

INFLUENCES OF DECISION-MAKING:
A QUALITATIVE ANALYSIS OF
PRIMIPARAE'S BIRTHING
PLAN DECISIONS

by

APRIL NICOLE BLOUNT

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ABSTRACT

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April Nicole Blount, MA

The University of Texas at Arlington, 2011

Supervising Professor: Charla Markham Shaw

In the U.S., the rate of delivery by cesarean section has increased more than 50% since 1996. On the other hand, home births increased 5% since 2005 and continue to be on the rise. Previous research is limited in examining the factors that influence the choices surrounding the birthing plan. Existing research indicates that few women ask questions and make an effort to learn about birthing options as they prepare for delivery. The common perception is that medical events dictate what will eventually happen; thus, responsibility is relinquished to the healthcare provider. This study used 12 in-depth interviews with primiparae, or first-time mothers, to examine who and what influences them as they make their birthing decisions. In order to understand what factors influence a woman's birthing decision, the interviews were analyzed for discursive themes. Three themes or factors emerged: others' birth experiences, trust, and fear. This study is a first step in an effort to develop a better understanding of communication needs of primiparae as they develop their birthing plans. Recommendations based on the findings are offered in an effort to improve patient-provider communication and increase satisfaction and adherence for both healthcare professionals and primiparae.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
Chapter	Page
1. INTRODUCTION.....	1
1.1 Review of Literature	4
1.1.1 Theoretical Perspectives.....	4
1.1.2 Health Communication and Women	6
1.1.3 Medical Decision-Making	8
1.1.3.1 Birthing Options.....	8
1.1.3.2 Medicalized Delivery	9
1.1.3.3 Non-medicalized Delivery	11
1.1.3.4 Decision-making during the Birthing Process	12
1.1.4 Birthing Experiences	17
2. METHODOLOGY.....	20
2.1 Introduction	20
2.2 Participants	21
2.2.1 Participant Profiles	22
2.3 Interviews.....	26
2.4 Interview Analysis	27
3. RESULTS	30
3.1 Factor One: Others' Birth Experiences	30

3.2 Factor Two: Trust.....	34
3.3 Factor Three: Fear	38
4. DISCUSSION.....	43
4.1 Factor One: Others' Birthing Experiences	43
4.2 Factor Two: Trust.....	47
4.3 Factor Three: Fear	52
4.4 Limitations	55
4.5 Future Research	56
4.6 Conclusion	58
APPENDIX	
A. INTERVIEW SCHEDULE	59
B. CONSENT FORM	61
REFERENCES	64
BIOGRAPHICAL INFORMATION.....	69

CHAPTER 1

INTRODUCTION

Becoming a primipara or first-time mother was one of the most confusing times in my life. For forty weeks, I had to make decision upon decision for the child I was carrying. The hardest choice I made was choosing the method of childbirth delivery. Throughout the decision-making process, I consulted my physician, mother, and friends. Many women recommended natural birth, meaning a non-medicalized delivery that is free from any external medical intervention (Gillespie & Strauss, 2007). Others shared stories of painful labor ending in emergency cesarean sections. Following the birth of my daughter, I began to question what other primiparae's birthing experiences are like.

Researching the different methods of delivery proved to be a confusing task. A collective effort of reading books, searching pregnancy Web sites, and talking to a variety of individuals including family, friends, and healthcare professionals provided what I thought was a complete list of childbirth delivery options. It was only after deciding to explore birthing experiences as a research study that I fully discovered the options available. Before giving birth, the only childbirth delivery option I considered available was a medicalized delivery. Although some women recommended natural birth, none of them were under the care of an obstetrician during their pregnancy. According to a study done by Rateliff (2002), the majority of the women interviewed felt there was no choice regarding delivery site and "merely complied with what they saw as the existing system of hospital births" (p. 6).

Gillespie and Strauss (2007) contend that few women ask questions and make an effort to learn about birth beforehand. Zadoroznyj's study (1999), however, found that middle-class primiparous women actively sought information and were involved in making birthing decisions more often than lower-class primiparous women. According to the study, a common perception

among the lower-class women was that their decisions would be irrelevant —medical events would dictate what eventually happens— thus, they relinquished responsibility to their providers (Zadoroznyj, 1999).

Recently there has been a significant shift in how women are delivering their children. According to the National Center for Health Statistics, the rate for cesarean delivery has increased more than 50% since a record low in 1996 (Martin et al., 2009). This statistic reflects medically necessary cesareans as well as elective cesarean sections. Safety is reported most often as the reason to deliver at a hospital (Goodall, McVittie, & Magill, 2009; Moffat et al., 2007; Rateliff, 2002; Zeldes & Norsigian, 2008); however, according to the Association of Texas Midwives, the infant mortality rate is higher among hospital deliveries as compared to midwife-assisted deliveries at home or in a birthing center (Rateliff, 2002).

Another delivery site option that women are exploring is at home. From 2005 to 2006, according to the National Center for Health Statistics, home deliveries increased 5% (MacDorman, Menacker & Declercq, 2010). With the assistance of a certified nurse midwife (CNM) or certified professional midwife/ documented midwife (CPM), women are able to deliver at home or at a freestanding birthing center. Home births are not, however, an option available in all states; currently, 11 states prohibit CPMs from attending births or do not allow homebirths at all (Gillespie & Strauss, 2007). Texas is a state that allows midwife-assisted deliveries.

Although there has been an increase in both homebirths and cesarean deliveries nationally, it is unclear what factors truly influence primiparae's birthing decisions. After conducting a preliminary search for studies examining what factors influence birthing decisions, I have found that few articles exist. Most of the research available has originated outside the U.S. [Armenia (Amoros, Callister, & Sarkisyan, 2010); Greece (Kontoyannis & Katsetos, 2008); Australia (Maher, 2003; Reiger & Dempsey, 2006) Great Britain (Stephens, 2009); and Ghana (Wilkinson & Callister, 2010)], which creates a gap in our understanding. In the U.S., there are a variety of birthing options made available to women; because our healthcare system is unlike

many that have been previously studied (Amoros, Callister, & Sarkisyan, 2010; Kontoyannis & Katsetos, 2008; Moffat, Bell, Porter, Lawton, Hundley, Danielian, & Bhattacharya, 2007; Wilkinson & Callister, 2010), it is important to examine what may be very different U.S. birthing experiences.

A greater part of the birthing research focuses on secondary birth experiences following previous cesarean sections (Donati, Grandolfo, & Andreozzi, 2003; Goodall et al., 2009; Moffat et al., 2007). From this research, a number of health-related reasons emerged as factors for choosing cesarean sections again. However, an integral element of the present study is interviewing primiparae who have no previous birthing experience to influence their decisions. By evaluating their discourse, I will be able to explore the reasons these primiparae choose a particular birthing plan.

This study will provide better insight into what primiparae value when making birthing decisions. Patients are healthcare consumers, and it is important for healthcare providers to understand their customers' needs. According to a study published in *Women's Health Issues* (Xu, Siefert, Jacobson, Lori, & Ransom, 2008), 34% of the obstetrician-gynecologists (OB-GYN) surveyed would not recommend obstetrics and gynecology to medical students looking for career advice. The study also found that the burden of malpractice claims and premiums had adversely affected OB-GYNs' career satisfaction. Not only are OB-GYNs not recommending their field as a career choice, but there has been an increase in the number of obstetricians leaving the field due to higher costs of malpractice insurance, which has reportedly increased 500% from 1992-2002 (Rateliff, 2002). The present study will seek to help healthcare providers understand the communication gap between what information is being shared and what primiparae actually understand and provide suggestions for ways primiparae can improve communication with their healthcare providers for their own desired outcomes.

1.1 Review of Literature

1.1.1 Theoretical Perspectives

The purpose of this study is to understand who and what influence primiparae to make their birthing decisions. Analyzing the discourse of primiparae is key to gaining a better understanding of their communication needs. Two theoretical perspectives are used to examine and understand the meaning making process and evaluate the primiparae's discourse. First, the theory of symbolic interaction (Mead, 1933) is used to understand how meaning is constructed. According to Mead (1933), meaning making is a three-part process between self, other, and society. This theory is applicable to this study because it helps explain what role these three forces play in the decision-making process of primiparae. Analyzing discourse matters as it is socially constructed. The result of symbolic interactionism is that socially constructed definitions create reality and provide a framework for learning how to interpret the world. Mead (1933) notes that an individual recognizes one's self as distinct from others; however, the development of self is negotiated through the viewpoint of others and through interaction with significant others. It is through this social interaction that discourse and ideologies are formed.

There are multiple competing ideologies that primiparae face while being pregnant. When determining how they will give birth to their children, the great responsibility of caring for another human's life is entrusted to them. Yet, the scrutiny and doubt of each prenatal decision drives many primiparae to relinquish responsibility to healthcare professionals (Goodall et al., 2009; Zadoroznyj, 1999). While, on one hand, women are encouraged to trust their bodies, on the other they are pushed to follow the physician's timetable when discussing childbirth delivery/ birthing plan options (Moffat et al., 2007). When primiparae decide to take responsibility and ownership of their healthcare by choosing natural home delivery, they can be stigmatized as reckless or rebellious (Maher, 2003; Stephens, 2009).

Multiparous mothers have birth experiences to share with primiparae and often choose to

disclose the most dramatized version of events. There are two versions of deliveries seen: one of failure and one of success. Medicalized delivery is often regarded as a failure when it results in a cesarean delivery. Failure comes when a mother cannot vaginally deliver her child. The competing idea is that success only occurs when a mother conquers delivery vaginally and naturally. A primipara must make sense of these competing ideologies and the conflicting discourses in order to make her own meaning and carry out her childbirth delivery decision.

The second theoretical perspective used to examine and understand the meaning making process in the present study is Leon Festinger's Cognitive Dissonance theory (1957). The theory of cognitive dissonance (Festinger, 1957) helps explain how collaborative and opposing discourses help negotiate meaning for us. According to Festinger (1957) cognitive dissonance occurs when an individual holds an opinion privately that, because of the social pressure, does not correspond with what that individual has publicly stated he/she believes. More specifically, the present study looks at the social negotiation between beliefs about self, social ideologies, and resulting behaviors of primiparae. As it pertains to the present study, cognitive dissonance occurs when the primipara holds an opinion and is then exposed to arguments in favor of the opposite opinion from a respected source. Cognitive dissonance can also occur when her behavior does not match her beliefs, or when the primipara believes the results of her behavior do not provide an adequate reward. Cognitive dissonance can be reduced if a primipara persuades herself to believe in the behavior she is engaged in, which may happen if the behavior provides a valuable reward, or if the primipara changes her behavior to follow her beliefs.

Each of these theories provides a framework from which the current study is centered. Knowing how meaning is socially constructed and how the effect of incompatible beliefs influence an individual's emotions and behavior are crucial parts of understanding who and what influence a primipara's childbirth decision. It is also important to review current health communication literature examining how women make healthcare related decisions.

1.1.2 Health Communication and Women

Health communication is the dissemination of information concerning an individual's emotional, physical, or social state of wellbeing in a variety of contexts. Many of the contexts in which previous research is focused are interpersonal communication contexts (Cline, 2003). These contexts range from patient-provider communication, provider-provider communication, patient-patient communication, and even patient-insurance carrier communication. Within these contexts, when a patient shares health-related information with another individual, the interaction may be planned or unplanned within formal or informal situations (Cline, 2003).

Clark and Delia (1979) identified three objectives of every communication transaction: instrumental, interpersonal, and identity. Instrumental objectives address everyday needs that are fulfilled through completing a task (Clark & Delia, 1979). According to Revicki and Mitchell (1986), instrumental objectives seek tangible aid that directly benefits an individual's medical need. An example of this is providing a mother with a list of midwives or birthing centers and their contact information in hopes of helping a mother to choose a midwife and, in turn, a more natural delivery. Interpersonal objectives try to establish or maintain a relationship with an individual (Clark & Delia, 1979), whereas identity objectives in a communicative situation seek to "present a desired self image for the speaker and create or maintain a particular sense of self for the others" (Clark & Delia, 1979, p. 200). Often these last two objectives are more difficult to differentiate because they are interrelated. If a friend tries to introduce a new mother-to-be to a group of women who have only delivered naturally at home, she has an interpersonal objective in mind. She is trying to include the mother in a group in order to strengthen the current relationship and create new ones. An example of an identity objective occurs when a healthcare provider presents morbidity rates as preventable via natural birth; he/she is furthering an "us versus them" mentality and leading a mother to choose who she is going to be: a mother who is strong enough to protect her child or a mother who is not. According to Coover and Murphy (2000), "the essence of communication is the formation and expression of an

identity” (p. 125). Identity is formed through a multitude of interactions (Coover & Murphy, 2000) and through a process in which social interaction defines our reality (Mead, 1933).

Upon reviewing previous research, two types of everyday communication were seen as factors influencing a woman’s decision regarding her birthing plan: formal and informal communication. Previous research examining birthing choice focused more prevalently on patient-provider communication (Bylund, 2005; Goodall et al., 2009; Kolip & Buchter, 2008; Moffat et al., 2007). Women have unique reproductive healthcare needs, which create unique communication needs. As a result, female patients require unique patient-provider interaction (Nussbaum, Ragan & Whaley, 2003). Nussbaum et al. (2003) contend that female patients inquire more often about their health than men and receive more information from physicians as a result of their persistence. Women try to empower themselves and actively seek a role in handling their unique health concerns (Kolip & Buchter, 2009; Nussbaum et al., 2003). Yet “providers tend to give shorter and less technical answers” (Nussbaum et al., 2003, p. 194). Unfortunately, as Moffat et al. (2007) discovered, many healthcare providers underestimate female patients and often perceive women as being “confused” by the technical information they receive from medical sources. Historically, women have faced inequality of medical care, often dismissing mental health issues as hysteria and promoting the medicalization of natural processes like childbirth (Nussbaum et al., 2003).

Nussbaum, Ragan, and Whaley (2003) contend that women perpetuate a communication gap between themselves and their physicians when they practice certain “feminine behaviors, such as politeness, compliance and non-assertiveness in their medical interactions” (p. 196). These behaviors often relinquish the patient’s status as an active participant when making medical decisions. Once women learn to negotiate “feminine behaviors” while adopting partnership communication skills (Nussbaum et al., 2003), women’s health needs will be more completely met.

1.1.3 Medical Decision-Making

After patients learn of their medical condition, they must process the information given to them to determine the best treatment option. After conducting a content analysis of patient-provider interactions, Braddock, Edwards, Hasenberg, Laidley and Levinson (1999) developed seven criteria for defining informed decision-making which includes: patient participation and preferences, discussion of the nature of the decision, discussion of risks, discussion of benefits, discussion of alternatives, discussion of uncertainties, and patient understanding. They found that only 9% of the coded interactions met all seven criteria (Braddock et al., 1999). They recommended providers, patients and the patients' families collaborate to achieve specific treatment goals.

Clarke and Evans (1998) identify numerous obstacles to medical decision-making. Interpreting complex statistical results makes it more difficult for patients to determine the best treatment options. Another obstacle is the media's influence on patient perceptions of options. Other issues identified are the physician's preferences for treatment and procedures, the language used to discuss the options in terms of uncertainty and risk, patient and physician emotions and, finally, cost. A majority of the medical decision-making research is devoted to terminal and end-of-life decisions (Basile, 1998; Kuczewski & DeVita, 1998; Nolan & Bruder, 1997; Ott, 1999) as opposed to birthing decisions.

1.1.3.1 Birthing options

A birthing plan describes the manner in which a woman wishes to deliver her child (Jones & Jones, 2004). It includes the ways she wishes to manage her pain during delivery as well. The first decision to consider when developing a plan for delivery is choosing a location: hospital, home, or freestanding birthing center (Jones & Jones, 2004). In certain situations, choosing the location for the delivery leads to choosing between a medicalized delivery and a non-medicalized delivery. Non-medicalized delivery is free from any external intervention, whereas medicalized delivery occurs when any instrument is used to assist in the delivery

(Gillespie & Strauss, 2007). Some of the instruments that make a delivery medicalized include forceps, vacuum, and epidural catheter. There are numerous types of medicalized and non-medicalized childbirth. Hospitals and birthing centers have the capability to offer a medicalized delivery if necessary, although it is not common practice for a birthing center to perform medicalized deliveries. Home births do not offer a medicalized option. Non-medicalized delivery, often known as natural birth, can occur at any of the three locations.

1.1.3.2 Medicalized delivery

The most commonly documented form of medicalized childbirth is operative vaginal delivery, according to the National Center for Health Statistics (Martin et al., 2009), which occurs when forceps or a vacuum (large suction cup) are used to assist in the delivery of a baby (Jones & Jones, 2004). Forceps delivery and vacuum extraction methods are chosen by the physician when the mother has reached the second stage of labor but the baby is not making progress toward being born. The mother is not always made aware of this intervention until it has occurred.

A mother may make the decision to have an epidural delivery, another form of medicalized delivery, prior to or once labor has begun. First, a numbing injection is inserted a little lower than halfway down the back. Once the space is numb, a long thin needle is inserted between the space in the vertebrae of the lower back until the epidural space that surrounds the spinal cord is located. A catheter is threaded through the needle and the needle removed. This tube is secured with tape and the other end fastened onto a syringe (Jones & Jones, 2004). Drugs are administered through the syringe in order to block the pain felt below the mother's waist. This helps to block the pain felt from the contractions during a vaginal delivery.

Analgesic delivery usually occurs when pain-relieving drugs are given intravenously through an IV drip. During childbirth, strong analgesics such as Demerol are frequently used. In most cases the medication is "dripped" slowly through a needle after active labor has begun. Analgesic delivery is viewed more negatively by patients and physicians due to the uncertain

effects it may have on the newborn (Jones & Jones, 2004). The effect of analgesics on the newborn depends on the dosage and how close to delivery the drug is administered (Jones & Jones, 2004). Some infants are born sleepy and unable to suck; others might have trouble breathing and need oxygen. These side effects are generally not dangerous and quickly wear off. Analgesics are not always offered, and the mother decides on analgesic delivery once labor has started. There is not always a discussion with the obstetrician beforehand regarding this type of delivery.

The most invasive medicalized delivery is a cesarean section (c-section), which is “the medical term for surgically delivering your baby by cutting open your abdomen and uterus” (Jones & Jones, 2004, p. 343). “C-sections have now become the most commonly performed surgical procedure in the U.S.” (Jones & Jones, 2004, p. 343). According to the National Center for Health Statistics, approximately one out of every three pregnancies ends in c-section (Menacker & Hamilton, 2010). A cesarean delivery may be necessary if one of the following complications is present: the baby is not in the head-down position; the baby is too large to pass through the pelvis; the baby or mother is in distress (Jones & Jones, 2004). Full anesthesia is rarely used for cesareans; instead, a stronger than normal dose of numbing drugs is administered through a spinal or an epidural. The vast majority of cesarean sections are not elective or chosen without medical justification. There are instances, however, in which a mother could have delivered subsequent births vaginally after having a cesarean but, instead, chooses cesarean delivery without medical cause (Rateliff, 2002). The above is a compilation of the medicalized birth choices available to women. During a medicalized delivery, nurses and physicians are responsible for the labor and delivery process. The following is a list of non-medicalized delivery options available to the majority of women in the U.S.; special attention has been paid to the rules and regulations that are recognized in Texas.

1.1.3.3 Non-medicalized Delivery

Non-medicalized deliveries, also known as natural birth, can be performed at hospitals, at home, or in birthing centers. It is important to note that the term “natural delivery” is defined in a number of ways. Some individuals believe that “labor and birth are a natural human process, engineered by evolution with such sensitivity that any intervention could cause it to malfunction” (Gillespie & Strauss, 2007, p. 2). Others believe that all births are “natural” and using instruments like electronic fetal monitoring is no less natural. For the purposes of this study, non-medicalized delivery is defined as a delivery free from any external intervention that induces or changes the organic nature of a vaginal delivery. Fetal monitoring does not change or induce labor, so it is not considered to be an instrument that interferes with natural delivery. Forceps, vacuum extraction and epidural catheters alter the organic nature of natural delivery; therefore, the use of such interventions would prevent that type of delivery from being categorized as a non-medicalized delivery.

If a mother decides to deliver in a freestanding birthing center, the delivery is managed by a Certified Nurse Midwife (CNM), Certified Professional Midwife (CPM) or, in rare instances, a physician. The Texas Department of State Health Services (2010) defines a birthing center as “an alternative means for a pregnant woman to deliver in a setting other than at home or in a hospital” (para. 1). According to the Association of Texas Midwives (2010), CNMs are registered nurses who have completed a graduate program in nurse-midwifery. These individuals manage women’s health care services relating to pregnancy, childbirth, postpartum, and gynecological needs. CPMs, or documented midwives, are not required to be nurses and are educated at direct-entry midwifery programs. In addition to program completion, they have assisted women through the normal child bearing process under supervision. CNMs and CPMs practice in a variety of settings including clinics, medical offices, and their own private practices. According to Gillespie and Strauss (2007), birthing centers offer a more personalized level of

attention and allow more control of decision-making for the mother. They also provide a greater sense of safety than home births in some mothers' minds (Gillespie & Strauss, 2007).

Delivering at home may be another option for healthy, low risk women expecting to have an uncomplicated labor. Services of a trained midwife are essential. Home birth provides mothers with uninterrupted privacy and a relaxed environment (Rateliff, 2002). Women delivering at home found it liberating to have the freedom to eat or drink during labor, change body positions during labor, prevent unwanted medical interventions, include any family members in the birth, and not have the baby removed from the mother following delivery (Gillespie & Strauss, 2007; Rateliff, 2002). According to researchers (Rateliff, 2002), the women were able to labor without restrictions on their own terms.

Another non-medicalized delivery option is water birth. According to Jones and Jones (2004), water birth helps reduce the need for drugs and other medical interventions. It requires careful monitoring of the baby's heart rate and should only be used when the baby is full term and in a normal head down position (Jones & Jones, 2004, p. 313). This type of delivery can be performed at home, a birthing center, or a hospital. It is an option for healthy, low risk pregnancies, which are evaluated on a personal basis by healthcare providers.

Although the previous discussion of medicalized and non-medicalized delivery options is not exhaustive, it does introduce the most prevalent options that make up a woman's birthing plan. In making the decisions necessary to develop a birthing plan, communication with family, peers, mentors, and/or healthcare providers is key.

1.1.3.4 Decision-making during the Birthing Process

Shared decision-making between a patient and healthcare provider is now becoming a popular area of research according to Bylund (2005). There is a well-established link between successful patient-provider communication and positive outcomes of adherence and patient satisfaction (Brown, Stewart, & Ryan, 2003; Bylund, 2005). The focus of the research has been on patient participation and patient behavior during decision-making (Bylund, 2005). However,

the behavior of healthcare providers directly affects decision-making and should be evaluated more closely (Brown, Carroll, Boon & Marmoreo, 2002).

According to Brown et al. (2003), healthy patient-provider communication can positively impact adherence outcomes. If physicians encourage patients to take an active role in their healthcare, they can work together to decide what is best, thus increasing patient satisfaction (Brown et al., 2003). Physicians may indirectly encourage mothers to consider alternative healthcare as Kontoyannis and Katsetos (2008) discovered. One study participant described how her physician aided her in choosing home birth following several disagreements and unsatisfying consultations with her physician. The doctor told her what *would* occur during delivery rather than discussing her options and working with her; she explained that the physician simply stated, "Shaving, enema and episiotomy will definitely take place" (Kontoyannis & Katsetos, 2008, p. 47). Knowing that patient-provider communication impacts healthcare decisions, it is necessary to understand how decisions are made during the birthing process.

Brown et al. (2003) discovered in their research that women want to be actively involved in the decision-making process about their healthcare, whether it concerns prenatal genetic testing, hormone replacement therapy, or the use of complementary/alternative medicine in treating cancer. Obtaining information about their healthcare issues allows women to make more informed decisions; hence, patient-provider communication is vital. Personal values and past experiences, such as previous cesarean section delivery, guide the decision-making process. In studies by Goodall et al. (2009) and Moffat et al. (2007), women's previous birthing experiences remained present in their memories and guided their future decisions. The majority delivered by cesarean the first time and, whether the experience was positive or negative, it was a powerful influence for their subsequent deliveries.

Moffat et al. (2007) discovered that some British women delivering for a second time were especially distrusting of their bodies and the birth process. If they were unable to deliver

vaginally the first time, what would allow them to deliver vaginally the second time? This doubt led them to choose cesarean delivery again. In the same study, however, women, who were delivering for a second time, regardless of how they delivered their first child, were guided by medical professionals to try a vaginal delivery first. As a result, some women felt the need to hide their birthing plan decision, especially if it went against their healthcare provider's recommendation for vaginal delivery. They expressed fear that their treatment in the hospital would be different if they blatantly went against their healthcare provider's recommendation. Even in the rare instances when these women thought about trying vaginal delivery, they would recall their previous experience and become less confident in their bodies (Moffat et al. 2007). This group of British mothers viewed cesarean sections as the safest mode of delivery available to them.

Goodall et al. (2009), however, found that other British mothers wanted to try non-medicalized delivery (also known as trial of labor). In fact, the majority of the research (Donati et al., 2003; Goodall et al., 2009; Moffat et al., 2007) evaluating cesarean sections specifically, found women would prefer to deliver vaginally, provided their bodies could handle it. Many of the mothers studied did not prefer cesarean sections as a medical procedure, yet healthcare providers added to the apprehension of trying to deliver vaginally. Goodall et al. (2009) found a different expectation from other British healthcare providers than Moffat et al. (2007). If a cesarean section had already been performed, it was likely the mother would "end up having to have an emergency [cesarean]" (Goodall et al., 2009, p. 8). Remarkably, according to this study, physicians were not the only healthcare providers advocating this particular birthing plan; midwives assisted physicians in presenting statistics and past birthing experiences to persuade patients to have a cesarean section (Goodall et al., 2009). These women were sometimes made to feel guilty for endangering their children's lives if they indicated a desire for a plan other than a cesarean section.

Some of the participants in previous studies wanted to fully participate in making birthing decisions (Donati et al., 2003; Kolip & Buchter, 2009) and needed the tools to do so. Participants wanted healthcare providers to offer more personalized information for their situations (Moffat et al., 2007). Throughout the previous research studies, a major complaint from participants in the UK, Italy, and Germany was the lack of information distributed by healthcare providers about the consequences of a cesarean section (Donati et al., 2003; Kolip & Buchter, 2009; Moffat et al., 2007). Some women were concerned with the practical implications of cesarean sections; these women were primiparae who had no previous experience to draw from (Donati et al., 2003; Kolip & Buchter, 2009). For instance, temporarily being unable to drive is a major consideration that healthcare providers did not always bring to the participants' attention (Moffat et al., 2007). Cesarean sections were not, however, always found to be a hindrance in previous research. In contrast to the finding of Moffat et al. (2007), Goodall et al. (2009) reported that, in the UK, sometimes social factors such as "family commitments and freedom from uncertainty" (p. 5) contributed to some women choosing cesareans. Moffat et al. (2007) investigated claims that other social considerations increased the incidence of cesarean sections. According to Moffat et al. (2007) a report from the House of Commons Health Committee claimed that the public perceived that cesarean sections were being scheduled as a matter of "convenience and vanity" (p. 87). It is important to note that Moffat et al. (2007) found no evidence to support that claim.

Another factor that may influence a primipara's decision is the fear of morbidity for child and self. In Goodall et al. (2009), no reference was made to morbidity as a guiding reason to choose a cesarean section. In fact, morbidity was only mentioned in the study to highlight its absence. However, morbidity was a chief influencer in the Moffat et al. (2007) study and led some British participants to feel pressure to choose vaginal delivery. The women in this study allowed fear and healthcare providers to guide their birthing plan decisions. In some cases, women were relieved to have the responsibility of making that decision taken from them so they

could not be held responsible for the consequences (Moffat et al., 2007). Other women in the study felt they were not given a choice at all; rather, they were cornered into choosing a specific mode of delivery that was promoted by their healthcare providers.

As a whole, the previous international research portrays physicians and midwives as a team working together to deliver children. In several studies, women had the opportunity to meet with both the physician and midwife (Goodall et al., 2009; Kolip & Buchter, 2008; Moffat et al., 2007). The perception of midwives and physicians working together is not found in the U.S. Physicians are seen as major proponents of medicalized births including elective cesarean sections (Zeldes & Norsigian, 2008). On the other hand, midwives and doulas are viewed as advocates of non-medicalized birthing plans (Zeldes & Norsigian, 2008). Despite the fact that, internationally, physicians and midwives are often seen as partners, there is still a great deal of controversy over modes of delivery. Finally, the previous international research indicates that advice from family and friends (confidants) is not a significant factor in influencing a mother's birthing plan. However, in one study done in Canada, it was discovered that a woman's mother was seen as being influential (Brown et al., 2003) in certain health contexts. She "knows you better than anybody else" (p. 227) and her life experience is seen as invaluable. Goodall et al. (2009), however, found that "friends, family and childbirth classes" would minimally influence a British woman's thoughts about a cesarean section (p.12). Moffat et al. (2007) contends that, in addition to friends and family, the influence of a British mother's partner and colleagues was seen as being "supplementary" (p. 90). The Internet and television programs were cited as a minor source of influence for these women and simply identified as "useful" (p. 90). The specific Web sites or programs were not listed nor was the extent of how these sources influenced the women.

Previous birth experience is an important aspect of a patient's decision-making process; however, it is often neglected by the physician, which most adversely influences adherence and

patient satisfaction. "Healthcare professionals' interactions with women patients need to take into consideration their life context" (Brown et al., 2003, p. 230).

Bylund (2005) found that, during delivery, a healthcare provider initiated most decisions and "less than 4% of decisions were made only by the patient" (p. 35). This finding supports what most of the international research reports regarding birthing experiences. The type of decisions being made determined how much a woman contributed to decision-making during her pregnancy. The mother was more vocal in giving her opinion when her immediate wellbeing was directly affected, but only if her child's wellbeing was not influenced. If the child's wellbeing was affected, the mother relied on the physician's expertise to make the decision for her (Bylund, 2005). This reinforces the validity of previous research that found many participants were anxious about making decisions and happy to have it "taken out of [their] hands" (Moffat et al., 2007, p. 89).

1.1.4 Birthing Experiences

Studies exploring birthing experiences have been conducted in different countries and present some conflicting findings. Donati et al. (2003) discovered that, in Italy, age and residential location influenced the incidence of cesarean sections. It was discovered that older primiparous women (30 years or older) delivered by cesarean section more frequently than younger women. Goodall et al. (2009) found that some mothers in the UK (Edinburgh, Scotland) felt pressured into having another cesarean section by physicians and midwives following a previous cesarean delivery. However, in a different area of the UK (Aberdeen, Scotland), Moffat et al. (2007) discovered that women who had previously delivered via cesarean wanted to deliver via cesarean section again. Despite the suggestion from physicians and midwives to try to deliver vaginally, the mothers knew they would deliver by cesarean. One factor influencing this birthing plan decision was reported to be "fear of the unknown" or fear of possible complications from having a natural delivery (Moffat et al., 2007). They feared medical

complications, such as “uterine scar rupturing” (p. 90) or their bodies failing to cope with the pain.

Most of the relevant previous research into birthing experiences explores the increased number of women who are choosing to deliver by cesarean section (Donati et al., 2003; Goodall et al., 2009; Kolip & Buchter, 2008; Moffat et al., 2007; Reiger & Dempsey, 2006; Sakala & Mayberry, 2006; Zeldes & Norsigian, 2008). Internationally, (Donati et al., 2003; Goodall et al., 2009) as well as in the U.S., there have been an increased number of children born by cesarean section. According to Goodall et al. (2009), on average, 24% of babies born across the UK are delivered by cesarean section. In 2000, it was reported that a little more than 33% of the total births in Italy were cesarean sections (Donati et al., 2003). Germany’s rate of cesarean sections reached 28.6% of all births in 2006, half of which were planned cesarean sections (Kolip & Buchter, 2008). According to the National Center for Health Statistics, in the U.S., 31% of all deliveries in 2006 were cesarean sections. This number reflects a 50% increase since 1996 (Martin et al., 2009). Although there are few studies that have been conducted in the U.S., there is a body of international research available. Unfortunately, few of these studies examine the factors that influence a woman’s birthing plan decision.

There is a body of research focused on sharing birth experiences through the feminist perspective (Kontoyannis & Katsetos, 2008; Maher, 2003; Pollock, 1999; Reiger & Dempsey, 2006; Stephens, 2009). From this perspective two of the studies describe the absence of the natural body, arguing that social and medical practices actually define the biological body and influence the birthing experience (Maher, 2003; Reiger & Dempsey, 2006). Particular attention is being paid to how the psychological effects the physiological. Other scholars, such as Pollock (1999), explore why women hide their true birth experiences and downplay their pain and fear. Both medicalized and non-medicalized birth experiences were examined. Medicalized births are seen as the perpetuation of a patriarchal medical authority over a woman’s body (Pollock, 1999), creating distrust in a woman’s natural ability to deliver her child.

Non-medicalized birth, or natural birth, “represents a woman’s resistance to patriarchy, as a way of gaining control and power over the birth process” (Kontoyannis & Katsetos, 2008, p. 46).

Maher’s (2003) research into women’s birth experiences through narratives discovered that (in the Western medical community) for a pregnancy to be considered healthy, it must be managed by recommendations developed from medical knowledge. Women, especially first time mothers, feed into the need for these recommendations, which helps to create a normalcy in medicalized births. Media’s common portrayal of a medicalized birth as “the norm” may be a key factor in why women feel “safer” delivering in a hospital. Being armed with certain medical knowledge might not impact a primipara’s birthing decision positively. Maher (2003) claims that this information sets mothers up for scenarios that rarely come to pass and unnecessarily place fears in their minds. After being inundated with research and news coverage of the trauma that giving birth could result in, it is apparent why women do not trust their bodies to deliver their children without medical intervention. As Mead (1933) stated, meaning making is a process influenced by self, other, and society. Meaning is constructed between self and society. The way society highlights birthing stories defines a mother’s expectation of delivery. As Reiger and Dempsey (2006) explain, “trust in the birth process is disappearing” (p. 365).

It is clear there are contradictions and gaps in the research. It is important to note that this body of research originated from various countries, which may be a basis for these contradictions. The lack of research in the U.S. is cause for further investigation. It appears that the previous research failed to discover the basic factors that influence a woman’s birthing plan decision and simply tried to understand a specific choice. The goal of this study is to uncover who and what influences primiparae to make their birthing decisions. A better understanding of the communication needs of primiparae will lead to recommendations that will improve patient-provider communication and increase satisfaction and adherence. Thus the following research question will guide this study:

RQ: What factors influence a primipara’s birthing plan?

CHAPTER 2
METHODOLOGY
2.1 Introduction

This thesis seeks to extend the previous research on patient-provider communication and how decision-making is influenced with regard to pregnant mothers (Amoros et al., 2010; Goodall et al., 2009; Kontoyannis & Katsetos, 2008; Moffat et al., 2007). The previous research examined factors that influence a woman's secondary childbirth delivery decision. The primary focus of these studies was the communication between patient and physician or other healthcare providers. Each study used qualitative methods, primarily in-depth, semi-structured interviews along with thematic analysis. With this body of research as a foundation, the present study will employ in-depth, semi-structured interviews to explore and extend what we know about primiparae and decision-making.

According to Lindlof and Taylor (2002), interviews uncover "commonsense conceptualizations" found in society. They provide a setting for more authentic reactions and responses. Unlike quantitative methods, interviews allow participants to explain themselves vernacularly. In-depth, semi-structured interviews were the most appropriate method to fully investigate what factors influence primiparae's birthing plan because little research has been done in the U.S. on this subject. Interviewing participants helps to exclude preconceived biases or assumptions from the study by allowing participants' voices and experiences to be heard. It also will not restrict an unlikely explanation from being offered. This snapshot of birthing experiences is best served by allowing the primiparae to speak for themselves and provides a rich understanding of the factors that influenced each woman's decision.

2.2 Participants

It is not the goal of a qualitative study to find a representative sample but to reach saturation with a purposeful sample (Brown et al., 2002). In the present study, although it was not imperative that each participant planned her pregnancy, it was important that each participant was in a position to choose her own birthing plan when pregnant. Five criteria defined which primiparae were appropriate for this study. The participants were women who have only one child to whom they gave birth. The mother's child could not be older than 18 months in order to ensure that the mother did not forget too much detail regarding her delivery. The participant had to be a high-school graduate and have an involved significant other. The mother could not use government assistance for healthcare; she had to have private insurance or had to pay cash for her healthcare. These requirements helped create a similarity in situation between participants.

Twelve mothers participated in this study and were recruited through social networks of family, friends, and coworkers. All of the mothers agreed to share their childbirth planning and birth experiences and disclosed personal health-related information. This sample is a snapshot of birth experiences, focused on child birthing decisions. Through the experiences of these 12 women, we can begin to learn what influences the personal decisions surrounding childbirth and the context in which these decisions are made.

Twelve mothers participated in the study and their ages ranged from 21 to 32; the average age was 27. Eleven of the women identified themselves as Caucasian, and one identified herself as Mexican-American. All of them spoke English as their first language. As a primipara, each participant had only one child. However, four of the mothers were pregnant for a second time at the time of the interview. The children's ages ranged from 1-month-old to 18-months-old. The average age of all the children in this sample was 14-months-old.

Specific details of their marital status and financial situation varied for each mother. All of the mothers were married during their pregnancies and at the time of their deliveries. Eight of

the mothers received health insurance from either their employers or their husbands' employers during their pregnancies. The other four mothers paid cash or out of pocket for their healthcare during their pregnancies. The out of pocket method of payment simply means that the mother had insurance; however, her insurance paid for little or none of her medical expenses. This can occur for a number of reasons: her deductible was higher than the sum of her total expenses or she chose a healthcare provider that was not covered by her insurance. All of the mothers reported that they were able to pay for the healthcare they were seeking. One of the mothers, without insurance, approached an obstetrician for prenatal care and was turned away even though she had the money to pay for any medical expenses. Eleven of the mothers worked outside of the home before getting pregnant. After delivering their first children, five of these mothers became stay-at-home mothers and did not return to work. In addition to these five mothers, one mother was not employed before getting pregnant or after delivering her child. The education level of the mothers varied from high school diploma to holding a master's degree. All of the mothers graduated from high school and either successfully or currently supplemented their education with additional classes. Five of the women hold a bachelor's degree and worked professionally before getting pregnant. Of these five mothers, one is currently working on her master's degree. In addition to these five, one mother holds a Master's in Kinesiology. She worked professionally before getting pregnant as well. Five mothers entered the workforce upon completing specialized training for their positions. One mother is currently enrolled in an undergraduate program and taking online courses.

2.2.1 Participant Profiles

Ava

Ava is a 30-year-old, Caucasian, first-time mother of a 1-month-old girl. She worked as a high school teacher until delivering her daughter. She holds a Bachelor's degree in Education and taught for seven years. Ava is married and her husband is employed full-time. Both individuals received health benefits from their employers during Ava's pregnancy and delivery. She and her husband were trying to have a child when Ava became pregnant. She delivered 10 weeks early and at the time of the interview was commuting to the hospital to visit her child. Ava's

baby was hospitalized due to a premature birth. Ava experienced an emergency cesarean section following a severe case of preeclampsia. She no longer works and takes care of her daughter full-time. Ava described herself as an anxiety prone person who did not experience a “normal” birth. Her experience will not keep her and her husband from trying to have more children. It is her hope to deliver vaginally if she gets pregnant again.

Charlotte

Charlotte is a 31-year-old, Caucasian, first-time mother of an 8-month-old girl. She works at the university level as a strength and conditioning coach. She holds Bachelor’s and Master’s degrees in Kinesiology and has worked professionally in this field for more than seven years. Charlotte is married, and her husband is employed full-time. Both individuals received health benefits during her pregnancy and delivery. However, she changed employers during her pregnancy and found it difficult to find a new physician during this transition. Many physicians refused to take over her prenatal care while her insurance was changing. This experience made it more difficult for her to find a hospital for delivery. She was able to find a physician and a hospital before delivering and had a cesarean delivery. Charlotte returned to work after her 6-week maternity leave expired.

Olivia

Olivia is a 25-year-old, Caucasian, first-time mother of an 18-month-old girl. Before delivering her daughter, she worked as a doula for two years and is one test from being a certified professional midwife. Now she stays home with her daughter. She is currently eight months pregnant with a girl. She is married and her husband is employed full-time. She did not have insurance and paid cash for the prenatal care and delivery of her child. The same is true for her current pregnancy. Olivia and her husband planned both pregnancies. After working in the hospital and assisting with numerous births, natural home birth was her first choice for delivery. Her husband, however, did his own research before agreeing to a home birth. A certified nurse midwife managed Olivia’s prenatal care and delivery. She delivered her daughter vaginally at home without any interventions. Olivia credits the success of her home birth with having a “low-risk” pregnancy and plans trying a home water birth next.

Sophia

Sophia is a 27-year-old, Caucasian, first-time mother of a 15-month-old boy. She works as a personal banker. She holds a Bachelor’s degree in Journalism. Sophia is married and her husband is self-employed. She and her husband received health benefits from her employer during her pregnancy and delivery. Sophia’s pregnancy was planned. In fact, she and her husband struggled to get pregnant for several years. It was only through in vitro fertilization that they successfully conceived. She described herself as not overly “health conscience”

and, as a result, she experienced numerous health related complications during her pregnancy. She was diagnosed with a severe case of gestational diabetes and preeclampsia, which restricted her to bed-rest in the hospital for five weeks prior to delivery. She delivered by cesarean section at 37 weeks. After her 6-week maternity leave, she returned to work to maintain her health benefits. She and her husband are planning to use in vitro fertilization again to get pregnant within the next few months. Sophia reported that her health insurance paid for more than 90% of her medical expenses, so they wanted to take advantage of that benefit for their next pregnancy.

Lorelai

Lorelai is a 32-year-old, Caucasian, first-time mother of an 18-month-old girl. She is a stay at home mother. She holds a Bachelor's degree in Public Relations, but after getting married she chose not to work because her husband's job requires occasional relocation. She is currently seven months pregnant with twin boys. She and her husband received health benefits from his employer during her first pregnancy and delivery as well as the current pregnancy. Lorelai and her husband were trying to have a child when she became pregnant. She researched different pain management techniques, which included Lamaze and hypno-birth, but opted for pain medicine during the delivery. She delivered her daughter vaginally with an epidural at a hospital with her obstetrician. She described her pregnancy as healthy and uncomplicated. She was pleased with her birth experience, but she knows that delivering twins will be a different experience.

Kate

Kate is a 24-year-old, Caucasian, first-time mother of an 18-month old girl. She works as a mortgage specialist at a bank. Kate holds a Bachelor's degree in Economics and is currently working on her Master's degree in Economics. Kate is married and her husband is employed full-time. She received health benefits from his employer during her pregnancy and delivery. Kate and her husband were planning to have a child; however, she admitted they thought it would take longer than it actually did. She describes herself as an "easy-going" person and preferred to "go with the flow" rather than stress about things. She delivered her daughter vaginally with an epidural at a hospital with the on-call obstetrician. She had an uncomplicated delivery and plans to have more children in the future. She reported that nothing in her birth experience would prevent her from delivering in the same manner.

Lilly

Lilly is a 29-year-old, Caucasian, first-time mother of a 17-month-old boy. She worked as a photographer until she delivered her son. Now she stays home with her son and occasionally photographs weddings on the side. She is married and her husband is self-employed. She is

seven months pregnant but has elected not to find out the sex of her baby. Since she and her husband are both self-employed, they paid cash for the prenatal care and delivery of her son. She does not have health benefits covering the current pregnancy either. For her first pregnancy, Lilly approached an obstetrician to manage her healthcare but was turned away for lack of health insurance. She and her husband were able to pay cash in advance for any medical expenses but decided to find another healthcare professional. She chose to have a certified nurse midwife manage her pregnancy and delivery. Lilly delivered vaginally in water without any interventions at a birthing center. She was so pleased with her delivery that she has decided to have another water birth for her current pregnancy.

Stella

Stella is a 31-year-old, Caucasian, first-time mother of an 18-month-old girl. Before delivering her daughter she worked as a wedding/event planner. Now she stays home with her daughter and occasionally works events on weekends. She holds a Bachelor's degree in Advertising. Stella is married and her husband works full-time. She and her husband received health benefits from his employer during her pregnancy. Stella and her husband never used contraception and tried to get pregnant for three and a half years. After taking Clomid for five months (a fertility drug) and using intrauterine insemination, they successfully conceived. After getting pregnant, Stella interviewed an obstetrician and two midwives before choosing to deliver at a birthing center with a midwife. She delivered vaginally without any intervention and had an uncomplicated delivery. For her next delivery she plans to try a water birth.

Amelia

Amelia is a 21-year-old, Hispanic, first-time mother of a 6-month-old boy. Before delivering her son, she worked part-time as a waitress and was a full-time student. She is married and her husband is employed full-time. Currently she is a stay-at-home mother and takes online courses. They both received health benefits from his employer during her pregnancy and the delivery. Amelia and her husband were not planning to have a child when she found out she was pregnant, but were excited when they found out. She had a vaginal delivery with an epidural at the hospital. The on-call obstetrician delivered Amelia's son. Her son was in the posterior position when he was delivered, which she described as very painful. Aside from the baby's position, she had an uncomplicated delivery.

Madelyn

Madelyn is a 24-year-old, Caucasian, first-time mother of a 15-month-old girl. She works as a bookkeeper in the accounting department for a shipping company. Madelyn is married and her husband is employed full-time. She and her husband were trying to get pregnant. During her pregnancy and delivery she received health-benefits from her

employer. Madelyn delivered vaginally with an epidural at the hospital. However, she reported feeling pressure from her mother-in-law to try delivering without pain medication. She had an uncomplicated delivery and was pleased with her birth experience. She and her husband plan to have more children in the future.

Felicity

Felicity is a 30-year-old, Caucasian, first-time mother of a 13-month-old boy. She worked full-time as a fitness instructor before getting pregnant. Currently, she stays at home with her son and works part-time as a fitness instructor. Felicity is married and her husband is employed full-time. She and her husband were not trying, nor preventing, a pregnancy. She received health-benefits from her employer during her pregnancy and delivery. Felicity had a cesarean delivery and experienced a post-operative infection. She was unsatisfied with her first birth experience and has researched midwife-assisted natural delivery. It is her plan to deliver her next child by that method.

Isabelle

Isabelle is a 25-year-old, Caucasian, first-time mother of an 18-month-old girl. She worked as a bank teller before giving birth to her daughter. Isabelle was also enrolled in an undergraduate program before getting pregnant; however, now she stays home with her daughter. She is married and her husband is self-employed. She and her husband were not preventing nor were they trying to have a child when she found out she was pregnant. During her pregnancy and delivery she received health-benefits from her employer. Isabelle delivered at a hospital with her obstetrician. She had a vaginal delivery with an epidural. The delivery was uncomplicated, and she reported to be pleased with her birth experience, describing it as “very normal” and “boring.” She and her husband would like to have more children in the future.

2.3 Interviews

Research began once approval was received from the thesis committee and the Institutional Review Board. Contacts through social networks were used to begin arranging interviews. Finding women who were primiparae proved to be difficult. Many prospective candidates did not meet all of the criteria and were disqualified from the study. Interviews were conducted in the mothers' homes or in private corners of restaurants. All of the interviews were conducted face-to-face. Each of the mothers selected the interview locations. Interviews were

recorded and transcribed. Women were assigned pseudonyms of my choosing to protect their identities.

The interview schedule was made up of ten open-ended questions (see Appendix A). The questions were guided by previous research. The initial interview schedule was based on the questions used by Kontoyannis and Katsetos (2008) when they interviewed women choosing home birth. However, for the present study, the interview schedule was modified to include questions regarding medicalized delivery. It was designed to allow each mother the opportunity for her voice to be heard. The questions used simple, uncomplicated terms to prevent confusion. Each mother was asked to share how she gave birth to her child, which provided insight into how she viewed her experience as well as the events that took place during her delivery. The interview schedule asked each primipara about the different factors that may or may not have been part of her birthing plan decision. There were also questions that measured how satisfied the mother was with her birthing plan now that she was reflecting on her experience. Through this combination of questions, the factors influencing these primiparae's birthing plans were revealed. As a first-time mother and researcher, it was important that my voice not be heard over the primiparae's voices. With this interview schedule as a guide, I was careful to ask the questions without guiding the mothers toward any particular answer. Interviews lasted about one hour, ranging from a half hour to 90 minutes. The interview schedule acted as a general guide for each interview. The mothers consented to the voluntary, audio-recorded interview and were able to stop at any time.

2.4 Interview Analysis

The present study used grounded theory (Glaser & Strauss, 1967; Corbin & Strauss, 1990; Strauss & Corbin, 1998) as the method of analysis. Glaser and Strauss (1967) developed grounded theory with the belief that theories should emerge from data collected, from the ground level. According to Corbin and Strauss's (1990) interpretation, grounded theory seeks to build theory inductively through open, axial, and selective coding. The idea is to

organize emerging concepts into categories that explain or further hypothesize interpretations about the studied phenomenon.

It is necessary to note that grounded theory is a method of constant comparison between similarities and differences of emerging concepts (Corbin & Strauss, 1990; Strauss & Corbin, 1998); it is a cyclical process that begins with the initial observation. During each interview, notes were made about each participant. Upon completion, interviews were transcribed and the transcripts read for general concepts; this is the open coding process. In some situations, several weeks went by between interviews; as more interviews were conducted, constant comparisons of the data were necessary. It is because phenomena are constantly evolving that only after all interviews were completed were the initial concepts found in the transcripts labeled.

As Corbin and Strauss (1990) established, the goal of grounded theory is to organize data in a way that results in “a thorough theoretical explanation” (Corbin & Strauss, 1990, p. 5). Categories were identified, which are more abstract than concepts. They are a gathering of concepts that share similar properties, which may be conditions that yield the observed phenomenon or even resulting consequences (Corbin & Strauss, 1990, Strauss & Corbin, 1998). This process is accomplished through axial coding. During this process, the observed relationships were critically evaluated and tested against the data. Not only is it the goal to uncover relevant conditions, but also to determine how individuals respond to changing conditions and to the consequences of their actions (Corbin & Strauss, 1990). It was not enough to provide a single observation as verification of a relationship. However, a single incident was not disregarded either. Sometimes one incident may be provisionally or conditionally linked to an action. The conditional relationships between the categories or themes emerged through the continuous process of answering the “why” and “how” questions related to the categories and the phenomena represented (Corbin & Strauss, 1990; Strauss & Corbin, 1998).

Finally, selective coding was used to create core categories. It was during this process that the richness of the data became apparent. This is the verification stage of the process, so it is important to have detailed descriptions to support the core themes being outlined. The properties that helped to create the core themes are found in the supporting data. As Corbin and Strauss (1990) outlined, the core categories in the present study described the conditions that contribute to the observed situation, the actions primiparae used to respond to the situation, and the consequences of their actions. As this study evaluates the discourse of primiparae and examines the role of communication as it pertains to decision-making, it is my goal to provide a better understanding of what truly influences the childbirth delivery decision as well as to offer communication strategies for greater satisfaction within a healthcare context.

CHAPTER 3

RESULTS

The purpose of the present study is to examine the factors that influence a primipara's birthing plan. The women who participated in this study were first-time mothers reflecting on their birth experiences and the choices they made leading up to their delivery. Each woman shared her view of the role she played in deciding on a birthing plan for her first delivery; some were satisfied and excited to deliver again and others were disappointed by the experience. Through analyzing their discourse, three key factors emerged. The first factor, other's birth stories, guided women towards an initial notion for a birthing plan. The second factor, trust, refers to the confidence these women found in trusting themselves and others, as well as being comfortable with the circumstances surrounding their delivery. Finally, the third factor, fear, describes how these women made birthing plan decisions out of a place of worry and lack of information.

3.1 Factor One: Others' Birth Experiences

When discussing their birth experiences, nine of the twelve primiparae interviewed referred to a friend, family member, or other person of significance several times throughout the interview. Most often, these individuals of importance were issuing bits of advice and disclosing their own birth experiences. After becoming pregnant, these primiparae's initial thoughts of delivery were influenced by listening to the birth experience of others as well as the others' opinions. Learning about others' birth experiences created an impression that remained with each woman throughout her pregnancy. Madelyn (24), Ava (30), and Sophia (27) had medicalized deliveries. Although, Ava and Sophia experienced cesarean deliveries due to medical reasons, their initial thoughts of delivery were still guided by others' birth experiences.

I've had my friends tell me that they decided before they went to deliver, they weren't going to have an epidural. . . . while in the middle of labor they told the doctor, "I have to an epidural!" and the doctor said, "It's too late, I'm sorry." . . .

It was after talking to that one person, who told me that they decided- and this was actually a couple of years before I even got pregnant. I was talking to my friend and she told me the story of about how she did not want one (epidural) and then when it was too late, she did want one. . . . She said it was the worst pain of her life, and she can't even remember the delivery because she was in so much pain. That it kind of felt like she was blacking out. (Madelyn)

My sister-in-law had had a c-section and I saw- I knew that it took her a long time to recover. I was like I don't want to have a c-section- you know, not like you can plan that. (Ava)

No one in my family had had a vaginal delivery. I honestly thought I would have a c-section because everyone in my family had, and everyone had big babies. I just figured that's how it's gonna be for me. (Sophia)

These mothers saw or heard first-hand how their friends and family experienced birth. These experiences impacted their visions of how their deliveries would be and, sometimes, how they hoped they would not be. Some mothers saw themselves as novices and searched for a real birth story that came from someone held in high regard. Discussing a close friend or family member's delivery provided the primipara the opportunity to revisit that conversation. The closer the individual, the more the primipara referenced her and her story. One mother, the youngest of the group, recalled the influence her mother and sister made on her birthing plan decision.

My mom did that (non-medicalized delivery) with all of her children, and I don't know how. But I knew right then and there and my mom even said, "No- you need to get it. You probably do, you know." My sister got it (epidural) and yah, you know- she said, "You are probably going to need to. There's nothing wrong with getting it." So I definitely knew right then that I wasn't going to try to do it at home or a water birth or anything natural. . . . I mean I definitely did talk to, you know, my mom and my sister and friends of mine who have had children and of course all of them except my mom had had epidurals and you know, my mom is definitely just a different kid of woman. (Amelia)

Amelia (21) gave birth to her son in the hospital with an epidural and felt very confident about her decision. Madelyn, who had an epidural delivery, also sought advice from a close family member when choosing a birth plan.

Well I'm gonna use my sister as an example cause I talk to her about a lot of things. I even told her, you know, "I think this is really what I want to do." It's in the privacy of your own home. I live close to a hospital so if something were to happen and she would say, "Is this really what you want to do, though- I mean

anything could go wrong. Is this really what you want to do?" And then I realized, I'm really making that decision based on money- not on what I feel like I need to do or I want to do or what I believe in. (Madelyn)

Another mother, Lilly (29), spoke with a close family member about her previous birth experiences; her sister-in-law introduced her to a new kind of birth experience.

She (gynecologist) just tried to brush us off- "Oh just try to get Medicaid- come back and see us after you do that." I was like, okay, whatever. So I was like, we're not gonna go back to her. . . . So I'm like, okay what are we gonna do? What's our options now? . . . So then Mandy was researching- you know midwife and doing that, they had been telling us, "You really should go that route, it's dirt cheap, you know. Even if you have insurance it's cheaper than your co-pay usually and you know, um, it's a much better experience." And they had already had two kids in the hospital, and they were doing this for their third. So I was like, oh, if it works for her, sure I'll do it. Whatever. . . . And I called Mandy, I said, "What-do you know anything about any of these midwives? You know, what do you-do you know anything about anybody in the area?" (Lilly)

Lilly gave birth to her son naturally in water at a birthing center.

In one situation, it was not one single person of importance but a mother's social network that influenced her initial thoughts about childbirth delivery, and it occurred without her consciously realizing it. When Felicity (30) became pregnant she wanted to have a natural, non-medicalized delivery. The only option, she felt, was to deliver in the hospital.

There was no quest- people I hung around with, the information that I had- there was no question of how you did it. It was- when you have a baby, you get a doctor and you have the baby in the hospital. So my eyes hadn't been opened to the fact that there is even a possibility. I didn't have a lot of friends who had babies and so it wasn't like I was around of a lot of other experiences. . . . I never thought- huh, maybe there's something different I could do until I met my friend that had her baby (naturally at home). (Felicity)

She delivered her son by cesarean section in the hospital. After Felicity's friend shared her birth experiences with her, Felicity discovered that delivering outside of a hospital was a viable option. She is now a believer in home birth and birthing center birth. It was only after meeting her new friend and hearing her story that her perception change regarding locations for delivery.

I met her- she had six kids -after having a cesarean- at home! I thought, "Oh my gosh, there's hope." So talking to her about her experiences, she connected me with other ladies that had done the same thing and then reading a ton of books. (Felicity)

Choosing a birth plan in spite of other's birth experiences is another aspect that the primiparae described.

My sister-in-law had an epidural, I guess Callie's 7, and if I would've, kind of, went off of her experience with an epidural, I would've not had one because she had an epidural. And she had to stay a few extra days in the hospital because she couldn't move her head very well, her neck. And so she had a really bad experience with it, um but I talked to several people since then who didn't have that same experience. . . . I definitely want one. (Madelyn)

I was hearing all of these people with horror stories- you know- or birth stories were all " I was induced," "This happened," "They gave me this drug, so I had to have a c-section." That just didn't sound like fun to have all those interventions. I didn't want all that. (Lilly)

But that was my one- my first reasoning- being able to avoid intervention is really hard to do in the hospital and I've seen a lot of moms who set out to do it that way, but one thing leads to another and it ended up with something small that kind of leads on to more, which as a doula-one of your jobs is to help them be able to avoid some of the things- if that's what they want. But it's hard to when the options are there. (Olivia)

Stella (31), who delivered naturally at a birthing center, was persuaded to research different birthing plan decisions after observing her friends' deliveries and subsequent recoveries. After listening to her friends' experiences and a family member's observations, she made the decision to research and, eventually, choose a natural delivery.

Then I had several friends that had babies before me, and they all had c-sections, and they were all induced. Um and I thought, "I don't want a c-section, and I don't really want to be induced. When my baby's ready to come- my baby will come." . . . My cousin is a labor and delivery nurse in a hospital, and she said you can walk into a nursery, and you can look at the babies and say "that baby was born naturally with no drugs," because they're so much more alert and they are just much more aware and um, so they cry quicker. They, their initial Apgars are typically higher because they're not, I mean they're not medicated so they didn't get anything. So that was when I really started thinking I need to look into this natural birthing thing and see if it's for me. (Stella)

Many of the mothers recalled others' describing their birth experiences as moments that were out of their control. Lorelai (32) felt that making too much of a plan would be pointless after talking with her friends about their birthing plans. She felt that the baby would dictate, more than anything else, the circumstances in which it would be born. She had an epidural delivery at the hospital.

I talked to other moms who said, "You know what? You can try to plan all you want, but the reality is you're gonna do whatever you have to do to get this baby in this world safely." (Lorelai)

Amelia described a similar feeling:

Plenty of women, you know, talk-they have this plan and they do it the whole time and then they get there in the moment and they can't do it. . . . My thought on it was that I don't really think you, I mean you can have a birth plan to a certain extent of course. Of course you and your doctor are going to work out if you want an epidural or if you want- you know, how you want to do it. But my whole outlook on it was- I really have no control over it when the time comes. (Amelia)

Others' birth experiences were referenced repeatedly throughout the analysis process and proved to be a major factor influencing a primipara's birthing plan decision.

3.2 Factor Two: Trust

For all of the women interviewed, trust is characterized in a number of ways: having faith, feeling confident, and being comfortable. These primiparae described their birthing plan choices as being influenced by the amount of trust they had in God, in themselves, in midwives, in physicians, and/or in the hospital. Often, when they described an abundance of trust in one area, a lack of trust followed in another area.

In relation to the group of primiparae interviewed in the present study, when a mother expressed trust in God, she chose to deliver naturally more often. Women who delivered naturally were not the only mothers who described a high level of trust in God; they did, however, report it more often than did mothers who chose medicalized delivery. Out of the four mothers who expressed a strong trust in God, only one chose to have a medicalized delivery, which was Madelyn.

That's kind of my philosophy, I've just always tried to go with you know-God made me to do this and I can do it and God's gonna take care of it. God's made women to have babies. I can do this. So, yes it may be hard, but I can do this. (Lilly)

My natural instinct was, "I can do this." My natural instinct was that I knew I could do it, and I knew that women had been doing it for years. And that, that is what we were made to do- is to give birth to children. That's not our sole purpose but that's a big part of who we are. And I knew I could do it, and I knew that God did not design me with a flaw to not be able to do that. . . . God didn't

make a mistake when he designed us, and you know we are created for our body to open up and shift and then go back to normal. (Stella)

Another result of trusting God that these primiparae reported is feeling less anxious and less worried about their birthing plan decisions.

I mean, I think ultimately, we trusted God that our baby was going to be delivered and whatever he was giving us was gonna be the end result, whether we were in a birthing center or in a hospital, his hand was in it. He had breathed life into this child, so we were just- we believed that. I think we just had peace, and we were able to rest in that. (Stella)

God made us to do this, and God will take care of whatever he needs to and these women can have babies. You know- it's no big deal and so that was just, you know- God will take care of whatever it is. (Lilly)

I feel like if you give something to the Lord, but then you're so worried about it and you're researching and asking people questions then, that's really not- I hate to say - it's not having faith because you need to know what your options are. But once I made the decision, you know, I know that I want an epidural and then once we decided the ways we were gonna go, I really didn't go back and start second guessing if I should do it or not because I just gave it to the Lord at that point and decided it's gonna be okay. (Madelyn)

The mothers who indicated their trust in God reported higher satisfaction with their birthing plan, and all wanted to repeat the same type of delivery they experienced the first time.

Two of the primiparae felt confidence or trust in themselves, which contributed to their birthing plan decisions. They described this trust as knowing themselves and being confident in their decisions.

My pain tolerance has changed from since I was little, and I just- I just don't have it anymore and the way that I get when I'm in pain- it's not a pretty sight at all. So I knew to save everyone and myself including- that is definitely what I needed to do because I wouldn't- I wouldn't, I don't think I could have given birth willingly, vaginally-anything without an epidural for sure. (Amelia)

I knew I was going to need something. I did not want anxiety medicine cause I was- you know- I wanted as few drugs as possible- you know for the safety of the baby. I heard about some babies come out all doped up and sleepy and groggy because the mom took too many drugs and I didn't want that. I knew that I for sure want the epidural. (Ava)

Seven of the mothers described the level of trust in their healthcare providers as a factor in determining their birthing plans. The greater the amount of trust a primipara had for her healthcare provider, the more likely she was to listen to her healthcare provider's

recommendations. It is no surprise, then, that the five women who trusted their obstetricians had medicalized deliveries more often than did women who trusted their midwives.

We pretty much just trusted the doctor in that whatever he thought was best for me and the baby was- we took his word for it. So we never discussed anything like that. (Sophia)

I totally, totally trust my OB, and for her- she wouldn't do anything that would potentially harm my baby. Um, but yeah, we didn't really lay out any guidelines. (Lorelai)

I'm really laid back when it comes to things (choosing where to deliver) like that. I had heard really good things about Dr. Y, and he's been around for a while so- and so I wasn't concerned at all that I was going to have a bad experience. (Kate)

So it really encouraged me about it too, that she was very spiritual and believed and had the same beliefs we have so that made it much easier to trust her and do whatever she says and so she's like, "Now, what do you want?" and I'm like, "Whatever you want me to do." (Lilly)

She tried to be very sure by the end that you felt like you were educated and that because- as having a homebirth- one of the things that they upfront tell you is that you're taking responsibility for your own health. . . . so one of her main jobs, she feels like and most midwives do, is to educate you as opposed to- like having or feeling like you are a bother when you ask questions. (Olivia)

My midwife had previously been a labor and delivery nurse, so I felt confident that she knew. I mean- they do everything - the doctor catches the baby. And I felt confident that she was gonna- they're the ones in the hospital that call the doctor and say we think there's a problem. So she was the one who would have noticed that anyway, and she had done over a thousand births, birthing center births. (Stella)

One of the mothers described having a high level of trust in her physician.

And so um they decided to go ahead with the cesarean and I trusted them and said well if that's what you think is best. I asked my doctor if this was- if I was your daughter is this what you would want to do. He said, "Absolutely." So I said, "Well, then that's what we should probably what we need to do." (Felicity)

After doing research about natural births and hearing the birth experiences of women who experienced natural births, however, she became less confident and less satisfied with her delivery. She expressed the idea that she had allowed herself to be talked into having medical intervention because her labor was taking too long according to the physicians. Looking back on it, she feels that first time mothers have longer labors and should be judged on an individual

basis. Her experience of a cesarean delivery left her unsatisfied, and she expressed her frustration physicians.

You put all your faith in the - that the doctor knows exactly what's best. And that was my reasoning for wanting to do it out of the hospital, because the doctor knows what's best for the mass- for the masses. Like for a thousand people this will probably work best. But on the individual basis- you cannot say that protocol is going to be perfect for each person. (Felicity)

Another dimension of trust refers to location of the delivery. Five of the mothers discussed how being comfortable in whichever location they chose was very important to them. Feeling relaxed and confident that their requests would actually be met played a significant role in making their decisions. Lilly (29), Olivia (25), and Stella (31) experienced non-medicalized deliveries, and Charlotte (31) and Amelia (21) had medicalized deliveries

I hate hospitals. I don't like doctors, so I don't like anything about hospitals. I don't like needles. I don't like whole aspect of that, that scared me. A midwife didn't scare me. It just seemed calm, relaxed. God's gonna take care of it. You know, it's gonna happen, what's gonna happen. . . . My comfort zone is I don't want to be anywhere near your hospital. I don't really want to be at home because that just seems- well it's my home and I don't like the hospital around here. If something happens at the birthing center, they have all the stuff you can- you know- that you need. So if something does go wrong, they can take care of it. I just think it's all in your comfort zone, if you're comfortable then you can do it. (Lilly)

I think of my comfort level of hospitals versus my knowledge of a woman's body and what her ability is to do. Um, I think of a hospital as a place that helps you when you're sick or that provides assistance and I don't feel like there's anything wrong when you're pregnant. So if there is, I'd be the first to be at the hospital and have an emergency c-section. If that is what I needed for an emergency case but in my case my pregnancy was low risk...now it was a factor that we live in the metroplex, we are close to medical care if we need it. That was another thing that my husband was more comfortable with and me too, knowing that we could get to a hospital in however amount of time we needed to. (Olivia)

In this day, an age of modern age, I figured I better be near something in case something happened. Where if I'm at home and there's something that happens-they're not going to be able to do anything. Where if I'm in the hospital, they can actually take the baby or take me and do something if something were to go down the wrong path. (Charlotte)

I just feel like that's crazy. I just feel like that's nuts and like you have a team of doctors and be in a hospital. I'm not saying that a hospital- I'm not saying that somebody isn't capable of taking care of someone in- in a home, you know- fixing what they need to fix and doing all that but I just feel like anything could

go wrong and when you're in a hospital, I'm sorry, but regardless you have more chance to be saved or for your child to be saved. Just that, kind of like, that peace of mind that you're in a hospital. (Amelia)

I thought, I'm gonna be in an environment where there's also sick people on other floors and if you give birth while you're sick you can't help it. You just come to the hospital anyway, and you are on the same floor as someone who is potentially sick and you're sharing air conditioning and all the vents are being shared and I have a new baby with no immune system and they're gonna take them to the nursery and those babies, who have just been delivered from a sick mom, is gonna be in there. So that's what was running through my head as I was sitting in this appointment with the OB. I don't feel safe here. I did not feel safe and I thought this is not a safe place for me and this is not a safe place for a new baby. There- no baby has any business being in the hospital unless they are sick. (Stella)

Each mother described different factors about the hospital, birthing center, or home that was appealing to her and ultimately made her comfortable enough to choose that particular location. Regardless of which location was chosen, it is important to understand that being comfortable and trusting the place where she would deliver influenced the birthing plan decisions of five of the primiparae in the present study. The more confident they were in the possibility of success of their deliveries, the less likely they were to want to deliver in a hospital. However, all of the women who chose to deliver somewhere other than a hospital reported they took comfort in knowing that, if something did go wrong during the delivery, they were close enough to get to a hospital in time to be saved. The women who feared complications were more likely to choose a hospital as the location for their deliveries.

3.3 Factor Three: Fear

As primiparae, none of these mothers had any actual experience of childbirth or the different types of delivery. Although they were inundated with others' birth experiences and trusted their healthcare providers, fear of the unknown influenced ten of the mothers' birthing plan decisions. There were multiple characteristics of fear: physical pain, being judged, and safety of self and child.

Fear of physical pain was the first type of fear that six primiparae described. These mothers reported that the fear of pain and the inability to handle a delivery drove them to choose certain types of birthing plans.

When I watched baby shows, the mothers (delivering without interventions) always seemed like they were in such pain, and I just- I don't see how that's lovely, or motherly, or whatever those people call it. (Sophia)

I know my pain tolerance, and I know that I, that I'm tough when it comes to certain things but I'm a weenie when it comes to stuff like that. I knew that I didn't want to deal with that. (Madelyn)

I looked into hypno-birthing and water birthing and thought- ooh, this looks really cool, but to be honest, it just seemed- I don't know- I was a wuss. Basically, I was a wuss, I didn't think I could do it. . . . I honestly didn't think I was cut out for it. I know how I am when I panic or if like I get high anxiety. I'm high anxiety, I guess- and I was afraid that it would- I would like break up the whole hypnotism process and then be screwed because it'd be too late to have an epidural and then I'd just be a mess throughout the rest of the labor. (Lorelai)

I guess I have a semi-okay tolerance for pain but I didn't want to take the chance and so. Like I knew it was a good idea from- you know whenever I went in that morning to have her. I knew it was a good idea when I got- I forget, it was like 5 or 6 centimeters or whatever you have to be before they give you the epidural. I was in pain! I'm like let's check this stuff (epidural drip) out now. (Isabelle)

I just felt in myself, I do not have the will power to withstand that much pain if I didn't have to. Now if I had no choice- you have 9 months, 10 months to kind of prepare yourself in any way. . . . My biggest fear was actually giving birth- I was just like this isn't something I can get away from-like it's gonna happen, it's gonna happen in 9 to 10 months regardless. There's nothing that I can do about it- you know, and I didn't really want a c-section just because I feared the actual vaginal delivery. (Amelia)

The idea of delivering a child was difficult for these mothers to envision. When they did think of their future deliveries, the images were filled with pain and discomfort. Keeping this fear in mind, Sophia, Madelyn, Lorelai, and Amelia chose to have an epidural before delivering their children. Ava expressed fear of physical pain as a factor that would influence her birthing plan; however, she delivered ten weeks early and was not able to follow her birthing plan. She experienced a severe case of preeclampsia, which made her delivery an emergency.

Another fear two of the mothers faced was the fear of being judged by healthcare providers, friends, and other individuals of significance. Sophia discussed how her fear of being judged kept her from asking her physician questions and getting enough information to make an informed birthing plan decision.

Pretty much, I winged it. I didn't want to be the crazy pregnant girl who called the doctor all the time and who was like, "Oh, this hurts," you know...We never really talked about it (delivery options). I didn't want to be the one all the nurses talked about. "Did you see that girl, she's such a wuss!" So I'm gonna tough it out as long as I can. . . . I think that society puts pressure on each other like that because you don't want to be made fun of because you got an epidural at a one and every time you threw up, you called the doctor. (Sophia)

Something that should be noted is, as part of Sophia's fear of being judged by healthcare professionals, she also feared asking her physician questions. She discussed her health more openly with the nursing staff and explains why.

It is easier to talk to your nurse than it is your doctor. And I don't know if it's because they're trying to get you in and out and you feel kind of rushed. Or maybe it's because the doctor was a man, maybe he doesn't understand. I mean, I know he went to school but maybe he doesn't understand. (Sophia)

Madelyn shared a similar experience when she feared being viewed as weak for choosing a medicated delivery as opposed to a non-medicated delivery like her mother-in-law.

Hearing Jimmie's (husband) mom say, " Well, I had all three kids without one (epidural)," you know that made me feel like I'm weak if I do... Should I or shouldn't I have an epidural? . . . Especially hearing my mother-in-law, you know, coming from her- she made me feel like I'm really weak and can't handle it (labor), if I have one (epidural). (Madelyn)

After talking to her mother-in-law further, Madelyn discovered that her mother-in-law's deliveries went very quickly and their situations could not be compared. Madelyn ultimately chose to have an epidural during her delivery and did what she felt was right for her. The fear of her mother-in-law's judgment impacted her initial feeling toward her birthing plan; however, the later discussions with her mother-in-law freed her to choose what was right for her.

Finally, the last characteristic of fear that four of the primiparae discussed was fear for self and child. These primiparae feared certain types of deliveries because they did not view them as physically safe for themselves or their children.

You know it's a fearful thing, childbirth. People in our society are scared of it, and I understand why because things have happened and it's a very vulnerable time. And it's your child, you know, and you- it puts a lot of fear in you. . . . I thought I can't, I'm not made to have children. I just can't do this (without intervention). And I think so many women think, they just think it will probably be like that every time. (Felicity)

According to Olivia, this kind of fear impacts a woman's birthing plan decisions when she is not doing research to see if what she fears is grounded in research or just based on her emotions. She did her research and delivered naturally at home.

I think once you get to a birth a lot of women make choices out of fear, at that point cause of course, they (physicians) tell you your baby's endangered for a certain reason. And you are gonna do whatever they say cause your- and I think they know that and not that they would lie but they're used to handling panic situations. . . . but if all of your decisions are educated- well that's your own choice. (Olivia)

Felicity, who had a cesarean delivery, also shared a similar view.

I think that's what drives most women to make the decisions that they make. It's because they're fearful, and they defer to the doctor that everything will be okay. And they think that if I have a doctor, everything will be okay. . . . Fear will drive you to make decisions that aren't always best- just keep an open mind. Don't be scared and don't be scared to think- I think I would rather have a hospital birth. Well that's your experience and that's what you think is best. Don't be afraid of what your decision is. (Felicity)

Being susceptible to fear made it more difficult for these mothers to evaluate a variety of birthing plan choices. Each mothers' fear guided them toward a specific birthing plan. It is not surprising that if a mother feared pain, she chose to have an epidural. It also makes sense for a mother not to persistently ask questions or call her healthcare provider when she fears being judged as "crazy" or difficult. The fear of endangering her child or herself also often resulted in delivering at the hospital; so that professionals were able to correct any problems if they occurred. It is clear that for these primiparae fear was taken into consideration during the decision-making process for making their birthing plan.

After discovering that others' birth experiences, trust, and fear are the three factors that influenced these primiparae's birthing plan decisions, it is vital to discuss the implications of

these results. Along with this information, the next chapter of the present study will provide application of the results and recommendations for future research.

CHAPTER 4

DISCUSSION

For a first-time mother, exploring the choices for a birthing plan is a new and unfamiliar situation. Sorting through medical jargon and the information presented in pregnancy books becomes a necessary task to complete when discovering the options available for a birthing plan. However, as Gillespie and Strauss (2007) discovered, few women use these methods for learning about birth. Thus, it is the purpose of the present study to understand what factors do influence a primipara's birthing plan.

The primiparae interviewed in the present study described their first birth experiences in detail and allowed a number of questions to be asked regarding the decisions they did and did not make. From the 12 interviews conducted, three major factors were discovered to influence their birthing plan decisions: others' birth experiences, trust, and fear.

4.1 Factor One: Others' Birth Experiences

Throughout my discussions with these primiparae, nine of the mothers made reference to others' birth experiences. With no personal experience to draw from, their first impressions of a birthing plan or delivery originated from the stories others shared. There were several ways in which others' birth experiences influenced these women and their birthing plan decisions. The collection of birth experiences that were shared with a primipara created an initial vision of what each primipara understood birth to be. This includes an expectation of how the primipara would deliver or how painful the delivery would be. The closer the woman was to the primipara, the more influence her story had over the primipara. When an acquaintance shared her birth experience, it was not referenced specifically or in detail. However, when the other was a close friend or relative, the primipara spoke of her experience often and tried to recount particular aspects of her experience that influenced the primipara's birthing plan. The primiparae would

also discuss multiple encounters with a close friend or relative. They were able to revisit the conversations more frequently and for longer periods of time. Accessibility to these women may contribute to how important their experience was to the primiparae's birthing plan decision.

Of the 12 primiparae interviewed, only two primiparae commented extensively on how maternal figures played a role in their birthing plan, both primiparae were the youngest two of the group. One primipara, Madelyn (24) commented on how her mother-in-law's negative judgment was factored into her birthing plan decision. However, the youngest mother, Amelia (21) is the only one to comment on how her own mother's experience or advice factored into her decision. This primipara was married a shorter amount of time and was younger than any of the other mothers. She was the only non-Caucasian mother as well. The other eight primiparae who discussed others' birth experiences referenced women who were closer to their own age. Their references were to sisters, sisters-in-law, close friends, and cousins. Two primiparae specifically remarked on how unhelpful their mothers were in giving advice or sharing relevant stories. They attributed their mothers' ages, as well as the medical advancements made since they gave birth, as reasons to disregard their mothers' experiences. When the person of significance was closer to the primipara's own age or had experienced birth more recently, she was viewed as a more reliable source of information.

As explained in Mead's (1933) theory of symbolic interaction, these significant others and their experiences surround the primiparae and create a sense of what is normal or what is to be expected. This social interaction guides the primipara's concept of what birth will be for her. The youngest primipara's social network may consist mostly of family members, specifically her mother and sister. If her mother's experience is most prominent in her mind, then this interaction cannot be overlooked.

Sometimes the birth experiences of another can stand as example of what the primipara wants to avoid. Stories of painful delivery, long recoveries, and unnecessary medical interventions impacted four primiparae interviewed to choose a different birthing plan. Learning

from their family members' and friends' experiences helped the primiparae feel that they could question and avoid negative situations.

When a primipara chooses to go against the social norm, she has to resolve the imbalance she experiences caused by the pull between what she believes and what she feels pressured to do. This cognitive dissonance was experienced by two of the primiparae interviewed when they chose to do what they believed in spite of what their social network believed. O'Keefe (2002) discussed one way to reduce dissonance, which is changing the proportion of the consonant and dissonant elements. When these two mothers chose to have a midwife deliver their children, as opposed to an obstetrician, the most common way they changed the proportion of these elements was through research. Each of them interviewed one obstetrician and at least one midwife. During their consultations, they asked questions about the medical procedures, the point at which medical intervention would occur during delivery, and how to prevent possible complications. Both of them spoke with mothers who had experienced medicalized and non-medicalized deliveries. Finally, they read books and journal articles trying to gather unbiased information about transfer rates and mortality rates during a natural delivery. By finding the answers to their questions, they were able to choose what they truly believed over what they felt pressured to do. They convinced themselves that the dissonant elements of experiencing physical pain of labor and being socially pressured to have a medicalized delivery were not as important as their children's safety. The consonant element of delivering a child into a calm and drug-free environment increased in importance for these primiparae.

The mothers choosing natural delivery are not the only ones to experience cognitive dissonance. When women deliver naturally, they share their experience in a variety of ways, through narrative in an interpersonal communication setting, through media on television, and through computer-mediated communication in blogs. They portray their experience as an empowering accomplishment that cannot be achieved in a medicalized setting. Three of the

primiparae reported feeling pressure to try delivering naturally as a result of these types of communication. It is because the stories of natural delivery are often shared through a variety of channels that these three women, choosing a medicalized birth in the present study, talked about overcoming the pressure to choose a painful, drug free delivery. They had to negotiate their cognitive dissonance in relation to the social pressure for natural delivery. One mother accomplished this by talking to her obstetrician about the likelihood of complications to arise during an epidural delivery, which decreased the proportion of dissonance. Another way to reduce dissonance is by changing the importance of the issues involved in making a decision (O'Keefe, 2002). The other two primiparae used this method, and they made their decisions by giving trust and/or fear more importance than others' birth experiences.

The majority of the primiparae (9 out of 12) discussed how the birth experiences of others influenced their birthing plan decisions in one or more ways. This finding supports Bylund's (2005) research that few mothers make a birth decision solely by themselves. Sharing birth experiences is a powerful way to construct our image of what and how birth will be. It is a tool that obstetricians and other physicians need to employ. This can be something as small as a bulletin board in their offices or something as widely accessible as their Web site. By asking primiparae what they have been hearing from others and providing a forum for their patients to share their birth experiences, obstetricians can better understand their patients' concerns and primiparae can be introduced to a new social network. Allowing patients to share real birth experiences, not only positive ones, helps patients feel less skeptical of the information they are being given. However, it is impractical to believe physicians would allow stories to be posted that disparage his/her practice. Physicians would thus need to be dedicated to an open forum and monitor that forum so they could be fully informed. Regardless, others' birth experiences factored into these primiparae's birthing plans and cannot be ignored.

4.2 Factor Two: Trust

From the interviews, trust emerged as a common theme among all the primiparae. The descriptions and explanations of why they chose their particular birthing plans always included an aspect of trust. They either expressed having faith, feeling confident, or being comfortable. Having faith represented trust in God as well as a trust in themselves and their bodies.

Similarities were seen among the mothers who expressed a high level of trust in God. Three out of the four primiparae who discussed their faith in God chose to have a natural delivery at home or in a birthing center. Each of them referenced their biblical duty and ability to birth children. Each saw her body as a vessel capable of delivering a child without medical interventions. These primiparae put their faith in the belief that God created them to handle a natural delivery and that being pregnant was not an illness in need of treatment. Rather, they saw birth as a natural process that they can successfully accomplish with the right tools and information. They described their bodies as being built for childbirth.

Primiparae who reported higher levels of faith in God also reported feeling lower levels of worry and anxiety. Once they made the decision to have a natural delivery, they chose to trust that God would take care of them and their children. Believing that God has the ability to keep them safe was not regarded as a “get-out-of-jail-free” card. This natural process was described as work or labor, and labor requires proper tools. By consciously choosing a non-medicalized or natural delivery, they were assuming responsibility for their prenatal care. Meeting with a midwife included more than just discussing health issues after they appeared. The midwife would discuss the prevention of complications by following a specific diet and maintaining a certain activity level. So not only were they placing their faith in God and the natural process of non-medicalized delivery, but they also prepared their bodies for the process to occur. Of the four mothers who expressed faith in God, all were happy with their overall birth experiences and would repeat the same type of birthing plan for future pregnancies.

Although three of the four primiparae who indicated faith in God chose natural delivery, the fourth primipara had an epidural delivery. Like the others, she expressed a strong faith in God and reported lower levels of anxiety during her pregnancy. She was satisfied with her birthing plan and intends to have another epidural delivery. One difference between her and the other three primiparae is that she shared two opposing birth stories. Both of these birth experiences were told by women this primipara viewed as significant others. One experience was a family member's medicalized delivery that ended with complications. The other experience came from a close friend who was unable to have an epidural because she waited until it was too late during her delivery. Her friend described the pain of delivery as being "the worst pain of her life" and revealed that she wished she had gotten an epidural. The other three primiparae shared views that were in keeping with the birth experiences of significant others in their lives; these experiences spoke negatively of medicalized delivery. It is possible that because the fourth primipara's reality is created around her religious beliefs; she trusted that God was providing her with the information she needed to make the birthing plan decision that was best for her. She considered natural delivery at home but, after talking with her friend about her experience without an epidural and then seeking counsel from her sister, she chose an epidural delivery. She trusted that God would protect and support her once she made her decision. Trust was not limited to faith. Primiparae also expressed a feeling of confidence or felt a sense of trust in themselves and their decisions or in their healthcare provider. All of the mothers referenced a feeling of trust or confidence as a factor in choosing a birthing plan. One mother who delivered naturally at home was an experienced doula. She relied on her personal experience of what she witnessed first-hand during deliveries to build her confidence. Feeling confident in her decision and her experience helped her trust the birthing plan decision she made. The two mothers who expressed confidence in themselves, without referring to faith in God, chose medicalized delivery. They were confident in their decision and knew what their bodies could and could not handle. They expressed an appreciation for natural delivery but

were confident that they wanted to have a medicalized delivery. They did not feel that delivering naturally was an added accomplishment to motherhood. Oppositely, two of the primiparae who delivered naturally reported a greater sense of accomplishment and empowerment than a mother who experienced a medicalized delivery. They were able to trust their bodies and avoided medical intervention. This idea supports Pollock's (1999) view of medicalized birth perpetuating the patriarchal authority over a woman's body. Delivering naturally at home or in a birthing center challenges the necessity of medical authority for a birthing plan.

Eight of the mothers interviewed expressed trust or confidence in their healthcare providers, which includes obstetricians and midwives. The higher level of trust the mothers had in their healthcare providers, the more likely the mothers were to follow their recommendations. The six primiparae who expressed high levels of trust in their obstetricians chose medicalized delivery. Four of the mothers in this group revealed that their level of trust in their obstetricians was high enough that they did not question or even discuss the recommendations made by their physician. They felt their obstetricians had their best interests in mind and would do nothing to harm their children. The primiparae also attributed their obstetricians' level of education and years of experience as reasons for trusting them. Knowing that the obstetrician was a trained professional gave them a greater sense of confidence.

Two primiparae who delivered naturally reported a similar feeling of confidence in their midwives. One mother's trust was built when she learned of her midwife's training. The number of the midwife's deliveries and locations in which they took place gave her a higher level of confidence. However, this mother questioned her midwife thoroughly before choosing to be her patient. The mother learned of her midwife's past as a labor and delivery nurse and her midwifery training in the African bush during their initial consultation. Once the midwife's level of expertise was proven, the mother trusted her recommendations. The other mother also inquired about her midwife's training and experience; however, she followed her midwife's

recommendations without questioning after building a friendship with her. This primipara described her midwife as being close in age and sharing the same religious beliefs. They “clicked” on a personal level, which created a high level of trust and confidence between the primipara and her midwife. She considered the midwife to be a friend.

For a healthcare provider, building trust and having the confidence of their patients is vital to having a satisfied patient. Without that trust, the healthcare provider will not retain his/her patients in the future (Brown et al., 2003). One primipara expressed a high level of trust in her physician before giving birth to her son. From the beginning, this mother wanted to deliver naturally in the hospital. She experienced a cesarean delivery with complications, which were never specifically addressed by her physician. After the delivery she felt as though the physician was not completely honest with her and wanted the delivery to occur on his timetable. Learning from that experience, she reported not wanting another medicalized delivery. She also disclosed that she would receive prenatal care from a midwife in the future. The cognitive dissonance she experienced occurred when the actions of her trusted physician did not meet her expectations. Prior to delivery she felt a sense of trust in her doctor, but after months of looking back on her experience, she felt the doctor was motivated by convenience instead of her wishes. She had the expectation of a long labor ending with a vaginal, natural delivery. However, her physician expressed concern for the baby’s safety and recommended she deliver by cesarean. The primipara expressed a feeling of uncertainty when she agreed to follow her physician’s orders. During delivery, she felt like the consequences of questioning her doctor were too uncertain. By not doing what the physician suggested there was no guarantee her delivery would have a positive outcome. Upon reflection, she felt like she allowed herself to be pressured into a medicalized delivery, which went against her true beliefs. In order to resolve her cognitive dissonance she blamed her physician for using that trust and fear to accomplish his goal. Although, her physician may have felt there were medically necessary reasons for her to deliver by cesarean.

Being comfortable in the setting of the delivery is another characteristic of trust. Five of the primiparae discussed the importance of being comfortable with the place in which the delivery occurred. Being relaxed and confident that the delivery would be executed as they planned was a factor that influenced their birthing plans. The more they trusted the facility, the more likely they were to deliver there. Three of the primiparae felt that a hospital would not be able to give them the delivery they wanted. They did not trust the hospital to do what was best for them individually but, rather, to follow protocol. Two mothers were not comfortable with the idea of delivering at the hospital. They felt delivering a child in a hospital was unsafe. Hospitals are full of sick individuals, and newborns have no immune system. Bringing a baby into a hospital, when they are not ill, was seen as irresponsible and unnecessary. The perception of a hospital not being a safe place was not common among the remaining nine mothers. Again, these two primiparae had to resolve the imbalance between what they believed to be true and what the social reality defined as being true. They felt that they would not be comfortable enough to deliver at a hospital. As seen through the other ten interviews, hospitals are regarded as places for healing and medical assistance. However, for these two mothers, their social reality identified hospitals as unhealthy. Their actions supported their true beliefs and defied the norm. The third primiparae who felt distrust in hospitals delivered at home, while the other two primiparae delivered at birthing centers. Interestingly, the mother who delivered at home was not comfortable delivering at a birthing center because it did not offer a greater sense of safety in her opinion. She lived near a hospital and that gave her an added sense of comfort. The remaining two primiparae chose to deliver in a hospital because they were more comfortable in a setting with a team of healthcare professionals and access to modern technology. They felt that delivering at any other location would be irresponsible and would open themselves up to the possibility of complications. If they experienced complications, they trusted the staff as well as the equipment available at the hospital to save them and their children. The more comfortable the mothers were with the hospital, the more likely they were to

include the hospital in their birthing plan. Also the more comfortable they were with the hospital, the more likely they were to seek prenatal care from an obstetrician.

Regardless of how the primiparae viewed trust, each one reported it as a being important to their birthing plan decisions. Some had faith that everything would work out during their deliveries. Some trusted themselves and felt confident in their healthcare providers to make the right decision during their deliveries. Some chose the location of their deliveries based on how comfortable they felt with the facility and its staff. They all described trust as a factor influencing their birthing plans. Healthcare providers, especially obstetricians, must facilitate an environment of trust and confidence. This may be achieved by partnering with the hospital where they deliver babies to promote safety measures. By listening to their patients' concerns, healthcare providers have an opportunity to specifically address the factors that prevent patients from feeling comfortable delivering at a hospital. Hospitals must understand the reasons that new mothers distrust hospitals. In the present study, some primiparae were not comfortable trusting the hospital staff to carry out their birthing plans. By encouraging the labor and delivery staff to discuss each mother's birthing plan with her, the hospital is building a trusting relationship. It is important for the labor and delivery staff to be honest with the mothers by explaining the various situations in which may the birthing plan would be reevaluated. Being transparent with their patients creates a greater sense of satisfaction (Brown et al., 2003). As for the present study, it was found that the more confidence these primiparae had in their healthcare providers, the more satisfied they were with their birth experiences.

4.3 Factor Three: Fear

Fear was the final factor that the primiparae discussed as influencing their birthing plans. Being a primipara is a new and unfamiliar experience. Even through others' birth experiences and conversations with healthcare providers, a primipara does not truly know what to expect during her first delivery. This inexperience often leads to a fear of the unknown. Ten

of the mothers interviewed reported fear as a factor that influenced their birthing plans. Fear was characterized in three ways: physical pain, being judged, and safety of self and child.

Five of the mothers described how the fear of the physical pain of natural delivery scared them. The image of a long labor with painful contractions created a fear that led them to feel that they would be unable to handle a delivery on their own. Four of these primiparae chose to have a medicalized delivery. The fear of physical pain was seen as an unnecessary part of the birthing experience. Their physicians offered the epidural, which was seen as a harmless intervention, and they all accepted it. These mothers did not want to miss out on the pleasures of childbirth just to be in intense pain. Even though the fifth primipara expressed her intention of having an epidural delivery because she feared the physical pain, she was unable to follow her birthing plan. She delivered ten weeks early due to the complications of her pregnancy. A severe case of preeclampsia put her child's life at risk, and she delivered by cesarean section.

Fear of being judged was another characteristic of fear. Two of the primiparae described how the fear of being judged by healthcare professionals and family members influenced their birthing plans. One mother feared being judged by her mother-in-law. Listening to her husband's mother made her feel that she would be seen as weak if she chose an epidural delivery. This primipara learned that her mother-in-law's deliveries occurred very quickly. Knowing that each woman delivers differently, the primipara chose an epidural delivery and used the birth experiences of others both to guide her birthing plan and create a rationale that diffused her fear of being judged.

Another mother discussed how she feared being judged by the nurses and physicians treating her. She did not want to be seen as a "wuss" or "crazy." In order to prevent being labeled as either of these names, her birthing plan included waiting as long as possible for an epidural and calling her obstetrician's office as little as possible. The primipara wanted her healthcare provider to see her as tough as well as laid back. However, by not asking the

obstetrician questions, the primipara failed to address serious health issues. She suffered from a severe case of preeclampsia and was hospitalized for five weeks before her delivery. When the obstetrician asked her why she never mentioned her symptoms, the primipara indicated that she assumed the symptoms were all part of being pregnant. She later explained that society puts pressure on mothers to be strong and hold out for an epidural. Society also judges mothers who call their physicians for every little problem during their pregnancies. This mother allowed her fear of judgment to dictate how she approached her birthing plan and prenatal care. Her social interactions created the definitions of what it means to be a “wuss” or to be a “crazy” patient. She started believing in this reality, and it almost prevented her from becoming a mother. Physicians must discuss possible complications with their patients. Had this primipara known what to look for or be aware of, it is possible her preeclampsia would not have been as severe as it was when she was admitted to the hospital. It is also important for healthcare providers to acknowledge that pregnant women are often negatively labeled; they need to reassure their patients that these labels are not how the healthcare providers view them. Encouraging primiparae to actively seek out information about their pregnancies and birthing plans will help these women to be reassured about their birthing plan decisions. Being informed, being involved, and working collaboratively with healthcare providers may increase patient satisfaction as well. Creating an environment of open communication between patient and provider is key to achieving this goal.

Finally, the third characteristic of fear is for the safety of self and child. Four primiparae described one of the factors influencing their birthing plan as fear for the safety of themselves and their children. Two of the mothers explained that women make birthing plan decisions out of fear for their children. The physicians talk about the safety of the mother’s child and the possibility of something going wrong, which creates a feeling of panic. This panic leads women to make rash decisions about their birthing plans without truly understanding the consequences. These primiparae believe women are not willing to risk their child’s health just to prove a point.

It is important to note that only one of these mothers was faced with this type of dilemma. Fear dictated her actions and she had a cesarean delivery. The other mother witnessed similar experiences when she worked as a doula.

Fear is a powerful force that influences a primipara's birthing plan. However, it can be resolved if healthcare providers address each concern. One way to do this is to educate patients. By adding an extra appointment that solely addresses birthing plan options, physicians allow their patients the opportunity to express any fears. Physicians have very full waiting rooms as several of the primiparae remarked and are not able to spend copious amounts of time with their patients; however, knowing what worries a primipara helps the physician adapt his/her consultations with patients. One way a physician can gather this information is by utilizing the nursing staff. All of the mothers who had medicalized deliveries commented on their interaction with the nurses in the doctor's office and at the hospital. Many of them were more comfortable communicating with the nurse. Taking this into consideration, it is appropriate to suggest that nurses be encouraged to discuss the numerous birthing plan options with patients. Once the options have been discussed at length between the nurse and the patient, the physician can address any questions or concerns at a subsequent appointment. This allows the patient time to research her options and compose any questions she may have. The primiparae who delivered with a midwife indicated that they discussed at length their birthing plan options during their consultations.

4.4 Limitations

Inherent in qualitative research is small size of the respondent group. Although the present study reached saturation, the primiparae interviewed did not constitute a representative sample. The racial and ethnic composition of the respondents is also a limitation of this study. Eleven of the 12 mothers were Caucasian and one mother was Hispanic. This convenience sample does not represent the birthing experiences of any other race or ethnicity, which would

alter the results. Having access to a variety of racially and ethnically diverse primiparae would have strengthened the present study.

Another limitation of this study is the lack of collaboration during transcript analysis. The analysis was not conducted by a team of researchers, but done by myself. As Corbin and Strauss (1990) outline analysis is strengthened when opened to the scrutiny of others. In particular, it guards against bias. However, the present study does contribute to the existing body of research regarding birthing experiences and presents compelling factors that influence primiparae, which should guide future research.

4.5 Future Research

Prior to my analysis, my initial thoughts of what would influence a primipara's birthing plan included the husband of the participant. In fact, it was surprising to find that when a mother mentioned her husband in the interview it was most often done by using "we." She explained how "we," meaning she and her husband, decided to deliver a certain way, or "we" had a certain feeling about the person delivering our child. When asked if her husband had any requests regarding the delivery, a few of the mothers remarked that the decision involved her body, so her husband wanted her to make the choice. The only time a primipara allowed her husband's feelings to influence her birthing plan was when he felt uncomfortable with her initial decision. When this was the situation, the father did his own research and became comfortable with the mother's original birthing plan. It is important to understand if there are any other circumstances in which the father's opinion would play a more dominant role. Further investigation into how the father influences a primipara's birthing plan is necessary.

The purpose of the present study is to present recommendations to healthcare providers as well as primiparae, ultimately increasing patient satisfaction. The most concerning discovery is the absence of questioning and research done by primiparae. Although this finding supports what Gillespie and Strauss (2007) found, I interviewed educated primiparae with access to the Internet and trained healthcare providers. Yet, only three mothers reported

asking healthcare providers questions, reading articles and searching the Internet for information about birthing plans. The majority of the primiparae interviewed who had a medicalized delivery did not question their healthcare providers. The three mothers who delivered naturally reported asking questions more often but not as much as I assumed they would prior to conducting this study. Although, one primipara did indicate fear of being judged prevented her from asking questions consistently; further investigation, into why asking questions is not a factor, must be done in order to improve patient satisfaction. In order to understand why questions are not being asked, healthcare providers should be included in future research. Observation of communication practices between patient and provider would provide greater insight into why this dilemma exists.

A second area in need of further study is understanding how a primipara decides whose previous birth experience is valuable. As the analysis revealed, others' birth experiences influence a primipara's birthing plan. It is not understood how one significant other's experience can outweigh a different significant other's experience. It is possible that the combination of a significant other's experience and corresponding fears work together to give that significant other's experience more power. This area requires further attention to gain an understanding of what makes a significant other's birth experience more reliable or trustworthy, which may be used in the future by healthcare providers to share important information.

Another area in need of further investigation is differences in the communication a mother receives when she is a primipara and the communication she receives during secondary birth experiences. A longitudinal study following mothers from their first birth experience to their second birth experience would provide a better understanding of what factors continue to influence them. This type of study would also provide insight into the amount of satisfaction each mother experienced during her first birth, and how she resolved to improve subsequent birth experiences. It is also important to include mothers from diverse racial and ethnic backgrounds as well as a variety of socioeconomic backgrounds. In order to increase

generalizability, inclusion of these women is necessary. Healthcare providers see patients with diverse backgrounds; therefore, providing recommendations that considers these mothers will make them much more useful.

4.6 Conclusion

Healthcare is perceived as more of a commodity, and patients see themselves as consumers. Encouraging women to take responsibility for their healthcare is vital to improving their patient satisfaction as Braddock et al. (1999) contend. As seen in the present study, collaboratively working with their healthcare providers creates a relationship women feel they can trust. When a mother actively researches and questions her birthing plan options, she is taking ownership of her healthcare. Not only is she more comfortable with her decision, but she sees herself as a partner and is more satisfied than is a mother who engages in “feminine behavior” (Nussbaum et al., 2003). Healthcare providers can benefit from partnering with their patients as well. It is important for healthcare providers to recognize factors that influence a mother’s birthing plan. In the present study, these factors included others’ birth experiences, trust, and fear. When healthcare providers take the mother’s context into consideration, they can adapt their communication style to relay important information needed to make an informed birthing plan decision. When patients are more satisfied, fewer malpractice suits follow. Without the burden of increasing malpractice insurance fees, physicians may be more satisfied with their practices. The key to accomplishing this is asking questions and actively seeking out the answers. When primiparae do this, and healthcare providers encourage this, they will be better equipped to make birthing plan decisions.

APPENDIX A

INTERVIEW SCHEDULE

Interview Schedule: Primipara Birthing Plans

1. How did you give birth to your child?
 - a. Was it a home delivery, birthing clinic or hospital?
 - b. Did you have any medical interventions?
2. Was it your first choice?
 - a. If not, what was?
 - b. Did you have a choice?
3. What guided you to choose this type of delivery?
4. Did anyone in particular influence your choice?
5. Did you read anything or watch anything that influenced your choice?
6. What were your expectations of childbirth before you delivered?
 - a. What made you feel that way?
7. Were you expectations correct?
 - a. How did you feel about the people or things that influenced your decision?
8. How do you feel about your birthing decision?
9. Would you decide to _____ the next time you deliver?
 - a. Why or why not?
10. Is there anything else you think I should know about why you delivered this way?

APPENDIX B
CONSENT FORM

AUG 10 2010
APPROVED

AUG 09 2011

Informed Consent

You have been asked to participate as a subject in the research project entitled "Influences of Decision-Making: A Qualitative Analysis of Primiparae's Birth Plan Decisions" conducted by the University of Texas at Arlington Communication graduate student, April N. Blount. This research is being collected as part of a graduate program resulting in a Master's thesis. The purpose of this project is to study a first-time mother's birthing plan decisions.

One-on-one, face-to-face interviews will be conducted by April N. Blount. Approximately 15 first-time mothers will be interviewed during the course of this study. Questions asked during the interview will center on issues related to your social, physical, and emotional experiences while choosing a birthing plan during your pregnancy. Your answers will be used to help me better understand how to more effectively communicate with first-time mothers during pregnancy. Your interview should last no longer than two hours and will be audio recorded in order to accurately document your statements. The recordings will not be used to personally identify you other than to record your statements; your name will not be associated with your statements. The recordings will be kept in a secure place in 118 Fine Arts building for 3 years. No audio recording will be used for any purpose other than the completion of this study. All recordings will be retained for possible future analysis. If the results of this research are published or presented at scientific meetings, your identity will not be disclosed.

You have the right to privacy, and all information that is obtained in connection with this study and that can be identified with you will remain confidential as far as possible within state and federal law. If in the unlikely event it becomes necessary for the Institutional Review Board to review your research records, then The University of Texas at Arlington will protect the confidentiality of those records to the extent permitted by law. Your research records will not be released without your consent unless required by law or court order. The data resulting from your participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate you with it, or with your participation in any study.

Participation is completely voluntary and your participation will not result in any compensation. You have the right to discontinue your participation at any time for any reason without explanation and without penalty. There are no known risks expected from participating in this study; however, you may decline participation and recording at no consequence.

An offer has been made to answer any questions that you may have about this project. If you have any questions before, during, or after the study, you may contact April N. Blount at 817-272-2163 or Dr. Charla Markham Shaw at 817-272-2678.

You may contact the Chairperson of UT Arlington Institutional Review Board at 817-272-3723 with any questions related to your rights as a research participant.

CONSENT:

Signatures:

As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:

Signature and printed name of principal investigator or person obtaining consent Date

By signing below, you confirm that you have read or had this document read to you. You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this from. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits, to which you are otherwise entitled.

Signature of Volunteer Date

AUG 18 2010

APPROVED

AUG 09 2011

Institutional Review Board

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BIOGRAPHICAL INFORMATION

April Blount earned a B.A in Communication, with a minor in Theatre from The University of Texas at Arlington. This thesis was funded in part by the Andrew. M. Clark Scholarship for thesis research. Upon completion of this thesis, her plans include devoting her time to being a wife and mother. In addition, she plans to educate healthcare providers on the importance of communicating with patients and advocating for patients, who have no voice. She hopes to pursue her Ph.D. in Communication as well.