 1000” and that “it would only take a few mischaracterized births to make the difference disappear altogether or swing the advantage to the home birth side”.

According to Vedam (2003), who also wrote critical commentary on the Pang, et al. study, this article sparked headlines such as “Home Births Double Risk of Newborn Death” from The American College of Obstetricians and Gynecologists (ACOG) and “Infants Born at Home are Twice as Likely to Die as those Born in Hospitals” from a commentary by the editor-in-chief of *Journal Watch: Women’s Health*, Sandra Ann Carson, M.D. (2002). Vedam’s commentary included several of the same critiques as Goer’s commentary. Vedam not only critiques the flaws of the research, but also questions why it was published to begin with, and asks why it was “published in such an inflammatory manner” (p. 62). Attacks such as these from the medical community are

continual attempts to take power away from midwives and ultimately the women and babies they serve. These efforts leave women with fewer choices in the area of maternity care.

An example of how far-reaching the effects of such an article can be is seen from Aetna Health Insurance. The Pang et al. article, along with the ACOG statement, is cited as a reason why they do not cover home birth under their plan (Aetna), thus denying women the right to have a choice in their own care. However, as described above, this denial is based on faulty evidence that has been misinterpreted and exaggerated, similar to the tactics used for over two centuries to further discredit midwives and the valuable work they do.

The editor of the journal *Birth*, Diony Young (2008) published an update on medical organizations and their continued attack of midwives and homebirth. In this editorial the author describes a more recent development of these organizations trying to eliminate midwifery and home birth. Apparently, ACOG and the American Medical Association (AMA) have teamed up in an attempt to develop legislation “in opposition to home birth” (p. 263). This legislation states that the safest place to give birth is in a hospital or birthing center that meets particular standards. Young notes that they offered “no science-based evidence in support of its anti-home birth or anti-midwife stance” (p. 263). Ultimately, these attacks serve to distract midwives and their supporters from providing the valuable services they have been trained to do: care for women and babies. Furthermore, they work to eliminate choice for women and their babies.

Midwives have focused on the safety issue to prove themselves in a medical field, which has tried to extinguish their profession of midwifery. Midwives worked diligently to prove that giving birth at home for healthy women with normal pregnancies is just as safe as giving birth in the hospital and that giving birth with a midwife at home has advantages that are not offered in the hospital setting, such as being in the comfort of one's own home, no threat of impending interventions or procedures, the ability to have friends and family present, and the freedom to eat and drink during labor. Interestingly, even while trashing midwives and home birth, the medical community has attempted to simulate a home environment in hospital rooms for maternity patients. For example, Poudre Valley Hospital in Fort Collins, CO describes that women will “have labor, delivery, and recovery all in the same comfortable, home-like private suite” that features “a TV, CD player, sleeper chair, telephone, bathroom with shower” making their rooms sound very much like the home a woman is leaving behind. The difference, though, is that these rooms include “equipment needed for your birth, such as fetal monitor to measure your contractions, the baby's heart rate, and other vital signs”, even though it has been established that fetal monitors do more harm than good for mother and child (Block, 2007). Interestingly, this webpage shows a thin woman in scrubs, presumably a medical care provider and not a mother, holding an infant (Poudre Valley Health System website). Architects are also drawing from studies of home births and from mothers who have experienced home birth when designing birthing units for hospitals and birth centers (Forbes, Homer, Foureur, & Leap, 2008). Part of the aim is to create a birth unit with home-like features and comforts, ironically without being at home.

Philosophical Differences between the Medical Model and the Midwifery Model

The Medical Model

The history of obstetrics and midwifery care is interwoven with two vastly different philosophies to maternity care: the medical model and the midwifery model. These different models affect the way practitioners treat the issue of maternity and treat the women with whom they work. Male medical physicians took power away from female midwives in order to have power over female patients using the medical model of pregnancy and childbirth. Turkel (1995), an Assistant Professor in the Women's Studies Program at the University of Delaware, describes the medical model:

The medical model of childbirth claims to be grounded in science and technology. It defines childbirth as a medical event requiring hospitalization, the attendance of a physician, and careful monitoring with high-technology devices and procedures. The body is equated with a machine, and the physician serves as its technician. Despite the fact that childbirth is an intimate event of great importance to the individuals involved, their experiences are sacrificed to "normalcy" and "risk" reduction. Each individual labor must conform to what is defined as normal by the profession of obstetrics. Deviations from the norm are defined as pathological and as requiring intervention with monitors, drugs, and, frequently, surgery. The medical model of childbirth is characterized by reliance on standard procedures, expert decision making, and technological apparatus, despite a lack of evidence that these lead to better birth outcomes. (p. 145-146)

Essentially the medical model attempts to control the pregnancy and birth experience under the auspices of it being in the best interest of women. However, as will be addressed later, many of these techniques and interventions are actually in the best interests of the medical staff, primarily the physician, and are often times far from being in the best interest of women or their children.

The Midwifery Model

Midwives offer a different standard of care, called the Midwifery Model of Care. This model is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention (Citizens for Midwifery, n.d.)

According to the Citizens for Midwifery organization, “the application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section”. This model was created to be an empowering model for the women for whom midwives care. Whereas the medical model is entrenched in risk, apprehension, and worst-case-scenario ways of thinking, the midwifery model provides an avenue of support, care, and comfort for mothers.

Davis-Floyd and Davis (1997) sum up the differences between the two models:

The technocracy [medical model] is largely hierarchical, male-dominated, machine-orientated, and oriented towards left-brained principles of separation and discrimination, while homebirth midwifery is primarily egalitarian, nature- and female-oriented, and aligned with right-brained principles of holism and connection. (p. 149)

However, just because one model is a medical model and one is a midwifery model does not mean that Direct Entry Midwives and CNMs always follow the same model. It is important to note that these two branches of midwifery can also have different models of

care. Direct entry midwives typically look towards the midwifery model of care, whereas CNMs sometimes focus on the Midwife part of their title and focus on the midwifery model of care, but others focus on the Nurse part of their title and adhere more to the medical model of care. “Direct-entry midwives, especially, have rejected many common (yet scientifically unsupported) medical practices, such as routine use of episiotomies, IVs, perineal prep and shave, enemas, lithotomy position for delivery, confinement to bed for the duration of labor, medicated childbirth, and continuous electronic fetal monitoring” (Steiger, 1993, p. 253).

Current Examples of Ways in Which Physicians are Attempting to Maintain Power

The struggle to maintain power and control over the field of maternity continues in modern history. In an effort to hold onto their power, physicians relying on the medical model have sometimes taken on a patriarchal role of “punishing” women who chose to pursue using midwife and planning a home birth. In Arizona it is legal for midwives to practice. However, physicians have still punished women pursuing midwifery care verbally, as well as sometimes making physical examinations and treatments painful (Turkel, 1995).

Physicians also attempted to hold onto control by restricting ways in which midwives practice. In the early 1980s, for example, two CNMs, Susan Sizemore and Victoria Henderson, wanted to open a private-sector nurse-midwifery practice in Tennessee. Dr. Darrell Martin had agreed to provide medical supervision and services. The midwives attempted to practice privileges at the hospital in which Dr. Martin worked, but were denied. They were subsequently denied privileges at two other

hospitals. Then when Dr. Martin approached his insurance company about leaving the hospital to work with the midwives, his insurance was dropped. As a result, Sizemore and Henderson were unable to work with Dr. Martin any longer. Unable to find another doctor to work with them, they had to close their business. Likewise, Dr. Martin's obstetric practice was ruined and he had to relocate to another location (Turkel, 1995). Unfortunately, this is not an isolated occurrence, and incidents such as this one have happened across the country over the past several decades.

Interestingly, the medical model purports itself to rely on scientifically proven methods. However, many of their methods, including episiotomy, fetal monitoring, and no food or drink during labor, have not been scientifically proven, and have in fact been shown to be harmful to women (Wolf, 2001). Other examples of inconsistencies within the medical community include *Williams Obstetrics* (Cunningham, et al., 2007), a book which is considered a classic textbook for the teaching of obstetrics. The 23rd edition of this book was due to be released in the fall of 2009. As Rothman (2007, "Laboring Then") noted in her book *Laboring On*, some of the medications prescribed by physicians for women during pregnancy are considered safe until proven otherwise. Regarding one antihypertensive drug, *Williams Obstetrics* concludes, "There are no large epidemiological studies in early pregnancy, but its many years of use attest to its safety" (Williams, p. 1024, cited in Rothman, "Laboring Then" p. 36). However, Rothman aptly notes, herbal remedies used for generations for midwives during pregnancy and labor have condemned by Williams: "because it is not possible to assess the safety of various herbal remedies during pregnancy, pregnant women should be counseled to avoid these substances" (Williams, p. 1029, cited in Rothman, "Laboring Then", p. 37).

Midwives still seek to provide care for women and their babies, but this care has been limited by physicians' attempts at maintaining power. Rothman (2007, "Laboring Then") describes the movement to eradicate midwifery succinctly:

Two important things happened in the history of midwifery: midwives lost autonomy, control of their work, to doctors; and doctors and midwives allocated patients according to notions of appropriate "territory." The two problems are interrelated. Doctors carved out as their territory pathological or abnormal births. They then went on to define all births as either inherently or at least potentially pathological and abnormal, so that there was no room for the midwife. Even today, midwifery care in the United States is seen as suitable only for "low-risk" births, while more and more births are being defined as "high-risk". (pp. 9-10)

Therefore, while the abolition has not been wholly successful, it has had an effect on the care women receive.

Laboring Women and Issues of Power

While direct entry midwives and CNMs strived to regain power in the area of maternity care, is this even where power should ultimately be held? I would argue that power ultimately belongs in the hands of the laboring women. How can women gain control over their birth process? One way is to stay in a place where they already have power (their home) instead of giving birth in a place where they do not ultimately have power: the hospital or birthing center. Rothman (2007, "Laboring Now") aptly shares a story told to her by Annemiek Cuppen, a midwife in the Netherlands, where 30 percent of women give birth at home. Cuppen was working with a woman who had chosen to give birth in the hospital. When the woman was in labor, Cuppen went to her home and found her still running her household, "bossing people around and remaining the center of her home" (p. 71). Upon arriving at the hospital, Cuppen noticed a drastic change in the woman's character:

The woman sat herself quietly on the edge of the bed. With a new demeanor now, looking up at Annemiek, the woman asked, “Uh, excuse me, do you think it would be OK if maybe we opened the window please?” (p. 71).

This change in disposition exemplifies what women undergo when they move from their homes to a foreign environment, no matter how much of a homey environment the architects and medical staff attempt to provide. Midwives have the ability to reclaim power for birthing mothers. As Rothman summarizes, “giving birth at home returns that power to the woman” (p. 72).

The location of the birth has a lot of meaning. Declercq, et al. (2001) describe it well:

Simply stated, the place of birth shapes the experience, determining who is in control and the technologies to be employed. In a home birth, those attending are visitors in the family’s domain, and midwives and doctors must rely on the family for an understanding of local customs and practices. The reverse is true for a mother in a hospital. In a hospital birth a mother is placed in a dependent condition reinforced by the use of unfamiliar language and machinery. The place of birth also determines the way care is organized. Birth at home is patterned around the values of the family. In hospitals – where hundreds, or even thousands, of births occur each year – birth is a routine event accomplished with speed and efficiency. (pp. 7-8)

Where a woman gives birth affects women in ways in which we are not even aware at this time. Hopefully in time more research will be conducted and we will come to know more about issues of power, caregivers, and place of birth.

Perspective of Women

Interestingly, because midwives, CNMs in particular, have had to conduct so much research on the issue of safety in order to prove themselves, there has been a consequence. Research has been conducted on midwifery, various birthing techniques,

and safety issues, but very little research been done from the perspective of mothers, who ultimately are the ones who need to be in power. The voices of midwives come through in the research, but the voices of birthing mothers have been lost in this process.

Women's voices are historically underrepresented or even missing from the research.

The area of maternity, truly a women's issue, is an area where women's voices are of great importance. While some descriptive work has been done categorizing characteristics such as age and income, more work needs to be done actually listening to what women have to say on the subject of home birth. This research is being called for. Bortin, Alzugaray, Dowd, and Kalman (1994) did a study applying a midwifery care framework to the experience of home birth. They suggested a need for doing qualitative research on women's experiences with home birth from a feminist perspective.

More research does need to be conducted on women's thoughts, opinions, and experiences. Midwives play a vital role in the realm of maternity in the United States and even more so around the world. They work hard to create an empowering experience for mothers. It is my hope that midwives will continue their efforts of reclaiming power in the field of maternity, which will in turn return power to women and mothers.

Characteristics of women choosing home birth

Some helpful information regarding the characteristics of women choosing home birth has been collected. Women who choose to plan a home birth in the United States tend to be older, white, married, of lower income, and more educated than the other women of childbearing years (Anderson & Greener, 1991; Johnson & Daviss, 2005). However, when looking at international information, there are some contradictions. For example, a Swedish study examined women's interest in home births and in-hospital

birth center care (Hildingsson, Waldenstrom, & Radestad, 2003). Women interested in home birth were more likely to be single and have a lower level of education. It is important to note that while these women were pregnant, they were not actually planning to birth at home; they were only reporting interest in home birth as an option.

An Australian study compared mothers who birthed in the hospital, at birth centers, and at home. In contrast with the Swedish mothers, but in conjunction with the mothers from North America, these results showed home birth mothers tended to be more educated than hospital mothers (Cunningham, 1993). Additionally, Cunningham found that home birth mothers comprised both the lowest and the highest income levels of the women in this study. Mothers choosing homebirth were an average of 2 years older (an average of 30.5 years vs. 28.8 years) than the other mothers, and were more educated than hospital mothers. Homebirth mothers scored significantly higher on feminist attitudes when compared to hospital mothers.

A study of Finnish mothers and some of their partners planning home birth found that the majority of the women in their sample were also married (Viisainen, 2001). The women in this sample also varied in their incomes; over half of the women were middle or upper middle-class, while 25% were not in the labor force.

In the Netherlands, giving birth at home is more common than it is in the United States. Over 30% of births take place at home, and nearly half of the women give birth without ever seeing a medical doctor, choosing to work with a midwife for their pre-natal care instead. At the same time, their infant and maternal mortality rates are some of the lowest in the world. There are several factors which, taken all together, help account for this difference. These include “the organization of health care, Dutch politics, and Dutch

cultural ideas about home, women, family, medicine and science” (Declercq, et al., 2001, p. 16). Women who choose to give birth in the Netherlands tend to be around the same age, marital status, and educational level as women choosing to utilize birth centres attached to hospitals (Borquez & Wiegers, 2006).

Birth Experience Satisfaction

Maternity and childbirth have evolved into a major business industry in the United States. It appears that many assume the most important issue regarding childbirth is the safety of the baby, seemingly followed by the safety of the mother. With increasing rates of cesarean sections and other costly, often times unnecessary, interventions being inflicted on women and babies, the issue of birth satisfaction has been neglected. For many, the issues of satisfaction and safety seem mutually exclusive, but they need not be. A woman can have a satisfying birth experience and a safe birth in a variety of locations. How do women feel about their birth experiences? What constitutes a satisfying birth experience? Why should birth experience satisfaction even matter? This section seeks to address the role control plays in the birth process as it relates to satisfaction as well as how the level of satisfaction is consistent with feminism and issues of power and agency.

Safety and interventions in childbirth

Intervention tools such as forceps started being introduced into childbirth practices in the early 1800s. Several doctors who were trained in England began teaching classes about childbirth to caregivers in the United States, primarily and then exclusivity to other men. Eventually these interventions became more common than relying on the natural techniques used by midwives for centuries (Wertz & Wertz, 1989). Today,

interventions include prescription medications, instruments, and surgical procedures. Currently, it is customary for women to endure interventions during their delivery, regardless of necessity. Women can “have up to 16 different tubes, drugs, or attachments” while she labors and delivers her child (Nelson, 2006, cited in Block, 2007, p. xiv)

Interventions are not singular events; they do not occur in isolation. One intervention leads to another, often times referred to as the cascade of intervention (Block, 2007). Block notes that even something as seemingly simple, innocuous, and routine such as administering intravenous fluids to a laboring woman can change the electrolyte levels in her system, therefore shifting the oxytocin hormone levels for the mother, thus shifting the frequency of contractions. This, in turn, can lead to other interventions. For example, “with Pitocin comes amniotomy, internal fetal monitoring, immobilization, epidural, and urine catheter; often times a blood sample will be taken from the fetus’s scalp to confirm a heart tracing, and an intrauterine pressure catheter will be inserted to measure the contractions’ strength within the womb” (p. 139).

One of the most common interventions given to women is a Pitocin drip. Pitocin is a drug used to speed up contractions if a woman is not progressing quickly enough for the medical professional’s satisfaction. It is a synthetic version of oxytocin, a hormone the body produces to stimulate labor. Women who have been given Pitocin experience contractions far more painful than natural contractions, and additionally the contractions are closer together, leaving the woman less time to recover. Therefore, Pitocin often times leads to an epidural, which is a nerve block to the lower half of the body. The epidural renders the mother unable to walk, and she is therefore placed on her back in a

hospital bed. She is also unable to feel her contractions, and is hooked up to yet another machine in order to monitor them. She is told when to push and for how long.

Additionally, she is also hooked up to a fetal monitor in order to monitor the baby's heart rate (Block, 2007).

Even with our increased use of interventions in the name of helping babies and mothers, the United States is far from the safest place to give birth. From 2000 to 2005, the infant mortality rate in The United States has not significantly declined (Mathews & MacDorman, 2002; Mathews & MacDorman, 2008). Preliminary data from 2006 shows a 2% decline from 2005 data, at 6.71 infant deaths for every 1000 live births (Heron, Hoyert, Xu, et al., 2008). Among industrialized countries, the World Health Organization positions The United States 29th in the world for infant mortality, with some Scandinavian and East Asian countries obtaining the lowest infant mortality rates. The United States is tied with Poland and Slovakia for infant mortality. Twenty-two of the countries ranking higher than The United States have infant mortality rates below 5.0. Interestingly, countries with high usages of midwives and home births are Scandinavian countries, including Sweden, Norway, and Finland. Sweden, for example, has an infant mortality rate of close to 3.0 per 1000 live births (National Center for Health Statistics, 2007). Infant mortality rates for non-Hispanic Blacks remain significantly higher than any other race, and rose from 13.59 in 2000 to 13.63 in 2005 (Macdorman & Mathews, 2008).

In order to have a safe birth experience, women may choose from a variety of options, provided they are accessible and the women know about them. Such options include giving birth at a hospital, birth center, or at home. Contrary to popular belief, for

women with low-risk pregnancies home birth has been found to be just as safe as hospital birth, and with fewer interventions (Johnson & Daviss, 2005), thus making them potentially even safer than hospital births given the negative effects interventions can have on mother and baby. Unfortunately, these choices are not often available and there are many misconceptions about home birth, such as that of the safety issue.

Nevertheless, women are interested in these as an option. For example, women in Sweden express interest in home birth, partially in response to their dissatisfaction with the medical aspects of care they received during pregnancy. Additionally, this same sample of women expressed interest in both home birth and birth center care even when they had already experienced a very positive previous birth in a hospital setting (Hildingsson, Waldenstrom, & Radestad, 2003). I speculate this could be because they have increased confidence in their bodies' ability to give birth, and wanting to have a different experience where they felt more in control of their birth experience.

Birth experience satisfaction

Numerous factors appear to be associated with a negative birth experience: having an emergency cesarean section, feelings of lacking control during the birth process, mothers' inability to participate in the decision making process about their own care, lack of time during antenatal checkups for the woman's questions to be answered, and inadequate support from the attending physician during the delivery (Walderstrom, Hildingsson, Rubertsson, & Radestad, 2004). For this same sample of Swedish women, another factor was experiencing the "worst imaginable" labor pain, regardless of if they received an epidural. Interestingly, another study found that when women gave birth at

home, their experience of the intensity of labor pain is lessened compared with women giving birth in the hospital (Morse & Park, 1988).

One of the strongest indicators of a negative birth experience for these women was a lack of control. In this particular study, lack of control is referring not to the decision making process regarding place of birth, but rather to the happenings during the labor and delivery process (Waldenström, et al., 2004). This finding appears to be consistent with other studies, which have found that satisfaction with one's experience of childbirth appears to be centered on a birth with fewer interventions and where the mother has a sense of control over the birth (Cunningham, 1993; Fleming, Ruble, Anderson, & Flett, 1988; Viisainen, 2001).

Women giving birth in the hospital and women giving birth at home report different experiences with birth satisfaction. Women giving birth in the hospital often times report feeling dissatisfied with their birth experience. This can be because of interventions commonly used in hospital births. In a study comparing birth satisfaction between mothers who gave birth in the hospital to mothers who gave birth in their home, women in the hospital birth group reported feeling that "everything seemed wrong and that someone else was in charge of their labor" (Janssen, Carty, & Reime, 2006, p. 93). These women also used more negative words to describe their experience, such as powerless, awkward, incapable, fearful, confined, and anxious. In comparison to the home birth group, the hospital group reported more often "not knowing what to expect from one moment to the next, that everything was unclear and unreal, and that they experienced a sense of conflict, of feeling that they were going to pieces, and of not being in control" (p. 93).

In contrast, women who have had a home birth tend to be more satisfied with their birth experience. They used words such as competent, responsible, secure, adequate, relaxed, victorious, feeling good about their behavior, and open and receptive to the experience to describe their feelings of their birth experience. These women felt like they were able to handle their labor better than their hospital counterparts. The home birth group “experienced a sense of being with others who cared, of actively striving, of having a sense of perspective on what was happening, and of having a sense of success” (Janssen, Carty, & Reime, 2006, p. 93). To these women, their birth experience made sense.

Similarly, in a comparison of Australian mothers who gave birth at home, in a birth center, or in a hospital, home birth mothers rated their midwives more highly in terms of support, encouragement, and contributing to their feelings of well-being than birth center or hospital mothers (Cunningham, 1993). In terms of positive feelings during the month after the birth, home birth mothers reported more feelings of love, satisfaction, fulfillment, pride, confidence, and achievement than mothers giving birth in the hospital. Ninety-seven percent of women in a stratified, random 10% sample of over 500 mothers from a large prospective study in North America reported feeling extremely or very satisfied with the care they received during their home birth based on responses to 11 questions regarding satisfaction with the childbirth experience (Johnson & Daviss, 2005).

In another study, while no difference was found between women choosing to birth at home and women choosing to give birth in a birth center attached to a hospital in terms of how they rated their overall experience, home birth mothers in the Netherlands did report more often that they would have their next baby in the same place (Borquez &

Wiegers, 2006). Women birthing at home also rated their birth setting higher than women birthing in the birth center. They were asked the question, “please describe your feeling about the place where you delivered” and asked to rank items on a 5-point Likert scale. Home birth mothers ranked the items including safety, intimacy, trust, and comfortable significantly more highly than birth-center mothers, and the items strange and anxiety-producing significantly lower than birth-center mothers.

For over twenty years this research has been consistent. In an older yet still valuable study comparing birth satisfaction of first-time mothers who either gave birth in the hospital or at home, Fleming, Ruble, Anderson, and Flett (1988) found that women giving birth at home experienced greater levels of satisfaction than mothers birthing in the hospital. These home birthing mothers reported more feelings of confidence and strength than their hospital counterparts. The mothers also reported feeling more in control of their labor pains. The authors found that there were three areas related to these increased feelings of satisfaction for home birth mothers: fewer interventions, greater time with their baby following the birth, and feeling as though they were an active participant in the birth process.

Control

Control seems to play a role in birth satisfaction and women’s decision to plan a home birth. What, exactly, control means to home birthing women is not always clear. For some, it indicates feeling in control of the birth process, including making most of the choices and decisions, as opposed to a medical professional being in control. It also includes being in control of the use of interventions. Cunningham (1993) found that Australian mothers choosing to birth at home felt influenced to choose home birth

because they could be active participants in the birth process and have control over it with no interventions.

Women giving birth in medical settings sometimes report a loss of control. Wolf (2001), in her interviews with women about their birth experiences, found “a number of women who had given birth described a moment at which they felt the medical institution simply took over, oblivious to the mother’s wishes, experience, or concerns; many new mothers dissociated from their birth experience because it was so distressing” (p. 148-149). One of the women in Wolf’s study reported experiences such as “I couldn’t move. I was lying there and felt I had no control at all” (p. 146) and “nothing happened according to what we had wanted or planned. And we had absolutely no say: the institution just took over” (p. 147). Wolf herself, upon reflecting on her birth experience, recalls “I did not feel safe in the hospital. I did not feel safe” (p. 138).

Women planning home births may learn from other women’s experiences such as these and therefore plan home births. Or, if women have previously had a dissatisfying hospital experience with birth, they may plan a home birth for subsequent births where they can have more control over their birthing experience. In Viisainen’s (2001) study of Finnish women choosing home birth, it was found that some of the women believed they could only have control of their birth experience in an environment away from the hospital.

If having a sense of control over the birth process is so important to birth satisfaction, then why women relinquish control over their birth experience and go along with numerous interventions? In a roundtable discussion addressing this very issue in the journal *Birth*, several maternity care professionals and birth advocates share their

opinions (Klein, Sakala, Simkin, et al., 2006). Klein, professor emeritus and senior scientist emeritus from British Columbia, Canada, asserts that part of the reason is that we live in “a terrified, risk-averse society”, that we are afraid, and that we are taught to go along with it (p. 245). Sakala, Director of Programs at Childbirth Connection in New York City, says it is because of multiple reasons, including fearing something will happen to the baby, our culture which does not teach women about their strengths, choices, and options, and that most women do not give much thought to their choices of caregivers or birth settings. Simkin, co-author of *The Labor Progress Handbook* (2000), believes that even asking the question of why women go along with this type of birth process is an unfair question because it “implies that women have choices and are making poor ones” (p. 247). Simkin asserts that many women do not have choices, and those that do often times do not question the care their doctor is giving them. The few women who do question their care face “an impossible burden” of doing research about their choices and finding a provider all by the end of pregnancy, and are meanwhile labeled by professionals as “difficult, untrusting, selfish, or ignorant” (p. 247). Davis-Floyd, senior research fellow at University of Texas Austin, believes it is because women want what the rest of our culture deems valuable: technology. Rooks, a consultant and epidemiologist specializing in midwifery and maternal and child health, speculates that it is because many women are waiting until they are older to get pregnant. These women rely on technology to get pregnant and see pregnancy as being high-risk and therefore opt for a technically-intensive birth. Pincus, co-founder of The Boston women’s Health Book Collective, and co-editor and co-author of *Our Bodies, Ourselves*, believe that despite all of the work of researchers, caregivers and activists who have worked hard to

dispel myths around pregnancy and childbirth, the general public does not know or understand that these are in fact myths.

It appears that experts in the field agree that many women are not aware that they are being misled by the medical community in terms of tests, treatments, interventions, and surgeries related to pregnancy and childbirth, and are therefore not aware that there are even choices to be made. Furthermore, it is challenging for women to go against this system and find alternative care because of how deeply entrenched this model of care is embedded in our culture.

Feminism and maternity

Maintaining a sense of control over one's personal body has always been at the root of feminism. Patriarchy, on the other hand, is an attempt to control others with power. As previously addressed, patriarchal men have attempted to gain control of maternity since the early 1800s. Weedon (1997), a feminist theorist, states that "the term 'patriarchal' refers to power relations in which women's interests are subordinated to the interests of men" (p. 1-2). Feminism has been a way to define these systems of power, and a way for women to gain power and control over their own lives.

Issues of maternity care are inherently feminist. Because of the politics and history surrounding childbirth, the slogan, "the personal is political," applies to women's experiences of childbirth in an inherently meaningful way. As Buckley (2005) succinctly stated in the first chapter of her book, *Gentle Birth, Gentle Mothering*, "birth is a women's issue, birth is a power issue; therefore birth is a feminist issue" (p. 9). Giving birth is a personal experience for many women, one which they will remember for the rest of their lives. The fact that it has been predominantly taken over by men, patriarchy,

and the medical model of childbirth shows just how impersonal this business has become, when I would argue it should be one of the most personal experiences a woman can choose to have. However, because it can be such a personal experience, it could also account for how women have lost their voices in the area of maternity care.

The very issues of satisfaction, control, and power are feminist issues. Medical professionals having power over pregnant women and their babies is a feminist issue. Some women do not appreciate the way doctors have the control when they are pregnant. Stewart (2004) points out that some women feel cheated when a medical professional listens to the heart rate of the fetus: “my doctor gave me the heartbeat. It’s like he took it away from me...I felt funny that I had to rely on him. I wanted to do it myself.” (Martin, 1987, p. 72 quoted in Stewart, p. 33).

The process of giving birth is riddled with control issues. Many interventions and birthing positions were created based on control and easing the experience for the attendant rather than the birthing mother. For instance, the lithotomy position became almost always used starting in the 1930s. In this position the laboring mother is on her back with her buttocks at the edge of the table and her feet in stirrups. The lithotomy position is ideal for physicians to control the childbirth experience. They have full access of the mother’s genitals. However, this position is not ideal for mothers for numerous reasons. First, having her genitals exposed to whoever walks into the room leaves a mother feeling vulnerable, which is not helpful when giving birth. Second, she is unable to move around. Third, her birth canal is tilted upwards and gravity is not able to assist in the birth at all. This position leaves the mother “totally unable to help herself” during the laboring process (Rothman, 2007, “Laboring Then”, p. 20). In addition to making birth

more difficult, being on one's back makes labor more painful. When a woman is upright, the contractions push the baby down onto the mother's cervix, but when a woman is laying down the contractions push the baby against the mother's back (Rothman).

Unfortunately, being hooked up to the electronic fetal monitor (EFM) forces a laboring mother to be on her back, the most ineffective laboring position. Currently most women giving birth in the hospital are automatically hooked up to this machine. In many hospitals this device is mandatory. However, it has been proven to be ineffective at measuring the fetus' heart rate, which is what it was created to do. In fact, EFM has been shown to double or triple the cesarean rate because of inaccurate readings to the infant's heart rate (Block, 2007). In De Vries (2004) study of midwives and maternity care in the Netherlands, it is noted that the only effect of EFM was to raise the rate of cesarean sections and that "it had no effect on the health of mothers and babies" (234). Further, the American College of Obstetricians and Gynecologists have formally recommended discontinuing the use of routine EFM, but that this has had little effect on actual practice in the United States.

Essentially, interventions and techniques touted as being helpful and necessary for a safe birth have proven to not be in the best interest of mothers and babies. Another example of this is the routine episiotomy. This surgery is a deep cut in the perineum from the vagina to the anus, allegedly to prevent tears, shorten labor and delivery, protect the baby, and prevent damage to the pelvic floor. Risks include "blood loss, infection, pain, painful sexual intercourse after episiotomy, and emotional trauma" (Wolf, 2001, p. 172). Some parents report episiotomies occurring against their will (Wolf). Wagner (2006), physician and consultant on maternity issues, likens episiotomies to female

genital mutilation. One reason OB-GYNs have promoted episiotomies is because they find an intentional cut easier to repair than a jagged tear which may or may not occur during birth. With natural childbirth, when women are allowed to move around as they please, tears are unlikely. There are also techniques prescribed by midwives which can reduce a woman's chances of tearing, such as perineum massage. Additionally, cutting can actually increase a woman's chances of tearing further (Rothman, 1993). Many of the reasons for doing a routine episiotomy have been scientifically disproved (Wolf), and thankfully, this is a practice that has recently slowly begun to decline, thanks to the hard work of activists and midwives (Simonds, 2007), although it should be noted that there is still a long ways to go.

Agency

Are women capable of making the decision of how they want to give birth themselves? Can women be trusted to make competent decisions about their bodies and their babies? Apparently, some hospitals and government officials do not think so. Block (2007) outlines the cases of several women pursuing vaginal births who were met with resistance and hostility at the hospital. One woman, Laura Pemberton, was “forced out of my home by armed men” (p. 249). These armed men included police and Emergency Medical Technicians (EMTs), who came with a court order issued by a judge stating that Pemberton had to have a cesarean section in the hospital because she had had a previous cesarean section. She was forced to leave her home, go to the hospital, and have the cesarean even though she was nine centimeters dilated (women can give birth vaginally at 10 centimeters) and was “literally inches from being born” (p. 251). A similar situation almost happened to Amber Marlowe in Pennsylvania, who, while in

active labor, had to go to three hospitals before being able to give birth vaginally. She was told at the first hospital that her baby was too big for a vaginal birth, even though Amber told the medical staff that all six of her previous babies were large (one was 12 pounds, 4 ounces) and she had given birth to all of them vaginally. In her case there was again a court order, but she delivered before the cesarean could be done.

Another example of patriarchy attempting to control women occurred in the state of Virginia during public debates regarding legislation for legalizing direct entry midwives. Craven (2005) critiques a statement given by Dr. Steven Bentheim, a representative of Virginia American College of Obstetricians and Gynecologists (ACOG) and the Virginia OB-GYN society. When asked about adult patient's rights to consent to treatment for themselves and their child, Bentheim criticized mothers seeking home birth and compared them to negligent mothers and illegal drug users. As Craven stated, "the medical opposition became more insistent that it was indeed state and medical officials who were more competent than mothers and parents to judge the 'best interests' of Virginia's future citizens" (p. 201). In 2005, with strong opposition from the medical community, Certified Professional Midwives became eligible for licensure, thus giving women interested in home birth a route to the agency they deserved.

Stories and experiences like these force some women to take what others might consider drastic measures in order to have a natural birth and feel empowered, trusting their own bodies. Laura Pemberton, mentioned above, gave birth the next time in hiding, believing she would not get support to have a natural vaginal birth after cesarean (VBAC) to her twins (Block, 2007). Other women also opt for unassisted birth and are sometimes called U-birthers. Peggy O'Mara, editor of *Mothering* magazine, noted to Block that she

has seen an increase in U-birthers since VBACs are increasingly denied in the hospital or at home with a midwife. Others, such as Laura Shanley, author of *Unassisted Childbirth* (1994) and owner of the website *Bornfree!*, believes that giving birth without the assistance of a physician or midwife is instinctual and natural, and that “women are the true experts of birth” (Shanley, www.unassistedchildbirth.com).

Young mother’s sense of agency was explored by Rudolfsdottir (2000) in an analysis of booklets given to pregnant women about pregnancy related topics in Icelandic health offices. Rudolfsdottir also interviewed women individually and in groups in order to gain a greater understanding of their experiences. In the analysis of booklets, the author “identified four strategies for downplaying the agency of pregnant women: the detached body, emphasis on emotional instability, pregnant women and new mother infantilized and the fetus as subject” (p. 344). Rudolfsdottir notes that for the detached body, descriptions of the birth process described the body as a machine, thus stripping a woman of agency. In terms of emotional instability, women were said to be more emotional during pregnancy. These emotions were portrayed as negative and uncontrollable. The author discovered patronizing tones in the booklets, even though they were sometimes encouraging women to make their own decisions. Some of the advice given in the booklets sounded as though it was geared more to a child than to a grown woman, such as reminders to eat and bathe regularly. Finally, in terms of fetus as subject, it was noted that sometimes “the booklets place the fetus as the super-subject, thereby transforming the body of the pregnant woman into a mere vessel or incubator” (p. 345). For example, the subject of not smoking while pregnant was directed entirely to the effects it has on the fetus, and maternal health was not mentioned. In addition, ways

to stop were not addressed. In the illustrations, women who smoked were portrayed with vacant expressions and cross-eyed, while non-smoking women were portrayed as smiling and blonde, holding a full-term blonde baby. Rudolfsdottir sums up this section by noting that the women “either exceeds to boundaries considered appropriate for mature agency through her childlike or emotional behavior, or is not present as agent at all” (p. 345).

To explore the effects of these publications on young mothers, Rudolfsdottir conducted interviews. She discovered that these women had positive and negative experiences with agency. For example, during the birth experience most of the women felt that they had a central role and that they had positive experiences with their emotions during pregnancy and childbirth. Rudolfsdottir found that, in contrast to the negative reading materials, these young women viewed pregnancy “as a maturing process where giving birth was a turning point in their own development as people” (p. 347).

In terms of negative experiences, women reported resenting being treated like children. One participant, Maria, commented that she wanted her caregivers to know that she was not a child, but “a woman capable of thinking for myself even though I am having a baby” (p. 347). Women also reported instances of being treated as though their bodies were machines, things were happening against their will, and not being listened to. They described feeling like a “piece of meat”, “like a hen laying eggs”, and “like a toy” (p. 348). Overall, women seemed to have mixed experiences. Rudolfsdottir notes that in terms of implications for feminism, it is important to remember that medicalization can be helpful in some aspects, but that it is essential that women have authority of their own bodies.

Women are not only deprived of agency in the area of childbirth, but also during the entirety of their childbearing years. For example, women of childbearing years are expected to keep their bodies in healthy conditions in case they should want to become pregnant or happen to become pregnant at a later date. Recommendations from the Center for Disease Control and the United States Public Health Service such as these statements urging “every woman who could become pregnant to get 400 micrograms (400 mcg) of synthetic folic acid every day” and “all women should get in the habit of taking folic acid daily even when they are not planning to get pregnant” have sparked popular press articles about women’s bodies and health issues. *Cosmopolitan* magazine recently published an article entitled “How to Keep Your Body Baby-Ready” (Stacey, 2009). This article included tips such as getting screened for Sexually Transmitted Infections, avoid getting stressed out, maintain a fertile weight, quit smoking – now, and your preconception checklist, which includes suggestions for vaccines, supplements, and birth-control methods. While it is undeniably good for women to want to be healthy, promoting maintaining a fertile body for all women in their “fertile years” implies that the purpose of women is to be carriers to babies. It discounts women who choose not to have a child, those who are finished having children, or those who are not planning a pregnancy for many years. Additionally, and most importantly, it relegates all women of childbearing years, regardless of their situation, to baby making machines, implying that women in their own right are of little value. The Center for Disease Control and Prevention states that folic acid is important for all women because of prevention for birth defects and that these birth defects to the brain and spine can occur in the first few weeks of pregnancy, before a woman knows she is pregnant. However, once again,

women are not seen as worthy in their own regard, but worthy as a carrier for a baby. Additionally, it implies that women cannot be trusted to create a safe environment for their babies and therefore need to be on supplements anytime they are fertile, not for their own health, but for the health of a potential, however improbable, fetus.

As previously mentioned, other professional organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Medical Association (AMA) have issued statements against home birth and midwifery, and are proposing to introduce legislation regarding these issues. The editor of the journal *Birth* notes that statements and legislation such as this limit a woman's right to choose what she believes is the best choice for herself and her baby (Young, 2008). The author also provides examples from other organizations in other countries who are not attacking home birth or midwives in their professional statements. Instead, they are advocating for informed choice.

Midwives view the process of birth vastly differently than the medical professionals. Overall, midwives believe that women can trust their own bodies, and are responsible entities capable of caring for themselves and their babies. For example, after a home birth, midwives will point out various signs to watch for in the care of a newborn, such as warnings of infant jaundice, but ultimately believe that "being alert for the signs of a problem and seeking assistance are the parents' responsibility" (Rothman, 2007, "Laboring Now", p. 73). Another example of the way in which midwives enable women to create their own experience is by remaining in the background instead of the foreground. One midwife quoted by Rothman shared that she never calls out "It's a boy"

or “It’s a girl” because “all of her life a woman will remember the sound of those words, and she should hear them in a voice she loves” (p. 70).

Moving forward

One way change has been happening in maternity care in Great Britain is through the implementation of the home birth helpline. This is a phone number in which women can call in order to get support and information about this as an option for birth. The women who call are looking for general information on how to pursue a homebirth, resources to learn more about home birth, and support in a non-supportive peer and familial environment. Many of the women who call the hotline follow up with the call-taker to update them on their situation. For instance, one woman called back to let the call-taker know she had contacted a home birth support group that was recommended by the helpline and other women called back to let the call-takers know they had found new midwives who were supportive of their choice to plan a home birth. Other women called back after having their child to let the call-taker know how their experience had gone (Shaw & Kitzinger, 2005).

The idea of a home birth helpline is one that could be used in The United States. It could be a way to be able to promote positive change in our communities, and a way of helping women understand they have a choice in the matter. In fact, we already have a model for this in La Leche League, a grassroots organization which promotes breastfeeding. They, too, have a phone number where women can call for breastfeeding advice and support.

Stephens (2004), a consultant midwife in the United Kingdom (UK), advocates for a feminist model of midwifery. She portrays feminist midwifery as providing choice, control, and continuity to pregnant women. She describes midwifery as a partnership between midwives and women, where the midwife is providing information to the pregnant woman “in an informative and nonjudgmental way, so that the woman can make decisions for herself and her baby that will suit her needs and circumstances” (p. 44). She further states that this partnership “should be based on equality, with the woman as the driving force as this is about her body, her pregnancy, and her birth experience” (p. 44). One more aspect of this model worth noting is that feminist midwifery needs to be community based and not hospital based. In the UK, student midwives are trained in the hospital, regardless of where they ultimately practice. This community based training is a good fit for the model of direct-entry midwifery already present in the United States, where midwives are trained via education and apprenticeship, and not in the hospital setting.

Women desire satisfying birth experiences as well as safe birth experiences. Women want to have control over the decisions regarding their pregnancies and births, and would like control over the birth process itself. Were women to be in control, they may inherently have a safer birth because they might naturally gravitate towards an intervention-free birth, or at least a birth with fewer interventions. Greater research in the area of women’s desires in maternity care needs to be done, with a special interest in learning more about what women have to say about their bodies, their babies, and their births.

Decision Making in Maternity Care

When it comes to having a baby, parents have many decisions to make: cloth or disposable diapers, whether or not to vaccinate, breast or formula feeding. But before the baby is born, there are many important decisions to make as well. First, women have to decide if they are even going to pursue prenatal care. In the United States, 83.9% of women do receive prenatal care during their first trimester (Martin, et al., 2007). If women cannot afford it, programs such as Medicaid exist to help women. Decisions regarding prenatal care include type of caregiver and place of birth. Women and their partners make a variety of decisions about the prenatal process, including type of caregiver and place of birth. Just the type of caregiver can influence many of the other decisions around prenatal care, such as location of the birth, interventions used during the birth, and care of the baby following the birth. The type of caregiver can also affect various factors prior to the birth, including philosophies about pregnancy and childbirth and prenatal testing options. Women can choose to pursue prenatal care with an Obstetrician-Gynecologist (OB-GYN), a midwife, or a family doctor depending upon the type of philosophy with which they are most comfortable.

Other areas of maternity care and decision making have been researched. These studies include the decision to breastfeed preterm infants “naturally” (Sweet, 2008), parental decision-making around circumcision of boys (Turini, Reinert, McQuiston, & Caldamone, 2006), and the decision of parents and neonatologists to resuscitate extremely premature babies (Payot, Gendron, Lefebvre, & Doucet, 2006). However, how women make the decision to plan a home birth has not been specifically addressed.

For some women, location of the birth is of utmost importance. Some women choose to not give birth in the hospital, and choose instead to give birth in a freestanding birth center or at home. This section centers around women's decision making process in giving birth at home. Choosing to give birth at home is often times a very deliberate act. Most women choosing to birth at home probably have very complex thinking patterns around this decision making process. How do women make that decision? What are various models of decision making which might be applied to this process? This section will address the various options available to women and cover several decision making models. In conclusion, it will provide a model specific to women choosing to plan a home birth.

Models of Care

Essentially women are able to choose between two vastly different models of care. If women choose midwifery care, they are choosing the previously mentioned Midwifery Model of Care, which is based on the fact that pregnancy and birth are normal life processes. If women choose to work with a physician, they are opting for the medical model. This model is based on the philosophy that pregnancy is a dangerous medical condition where anything could go wrong at any time. It is a fear-based model which relies heavily on technology and does not seem to trust women's bodies or abilities (Turkel, 1995). Even after choosing to work with a midwife, women still have important decisions to make regarding their prenatal care. They must decide between a Certified Nurse Midwife (CNM) and a direct-entry midwife, both previously described.

Decision making

Given that the majority of women in our culture give birth in hospitals, I would argue that most are not making any sort of choice in terms of place of birth. Many women may not even be aware that they have the option to pursue birthing in a free-standing birth center or at home. If they do know about these options, they may have inaccurate information regarding the safety of such options. Lamanna and Riedmann (2009) differentiate between two types of decision making: choosing by default and choosing knowledgeably. Choosing by default is the equivalent to unconscious decisions. These are decisions in which “people make when they are not aware of all the alternatives or when they pursue the proverbial path of least resistance” (p. 13). Most women giving birth in hospitals are making a decision by default. Choosing knowledgeably, on the other hand, entails “recognizing as many options or alternatives as possible” (p. 14). Women planning home births have made a knowledgeable decision, and not one by default.

Why is the place of birth even important? As Declercq, et al. (2001) describe it, it matters a great deal:

Simply stated, the place of birth shapes the experience, determining who is in control and the technologies to be employed. In a home birth, those attending are visitors in the family’s domain, and midwives and doctors must rely on the family for an understanding of local customs and practices. The reverse is true for a mother in a hospital. In a hospital birth a mother is placed in a dependent condition reinforced by the use of unfamiliar language and machinery. The place of birth also determines the way care is organized. Birth at home is patterned around the values of the family. In hospitals – where hundreds, or even thousands, of births occur each year – birth is a routine event accomplished with speed and efficiency. (pp. 7-8)

Where a woman gives birth affects women in ways in which we are not even aware at this time.

The idea of home birth also brings up other issues for people, typically the issue of safety. Many people are immediately skeptical of home birth given the possible safety issues. However, for women with low-risk pregnancies the option of home birth has been found to be just as safe as hospital birth, and with fewer interventions (Johnson & Daviss, 2005), thus making them potentially even safer than hospital births given the negative effects interventions can have on mother and baby. Other reasons women have reported for choosing to give birth at home include having more control over the pregnancy and birth process, desiring a natural childbirth free of interventions, and the ability to have friends and family present at the birth (Cunningham, 1993).

Given that home birth can be safe knowing why women might choose this option, how do women make the decision to plan a home birth? There are many decision making models available today. Which may be the best fit for this decision in particular? The following section will provide a detailed overview of decision making models and will conclude with a proposed model of decision making specifically for women who pursue planning a home birth.

Decision Making Models

Family Decision Making Model

Hanks (1993) advocates for a family decision making model, which in some ways is definitely appropriate for a decision regarding home birth. Presumably, if a woman is partnered, this decision would be a joint one. Hanks notes that often times family members have varying levels of education and knowledge around decision making in

general, and around the topic upon which a decision is being made, and that these differences can be impediments or enhancements to the decision making process. I agree with many of Hanks' points, and have attempted to address the partner's perspective in the interview and journaling questions. Additionally, in terms of the decision making process I have noted where it seems the mother may ask for outside participation, including a partner's input. A partner's input is essential in the decision to plan a home birth, and a partner's support of or objection to the idea of homebirth can seriously influence the birthing mother. However, because this is specifically a study on first-time mother's decision making process when planning a home birth, I am going to limit this to her decision making process, and not specifically incorporate joint decision making models.

The Smart Choices Model

One helpful model was proposed by Hammond, Keeney, and Raiffa (1999) and entitled Smart Choices. This guide outlines eight elements of a decision making process: problem, objectives, alternatives, consequences, tradeoffs, uncertainty, risk tolerance, and linked decisions. According to the authors, the first step in making a decision is to work on the right decision problem. This step involves identifying the problems carefully, "acknowledging their complexity and avoiding unwarranted assumptions and option-limiting prejudices" (p. 6-7). For women making the decision to plan a home birth, this question could center around where she wants to give birth, what type of birth she wants to experience, or what type of care provider she wants to use. For example, if she chooses to work with a CNM in the state of Colorado, she is limited to a hospital birth, as CNMs are prohibited from delivering babies elsewhere. For some women choosing to

explore planning a home birth, the choice might involve avoiding experiencing what they consider to be unnecessary interventions, which they know they will be subjected to if they give birth in a hospital.

The second step in this process is to specify the objectives. The authors stress that this step is important in order to be able to:

- Determine the information to seek to make a good decision
- Explain the choice to others as the best choice
- Determine the decision's importance, and as a result, how much time and energy to put into this decision

When setting objectives, a person is attempting to discover what is most important to accomplish, and which “interests, values, concerns, fears, and aspirations are most relevant to achieving” that goal (p. 7). For these women, they would need to identify their values and what they are trying to accomplish when it comes to making this decision. While the literature does not include how women make the decision to plan a home birth, it does include some of the reasons why women choose home birth. For home birthing women, these reasons may include striving for a natural birth, wanting friends and family present, or wanting to avoid unnecessary interventions (Cunningham, 1993).

The third step in making a smart choice is to create imaginative alternatives. These alternatives should include all of the options from which a person can choose. In order to create this list, the authors have several recommendations, including looking at each objective separately and asking how it would be possible to achieve that objective. Additionally, they recommend talking to others, creating alternatives and evaluating them later in order to not immediately disregard them, and giving the subconscious time to

work by thinking about the decision problem over time. For women, this might include making a list similar to this one:

- Hospital birth with an obstetrician/gynecologist
- Hospital birth with a family physician
- Hospital birth with a CNM
- Birth center attached to a hospital with a CNM or physician
- Free-standing birth center with CNM (not an option in Fort Collins, Colorado)
- Home birth with a midwife
- Unassisted home birth

In creating imaginative alternatives, other options could be added to this list based on the objectives previously created. For example, if it is important for a woman to plan a natural birth, she could plan to have a doula present for support and she could learn about natural childbirth techniques from reading and from a childbirth education class. Unfortunately, women may not be aware of all of their options, or may have misconceptions about them. It is common, for example, for women to have misconceptions about the safety of homebirth, even though it has been shown to be as safe if not safer for healthy women with normal, low-risk pregnancies (Johnson & Daviss, 2005). However, as Davis-Floyd and Davis (1997) note, “this evidence is little known and not at all acknowledged in the wider culture, which still assumes the authority of the technomedical tenet at hospital birth is far superior to birth at home” (p. 147). Women may also not be aware that the role of a doula is to serve as an advocate and support to a mother before, during, and after labor. Women might therefore disregard these as options, or not even know that they are options, which is why this step is so important in this situation in particular.

Step four involves understanding the consequences. Hammond, et al. recommend learning what the consequence to each alternative is, and how well that consequence

satisfies the objectives of the decision problem. The authors caution against making a list of hasty consequences, as these may be inaccurate, incomplete, or imprecise, thus leading to a faulty end decision. Comparing the various alternatives using a consequence table is recommended. This table has all of the alternatives listed across the top, and the objectives listed on the side. It creates an easy-to-read spreadsheet with a lot of information gathered on one page. One of the biggest recommendations made for this step is to try to look into the future and see how the consequences of each alternative may play out. The result of this step is that the correct decision may present itself, or one or more alternatives may be eliminated from the list of possibilities.

Step five involves grappling with the tradeoffs for each remaining alternative. Simplified, this step is weighing the pros and the cons of each objective for each alternative. It also involves looking at what will be given up and what will be gained with each alternative. For example, a woman having a home birth might gain being able to have more control over her birth process (Cunningham, 1993; Viisainen, 2001), and might give up having access to around-the-clock care found in a hospital setting. Hammond, et al. outline several ways of proceeding with this step, including creating a consequence table similar to the one in step four, and including rankings for each objective.

The sixth step is clarifying any uncertainties. This involves thinking about what could happen in the future and how likely it is that this incident will actually happen. This step is specifically for situations where the consequences will not fully be known until after the decision has been made. The authors make two distinctions here: there can be smart choices with bad consequences, and poor choices with good consequences. This

is an important distinction when making choices in the area of maternity, as there can be no guarantees to the outcomes, as experienced midwife Cynthia Caillagh told Block, the author of *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* (2007):

You cannot guarantee that a conception will result in a full-term pregnancy... You cannot guarantee that a labor will result in a living child. And you cannot guarantee that the birth process itself will see a live mother. You cannot guarantee life. Yet we live in a society that wants those guarantees. (p. 247)

These uncertainties are all a part of childbirth, and are all uncertainties women should think about when planning the birth of their child, regardless of where that birth is to take place. A woman wanting natural childbirth with friends and family present could plan a home birth (a smart choice for her), and she could end up dying (an unlikely, but bad consequence). Likewise, this same woman could plan a birth with an OB-GYN known for having high rates of episiotomies and cesarean-sections (a poor choice) and end up having a natural birth experience in the hospital (an unlikely, but good consequence). Poor consequences do not necessarily mean poor choices, just as good consequences do not necessarily mean that a smart choice was made.

To assist in step six regarding uncertainties, Hammond, et al. recommend constructing a risk profile. This profile provides a framework to answer the following four questions:

1. What are the key *uncertainties*?
2. What are the possible *outcomes* of these uncertainties?
3. What are the *chances* of occurrence of each possible outcome?
4. What are the *consequences* of each outcome? (emphasis in original)

It is suggested that creating a decision tree may be helpful with this process as well.

Step seven involves thinking about risk tolerance. Everyone has a different tolerance for risk, and every decision involves risk. “When decisions involve uncertainties, the desired consequence may not be the one that actually results” (p. 8-9). For example, in the case of women planning a home birth, the home birth (the desired consequence) may not actually occur due to factors such as unanticipated complications during the labor or delivery process. In this case, the risk is that a woman would probably be taken to the hospital and have to deal with the consequences of having a delivery in a hospital which would probably be unlike the one she planned at home. The authors suggest creating a risk profile or desirability scoring to help with the decision making process at this point.

The eighth and final step in the Smart Choices model is considering linked decisions. While every decision can affect the future, linked decisions are those that directly affect the future. In the case of home birth, making the decision to give birth at home is linked to potential decisions around how to handle complications which arise during the delivery (probable solution: have a trained midwife present). The authors identify six steps to analyze linked decisions:

1. Understand the basic decision problem
2. Identify ways to reduce critical uncertainties
3. Identify future decisions linked to the basic decision
4. Understand relationships in linked decisions
5. Decide what to do in the basic decision
6. Treat later decisions as new decision problems.

Obviously, some future decisions can be planned for, but not all can, which is why step six of treating later decisions as new decision problems may be helpful.

Psychological Traps in Decision Making

Another part of Hammond, et al.'s model that is important to mention are the psychological traps in decision making. The ones I believe women planning their birth experience should consider include the anchoring, status quo, recallability, and prudence traps. Each will be briefly discussed in turn.

The anchoring trap. The authors describe this trap as over-relying on first thoughts. "In considering a decision, the mind gives disproportionate weight to the first information it receives" (p. 191). Because of this phenomenon, the mind "anchors" any subsequent thoughts around the first idea. In the area of childbirth, giving birth in the hospital is the norm, with approximately 1% of women giving birth at home (Martin, et al., 2007). Therefore, hospital birth would serve as the anchor for a women contemplating where to give birth and would hold more weight than any other option. Hammond, et al. note that anchors can take on many forms, from a comment offered by a spouse or partner to past events or trends. They encourage people to be aware of them and how they may affect a decision.

The status quo trap. This trap is described as keeping on keeping on. This trap has to do with choosing an option simply because it is the one we are already doing. For example, a woman may already be working with an OB-GYN, not really thinking about her options upon first becoming pregnant. Suppose this woman realizes she is not very happy with the standard medical model of care. She may even investigate other options, such as the Midwifery Model of Care and working with a midwife instead of an OB-GYN. A potential trap would be the status quo trap. It can be easier to stay with an option we have already chosen than making the effort to choose a different option.

The recallability trap. This trap is described as focusing on dramatic events, which are often given disproportionate attention in the media and are therefore easy to recall. However, this cycle leads us to believe that dramatic events occur far more often than they actually do. For example, if an infant were to die in childbirth while being born at home, it would be more likely to make the news than if the same event were to happen in a hospital because of the unusual place of birth. But, in reality, how likely is it that a child will die in a home birth? These are issues women need to actually investigate rather than assuming they know the answer to in order to avoid the recallability trap.

The prudence trap. This trap involves slanting probabilities and estimates. The authors note that “even one of our best decision-making impulses -- caution -- can lead us into error” (p. 209). This trap happens when we base a decision on worst-case scenario situations which are not accurate. In the case of childbirth, this trap happens all the time. Women choose to give birth in the hospital “just in case something were to happen” even though the likelihood of something happening is slim (for healthy women), midwives are trained to handle those types of situations, and it is safer in many ways (such as fewer unnecessary interventions) to give birth at home.

Personality Categories in Regards to Decision Making

I fully believe that every woman has to make the correct decision for herself in terms of where she gives birth. Planning a home birth is not for every woman; however, I do believe that if more people were educated about the realities of giving birth at home, more women would be choosing it as a safe, viable, and satisfying option. O’Neill and O’Neill in their book *Shifting Gears: Finding Security in a Changing World* (1974),

describe four categories into which people fall when making major life decisions which affect other people, such as choosing to plan a home birth:

1. Those who know their own needs and priorities and are also aware of the needs and priorities of others.
2. Those who know their own needs and priorities but whose first concern is the approval of others.
3. Those who are uncertain as to their own needs and priorities and look to others to tell them what to do.
4. Those who know their own needs and priorities and simply do not give a damn about the needs and priorities of others.

O'Neill and O'Neill contest that people fall into these categories because they are not aware of their own priorities, which as we have seen, is essential regardless of the decision-making model used.

In terms of women for whom home birth might be a good option, it is my hypothesis that women who go through with planning a home birth probably fall into the first category. I conclude that women who are planning a home birth have put a lot of thought into their decision and have thought about how it might affect their family and their child.

Women falling into the second category have potentially put a lot of thought into what they want, but given that our society buys into the medical model, viewing childbirth as a dangerous medical problem and therefore feeling skeptical or even outwardly hostile toward the idea of home birth, these women make the decision to give birth in the hospital in order to gain approval from others. I wonder if these women, possibly having a dissatisfying hospital birth, may decide to put their needs for

themselves and their child ahead of approval from others should they have another child. In this case, for subsequent births, these women may move into category one.

Women in category three fear change and fear going against the norm. The thought of planning a home birth may cross their minds if they are already familiar with the idea, but they probably will not rock the boat and move forward with planning one. These women are not likely to have much of a voice in their maternity care.

Women in category four would be considered dangerous by O'Neill and O'Neill (1974) because they do not think of others needs or feelings at all and simply go ahead with whatever it is they want to do, regardless of the harm it may bring to others. I would argue that sometime when planning a home birth, it may be important to disregard the opinions of those objecting to the home birth if those people are not informed. However, if someone who is informed, such as the woman's midwife, is telling her that she should reconsider her decision to have the baby at home, there may be valid reasons behind this concern and those reasons should be considered.

Women's Ways of Knowing

Because only around 1% of women give birth in their homes (Martin, et al., 2007), it would appear that only about 1% of women giving birth every year fall into the first category of being aware of their own needs and priorities (and acting on them). Why is this? In order for women to make the decision to plan a home birth, they have to really know it is the right decision for them. In their book *Women's Ways of Knowing*, Belenky, Clinchy, Goldberger, and Tarule (1997) speculate that women gain knowledge,

truth, and authority differently from men. In their research, they describe a continuum encompassing five different perspectives:

- *Silence*: a position in which women experience themselves as mindless and voiceless and subject to the whims of external authority
- *Received knowledge*: a perspective from which women conceive themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge on their own
- *Subjective knowledge*: a perspective from which truth and knowledge are conceived of as personal, private, and subjectively known or intuited
- *Procedural knowledge*: a position in which women are invested in learning and applying objective procedures for obtaining and communicating knowledge
- *Constructed knowledge*: a position in which women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing (p. 15)

My inclination is to believe that women planning home births are at various points on this continuum, and that many may be in either the subjective, procedural, or constructed knowledge realms in order to make the decision to plan a home birth. Where women are in their perceived knowledge influences the way they make decisions.

Belenky, et al., describe the influence male ways of thinking have affected our ways of thinking about knowledge:

Along with other academic feminists, we believe that conceptions of knowledge and truth that are accepted and articulated today have been shaped throughout history by the male-dominated majority culture. Drawing on their own perspectives and visions, men have constructed the prevailing theories, written history, and set values that have become the guiding principles for men and women alike...Relatively little attention has been given to modes of learning, knowing, and valuing that may be specific to, or at least common in, women. (p. 5-6)

The decision-making models previously addressed were primarily created by men, presumably without thought to how women and men may differ in their acquisition of knowledge and therefore what goes into making a decision.

It is my belief that choosing a home birth is inherently a feminist decision. I believe that women choosing home birth place value on themselves, their bodies, and their child's strength and inherent knowledge. Women choosing home birth trust their bodies and their babies, and trust that birth is a normal, natural process. These are the women who "supervalue nature and their natural bodies over science and technology, who regard the technological deconstruction of birth as harmful and dangerous, who desire to experience the whole of birth" (Davis-Floyd with Davis, 1997, p. 147). These beliefs of trusting oneself are also feminist beliefs. Adrienne Rich (1979) urges that we take strong consideration in what it means to think about feminism:

If we conceive of feminism as more than a frivolous label, if we conceive of it as an ethics, a methodology, a more complex way of thinking about, thus more responsibly acting upon, the conditions of human life, we need a self-knowledge which can only develop through a steady, passionate attention to *all* female experience. I cannot imagine a feminist evolution leading to radical change in the private/political realm of gender that is not rooted in the conviction that all women's lives are important; that the lives of men cannot be understood by burying the lives of women; and that to make visible the full meaning of women's experience, to reinterpret knowledge in terms of that experience, is now the most important task of thinking. (p. 213)

Women's and men's experiences and their ways of learning and growing may be different. With the area of maternity, and its direct affect on women's lives, I was also curious to examine a feminist model of ethical decision making to see what it might add.

Overview of a Feminist Model for Ethical Decision Making

To address this issue, a decision making model based on Hill, Glaser, and Harden's (1998) "A Feminist Model for Ethical Decision Making" was examined. This model is comprised of seven stages: recognizing a problem, defining the problem, developing solutions, choosing a solution, reviewing process, implementing and

evaluating the decision, and continuing reflection. Each stage has two parts: The rational-evaluative process and the feeling intuitive process. While this model was initially created for psychotherapists contemplating ethical decisions regarding clients, it was easily adapted to women's decision making process regarding childbirth.

While other models of decision making (Hanks, 1993; Hammond, Keeney, & Raiffa 1999; Lamanna & Riedmann, 2009) are useful, they are also limited for the purposes of this project. In addition to the rational-evaluative process outlined by most decision making models, this feminist model utilizes the emotional-intuitive response, and takes into consideration the social context of the mother. The Hammond, et al. *Smart Choices* model did include small amounts of the emotional-intuitive process embedded in its steps; however, the Hill, Glaser, and Harden feminist model makes the emotional-intuitive part of the process equally important to the rational-evaluative response, which is helpful as choosing to plan a homebirth has been described as “an instinctive choice” (Buckley, 2005). Unfortunately, we live in a culture which does not always value or even acknowledge intuition as a way of processing knowledge. July Luce, a homebirth midwife, was quoted in Davis-Floyd and Davis's (1997) chapter on intuition and homebirth:

I think, because we're in a culture that doesn't respect intuition, and has a very narrow definition of knowledge, we can get caught into the trap of that narrowness. Intuition is another kind of knowledge – deeply embodied. It's not up there in the stars. It *is* knowing, just as much as intellectual knowing. It's not fluff, which is what the culture tried to do to it. (p. 148)

Just as Luce acknowledges that intuition is a part of a midwife's decision making process when delivering a baby, intuition plays a role for the mother. It is part of a mother's

decision to plan a home birth for her baby and her self, as well as a guiding force through her pregnancy and delivery.

By utilizing both the rational-evaluative process and the emotional-intuitive response, Hill, Glaser, and Harden are acknowledging that people use their entire brain and being when making ethical decisions. Therefore, I believe it is essential to utilize both parts, which this feminist model enables us to do. The differences between the rational-evaluative process and the feeling-intuitive process can also be applied to the areas of home birth and midwifery. “The technocracy [medical model] is largely hierarchical, male-dominated, machine-orientated, and oriented towards left-brained principles of separation and discrimination, while homebirth midwifery is primarily egalitarian, nature- and female-oriented, and aligned with right-brained principles of holism and connection” (Davis-Floyd with Davis, 1997, p. 149). Hospital birth, even when utilizing a CNM, has the probability of being more technocracy, and home birth is at such polar opposites on a continuum, utilizing a model which has components of each for a decision making process regarding birth should be helpful.

Description of A Feminist Model for Ethical Decision Making

Stage one of the feminist decision making model is about recognition of a problem. Hill, et al. (1998) believe that the first indication that there is a problem stems from feelings of discomfort. The authors identify the first task is to “identify any aspects of her or his feelings that might stand in the way of understanding and sorting through the problem” (p. 111). For pregnant women, this process may include feelings that care within the medical model are not a good fit, or that the thought of giving birth in a particular place feels uncomfortable.

The second stage is to define the problem. In this stage the person identifies “the people or institutions whose needs must be considered in the decision” (Hill, et al., 1998, p., 112). In the case of a pregnant woman, the people may include herself, her baby, and her partner. Other people may or may not be included. Institutions include insurance companies and possibly care providers. Listening to intuition plays an important role in defining the problem.

Stage three involves developing solutions. After brainstorming a list of possibilities, the authors advocate for doing a cost-benefit analysis of each option. They add that paying special attention to any feelings which arise from this method is an important part of the process. I actually prefer Hammond, et al.’s (1999) wording of this step, which they describe as creating imaginative alternatives, because it may have the potential to lead to more creative options, which is where a woman might discover the option of birthing at home. Because home birth is often times disregarded as an option, it takes imaginative thinking to even place it on the list of possible solutions.

Step four is about choosing a solution. The rational-evaluative process and the feeling-intuitive process are combined in this step. Hill, at al. (1998) advocate that “the best decisions are made when both of these sources of information are included in an integrated way” (113). Unfortunately, the authors do not give a lot of guidance as to how to make this decision.

A reviewing process is stage five of this model. The authors cite how critical it is for the decision-maker to examine how her “values and personal characteristics might be influencing the choice of a solution” (Hill et al.,1998, p. 114). They advocate for the decision-maker to feel comfortable subjecting her choice to the scrutiny of others. I

actually disagree with this part of the process, as home birth is commonly misunderstood, and many people may disagree with the mother for making this choice. This potential disagreement with others does not imply that the woman is making a wrong decision in this case; rather that others are probably misinformed. The other part of this stage is paying close attention to how the decision feels. This intuitive sense can be quite informative to the mother.

Step six of the feminist model is implementing and evaluating the decision. This involves carrying out the decision, in this case giving birth at home, and noticing the consequences of this decision. In the case of home birthing mothers, as with any mothers, consequences could range from a satisfying birth experience where mother and baby are healthy, to infant or maternal mortality, although the later is extremely unlikely.

Stage seven involves continuing reflection. This stage is about noticing any changes that may have occurred as a result of implementing the decision, or what has been learned. For mothers who gave birth at home, they may have learned something about their personal strength and fortitude.

A Feminist Decision Making Model for Women Choosing to Birth at Home

Ultimately, there is value in both the Hill, et al. (1998) model and the Hammond, et al. (1999) model. Specifically, I appreciate the detailed steps laid out in the Hammond model pertaining to specifically deciding how to select the correct option. In terms of the Hill, et al. model, I appreciate that the feeling-intuitive process is included. I propose utilizing a combination of the models as seen in Table 1. This model takes into account the pertinent and valuable components of both models as they apply to making the decision to plan a home birth.

Table 1

Feminist decision making model for women choosing to birth at home

Rational-evaluative process	Feeling-intuitive process
Recognizing a problem	
Personal information; advice from others	Uncertainty about how to proceed in situation Identify what stands in the way of working through the problem: feelings about the nature of the issue
Defining the right problem	
What is the conflict? Who are the players? What are the relevant standards? What personal characteristics and cultural values do I bring to this decision? How do these factors influence my decision to the problem? How does (my partner) define the problem? What personal characteristics, values does my partner bring to this process? (If consulting with others): What personal characteristics, values does my consultant bring to this process?	What else is my discomfort about? What do my feelings tell me about the situation? What am I worried about? What are my partner's feelings about the dilemma? How do my partner's characteristics effect me? How does my consultant's characteristics effect me?
Specify objectives	
Determine the information to seek to make a good decision. What is most important to accomplish? What am I trying to avoid?	What do you want? What do you need? What are your hopes? Goals? Values? What does my partner need/want?
Create imaginative solutions	
Brainstorm list of <i>all</i> possibilities. Cost-benefit analysis. Prioritize values. How do these solutions meet all of the objectives?	What do my reactions to each choice tell me? What does my subconscious tell me over time?
Understand the consequences	
What are the positive and negative consequences of each option? What do you have to give up? What do you gain? Clarify any uncertainties. Create a consequence table.	How do the consequences feel? What emotions come up when faced with the tradeoffs?
Think hard about risk tolerance	
If you pick one option, it still may not be the one to occur. What are the risks associated with this?	How would you feel if the option picked is not the option that occurs? What does this say about the decision?
Consider linked decisions	
How are future decisions connected to this decision?	

Choosing a solution	
<p>What is the best fit both emotionally and rationally? Does this solution meet everyone's needs, including mine? Can I implement and live with the outcome (emotional outcome, cognitive outcome, physical outcome)?</p> <p>Understand the consequences: How well do your alternatives satisfy your objectives?</p> <p>Grapple with your tradeoffs: you will need to strike a balance. What did you have to give up?</p>	
Reviewing process	
<p>Would I want to be treated in this way?</p> <p>Would this decision withstand the scrutiny of others?</p> <p>How are my values, personal characteristics influencing my choice? How am I using my power?</p> <p>Have I taken my partner's perspective into account?</p> <p>Clarify your uncertainties: what could happen in the future, and how likely is it that it will?</p> <p>Think hard about your risk tolerance: When decisions involve uncertainties, the desired consequence (HB) may not be the one that actually results. People vary in their tolerance of such risks and, depending on the stakes involved, in the risk they will accept from one decision to the next.</p>	<p>Does the decision feel right? Have I given myself time to let reservations emerge?</p> <p>Does the manner in which I carry out this decision fit my style?</p>
Implementing and evaluating the process	
<p>Carry out the decision</p> <p>Observe consequences</p> <p>Reassess the decision</p>	<p>Is this solution the best I can do?</p> <p>Does the outcome continue to feel right?</p>
Continued reflection	
<p>What did I learn?</p> <p>What would I do differently?</p> <p>Consider linked decisions: What you decide today could influence your choices tomorrow, and your goals for tomorrow (breastfeeding) may should influence your choices today. Many important decisions are linked over time.</p> <p>Key: isolate and resolve near-term issues while gathering the information needed to resolve those that will arise later.</p>	<p>Have I changed as a result of this process? How?</p> <p>How might this experience affect me in the future?</p>

Mary Katherine Godfrey (2009). Adapted from Hill, Glaser, and Harden (1998) and Hammond, Keeney, and Raiffa (1999).

This new model is based on what is known about what is important to women in childbirth and how they obtain knowledge. From the literature, it is known that the decision to plan a home birth has many factors, including concrete objectives and intuitive thoughts. For some women, it is also possible that the decision to plan a home birth is not one made lightly; rather, it is probably decision requiring a lot of thought. Additionally, this process probably involves consultation with others, which is also incorporated into this model. This model is an attempt to honor and acknowledge all aspects of a woman as she makes her way through this important decision.

When making this decision, women may take different paths. Some women may go through it step-by-step, completing one task before moving on to the next. Other women may skip steps. While some parts of this process may be more beneficial than others, I suspect that women can find value in this model.

The decisions of what type of prenatal care to pursue, type of caregiver with whom to work, and place of birth are not decisions to be taken lightly. Women need to make the decision that is best for them. However, many women do not know which options are even available to them. This model may serve as a guide for helping women to make the correct decision for themselves. It serves as a way of organizing thoughts, questions, and considerations which may be important to process when making a decision such as this one. Further research is needed to learn more about women's decision making when planning a home birth in order to make this model more accurate. Ultimately, the goal is to make this decision more accessible to more women. Further research is a way to ensure the completion of that goal.

Ecological Systems Theory

Ecological Systems Theory was used as a conceptual framework for this research. Uri Bronfenbrenner (1979), one of the major contributors to human ecology theory, describes that “human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment” (p.38).

Bronfenbrenner originally outlined four levels: micro-, meso-, exo-, and macrosystems. Later, a fifth system, the chronosystem, was added (see Table 2). This theory can be pictured like a target with a bull’s-eye, with the developing person, in this case the expecting mother, at the center. Characteristics of the mother, such as her age, sexual orientation, and health are included in the center. The microsystem composes the first ring around the center and includes the family and home. This is considered to be the “principal microsystem context in which development takes place” (Bulbolz & Sontag, 1993, p. 423). This system includes a person’s immediate environments. These include people, activities, and organizations with whom the person has immediate contact. For example, a person’s family, medical caregivers, and neighborhood would be included. The next level, the mesosystem, comprises connections among the various components in the microsystem. The connection between a woman and her medical caregiver is an example. The third level is the exosystem, which includes situations in which the mother is not actively included but in which significant decisions are made affecting the mother. Included in the exosystem are the media and policy makers, including medical policy makers. The outer ring, the macrosystem, is composed of the larger cultural context. It includes attitudes and beliefs of the culture in which the individual lives, including beliefs

about how things should be done, such as how women should give birth.

Bronfenbrenner (1992) notes that “the macrosystem may be thought of as a societal blueprint for a particular culture, subculture, or other broader context” (p. 150). Finally, the chronosystem incorporates the aspect of time. It is helpful for examining changes and transitions over the course of life.

Table 2
Ecological Systems with examples regarding birth experiences

System	Example
Center	The mother and her characteristics: age, sexual orientation, health
Micro-	Close friends and family members, midwife
Meso-	Connection between woman and midwife
Exo-	Media and how it portrays birth; policy makers in the medical field
Macro-	Cultural beliefs about how women should give birth
Chrono-	Dimension of time: changes in thinking about the birth process over time

Because women make decisions utilizing all of the systems, this framework served as a backbone for how women make the decision to plan a home birth. Other studies utilizing this model include a study on lesbian couples decision making process around utilizing donor insemination (Chabot, 1999), career development decisions for low-income African-American youth (King & Madson, 2007), and applying and ecological systems framework to family food decision making (Gillespie & Gillespie, 2007).

Based on reviewing the current literature, it seems that additional information around homebirth and women’s voices needs to be provided. This study provides a link between decision making and the home birth literature. The findings of this study will enable educators, social scientists, developmentalists, and feminist scholars to know more about how and why women chose to plan a home birth. The findings could also be useful to childbirth educators interested in helping their students make the correct decision for

themselves in terms of place of birth. Activists may also find this information useful in promoting choice for women.

CHAPTER 3: METHODOLOGY

The purpose of this chapter is to explain the methodology used for this study. I begin by describing pre-data collection including the research approach and rationale. I then explain the data collection procedures including the participants and the sampling procedure, the measures, and the procedure used for data collection. Last, I discuss post data collection, including the analysis of the data, and trustworthiness.

Research approach and rationale

This study describes the experience of first-time mothers who chose to plan a home birth with a care provider. A qualitative approach was chosen because limited research has been done on this phenomenon and we really need to capture women's voices of this personal decision. A qualitative approach was utilized because getting in-depth knowledge about the women's experiences was of utmost importance. Strauss and Corbin (1990) describe qualitative research as being a useful and appropriate method when trying to "uncover and understand what lies behind any phenomenon about which little is yet known" (p. 19), in this case, home birth. Additionally, Strauss and Corbin note that "qualitative methods can give the intricate details of phenomena that are difficult to convey with quantitative methods" (p. 19). Qualitative researchers will often frame their research questions in such a way that can only be answered with qualitative

research (Corbin & Strauss, 2008). Corbin and Strauss also note that qualitative researchers frequently want their research to be used in nonacademic settings as well as academic settings, as is the case with this research. Because this research study is specifically attempting to discover more about the intricate details and nuances of women's decision-making processes around planning a home birth, qualitative methods are appropriate.

This was a phenomenological study. Creswell (2009) defines phenomenological research as "a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants" (p. 13). Phenomenological research "involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning" (Moustakas, 1994, cited in Creswell, 2009, p. 13). Willig (2001) notes that phenomenology is concerned with the ways in which people gain knowledge of the world around them (p. 50). In this case, women were gathering information necessary to make the decision to plan a home birth. How did these women do that? What types of information did they seek? Because making the decision to plan a home birth is fairly unique, it deserved in-depth study in such a way that a phenomenological study permitted. Other childbirth studies have also utilized this research method (Callister, et al., 2007; Lundgren, 2004; Milliken, 2007).

Bortin, Alzugaray, Dowd, and Kalman (1994) conducted a study applying a midwifery care framework to the experience of home birth. They suggested a need for doing qualitative research on women's experiences with home birth. They also suggested that this research be from a feminist perspective, which this research utilized.

More specifically, this study utilized Interpretative Phenomenological Analysis (IPA). IPA is described by Willig (2001) as:

A version of the phenomenological method which accepts the impossibility of gaining direct access to research participants' life worlds. Even though IPA aims to explore the research participant's experience from his or her perspective, it recognizes that such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant. As a result, phenomenological analysis produced by the researcher is always an *interpretation* of the participant's experience.... Interpretative Phenomenological Analysis shares the aims of other phenomenological approaches to data analysis in that it wishes to capture the quality and texture of the individual experience. However, it recognizes that such experience is never directly accessible to the researcher. (53)

Because feminism values the uniqueness of individual experience, and this was a feminist study, IPA was a valuable perspective for this research.

Population

The population for this study was pregnant women in Northern Colorado planning a home birth with a caregiver. Criteria for the sample included women who were pregnant with their first child and planning a home birth with a registered midwife or apprentice midwife and mothers who had given birth at home in a planned home birth with a caregiver. Typically, mothers who plan a home birth have previously given birth (MacDorman & Menacker, 2010); therefore, first-time mothers are potentially coming from a different perspective. If mothers had given birth multiple times, but the first birth was a home birth, they were included; however, this study focused on their first birth. Mothers who had planned a home birth, but were transferred to the hospital for medical reasons, were included because they had gone through the process of making the decision to plan a home birth. Additionally, only women who had planned a home birth or had

given birth within the past three years were included due to the challenges of recall. Mothers who had previously given birth in a hospital, had unplanned home births, or planned a homebirth without an attendant were excluded. Creswell (2007) reports seeing phenomenology studies with as few as one participant and as many as 325; however, the majority of phenomenology studies tend to have around ten participants. Nine women were included in this sample.

These criteria were established in order to have as homogenous a group as possible. Women do not typically pursue home birth for their first child, and so I was curious about these women specifically. Additionally, I planned a home birth for the birth of my child and was therefore curious about the experiences of other women in similar situations.

Sampling Procedures

This sample was a purposive sample. Some participants were known to the researcher and when asked, they agreed to participate. Others were recruited through a local midwife. As recommended by Creswell (2007) for phenomenological studies, criterion sampling was utilized for quality assurance. All potential participants were given a letter describing the purpose of the study and requesting their participation if they fit the criteria listed previously (see Appendix A). The potential participants then contacted the researcher directly if they were interested.

Data Collection

Two methods of data collection were chosen to ensure a quality study: journaling and interviewing. Journaling was a method chosen because it was an instrument that can be used continuously while a woman was pregnant and actually in the midst of making

the decision to plan a home birth. For women journaling in the process of planning their home births, the issue of recallability is lessened compared to retrospective interviews. However, interviews were also included for women who have already given birth. These women, too, had something of value to offer this study in that they may have learned something from having completed their decision to plan a home birth. Therefore, both methods are seen as being of value for this study.

Women who were pregnant with their first child were given the option of writing in a journal throughout their pregnancies, answering specific questions and doing sentence completions (see Appendix B). Journals were returned to the participants after transcription.

The method of journaling is frequently referred to in the literature as the diary method. However, because the method for this study is so prescribed with specific questions, the term journal was chosen instead. Journal methods have been recommended for studying family life (Laurenceau & Bolger, 2005). They have been used with women's experiences of bulimia nervosa (Broussard, 2005), to study children's television advertising exposure and their food consumption patterns (Buijzen, Schuurman, & Bomhof, 2007), and in studying economic decisions within private households (Kirchler, 1995).

There has been some debate about paper-and-pencil versus electronic writing in terms of participant compliance (Broderick & Stone, 2006; Green, Rafaeli, Bolger, Shrout, & Reis, 2006; Takarangi, Garry, & Loftus, 2006; Tennen, Affleck, Coyne, Larsen, & DeLongis, 2006). There appears to be little agreement on which method is preferable in terms of compliance. As a result, women were given the option of

completing their journals in a paper-and-pencil format or on their personal computers. All of the women in this study chose the paper-and-pencil format.

Journaling is an appropriate research method when wanting information about how a person changes over time (Bolger, Davis, & Rafaeli, 2003). Because this study was seeking to gain information about women's decision making process, which is a process which occurs over time, journaling was an appropriate method.

Journaling is considered effective in situations in which the researcher wants information over a period of time, such as a pregnancy. One of the greatest advantages of journaling is that the data is temporally ordered. Any changes over time are apparent through the writing. Journaling is a cost- and time-effective means of obtaining data. Participants were also familiar with what a journal was, making it easy to explain the instrument to them. They were also able to write when and where they felt comfortable (Breakwell & Wood, 1995).

Disadvantages to the journal method include the researcher having a lack of control over the content, participants submitting incomplete journals or dropping out of the study, the issue of not being certain if journal writers are telling the truth, and "the very fact that having to produce the diary might alter the behavior, thoughts, feelings, and so on" of the women (Breakwell & Wood, 1995, p. 296). The lack of control over the content was addressed in this study by the specific journaling questions and sentence completions provided by the researcher to the women, which enabled the women to answer specific questions, thus answering the researcher's research questions. To lesson incomplete journals or women leaving the study, women were carefully screened prior to the study and sent gentle journaling reminders (via telephone, email, and/or letter) during

their pregnancies. The women were free to contact the researcher if they had any questions about the process along the way.

Qualitative interviews were selected as the other method for data collection. Interviews were conducted for women who had given birth within the past three years. Patton (2002) describes choosing to do qualitative interviews to gain perspective on what we cannot directly observe. Because a person's decision-making process cannot be directly observed, interviews are advantageous to be able to ask questions about peoples' thoughts and feelings. An additional advantage included the ability to incorporate relevant historical information provided by the participants (Creswell, 2009). Specifically, an interview guide method was utilized for this study. This form of interviewing included creating an interview guide with specific questions. This guide helped ensure that topics of conversation remained consistent among interviews. This particular interview method also increased the comprehensiveness of the data. A potential weakness of this method included inadvertently omitting important lines of questioning (Patton). Additional limitations included the fact that information was filtered through the views of the interviewees, that the responses may have been biased by the researcher's presence, and that not all participants were equally articulate and insightful (Creswell). However, some of these factors were relevant regardless of the method of design.

All interviews were face-to-face, one-on-one interviews lasting one to two hours. A practice interview was conducted in May of 2009. This included an interview with a woman who had planned a home birth five years prior to the interview. This interview was conducted to determine the time it took to conduct the interview and to make sure the

questions were clear to the interviewee. Based on this initial experience several of the questions were re-worded.

All other interviews were conducted between May and August, 2009. Interviews took place either in the home of the woman or in the researcher's private office, whichever was preferred by the participant. Field notes during the interviews were taken, as well as the researcher's thoughts immediately following the interview. All interviews were digitally recorded and transcribed verbatim. After transcription and review for accuracy, all recordings were destroyed. To protect confidentiality, pseudo names were used in the transcriptions. Each participant was assigned a code (09-001) which was on all of her paperwork. A linked list was created and stored separately from the data. The transcriptions, field notes, and demographic forms were stored in a locked filing cabinet in the researcher's private practice office. Consent forms were stored in separate locked filing cabinet in the researcher's office. After completion of the study, all paperwork will be stored in a locked file cabinet in a locked office at Colorado State University. All paperwork will be destroyed within the number of years required by University guidelines.

An interview guide was used (see Appendix B). This guide focused on decision making and influential systems. While specific questions were written with careful wording, this guide was not always followed precisely or in order, depending on the direction of the interview. Participants were mailed the interview guide in advance in order to be thinking about responses to the potential questions.

Prior to the interviews, participants signed a letter of consent (see Appendix A). This consent included information about Colorado State University's Human Research Committee (HRC) approval, permission to withdraw from the study at any time, and assurances of anonymity. Participants also filled out a questionnaire with demographic information (see Appendix B) in advance, which they returned with their journals or at the interview.

Approval from Colorado State University's HRC was sought. In accordance with HRC, all participants were provided with consent forms which outlined the study and the potential risks and benefits in participating. This consent form can be found in Appendix A. All participants' names were kept confidential.

Data analysis

Giorgi and Giorgi (2008) stress the importance of maintaining a phenomenological attitude. This attitude is different from a natural attitude or a life-world perspective, which is the perspective from which the participants are coming. Giorgi and Giorgi describe the natural attitude as "the attitude of everyday life" (p. 170). The phenomenological attitude, on the other hand, means two things:

- (1) The researcher must bracket all past knowledge about the phenomenon being researched so that he or she can be freshly present to the current instance of it and (2) the researcher does not posit the phenomenon he or she is experiencing to be real (even if it is) but merely considers it to be a presence to the experiencing person. (p. 170)

Therefore, the experiences of the women participating are phenomenons for them, but not necessarily a world reality. Before even beginning to analyze the

transcripts I worked to obtain a phenomenological attitude as opposed to a natural attitude.

As recommended by Willig (2001) the transcripts of the journals and semi-structured interviews were analyzed individually. In the first stage, the transcripts were read through completely and notes were made. These notes included any thoughts, questions, comments, and summary statements which came to mind during the initial reading and were be broad, “wide-ranging and unfocused” (p. 54). Willig recommends including any “associations, questions, summary statements, comments on language use, absences, descriptive levels, and so on” (p. 54). All such notes were recorded in the right margin of the transcription.

Next, any themes identified were recorded in the left margin of the transcription. Themes differed from the previous notes in that they were conceptual and they “capture something about the essential quality of what is represented by the text” (Willig, 2001, p. 55).

The third stage of analysis consisted of organizing and clustering the themes found in stage two. These clusters were formed on the basis of shared meanings or ideas. The clusters were then be labeled with appropriate titles. This third stage of analysis occurred with Interview 09-001 in order to get a sense of what titles may appear. These titles were then assigned colors. For example, anything related to the medical model was assigned the color orange.

In the fourth stage of analysis, all prominent previously identified theme titles in the left hand column were color coded. Potentially new themes were referenced with

previous themes to see if they were in fact new themes or if they fit better with previously discovered themes.

In addition, Bronfenbrenner's (1979) Ecological Systems Theory also influences decision making. This theory is based on five systems and the bidirectional influences these systems have on one another. These systems include the micro-, meso-, exo-, macro-, and chrono-systems, and are described in the review of literature. Each system contains rules, standards, and beliefs that can strongly influence a person's development and decision making process. Data was analyzed for the micro-, meso-, exo-, macro-, and chrono-system components, based on Bronfenbrenner's Ecological Systems Theory. A discussion of this analysis can be found in Chapter 5.

Trustworthiness

To ensure that the transcriptions captured the participants views accurately, completed transcripts were returned to participants for review. Participants had two weeks to make corrections and additions. As stated in a letter to the participants (see Appendix A), transcripts not returned to the researcher within two weeks were assumed to be satisfactory.

Hammersley and Comm (2000) examine three types of bias: willful bias, negligent bias, and bias based on our life experience and values. This study utilized several methods to ensure the first two were avoided. It is acknowledged that the third type of bias cannot be avoided. I attempted to be transparent about my personal life experiences which may have affected this research in the Researcher's Perspective section of Chapter 1. Additionally, an audit trail was established in order to minimize

bias and maximize accuracy. A log was kept by the researcher during the project to ensure trustworthiness, and all coding was peer reviewed with my advisor. Coding decisions were discussed with my advisor as well. Member checking was conducted.

CHAPTER 4: RESULTS

As stated in Chapter 1, this study examines the factors influencing first-time mothers in making the decision to plan a home birth. I will present the major thematic structures that emerged from the study as a result of my cross-case analysis and then to illustrate this structural framework I will present and explore the structure through the experiences of each individual participant. In Chapter 5 I will set the structural framework within the conceptual perspective of Bronfenbreners's Ecological Systems Theory.

Participants

The women participating in this study were either pregnant with their first child or had planned a home birth with a midwife for their first child (see Table 1). All of the

women were either married or partnered and all, except Lynn, were Caucasian. Their ages at the time of the birth of their child ranged from 23 to 35, with the mean age being 30. They all planned their home births in the Northern Colorado area.

The first participant was Linden. As outlined in Chapter 3, Linden wrote journal entries because she was pregnant with her first child during the time of the study. Linden was 32 years old at the time she was writing and was 33 weeks pregnant. She was employed full time and had completed two years of post-graduate education.

Table 1
Demographics of participants

Pseudo name	Currently pregnant?	Journal or Interview	Weeks pregnant	Current age	Age when child born	Number of subsequent children	Relationship status	Ethnicity	Education level*	Employment status
Linden	Yes	Journal	33	32	32	0	Married / Partnered	Caucasian	18	Full time
Maya	Yes	Journal	37.5	32	32	0	Married / Partnered	Caucasian	15	Self employed
Susie	Yes	Journal	18	35	35	0	Married / Partnered	Caucasian	16	Full time
Lynn	No	Interview	n/a	37	34	0	Married / Partnered	Caucasian/ Asian	16	Part time
Rose	No	Interview	n/a	29	29	0	Married / Partnered	Caucasian	16	Homemaker
Trixie	No	Interview	n/a	32	32	0	Married / Partnered	Caucasian	19	Homemaker
Janet	No	Interview	n/a	28	27	0	Married / Partnered	Caucasian	19	Full time
Ella	No	Interview	n/a	25	23	0	Married / Partnered	Caucasian	15	Student
Maggie	No	Interview	n/a	31	29	1	Married / Partnered	Caucasian	17	Homemaker

* Women indicated their highest level or year of education they had completed based on the following scale:

Elementary School	1	2	3	4	5	6
Jr. High/High School	7	8	9	10	11	12
College	13	14	15	16		
Post Graduate	17	18	19	20	21	22

Susie also completed a journal. She was 18 weeks when she began journaling and was 35 years old. She was employed full time and had completed four years of college.

Lynn was 37 and had already had her baby so she sat for an interview. She was 34 years old when she gave birth. Lynn was a Caucasian and Asian woman who had completed four years of college and was employed part time.

Rose was twenty-nine years old when she was interviewed and was 29 years old when she gave birth to her first child. She was a homemaker who had completed four years of college.

Trixie was 32 years old at the time of her interview and when she gave birth. Trixie was also a homemaker who had completed three years of post-graduate work.

Janet was 28 years old when she was interviewed and she had her first child at age 27. She was employed full time and had completed three years of post-graduate work.

Ella was a student who had completed three years of college. She was 25 when interviewed and 23 years old when she gave birth.

Maggie was a homemaker who had completed one year of post graduate work. She was 31 at the time of the interview and had her first child at age 29. Maggie planned a home birth for her first child, but ended up having to give birth in the hospital because of some potential complications. Maggie did plan a home birth for her second child, who was born at home.

Major Thematic Structures

All of the women reported similar themes which will be described in this section. These include concerns regarding the medical model, the desire for natural childbirth, the role of intuition, and issues of power and control. The women discussed the reaction

their partner had to the decision to plan a home birth, and the role of their partner in this process. All of the women reported ways in which they had changed or what they had learned through this experience.

Women identified materials they found helpful in making their decision (see Table 2), and influential values and demographics (see Table 3). Please refer to Appendix C for a full reference list of recommendations. The most influential materials included *Birthing from Within* (England, & Horowitz, 1998), *The Bradley Method* (Bradley, Hathaway, Hathaway & Hathaway, 2008), and materials handed out by midwives. The most influential values and demographics included gender and socio-economic class. When women spoke of their gender, they mentioned how strong they were as women. Socio-economic class included being able to afford a home birth, whether this was paying out-of-pocket or because their insurance covered home birth. Being in a location in which planning a home birth was an option was also important. As mentioned in Chapter 2, in certain parts of The United States, midwives are not regulated and giving birth at home may be illegal.

Medical model

Women had a variety of reasons for choosing to plan a home birth. These reasons revolved around hospitals, doctors, and medical procedures. Several of the women reported a distrust of doctors and/or hospitals. Some of the women were afraid of needles and therefore scared of hospitals. They were also apprehensive that they would be able to have an intervention-free childbirth experience if they were in a hospital setting.

Table 2

Materials participants found helpful in making their decision to plan a home birth

	<i>Spiritual Midwifery</i>	<i>Ina May's Guide to Childbirth</i>	<i>Pushed</i>	<i>Misconceptions</i>	<i>Hypno-Birthing</i>	<i>Birthing From Within</i> (class and/or book)	<i>The Bradley Method</i>	<i>The Baby Book</i>	<i>The Business of Being Born</i> (film)	<i>Birth Into Being</i> (film)	Materials from midwife
Linden									X		X
Maya							X				
Susie	X	X	X	X							
Lynn						X					X
Rose						X			X		
Trixie						X	X				X
Janet	X	X			X				X		X
Ella	X	X				X	X	X		X	X
Maggie						X	X				

Table 3

Values and Demographics women found helpful in planning a home birth

	Gender	Class	Location	Age	Education	Strong and Independent	Health	Spiritual	Simple living
Linden	X	X			X		X		
Maya								X	X
Susie	X			X		X			
Lynn		X	X						
Rose	X	X	X			X			
Trixie				X	X	X			
Janet		X	X				X	X	
Ella	X								
Maggie									X

Power and control

All of the women expressed a desire to be in control of their childbirth experience. They wanted to be free to eat, drink, and move without restrictions. They wanted to make informed decisions about their care and the care of their baby without pressure.

Natural childbirth

When thinking about how they wanted to deliver their babies, all of the women desired a natural childbirth experience. They specifically mentioned not wanting to be attached to machines such as an Electronic Fetal Monitor and not wanting to take drugs during labor.

Intuition

Intuition was a guiding force for these women. They found that they could really listen to themselves and trust themselves throughout the process of planning a home birth. They also found that midwifery care provided a space that encouraged listening to intuition.

Partner

Partners were influential to women's decision making processes on one of two ways. Women typically noted whether they made the decision to plan a home birth independently or with their partner. Regardless, all women reported having partners who were supportive of their decision to plan a home birth. Several women also commented that their partners became more supportive with education.

Lessons learned

Women learned to trust themselves and their bodies through planning a home birth. They reported an increase in self-confidence, that they were better able to think for themselves and make decisions. Through this process they became more knowledgeable about pregnancy and childbirth. Overall they found the experience to be an empowering one. Several of the women mentioned feeling inspired to do some sort of work in the area of childbirth, such as becoming a childbirth educator.

Suggestions for other women

Women who had already had their babies were interviewed. These women were asked if they had any suggestions for other women. Women who were currently pregnant were not asked about this. Repeatedly, mothers suggested that prospective mothers ask questions and do their own research. They stressed the need for women to educate themselves and to make the decision that feels right for them in terms of the type of birth experience they desire. They also wanted others to know that the pain of childbirth is short-lived.

Individual Participants

Linden

Medical Model.

A major thematic concern for Linden included concerns with the medical model. To begin with, Linden reported that she has “a big phobia of needles and hospitals are very anxiety provoking for me”. Linden was interested in having the freedom to birth as she wanted and was concerned that she would not be able to achieve her desired birth experience in a hospital setting. In terms of how Linden first became aware of the option

to plan a home birth, she wrote, “I started to think more about how the medical model (in my opinion driven by strong patriarchal values) was starting to hijack one of the most profoundly feminine experiences of a woman’s life, not to mention getting horrible outcomes for both mom and baby (high C-section rates, episiotomy, infant death, etc).” Linden followed this theme throughout her journal.

Power and control.

Having control over her birthing experience was of great importance to Linden. Many of the advantages she wrote about pertained to this area, such as “freedom of movement and opportunity to go outside”, “control over people involved in intimate experience (birth) versus interruptions from random nurses”, and support of the philosophy that birthing is a natural process versus a medical condition”. Linden also noted that with a home birth there are typically “no unnecessary interventions” such as being required to have intravenous fluids, an epidural, or an episiotomy.

Natural childbirth.

Having a natural childbirth experience was important for Linden and this desire played a role in her decision to plan a home birth. “I also chose a home birth because I really want to have a natural birth experience (no meds) and I feel it is more likely for me to get that outcome at home”.

Intuition.

Linden’s intuition played into this aspect as well. Linden viewed intuition as one of the components in having a natural childbirth experience:

Intuitively, I really believe that I am capable of having a normal/healthy birthing experience. Making a decision to birth in a hospital would be a fear based

decision for me (fear of the worst vs. expecting the best – or knowing that even if the worst happens, everything will be OK in the end). If I intuitively believe that I can be a part of the 90% of women that can have a natural childbirth experience, then I wanted to set myself up for success with a homebirth, which I think better supports people who believe in natural childbirth.

Linden's intuition helped her make the decision to plan a home birth.

Partner.

Linden identified her partner as being supportive. She wrote that his role was to be a supporter of her. While she acknowledged that she was “more active in the decision-making process and had stronger feelings about homebirth”, he supported her decision because “you're smart, you know your options and your body”.

Lessons learned.

For Linden, the learning experience while planning a home birth was significant: I am learning so much about pregnancy, my own body, the process of childbirth, options for birthing, and parenting choices that I have as the mom of a fetus and mom of a newborn baby. It is really quite remarkable to me how ignorant I was of all these things prior to getting pregnant. I feel so much wiser, and older somehow, being faced with these decisions.

Linden adds that she did a lot of research on childbirth and learned a lot about it. She wrote about feeling like she could now “be a feminist spokesperson for this issue”.

Linden wrote about how her opinions on healthcare in general have been reinforced. Through making the decision to plan a home birth and all of the research she has done in the area, she has “become more critical of the medical model”. Linden

believes that “hospitals are serving pregnant, delivering moms in a substandard way. They are, however, doing quite a good job making money for insurance companies and advocating for the needs of (male) OBs. Good for them.”

While Linden does not feel that she really changed all that much while planning her home birth, she did write that she feels “wiser and more informed about my body, about the choices I have related to parenting and pregnancy.”

Maya

Medical model.

Maya expressed concerns about hospitals and the medical model way of facilitating childbirth. Her mother suggested she pursue planning a home birth because “knew how much I don’t like hospitals and their very western-linear way of thinking and protocols”. A significant event for Maya was witnessing a friend’s pregnancy and labor. She noticed things such as her friend receiving no nutritional education from her medical doctor and a traumatic birth experience facilitated by a medical staff. “This experience only fueled me to believe doctors even less. In my opinion there are very few honest and trust worthy doctors in the world and I don’t know any of them. My mother worked in the ER for 7 years, my grandmother was a nurse, I have been certified in first aid & CPR most of my life, I have taken the EMT course, and the Outdoor Emergency First Responder. The hospital is the last place I would go for medical help.”

Maya was concerned about the cascade of interventions which can occur in a hospital birth experience:

Other than the comfort of my own home we believe there are many advantages [to planning a home birth]. Once I start labor there will be less chance of a stall due

to transport. I won't have as many exams that really don't tell me much. I won't have to fight off anyone trying to hook me up to monitors. If my labor lasts more than 12 hours I won't have to fight off those who would want to induce me, which usually leads to an unwanted epidural, which leads to unwanted lack of mobility, being stuck in the bed and on my back, basically the forfeit of most decisions concerning me and my birth. No chance of someone giving me Pitocin to aid in the delivery of my placenta even if I did have a totally natural birth. No chance of being just a routine, follow the protocols birth if one is at home. Also I will be able to hold my baby and breast feed immediately after the birth with nobody wanting to take him/her away to clean or do unwanted tests.

Maya was determined to avoid the hospital and all of the potential interventions she perceived could happen in that environment.

Power and control.

Maya expressed a desire to be in control of her childbirth experience. For example, Maya appreciated that her home birth midwife “gives us information so we can make educated decisions about our baby, versus telling us what is going to be done.” Additionally, Maya wanted to be in control of her birth experience instead of a medical provider being in control: “We believe every birth experience is unique and should be treated so. Doctors in hospitals have a way they like to do things, and a protocol. They are more likely to take control of your birth than allowing you to be in control and merely assisting you when needed.”

Natural childbirth.

Another significant theme for Maya was the desire for a natural birth. This was evidenced by her writing statements such as, “We believe the birth of our baby to be an experience for us to share. It should be a natural process. In fact it has been a natural process for thousands of years” and “I want my birth to be as natural as possible with as little outside interference as possible.”

Intuition.

Maya mentions trusting “her gut” in making the decision to plan a home birth. She wrote about doctors having set protocols to follow and that “intuition is looked at as skeptical”, whereas for Maya it appears to be a guiding force. She wrote about feeling like she and her husband had made the best decision they could in planning a home birth, and that they felt “relaxed and calm” about the decision.

Partner.

Maya wrote about her husband being very interested in planning a home birth. Maya describes theirs as a mutual decision and says that her husband believes “we made the best decision for us” and that he “loves the opportunity to be the one who delivers our baby”.

Lessons learned.

By planning a home birth, Maya became “more knowledgeable on pregnancy and birth”. She wrote about realizing that our culture is pretty uneducated about childbirth in general and that most people do not know planning a home birth is an option or choice. Part of this, Maya wrote, is because “we have been brain washed into believing everything our doctor tells us.” She wrote about becoming “more open-minded and able

to make decisions for myself.” Maya also became a stronger woman because of this process. She wrote, “I have learned not to be afraid to think for myself, do research if I don’t like what is presented to me. Having a baby is not something to be feared but cherished.” Maya also noted a difference in how women perceive their childbirth experience based on where they gave birth. She wrote, “that the women who explain labor as painful gave birth in a hospital and women who gave birth at home had a very different description”.

Susie

Natural childbirth.

Susie first became aware of the idea to have a home birth when a friend of hers planned one. Susie wanted a natural birth experience. Susie was present when her sister labored in the hospital. Her sister had an epidural and Susie found it “unnatural” that her friend slept through her labor because of the epidural. She also noted that “the birthing experience doesn’t get easier for the baby as it does for the mother with an epidural”. After this experience it became more important for Susie to be an active participant in her natural childbirth experience, and Susie believed she had the best chance of achieving this goal at home.

Because of Susie’s commitment to a natural birth experience, she decided she would be better able to pursue it at home. Susie believed the hospital would hinder this experience:

I think if I was to try and do a natural birth in the hospital the nurses would be annoyed to have to take the [fetal] monitor off and on. I also felt like I wouldn’t

be able to birth in a position of my choosing -- I also felt like I would feel inhibited or pressure to conform in a hospital environment.

Because Susie views childbirth as a normal, natural event “and not a pathology”, and “the hospital is where you go when you are sick”, Susie choose “not to plan a hospital birth because I wanted to approach this birth the most natural way possible”.

Medical model.

Susie was clear in her decision to work with a midwife instead of a medical doctor or certified nurse midwife because of the different level of care she received from a home birth midwife:

I also chose a homebirth because I wanted to work with a midwife. It was shocking to me to learn that there were only 6 nurse midwives that were able to deliver at the hospital, we are very limited on our choices in Ft. Collins -- no birth center either. I felt like 3 of the nurse midwives at the Women’s Clinic were almost just like choosing an Ob-Gyn -- you couldn’t choose one -- you would see one of the three at each of your visits and one of the three would be with you at the hospital. However they were just like doctors in the fact that most of your care would be done by the nurses and they would simply deliver your baby. This to me was not the true midwife experience. They are still educated on the medical model therefore the approach is more medical than natural.

Susie believed that hospitals “don’t have experiences with natural medication-free births” and that therefore the hospital would not be a good fit for her. Susie felt that home birth midwifery care was “much more personal care and much more woman centered”.

Power and control.

Susie saw issues of power and control in her decision to plan a home birth. She wrote about the importance of feeling “comfortable” and being able “to act however I choose, be vocal if I wish -- control the environment and who is there”. Susie believed that by taking control of her birth experience she, along with her husband and her midwife, would be in a position “to make the best decisions for me and our baby”. Stacy defines control:

To me, control means taking charge and asking for what I want. It means not feeling vulnerable to someone else telling me about my body. There is a time — place for that but in a normal, healthy birth my body knows what to do and how to do it. To me, control means trusting myself and my body without being influenced by OB nurses and doctors with different expectations— to be in control means not feeling like I will have to act in a way or do something that I don’t want to do.

For Susie, control was about being in charge of her childbirth experience.

Intuition.

Intuition was also helpful to Susie in making the decision. She wrote in her journal about doing some reading to learn more about home birth, although she “really knew all along” that home birth was what she wanted. She wrote that she “felt a little relieved thinking about having this baby my way in my own space”. Susie wrote that while she knew she wanted a home birth, her husband was a little unsure, so she did meet with an obstetrician-gynecologist. Susie wrote that “My gut was telling me this whole time, this is not what I wanted” and so she “ultimately went with my gut at that point and

had decided on the home birth prior to leaving the Dr's office. . . The midwife just felt right.”

Partner.

As mentioned, Susie's husband was apprehensive about the decision to plan a home birth. He had concerns and fears about home birth not being a safe option, especially when all of the technology was available at the hospital. He already had two children born in the hospital from his previous marriage who were healthy, although the hospital births were not ideal for his ex-wife. However, after Susie had him watch a couple of films and read parts of books, he made the decision to support her. “I think in the end he trusted me and supported and even embraced the idea.” Susie noted that she “wanted his support” but that ultimately she “really felt I had to do what I felt was right and my gut always said home vs. hospital”. Again, an example of how her intuition guided her in this decision making process.

Lessons Learned.

Susie wrote about learning more about local childbirth options. For example, she learned “that there were only 6 nurse midwives that were able to deliver at the hospital, we are very limited on our choices in Ft. Collins—no birth center either”. Susie learned a lot about what did not like about our current childbirth system, such as the cascade of interventions common in hospitals, and about the history of childbirth and how our system came into being. Through her education she gained “confidence in the ability of my body to birth and be able to do so at home”.

Suggestions for other women.

While Susie was not directly asked to write about her suggestions for other women, when writing about other aspects of her decision making process she wanted to share she wrote about her recommendations:

I think you have to do what's best for you and your family and what is comfortable for you. Don't make fear based decisions. Do your own research. If you have a normal, healthy pregnancy and your want a natural child birth experience, home birth may be the way to go!

Here Susie encourages women to think for themselves and give the option to plan a home birth some consideration.

Lynn

Lynn had already had her baby and so she sat for an interview.

Medical model.

For Lynn, issues of avoiding a medical model of childbirth and issues of power and control were entwined. In planning her home birth Lynn discussed choosing to avoid a hospital birth. Lynn perceived the hospital as a restrictive place where her choices and freedoms would be limited. Lynn saw home birth as being a more "gentle way" of approaching childbirth. With a home birth Lynn believed she would be able to avoid the bright lights of the hospital "and people taking him away to do different things and instead of giving us that time and that chance to bond". She was looking for a particular experience and "didn't think a hospital situation would allow me to do that". The option to plan a home birth became more appealing to her.

Power and control.

Issues of power and control came up multiple times during Lynn's interview. Lynn wanted to labor in a way that felt right to her and she was afraid she would not have that freedom in a hospital setting. She described herself as "a shy person" and that she faces "challenges best when I can kind of do it alone and think it through". Lynn describes childbirth as a challenge she wanted to do herself and that she didn't want anyone to take away her power:

I just knew that if I was in a hospital situation that I would turn all that over to the doctors, to where my doctor was and I knew that I wouldn't feel that power within myself or that strength within myself that I would feel in such a vulnerable position that I would want the experts to take over and so I really wanted to do this for just myself.

Lynn wanted to be the expert at her birth: "Just for me to be the mom in that situation than to have the experts take care of him." She reported having a greater sense of feelings of power and control in a home birth experience than a hospital birth experience. In her home birth, Lynn was able to have music, a tub, and food and beverage when she chose. For Lynn, control meant being the one "to make the decisions".

Natural childbirth.

Lynn discussed working to live her life in a more natural way. This vision included working for a person in the natural health-care field, growing her own food, and eating organically. As a result of this life vision she "wanted to birth more naturally" as well.

Intuition.

Lynn reported that while she is a “pretty heady” type of woman who “tends to think things through”, she also believes that she is intuitive. When asked how intuition played a role in her decision making process, Lynn said that she had not given it much thought, but that it was part of the process: “I know it did play some part ... I wanted to bond with my baby during that time of coming into the world. I think that was more of the intuition coming into play because that’s not something that’s really logical.” Lynn also talked about how she learned to trust her intuition more through the process of planning a home birth.

Partner.

Lynn discussed how her partner was “very open” to her decision to plan a home birth. This was in part because when his daughter, Lynn’s stepdaughter, was born it was “a very traumatic hospital experience”. Lynn discussed how he also wanted to be supportive of whatever she wanted to do because she was the one giving birth.

Lessons learned.

Through the experience of planning a home birth Lynn learned to trust her self, her body, and her intuition. Now that she is a parent, she pulls from that inner strength to be a better parent. She knows now that if she can give birth, she can be a good parent. Lynn also learned that she could depend on her husband for support.

Suggestions for other women.

Lynn had several things she would share with other women. First of all, she wanted to share her experience and “encourage other women to consider the home birth option -- that it’s not a scary, archaic thing”. Second, she encouraged women to educate

themselves and not to “totally depend on the medical field and relinquish our power in that way”. Lynn believes that sharing education in itself is an “empowering and powerful thing”. Third, Lynn’s last words of wisdom regard the pain of labor and childbirth. She wants women to know that childbirth pain is “pain with a purpose” and that “pain doesn’t necessarily have to be a negative thing”.

Rose

Medical model.

When she first became pregnant Rose had an unsatisfactory appointment with a medical doctor. When she asked the doctor what foods are high in folic acid and the doctor could not answer her she took that as a warning sign that she was not in the right place. At the time Rose was living in a small community in the mountains and home birth was not an option there, so she moved to Fort Collins where it would be. Seeing a home birth midwife was a very different experience for her than seeing a medical doctor:

I really liked [my midwife] a lot and the reason I chose to go with her is because she is so homeopathic and when I walked into her office, she had a whole row of herbs up on her top shelf, and I was like, “oh that’s great” and she said to me the first time, “oh you rode your bike over here. That’s great, even though you’re pregnant you can keep riding your bike,” and I was like, “that is exactly what I wanted to hear, that’s great”.

Rose describes herself as being “deathly afraid of hospitals”. She considers hospitals to not be “welcoming places; they are not about healing” and that she does not want to go to the hospital unless it is absolutely necessary. She therefore felt that planning a home birth was a good option.

Power and control.

Rose stated that she “wanted to have control over the situation” and she wanted to have the freedom to make choices. In terms of planning her home birth, Rose liked that she would not be asked whether or not she wanted pain medications and that there would not be pressure to be induced. She liked that she would have choices such as being naked, having a birth ball, laboring and/or giving birth in a tub, and having her husband and dog present. She did not believe she would have these freedoms in a hospital setting.

Natural childbirth.

Rose wanted to avoid a cesarean section because of the importance of a baby going through the birth canal. Rose discussed how something is not quite right with children today and she hypothesizes this may have something to do with childbirth:

Kids nowadays are . . . something’s not quite right. Something’s missing.

Common sense or intuition, or something’s not there. People are violent and they’re mean and they don’t see any consequences in that, and they don’t have a greater connection to people to understand exactly what they’re doing and so I think that has a lot to do with it. I think parents being drugged up when they have kids is... it has an effect; you can’t say that it doesn’t. I mean, if you know anything about your body I mean you know it does, you just know. I don’t have to be a doctor to know that so...

Natural childbirth was important to Rose, and she believed it would be good for her baby as well. She wanted her baby to “come out into an atmosphere that wasn’t sterile and full of bright lights and being whisked away, but into a place where he’s going to be for a

while at home”. It was important to Rose that her child be born into a comfortable home and that their dog be present.

Intuition.

Rose believed that childbirth was an “instinctual” process. She and her midwife believed in the importance of listening to and following one’s instincts in the childbirth process. Rose describes her choice to plan a home birth as using her intuition. “I think it really was just instinctual, that it was the safest place for me to have a baby, where I would feel most comfortable.” She also trusted her body to tell her if anything was wrong during the pregnancy and childbirth experience.

Partner.

Rose describes her partner as being “very supportive” of her decision to plan a home birth. He also wanted the decision to be her decision: “he wanted me to make the decision as far as what was best for me and that would be best for him”.

Lessons learned.

Rose learned to have a new respect for her body and its abilities following her home birth experience:

I didn’t know this at the time [when planning the home birth], but how much it empowers you as a, as a woman, I had no idea that it was going to make me feel the way that I feel now. I’ve always had the body issues and I remember umm looking in the mirror a couple weeks after I had give birth and I was like, “Damn! Your body is so amazing, it just, you just like gave birth to a human being and it just keeps on working and it just can take care of a baby. You haven’t slept and it’s making milk and it’s just doing all of these things,” and it’s just amazing. I

had no idea that I was going to feel that way and really appreciate my body. You know, I've always been mean to it, like it's not good enough you know, you're not skinny enough or whatever. And after that, I was like "Man, you are amazing. You deserve the utmost respect."

Rose discussed treating her body better following her home birth. Rose discussed how this was a new way of thinking for her because of previously having an eating disorder.

Rose also discussed a new bond she feels with women, and mothers in particular. She thought it was "neat" that she would "see a woman with a baby and automatically have something to talk about."

As a consequence of planning a home birth, Rose found herself increasingly interested in childbirth. She wants to let other women know they can plan a home birth too.

Through this experience Rose found greater value in her interpersonal relationships. For example, Rose learned "how amazing my husband is" by how he supported her decision to plan a home birth and how attentive he was during the birth. She learned how much home birth can do for an intimate partnership. Prior to being pregnant, Rose has found it easier to be friends with men than women. Now, because of her home birth experience, she has learned how much she likes talking to and connecting with women. Rose also talked about how her relationship with her own mother has improved since her home birth, and that she now sees her mother in a different way. For example, she is now more patient with her mother. She also feels a great deal of love for her midwives and the role they play in her life and the lives of other women.

Finally, Rose learned about self-empowerment. She was very clear she was not referring to power over anyone else, but an “instinctual, innate ability to do anything”. She credits the pain of childbirth for this sense of empowerment: “it’s the most pain you’re probably ever going to have in your life and you can look at it in the face and handle it and get through it”. Rose wants to teach childbirth education in the future to be able to teach other women about this power that they innately have. She is also interested in attending births.

Suggestions for other women.

Rose suggests that women and men watch *The Business of Being Born*. She recommends natural childbirth and also that women work to create the childbirth experience in which they are the most comfortable. She wants women to know that the pain is really for just a short while. Rose sees that men are also interested in childbirth and sees a need to get them more involved.

Trixie

Trixie first learned of the option to plan a home birth when her step mother had a child at home. When she became pregnant she had already decided to work with a midwife.

Medical model.

Trixie talked about wanting to avoid the hospital unless it was a necessity. She wanted a natural childbirth experience and thought it would be more difficult to achieve that in a hospital setting. When asked if she chose a homebirth or she chose not to have a hospital birth, Trixie replied that in the beginning she was choosing not to have hospital birth. She went on to say that over time her through process

changed, and she felt that she was really choosing home birth in the end. Additionally, Trixie preferred the germs already present in her home to the germs in the hospital. She considered hospitals to be unclean. Trixie also reported having some apprehensions about the medical model and how it pushes for induction when a baby is late.

Power and control.

Being in control of her childbirth experience was important to Trixie. It was very important to her that whoever she was working with would “let me do whatever I needed to do”. She wanted freedom to “do whatever felt most comfortable to me”. Trixie believed that giving birth was a normal process and she did not want anyone telling her how to do it. With a home birth, Trixie felt freedom. She said, “I could do whatever I wanted . . . I mean totally comfortable and safe”.

Trixie appreciated that the midwife gave her a lot of information and choices during the planning process. Planning a home birth enabled Trixie to think more about the various tests and potential interventions, and her midwife would make recommendations but left the decisions up to Trixie and her partner. This freedom and process “felt good” to Trixie.

During her childbirth experience, Trixie appreciated that she “could allow labor to progress at its own rate” and that she “didn’t feel like people were interfering”. This gave her more control over her experience. Trixie liked that she did not have to worry about anyone such as nurses interfering with her labor. She did have her partner and her midwife there “to offer suggestions” and to offer support, but they were “definitely open to whatever worked best for me”. Trixie “felt like I was in control of what happened to me” during her pregnancy and labor and that she “didn’t feel like I had to fight for it”. It

was important to Trixie that she not turn her control over to someone else, and planning a home birth enabled her to hold onto that control.

Natural childbirth.

Trixie reported a strong family history of women having positive natural childbirth experiences, including her mother and stepmother who gave birth naturally, and an aunt who is a midwife:

I kind of grew up around natural...having a natural birth is normal and do-able and there isn't any... that's what our bodies are made for. So I think that's probably what influenced me the most is the knowledge that , yes this isn't something I need to worry about, I can do it and I can do it in my own way.

Natural childbirth was a theme that ran throughout Trixie's interview. She wanted to avoid the hospital and any of the "typical medical interventions" including drugs and electronic fetal monitoring because she wanted the freedom to be able to move around during labor.

Intuition.

Trixie describes intuition as being a big part of her decision to plan a home birth. She described how even thinking about the hospital would bring up feelings of anxiety for her, and so she knew that was not going to be a good option for her. When Trixie met with the midwife, she "just said yeah this is it, this is what I want to do". Working with the midwife to plan a home birth felt "really comfortable" and "like the right way to go". Trixie talked about how she never questioned her decision and "knew it was the right choice" even though this was her first child and she had not experienced pregnancy, labor

or delivery before. She liked that she “felt comfortable”. She let her intuition guide her decision making process.

Intuition also told Trixie that childbirth was a natural process and that she could trust herself and the process:

I’m pretty aware of my body and I didn’t want anybody to tell me that... I feel like I was pretty aware that I wouldn’t have any issues birthing a baby. I feel like it’s normal. It’s not something strange. Women do it everyday without complications and so I really just wanted to be as comfortable as possible. So I’d say intuition was really a huge factor. And I listened.

Trusting her body during her pregnancy and childbirth experience was an aspect that came up several times during the interview: “I just trusted that it would do what it needs to do”. Listening to her intuition was a guiding part of Trixie’s decision to plan a home birth.

It also felt normal and natural to Trixie to have her pets present at the birth. She appreciated having her cat keep her company during labor and the dogs coming in periodically to check on them after the baby was born. Trixie believed giving birth at home contributed towards a smoother introduction between the pets and the baby.

Partner.

Trixie’s partner had no objections to her planning a home birth and “he was willing to go with whatever made me the most comfortable”. He was very interested in a natural birth process and attended most of the meetings Trixie had with her midwife. One aspect that was challenging to Trixie’s partner was that his family was not

supportive of the decision to plan a home birth. They questioned him on the decision and had concerns about her care.

Trixie discussed liking that her partner could really be present for the home birth and not have to act like “a doorman” or “a guardian”, which is the role she believed he would have to undertake had they given birth in the hospital in order to have a natural birth experience and protect themselves from interventions. She also liked that he did not have to go anywhere like a cafeteria if he wanted to get some food and he could therefore be present for the entire experience.

Lessons learned.

Trixie learned the importance of trusting herself and trusting nature. She learned that we, as a culture, are getting further and further away from trusting in nature. She now feels more strongly about natural childbirth and the option to plan a home birth, and at the same time acknowledges that women need to make the decision that feels the most comfortable to them. Trixie also has more concerns now about routine interventions and tests, such as ultrasound.

Suggestions for other women.

Trixie suggests that other women look into alternatives when planning their childbirth experience, that they ask questions and do their own research. She advises women to trust their own bodies, really listen to themselves, and not worry what other people might think. She emphasizes the importance of not turning control over to another person, that women can trust themselves and “choose what’s best for you”.

Janet

Janet's pregnancy was unplanned, but her "first thought was that I would want to do a home birth and that was based on friends who had successful homebirths and were really happy with it".

Medical model.

Janet felt that if she were to give birth at the hospital, there would be people offering her drugs or telling her what to do, and not really listening to her or what she wanted. When she first began looking into options for her birth she was choosing to not give birth in the hospital. Over time, this rationale changed and she was more actively making the choice to plan a home birth. Janet discussed having a healthy pregnancy and that she "never had any reason in my mind to go to the hospital". She preferred being in a place that was more comfortable.

Power and control.

Janet appreciated that she had control over her childbirth experience in a home birth setting. She, her partner, and their midwife "were all very clear on how much I wanted help and in what context ... as opposed in the hospital I wouldn't have that power".

Janet described home birth as feeling "more connected". She appreciated that there were not "people intervening and pushing things on me: and that things were going to be in her control. Janet described planning a home birth as "empowering", and that these feelings of empowerment have stayed with her.

Janet wanted the freedom to labor in a tub. She did not think she would get that option in a hospital setting.

Natural childbirth.

The theme of natural childbirth did not come up a lot during the interview, but Janet did mention the importance of giving birth without using drugs. Janet discussed the mantra she used during labor: “I can do this, my body can do this and it was meant to do this”. She had trust in her body’s ability to give birth naturally.

Intuition.

For Janet, “intuition played a big part”. She described how she “just knew my body could do it”. Janet trusted in her confidence in her body. She was in the best physical shape she had ever been in. She said, “we were sure we could do this. I had no reason not to, I guess.” Janet said that “it felt right inside for me to do it”.

Partner.

Initially, Janet’s husband was somewhat skeptical of planning a home birth. However, after meeting with the midwife and watching the film *The Business of Being Born* he felt more comfortable with the decision.

Lessons learned.

Through the process of planning a home birth, Janet confidence in herself was boosted. She learned a lot about biology and how the female body works, which she found amazing. Janet learned more about emotions and love, “I learned emotionally that I was capable of loving someone on a whole new level”. Janet also discussed learning more about the beauty of community because of the way people came together to support her during the birth process in a “really intimate setting”.

Suggestions for other women.

Janet discussed being a big supporter of planning a home birth and does not see any reason for women to go to the hospital to give birth if they are healthy and confident and it feels right. She wants women to know it is an option and is happy to share her experience in order to educate people.

Ella

Medical model.

Ella has always been “leery of doctors” and had heard “scary” things about hospital births, while had heard of home births being portrayed differently and more positively. Ella and her partner interviewed a Certified Nurse Midwife, but at that particular clinic were told that while the CNM would do all of the prenatal care, a physician would have to do the delivery. This did not feel good to Ella and her husband, so they began looking into home birth options.

In planning her home birth, Ella was trying to avoid a hospital birth because she “just felt scared and nervous thinking about being in a hospital”. Avoiding the hospital was very important to Ella: “I would have gone to anyone’s home...I would have gone to my midwife’s home, my mother-in-law’s...my best friend’s, you know, anybody’s home, to avoid a hospital. If ours collapsed and burned to the ground, I would go to someone else’s”. Ella said, “thinking about being in the sterile hospital can be a scary thing”, and thus a thing to be avoided if at all possible.

While Ella “knows they are better about it now”, she still harbored a fear of the hospital staff taking her child away from her after the birth. Additionally, she “didn’t want them poking and prodding and treating him like he was cattle or something”.

Power and control.

Being able to birth at her own pace was important to Ella, and she believed she was more likely to gain that aspect in planning a home birth.

Ella also liked the choices and freedoms home birth offered, which she thought she might not be able to have in a hospital situation. One example she gave was being able to labor in the tub or lay wherever she wanted, whereas in the hospital “you have to be hooked up to the machine and all the different protocols that hospitals have to go with”. Ella wanted freedom from those rules and protocols. She liked that children and animals could be present at a home birth.

Natural childbirth.

Natural childbirth was a priority for Ella: “I knew I wanted to have a natural birth without medication”. Ella believed that in the hospital the staff would be repeatedly offering the option of an epidural, which they did not want, and she really wanted to avoid an epidural:

I started getting [interested in] the biological aspects of how your body actually works through labor and how your body deals with pain naturally and how having an epidural or anything that would stop the natural process like getting up and moving or changing position or whatever. It could make it worse for you in the long run, so that was a big part of it.

Planning a home birth was a way for Ella to avoid an epidural and be able to rely more on natural techniques.

Intuition.

For Ella, planning a home birth “felt more secure and calm” than planning a hospital birth. Additionally, she wanted to be in an environment which incorporated intuition. She saw medical doctors as being intellectual, but not listening to their intuition. Ella said, “I’m going to show everybody that I can do this”.

Partner.

Initially, Ella’s partner was concerned about planning a home birth. Ella said, “He thought it was risky, and that there should be doctor there”. He was concerned that something might go wrong. However, once he was informed about home birth he was supportive. In the end, he ended up as the labor assistant because the assistant did not have time to get there.

Lessons learned.

Ella wants to “help change that view of birth and the more people I can tell, ‘hey, it’s not really that bad’, the better off women would be. Not be subjected to the patriarchal version of how a birth should be: in stirrups and like.”

Ella learned that she “can do anything I want”. She learned that “birth isn’t scary; it’s natural. It’s actually kind of fun”. Now she wants to let other women know this, and wants to be a Bradley Method instructor.

Suggestions for other women.

Ella suggests that women educate themselves and really think through their decisions. She suggests taking The Bradley Method classes while pregnant. She

recommends “just being informed and making decisions based on what you learn, not just what your doctor gives you as advice”.

Maggie

Maggie did not consider a home birth until she was three months pregnant. She had been meeting with a CNM group but the experience did not meet her expectations because it was not very personal. She knew she wanted something else. However, even after all of her careful planning and consideration, she had a complication which required her to have a hospital birth. While she was not able to have the home birth she had planned, because of her education and planning, she was able to find a doctor who honored her choice to birth naturally. Unfortunately, she did not feel “quite safe or comfortable” while in the hospital and had a difficult time trusting herself because of all of the people around. In looking back, she believes this hospital birth was not warranted and that she would have been fine with a home birth. For her second child there was the same complication and the home birth went smoothly.

Medical model.

Maggie was not satisfied with the more medicalized approach to pre-natal care she received with the CNM group. She felt it was impersonal and felt like a number. Maggie felt like “there was no talking about the experience or really educating you about anything”. Maggie wanted to go through such an “important monumental experience... with somebody I had a relationship with”. Maggie was concerned about “the C-section rate and how drugs can be kind of almost pushed on you sometime and I started learning about how it is just so often treated as this medical emergency”. This view of childbirth was in conflict to Maggie’s view that childbirth is a normal, natural process. Maggie did

not want “a lot of interventions from nurses and doctors and...beeping machines and people telling you whether or not you can sit or lie down”, all of which are more consistent with a hospital birth experience.

Power and control.

Maggie was excited to plan a home birth because she would be in her own comfort zone and have freedom without being pressured to take drugs. Maggie liked that she would be making decisions and be in control of the childbirth experience as opposed to the hospital where there would be feelings of “helplessness”.

Maggie wanted to be able to listen to her body:

I really felt like this way I can be doing what my body tells me I need to be doing...I need to walk or if I need to be sitting up, squatting or if I need to eat a snack or have something to drink. It just made me feel like I could listen to my body. I did feel that my body would know what to do.

Maggie trusted her body’s wisdom throughout this process.

Natural childbirth.

Even prior to starting to plan a home birth, giving birth without drugs was important to Maggie. She viewed childbirth as “a natural process that women have been doing it since the beginning and so I just wanted to experience it that way”. In planning her home birth, she said she was working to have a home birth rather than avoiding a hospital birth. The entire process was important to Maggie: “I just wanted to have the real organic birthing experience . . . just really experience it and be able to be present for it, and be able to hold on to that experience is something that I was really there for”.

Towards the end of her pregnancy when Maggie had to stop planning her home birth and start planning for a hospital birth, she consulted with a doctor her midwife recommended:

He was really just willing to let the natural processes happen, he wasn't into like inducing people and scooting things along and just making sure that they fit into his schedule, so it was somebody that my midwife knew and um, we had planned all along that she would still sort of act as the doula. She would be here, she came in while I was laboring at home, and she went to the hospital with us and stayed with us there.

The natural birth experience was still of great importance to Maggie even though she had to give birth in the hospital.

Intuition.

Maggie let her intuition guide her when selecting a care provider to help her plan her home birth:

My intuition told me that I didn't feel comfortable with the setup that I had initially, just with not having relationships. And when I did meet my midwife, in the first you know, visit or so I did really feel, like it just felt right and I felt really comfortable with her and I just you know, kind of all of a sudden I was just really excited for the whole process because it seemed more right, to build a relationship, to have longer prenatal appointments where you're really talking about I mean, if it's you're emotions or your feelings or prenatal care.

This connection and relationship was of great importance to Maggie and is a theme throughout her interview. "I developed this one-on-one relationship with the midwife

and just felt so comfortable with her and just trusted her so much...on more of a level than just being able to deliver a baby, but just on a emotional level I trusted her.”

Maggie also intuitively trusted in the childbirth process. She said, “I think ultimately we decided that we just needed to trust in the process, that it would be ok, and that we were with a skilled professional who’s done this and that women have been doing it since the beginning”.

Maggie described some feelings of failure because she was unable to give birth at home:

While I was planning [my first home] birth because I did...I had felt that I had failed in some ways with [the first] birth because I was so uncertain and maybe it was like the first-time mother thing that I was...I just didn’t know what it was going to be like and I was so scared and doubtful, I didn’t think I could do it.

Maggie went on to say that in retrospect, she sees that it would have been fine to give birth at home, but that she did not know any better when she had to make the decision.

Partner.

Maggie describes her husband as being “really, he was really supportive” of the option to plan a home birth, and that his role in the decision making process was to support her. Maggie also said he came to her initial appointment and met with midwife and thought the home birth plan seemed “really great”.

Lessons learned.

Maggie talked about having more trust in her body as well as her emotional self as a result of planning a home birth. Maggie learned she really wanted to have a home birth and not a hospital birth experience. She also feels closer to her husband now.

Suggestions for other women.

Maggie suggests women educate themselves and talk to women who have had hospital births and those who have had home births. She encourages women to think for themselves and not just trust their doctors. She encourages women to read birth stories. She also advocates that women make the decision that is best for them. Maggie recommends home birth to women because it is an “intimate and empowering and beautiful experience that I think some of those things you miss out on in the hospital and certainly missed out on if you do drugs...I think if you’re not quite present for the birth”. She wants to tell women to be present for their birth experience and to remember it. She also recommends getting breastfeeding support from a midwife.

In conclusion, important themes for first time mothers in planning a home birth included avoiding the medical model typically used in hospitals, issues of power and control, the importance of natural childbirth, the role of intuition, and the woman’s partner’s perspective. Additionally, women shared lessons they learned while planning their home birth experience and suggestions for other women.

CHAPTER 5: DISCUSSION

Introduction

When pregnant, the majority of women plan a hospital birth while less than 1% of women give birth at home (Martin, et al., 2007) even though home birth is a safe, satisfying option for low-risk women and newborns (Anderson & Murphy, 1995; de Jong, et al., 2009; Durand, 1992; Hutton, Reitsma & Kaufman, 2009; Janssen, Carty, & Reime, 2006; Johnson & Daviss, 2005). These numbers and percentages also vary state to state. For example, in Colorado more than 1% of all births are in the home, which is significantly higher than other states (MacDorman & Menacker, 2010). This qualitative study incorporated journal writing and interviews from nine women who made the decision to plan a home birth with their first child. In order to frame this discussion, I will review the purpose and methodology used in this study, review the major findings within the context of Bronfenbrenner's (1979) Ecological Systems Theory, discuss implications for action and end with recommendations for further research.

Overview of the Problem

Purpose statement and research questions

This study sought to answer the question of how do first-time mothers describe the influential factors in their decision making process to plan a home birth from their

initial consideration to its implementation. As described in Chapter 3, Lamanna and Riedmann (2009) discuss the differences between default decision making versus knowledgeable decision making. While some decisions are default decisions in that there is not a great deal of thought put into them, making the decision to plan a home birth is more of a knowledgeable decision made up of many questions and much education.

Review of the methodology

Data were collected in two ways for this study. Women who were pregnant wrote answered sentence completions in journals (see Appendix XX). Women who had already had their baby were interviewed. Three women completed journals and six women were interviewed.

This study utilized Interpretative Phenomenological Analysis (IPA). As Willig (2001) stresses, IPA is a method in which it is acknowledged that this research is an interpretation of the participants' experiences.

Data were analyzed by finding common themes within the journal and interview transcripts. These themes will now be discussed utilizing Bronfenbrenner's (1979) Ecological Systems Theory.

Major Findings

Ecological Systems Theory

In order to frame the discussion of cross-case themes, an Ecological Systems approach was taken. Table 1 shows themes from each of systems.

Table 1
Ecological Systems with examples regarding influential factors in the decision to plan a home birth

System	Examples from the women
Center	The mother and her characteristics: gender, geographic location, class, education, health, spirituality, simple living value, independence, and age; Feminism; Intuition as a guiding force
Micro-	Close friends and family members; husbands and partners; midwife and assistants
Meso-	Relationship between woman and midwife; relationship between woman and her partner; relationship between the woman and her baby
Exo-	Policy makers in the medical field; geographical legalities surrounding home birth; insurance companies and their policies regarding home birth
Macro-	Cultural beliefs about how women should give birth, especially related to the medical model
Chrono-	Dimension of time: changes in thinking about the decision to plan a home birth over time: Women felt more confident about their decision over time

Center System

The Center of the system represents the individual woman. It includes her personal characteristics and values. As detailed in Chapter 4, for women in this study it includes being partnered or married, Caucasian, or for Lynn, Caucasian-Asian, and having a minimum of three years of college education. Common values include gender, class, geographical location, and being strong, independent women. Intuition was a guiding force for these women.

While the term feminism was rarely used by the women, it did appear to be one of their guiding values. Linden did discuss how home birth was a feminist choice for her:

With regard to gender, I feel very strongly that birthing a child is a powerful rite of passage for women and is an intensely feminine experience. The medical model has intervened in this natural and beautiful process in a way that I find to be disempowering to women. I think hospital births do more to support insurance companies & doctors (mostly men) than moms, babies, and families. I consider

choosing homebirth a feminist choice – a choice that advocates for justice for me & my family.

Other women did not use the term feminism, but did discuss some values common to feminism, such as independence, strength, and control. For example, Ella wanted to be clear she did not consider herself a feminist. “I wouldn’t call myself a feminist because I am not going to go burn my bras; I still like bras. I’m not going to like shave my head or something.” Ella is basing her belief that she is not a feminist on stereotypes and not on the true meaning of feminism. Professor, author, and social activist bell hooks defines feminism as, “a movement to end sexist oppression” (hooks, 2000, p. 33). Hooks makes sure to clarify that feminism “does not privilege women over men”, as is a common misconception (p. 28). Ella goes on to pronounce some true feminist beliefs about women and childbirth:

I do believe that women don’t realize their full potential and [planning a home birth] was part of the way to change. You know, to start the ball rolling because for the last period of time... There was 50 years or something that it was illegal to have your baby at home... So the more I can help change that view of birth and the more people I can tell, “hey, it’s not really that bad”, the better off women would be. Not be subjected to the patriarchal version of how a birth should be, in stirrups, so that part too. I’m going to show everybody that I can do this, and I can, and I will.

In planning her home birth, Ella is actively working to end the sexist exploitation and oppression seemingly inherent in the hospital birthing system. She is seeking to empower women into making decisions for themselves.

Microsystem

The Microsystem includes those systems in which a woman is in direct contact: her family, workplace, religious institution. Overall, women found those in their Microsystem to be helpful and supportive of their decision to plan a home birth. Occasionally, women mentioned their parents feeling scared of the decision to plan a home birth. Women dealt with this by providing education to their parents and continuing conversations with them.

Mesosystem

The Mesosystem is the relationship between one component of the Microsystem and another. An example is the relationship of the woman and her midwife. As a Marriage and Family Therapist, I recognize the tremendous importance of relationships. The women echoed this importance. For example, Susie spoke about the importance of the relationship she had with her midwife. Maggie spoke about how her relationship with her husband became stronger while planning her home birth.

Exosystem

The Exosystem includes systems with which the woman may not have direct contact, but can still impact her decision making process. Policy makers make it challenging for women to have the offer to plan a home birth. In Chapter 2, the ability to home birth in the state of Wyoming was addressed. Very recently, the laws in Wyoming changed. According to newly adapted legislation, midwives will now be able to become licensed in Wyoming and women will be able to have the option to plan a home birth (Wolfson, 2010).

Several of the women mentioned geographical location as a factor in planning their home births. They discussed how this was a factor because home birth is not accessible everywhere due to various policies.

Macrosystem

The Macrosystem includes societal beliefs and attitudes. In the culture of The United States, it is expected that women will give birth in a hospital setting with a medical doctor. In order to give birth at home, women have to go against what is a cultural norm. For some women this can be challenging. Susie addressed these societal norms and how she dealt with them:

There of course is always this part of you, the voice of society that is rules by fear which asks, “what if...” So, at first I had to do a lot of reading to really figure out what was right for me, although I really knew all along.

Susie combated the “voice of society” by listening to herself and her intuition.

Chronosystem

The Chronosystem incorporates the dimension of time. Over time, women’s confidence in their decision to plan a home birth became stronger. This appeared to be because of increased education on childbirth and increased confidence in themselves to give birth naturally.

As seen from this discussion and Table 1, the further away from the Center System the less support a woman is likely to find for her decision to plan a home birth. Women, in the Center System, supported themselves. Moving through the Micro-, and Meso-systems, the women found support from family, midwives, close friends, and relationships. When moving on into the Exo- and Macro-systems, this support

deteriorated due to policy makers and cultural beliefs. However, when adding in the Chrono-system, women gain confidence in their decision to plan a home birth over time.

The further out on the systems model, the more hindrances women felt. As a result many women kept close to their inner circles during their pregnancies.

Findings Related to the Literature

Issues around child birth such as childbirth satisfaction, control, and agency were identified in Chapter 2 as being important in choosing to plan a home birth. Another issue identified was the history of home birth and midwifery. All of these issues will be re-addressed in this section.

History

As outlined in Chapter 2, there has been a push to eradicate midwives from the childbirth industry. For study participant CCC, this was a reality. Rose was living in a small mountain community in Colorado when she realized she was pregnant. She was dissatisfied with the pre-natal care she received from a medical doctor there and desired to plan a home birth with a midwife. Unfortunately, there were no midwives available in her area. Rose ended up relocating to Northern Colorado in order to obtain the midwifery care she desired.

Satisfaction

Waldersstrom, Hildingsson, Rubertsson, and Radestad (2004) noted that the factors of a negative birth experience include feelings of lacking control during the birth process, mothers' inability to participate in the decision making process about their own care, lack of time during antenatal checkups for the woman's questions to be answered, and inadequate support from the attending physician during the delivery. Many of these

reasons are why the women in this sample chose to plan a home birth; they wanted longer appointments, a feeling of control, and to be able to participate in their own birth process.

Other women choosing home birth report satisfaction with their choice. In British Columbia, Canada, the experiences of over 500 women who planned home births were reported (Janssen, Henderson, & Vedam, 2009). The authors report the women in their study were “extremely positive” about their experience with planning a home birth (p. 302). They identified the theme of feelings of empowerment and also reported that the women experienced significant emotional and informational support from their midwives.

Control

As addressed in Chapter 4, the issue of control was a significant one in this study. Similarly, Janssen, Henderson, & Vedam (2009) found that home birth as a way of maintaining control and avoiding intervention. The mothers in Boucher, Bennett, McFarlin, and Freeze’s (2009) study of 160 women in the United States also reported choosing home birth because it could be intervention-free and because of issues of control.

Agency

Because women in this study and others desired to have control over an intervention-free birth, they opted to plan home births. It appears that for many women this is a well thought out decision. Boucher, et al. (2009) describe the women in their sample as making “a careful choice to birth at home” because they felt “that routine obstetric interventions were not safe” and make the knowledgeable decision to birth at home (p. 124).

Women's Ways of Knowing

As previously described, Belenky, Clinchy, Goldberger, and Tarule (1997) speculate that women gain knowledge, truth, and authority differently from men. In their research, they describe a continuum encompassing five different perspectives:

- *Silence*: a position in which women experience themselves as mindless and voiceless and subject to the whims of external authority
- *Received knowledge*: a perspective from which women conceive themselves as capable of receiving, even reproducing, knowledge from the all-knowing external authorities but not capable of creating knowledge on their own
- *Subjective knowledge*: a perspective from which truth and knowledge are conceived of as personal, private, and subjectively known or intuited
- *Procedural knowledge*: a position in which women are invested in learning and applying objective procedures for obtaining and communicating knowledge
- *Constructed knowledge*: a position in which women view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing (p. 15)

While women planning home births are at various points on this continuum, probably in either the subjective, procedural, or constructed knowledge realms, I speculate that women planning hospital births are often times in the realm of silence, or end up there soon after arriving at the hospital. Women who make the decision to plan a home birth are going against the cultural norms of our society by tapping into other realms of knowledge. Intuition may be a driving force behind what allows home birthing mothers to go against the cultural grain.

Safety

Interestingly, while the women in this study did express concern about interventions and wanting to avoid them, they did not seem overly concerned with the other safety aspects of home birth, such as infant and maternal mortality rates. This

could be because they had already educated themselves on how safe the option to birth at home really is. They seemed to have a great trust in their bodies and their ability to give birth, similar to the mothers in the Janssen, Henderson, & Vedam (2009) study.

Sometimes they did report having family members concerned about safety issues when birthing at home, but many of these family members felt better after receiving some education. Women in the Boucher, et al. (2009) study did report maternal and infant mortality safety as being a significant issue.

Recommendations

Recommendations for women considering home birth

According to the women in this study, women considering home birth should carefully consider all of their options. They should educate themselves and make intuitive decisions, not fear based ones. I would add that it is important to find a midwife you respect and trust.

Recommendations to those in the childbirth field and to family therapists

When working with families who make the decision to have a child, it is important to let them know that they have options. Most likely, they will know they have the option to give birth in a hospital with a medical doctor. They might be unaware that they have the option to give birth in the hospital with a nurse-midwife, in a birthing center with a nurse-midwife, or in their home with a midwife. They may also be concerned about perceived dangers of birthing at home. Providing basic education on midwifery care and home birth can be empowering to families. Providing referrals to doulas, midwives, and resources is helpful and important. See Appendix C for a list of resources.

Decision Making Models

In Chapter 2 several decision making models were outlined. These models all had valuable points. A similarity of these models was that they were linear, stage type models. The model constructed for this study (see Table 2) was also a stage-based model. The women in this study did appear to use both the rational-evaluative process and the feeling-intuitive process. For example, they sought out answers and thought about what they learned (rational-evaluative) while also listening to their intuition (feeling-intuitive). However, these women did not appear to go through the stages in a particular order. The linear aspect of a decision making model did not appear to be of great importance to them. Therefore, while there is value in this model, and it may be of use for some women, after conducting this study, I am not certain that women actually go through these stages in any sort of order.

Limitations

This study obtained journals and interviews from women working with one midwife in Northern Colorado. Other women working with other midwives may have differing experiences or reasons for planning a home birth. Additionally, this was a relatively homogenous group. A more diverse range of ages, ethnicities, and sexual orientations may yield differing experiences.

A potential limitation to this study is the lack of negative experiences reported by this sample of mothers even though questions to this effect were asked (see Appendix B). One explanation to this is that women who give birth at home report higher levels of birth satisfaction than mothers who give birth in the hospital (Janssen, Carty, & Reime, 2006). However, a different sample of home birth mothers may report more negative feelings.

Table 2

Feminist decision making model for women choosing to birth at home

Rational-evaluative process	Feeling-intuitive process
Recognizing a problem	
Personal information; advice from others	Uncertainty about how to proceed in situation Identify what stands in the way of working through the problem: feelings about the nature of the issue
Defining the right problem	
What is the conflict? Who are the players? What are the relevant standards? What personal characteristics and cultural values do I bring to this decision? How do these factors influence my decision to the problem? How does (my partner) define the problem? What personal characteristics, values does my partner bring to this process? (If consulting with others): What personal characteristics, values does my consultant bring to this process?	What else is my discomfort about? What do my feelings tell me about the situation? What am I worried about? What are my partner's feelings about the dilemma? How do my partner's characteristics effect me? How does my consultant's characteristics effect me?
Specify objectives	
Determine the information to seek to make a good decision. What is most important to accomplish? What am I trying to avoid?	What do you want? What do you need? What are your hopes? Goals? Values? What does my partner need/want?
Create imaginative solutions	
Brainstorm list of <i>all</i> possibilities. Cost-benefit analysis. Prioritize values. How do these solutions meet all of the objectives?	What do my reactions to each choice tell me? What does my subconscious tell me over time?
Understand the consequences	
What are the positive and negative consequences of each option? What do you have to give up? What do you gain? Clarify any uncertainties. Create a consequence table.	How do the consequences feel? What emotions come up when faced with the tradeoffs?
Think hard about risk tolerance	
If you pick one option, it still may not be the one to occur. What are the risks associated with this?	How would you feel if the option picked is not the option that occurs? What does this say about the decision?
Consider linked decisions	
How are future decisions connected to this decision?	

Choosing a solution	
<p>What is the best fit both emotionally and rationally? Does this solution meet everyone's needs, including mine? Can I implement and live with the outcome (emotional outcome, cognitive outcome, physical outcome)?</p> <p>Understand the consequences: How well do your alternatives satisfy your objectives?</p> <p>Grapple with your tradeoffs: you will need to strike a balance. What did you have to give up?</p>	
Reviewing process	
<p>Would I want to be treated in this way?</p> <p>Would this decision withstand the scrutiny of others?</p> <p>How are my values, personal characteristics influencing my choice? How am I using my power?</p> <p>Have I taken my partner's perspective into account?</p> <p>Clarify your uncertainties: what could happen in the future, and how likely is it that it will?</p> <p>Think hard about your risk tolerance: When decisions involve uncertainties, the desired consequence (HB) may not be the one that actually results. People vary in their tolerance of such risks and, depending on the stakes involved, in the risk they will accept from one decision to the next.</p>	<p>Does the decision feel right? Have I given myself time to let reservations emerge?</p> <p>Does the manner in which I carry out this decision fit my style?</p>
Implementing and evaluating the process	
<p>Carry out the decision</p> <p>Observe consequences</p> <p>Reassess the decision</p>	<p>Is this solution the best I can do?</p> <p>Does the outcome continue to feel right?</p>
Continued reflection	
<p>What did I learn?</p> <p>What would I do differently?</p> <p>Consider linked decisions: What you decide today could influence your choices tomorrow, and your goals for tomorrow (breastfeeding) may should influence your choices today. Many important decisions are linked over time.</p> <p>Key: isolate and resolve near-term issues while gathering the information needed to resolve those that will arise later.</p>	<p>Have I changed as a result of this process? How?</p> <p>How might this experience affect me in the future?</p>

Mary Katherine Godfrey (2009). Adapted from Hill, Glaser, and Harden (1998) and Hammond, Keeney, and Raiffa (1999).

Recommendations for further research

It is concerning that so little research has been done of a childbirth option that is safe and empowering for women. While more research has been done on safety issues pertaining to homebirth in recent years, there continues to be a need for research on home birth issues, especially feminist research which listens to the voices of women. A study to discover what it is that enables home birthing mothers to go against the cultural grain and plan a home birth would be informative. It would be beneficial to conduct qualitative interviews of couples who have made the decision to plan a home birth in order to get the mother's opinion as well as that of her partner. More detailed research on the empowering effects of natural childbirth and home birth would be beneficial. A comparison of decision making models between hospital mothers and home birth mothers may also be helpful. Finally, an analysis of decision factors when planning a home birth may be useful as well.

Conclusions

Concluding remarks

While only a limited number of women pursue home birth each year, the Center for Disease Control reports this number is increasing (MacDorman & Menacker, 2010). It is helpful for those in the helping professions to be aware of the benefits to planning a home birth, including a sense of control over one's body and the childbirth experience, increased feelings of confidence, and empowerment.

Specifically addressing the research question of how first-time mothers describe the influential factors in their decision making process to plan a home birth from their initial consideration to its implementation, there are many factors to take into

consideration. These include rational-evaluative processes such as evaluating the medical model and desiring a natural childbirth experience as well as feeling-intuitive processes such as issues of power and control, intuition, and taking their partner's feelings and opinions into consideration. These reasons range from the Center System of Bronfenbrenner's (1979) Ecological Theory model all the way to the Chronosystem. And all of the themes seem to be important to the women. No one part of the process is necessarily more important than any others, nor did they occur in any certain order.

EPILOGUE

While working on my literature review, designing the study, interviewing the women, and reading their journals and transcripts, I could not help but reflect back on my own experience of being a first time mother and planning a home birth with a midwife. I found some of the participants' experiences to be quite similar to my own.

When my partner and I first decided to have a baby we knew having a natural childbirth experience was important to us. Throughout my pregnancy, the more I learned the more I knew this was an important piece. Like some of the women in this study, living naturally was already an important aspect of my life so choosing natural childbirth seemed like an extension of this value. We were not convinced we could have this experience in a hospital setting and the more we learned the more strongly we felt.

We pursued various options when making the decision on where to give birth. We had several friends who had used the services of Certified Nurse Midwives in the hospital. My partner and I met with one of the CNMs at her practice. While we really liked her, we did not feel great about the fact that our care would rotate among three or four midwives, and that whoever was on call when I went into labor would attend the birth. Like Susie, the relationship between the midwife and me seemed very important.

When I spoke with Beth Karberg, Certified Professional Midwife, about the option of pursuing a home birth, she was very supportive. Barring unforeseen circumstances, she would be the one I met with throughout my pregnancy and the one, with an apprentice midwife, to attend the birth. Additionally, there would not be people I had not met, such as nurses or other care providers, coming into my room as would happen in the hospital. I would have control over the environment and it would be a more private, personal experience, which was important to me.

During a first consultation Beth answered all of our questions, including concerns we had about safety. She provided us with education and access to research studies showing that home birth is a safe option for women with a healthy pregnancy. After meeting with Beth and doing some more research, my partner and I decided planning a home birth seemed like a great option.

The more we planned for the home birth the more our decision felt like the right one. I appreciated the relationship we were able to build with our midwife. I also became more determined than ever that home birth just felt right. My intuition told me I really did not want to give birth in the hospital. Pregnancy and childbirth were normal, natural processes and giving birth at home seemed normal and natural as well. Additionally, we knew we had a highly qualified, trained midwife there to take care of any emergencies that might arise.

Towards the end of my pregnancy the baby turned breech, and regulations around home birth do not allow for midwives to deliver babies they know to be breech at home. At this point Beth told us we would need to transfer my care over to an OB-GYN so that I could have a cesarean section unless the baby turned head down again. To me, this felt

like it was at the complete other end of the continuum of birth options from the natural home birth I had been planning. I asked if there was any way other way. Perhaps a doctor who would let me deliver a breech baby naturally? Beth said she did not know of any in Colorado. When I asked about other options she said that there was a midwifery clinic in New Mexico that might help me or that Ina May Gaskin and the midwives at The Farm in Tennessee would probably help me. I knew I could not fly at nine months pregnant and that driving down to New Mexico or over to Tennessee and giving birth without the support of my community felt ridiculous. Even more ridiculous was the fact that there were no known doctors in the state of Colorado who delivered breech babies. All in all, it felt disheartening.

Thankfully, through chiropractic care, elevating my hips and other measures, the baby turned head down again and I was able to labor and deliver at home. The experience of the baby being breech worked to solidify my desire to give birth at home. Any doubts I was having about birthing at home disappeared when it felt like that choice might be taken away from me.

In the end, we had a beautiful home birth experience. I labored for many hours in a huge tub of water in our kitchen and gave birth to a healthy eight pound baby girl in our bedroom. I was able to labor at my own pace with no pressure to do things differently. Our midwife was there offering support, assistance, and guidance as needed. Throughout the birth experience we were able to remain in the comfort and privacy of our own home. The experience was a profound and empowering one for me.

Doing this study affected my decision and experience by reminding me and reinforcing the importance of choice. Echoing Linden's experiences, I found the choice

to plan a home birth to be a feminist choice. Feminism is at the core of many of the choices I make for myself and my family, and this choice was no different. Planning a home birth and giving birth at home was a profoundly empowering experience for me, one of the most significant experiences of my life. I have never felt stronger or safer than I did when I gave birth in our home. My wish for other women is that they can have a similar experience.

APPENDIX A
Correspondence



School of Education
1588 Campus Delivery
Fort Collins, CO 80523-1588

DATE

Dear Potential Participant:

You are receiving this letter as an invitation to participate in our research study :
“Decision Making Processes of First-time Mothers in Planning Home Births”. As you may be aware, not much is known about the decision making process women experience when planning a home birth. Our research team is dedicated to learning more about this personal phenomenon because we want to further the knowledge base of women’s choices in choosing the place of birth.

To participate for this study, you need to meet one of the following criterion:

- You are pregnant with your first child and are currently planning a home birth with a midwife, or
- You planned a homebirth with a midwife for your first child within the past 3 years (please note that if you planned a home birth and transferred to the hospital you are still eligible to participate)

Women who are currently pregnant will be asked to participate in a journaling experience and possibly a follow-up interview. Women who have already given birth will be asked to participate in an interview. More details are provided in the enclosed consent form, which we will both sign at our initial meeting should you choose to participate.

If you meet the eligibility criteria above and are interested in participating, please complete the enclosed participation interest form and return it to us, using the enclosed self-addressed, stamped envelope. If you are interested and have questions, please contact me at the number below. If you know of others who may be interested in participating, please inform them about our study and ask them to contact me.

If you have any questions or comments, please contact Katie Godfrey at (970)231-2945 or kgodfrey@colostate.edu.

Thank you for your time and consideration.

Katie Godfrey, M.S.
Doctoral candidate
Education and Human Resource Studies

James Banning, PhD
Professor



Participation Interest

I am interested in participating in the “Decision Making Processes of First-time Mothers in Planning Home Births” study. Please contact me so that we may discuss this as an option.

Name: _____

Telephone number: _____

May I leave a message? Yes No

Email: _____

Mailing Address: _____

Please mark the option which best describes you:

_____ I am pregnant with my first child and am currently planning a home birth with a midwife

_____ I planned a homebirth for my first child within the past 3 years and used the services of a midwife

If you have any questions or comments before deciding on participating, please contact Katie Godfrey at (970)231-2945 or kgodfrey@colostate.edu.



Consent for Participation in “Decision Making Processes of First-time Mothers in Planning Home Births” study

Overview: You have been asked to consent to an interview and/or journaling experience for a research study conducted by a doctoral graduate student from Colorado State University. Journaling and interviewing will be used to obtain thoughts and experiences of approximately 10 first-time mothers who are planning or have planned a home birth with a midwife. Participants will be asked a variety of questions about their planning process. The findings of this study have important implications for other women who chose the decisions to plan a home birth, as well as for childbirth educators and other professionals.

Study Procedure: As a participant you will be asked to participate in a journaling activity **if you are currently pregnant**. You will be given a journal and a series of questions to answer on a semi-weekly basis, which will take approximately 2 hours to complete over the course of the study. Each entry will take approximately 15 minutes, depending on your responses. Your journal will be turned into the research team after your birth experience. After transcription, it will be returned to you as a keepsake of your pregnancy and birth experience. A follow-up interview may be scheduled from the research team to explore your experience. You will have the option of participating in the interview or declining participation.

If you have given birth within the past three years, you have the option of participating in an interview. Interviews are one-on-one, and take place in either a private office or your home, whichever you prefer. You will receive a copy of the interview questions in advance. Interviews last approximately 1-2 hours and are digitally recorded. Upon completion of the interview, interviews are transcribed and returned to you for review.

Benefits: The benefit of participating in this study is that you will gain more insight into your personal experiences. You will be able to keep your journal upon completion of the study, and/or you will receive a copy of your interview transcript, depending on the part of the study in which you choose to participate. You will also receive a copy of the findings of the completed study.

Potential Risks: There are no known risks of involvement in this study.

Confidentiality: Your identity will remain completely confidential. A list will be created with your name and contact information solely for the purpose of contacting and providing the journal, transcripts or study summary to you. The list will be kept in a secure filing cabinet. This list will be destroyed upon completion of the study. Transcriptions

will use pseudo names whether yours or other people you mention. The study report will do the same. .

Institutional Review Board: Your participation in this research is voluntary. If you decide to participate in this study, you may withdraw your consent and stop participating at any time without penalty or loss of benefits to which you are otherwise entitled. The Principal Investigator of this study is Dr. Jim Banning. Questions about participants' rights may be directed to Kathy Partin at (970) 491-1563.

Contact person: If you have any questions or comments, please contact Katie Godfrey at (970)231-2945 or kgodfrey@colostate.edu.

Consent: I have read this consent document and agree to participate in this study.

Name of participant

Katie Godfrey, M.S

Name of researcher

Signature of participant date

Signature of researcher date



School of Education
1588 Campus Delivery
Fort Collins, CO 80523-1588

DATE

Dear Participant:

Thank you for taking part in an interview for the research study entitled: "Decision Making Processes of First-time Mothers in Planning Home Births". As we discussed, here is a copy of the transcript of the interview. If you have any additions or corrections, please make them directly on the transcript. Please return the corrected transcript using the enclosed self-addressed, stamped envelope within 10 days of receiving it. If I have not received it by DATE, I will assume that you are comfortable with it and that no changes need to be made.

As always, if you have any questions or comments, please contact Katie Godfrey at (970)231-2945 or kgodfrey@colostate.edu.

Again, thank you for your time. Final results will be sent to you when the study is complete.

Katie Godfrey, M.S.
Doctoral candidate
Education and Human Resource Studies

James Banning, PhD
Professor

APPENDIX B

Measures

10. How would you describe your current primary employment status? (Please check **the one** that best applies)

- Paid full time employment
- Paid part time employment
- Seeking work for less than 1 year
- Seeking work for more than one year
- Non-paid work such as volunteer work
- A homemaker
- A student
- Unable to work
- Other (Please specify: _____)

Thank you. Please either return this with your journal or bring it to your interview.

Journaling Questions
Decision Making Processes of First-Time Mothers in Planning Home Births

Instructions: (These were posted inside each journal)

Welcome! Thank you for participating in this study. Here are some instructions to help guide your journaling process.

- Please date all entries.
- Write as much or as little as you please.
- If you come back to an entry at a later date to add to it, please date your addition.
- If you choose to not answer a question, please write “no response” under it.
- You may journal at your own pace; however, with your permission I will be sending email reminders and checking in with you to see if you have any questions.
- Aim to complete your journal two weeks prior to your due date or within the next six weeks, whichever comes sooner.

Questions? Contact Katie Godfrey at 231-2945.

Journaling Questions: (These were posted directly into each journal)

a. **Awareness: When and how you first become aware of the option to plan a homebirth**

- a. Prior to getting pregnant, I did or did not consider the option of home birth because...I first became aware of the option to plan a home birth when... My first reactions to thinking about this option were...
- b. Questions that shaped my decision to plan a home birth were...Knowledge I needed to gain to make the decision to plan a home birth was...
- c. If I have ever attended a birth before, it effected me by...This birth experience took place in a (hospital, birthing center, home)...This experience effected my decision by...
- d. If I know of anyone else who has given birth at home, this has effected me by...If I do not know of anyone else who has given birth at home, this has effected me by...

b. **Decision factors: How you knew you wanted to make the decision to plan a home birth**

- a. I chose to plan a home birth because...I chose not to plan a hospital birth because...
- b. My intuition influenced my decision to plan a home birth by... My feelings played the following role in making my decision on where to give birth...

- c. My rationale to choose home birth changed over time by...
- d. The people I consulted about my choices were...They shared or said...
- e. My partner's initial reactions to the idea of home birth were...My partner's thoughts and feelings about planning this home birth have been...My partner's role in the decision making process was...
- f. The people who supported my decision to plan a home birth were...They supported me by...
- g. The people who were not supportive of my decision to plan a home birth were...I coped with this by...Did they come from a position of power, such as someone who had influence or authority over you? Please describe.
- h. The knowledge or perceived knowledge that stood in my way of understanding and sorting though of choosing where to give birth was...
- i. I would describe the role of my values and personal characteristics (i.e.: gender, religious experiences, age, class and/or geographical location) played in making this decision as...

c. Experiences: The experiences of choosing to plan a home birth

- a. Sometimes things happen so that home birth is no longer an possibility. This affected my decision making process by...My contingency plans include...
- b. I believe the advantages of home birth are...I believe the disadvantages of home birth are...
- c. The complications which arose during my pregnancy that jeopardized my decision to plan a home birth were...
- d. A situation where I questioned my decision to plan a home birth was when...
- e. Planning a home birth gave me feelings of control and power by...To me, control means...
- f. Specific materials I read or viewed which were helpful in planning my home birth were...Unhelpful materials included...

- g. I believe I did or did not make the best decision for myself in planning a home birth because...
- d. **Looking back: What you have learned when looking back at your home birth decision making process**
 - a. From my experience of planning a home birth, I am learning...Would you choose to plan a hb again?
 - b. If I could repeat the decision making process, this is what I would do differently ...
 - c. As a result of this process, these are the ways in which I have changed...
 - d. I anticipate that this experience may affect me in the future by...In making my decision to plan a home birth, I was thinking about the following future goals because...
 - e. Other aspects of my decision making process that I would like to share are...
 - f. Other aspects of my experience I would like to share are...

Interview Guide
Decision Making Processes of First-Time Mothers Planning Home Births

This guide contains five major areas of exploration (labeled with numbers). Following each area are optional follow-up questions (labeled with letters) to be used if necessary.

1. Awareness: When and how did you first become aware of the option to plan a homebirth?

- a. What were your initial reactions to thinking about this option?
- b. What questions did you have that shaped your decision to plan a home birth? What knowledge did you need to gain to make the decision to home birth?
- c. Have you ever attended a birth before? Was it a hospital, birth center, or home birth? How did it effect your decision making process?
- d. Do you know anyone who has given birth at home? How did this effect your decision?

2. Decision factors: How did you know you wanted to make this decision?

- a. Do you feel that you chose to have a homebirth, or chose to not have a hospital birth? Please explain.
- b. How did your intuition influence your decision to plan a home birth?
- c. What feelings did you have and how did they influence your decision to plan a home birth?
- d. Who did you consult about your choices? What did they share/say?
- e. If you have a partner, what did s/he think about planning a home birth? What were her/his initial reactions to the idea of home birth? What was your partner's role in the decision making process?
- f. Who supported you in your decision to plan a home birth?
- g. Who was not supportive in your decision to plan a home birth? Why?
 - i. How did you cope with this?
 - ii. Was this person someone who had influence or authority over you? Please describe
- h. What role did your values and personal characteristics (i.e.: gender, religious experiences, age, class, sexual orientation, and/or geographical location, etc.) play in making this decision?

3. **Experiences (consequences): What were the consequences of choosing to plan a home birth?**
 - a. What did you consider as the advantages/disadvantages to home birth?
 - b. Sometimes things occur that make home birth no longer an option. How did this affect your decision making process? How did you plan for contingencies?
 - c. Were there any complications which arose during your pregnancy that jeopardized your decision to plan a home birth?
 - d. Please describe any situations that had you question your decision to plan a home birth?

4. **Looking back: In looking back on your home birth experience, what did you learn?**
 - a. What feelings of control and power did planning a home birth give you? What does control mean to you? Explain control as “control over one’s own process” if necessary.
 - b. Specifically, what materials did you read/viewed to plan your home birth? What was helpful? What was not?
 - c. Looking back, do you believe you made the best decision for yourself? Your baby? Why?
 - d. What did you learn from your experience of planning a home birth? Have you chosen to plan another homebirth? Would you choose to plan a home birth again?
 - e. If you could repeat the decision, what would you do differently?
 - f. How have you been changed from this process of planning a home birth and giving birth at home? How has this process affected you? How might this experience affect you in the future?
 - g. In making your decision to home birth, were you also thinking of future parenting goals? If so, how did future goals play into your decision to pursue a home birth? How have these goals played out/been fulfilled?
 - h. Now that you have experienced your decision, what suggestions would you share with other women?

5. **Are there any other aspects of your decision making process that you would like to share?**

APPENDIX C

Recommendations from Participants

BOOK AND AUDIO-VISUAL RECOMMENDATIONS
FROM PARTICIPANTS

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