Washington State Childbearing Women's Experiences of Planned Home Births: A Heideggerian Phenomenological Investigation

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ABSTRACT

The purpose of this interpretive study was to investigate planned home births that occurred in Washington State and to provide meaning. A Heideggerian phenomenological approach was chosen to investigate and interview a purposive sample of 9 childbearing women who experienced at least 1 home birth between 2010 and 2014 in Washington State. The results of this study suggest that childbirth education is an essential and valued aspect of birthing. Childbirth educators can use the findings from this investigation as a means to increase their awareness of birthing in the home. This interpretive investigation can give “voice” to the compelling evidence accumulating that is investigating planned home births as a sanctuary to allow physiological and low-intervention births to transpire.

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In the past decade, a steady increase in the number of out-of-hospital births in the United States has been observed with nearly 0.9% of births occurring in the home (MacDorman, Declercq, & Mathews, 2013). The Pacific Northwestern region of the United States leads this increase. During 2013, in Washington State, there were 86,432 births. Of these births, 3.4% had occurred out of hospitals, with most of these births (2%) occurring in the home ($n = 1,753$) and the remainder (1.4%) in birthing centers ($n = 1,161$; Washington State Department of Health, 2015). Nearly a

100% increase of home births was witnessed between 2004 ($n = 880$) and 2010 ($n = 1,616$) in Washington State. Often, when births occur in the home, they are associated with increased spontaneous births, reduced interventions, and increased maternal satisfaction (Arcia, 2015; Callister, 2006; Cheyney et al., 2014; Fleming et al., 2016; Hodnett, Downe, Walsh, & Weston, 2010; Lothian, 2010; Martin et al., in press). Although precisely why women decide to birth at home is not clearly understood nor is normal physiological birthing entirely comprehended. The “home”

is a very naturalistic setting, which provides a pristine laboratory for researchers to investigate how physiological birthing transpires in its uninterrupted state. Therefore, the purpose of this interpretive study was to investigate planned home births that occurred in Washington State and provide meaning.

Is it possible that today's women desiring to birth can experience a naturalistic "good birth" their first time? Can this scholarly investigation provide researchers and birthing experts (i.e., childbirth educators, midwives, doulas, physicians) with an "optimal grip" of the natural state of birthing as mothers share their personal experiences of choosing and experiencing planned home births? Merleau-Ponty, a 20th century Continental philosopher, was known for his focus on the experience of the physical body stated, "We know not through our intellect but through our experience" (Merleau-Ponty, 1962). The primary objective of this interpretive study was to investigate and explore planned home births occurring in Washington State. The research conducted was based on the research question, "What does it mean to 'be' a childbearing woman and experience a planned home birth in Washington State?" This article can provide the qualitative evidence for perinatal educators to call on as they assist women with navigating their birth options (e.g., providers [physicians, midwives, doulas] and settings [hospital, birthing centers, homes]).

METHOD

Research Design

A Heideggerian phenomenological approach was employed to explore and construct meaning from the experiences of childbearing women who chose to have a planned home birth. This method provides researchers data of what it means "to be" (Heidegger, 1927/1962) with the intent to provide an in-depth meaning of the experience. This methodology differs from traditional phenomenological designs by having the researchers cocreate the interview with their participants and using their expertise (e.g., birthing experiences as professionals and personal) to contribute to the analysis. This scholarly approach, which is grounded in philosophical interpretive phenomenology, is intended to provide a rich, broad, comprehensive, contextual, and interpretive understanding of common, yet often undiscovered, experiences of the phenomena being investigated (Diekelmann & Ironside, 2006; Healy, 2011; Smythe, 2011; Vandermause & Fleming, 2011). This interpretive method was deemed appropriate because "birthing" is one of the most primal experiences in which the human body can partake.

Ethical Considerations. University Institutional Review Board certification for exemption status was obtained. Therefore, no formal review was conducted. Each woman was introduced to the study and asked to volunteer. If they accepted, they were asked to self-select a pseudonym as a means to contribute to this study and ensure confidentiality.

Sampling. A purposive convenience sample of nine ($n = 9$) childbearing women who had a mean age = 29 years (range = 24–39 years) and had experienced at least one home birth between 2010 and 2014 was recruited from personal and professional contacts. Snowballing recruitment techniques were used, as often, one mother referred another mother to join the study. A theoretical saturation was reached when it became clear that we were collecting enough common experiences to derive meaning; thus, no other participants were asked to join. Together, the participants had experienced 6 hospital and 21 home births. Of the 21 home births, certified nurse midwives had attended 11 home births and licensed midwives attended the remaining 10. All of the home births included a midwife apprentice or assistant. In addition, four of the home births included a doula. The women were all English speaking and did not have a history of psychosis.

Data Collection. Data were collected via one-to-one in-depth 60-minute to 2-hour interviews in the participant's home using open-ended questions. The interviews were subsequently audio-recorded then transcribed verbatim by a professional transcriptionist. The initial interview question presented to the participants was, "I'm interested in childbearing women's decision to birth at home. Is there an experience you would like to share?" All of the participants were allowed ample time to mull over the question, then answer and ascribe meaning. Supplementary questions followed to clarify or encourage dialogue to continue (e.g., "then what happened?"; "tell me more"; "What do you mean when you say . . . ?" (Vandermause & Fleming, 2011).

Data Analysis. A Heideggerian phenomenological analysis was the driving force as transcripts were judiciously read and interpreted by the research team. The analysis of these texts garners from the meticulous work of Martin Heidegger (1889–1976) and Hans Gadamer (1900–2002), where by nature the interpretations are meditative and circular. An international analysis team was formed consisting of

three experienced Heideggerian phenomenologists consisting of two nurse scientists (one being a perinatal clinical nurse specialist and a current nurse midwife student) from the United States and a midwife (who is also a nurse) from Ireland. In addition, a certified nurse midwife from Washington State was asked to contribute to the analysis of this study because her clinical expertise was diverse (i.e., home births, birthing centers, and hospital births; Figure 1). Researchers carefully read each transcript and brought written interpretations to meetings, reading and discussing the interpretations with one another. An inclusive gathering of notes was generated, adding to the data. During the entirety of this study, a comprehensive pattern emerged as the themes were formed. Initially, undeveloped themes emerged and were discussed and revised, keeping closely to the text on behalf of the shared experiences derived from childbearing women choosing to birth at home. The attentive procedure consisted of initially naming the themes, then revising and renaming as indicated. Members of the analysis team brought their own ideas and professional experiences working with mothers as a means to contribute to the analysis. Furthermore, the aim of this analysis is to encourage the reader to continue in the interpretation of the text presented. A consensual agreement among interpreters was stipulated and deemed that indeed the findings were warranted (Vandermause & Fleming, 2011).

Validity. Validity was a significant part of this study. The primary criteria of credibility, authenticity, criticality, and integrity were scrutinized alongside the findings. In addition, secondary criteria of explicitness, vividness, creativity, thoroughness, congruence, and sensitivity were used

Figure 1. Colleen Donovan-Batson, CNM, Home Birth Midwife and advocate, board member at MANA.

to supplement the guiding principles of this study (Whittemore, Chase, & Mandle, 2001).

RESULTS

Childbearing women's experiences of choosing to birth in home was explicated and examined. All of the women of this study vocalized that birthing in their home with a trusted midwife allowed for them to achieve their desire to have a naturalistic birth. One constitutive pattern emerged, "Striking a Balance: Planning My Birth at Home," which subsumed four overarching themes: "Building My Nest While Listening to My Childbirth Educator, Midwife, Doula"; "Providing a Safe Passage for Baby While Avoiding Needless Stress"; "Resisting the System While Staying Connected"; and "Governing My Birth While Letting Go of Control."

The results accumulated from this investigation are not intended to be generalized to specific populations but to resonate with childbirth experts (i.e., childbirth educators, midwives, midwife assistants, doulas, physicians, researchers) as well as with women who decide to plan a birth in their home, as a means to increase our understanding of planned home births and how this can influence our clinical practice. This study offered a present view of childbearing women deciding to birth in their home and can raise our awareness and offer an astute insight to the phenomena of "experiencing a planned home birth" being investigated.

Pattern: Striking a Balance: Planning My Birth at Home

Although each mother had a unique story to be told, the texts of the transcripts were drawn together as a collective story, which revealed that the mothers were "Striking a Balance" as they planned their births and made it possible to birth in their home.

Mandi Lou (two hospital and two home births) shared her insightful experiences of planning to birth in hospitals and then in her home. She had experienced her first two births in the hospital and then had chosen her home for her last two births. She had always desired to birth naturally. However, she conveyed that in the hospital, she had to fight to keep the birth natural. Therefore, she investigated her options with childbirth educators about birthing in her home. She decided the home would be the best place for a natural birthing experience to occur. She gave an insightful comment about preparing for birthing.

I took a hospital class. . . I was told that it would be the worst pain I would ever feel. And it was. It was horrible. So when I was planning my third birth, a home

birth, I did have a lot of fear. . . . I took Hypnobirthing [class]. I was told it would be a very easy experience, relaxed, and I wouldn't feel much pain . . . that's exactly what happened. It was easy. (Mandi Lou)

Mandi Lou's experiences truly suggest the importance and power of teachings that can influence the mother's self-fulfilling prophecy on her upcoming births.

Theme 1: Building My Nest While Listening to My Childbirth Educator, Midwife, Doula

Every one of the participants shared the importance of selecting a trusted childbirth educator, midwife, and/or doula, while having a decisive, yet flexible plan, and a safe place to give birth. Most of the women enrolled in classes with childbirth educators or sought out advice or care from their midwife and/or doula. More than one-half of the women shared that they had used the Internet or downloaded apps to help with making their birthing decisions. However, they shared that they were careful of the sites they had visited and often discussed their information with their childbirth educator, midwife, and/or doula.

Redeemed (two home births) shared that she chose her name decisively as truly a liberated childbearing woman. Even though this was her second birth, she and her partner felt compelled to prepare with a birthing class. She shared the importance of preparing for birth by taking a class and selecting a midwife who she could trust and who could instill within her the confidence to have a baby at home. She had not planned a specific place to give birth; rather, she allowed her body to lead her to where she should be at the time of the birth.

. . . we chose just this really awesome midwife who's extremely confident and calm and just very hands-off. You know, not really into a lot of interventions, but I knew that she was just watching me and that I knew that she just had this great sense of women and what they needed and what was happening with their bodies without using a lot of interventions. And so she really instilled a lot of confidence in me. And, we did some things to prepare. My husband and I went to a class called Birthing as Nature Intended "When others asked, 'So where in the house is the baby going to be born?' I was like, 'I'm not choosing a place. I want it wherever I'm feeling good at the moment.' . . . sure enough as my labor progressed I ended up in the bathroom, a real small one . . . my labor had been really slow, and they were really try-

ing to get me to dilate so that I could have the baby. So they put me backwards on that toilet so that I would dilate, a supported squat 'dilation-station' as my childbirth educator called it." (Redeemed)

Redeemed shared that what she had learned in her childbirth class had empowered her to truly take control of her birth and birth where her body desired.

Theme 2: Providing a Safe Passage for Baby While Avoiding Needless Stress

Although each childbearing woman shared her unique desire for choosing to birth in the home, when the transcripts were compiled, the story unveiled the notion of the woman's desire to maintain a balance as she strived to keep the birth safe without subjecting herself to undue stress from fear. Every woman maintained the importance of birthing in an environment that could provide a safe passage for her baby with a birthing professional she could trust while avoiding unnecessary stress and interventions. A few women shared that there was a time in their lives when they were living in a paper-thin walled apartment, which was not conducive to have a home birth. Therefore, a birthing center would be considered as a suitable option. Every woman shared that her midwife was able to transfer her to a hospital if the midwife deemed it was indicated.

If something had had happened—and that was another great thing about my midwife. I loved her. It's one of the reasons why I chose her. If we needed to transfer to the hospital, she would've been a-okay with that . . . It was very cool. But it made—without having to be in a hospital environment, I was at home, I was in my comfort zone. It felt more empowering to me as a woman. (Arizona; one home birth)

Arizona, with her partner, had recently bought an older home and was excited that this birth would become part of their homes' history: "It was one of the most beautiful experiences to say that my daughter was born here at this house."

Celeste (three hospital births, three home births) shared that her own mother had birthed her first five children in home with her own doctor; however, when her doctor was forced to relinquish his home birthing option and solely provide births in the hospital, she decided to birth in the hospital with him. Many years later, Celeste had experienced her first three births in the safety of a hospital. However,

multiple interventions were common, and each one of her births was being induced or augmented with oxytocin. She considered her first birth traumatic for her and her baby. During her second and third births, the nurses were more supportive. However, for her remaining three births, she chose a home birth where she could reduce her stress, be reassured of low interventions, and allowed to have a natural birth transpire on her own time.

. . . the nurse [2nd baby] was in the room the entire time inducing me. If the pain got too much, she would back off the Pitocin. I think it is how inducing was supposed to be; whereas with the first baby, they just cranked it up and left the room, and I thought I was on my own in this torture chamber “This torture bed.” So, that birth [2nd birth] ended up being a nice, doable labor, and I was able to deliver again naturally with no drugs [pain] for the third baby. (Celeste)

Theme 3: Resisting the System While Staying Connected

Most of the women had experienced or investigated the possibility of birthing in a hospital. However, they each shared unique feelings or experiences that drove them away from birthing in a hospital and led them to choosing to birth in the home.

Diana had her first birth in a hospital where she was reprimanded for trying to birth naturally.

When it came time to deliver the baby, I requested to squat and she [the doctor] insisted that I lie flat. Then when I made some noises, she ask me to be quiet and save my energy for the delivery. (Diana)

After that hospital experience, Diana was more insistent on her next births to be at home. She shared, “. . . home birth is the best place, I need to be with my midwife. My midwife was the best ever.”

Redeemed (two home births) had experienced her first birth at home 6 years prior. However, she had recently been trained as a nurse, then as a nurse practitioner and decided to investigate the possibility of birthing in a hospital.

So when I went to the hospital, I walked out of there thinking, “I just don’t think I can do a hospital birth.” And it’s like I think that practice is awesome and I think they’ve been very good for my friends, and that’s why I went there. I just thought I can’t do this. ‘Cause I felt like I was going to have to come in

and almost feel defensive about my care if I didn’t want a lot of interventions. (Redeemed)

Blessed with Six (six home births) only inquired about birthing in a hospital with her first birth. That experience left her to make a deliberate decision to birth all six of her children in the home.

I was about 6 months pregnant, um, after seeing the doctor and talking with them, it was sort of understood—or they were trying to get me to understand that it most likely would be a cesarean birth because I’m tiny and, you know, it just seemed like probably what would happen. And so—and they began asking me my feelings on cesarean birth. I became very uncomfortable . . . I thought I don’t think that going to the hospital is what is going to be right for me. (Blessed with Six)

Theme 4: Governing My Birth While Letting Go of Control

For Celeste, with her fourth birth, she found a midwife who was willing to give her a water birth, which she felt was equivalent to an epidural. Therefore, with her fifth and sixth birth, it was no question, water birth – home birth. She shared that for her, the tub was her saving grace; not only did it relieve her of pain, it allowed her a sense of control when the pain had intensified.

That if you can have something, even mentally, to know if I get to the point—and for me, when I get to the point of transition, the pain increases, but I know I’m almost there, and I can at that point hop in the tub. (Celeste)

Marie (one home birth) speaks of “birthing norms” as well as the importance of being taken care of alongside of her role to actively participate in the labor process.

. . . as American women, we look at the due date as an expiration date like “40 weeks, here we go, contractions right?” (Marie)

Marie stated this due date is not necessarily so. And when the labor does transition into active labor, women need to get active. For Marie, this meant walking during the active phase, and when the time was right, at her choosing, “I jumped into that birth pool . . . I call it the organic epidural. It was amazing.”

Marie considers herself a “placenta alchemist” and artist (Figure 2).

Figure 2. Placenta art and alchemy.

DISCUSSION

The aim of this study was to explore and investigate what it means to “be” a childbearing woman and experience a planned home birth in Washington State. Results from this analysis provide qualitative evidence and raise firsthand insights about the escalating occurrence of childbearing women choosing to have a planned home birth. The women’s stories give “voice” to current research that is emerging. These women carefully planned out their birth with safety as one of their top priorities. It was always a balance for the women of the study, as evident by the pattern and four themes that surfaced.

Remarkably, in this study, regardless if this was a women’s first birth or sixth, women wanted to become more knowledgeable and even assisted as they planned out their birth in the home. Reliable childbirth education was deemed essential and regarded as a vital part of their birth stories that were told. Selecting a provider that they could trust and safety were major concerns for the women of this study, which is remarkably similar to women who choose to birth in a hospital. However, what sets the women of this study apart was their utmost desire to birth in a place where they could relax and allow a natural and low-intervention birthing experience to transpire. The women of this study shared their triumphal accounts of childbirth care, and their excitement flourished. The research team suggested that these “exhilarating” stories were similar to the excitement that may be shared by athletes (e.g., marathon runners, football players) as they share their victories. The experience of giving birth in the home had positively impacted the physical and mental postnatal health of the women in this study.

Many of the women in this study considered the hospital. In contrast to the home as a place to birth, is the hospital. In 2009–2010, two cohorts, with a combined total of 27 veteran grand multiparas were interviewed as they shared their evolving experiences of birthing in the hospital (Fleming, Smart, & Eide, 2011; Fleming & Vandermause, 2011). Most of the mothers had shared that the hospital provided for them a safe place to birth their babies. Nevertheless, nearly every mother interviewed in these two studies shared that they had initially joined the natural childbirth movement of the 1970s or early 1980s and that they had attended non-hospital-affiliated birthing classes (e.g., Lamaze, Bradley). Many of their stories revealed they had desired to experience a naturalistic birth. However, nearly all of the mothers stated that what they were taught in their childbirth classes, about the naturalistic ways of birthing, was not always accepted in the hospital (e.g., using the birthing rooms, no IVs, nondirected pushing). As their birthing journeys evolved, many mothers had succumbed to the increasing technology (e.g., fetal monitoring) and/or interventions (e.g., oxytocin inductions/augmentations, epidural) being offered. Alternatively, if they had desired to maintain their goal of birthing in a naturalistic fashion, it often took many births/years before they could relax and experience a naturalistic “good birth” in a hospital setting (Fleming et al., 2011; Fleming & Vandermause, 2011).

The women of this study also shared that they were often not allowed to experience birth in the hospital as they were taught in the perinatal education classes. The women of this study strived to keep the births physiological. Romano and Lothian’s (2008) six evidence-based care practices that promote physiological birth—avoiding medically unnecessary induction of labor, allowing freedom of movement for the laboring woman, providing continuous labor support, avoiding routine interventions and restrictions, encouraging spontaneous pushing in nonsupine positions, and keeping mothers and babies together after birth without restrictions on breastfeeding—were plentiful as the women of this study shared during their home birth stories and at times can be seen in hospital birthing. However, in hospitals, it can be a struggle to keep evidence-based care practices during birth because birthing technology may take precedence (Fleming et al., 2011; Fleming & Vandermause, 2011).

All of the women of this study wanted to self-manage their births. Many of them shared that

having a birthing tub ready was just as much about control as about relieving the pain. Most of the women of this study referred to the pool as their solace, their peace, and their ability to “self-medicate” and to care for oneself. Control is a salient matter for many childbearing women regardless of where they give birth. The ability to control a birth is desirous by many including the women of this study involved (Namey & Lyerly, 2010). Namey and Lyerly set out to deconstruct the meaning of control as they interviewed 101 multiparas. Their five distinct domains of control—self-determination, respect, personal security, attachment, and knowledge—aligned with the results of this study. Fleming and Vandermause (2011) investigated grand multiparas’ evolving experiences of birthing in a hospital. Their study also fit well with the five distinct domains of control; however, they revealed another behavior women used to express control with hospital birthing, which was avoidance. For instance, in an attempt to control their ability to freely move or avoid intravenous therapy, they might arrive at the hospital late.

The birthing stories that the women of this study shared gives “voice” for the mounting research on home births that is occurring. The Midwives Alliance of North America (MANA) had witnessed a 41% increase in the number of planned home births between 2004 and 2010 occurring in the United States (MacDorman et al., 2013). MANA deemed that a thorough investigation of the safety of home births was warranted. In 2004, a web-based data collection system (the MANA Statistics Project [MANA STATS]) had commenced. A varied pool of data was extracted of midwifery-led births occurring in the home or birth centers between 2004 and 2009 and provided a robust sample of outcomes for their study. Of the 16,924 women who had planned to birth in their home, more than 89% had achieved their goal. More than 93% of the women experienced a spontaneous birth, and a low number of those births (5.2%) resulted in a cesarean birth. In addition, the MANA study confirmed that a high rate of physiological births and low interventions occurred in a home setting and that for low-risk women, desiring to experience a planned home birth is a valid option (Cheyney et al., 2014).

In this study, the women shared that they were being respected and felt in control and listened to, which are the key concepts of birth satisfaction (Hollins Martin & Fleming, 2011). Two of the authors of this Home Birth study (Fleming et al., 2016; Martin et al., in press) recently conducted a sizeable

national study ($n = 2,229$) using the Birth Satisfaction Scale (BSS) to quantify the prevalence of birth satisfaction among women desiring to birth at home or at a birth center in the United States (Fleming et al., 2016; Hollins et al., 2011; Martin et al., in press). The respondents represented every state in the United States except Rhode Island. The Home Birth respondents ($n = 1,436$) shared that 88% of labor was spontaneous, 75% had planned their births, and that 68% were breastfeeding 12 months or greater. This may suggest that women were committed to keeping their birth physiological as a commitment to their births and babies. More than 65% of the home births were with CPMs (certified professional midwives), LMs (licensed midwives) or midwives (unsure of license or no license), whereas >28% were with CNMs (certified nurse midwives) and CMs (certified midwives). Birth satisfaction is vital. High-quality maternal birth care cannot be achieved unless the childbearing woman is satisfied (Fleming et al., 2016). Quality prenatal education is needed and warranted to educate childbearing women, providers, and staff members of safe birthing practices based on the current evidence.

Limitations

The narrow geographical pool from Washington State, which participants were sought, limited this study. The women from Washington were recruited from various self-employed midwives. However, because of the snowball recruiting method, several of the midwives were the same. A more diversified sample could provide additional insights influenced by location, including area practice standards, demographic characteristics of patients, and sociocultural backgrounds of the childbearing women. The need for future research is warranted.

Implications for Practice

This study illuminated the need and desire for trustworthy perinatal education. Childbirth educators, doulas, and midwives can be privy to the multiple birthing options available for today’s childbearing woman. The childbearing women of this investigation sought out to be informed about birthing through their childbirth education classes, midwife, and/or doula. The women of this study shared that they were confident and empowered as educators/midwives and that doulas offered them sound evidence-based birthing practices to select from as they created their own plan to birth. Hence, the women maintained the importance of birthing in an

environment that could provide a safe passage for their baby, with birthing professional(s) they could trust, while avoiding unnecessary stress and interventions. Childbirth educators, midwives, and doulas were valued and appreciated as the stories unfolded in this study. Childbirth educators are an important part of preparing women for birthing, regardless where or with whom a mother chooses to birth.

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REFERENCES

- Arcia, A. (2015). U.S. nulliparas' reasons for expected provider type and childbirth setting. *The Journal of Perinatal Education*, 24(1), 61–72.
- Callister, L. C. (2006). The meaning of giving birth and mastery of the experience. *International Journal of Childbirth Education*, 21(3), 7–8.
- Cheyney, M., Bovbjerg, M., Everson, C., Gordon, W., Hannibal, D., & Vedam, S. (2014). Outcomes of care for 16,924 planned home births in the United States: The Midwives Alliance of North America statistic project, 2004 to 2009. *Journal of Midwifery & Women's Health*, 59(1), 17–27.
- Diekelmann, N., & Ironside, P. (2006). Hermeneutics. In J. J. Fitzpatrick & M. Wallace (Eds.), *Encyclopedia of nursing research* (2nd ed., pp. 260–262). New York, NY: Springer Publishing.
- Fleming, S., Donovan-Batson, C., Burduli, E., Barbosa-Leiker, C., Hollins Martin, C. J., & Martin, C. R. (2016). Birth Satisfaction Scale/Birth Satisfaction Scale-Revised (BSS/BSS-R): A large scale United States planned home birth and birth centre survey. *Midwifery*, 41, 9–15. <http://dx.doi.org/10.1016/j.midw.2016.07.008>
- Fleming, S., Smart, D., & Eide, P. (2011). Grand multiparous women's perceptions of birthing, nursing care, and childbirth technology. *The Journal of Perinatal Education*, 20(2), 108–117. <http://dx.doi.org/10.1891/10581243.20.2.108>
- Fleming, S., & Vandermause, R. (2011). Grand multiparae's evolving experiences of birthing and technology in U.S. hospitals. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 40(6), 742–752. <http://dx.doi.org/10.1111/j.1552-6909.2011.01304.x>
- Healy, M. (2011). Heidegger's contribution to hermeneutic phenomenological research. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative health research in midwifery and childbirth* (pp. 215–231). London, United Kingdom: Routledge.
- Heidegger, M. (1962). *Being and time* (J. M. E. Robinson, Trans.). San Francisco, CA: Harper and Row. (Original work published 1927)
- Hodnett, E., Downe, S., Walsh, D., & Weston, J. (2010). Alternative versus conventional institutional settings for birth. *Cochrane Database of Systematic Reviews*, (9), CD000012.
- Hollins Martin, C. J., & Fleming, V. (2011). The Birth Satisfaction Scale (BSS). *International Journal of Health Care Quality Assurance*, 24(2), 124–135.
- Lothian, J. (2010). How do women who plan home birth prepare for childbirth? *The Journal of Perinatal Education*, 19(3), 62–67.
- MacDorman, M., Declercq, E., & Mathews, T. J. (2013). Recent trends in out-of-hospital births in the United States. *Journal of Midwifery & Women's Health*, 58(5), 494–501.
- Martin, C. R., Hollins Martin, C. J., Burduli, E., Barbosa-Leiker, C., Donovan-Batson, C., & Fleming, S. E. (in press). Measurement and structural invariance of the US version of the Birth Satisfaction Scale-Revised (BSS-R) in a large sample. *Women and Birth*.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. London, United Kingdom: Routledge.
- Namey, E., & Lyrerly, A. (2010). The meaning of “control” for childbearing women in the US. *Social Science & Medicine*, 71, 769–776. <http://dx.doi.org/10.1016/j.socscimed.2010.05.024>
- Romano, A., & Lothian, J. (2008). Promoting, protecting, and supporting normal birth: A look at the evidence. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 37(1), 94–104. <http://dx.doi.org/10.1111/j.1552-6909.2007.00210.x>
- Smythe, E. (2011). From beginning to end: How to do hermeneutic interpretive phenomenology. In G. Thomson, F. Dykes, & S. Downe (Eds.), *Qualitative health research in midwifery and childbirth* (pp. 35–53). London, United Kingdom: Routledge.
- Vandermause, R., & Fleming, S. (2011). Philosophical hermeneutic interviewing. *International Journal of Qualitative Methods*, 10(4), 367–377.
- Washington State Department of Health. (2015). *Birth data: Vital statistics*. Retrieved from <http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsData/BirthData.aspx>
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11, 522–537. <http://dx.doi.org/10.1177/2F104973201129119299>

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