GETTING TO 40 WEEKS: CONSTRUCTING THE UNCERTAINTY OF DUE DATES

Sarah Cornelia Vos
University of Kentucky, sarah.vos@uky.edu

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Sarah Cornelia Vos, Student
Dr. H. Dan O’Hair, Major Professor
Dr. Tim Sellnow, Director of Graduate Studies
GETTING TO 40 WEEKS:

CONSTRUCTING THE UNCERTAINTY OF DUE DATES

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Masters of Arts in the College of Communications and Information Studies at the University of Kentucky

By

Sarah Cornelia Vos

Lexington, Kentucky

Director: Dr. H. Dan O’Hair, Dean of the College of Communications and Information Studies

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In the United States as many as 15% of births occur before 39 weeks because of elective inductions or cesarean sections. This qualitative study employs a grounded theory approach to understand the decisions women make of how and when to give birth. Thirty-three women who were pregnant or had given birth within the past two years participated in key informant or small group interviews. The women’s birth narratives and reflections reveal how they construct the uncertainty of their due dates and how this construction influences their birth decisions. Problematic integration theory is used to analyze this construction and identify points of influence. The results suggest that women construct the uncertainty of due dates as a reason to wait on birth and as a reason to start the process early. The results suggest that information about a baby’s brain development in the final weeks of pregnancy may persuade women to remain pregnant longer. The results demonstrate the utility of using problematic integration theory to understand a medical situation that is the result of epistemological and ontological uncertainty. The analysis suggests the existence of a third type of uncertainty, axiological uncertainty. Axiological uncertainty is rooted in the values and ethics of outcomes.

KEYWORDS: pregnancy, due dates, uncertainty, problematic integration theory, narrative theory
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By

Sarah Cornelia Vos

H. Dan O’Hair, Ph.D.
Director of Thesis

Tim Sellnow, Ph.D.
Director of Graduate Studies

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Chapter 1

Getting to 40 Weeks: Constructing the Uncertainty of Due Dates

Why do women seek elective cesarean or induction procedures instead of carrying their babies to full term, 40 weeks of gestation? The medical and communication literature do not offer much background on expectant mothers’ decisions. Early term births, defined as births occurring between 37 to 39 weeks, and late preterm births, 34 to 36 weeks, are complicated and multifaceted problems with many antecedents (Engle & Kominiarkek, 2008). This research considers one aspect, elective induction or c-section at the mother’s request.

Infants born late preterm and those born early term are sometimes called “great imposters”: They come out of the womb looking just like full-term infants, but they aren’t (Buus-Frank, 2005, p. 233). Infants born late preterm and early term are at a higher risk for neonatal morbidity (Cheschair & Menard, 2011). These infants also incur higher healthcare costs than their full-term counterparts. These infants have a higher risk for breathing problems, are more likely to spend time in the neonatal intensive care unit (NICU), and are more likely to be readmitted to the hospital (Buus-Frank). In addition, a substantial amount of brain development occurs in the final weeks of pregnancy, creating problems for these near-term infants later in life (Darnall, Ariagno, & Kinney, 2006). Research shows that these early term and late preterm infants are more likely to develop attention deficit hyperactivity disorder (ADHD) as they grow older and are more likely to suffer from other behavioral problems that their full-term counterparts (Engle & Kominiarek, 2008).
The American College of Obstetricians and Gynecologists (ACOG) recommends that women wait to schedule an elective c-section section or induction until at least 39 weeks, because a full-term pregnancy lasts 39 to 40 weeks of gestation (Ashton, 2010). The optimal time to give birth in terms of outcomes for the baby is 40 weeks (Cheschair & Menard, 2011). In the United States, however, the trend for maintaining a pregnancy for 40 weeks has been declining since the 1990s, and an increasing number of women give birth before 39 weeks (Engle & Kominiarek, 2008). Many of these early births are thought to be the result of elective inductions and c-sections, meaning they were performed for nonmedical reasons (Ashton). Just how many is unknown due to inadequate documentation in medical records. Researchers estimate that 10-15% of all births in the United States are the result of elective deliveries before 39 weeks of gestation (Clark et al., 2010). Researchers suspect that much of the increase in late preterm and early term births may be driven by inductions and c-sections that are either elective or justified medically by flimsy evidence (Goldenberg, McClure, Bhattacharya, Groat, & Stahl, 2009). These births are expensive in emotional and medical terms (Clark, Meyers, & Perlin, 2011). If the number of these elective early term births were reduced nationally to less than 2% of all births, the medical savings from the resulting decrease in the neonatal intensive care unit (NICU) admissions would approach an estimated $1 billion annually (Clark et al.).

Scholars note that the inability of medical science to predict exact due dates may be a cause of early term and preterm birth (Engle & Kominiarek, 2008). However, little attention has been paid to the way women construct this uncertainty and how this construction influences how they approach giving birth and thus the decision to induce or
perform a c-section before 39 weeks. Due dates are calculated based on the first day of a woman’s last menstrual period, and this estimate is usually confirmed by a crown-to-rump measurement of the fetus with an ultrasound in the first trimester. These calculations are accurate within 5 days of delivery 95% of the time (Salomon, Pizzi, Gasparrini, Bernard, & Ville, 2010). How women understand this medical knowledge and negotiate the uncertain due date with their medical providers and families may be critical to understanding elective early-term births.

The idea that women are “demanding” c-sections or early inductions, although often stated in the medical literature, is controversial. A 2007 critique of 17 studies of c-section on maternal demand found that, in general, the studies did not examine whether the women “choosing” a c-section were informed of the risks and benefits of the procedure; in addition, the studies did not investigate the physician’s role in the decision (Gamble, Creedy, McCourt, Weaver, & Beake, 2007). Survey research suggests that most women do not understand the risks of induction and cesarean sections, even if they have had those procedures (Declerq, Sakala, Corry, & Applebaum, 2006). In addition, pregnant women may not understand the importance of maintaining a pregnancy through 39 weeks: A 2009 survey of 650 women who had been pregnant within the previous 18 months found that 51.7% of women thought it was safe to deliver between 34 to 36 weeks and another 40.7% thought it was safe to deliver between 37 to 38 weeks (Goldenberg et al., 2009). Only 7.6% chose 39 to 40 weeks as the safe time to deliver. However, Goldenberg and colleagues do not identify why women think that early births are safe and what can influence that belief and their subsequent requests for early birth.
The problem of early term births is being addressed nationally at many levels, including changes in hospital policies, in national quality-of-care standards, and in requirements from third-party payers (Clark et al., 2011). Several scholars have argued that the need still exists to help women understand the risks associated with late preterm and early term births (Ashton, 2010; Clark, 2010; Fleischman, Oinuma, & Clark, 2010). Given the high medical and quality-of-life costs of late preterm and early term births and given the large number of scheduled births in the United States, a persuasive intervention is needed to convince women to carry their babies to full-term.

The Social Construction of Health

Health and illness can be viewed as constructions of our sociocultural environments (Lupton, 2000). From this perspective, the decisions individuals make about their health, and, in the case of this study, the decisions surrounding birth, can be understood in terms of the cultural contexts individuals inhabit, the meanings they make of their worlds. Health decisions are made in the context of individuals’ daily, lived experiences and embodiments in the world. Thus, health decisions are a product of the meanings created from interpersonal relationships, social networks, institutional engagement, and mediated interactions.

By taking a cultural approach to health, this study engages culture as a dynamic space that is “constituted by the day-to-day practices of its members as they come to develop their interpretations of health and illness and engage in their day-to-day practices” (Dutta & Basu, 2011, p. 320). Following Dutta and Basu’s approach, this study seeks to contextualize how women’s understanding of pregnancy, health, and illness are interpreted from the perspective of the women making the decisions and to
consider the ways in which networks, relationships, and social systems help create women’s pregnancy realities and influence their decisions.

**The Integrative Model of Behavioral Effects**

As little is known about how women make the decision of when to give birth, the integrative model of behavioral prediction was chosen as one model through which to consider this behavior. The model provides a framework through which campaign designers can understand what determines a behavior, and, thus, enable them to design an intervention to prevent or influence the behavior (Fishbein & Cappella, 2006). The model predicts that if one has a strong intention to engage in a behavior and the skills needed to perform the behavior and no environmental factors prevent the behavior, then a person will engage in the behavior. Key to the performance is strong behavioral intention (Montaño & Kaspryzk, 2008).

The model emphasizes three determinants of behavioral intention: the attitude toward performing the behavior, the social norms associated with the behavior, and the self-efficacy or perceived control an individual has over the behavior (Kaspyrzyk, Montaño, & Fishbein, 1998). According to Kasprzyk et al., the indirect measures of these constructs are the most useful for developing health interventions. Attitude toward a behavior is based on beliefs about the positive and negative consequences of performing a behavior (Montaño & Kaspryzk, 2008). Perceived norms are indicated by both injunctive/subjective norms (what others think I should do) and descriptive norms (what I think others are doing). Perceived control is a function of the difficulty individuals attribute to performing a particular behavior and whether individuals believe they have the skills to perform the behavior.
Narrative as a Framework for Understanding Birth Decisions

In many ways, narrative is an obvious framework through which to understand birth decisions. Narratives of birth or birth stories are recognized as a way that women have traditionally learned about birth and shared their experiences (Munro, Kornelsen, & Hutton, 2009). Pregnant women value these personal stories for the emotional understanding they offer (Lowe, Powell, Griffiths, Thorogood, & Locock, 2009). Women who are pregnant for the first time often seek birth stories as a way to cope with their pregnancies, and these stories help to incorporate women into the culture of being pregnant (Savage, 2001).

The appeal of narrative is that people engage with one another and the world through narrative (Kreuter et al., 2007). Narratives “situate us in socially constructed time, space, and relationships” (Babrow, Kline, & Rawlins, 2005, p. 50). They help us make sense of the world, particularly in the chaotic and often uncertain realm of health (Sharf, Harter, Yamasaki, & Haidet, 2011). But they also offer a way to identify the assumptions held by a target population in relation to a particular behavior (Hopfer & Clippard, 2011). Stories not only provide a way for women individually to make sense of the experience of giving birth but also embody and reveal cultural beliefs, norms, and values women bring to the experience (Larkey & Hecht, 2010).

Birth stories have been studied to uncover the master narratives of pregnancy as an illness to be cured, for example, or as a complication to be scheduled around work (Buzzanell & Ellingson, 2005). They have also been used to examine the social and cultural influences surrounding elective c-sections (Munro et al., 2009). Munro et. al. limited their study to women who had chosen elective c-sections but did not explore the
stories of women who had not chosen a scheduled birth. The focus on women who had chosen elective c-sections limits the applicability of the study, as the researchers cannot tell us whether their findings – that these women tend to be afraid of giving birth – are unique to women who chose elective c-sections. Women who give birth vaginally may be afraid of birth as well. Vandevusse (1999) used birth stories to examine the involvement women felt in the decision-making process and thus their satisfaction with the birth experience. Bylund (2005) used content analysis to further Vandevusse’s work by exploring decision-making and patient satisfaction in 551 birth stories posted to a web site. Bylund’s analysis found that women most often felt involved in the decision of whether to use pain medication but did not feel as involved in other decisions in the birth experience. Although the study found that 201 decisions that involved c-sections and inductions, Bylund’s analysis doesn’t examine whether these decisions of how to give birth involved elective procedures or whether these procedures were initiated by the mothers or the providers. Like Vandevusse, Bylund is interested in how shared-decision making contributes to patient satisfaction and outcomes and does not consider the problem of late preterm and early term births.

**Narrative and Health Communication Campaigns**

Larkey and Hecht (2010) argue that the sense-making aspect that narratives can illuminate are useful to culturally-ground health promotion campaigns and make these campaigns more effective by identifying elements that will appeal to a particular population. Narrative can be effective, in particular, in understanding the messages women receive around a particular issue and how they make sense of these messages and incorporate them into their decisions (Hopfer & Clifford, 2011). Narrative in this context
focuses on the way in which a particular population conceives of an issue and thus seeks to capture the issue in terms that will inspire that population to change behavior. However, the implication in narrative theory is that cultural narratives aren’t just another variable in the behavior equation but are intrinsically part of the behavior itself (Larkey & Hecht, 2010). Kreuter et al. (2007) suggest that in health communication, narratives can be used as a way to overcome resistance, facilitate information processing, provide surrogate social connections, and address the emotional and existential issues surrounding a behavior.

This line of narrative inquiry falls within the experience-centered tradition of Paul Ricoeur (Squire, 2008), which sees narrative as means of sense-making. Instead of focusing on narrative structures within life stories and events, this tradition is interested in narrative as experience, as the basic way through which individuals understand who they are. This tradition makes several assumptions about narrative: that the narratives we tell are meaningful and sequential; that narratives are a primary way through which individuals make sense of the world; that narratives represent, construct, and reconstruct experience; and that narratives are, by nature, transformative.

**Narrative Sense-Making and Uncertainty**

This sense-making aspect of narratives can be analyzed using Babrow’s problematic integration theory (Babrow et al., 2005). According to problematic integration theory, individuals orientations to the world, probabilistic orientations and evaluative orientations (Babrow, 2001). Probabilistic orientations are concerned with individuals’ understandings of experience, the hows and whats of experience (Babrow et al., 2005). Evaluative orientations are concerned with the goodness or badness of a
particular outcome; these are essentially the emotional and moral understandings of experience. In order to create meaning, problematic integration theory says that individuals need to integrate their probabilistic and evaluative orientations, their expectations and desires. This integration is inherently problematic, as the orientations often destabilize one another (Babrow). Much of this integration occurs through narrative activities (Babrow et al., 2005), as individuals integrate their probabilistic and evaluative orientations to produce a coherent understanding of their realities. Through stories, individuals make sense of what doesn’t make sense and create certainty out of uncertainty. Integration is necessarily messy and lacks mathematic rationality. It is a way of making sense of the uncertainty of existence and, at the same time, accepting that uncertainty.

Babrow (2001) distinguishes between two main types of uncertainty that destabilize probabilistic orientations, ontological uncertainties and epistemological uncertainties. Ontological uncertainties arise from the indeterminacy and undeterminacy of causes, while epistemological uncertainties arise from the nature of how we know. Epistemological uncertainties may arise from concerns about the quality of information, the source of information, and the way in which we associate objects of thought – our probabilistic orientations – with one another.

Problematic integration theory was developed originally to understand uncertainty in illness and thus respond to it (Babrow, Kasch, & Ford, 1998). “Effective response to illness depends on the ways that patients, loved ones, and health practitioners understand and co-construct the many uncertainties that comprise the illness experience” (Babrow et al., 1998, p. 3). Although the status of pregnancy as an illness is contested, one can
easily substitute “pregnancy” for illness in the quote above. Brashers (2001) argues that even the healthy are no longer immune to the uncertainty of illness, as the current state of medical knowledge gives the healthy much about which to worry and be uncertain. This is especially true for the healthy state of pregnancy, which encompasses many uncertainties, including questions of when it began and when it should end.

**Research Questions:**

Based on the discussion above, this study explores the following research questions:

RQ1: How do women understand the uncertainty of their due dates?

RQ2: What probabilistic and evaluative orientations do women bring to the experience of giving birth and their views of when it should happen?

RQ3: What beliefs and attitudes lead women to believe that it is important to stay pregnant until 40 weeks?
Chapter 2

Methods

The study considered three groups of women: currently pregnant women, women who had given birth within the past two years by means of a spontaneous birth or a medically necessary c-section or induction, and women who had given birth within the past two years by means of an elective induction or c-section. The participants had a wide range of birth experiences: unmedicalized vaginal births, home births, hospital births, inductions and c-sections for medical reasons, and elective inductions and c-sections. This range of experiences was sought to capture the variations in birth experiences women have and to understand whether the women who had elective inductions or c-sections were qualitatively different from their non-elective counterparts or represented part of the continuum of birth experiences. Both pregnant and recently pregnant women were included in order to collect stories from women during the experience of being pregnant and after, as one way to triangulate the findings of the study. The women’s stories told during pregnancy and after provided a point of comparison, a check on one another, and, during the analysis process, a check on the interpretation.

Triangulation is a method used by qualitative researchers to achieve validation and involves the comparison of multiple forms of evidence (Lindlof & Taylor, 2011). If the different forms of evidence confirm one another, then they strengthen the validity of the study. Unlike quantitative research, qualitative research does not seek reliability because qualitative studies do not tend to create the repeatable events needed to establish reliability. Instead, qualitative research seeks to provide valid findings, ones that are
implicative outside of the individual situations being considered. This study employed several forms of triangulation to validate the findings, including the use of multiple theories to guide interview protocols, two coders in the analysis process, recruitment in three geographic regions, pregnant and recently pregnant participants, participants with elective and non-elective birth experiences, and, during coding, negative case analysis.

This study employed both individual and group interviews to collect the women’s stories. Group interviews take advantage of the way in which people tend to comment on the experiences of others (Lindlof & Taylor, 2011). It is the dynamic of the group interaction that makes the group interview a powerful tool for understanding how people approach reality and their experience of it, and, in this case, how pregnant women approach birth decisions. However, group interviews are not appropriate for all participants, since the advantage of the group is a disadvantage when the interviews include participants who may not speak if they feel that their experiences are different from others’ experiences or expectations. For this reason the women who had experienced elective c-sections or inductions were interviewed individually.

**Recruitment Procedures**

After Institutional Review Board approval was obtained, participants were recruited to take part in group and individual interviews. Women 18 years and older were recruited in three geographic locations. The recruitment methods varied slightly, depending on location. In the first location, women were recruited with the help of a large nurse-midwife practice at a regional hospital. Most of the participants from this area were patients at the practice. In the second location, participants were recruited through the local health department and an associated social-media mom’s group. In the third
location, participants were recruited through on-line mom’s groups, craigslist ads, flyers posted at a large academic medical center, the medical center’s research web sites, and businesses around town. In all locations, the flyers directed women to contact the researchers if they were interested in the study. As an incentive to participate, women were offered a $10 gift card to Wal-Mart or Babies R Us. Women who contacted researchers were screened and assigned to group or individual interviews.

**Interview Procedures**

Group and individual interviews with a total of 33 women began on July 5, 2011, and continued until January 26, 2012, when theoretical saturation was reached. The group interviews ($N=7$, 29 participants) were conducted at three different private locations and consisted of 3 to 5 participants. Although group interviews traditionally consist of 6 to 12 participants (Lindlof & Taylor, 2011), the small size of the group interviews in this study allowed each member of the group to share their stories within the time constraints, making it easier for individual women to participate. Individual interviews ($N=4$) were held at private locations convenient to participants. All of the women who participated in individual interviews indicated during the screening process that they had had an elective c-section or induction. All interviews were digitally recorded. Before beginning the interviews, the participants read and signed informed consent forms and then filled out questionnaires, in which they were asked to report demographic and pregnancy information. A copy of the questionnaire is in Appendix A.

The group and individual interviews followed a similar format. The protocols began with open-ended questions guided by narrative theory (Hopfer & Cliffard, 2010; Krueter et al., 2007; Larkey & Hetcht, 2010; Munro et al., 2009; Squire, 2008). These
questions asked the participants to tell stories about their birth decisions and influential moments in the decision-making process. Questions included, “Can you tell me a story about how you decided to give birth, whether to wait for your due date or to schedule it?” and “Can you tell me a story about a key moment in making that decision, maybe talking to someone influential?” From there, the protocols explored women’s thoughts about the length of a pregnancy and their knowledge of the causes and consequences of preterm birth. These questions were modeled on previous research on birth and decision-making (Darnall et al., 2006; Declerq et al., 2006; Goldenberg et al., 2009; Romano, 2007). Questions included, “Are there any risks for a baby when it is born before 40 weeks?” and “Do you know what makes a woman more likely to have a preterm birth?” The next set of questions focused on beliefs, attitudes, and norms about birth and birth decisions and were modeled on the integrated model of behavioral effects (Fishbien & Cappella, 2006; Montaño & Kasprzyk, 2008). Questions included, “How did you feel/would you have felt about waiting until your due date?” and “How would you tell someone about the advantages/benefits of waiting until your due date to deliver?” The final questions dealt with women’s knowledge of brain development in the final weeks of pregnancy. These questions were modeled on questions from the medical literature (Engle & Kominiarek, 2008). Questions included, “What do you know about your baby’s brain development?” and “What happens in the final weeks of pregnancy?” During the final set of questions, women were also shown the Healthy Babies are Worth the Wait Brain Card (see Figures 2.1 & 2.2). The card, which was developed for the March of Dimes and the Healthy Babies are Worth the Wait campaign, visually illustrates the differences between a baby’s brain at 35 weeks of gestation and 40 weeks of gestation. The card also verbally explains
the development that occurs in the cerebral cortex, cerebellum, and brainstem during the final weeks of pregnancy. The protocols were vetted by a medical doctor (MD) and other researchers and were modified according to their suggestions. A full copy of the protocols are available in Appendices B and C.

The individual and group interviews used a semi-structured format (Lindlof & Taylor, 2011), allowing for follow-up questions and reworded questions as needed. In the group interviews, each woman answered each question individually, but the women also responded to each other. The individual interviews lasted 30 to 50 minutes, and the group interviews lasted 50 to 130 minutes. At the end of the interviews, the women
Facts About the Importance of Going to Full Term

- At 35 weeks of pregnancy, your baby’s brain weighs only 2/3 of what it will weigh at term, which is about 40 weeks.
- During your last few weeks of pregnancy, your baby’s brain grows a lot and adds new connections that are important for thinking, muscle control, talking, and learning.
- New research also shows that babies born just a few weeks early may have learning and behavior problems.
- During the last few weeks of pregnancy, the part of the brain that controls balance, coordination, and social functioning grows and matures and almost doubles in size.
- Babies born just a few weeks early are also more likely to have apnea (they sometimes “forget to breathe”) and they are more likely to die of SIDS (“Sudden Infant Death Syndrome”).
- Babies born early are much more likely to have problems feeding since the sucking, swallowing, and breathing coordination is not yet well developed.

For all of these and many other reasons, unless you or your baby have problems, it’s best for your baby to be born around 40 weeks.

Figure 2.2: Healthy Babies are Worth the Wait Brain Card, side two. Johnson and Johnson Pediatric Institute, LLC and March of Dimes Foundation, July 2007. Printed by permission.

were thanked, compensated for their time ($10 gift cards), and given information from the March of Dimes about preterm births.

Participant Demographics

Across group and individual interviews, most of the 33 participants were White and, on average, 28 years old. Participants ranged in age from 19 to 40 years old. One Black woman and one Hispanic woman participated in the study. Most of the women reported having attained more than a high school degree, with 36.4% (N=12) reporting some college, 24.2% (N=8) reporting a college degree, and 30.3% (N=10) reporting a
graduate degree. The remaining women (9.1%, \(N=3\)) reported a high school degree or a GED certificate. The women reported family incomes of less than $20,000 to more than $80,000. Almost half of the participants reported an annual income between $20,000 and $60,000 (45.5%, \(N=15\)). One-third 33% (\(N=11\)) reported income of more than $60,000. Approximately 15% (\(N=5\)) of participants reported income of less than $20,000. Two of the women declined to indicate their income. Almost one-third (30.3%, \(N=10\)) of the participants indicated that they received health insurance through Medicaid, the state and federally funded insurance program for low-income earners. A list of the participants is in Table 2.1.

**Analytic Procedures**

**Data preparation.** The author and a professional transcriptionist transcribed the digital recordings verbatim, and then the author edited the transcripts to remove all identifying information. Participants’ names and the names of their friends, children, and providers were changed to ensure anonymity. In order to ensure the accuracy of the transcripts, the author read the transcripts and listened to the recordings multiple times. The coding began midway through the data collection process, as Strauss and Corbin recommend (1990). As new transcripts were added to the data collection, existing codes were revisited and refined, and new codes were identified.

**Grounded theory.** The coding took a grounded theory approach, in which the researchers allowed themes and concepts to emerge from the data (Lindlof & Taylor, 2011), using a constant comparison method (Strauss & Corbin, 1990). The coding began with open coding, and the author read the transcripts line-by-line, looking for points where the data aligned with concepts from the technical and theoretical literature as well.
Table 2.1

*Study Participants*

<table>
<thead>
<tr>
<th>Participant Pseudonym</th>
<th>Age</th>
<th>Interview</th>
<th>Gestational Age of Child at Birth</th>
<th>Prior Knowledge of Brain Development/Brain Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abby</td>
<td>33</td>
<td>group</td>
<td>38 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Alice**</td>
<td>29</td>
<td>group</td>
<td>40 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Allison</td>
<td>25</td>
<td>group</td>
<td>39 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Andrea</td>
<td>19</td>
<td>group</td>
<td>40 weeks</td>
<td>Unclear</td>
</tr>
<tr>
<td>Barbara</td>
<td>23</td>
<td>group</td>
<td>40 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Beth</td>
<td>28</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>Yes</td>
</tr>
<tr>
<td>Carrie</td>
<td>28</td>
<td>group</td>
<td>37 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Clacie</td>
<td>29</td>
<td>group</td>
<td>40 weeks</td>
<td>Unclear</td>
</tr>
<tr>
<td>Debbie**</td>
<td>28</td>
<td>group</td>
<td>37 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Diana</td>
<td>37</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>No</td>
</tr>
<tr>
<td>Heather</td>
<td>29</td>
<td>group</td>
<td>37 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Holly</td>
<td>28</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>Yes</td>
</tr>
<tr>
<td>Jamie</td>
<td>28</td>
<td>group</td>
<td>39 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Jennifer</td>
<td>29</td>
<td>group</td>
<td>37 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Jessica</td>
<td>30</td>
<td>group</td>
<td>39 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Judy</td>
<td>32</td>
<td>group</td>
<td>40 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Julie</td>
<td>31</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>No</td>
</tr>
<tr>
<td>Kate</td>
<td>28</td>
<td>group</td>
<td>41 weeks</td>
<td>Unclear</td>
</tr>
<tr>
<td>Kathy***</td>
<td>32</td>
<td>individual</td>
<td>39 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Kim</td>
<td>31</td>
<td>group</td>
<td>41 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Leslie**</td>
<td>24</td>
<td>group</td>
<td>(missing)</td>
<td>No</td>
</tr>
<tr>
<td>Lisa**</td>
<td>40</td>
<td>individual</td>
<td>37 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Liz*</td>
<td>24</td>
<td>individual</td>
<td>39 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Maggie*</td>
<td>36</td>
<td>individual</td>
<td>36 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Marcia</td>
<td>28</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>No</td>
</tr>
<tr>
<td>Mary**</td>
<td>21</td>
<td>group</td>
<td>39 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Molly**</td>
<td>26</td>
<td>group</td>
<td>41 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Monica</td>
<td>39</td>
<td>group</td>
<td>41 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Nancy</td>
<td>20</td>
<td>group</td>
<td>34 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Samantha</td>
<td>19</td>
<td>group</td>
<td>39 weeks</td>
<td>Yes</td>
</tr>
<tr>
<td>Stacey</td>
<td>30</td>
<td>group</td>
<td>41 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Tammy</td>
<td>27</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>Yes</td>
</tr>
<tr>
<td>Tiffany</td>
<td>23</td>
<td>group</td>
<td>N/A (pregnant)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Elective inductive c-section or induction before 40 weeks
**Request for elective induction or c-section before 39 weeks
as points of comparison within the data.\textsuperscript{1} In vivo coding was also used in this first phase, as the author looked for points of comparison in the language the participants used to describe their births and birth decisions. Key points of text were extracted from the data and then reassembled as codes in a separate document. In this stage of analysis, the codes that emerged described the women’s thoughts and feelings as they approached birth, their interactions with their providers, their knowledge of brain development, and the ways in which they acquired information about birth. Wanting to Be Done was an in vivo code that included the women’s stories of discomfort at the end of their pregnancies and their desires to give birth. Uncertainty of Due Date was an initial code that arose out the ways women talked about their due dates. The code Provider as Gatekeeper captured points where the women told stories of asking their providers for a c-section or induction. Throughout the first stage, the codes were revisited, reconsidered, renamed, and revised. A list of the codes that emerged from this process is in Table 2.2. Excerpts from the dataset for each code are in Appendix D.

Throughout this process, the author consulted with a second researcher. The second researcher was present at the first five focus groups and coded the transcripts.

\textsuperscript{1} Although Strauss and Corbin (1990) emphasize that researchers should not apply concepts to the data, they note that is useful in the open coding stage to use the technical (in this case, the medical) literature and the theoretical literature as a starting point for some of the initial codes.
Table 2.2

*Inductive Codes*

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meanings of Natural</td>
<td>Use of &quot;natural&quot; to describe a particular birth process</td>
</tr>
<tr>
<td>Wanting to Be Done-Misery</td>
<td>Women's desire to be &quot;done&quot; being pregnant because of discomfort</td>
</tr>
<tr>
<td>Wanting to Be Done-Keeping Baby In</td>
<td>Descriptions of managing the discomfort of pregnancy and the determination to stay pregnant</td>
</tr>
<tr>
<td>Wanting to Be Done-Life Complications</td>
<td>Descriptions of situations that made a certain birth date desirable</td>
</tr>
<tr>
<td>Wanting to be Done-Excitement/Anticipation</td>
<td>Descriptions of eagerness to meet their babies</td>
</tr>
<tr>
<td>Uncertainty of Due Dates - Waiting for 40 weeks</td>
<td>Discussions of the uncertainty of due dates and the importance of staying pregnant</td>
</tr>
<tr>
<td>Uncertainty of Due Dates- No Need to Wait</td>
<td>Discussions of the uncertainty of due dates to justify births before 39 weeks</td>
</tr>
<tr>
<td>Sense of I Can</td>
<td>Descriptions of how women developed the knowledge that they could give birth vaginally</td>
</tr>
<tr>
<td>Provider as Gatekeeper</td>
<td>Negotiations with providers for elective inductions and c-sections</td>
</tr>
<tr>
<td>Provider as Initiator/Decider</td>
<td>Descriptions of providers making birth decisions</td>
</tr>
<tr>
<td>Providers as Confidant</td>
<td>Descriptions of collaborative decisions with providers</td>
</tr>
<tr>
<td>Trusting Provider</td>
<td>Descriptions of trusting providers</td>
</tr>
<tr>
<td>Fear of Birth</td>
<td>Descriptions of fears related to birth</td>
</tr>
<tr>
<td>Baby-size/Fear of Big Babies</td>
<td>Assertions about babies, birth, and size</td>
</tr>
<tr>
<td>Wanting to Remember</td>
<td>Descriptions of how the women want to remember birth</td>
</tr>
<tr>
<td>Wanting to be with Baby/ Wanting a Healthy Baby</td>
<td>Emphasis on the importance of taking care of their babies after birth</td>
</tr>
</tbody>
</table>
Table 2.2

Inductive Codes (Cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Explanation/Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bodily Knowledge/Baby Knowledge: Let the Baby Decide</td>
<td>Explanations of birth that incorporate bodies/babies as the initiator</td>
</tr>
<tr>
<td>Other Women’s Stories</td>
<td>Influence of other women’s birth stories</td>
</tr>
<tr>
<td>Foundation of Information</td>
<td>Influence of media information on birth decisions</td>
</tr>
<tr>
<td>Foundation of Information and the Importance of 40</td>
<td>Influence of media information on the goodness/badness of the length of a pregnancy</td>
</tr>
<tr>
<td>Uncertainty and Information Seeking</td>
<td>Stories of seeking information to relieve uncertainty</td>
</tr>
<tr>
<td>Brain Development – Knowledge During Pregnancy</td>
<td>Stories of encountering the brain card/brain information during pregnancy</td>
</tr>
<tr>
<td>Brain Development- Reactions to the Brain Card</td>
<td>Reactions to the March of Dimes Brain Card when encountered during the focus group (for the first time)</td>
</tr>
<tr>
<td>Meaning of Preterm</td>
<td>Descriptions of thoughts/feelings related to preterm birth</td>
</tr>
<tr>
<td>Causes of Preterm Birth</td>
<td>Knowledge of the causes of preterm birth</td>
</tr>
<tr>
<td>Getting to 40 Weeks</td>
<td>Discussion of how women view the importance of 40 weeks of pregnancy</td>
</tr>
<tr>
<td>Meanings of Early</td>
<td>Use of the word “early” to describe babies that aren’t preterm but aren’t full-term either</td>
</tr>
</tbody>
</table>

separately from the author. The author and the second coder met four times during the process, in November 2011, January 2012, February 2012, and March 2012. During these meetings, the author and second researcher discussed the data and the emerging codes, resolved any disagreements that arose in their interpretations, refined and created
codes through discussion, and then returned to the data separately to continue the coding process.

In the Second Cycle of Coding (Saldaña, 2009), the codes were examined for patterns, which could explain the data and put them in perspective. Following Strauss and Corbin’s (1990) methods, the codes and categories that emerged and were refined during open and *in vivo* coding were re-analyzed, looking for the relationships among and between codes through axial coding. The codes were reassembled in order to consider causal conditions, intervening conditions, and consequences. The coding at this stage included both inductive and deductive approaches, as codes and relationships among codes continued to be refined and defined inductively, and existing codes and relationships were tested against the data. Through writing and modeling, it became apparent that the relationships among codes mirrored Babrow’s problematic integration theory (Babrow, 2001; Babrow et al., 1998; Babrow et al., 2005). Problematic integration offered a way to understand and explain how the women made their decisions of when and how to give birth. Another strategy used at this stage was negative-case analysis, in which the researcher looks for individual incidents that disconfirm the analysis and those incidents are used to revise and revisit categories. This iterative process continued until theoretical saturation was reached (Strauss & Corbin). At that point, the analysis could account for the participants’ narratives of their birth decisions, and, at the same time, no new information seemed to be emerging from the data.
Chapter 3

The Epistemological and Ontological Uncertainty of Due Dates

In this chapter, the results from the study will be discussed. These results describe how, in the group and individual interviews, the women told stories both of deciding how to give birth and of giving birth. For the women, the uncertainty of their due dates was both epistemological, in that they did not know how accurate their individual predicted due dates were, and ontological, in that they did know the exact beginning of their pregnancies or when exactly those pregnancies should come to an end. The due date represented not just an uncertainty but an unknowingness. The women interpreted these uncertainties as a give and take of two weeks or more. This interpretation was also an evaluative orientation toward the timing of birth. For some women, it was okay to have an elective c-section or induction as early as 36 weeks. For others, it was wrong to have an elective c-section or induction before 41 weeks; these women wanted their babies and their bodies to decide the timing of birth. These evaluative orientations were shaped by the women’s probabilistic orientations, but it was these evaluative orientations of the misery of pregnancy, of the excitement to meet their babies, of trust in their providers, and of the importance of 40 weeks that became primary in integration. One key factor in whether a woman received an elective induction or c-section before 40 weeks was her provider. The findings also suggest ways to influence women’s evaluative orientations, primarily through knowledge of brain development in the final weeks of pregnancy, and point to the existence of epistemological uncertainty.
Uncertainty of Due Dates

The women in this study understood that a full-term pregnancy lasted 40 weeks, but they viewed their individual due dates as medically uncertain. Tiffany called the uncertainty surrounding the due date “give time.” “Because they can halfway pinpoint where you got pregnant,” she explained. “But most of the time there is no exact knowledge of, unless you’ve been really working it out – but there’s no exact time that you did get pregnant.” Mary explained it this way, “They can’t pinpoint exactly what day you conceived.” Andrea said, “They could always be off on your due date.” Julie compared the baby’s development in the womb to a cake in the oven. “Sometimes it takes shorter, sometimes it takes longer, depending on the oven,” she said.

Both the epistemological and the ontological uncertainty of due dates is apparent in the women’s discussion of their due dates. The women understood that the estimate itself could be off, meaning that the quality of the information they were given could be wrong, and that the due date itself was unknowable. The women interpreted the uncertainty of their due dates as both a reason to wait on the baby and as a justification for inducing before 40 weeks. The women who interpreted the uncertainty as a justification for inducing early did not view the final weeks of pregnancy as important to their babies’ development as the women who interpreted the uncertainty as a reason to wait.

The women interpreted this “give time” to mean that their pregnancy could be shorter or longer than 39 to 40 weeks. Several of the women said 37 weeks would be “safe.”

2 All names have been changed to protect the identity of the participants.
Samantha explained that 38 was a “good number.” “Like 40 is the number that everyone says, but I think two weeks early is okay,” she said. “They say that usually by then they’re pretty developed and everything. They’re good, and, um, are ready.” Beth, who was pregnant with her third baby, had had two inductions for non-medical reasons, one at 39 weeks and one at 38 weeks. She also thought 38 was a good number because her boys “didn’t have any problems.”

Other women, however, interpreted the uncertainty of due dates as a reason to stay pregnant as long as possible and let the baby and their bodies decide when to give birth. Jamie thought it was important not to induce, even at 40 weeks. “Because the baby knows when it’s okay,” she said, “You know, they say it’s something that the baby secretes that starts the labor process, when their lungs are mature, and so, just let the baby decide.” Monica explained, “When your body starts labor, then you know you’re full term.”

**Probabilistic Orientations**

The women’s probabilistic orientations about the length of a pregnancy were shaped by their own experiences and by information they gleaned from media sources, both online and in books, from other women, and from their providers. These probabilistic orientations were closely related to the women’s evaluative orientations toward the timing of their births. Babrow (2001) argues that probabilistic and evaluative orientations are interdependent and integrated into our experience. This is apparent in the women’s stories, as they talk of what they know and have learned and whether this knowledge is good or bad. The women’s probabilistic orientations shaped their evaluative orientations of whether giving birth before 39 weeks was okay.
**Information as foundation.** The women in this study often relied on commercial websites and books for information about birth and pregnancy, and the information they acquired served as foundation for the decisions they later made. Many of the women simply “googled” a particular subject seeking information about pregnancy or how to understand a particular sensation. “I would look up, you know, certain things that were going on with me,” Maggie explained, “like if I had really bad heartburn or whatever, aches and pains or weird feelings.” Barbara said, “I started looking up on the Internet, how many different ways you can have a baby at home, have a baby without pain medicine, and everything.” Others relied on sites like Babycenter.com and theBump.com.

Especially at the beginning of a first pregnancy, the women reported a high need for information, motivated by a lack of information, epistemological uncertainty. “I don’t know what’s going on,” explained Marcia, who was six weeks pregnant with her first child at the time of the focus group. “I really don’t. This is the most confused I’ve ever been in my life.” Marcia was seeking information online, in books, and from other women. Tammy, another first-time pregnant woman, reported that she watched a lot of YouTube videos that showed the week-to-week growth of a fetus, and she had ordered “a lot of books.” “I’ve just read, and some of the stuff is kind of scary,” she said. “The other mothers that have had kids don’t tell you about some of that stuff. Sometimes you find out too much information.”

For some women, these sources provided a sense of “I can” – a sense that they could give birth vaginally without medical interventions. Jessica was scared of birth before she watched videos on Netflix and YouTube, but watching other women give birth
helped calm her. “I was just like, oh, I think I can do that,” she explained. Mary had a
similar experience. “Watching all the other women did it, and they didn’t die,” she said.
“So, you know, I could have done it. So that’s what was, what was cool.”

Some women reported that these sites gave them a false sense of their baby being
ready, especially when compared to illustrations of brain development that were
discussed as part of the interviews. Judy signed up for updates on the progress of her
pregnancy from a website. By 35 weeks, the babies in the emails looked “perfectly
normal,” she said. “They look just like a baby. Just smaller. And so I don’t think
anybody would guess there’s that much difference.” Stacey said she “struggled” because
at 37 weeks, the pregnancy websites used words like “healthy” and “viable.” These
words, Stacey explained, made it seem as though the baby was ready to be born. Lisa
reported that she understood that babies were ready to be born at 37 weeks. “And I did
read online where 37 weeks they’re developed,” she said. Diana reported that what she
had read in books and online, including the *What to Expect When You’re Expecting* app
she had for her iPhone, emphasized that 37 weeks was okay. From the women’s
comments, it’s apparent that information they obtained through the information-seeking
process becomes a foundation for later evaluative orientations toward the timing of their
births.

**Other women’s stories.** The women also spoke of the influence of other
women’s stories of giving birth. Judy explained that her approach toward birth started
with her grandmother and her mother. “My grandmother had her babies at home until the
last two,” Judy said. “And she did everything at home, like naturally. And then my mom
was in the hospital, but waited a long time to have drugs.” Kim explained that her own
birth and the stories she heard from her mom influenced her decision. “She had me natural\textsuperscript{3},” Kim said. “She didn’t have any epidural. I was actually born in a bathtub. So it was very natural.”

In some cases, the knowledge from other mothers came from on-line relationships. Carrie had friends with whom she kept up through social media that encouraged her, beginning with her third child, to wait as long as possible before giving birth and not have an early induction. “There’s a few other women through a group that I was a part of, that just talked about natural child birth and just gave their stories,” she said. Allison joined an online group called Café mom. “Most of those women have homebirths, and a lot of them are midwives, so I got a lot of information and good tips from them,” she said.

\textbf{Providers}. Providers also shaped women’s views of how long a pregnancy should last, although the women mentioned this source of information less often than they mentioned other women and the media. Lisa’s provider gave her the impression that her daughter would be okay, once an amniocentesis showed the lungs were developed, at 37 weeks. Heather said that her provider wouldn’t induce before 41 weeks with her first because “he wants to know what your body is capable of,” she said. With her second

\textsuperscript{3} It should be noted that the women in the study used “natural” to refer to two types of birth. Some women used natural birth to mean vaginal births as opposed to c-sections. The majority of the participants, however, defined natural birth as giving birth without assistance from medications, both ones that would speed up the birth process, like Pitocin, and ones that would relieve pain, like an epidural.
baby, he was willing to schedule an induction at 37 weeks because, “you’re safe and
everything,” she said. “So he was very open to whatever I wanted.” The women
reported that providers sometimes pushed them to stay pregnant longer. Mary’s provider
reminded her when she asked for an early induction that it was, “best to stay pregnant
until 39 weeks.” Allison’s provider encouraged her to wait as long as possible and told
her, “You might be pregnant until 42 weeks.”

Evaluative Orientations

The women’s evaluative orientations toward their due dates were shaped by their
probabilistic orientations. Their evaluation of the goodness or badness of staying
pregnant was predicated to some degree on their knowledge of the development that
occurs in the final weeks of pregnancy. Women who knew more about the development
in the final weeks of pregnancy tended to regard early births as bad. However, their
evaluative orientations were also shaped by their experience of pregnancy, the amount of
discomfort they felt from the state of being pregnant, and the excitement they felt to meet
their babies.

Women are “done.” By the end of the pregnancy, many of the women said they
were “done” being pregnant. Molly, who began asking her provider for an induction at
36 weeks, explained, “I was absolutely miserable... Yeah, I was like, let’s get it done.”
Leslie reported, “I so wanted the baby out of me. I blew up so bad that it hurt to walk. I
got carpal tunnel. It hurt so bad. I started like itching everywhere…It was just
miserable.” Kathy, who had an elective c-section at 39 weeks, tried to have her baby
earlier. She was uncomfortable from swelling, and, as will be discussed later, pretended
to have symptoms of preeclampsia, a pregnancy condition that is a justifiable medical
reason for inducing or performing a c-section before 39 weeks. “I was just, I was done,” she explained, laughing. “Not that that’s okay. But, you know, that last four weeks is very, very tough.”

**Ready to meet their babies.** The women were also ready to meet their babies and excited about the birth of a new child. Heather, who went into labor at 36 weeks without an induction with her most recent child and was induced at 41 weeks with her first, said that even women who have comfortable pregnancies get tired of being pregnant, of the looks and the comments about how they’ll “pop tomorrow.” At the end of her pregnancies, she was tired of being bigger and feeling ungainly, and, at the same time, she was excited to meet her babies. “So it’s a combination of the being done and the being ready for that next step,” she said. Liz didn’t feel too uncomfortable in her final weeks, but she echoed Heather’s sentiment about wanting to meet her baby. “You’re always ready for them to come out,” Liz said. “Because you want to see what they look like.” Diana described the excitement as an anxiousness to see her baby and know that it was okay. “The closer I get, the more anxious I get,” she said. “…After I get past that 36-week mark, knowing that I’m rounding that corner to 37, I start getting more anxious.”

**Wanting a healthy baby, wanting to be with babies.** Even though the women told stories of wanting to be done with their pregnancies, they feared the Neonatal Intensive Care Unit (NICU, pronounced NIK-u) where medically compromised babies go after birth. They didn’t want to be separated from their babies. The idea that “other people” might take care of their baby, as Carrie put it, was scary. Samantha didn’t want to be induced or scheduled:
I felt like if I did that, then he wasn’t really ready. And it would have put more stress on me. And I would have been worried about, what if it’s too early? What if he’s not ready and then he’s born, and he has to be in the NICU? Then I think that it’s my fault, because I had him come early.

Nancy, who had a preterm birth because her water broke early, talked about the pain of not being with her baby. After Nancy had her baby, the baby was immediately taken to the NICU, and Nancy felt like her heart had been ripped out:

Usually moms, who have their baby in the hospital room, they can be like, go and pick them up and lay in bed with them. I didn’t have that. You know, I sat in a chair with my hand in the little holes in the incubator rubbing my baby.

Feeling that their babies had come early was a source of regret and sadness. Kathy, who had a elective c-section at 39 weeks, felt like her baby had been “plucked a little bit early.” Her daughter needed oxygen at delivery, didn’t breastfeed well, and lost a troubling amount of weight after birth. “She would have had an easier time had I waited a couple weeks,” Kathy said. “And you know, for that, you know, I regret that, too.” Liz also felt that her baby had been forced out earlier than necessary. “If she had went longer, she might have been a little bit more developed than she was,” Liz explained.

Women also wanted to remember the birth experience. Clacie didn’t want to have an “awful” birth. “You want to remember it,” she said. Liz had an elective induction at 39 weeks and ended up with an emergency c-section because of a prolapsed cord. The experience made her vow never to have an induction again, even if she had to wait until 43 weeks. “It was hard on both of us, and I don’t remember seeing her,” Liz said. “And
obviously I did, because my husband took pictures of us. And I don’t remember any of it.”

**Preterm is bad.** The women were familiar with the problem of preterm birth and knew they wanted to avoid preterm births. However, they knew little about the causes of preterm birth or what they should do to avoid preterm births. Unless they had experienced preterm births, the women tended to have vague notions of what caused preterm births. Kim remembered that “stress” could be a cause of preterm birth. Leslie identified the environment, “Something you eat could cause you do go into labor or something you’re doing,” she said. Alice thought that some women were at a high risk because “of the way their bodies are built.” Despite these vague understandings of the causes of preterm birth, preterm births were seen as bad and “scary,” as Maggie put it, something to avoid. Heather explained that preterm meant worry about the “significant” health issues a baby might have.

Babies born after 37 weeks but before 39 weeks, however, were seen as qualitatively different from preterm babies. Even women who did not want to schedule inductions or c-sections did not regard early births as bad. Tiffany explained that “most babies I’ve seen come at 38 weeks” were fine. “They went home in the normal amount of time and everything,” she said. Clacie had a friend who had a baby three weeks early “She seems really healthy and everything,” Clacie explained. “And there wasn’t a problem.” These sentiments echo the medical literature, in which babies born after 36 weeks of gestation but before 39 weeks are called great imposters (Buus-Frank, 2005). However, medical research has shown that despite their healthy looks these babies are
medically fragile and at higher risk for admission to the NICU and readmission to the hospital.

**Bodily knowledge.** While some of the women talked about wanting to give birth before 39 weeks, other women didn’t want an induction or c-section at any cost. These women tended to speak of birth as a “natural” process, which they were made to do, and they placed importance on waiting until their bodies and their babies knew it was time to give birth. These were the same women who, as mentioned earlier, saw the uncertainty of the due date as a reason to wait as long as possible to give birth. Tiffany’s husband, for example, was a truck driver, and so she had good reasons to want a scheduled birth, she explained. If she scheduled it, then she would know that her husband would be present for the birth of her baby and not stuck in Washington state or some other far-away place. However, Tiffany didn’t want a scheduled birth. She wanted to wait for her baby to be ready. “Because the doctors and even I don’t know when she’s ready as much as she does, as my body does,” Tiffany explained. For Jamie, this sense that her body was made to have children and that her body would know when her baby was ready came, in part, from her religious beliefs. “I do very much believe that we were created and that God made us to be able to do it,” she said. Clacie attributed her determination to stay pregnant to her determination to not “mess anything up.” “Because I was really uncomfortable,” she said. “I mean I was constipated the whole time…I’m always on my feet at work. I was swelling, and so just kind of tired mostly. But I’m so hardheaded that I was not even gonna think about getting induced.”
Providers as Gatekeepers

While the women’s probabilistic and evaluative orientations shaped their understanding of the uncertainty surrounding their due dates and their desires to give birth before labor began on its own, whether or not the women received an elective induction or c-section before 39 weeks depended on their provider. In both the group and individual interviews, women told stories of asking their providers for c-sections and inductions before 39 weeks. In these stories, the providers function as gatekeepers: They will do as the mother requests, or they won’t.

Lisa asked her provider when was the earliest she could have c-section, and, with the provider’s approval, scheduled it for 37 weeks and a couple days because of her husband’s vacation schedule. “We mainly did the c-section just for our convenience,” she explained. “That was the only week he could get off.”

Kathy pretended to have symptoms of preeclampsia in order to deliver her daughter early:

My protein was negative in my urine, my blood pressure was fine, but there’s other symptoms that go along with preeclampsia like seeing spots, having headaches, stuff that nobody else can measure except for you. So I was like, I’m starting to have headaches.

Molly was also uncomfortable and also tried to convince her provider to let her have an early birth. “And every week, I’d be like, ‘Are you going to give me an induction today?’ She’s like, ‘No.’ I’m like, ‘Yes you are.’ …She’s like, ‘No, let’s wait ‘til next week.’ …So, of course, she pushed me up to 39…”
Leslie also wanted her pregnancy to be over. She was miserable. She itched. It was hard to walk. But her doctor was not ready to induce. “And I kept talking to her about it, she’s like, ‘Well, I don’t want to do anything. Just try to bear with it. It will be over before you know it.’ I’m just like, uhhhhhh.”

These stories of negotiation echo the concerns expressed in the medical literature of women demanding c-sections and inductions before 39 weeks (Gamble et al., 2007). These stories lend credence to the idea that providers often encounter patients who wish to induce or have a c-section before 39 weeks.

In some cases, providers seemed to offer women early inductions and c-sections. With her second child, Heather reported her provider was “very open to whatever I wanted” at 37 weeks. Carrie said her provider wanted to induce her at 35 weeks because her blood pressure was elevated:

I was already dilating, and my blood pressure was up, and he tried to – he talked about inducing because of that. But I seemed to wait. He let me wait at least two more weeks, I think. He was like, “We’ll wait it, we’ll watch it.” I was like, “I just want to wait as long as possible.”

In two cases, the women felt as though their providers initiated early births for the providers’ convenience. Liz said that her provider came into an appointment the week before her due date and said, “‘Okay, you want to have a baby Tuesday?’” She didn’t question the reason for scheduling the birth until afterward.

It’s one of these things that I guess you trust your doctor to do what they are supposed to do. And, like later, when I thought back on it, her due date was Memorial Day. I’m not stupid. He didn’t want to worry about it.
With her first child, Maggie’s provider broke her water at 36 weeks. Maggie didn’t question the decision, and her doctor didn’t give her a reason. “It was like total trust in the doctor,” she said. Maggie found out later that her provider had plans to leave town the following day.

**Brain Development as Influential Factor**

Across interviews, brain development was seen as an important factor to consider when deciding when to give birth. Some of the women were aware of the brain growth that occurs in the final weeks of pregnancy and had seen the Healthy Babies are Worth the Wait Brain Card (see Figures 2.1 & 2.2). Women who had seen the card before the interviews talked about the information on it before the card was presented to the group. The women presented the information about brain growth in the final weeks of pregnancy as an important reason to stay pregnant until their due dates. For example, when women were asked about the differences between a baby born at 37 weeks versus one born at 40 weeks, Holly said it was “massive.” “They show pictures of the brain of a 36-week-old and a 40-week-old,” she said, “and it’s a massive difference.” Samantha said that the pictures “stuck” with her. “This is one of the reasons why I wanted to wait for him to reach 40 weeks, or at least really close,” she said.

For the women who had not seen the card before, the information was seen as important and persuasive. In addition, it changed their evaluative orientations toward birth before 40 weeks. Leslie, who had seemed angry with her doctor for not providing an induction when she wanted one, became glad that she had waited:
Like knowing this now and 40 weeks – they don’t forget to breathe. And like I’m so scared now from the whole SIDS situation, and if I would have him taken out early, you know, he may have had a greater chance of that.

Maggie said that the information would have encouraged her to question her doctor and ask for reasons. “I probably would have been like, hey, what’s up with this?” Diana reported that seeing the difference in the size of the brain at 35 week and 40 weeks quelled some of her anxiousness and excitement to see her baby and helped her to “chill out.” “So, like, this actually helps take away some of that anxiety of, over I want to see my baby, I want to hold my baby, I want to see what he looks like,” she said.
Chapter 4

Interpreting the Uncertainty of Due Dates

The findings suggest that how women understand and interpret the uncertainty of their due dates influences how they approach the decision of when to give birth and whether they should seek an elective induction or c-section before 39 weeks of gestation. The women in this study understood that preterm births were bad and should be avoided, but they did not consider babies born after 36 weeks and before 39 weeks to be much different than babies born full term. These babies seemed normal to them. This positive evaluative orientation toward late preterm and early term births is easily understood. In the medical literature, these babies are often called “great imposters” (Buus-Frank, 2005, p. 233), because they look just like full term babies, but they are not just like full term babies.

The women formed probabilistic orientations toward the timing of birth based on knowledge they obtained from websites and books, their providers, their own experience, and other women. Their evaluative orientations were based on the same information but were also shaped by the discomfort they experienced, the excitement they felt to meet their babies, and their understanding of the ontological and epistemological uncertainties of their due dates. Whether a woman ultimately received an elective induction or c-section before 39 weeks, however, depended on her provider’s willingness to initiate the birth process and hospital policies. (See Figure 4.1.)

Knowledge of how an infant’s brain grows and develops in the final weeks of pregnancy was key to women’s negative evaluative orientations toward an early birth. The idea that less time in their bodies could rob their babies of brain development was
Figure 4.1: A model of how women decide when to give birth, using problematic integration theory
scary. In addition, several found the information about SIDS, the idea that their babies could forget to breathe because of a lack of brain development, frightening.

The birth decision model (Figure 4.1) describes two routes to a woman’s decision of the timing of birth. It begins with the women’s probabilistic and evaluative orientations toward birth. The women who follow the top half of the model tend to believe that waiting is good and important. They also tend to know that the final weeks of pregnancy are critical to their babies’ development. When these women integrate their probabilistic and evaluative orientations, they tend to interpret the uncertainty of their due dates as a reason to wait. The women who follow the bottom half of the model tend to have probabilistic orientations that emphasize how developed their babies are, starting around 37 weeks. These women’s evaluative orientations tend to emphasize the difficulty and discomfort of waiting and their eagerness to see their babies. When these women integrate their probabilistic and evaluative orientations, they tend to interpret the uncertainty of their due dates as a reason to schedule their babies’ birth before 39 weeks.

From both of these groups of women, some women go into labor spontaneously before 39 weeks of gestation. As the model shows, a key factor in whether these women receive early elective inductions and c-sections are the providers. The providers tend to be willing to schedule birth before 39 weeks or not. Depending on the provider’s orientation, then, the women in this study either have inductions and c-sections before 39 weeks, or they wait for a spontaneous birth or a scheduled induction or c-section after 39 weeks of gestation.
Practical Implications

This study points to the need to educate and persuade women of the importance of staying pregnant until 39 weeks. In this study, the women’s views on birth before 39 weeks echoed other, larger studies that have shown that women do not appreciate the risks of giving birth before 39 weeks (Goldenberg et al., 2009). In addition, this study provides an explanation as to why women see preterm births (those before 35 weeks) as bad but early term births were seen acceptable and sometimes desired. The analysis suggests that women’s evaluations of early birth can be changed using information about brain development in the final weeks of pregnancy.

The analysis points to the need to disseminate information about brain development in mediated, clinical, and interpersonal contexts. Many of the women in this study thought that births as early as 37 weeks were safe, in part because of information that they had gleaned from commercial websites and pregnancy books like What to Expect When You’re Expecting. Women are high information seekers during pregnancy (Bernhardt & Feltner, 2004), and, as this study has demonstrated, the information obtained serves as a foundation for later choices. This points to the need for health communication researchers to persuade commercial producers of medical information to update their materials. For example, the description of the 37th week on BabyCenter.com, a top pregnancy website begins: “Your baby is now considered full-term even though your due date is three weeks away” (“Your pregnancy,” 2012; see Figure 4.2). The message implies that the baby is ready.

This research suggests that these messages should emphasize the development that is occurring and importance of the final weeks of pregnancy for brain development.
Figure 4.2: Excerpt from BabyCenter.com on the 37th week of pregnancy.

This message could begin, for example, “Your baby will soon be here, but these final weeks of pregnancy are very important for your baby’s brain,” and then provide information about brain development in the final weeks of pregnancy and encourage women to continue eating healthy and exercising as they approach their due dates. In addition, these messages need to remind women that the length of their individual pregnancy is uncertain and that their pregnancy may last more than 40 weeks. These messages should remind women that, in most cases, their bodies will know when it is time to give birth and will begin the birth process without medical interventions.

The March of Dimes should reach out to these commercial providers to alter their messages and begin a campaign of its own to disseminate this information through targeted Internet ads, social media, and other channels. The information from the brain
card could be translated into an interactive video or Facebook application of brain development in the final weeks.

This study also suggests that women need help when their doctors recommend inductions or c-sections before 39 weeks. One way to provide that support would be to encourage women to ask their providers why a birth before 39 weeks is medically necessary and give women model questions they should ask if their provider recommends an induction before 39 weeks. Given the ontological uncertainty of due dates and the medical evidence that suggests that 40 weeks is optimal time for delivery (Cheschair & Menard, 2011), these messages may need to emphasize 40 weeks or longer as the appropriate goal for a full-term birth.

At the clinic level, providers need to direct women to good sources of information that emphasize the importance of the final weeks of pregnancy and to encourage women to stay pregnant as long as possible, starting at the beginning of pregnancy. Information about brain development should be distributed early in a women’s pregnancy and distributed at multiple points. Providers should emphasize the uncertainty of due dates as a reason to wait for birth to begin on its own. Providers could ask women to make a pre-commitment to going full-term, as a way to encourage women to stay pregnant longer.

A low-cost way to distribute this information at the community level would be through the development of brochures and posters. These could be distributed through provider practices, maternity fairs, and birth education classes. In particular, hospitals may want to evaluate the curriculum they provide in birth education classes and maternity tours and update the curriculum to include information about brain development in the final weeks of pregnancy.
Finally, providers and campaign designers also need a way to talk about the final
weeks of pregnancy. Births during these final weeks aren’t technically preterm, and the
women in this study saw these babies as separate from preterm babies. At the same time,
unlike some of the women’s impressions, these babies are not like full-term babies, as is
evidenced in the medical literature. In the medical literature, these babies are called early
term and late preterm (Engle & Kominiarek, 2008), but such nomenclature is clunky and
impractical for everyday conversations. Instead, the time between 36 and 39 weeks could
be called “early.” For the women in this study, this term implied that although these
babies were not preterm, they were not fully ready to enter the world. It should be noted,
however, that this term was neutral. If its use were to be effective it would need to be
framed as a problem through message design.

Theoretical Implications

This study demonstrates how a grounded theory approach can be useful in
understanding a problem at its base level and allowing the participants’ views and the
problem itself to define the theoretical lens that allows for the richest understanding of
the problem. The study also demonstrates how problematic integration theory can be
used to understand the decision process and the multiple layers, the probabilistic and
evaluative orientations, involved in the decision, particularly when the decision involves
both epistemological and ontological uncertainty. Although many campaign designers
use behavior-based theories when analyzing a problem that is appropriate for large-scale
interventions, using problematic integration theory allows a rich and nuanced
understanding of how a decision is made and offers insight into how that decision might
be influenced through an intervention. This insight gives researchers a nuanced picture of how facts and feelings contributes to an individual’s understanding of their choices.

The analysis points to a third type of uncertainty that may further illuminate the nuances of uncertainty. On several occasions Babrow has called for a more nuanced understanding of uncertainty (Babrow, 2001; Babrow & Matthias, 2008), as a way to identify better responses to uncertainty. Babrow argues that uncertainty is often used as a catch-all term by scholars, and the lack of precision in the term impedes scholars’ understanding of uncertainty. As noted earlier, Babrow has distinguished between two main types of uncertainty that destabilize probabilistic orientations, ontological uncertainties and epistemological uncertainties. However, he does consider how evaluative orientations may be destabilized by a third type of uncertainty, axiological uncertainty. Babrow (2008) notes that probabilistic orientations can shape and destabilize evaluative orientations, but he does not explore the possibility that evaluative orientations may be uncertain in and of themselves.

Axiological uncertainties are uncertainties that have to do with the ethics and values individuals bring to evaluative orientations. This happens when individuals don’t know whether an event would be good or bad; individuals are uncertain as to the moral and ethical implications of the event. For the women in this study, for instance, ending a pregnancy a little early would be good, because they were uncomfortable, they were ready to be done being pregnant, and they wanted to meet their babies. At the same time, ending a pregnancy too early would be bad, because they didn’t want their babies to end up in the NICU, they didn’t want to be separated from their babies, and they wanted their babies to have the best start possible, especially when it came to brain development.
These diverging desires destabilize the women’s evaluative orientations, creating uncertainty as to whether the timing of an elective birth would be good or bad.

In the realm of medical decision-making, axiological uncertainties must often occur with more profound implications than were seen in this study. A treatment may save a life, but at what cost and at what quality? Patients and their loved ones navigate a world where medical science has accomplished much, and they have much for which they may be thankful. At the same time, patients and family members ask themselves whether it is good to prolong a life using ventilators and feeding tubes when there is no hope of restoring consciousness or whether a heroic 15-hour surgery that temporarily saves a life is worth the pain to the patient. These are not easy questions, and the uncertainty of what is good and right destabilizes evaluative orientations, making integration problematic and messy. Indeed, these moments of axiological uncertainty may be moments when patients and their families experience profound uncertainty. These moments of uncertainty may be so devastating that patients and families cannot act. While this study does not provide enough evidence to fully define axiological uncertainty and unravel it from epistemological and ontological uncertainty, this study points to its existence and the need to further consider what axiological uncertainty means and how providers and others can best help those who experience axiological uncertainty.

**Conclusion**

The findings from this study suggest that women often ask for c-sections or inductions before 39 weeks of pregnancy, but that the decision to induce or have a c-section is one that is made in conjunction with their providers, a joint negotiation of what different risks mean and what is best for the baby and mother. The women in this study
translated medical knowledge of their due dates as an uncertainty and regarded their due
dates as uncertain, a plus or minus two weeks. They constructed this uncertainty as both
justification for inducing or having a c-section before 39 weeks and as a reason to wait
until their babies and their bodies decided it was time to give birth. How the women
constructed this uncertainty depended on their probabilistic and evaluative orientations
toward the length of a pregnancy. The findings point to several ways in which providers
and health communication campaign designers can influence women and encourage them
to stay pregnant as long as possible.

These findings are limited, however, by the small number of women involved in
the study who had elective inductions or c-sections before 39 weeks (although it included
several who had seriously considered one). This may be because these women are
difficult to identify, and it may be because of the low incentive offered for participation.
In addition, it may be that women who are eager to discuss their birth experiences and
pregnancies were more likely to want to participate in this study, and these women may
be qualitatively different from women who are less eager to talk about their birth
experiences and pregnancies.

The findings suggest several areas for future research. First, more work needs to
be done to understand how providers engage women when they ask for inductions or c-
sections. It may be that examining this negotiation from the providers’ standpoint could
provide better guidance for providers on how to handle patients who want early
inductions or c-sections. Another way to approach this question would be to video record
and analyze dyadic interactions between providers and expectant mothers in the final
month of pregnancy. Second, the finding of the influence of the brain card, while

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promising, may be limited to certain populations of women. A larger, quantitative study is needed to examine the brain card’s persuasive appeal in a larger population. Third, more work needs to be done to examine commercial web sites and their portrayal of birth decisions. Fourth, social media, micro-blogging, and chat rooms should be examined as sources of influence. In particular, networks that provide on-line and off-line components, may offer an effective way to incorporate women whose off-line social networks don’t emphasize the importance of waiting for birth into a culture that emphasizes birth as a process that is initiated by their babies and their bodies. More research is needed to understand the characteristics of effective online networks and how these networks could be replicated. Finally, the analysis suggests the existence of a third type of uncertainty, axiological uncertainty. More research is needed to further define axiological uncertainty and elucidate its role in decision-making.
Appendix A: Demographic Questionnaire

Age:____  County of residence ____________

Race:  ___White ___African-American ___Asian American 
       ___Hispanic ___American Indian ___Other

Highest level of education:  ___8th grade or less  ___Some high school 
                            ___High School /G.E.D.  ___Some college  ___College  ___Graduate degree

Yearly Family Income: ___Less than $20,000 ___$20,000-$40,000 ___$40,000-$60,000 
                       ___$60,000 to $80,000 ___$80,000 or more ___Decline to answer

Medical Insurance: ___No insurance ___Medicaid ___Employer-provided ___Private 

I took/have taken/am taking a childbirth class: ___Yes ___No

If pregnant now:  First trimester ___  Second trimester ___  Third trimester ___

I have given birth before: ___Yes ___No

Plan for birth: ___Wait for labor to start ___Scheduled Induction ___Scheduled C-section 

If choosing a scheduled birth, please briefly explain why: ____________________________
________________________________________________________________________

For scheduled births, how many weeks pregnant will you be at the time of the birth? ___

If pregnant with last two years: When I gave birth, I ___waited for labor to start 
                                ___had a scheduled induction ___had a scheduled C-section 

How many weeks pregnant were you at the time of birth? ____

If you had a scheduled birth, please briefly explain why: __________________________
________________________________________________________________________

How long ago did you give birth? ___1-6 months ___7-12 months 
                                    ___13-18 months ___18-24 months

Internet Access:

Have you used the Internet to get information about pregnancy? ___Yes ___No 

I access the Internet (check all that apply): ___at home ___at work 
                                         ___with my cell phone/handheld device ___at the library/other public space
Appendix B: Interview Introduction and Protocol

Interview introduction:
As I said before, my name is Sarah Vos, and I am a graduate student at the University of Kentucky College of Communications and Information Studies. I’m working on this project with College Dean Dan O’Hair and the Kentucky Chapter of the March of Dimes. We’re interested in learning how women make birth decisions and what they know about preterm birth, and this is why we wanted to talk to you. Before we get started, do you have any questions?

<table>
<thead>
<tr>
<th>Question</th>
<th>Theoretical/Practical Basis</th>
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</thead>
<tbody>
<tr>
<td>What stories do you tell other pregnant women about your birth experience?</td>
<td>Squire, 2008; Kreuter et al., 2007; Larkey &amp; Hecht, 2010</td>
</tr>
<tr>
<td>Can you tell me a story about your decision to give birth at XX weeks, to schedule your birth?</td>
<td>Hopfer &amp; Cliffard, 2010</td>
</tr>
<tr>
<td>How did that decision come about?</td>
<td>Munro et al., 2009</td>
</tr>
<tr>
<td>When did you make your decision?</td>
<td></td>
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<tr>
<td>What would you tell other pregnant women about your decision to induce/have a cesarean at XX weeks?</td>
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<tr>
<td>Can you tell me a story talking to someone influential, someone you relied on when making this decision? How did they react? What do you think about what they said?</td>
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<tr>
<td>Can you tell me a story about how your healthcare provider talked to you about when to give birth? What do you think about what he/she said?</td>
<td></td>
</tr>
<tr>
<td>Can you tell me a story about another source of information -- a person or a resource --that played an important role in your birth decision?</td>
<td>Declerq et al., 2006</td>
</tr>
<tr>
<td>Can you tell me a story about a time that you got information from the Internet that you found helpful? Where did you go for information on the Internet? Which resources did you find most helpful?</td>
<td>Romano, 2007</td>
</tr>
<tr>
<td>Do you use social media? Facebook? Twitter? Were these resources helpful?</td>
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</table>
What do you consider a full-term pregnancy to be? Where did you learn that?

I want you to think back to those final weeks of pregnancy: How were you feeling? How did you manage those feelings? How did those feelings influence your decision to induce/have a c-section? What convinced you/would have convinced you to wait until 40 weeks? What would have persuaded you to wait longer?

What words or thoughts comes to mind when you thinking about preterm birth? What do you know about preterm birth? What is it? Why does it happen?

At how many weeks is it safe to give birth? Ideally, how long should a pregnancy last? Do you know how many weeks your due date represented?

Are there any the risks for a baby when it is born before 40 weeks? Before 37 weeks?

What makes a pregnant woman more likely to have a preterm birth?

If I told you that a full-term birth was 40 weeks, what would that mean to you? If I told you that a full-term birth was 39 weeks, how would that change? Why would you think that 39 and 40 are different? (Explain that a full-term pregnancy is 39 to 40 weeks.)

How did you feel about waiting until your due date to give birth? What would you have disliked about continuing your pregnancy until your due date?

How would you tell someone about the advantages/benefits of waiting until their due date to deliver? The disadvantages?

What would you tell someone are the advantages of scheduling a delivery? What are the disadvantages?

Who would have supported your decision to give birth before your due date? Who wouldn’t have supported...
it? Would that support be different three weeks earlier?

What would make it easier for you to maintain a pregnancy until your due date? What would make it harder?

What prevented you from maintaining a pregnancy to your due date?

What do you know about your baby’s brain development? What happens in the final weeks of pregnancy? If you were thinking about delivering early, how would knowing about brain development influence your decision?
Appendix C: Focus Group Introduction and Protocol

Focus Group introduction:
My name is Sarah Vos and this is Katie Anthony, and we’re graduate students at the University of Kentucky College of Communications and Information Studies. We’re working on this project with College Dean Dan O’Hair and the Kentucky Chapter of the March of Dimes. We’re interested in learning how women make birth decisions and what they know about preterm birth, and this is why we wanted to talk to you today.

Before we get started, I’d like to ask everyone to say their first name when they begin to speak. Also, we’d appreciate it if everyone could take turns and not interrupt one another. We also like to ask each of you to not to repeat the personal information other women share today when you go home. We’re going to talk today about how you make your birth decisions – the decision of how to give birth and when to give birth. We’ll do our best to keep what you share confidential, but, in order to do that, we need your help, too. We really appreciate you coming out today to help us with this project. Before we get started, do you have any questions?

We’re going to start with some questions that ask you to tell us a story and, since there are (number in group) of you today, we’re going to ask that everyone tell quick stories. Give us the 90-second versions.

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<tr>
<th>Question</th>
<th>Theoretical/Practical Basis</th>
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<tr>
<td>Briefly, can you tell me a story about how you decided/are deciding when to give birth – whether to wait for your due date, wait for the baby or to schedule to give birth at XX weeks, to schedule your birth? It? If you are scheduling it, how are you deciding when to schedule it?</td>
<td>Hopfer &amp; Cliffard, 2010; Kreuter et al., 2007; Larkey &amp; Hecht, 2010; Munro et al., 2009; Squire, 2008</td>
</tr>
<tr>
<td>Can you tell me a story about a key moment in making that decision, talking to someone influential, someone you relied on when making this decision? How did they react? What do you think about what they said?</td>
<td>Declerq et al., 2006</td>
</tr>
<tr>
<td>Can you tell me a story about how your healthcare provider talked to you/is talking to you about your decision? What do you think about what he/she said?</td>
<td></td>
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<tr>
<td>Can you tell me a story about a time that you got information from the Internet that you found helpful? Where did you go for information on the Internet? Which resources did you find most helpful? Do you use social media? Facebook?</td>
<td>Romano, 2007</td>
</tr>
</tbody>
</table>
Twitter? Were these resources helpful?

On the writing tablet I gave you when you came in, write down the number of weeks in a full-term pregnancy. Let’s go around and share that number and explain where you learned that number.

Who can tell me how many weeks of pregnancy their due date represents?

If I told you that a full-term birth was 40 weeks, what would that mean to you? If I told you that a full-term birth was 39 weeks, how would that meaning change? Why would you think that 39 and 40 are different?

If a full-term pregnancy is 40 weeks, when would it be safe to give birth? If a full-term pregnancy is 39 weeks, when would it be safe to deliver? (Clarify that a full-term pregnancy lasts 40 weeks.)

Now, I want everyone to write down some words or thoughts that come to mind when you think of preterm birth. Then, I want you to write down the number of weeks at which it is safe to give birth – when it would be okay to induce or have a c-section for nonmedical reasons. After everyone is done writing, we’ll go around and share what you wrote.

What do you know about preterm birth? Goldenberg et al., 2009
What is it? Why does it happen?

Are there any the risks for a baby when it is born before 40 weeks? Before 37 weeks?

Do you know what makes a woman more likely to have a preterm birth? Engle, 2008

(pregnancy group) How do you feel about waiting until your due date? What would you dislike about continuing your pregnancy until your due date? Fishbein & Cappella, 2008

Montaño & Kasprzyk, 2008

(for previously pregnant group) I want you to think back to those final weeks of pregnancy: How were you feeling? How did you manage those feelings? Why did you/didn’t you decide to schedule your birth?
How would you tell someone about the advantages/benefits of waiting until your due date to deliver? How would you tell someone the disadvantages?

What are some of the differences between a baby born at full-term and a baby born early?

(for pregnancy groups) For those of you who are scheduling, what are some of the advantages of scheduling a delivery? The disadvantages?

Who would support your decision to give birth before your due date? Who wouldn’t support it? Would that support change three weeks before your due date?

What prevented/what would prevent you from maintaining a pregnancy until your due date?

What do you know about your baby’s brain development? Darnall et al., 2006

What happens in the final weeks of pregnancy? Let’s take a look at the “Brain Growth Matters” card. What do you think about this? If you were thinking about delivering early, how would knowing about brain development influence your decision?
Appendix D: Example Codes

Meanings of Natural – No Interventions

Holly: My decision is natural. Um, mainly just because my mom had all three of us natural and, um, I just hope to be able to do it without an epidural or a c-section, because I’m really scared about a c-section. (p. 17)

Samantha: It’s just natural for them to come when they’re ready. (p. 12)

Clacie: I pretty much had the second one exactly the way I wanted. I didn’t have any pain medicine. No epidural. Nothing. Just went totally natural. (pp. 30-31)

Barbara: So when I got pregnant with Ann, I decided that I wanted to go as natural as possible as long as I could. No IVs, no Pitocin, pain medicine. I wanted to be able to do this my way. (p. 30)

Andrea: Because I didn’t want my birth experience to be awful. Like, you know, you want to remember it. So I wanted to make sure that I didn’t get in so much pain that I just asked for something I didn’t know much about. That’s really how I made my decision to try to go natural… (p. 29)

Nancy: I was just going to wait until it happened naturally. I mean I didn’t want to have a c-section, and I didn’t want to have to be induced unless I was overdue. (p. 29)

Jessica: It’s the mindset too that it is a natural thing so I shouldn’t schedule. (p. 24)

Molly: And she had just, you know, decided to help out, maybe to make it a little easier she would induce me, but we -- I ended up going natural. (p. 6)

Carrie: With him, we -- I was going to wait until labor came naturally, because I had had Pitocin inductions with all the others and I didn’t want that – I wanted to finally have just a normal birth experience without Pitocin contractions. (p. 44)… I hadn’t had many friends that had had children naturally. And I hadn’t been into a group that had that kind of support or had those kinds of stories. So I just didn’t know. I was just very naïve about the whole process. (p. 46)

Jamie: I kind of knew from the beginning I wanted to do it naturally…my mom had all of us naturally, without any drugs or induction or anything. (p. 46)

Judy: I was thinking about that, and my grandmother had her babies at home until the last two. And she did everything at home, like naturally. And then my mom was in the hospital, but waited a long time to have the drugs. (p. 47).

Jessica: I was overdue, and I wanted to go all natural and, um, with no medicine and all that. (pp. 2-3)

Page numbers refer to the quote’s place in the full data set.
Mary: My goal was to go natural, or to go as long as I could without any pain medication. I wasn’t totally against pain medication, because labor is unpredictable, things happen. (p. 2)

Samantha: My boyfriend really wanted me to go all natural, and I told him that that was not happening, absolutely not happening. And, um, I told him that I would try to go as long as I could without the epidural, but, um, when the time actually came he was like, you need it. (laughs) (p. 4)

Kim: I think my mom had to do a lot with the way I wanted my birth. Because she had me natural. She didn’t have any epidural. I was actually born in a bathtub. So, it was very natural. (p. 62)

Maggie: Like she had nothing. She had no Pitocin, no epidurals, no anything. She had the midwife and the doula and the doctor and had an absolute natural childbirth in the hospital, in case there was any problems. (p. 115)

Kate: Yes. We had totally planned on having a natural birth, and I really would’ve went for a home birth if the first birth would’ve went okay (p. 147)

Meanings of Natural – No C-section

Beth: I just told her that um I had my boys, it was kind of planned to have them, um, the earliest one was two weeks early. And, uh, she was okay with it. To go natural. I told her I did not want to do a c-section. (p. 17)

Heather: I was able to have two natural births—with the assistance of the epidural—other than that. (p. 60)

Kathy: If I had wanted a natural birth and not wanted a c-section, if I had been as head strong on wanting a vaginal birth as I was on a C-section, I would have never scheduled at 39 or probably even 40 because I would have know that would have been a failed induction and ended up a c-section. (p. 87)

Lisa: So if I had knew he was 7, I wouldn’t have had a c-section, I would have just had him natural. (p. 100)

Wanting to be Done – Misery

Molly: I mean I was absolutely miserable. And with my age – I think it was worse. Five years earlier I didn’t feel as bad. So at 25 when I had Ashley – it was, 40 weeks didn’t matter to me. But when I got to 36 weeks at 30, and I was ready. Yeah. I was like, let’s get it done. You know. We were walking. We were doing whatever we could at the beginning of 36 weeks – to help the process. And you know, she was healthy. We had already had two or three ultrasounds by that point. She was healthy. She was a good weight. Her lungs were developed. And you know, we felt like it was feasible that I should try to, you know, move the process along. (p. 8) … I was miserable, and I knew that I needed to go to 40 weeks, but I think when you’re that miserable at 39 weeks, you’re like just do it. Just get out. (p. 15)
Mary: I was like 34 or 35 weeks… I was so miserable. You know, I’m just ready to get this baby out. I just want to go into labor. And she’s like, it’s best to stay pregnant until 39 weeks. All the exam rooms I was ever in, there’s always posters say that it’s best to stay pregnant until 39 weeks because of brain development and everything. (p.9) …In fact, like, the place I’m talking about, that does inductions at 38 weeks. Whenever I was 38 weeks, I thought very seriously about going to that hospital and walking into the emergency room and saying break my water and induce me. I wanted to so bad. I wanted to. But it was my husband who talked me out of it…He just said, you know, he’ll come when he’s ready. There’s no sense in rushing it. You know. And it was that next week, 39 weeks, whenever we scheduled my induction for 40 weeks. And he’s like that’s what you want to do and I want to be here for you because – that was my worst fear, if I had waited until 41 weeks to be induced, my husband wouldn’t be here. If my water would break beforehand and my husband would be gone. So, yeah, I thought very seriously about going to the hospital. …Yeah, you know, it took us 10 months to get pregnant. He said you know we worked so hard for 10 months to try to make him, and you know, try just to make it. You don’t have very much longer. He was really the backbone, and you know, pushed me to want to stay pregnant for a week longer. (pp. 15-16)

Nancy: A lot of people I know who get induced are people who get to 38, 39 weeks and just are uncomfortable. Like are in pain, of their feet and their back, and they’re just ready to have this baby. At least my friends who have got induced. That’s why they had it – because they were uncomfortable. (pp. 40)

Leslie: I so wanted the baby out of me. I blew up so bad that it hurt to walk. I got carpal tunnel. It hurt so bad. I started like itching everywhere. And I just wanted to itch my skin off. You know, I tried everything. I tried calamine. And I didn’t want to take medication but finally I was like – you got to give me something, and even the steroids they gave me – it still like bothered me. And going to work bothered me. So I had – put me on sick leave a month early, even though the doctor’s like, well… I was like, it’s hard to walk around, you know. It was just miserable. And kept talking to her about it, she’s like well, I don’t want to do anything. Just try to bear with it. It will be over before you know it. I’m just like uhhhh…..(FG5, pp. 70-71)

Debbie: There was a you’ve got to get this kid out because I’m uncomfortable but there was also the he’s really, really small. (p.73)

Kathy: … uncomfortable from being pregnant and swelling, I was just, I was done. (laughs) Not that that’s okay. But you know, it was just that last four weeks is very, very tough. (p. 76) …You’re just miserable and selfish and want the baby out. And then she was telling her story. Labor wasn’t that uncomfortable, got an epidural, pushing wasn’t that bad, you know you can do it. I was like I don’t want to. For one thing, I don’t want to be pregnant another two weeks and another thing, I just, I want her out. (p. 77)… I just wanted her out. I wanted her out. And I knew I could get her out at 39 weeks. At that point, I wanted her out, wanted her out. (p. 84)

Maggie: Miserable. I was miserable. I was, my legs were swollen, feet were swollen. Um, I was just miserable. And I don’t know if that had anything to do with why she
knew that as well? ... She would ask, she’d be gall-ee you’re legs are really swollen, and you know, are you feeling okay. I’m just like I’m really tired, you know this and that, and so I was just miserable in that sense. So I don’t know if she was thinking, maybe.. .Sure. You’re always ready to be done. Just kidding. At that end of the game – I guess, my thing is the whole when is it going to happen, I guess? You just walk around like, is my water going to break? And I know it typically doesn’t at 36 weeks, but it’s like if I would have gone to 40 – like I was just, everyday, just kind of like when… I don’t know. It’s like an anticipation thing. You just don’t know when it’s going to happen. (p. 117)

Diana: I don’t like being pregnant. (laughs). So the sooner I can have my babies the happier I am, but I also want them to be healthy and to be assured that they’re fully developed. (p. 123)… Although when I come to the 38\textsuperscript{th} week and I’m completely miserable, and I wished I had pushed for that earlier c-section…(p. 124)

Wanting to be Done – Keeping Baby In

Clacie: I was just so hard-headed that I just didn’t want to, you know, mess anything up. Because I was really uncomfortable. I mean I was constipated the whole time and, yeah, (general yeahs)… My work – I’m always on my feet at work. I was swelling, and so just kind of tired mostly. But I’m so hardheaded that I was not gonna even think about getting induced. (p. 40)

Carrie: … I was prepared to go as long as I had to… And you think that but then you’re baby you’re like oh please don’t go over. You would do it for the baby, but just please don’t do it (talking to baby) don’t make me. But, yeah, I mean – after reading, you know, what I had about the development and all that, I didn’t want to face him coming early, didn’t want to have to you know be induced early. (p. 52)

Monica: Well I can understand though when you get to that point in your late, your pregnancy, you are so done….You know, you just want it to end and you’re not thinking straight…You know at least for me because with my second, I mean I’d never been pregnant that long. I was like, I can’t, you know, this is just ridiculous, it’s going on and on and I was huge, and you know I couldn’t get up, I couldn’t breathe, and I…Yeah, and yeah, I’m just like yeah, you know if he came early, you know I don’t care; let’s be done. See that logic just…And I knew, I knew better about the whole thing but I remember secretly wishing…Can I just be, can I just be done?...I never did but you know I, you know I’d blog about it or whatever and just kind of like complain about it. …And you can’t see your feet, difficult to, you know you’re always going to the bathroom, but it’s hard to go to the bathroom. (p. 172)

Jennifer: But there is a thing I’ve always wondered, like why, because I was grumpy and crazy and I’m like, I’m ready, I’m over and done so I’ve always also wondered what would I do if I get to 40 weeks. I was just dying. (p. 172)
Wanting to be Done – Life Complications

Lisa: Oh, I mean I could have went on until July. Like I said, we mainly did the c-section just for our convenience. …if his vacation was another week, we probably would have waited longer. …Well, that was the only week he could get off, because we usually do it – we wanted the last week, end of July, because he was going on vacation Aug. 3. So we’ll do it that last Friday in July, closer to her due date. But he couldn’t get the last week of July. He got the week before. So that’s the only reason we scheduled it the week before. (p. 106)

Mary: I was scheduled to be induced on June first. And the reason while we were doing induction was because my husband was in the National Guard, and he was leaving a week later and we wanted him to have some time with the baby and everything. And it was our first child. But, um, my water broke, at Wal-Mart, on the Sunday before my due date. (p. 2)

Tiffany: There’s more disadvantages to waiting until your baby just comes because there’s no way to be completely prepared. There’s no way to --- I mean my husband’s a truck driver. So he could be out in Washington state when I go into labor, and I’m here with my son alone. So yeah, to that. But I really believe you have to make sacrifices in order for the well-being of your child. And so if that’s part of it and just waiting and doing that. I would rather do that and her be healthy and come when she’s ready, because doctors and even I don’t know when she’s ready as much as she does, as my body does. So. (p. 24)

Wanting to be Done – Excitement/Anticipation

Liz: You’re always ready for them to come out, because you want to see what they look like. But I think uncomfortable wise that was never really an issue. It’s like, well it’s part of pregnancy. You just do it. It goes away. (p. 94)

Heather: You start getting to that point where you’re just like okay just a few more weeks. I’m ready. You know, cause it’s you’re tired of being pregnant…You’re tired of people making comments like oh my goodness you’re going to pop tomorrow aren’t you. And no, I got three more weeks to go, you know. So you get tired of things like that – the, you know, the just being a lot bigger and just being ungainly and nothing fits anymore and everything and then you’re just really excited, um, to meet that person. You know, so it’s a combination of being done and being ready for that next step, somewhere in that mix. And you know – but, like, there is a huge difference between 39 and 40, and that’s six more days the processes doing as they should be doing and you’re body keeping your baby safe. (p. 66)

Maggie: …At that end of the game – I guess, my thing is the whole when is it going to happen, I guess? You just walk around like, is my water going to break? And I know it typically doesn’t at 36 weeks, but it’s like if I would have gone to 40 – like I was just, everyday, just kind of like when… – I don’t know. It’s like an anticipation thing. You just don’t know when it’s going to happen. (p. 117)
Diana: I just want to see my baby. I don’t care at this point. Um, but then I had a lot of guilt over that too. (p. 127) … I think if I were not having scheduled c-sections and, um, were just waiting for labor to happen, um, I think the closer I got to 40 and over the 40 week mark, I think the more anxious I would get. (laughs) Because I tend to be a worrier, and I have had to make myself chill out, and I’ve had to force myself to do it, but now that I’ve done it three times I’ve chilled out I think it just comes more naturally because I’ve done it, but I think if that 39 week, you’re like okay at any moment. We can do it at any moment and then at 40 you’re like, oh, come on. Is this going to happen, ever. So I can see myself at the 39 week being really excited, and to meet my baby, you know, and kind of wondering what’s going to happen with labor and then at 40 going, kind of feeling deflated, like ahh. Didn’t happen. Like, is it going to happen? (laughter) Do I have to go through induction? I can just see myself being a little more anxious and stressed out once I hit that 40. (pp. 134-135).… you know that you’ve got one week to go to 37 and that’s more of the – the scientifically believed, uh, safety zones. Be like okay, just one more week. I can go one more week, and maybe we can talk about – just you know, and then knowing that you – not that I’m a proponent of running tests all the time, but you know I would rather have a test and see my baby than to stay pregnant and have to wait longer to see the baby. I just get really anxious. (p. 137)

Julie: I enjoy being pregnant, just because – and I don’t have problems to go along with it so that’s probably why…But I’d still be like you, oh I want to meet the baby. I’d be like, what’s the soonest we can get the kid out and be healthy. Okay, cool, that will work for me. So if I was scheduling that’s what it would be. (p. 136)

Lisa: To go through the—my water broke – you know, that’s supposed to be the – I’ve never had that happen. Just like the excitement, okay honey, the baby’s coming. Let go … It’s like okay, grab your suitcase. We got an appointment at 10 o’clock. You know, just the excitement of you know – just doing it on your own. … You don’t know when they’re going to be here. You don’t know when their birthday is going to be. That’s exciting. ’Cause like c-section, we have to be there at 8, and she’ll be here by 12. We already know the birthdate, just don’t know the time and stuff. (pp. 108-109)

Heather: But it was definitely you can see the light at the end of the tunnel kind of thing, and you’re just – it was a huge combination of the being done and the ready to meet him, you know. We also had a surprise gender. We didn’t find out what he was, and, uh, so it was even more exciting to get to that point, because we wanted to be there and stuff, But didn’t quite expect it to be that early, especially since we went 9 days over with the first, but he’d come 3 weeks early. (p. 66)

Julie: I don’t know if I’m having a boy or a girl, so like really ohhh – this would be fun to find out, so I get really kind of anxious, excited… Noooo. Don’t know at all. It will be a surprise. We didn’t know for the first one either. (p. 137)
Uncertainty of Due Date – Waiting for 40 Weeks

Mary: I mean, I’ve always considered pregnancy being 40 weeks. But I know you can go earlier. I’ve always heard two weeks earlier, two weeks later, whatever…I mean they can’t pinpoint exactly what day you conceived. Unless know what day you ovulated and stuff, it isn’t …(p. 8)

Molly: That number is flexible, um, depending on the person. I think, there’s some women that you know can’t carry a baby to 40 weeks. So they’re normal pregnancy might be 35 weeks or 36 weeks, and they still come out with a perfectly normal healthy baby….That’s why I’ve always heard that you can go two weeks early or two weeks late, because it’s not exact. I don’t think they should give due dates, they should give due months. (laughs) Just say you’re going to go during this month. (p. 7-8)

Jessica: The due date never really made a difference to me. It was just whenever the baby was ready to come. (p. 8)

Mary: Yeah, I was trying to hurry it up. But I mean, it was what it was. He was healthy by 39 weeks and no problems. (p. 8)

Samantha: Like 40 is like the number that everyone says, but I think that 2 weeks early is okay. They say that usually by then they’re pretty developed and everything. They’re good. And, um, are ready. And I don’t know. Like. I don’t know. I think that they are fine at that point. They should be developed enough. (p. 9)

Jessica: …the last week I felt like I was overdue, even though you never know, I could have just been right on time, but I felt like I was overdue. So I was walking. I was eating spicy food – not that it was any spicier than what I would normally eat. …. (laughter) (p. 11)

Tiffany: Probably there is a certain part of give time. Because they can halfway pinpoint where you got pregnant but most of the time there is not exact knowledge of, unless you’ve been really working it out – but there’s no exact time that you did get pregnant so, yeah, there is a little give time. (p. 19)

Andrea: I think they could always be off on you’re due date, so if you went a little early or a little late, it would be okay.

Moderator 1: But what about scheduling, would you be okay with scheduling at 38?

Andrea: No. Because they could be off two weeks, and you could really be 36 weeks

Moderator 1: And why would that be bad?

Andrea: Because they might not be fully developed. Like she said. It’s better to wait was long as you can. Go natural. (p. 34)

Barbara: I think there’s a risk for ‘em whether they’re born before 40 weeks or before 37 weeks. I think there’s the same risk there. Because you still have the give and take two weeks on you’re due date. So you may think you’re 40 and you may end up being 38. (p. 37)

Jamie: I just think it’s very much an estimate. You know, it’s just kind of a – you’re not going to go into labor on the 40th, not necessarily, unless your baby came on the due date (laughter). You know it’s an average. It’s a – everyone’s different. Some
babies might be ready a little sooner, and some might take longer. And that’s kind of how I think about it. (p. 51)

Carrie: And not every woman knows exactly when they got pregnant either. So, you know, they’re maybe going to do an ultra sound. And be like okay, the baby is measuring at this. So what are you due dates at this time. Well, maybe the baby is measuring small, or smaller than they are or bigger than they are, and here you’re setting a date and they tell you plus or minus two weeks and then that could be plus or minus four weeks, and that’s a big difference for a baby. Because I mean the last few weeks are very crucial for lungs and brain. It could be a matter of a premature baby versus a healthy baby. (p. 51)

Marcia: To me, you’re taking nine months to make a whole human, maybe every single minute of those months are needed. But the baby is going to come when it’s ready. You know, I don’t think – I know there’s a lot of complications and stuff that people have, but your baby may develop – it’s just like being out here. Some people develop quicker than others and some people don’t. (p. 135)

Julie: I’m learning how to do cake decorating …you know, you get a recipe to bake a cake in the oven – it says put it in for this long. Well, it’s sometimes it takes shorter sometimes it takes longer, depending on the oven. That’s kind of how I look at it. I’m like, ah, maybe it’s a general suggestion. People are like when are you due, I’m like middle of March, they’re like what day? I’m like, what’s the point? I’m just like it’s – you know, technically it’s March 15, but I would put that as a suggestion. Two weeks before or two weeks after or whatever, because unless you know the actual day the kid was conceived, it’s really hard to like pinpoint it exactly, and my attitude has to be provided that you don’t have a history of complications, or you don’t have like a family history of, like going – like premature laboring or anything, pretty much when the cake is done, the cake is done and it will be time – even if the timer hasn’t gone off yet, …40 weeks, is like, in my mind, it’s a suggestion – so if you realize oh crap I’ve gone 42 weeks, something is probably wrong, so I need to probably get this baby out now….it might be okay we need to get this baby moving. Or you know if it’s 36 weeks or 37 weeks, and you’re body is going, hey, let’s kick this kid out now – then you need to go to the doctor and be like, is the baby big enough. Is it a healthy size? And it may be, it may not be. …Because there have been some women who have been like, I’m 42 weeks. (deep voice) I’d be like you probably need to go to the doctor. Cause if you know definitively that this where your at – you probably need – it’s probably not healthy to hold onto the baby too much longer. (pp. 135-136).

Diana: I remember hearing a conversation that even at 37, if there’s signs of going into labor or concerns about maybe complications about maybe having to do a c-section – that they’ve still done the tests to make sure the lungs are developed, even after 37 because of the fact that babies do develop at different rates and just because you are at 37 weeks doesn’t mean that that baby’s development is at 37 weeks (p. 137)) … And you also don’t know, because all children develop differently, even in the womb, and you really don’t know – I guess there’s probably an average, you could figure out. But you still don’t know if this baby developed exactly on track. (p. 143)
Monica: I think it varies from woman to woman... a full term pregnancy can be 38 weeks; a full term pregnancy can be 44 weeks. I mean I think it depends on the mother’s body. ...I mean it’s obviously an average of many people’s births you know... Well I think so. I mean I think anytime they move it back, then women that expectation, oh I’m 39 weeks, why aren’t I done yet you know.... If they’re 39 weeks and 2 days, well let’s induce you know. Why, I should be done you know. Or same thing with 40, and so I do think it’s dangerous. I know that they frequently will schedule a c-section at 38 weeks or something you know saying that that’s considered full term, but I wouldn’t agree. I think when your body starts labor, then you know you’re full term. (p. 165)

Kate: I always hated the whole due date thing and all that because I know that you know my full development may not be on 40 but. ... I mean it’s so, people are thinking more you know 38, and I mean I’ve even heard people say 36 you know as full term. ....And, but no I definitely thought 40. (p. 165)

Abby: Like I was like, with my daughter, my first child, I did not agree with my doctor. They said that she was due March 31st and I said, no she was due March 19th and she was born March 17th. So in my mind, she really wasn’t 38 weeks... In my mind, she was 40 weeks so.

Monica: Same with my twins. I think my due date was off; that’s why I’m not really sure exactly what week they were born in; I just go with the 33.

Monica: ..But yeah, where was I going with that?

Abby: That it’s all a guesstimate?

Monica: ..It’s all a guesstimate. (p. 165)

Uncertainty of Due Date – No Need to Wait

Beth: Now my boys, like I said, I had one 7 days early and the other one 14 days early. Um, they were about the same. One was 6’ 15” the other was 7’ 6”. And they were healthy. They didn’t have any problems. So I guess it really depends on, I guess, how your body is. When you’re going to have the baby. (p. 20) ...I don’t think there’s a difference. Because it’s just that many, you know, 7 days. (p. 21)

Debbie: ... You know I had an induction at 37 weeks and 5 days with my youngest, because I was ill, and we were severely worried about his size. He was measuring in the 3rd percentile, but I was so sick he had to be evicted ... we were severely worried because at that point what can you do. And my doctor knew – my doctor wanted to induce earlier but he had said no, no, no we need to wait to 37 weeks. And he wouldn’t induce after 37 weeks until after we had checked multiple times with the amnio to make sure that the baby’s lungs are mature. (p. 67)

Alice: ...40 is what you always hear. 40 is what is kind of been grained in as the full-term birth quote-unquote and so I know a lot happens between 39 and 40 – but you know also know that a lot happens between 36 and 40 and 37 and 40 and again, like they said, the longer you go the better it is for the baby. So, you know, at a certain point I guess it’s – you know there’s certain milestones you hit – 28, and 30, I can’t remember if it’s 32 or 34 and every time you hit one of those it’s kind of like, okay, if
it happens now it’s okay and then it’s like okay if it happens now these things are probably not going to be a problem but these things could still be a problem. Okay, if it happens now, I probably don’t have to worry about all these things – it’s still possible that the risks go down – the longer you can be pregnant. (p. 67-68)

Kathy: Well, I mean, in reality that due date is based on that 40 weeks but can be plus or minus two weeks very easily, depending on when you do conceive. So I mean, ideally we wouldn’t schedule all this elective stuff, and we would just wait and let nature take it’s course, which would push back to that 40 weeks… (p. 83)

Nancy: A 38-week baby isn’t preterm to me because a lot of 38-week babies I know – my half-brother, he was born at 38 weeks, and he was almost 10 pounds. So I mean… A full-term baby is supposed to be 40 weeks, but it’s safe to have a baby at 38 weeks. But nothing before 38 weeks. That would be preterm, at least to me. (p. 36)

Lisa: Yeah, a friend of mine. She just had her e-section, but you know. Like my sister-in-law, she was nervous. I said as long as at 37 weeks, that’s when you can go into labor or you can have them. I said as long as you make sure that the baby’s lungs are okay. But I said anything before 37 weeks, they’re not going to do it because the baby’s not ready… I said you can’t do nothing until 37 weeks. That’s the magic number. (laughs) …Through our doctor too, and then I was reading when I’d done our daughter too and then online. …Like when I’ve had her book. She has like every doctor visit I went, and I saw where I had her at 37 weeks and 2 days, so. And I did read online where 37 weeks they’re developed, …(p. 102-103)

Maggie: I was under the impression that anywhere from like 36 to 42 is I guess a safe thing, because I had asked her, you know, when are the lungs developed, you know, is everything going to be fine, and she said, yeah, 36 weeks they’re going to be fine. So that was kind of like a reassurance from her – that she was completely fine with taking them at 36, so…(p. 117). … The dates that you could be off from the beginning. It’s what I’ve always heard. That 36 to 40 weeks or 41 weeks or whatever, it may not have been right – you may have got the date a week off or whatever – just kind of like a … I think on BabyCenter or whatever. Through the Internet and people talking and things like that. (p. 120)

Sense of I Can

Jessica: I googled a lot. I think BabyCenter.com was one of the ones I went to for information. And then I watched a couple of videos on my Netflix, off the Internet, um the Business of Being Born. Um, I watched Pregnant America. But the Business of Being Born – it was a lot about natural births and midwives and it just lets you see how the women could do it. And it didn’t seem like – it was it’s not going to kill them. So I really, um, liked watching that video. Because I was scared before that, but after that, even though I had seen a few births from that video. I was just like, oh, I think I can do that. So I like, go online. YouTube, Also. (p. 5)

Mary: I did a lot of YouTube, and the Babycenter. The Babycenter had videos. They had a water birth video. There was a medicated childbirth, an unmedicated childbirth.
And there was even a home birth. And so those were really pretty interesting to watch. And the Business of Being Born – it’s empowering. Watching all the other women, did it, and they didn’t die. So you know I could have done it. So that’s what was, what was cool. (p. 5)

Barbara: …With Jennifer, I had a doctor, and I had a scheduled induced date. Of course I went into labor the night before with her, so I didn’t actually get induced. They did give me Pitocin to speed things up. I didn’t have my own timeline. Her heart rate would drop a bit, and it ended up just big doses of the Pitocin. But I had the epidural with Jennifer. I was -- I had to stay in bed. I hated it. So when I got pregnant with Ann, I decided that I wanted to go as natural as possible as long as I could. No IVs, no Pitocin, pain medicine. I wanted to be able to do this my way. … Cause with her, it was like as soon as I got there. Do you want an epidural, do you want this, do you want that? Do you need something for pain? And it was, I was stuck in bed. I didn’t know I had options to get up and move around. I didn’t know I could get in the tub. The shower. Nothing. I was just laying there, hurting. And laying in bed for 22 hours is not fun. And I hated it. It was just not what I wanted. And then I got pregnant with her. I started looking up on the Internet, how many different ways you can have a baby at home, have a baby without pain medicine and everything. So I want to do that. (Switches into baby talk) (p. 31)

Carrie: It was kind of like, right about when my, duh, really it was when my second child was older was when I really started getting into like – more of trying to do things more naturally. … Ever since then I just knew like that was best, to let it go naturally. Just from reading and just from hearing others that did it. It was like, yeah, my body should be able to do this. So. That’s all. (p. 46)

Jamie: Um, my mom had all of us naturally without any drugs or induction or anything. And so I guess I just grew up knowing that it can happen. You know most people these days think you can’t do it without the doctor there to you know fix you and make everything happen right. I just knew that she could do it … I just was reading for fun about it. You know reading books and Internet research – and just I couldn’t get enough information. And, so just kind of wanting to do it naturally lead me to authors and sites that supported natural things and the more I read the more I believed in that – so I guess that’s kind of how I got to that point. And I do very much believe that we were created and that God made us to be able to do it – so that probably steered me in that direction too, so. (p. 46)

Alice: I didn’t really want to have a c-section, so I was trying to let my body do whatever it was going to do. And I wanted to go as long as I could before getting an epidural, just to see, for curiosity, how far I could go. Because there’s some women that can do it all without. And I was honestly just curious how far I could go, how far I could go without getting an epidural….Um, I didn’t think I would need one. Like I guess I just didn’t want to have to go through the whole surgical and recovery aspect of it. Unless it was absolutely necessary. So I wanted to try it. Most of you know, our bodies were built to labor and give birth, so I wanted to try and have him without having a c-section. (FG5, p. 58-59) …We all have ideas on how we wanted it to go, or
like how I thought I wanted it to go. And being able to read that what I was thinking was possible I guess sort of reinforced that what I was thinking and what I was expecting – like it was normal. It was okay to think that and okay to expect that because that can happen that way. (p. 63)

Provider as Gatekeeper

Molly: Every week I’d be like, “Are you going to give me an induction today?” She’s like, “No.” I’m like, “Yes, you are.” She’s like, “No.” I’m like, “Yes, you are.” She’s like, “No, let’s wait ’til next week.” Of course I would wait ’til next week, she’s go, “Well let’s wait ’til next week.” “Well, let’s wait ’til next week.” So of course she pushed me up to 39.6. (p.15)

Debbie: I kept telling her I’m having the same symptoms, I’m having the same symptoms, and she kept saying you’re overreacting you’re over reacting. Until I went into her about – my two oldest son’s birthdays are four days apart in October– they’re 2 year and 4 days apart. And I went into her on the 24th of October, and said look, I cannot have this child on my other child’s birthday. I just can’t do it. She said, well, okay let’s do the test. You’ve been complaining about this and I think you’re wrong, but she said let’s just do the test to humor you and if you have preeclampsia again we’ll induce you. And I said okay great. You know I was very sarcastic and very mean about it, and come back and obviously I had preeclampsia. I mean my feet were swollen and purple, and when I woke I was dizzy and, you know, all the classic symptoms, and she said okay we’ll induce you today. (p. 64)

Leslie: And I was concerned because, you know, I go on the Internet and you read all this stuff and she couldn’t tell me what was wrong with my skin. And she checked my liver enzymes, but they came back fine, which is normally what it is. And um, I’m like, you know, I could putting this to my baby, and just from reading stuff. It was miserable. (FG5, pp. 70-71) … I wasn’t dilating, so it’s like – it’s all up to my doctor. She, I don’t think, was comfortable to induce me until it was my due date, and I went in the office, and she checked me and I was only one centimeter and she was like oh, we’re going to have to … I understood her viewpoint. It didn’t mean that I want go and have the baby. But if she’s not going to induce, and she has good reasons – I think we had talked about the fact that I really, really, really didn’t want to have a c-section unless it was absolutely necessary, so I’m guessing that somewhere she knew that throwing out you’re more likely to have a c-section – was going to be like okay fine. (p. 71)

Kathy: Now, about 36, 37 weeks I started trying to whine her out early and that’s when my doctor was like no, no, no. And I’m thankful for that. I’m definitely thankful for that. … I started swelling from 28 weeks on. Lots of swelling… My protein was negative in my urine, my blood pressure was fine, but there’s other symptoms that go along with preeclampsia like seeing spots, having headaches, stuff that nobody else can measure except for you. So I was like I’m starting to have headaches …uncomfortable from being pregnant and swelling, I was just, I was done. (laughs) Not that that’s okay. But you know, it was just that last four weeks is very, very tough.
… I was like I have a headache. So he was like, when was the last time you ate, have you been drinking okay, and when he said well I’ll take you off work, I was like no. That’s where I kind of drew the line and quit complaining because I didn’t want to be off work beforehand. I wanted to be off work after, so when you know and he said you know you’re protein is negative, you’re blood pressure is fine. You’re not sick. You’re just miserable, and I can take you off work. And that’s when I was like I’ll work up until we have her. … So I’m thankful for that part – where he was the doctor and I wasn’t in charge anymore, for sure. (p. 76)… Well, I was a control freak up until about that 36-37 weeks, and then I kind of did let my doctor take over. So I probably would have followed his lead. Probably. Although I was pretty determined. And at that point, the date had been picked for so long that everybody else had planned their life around it (p. 84)

Alice: …When we were getting closer, they thought that my daughter was going to be big, and so my doctor and me had been talking about 38 weeks. She said we’ll talk about induction at 37, we’ll talk about doing it at 38, see how things are going, talk about doing it at 38. And we hit 37, and there wasn’t any talk of it. And we hit 38, and she was like, you know, if I do her early, you’re not showing any signs, if I do it earlier, the likelihood of c-section is going to go up, so we’re just going to wait. I’m like, uh. Because in my head, for a long time, it’d been 38 – 38 – 38 – and then I get there and it’s like no, we’re going to wait. And I’m like oh my god, two more weeks. That’s a long time to be pregnant in the summer, in August, September when it’s really, really hot. Because in my mind, I had 38. That was the number. And then I get there and it’s like no. (p. 70)

Mary: Oh yeah, I tried every self-inducing method at home– everything I could. …I started at 38 weeks. I didn’t do anything too drastic until 39 weeks. …But at 38 weeks I started bouncing on the ball, I started walking, squatting, intercourse – because I wanted my husband to be here. (p. 9)

Lisa: Well, we knew that she was going to be big, and I asked the doctor, I was like, my husband’s fixing to go on vacation on the last week of July, and I said, and you know, I read up, and I said, when is it safe. He said anything after the 13th of July. Because that’s right at 37 weeks. So the 13th of July I had my amnio done that night. Her lungs were fine. They scheduled it that Friday. It was more convenience for me. (laughs). They scheduled that Friday because my husband was going on vacation that Monday. So he was going to be home with me that week, that’s why we scheduled it that week, we went ahead with it. …We had the amnio on the 13th. She was born on July 16th. Okay. That’s a Friday because I didn’t want it on the 14th, because that’s my birthday. And the 15th they didn’t have enough — you know, they needed another doctor in there. So she was born on the 16th. Because my due date wasn’t until Aug. 3. So we already knew she was going to be big anyway so they went ahead and took her. But they made me do to make sure that her lungs were fine. But they said that if her lungs weren’t developed, they was not going to do it. …They worked good with me. They sat down and talked to me. They gave me the date. They said as long as she’s healthy you can have one. But they said if she’s not ready, they will not do it. (p. 102)
… We already knew that we’s having a c-section and it’s like, we calculated and it’s like, where he was going on vacation, and it was like, we know we’re going to have a c-section, do wait until the end of month, the week that you’re there or the week ahead with it. And we decided to go ahead, you know. Just for our convenience, mainly. But she was healthy and stuff. And everybody asked. We’ve made sure here lungs were fine. …And, you know, he would look at her every week and you know he would – and he’s like, she’s getting bigger. But he won’t let her get too big. And then, that’s when I asked him, we’re having a c-section anyway, I said when’s the earliest I can have a C-section. And he said my 37-week was July 13. (p. 103) My doctor just wanted to make sure, they wasn’t going to take her any sooner than she was supposed to be. (p. 107)

Provider as Initiator/Decider

Liz: And they convinced me that she had stopped growing, and that they needed to do induction – it was about five days before that. … I was like okay, you know, if she stopped growing I really feel the need that she needs to be out. Because I figured that they weren’t going to take her out unless. Well, that wasn’t the case. He induced me. … He came in and said can I break your water. I though, okay, because we weren’t going no where. I was still at 4. Which I didn’t do with my son. I went from 4 to 8, pretty quickly. And when they broke my water the contractions had been so hard in there, she had had a bowel movement in there. So I was done mad at that point because that had happened. Well then he broke my water, of course, the force of the water coming out pushed her cord out so she had a prolapsed cord, and they took me in for an emergency c-section. I don’t remember seeing her until 4:30 that afternoon. … I trusted him. I was like yeah, do this. And the only reason I even now wish I could go back and change it, is because after the c-section, he come into my room, after he made sure I was awake, and hugged me and told me he was sorry. And was like Oh. … I wish I just told them no. Because it was hard on both of us, and I don’t remember seeing her. And obviously I did because my husband took pictures of us. And I don’t remember any of it…..Actually there wasn’t a whole lot of decision. …He came in there, and he says okay you want to have a baby Tuesday? And I said, why? And he said cause we’ve not been gaining weight we’d kind of like to get her out of there. I was like well okay if you think so. He said yeah, so he said, he checked me and I was at 3 and he said I’ll see you Tuesday. That was it. There was no more. He was in there I guess a total of about four minutes…. I had talked about it with John, and he was like if he thinks and I kept thinking I don’t want to do this. But I guess Mommy knows better, and, but I let them do it because they said that she needed it. So it was one of those whether I approve it if she needs it, we’ll do it. …I didn’t question him because I had known him for so long. It’s one of these things that I guess you trust your doctor to do what their supposed to do. And like later when I thought back on it. Her due date was Memorial Day. I’m not stupid. (pp. 89-90)

Stacey: I, um, went on my due date, which was Dec. 21, which I think was a Monday, I went to the doctor -- he -- and everything was fine and he said we can have the baby on Wednesday, and we can be home by Christmas. So that was my offer, and I said no
way. He said, well if you come in on Monday – yeah, Christmas was on a Saturday. Yeah, Monday. He said if you come in on Monday, and you haven’t had the baby. We’re going to go ahead and get the baby. And I had her on the day after Christmas, so I went into labor on my own. (p. 44)

Carrie: …by 37 weeks, I was already dilating and my blood pressure was up. And he tried to-- he talked about inducing because of that. But I seemed to wait he let me wait at least two more weeks, I think. He was like, we’ll wait it, we’ll watch it. I was like I just want to wait as long as possible. So that I’m not – you know, I wasn’t too concerned because I didn’t feel bad. You know, I wasn’t too concerned. He was okay. (garbled) Um, but like – I think it was almost 38 weeks, when I went in. My blood pressure was still high. He made me do the NST to watch the baby, and I was having contractions still dilating more – I think I was 4 ….and he wasn’t really comfortable. He was like, what do you think about just coming in since you’re blood pressure is still high, coming in and letting me break your water, since your already progressing – he thought that it would you know help my labor and I was like, I felt comfortable with that – since I was already progressing, I felt comfortable with that – that I wouldn’t have to have Pitocin. So I agreed to that. When I finally got in, because the hospital was packed, they couldn’t get me in until like 5 the next day – when he came in to break my water I was six centimeters. So I was in labor. I was having contractions, but they weren’t real strong, and they weren’t real regular. But we went a head and break my water. So then it was kind of ---so it was forced on me but then I barely was already in labor…. So I was kind of induced and kind of not. (p. 45)

Carrie: With him, we -- I was going to wait until labor came naturally, because I had had Pitocin inductions with all the others and I didn’t want that – I wanted to finally have just a normal birth experience without Pitocin contractions. (p. 44) I hadn’t had many friends that had had children naturally. And I hadn’t been into a group that had that kind of support or had those kinds of stories. So I just didn’t know. I was just very naïve about the whole process. And so I okayed an induction – you know, chose an induction… It was kind of like, right about when my, duh, really it was when my second child was older when I really started getting into like – more of trying to do things more naturally. … ever since then I just knew like that was best, to let it go naturally. Just from reading and just from hearing others that did it. It was like, yeah, my body should be able to do this. (p. 46)

Maggie: … And when I went in for like my regular weekly check up at 36 weeks, she said that I was 3 centimeters dilated …You are contracting. I didn’t feel any of the contractions or anything, so I was kind of shocked. And, then, she’s like, we’re going to go ahead and break your water. At four o’clock. And that point it was like one. So she was like, why don’t you go ahead and just get admitted into the hospital next door and I’ll be over at 4 o’clock to break your water. …That was a Friday. So, come to find out – so I had the baby, that was at four o’clock, and I had him 6 hours later, and then I found out she was leaving out of town to go to Chicago that morning. So I kind of figured she probably thought that she was going to go over the weekend. So she went a head and just pushed it, is what I’m thinking. …I was ignorant. (laughs). I just thought oh gosh I’m three centimeters dilated. He needs to come out. Okay let’s do it.
I was totally like – total trust in the (provider) basically. If she thinks it’s time, okay let’s do this. You know, deer in headlights, okay, I’m ready. Let’s go. (p. 111)

…Well, the second one, same way…36 weeks, and I was contracting. And went in three times that week, and she hooked me up to the monitor and I was just – but I couldn’t – they were painless, and I mean I was okay. And she’s like, we’re going to go a head and, and do it, and I went in like Thursday, and she said, okay, come back in the morning at like 9 a.m., we’re just going to go ahead and get him out of there. So I don’t know if in her head she was thinking they’re ready to go, because she’s like he’s a big one. He’s bigger than you’re first one, and so I’m going to go ahead and do it and I think because of the history of the diabetes, I think she was just a little bit kind of iffey, and so… I was okay, because like I said she was monitoring him. And because I had gone in three times and done that I felt like, well, if she didn’t think it was absolutely necessary and she wasn’t going out of town this time or thing like that so…I was like, are you going out of town or anything? And she was like oh no. I’m here, and I was just like, okay. So, um, she went a head and actually – yeah she did break my water on this one. But she said it was going to break anyway. I went ahead, I was admitted and they were checking me and the ladies kept coming in and man you’re really contracting. And I was just like, I don’t feel it. They gave me another epidural, and you know I said – I didn’t take it this time – well, let me wait a little bit longer, I want to see if there’s actual pain that comes before – I kind of want to be like give it to me now. You know I want that uncomfortable feeling. I never got it. And then I was like, I don’t know 4 or 5 centimeters, and they were like let’s just go a head and do it. So I got the epidural. (p. 113)

Kate: Okay, so I was 41 ½ weeks, and I wasn’t making any progress and my (provider), and I knew in the back of my head that you can go a lot farther than 41 weeks, but my doctor was on my tail end you know; this is getting dangerous, this is you know. So we discussed it, me and my husband, and we went in for an induction at 41 ½ weeks. (p. 148)

Provider as Confidant

Molly: My husband didn’t want me to go, but he didn’t want to see me miserable. He knew how the first one was. He knew it was so bad. So he wanted me comfortable. And you know, and if I was, if I had said at 38 ½ weeks we’re going right now, he would have been like okay let’s go. But you know, they -- we probably have some of the best (providers) ever. That provide you with information and say calm down, this is all emotion for you. I know you’re tired. I know you’re sick. I know you don’t feel good. I know you’re feet are big. But we need to do it the smart way. And they were very, very helpful in that decision. (p. 16)

Mary: … I told (my provider) that I scheduled my induction and she wasn’t happy about it. I told her had my membranes stripped the day before, and she’s like, well, do you want to try stripping them again? You know, any kind of manipulation will help things along. So she stripped me again that day, that was Thursday, and my water broke that Sunday. (p. 17)
Tiffany: And, um, another influencing factor has been my (provider) and how she’s really been a spokesperson for going natural. So. (p. 17)

Carrie: … You know. But, yeah, really my (provider), he is supportive of natural birth, but he’s also just used to women being like induce me and he’ll do it, you know So , and he knew what I wanted. He was just concerned. But he was okay with me. Like I just said no and he was like okay. You know. He let it go. So he wasn’t really pushy – you know, he was concerned. You know I appreciate him being that way. (FG4, p. 49)

Heather: And my oldest, um, it was an induction. She basically had to be evicted. She was 9 days past due, and I was done. I obviously my body wasn’t going to – it wasn’t showing any signs of like – like I hadn’t had any Braxton hicks, didn’t have any noticeable contractions. And I was ready when my (provider) said would you like an induction. I said yes. How soon can we do this? Like I said, at that point I was 41 weeks and two days, and when you start counting days and hours you’re done. So. …The first one, it was on Mondays. We were meeting on Mondays. Every Monday I had my weekly appointment with him. And so on Monday he said, well, um I’m available Wednesday, if you’d like to get this show on the road. There was no pressure at all, but we were all just kind of ready. I also had to the added issue – we were the only people. Me and my husband, we’re here alone in Kentucky. All of our family is in Ohio. So, having it scheduled was convenient to being able to bring both sets of grandparents down for first grandchild, on both sides. So it was convenient and nice. Um, I wouldn’t have done it early. (pp. 60-61)

Diana: Um, at the beginning, it was concern that, she’s a new…to the practice, my other one left, so she’s new to me, and new to the practice – so when it was first scheduled, I asked her, do we need to be concerned about it being so close to my due date, and she said, oh my goodness, yeah, I don’t want you to going into labor and having an emergency c-section. Let’s schedule it earlier. But do to just situations, it was like two months … and it still hadn’t been rescheduled. So then, she came in…and said, hey we haven’t rescheduled you yet, have we, and I said no, but I was thinking with my history, do we need to be concerned about emergency c-sections with labor and then she looked at my records – and I said I don’t think I’ve ever even dilated. So she looked back in my records, and she just said, you know what, I don’t think we need to be concerned about because I doubt your body is going to go into labor so then we just decided – given the fact that I had that nice early morning time slot and it was a Thursday that we would just leave it. (p. 124)

Monica: With my regular ob, then the high risk ob because of my, I had problems with my first pregnancy. So I went to see him and the nurse says, oh so you’re going to have another c-section. I was like, no. She was like, great, good for you. You know and she goes on and on about how the doctor is like so pro VBAC and everything. I’m like, so how do I get my care shifted over. (p. 149)
Trusting Provider

Liz: … I trusted him. I was like yeah, do this. And the only reason I even now wish I could go back and change it, is because after the c-section, he come into my room, after he made sure I was awake, and hugged me and told me he was sorry. And was like Oh. … I wish I just told them no. Because it was hard on both of us, and I don’t remember seeing her. (pp. 89-90)

Lisa: … They wasn’t going to take her any sooner than she was supposed to be. I mean, I could have been like I want the c-section this day, but if she wasn’t ready, they wasn’t going to do it. And they did tell me, if she’s not ready, if her lungs are not developed, they will not do it. They will wait until she’s ready. Where she can survive and not have any problems. (p. 107)

Maggie: I was ignorant. (laughs). I just thought, oh gosh, I’m three centimeters dilated. He needs to come out. Okay let’s do it. I was totally like – total trust in the (provider) basically. If she thinks it’s time, okay let’s do this (p. 111)… There was never really any explanation. It was just kind of like, it’s time, and you totally put your trust, especially with your first, because you have no idea what to expect or what’s going on. And the first time someone in the white coat says something you’re like, okay, let’s do it. Whatever you say. You’re looking out for me and the baby, you know. I’m like if you think it’s time, then okay. Let’s go. (pp. 115-116)

Monica: I think you really need to get to the doctors and the nurses. Kate: Yes, yeah.
Monica: Because they’re so casual about, oh 37 yeah, go ahead. Kate: Yeah, exactly.
Monica: You know just go for it. And the patient, if you’re, if, I always have said you have to be pregnant before you get pregnant to really know what it’s, what you need to know. … You know you have to like go through the whole experience once and then you can make better decisions, and you rely on your doctor and if your doctor’s very casual about it, you’re not going to question that so much unless you had a bad experience or you had a friend who’s like really talking to you about it or something else. But so often we’ll just take the doctor’s advice, and if the doctor you know, if the doctor’s telling me, …

Jennifer: If I’m a mother and then I’m having my first baby and I don’t know anything and I go to the doctor, and I have my nurse like she had that said, at 37 weeks is fine. Monica: And that same mother has friends like I did, oh yeah, at 24 weeks you’re fine, and, you know, and I’m not a nurse, I’m not educated or you know all those things, then yeah, what are my decisions going to be based on; on things that I, you know maybe incorrect things so I just think that somebody, sometimes people is just not informed and because of that, no experience, no education or things like that, I mean they’re.
Kate: And you trust your doctor.
Monica: Yeah, you do.
Jennifer: You trust your doctor, yeah. (p. 188)
Fear of Birth

Beth: I guess because I’ve not really known – and I know this probably sounds crazy – but I probably wouldn’t know if I was actually having contractions. Because once I started feeling that uncomfortable with my boys, um, I had pain medicine. So like I don’t know what a contraction felt like because I slept the whole time. (laughs). So I don’t remember any of it. And so that’s my biggest fear is, what’s going to happen if I’m at home, and I go into labor and not really know what’s going on with my body. So that’s my biggest thing. So I kind of want to schedule, but I don’t know what she’s going to do for sure. (p. 18)

Nancy: ….My biggest fear of being in labor, like, you know, on the TV shows you always see these girls laying on the bed pushing, I didn’t want to be like that. I wanted to be able to get up and walk around until I couldn’t stand it any more, so that’s what I did. (p. 30)

Kathy: Unless I had went into labor. And I would have considered – yeah. Basically if I had gone into labor on my own and got an epidural. I was afraid of the pain too. Which sounds stupid, because I was willing to have a c-section, but I knew I could – you know, labor is out of my control. You can’t control labor. Epidurals don’t always work. So I was kind of afraid of the pain too (p. 80)

Maggie: …I got an epidural. I felt no pain. I was waiting for the pain to kick in at anytime, it never did. And then I had the baby, and I still had no pain and I was so like, I thought this was going to be painful. (laughs) (p. 111)

Baby-size/Fear of Big Babies

Jessica: And he was big. He was born at 9 pounds, six ounces. So if I had went another week, you know, he would have been really big. (p. 2) …

Tammy: It might be a good thing, if you’re doing it naturally. (p. 25)

Jamie: At one time I was concerned, you know, do you think it’s going to be a big baby. And she’s like… you’re body’s not going to make a baby too big for you to give birth to. She was just very, very much believing in that process. So that was encouraging. (p. 50)

Alice: When we were getting closer, they thought that my daughter was going to be big, and so my (provider) and me had been talking about 38 weeks. (p. 70)

Heather: But I worry though. He was born at eight pounds at three weeks early. I very much worry about the state of things if he made it to full-term. Because my daughter was eight-nine at 41 weeks, two days. So I was very surprised to have an eight pound, 3-week-early baby (laughter). So I was a little bit happy on that end. You know, eight pounds is a large baby (p. 72)

Kathy: I weight 9 pounds, 9 ounces so I just assumed I would have this huge baby. She only weighed 7 – 14, so she was small. But I just assumed I would have a big baby…. (p. 74)
Lisa: She was ready, I mean. She was a big (whispers) baby…. And, you know, he would look at her every week and you know he would – and he’s like, she’s getting bigger. But he won’t let her get too big. (p. 103)

Maggie: …Because she’s like he’s a big one. He’s bigger than you’re first one, and so I’m going to go ahead and do it. (p. 113)

Wanting to Remember

Andrea: Because I didn’t want my birth experience to be awful. Like, you know, you want to remember it. So I wanted to make sure that I didn’t get in so much pain that I just asked for something I didn’t know much about. That’s really how I made my decision to try to go natural… (p. 29)

Liz: So I was like okay, and I wish I just told them no. Because it was hard on both of us, and I don’t remember seeing her. And obviously I did because my husband took pictures of us. And I don’t remember any of it. (p.90)

Wanting to be with Baby/Wanting a Healthy Baby

Samantha: Yeah, I was scared like the whole time that he was going to have problems and then have to be in the NICU or something like that. I don’t think it was until 39 weeks until I wasn’t worried about it as much. But they also told me he was small too, so. (FG1, p. 11) …. And I would have been worried about what if it’s too early. What if he’s not ready and then he’s born, and he has to be in the NICU. Then I would think that it’s my fault, because I had him come early. And I would have felt like it was a selfish thing to do. But waiting for him to come, I just felt like it was --- I didn’t feel like he was going to be in the NICU. I felt like he was really ready to come, and that he would be healthy. (p. 13)

Clacie: I just never wanted to risk anything being wrong with my kids. Or me. You know, if you induce then there’s always that chance for a c-section. I can’t afford to take any time, you know, any extra time off work, and I don’t want anything bad to happen, so. That’s why I wanted to wait. (p. 37)

Andrea: I have the same opinion on that. Just don’t want anything wrong to happen with the baby. I don’t want -- and a lot of it was, I wanted to be able to take her home right after. I didn’t want her to have to stay in the hospital longer. (pp. 37-38)

Barbara: My nephew was early. I just kept thinking about him laying there in his little incubator for those, I think 3 weeks he was in the NICU, and I didn’t want that for my daughter. (p. 38)

Nancy: But I got to stay in the hospital for 72 hours because my baby was in the NICU. And I was really depressed. All I wanted to do was cry. And all my other friends who were having their babies – and their babies got to be in the room with them. And you know they got to hold them whenever they wanted to. You know, just talk to them, play with them. I didn’t have that. Because most of the time, up until the last five days she was in the hospital, I had to look at her through this little box. You know, I couldn’t get her in and out because her temperature dropped, and it’s just
really hard to cope with. It really is. (p. 39) …And then, after I had her, and I had her on my chest for that 5, 10 seconds, you know, and then they took her away from me, it’s like having my heart just got ripped out. It was really, really hard to deal with. Because, you know, usually moms who have their baby in the hospital room, they can be like, go and pick them up, and lay in bed with them. I didn’t have that. You know. I sat in a chair with my hand in the little holes in the incubator rubbing my baby, you know. (p. 42)

Carrie: I couldn’t imagine how scary it would be just to have to worry about it. And, too, just not being the one that’s taking care of your child. Like you know you have your baby and you’ve got to rely on these other people and trust that they’re going to watch the baby and take care of the baby in the hospital. And you expect to be able to bring that baby home and you be the one to take care of them. And then with induction – I, my feeling on like, when you decide to become a mother, you automatically are deciding to be selfless. And inducing because you’re uncomfortable is not selfless. You know, that’s I don’t feel good. You know. That’s just because – you’re not selfless. You decide to have a child and stuff, you’re automatically like it’s going to be all about that baby and about that child. And you know shoving them out because you don’t feel like – you know you’re not making it about them because they could be unhealthy because of your decision. (p. 53)

Allison: My nephew was born at 32 weeks, so I remember it was the saddest thing because he had to go to NICU at a different hospital and watching my sister-in-law say goodbye to him was like the saddest thing I’ve ever seen. You know, somebody else takes care of your baby. He was in the NICU for a month, I think… (p. 54)

Kathy: 37 you’re kind of cutting it close if they’re lungs are going to be developed. enough for them to breathe on their own. And I think of 37 weeks, I think of high risk of being admitted into the intensive care nursery, going to the NICU, which you know, makes everything way worse. Even if you have a 39-weeker whose okay and well-baby in the room with you – they’re just not eating real well, a little bit of jaundice… They’re still in the room with you, so about 37 weeks that risk of being separated I think would just make everything worse. (p. 82)

Liz: I would have got to see her when she was born. Um, I think she wouldn’t have got the virus if we had waited. I think – I mean I know their immune system really gets built up by breast milk and stuff, but I think if she had went longer, she might have been a little bit more developed than what she was. So maybe she wouldn’t have got as sick. (p. 96)

Clacie: I was more thinking about the baby. I was really uncomfortable, but there was no reason, absolutely no reason why I should try to rush things. I was still able to work fine. I wasn’t having any problems. (p. 38)

Lisa: There wasn’t nothing I could do. (laughs). I mean I’d be, you know anxious for her to come, but it would be whatever is best for her, you know, just waiting. Cause it’s all about the baby. It’s not about how you’re feeling and what you’re doing. It’s all about her. It’s all about your baby, make sure you have a healthy baby. Because you
don’t want to rush that. You want your baby to be healthy. You may be miserable but
(laughs) (p. 108). …. Cause I don’t even think I would have wanted to have it.
Because I would be afraid something would be wrong with her. Because they say 37
weeks, that’s—you can safely have it. Anything before that you risk them having, you
know problems. Either mentally or delayed or…(p. 109)

Maggie: Like I think preterm before even 36 weeks and it’s just scary. …and it’s just
scary. Not developed completely. …Just them not being able to survive outside. So.
…Being in the NICU. Not being completely fully developed, and just really struggling
to make it. (p. 118)

Diana: I don’t like being pregnant. (laughs). So the sooner I can have my babies the
happier I am, but I also want them to be healthy and to be assured that they’re fully
developed. (p. 123)

Marcia: I just hope my baby doesn’t come out before it’s ready, you know? No
complications, that’s all I know. (p. 135)

Jennifer: That’s one of the things that scares me the most of having a premature baby,
that you would have to be in the NIC Unit and I won’t be able to feed it and what am I
going to do and how am I going to do it. (p. 185)

Bodily Knowledge/Baby Knowledge: Let the Baby Decide

Tiffany: There is definitely more disadvantages, when you really think about it.
There’s more disadvantages to waiting until your baby just comes because there’s no
way to be completely prepared. There’s no way to --- I mean my husband’s a truck
driver. So he could be out in Washington state when I go into labor, and I’m here with
my son alone. So yeah, to that. But I really believe you have to make sacrifices in
order for the well-being of your child. And so if that’s part of it and just waiting and
doing that. I would rather do that and her be healthy and come when she’s ready,
because doctors and even I don’t know when she’s ready as much as she does, as my
body does. (p. 24)

Stacey: Because she would have come when she was ready… Because our bodies
were programmed to do this when we were created to. (p. 44)

Carrie: I just really wanted to let him come when he was ready. I didn’t want to force
him out if it was not – if my health was not in that great of a, you know – if it wasn’t
that bad, then I wasn’t going to worry about it. Because I didn’t feel like – like I didn’t
feel bad. I didn’t feel like I was in, you know, if it was a huge health concern for me
yet, and it wasn’t that high to really be worried. Like it wasn’t preeclampsia worry at
that point. It was just high. You know. So. You know, I just really wanted to try and
give him that – you know that little extra time. Because I knew how much
development happens in the last weeks and I just wanted to make sure that he was not
going to be – and it was really early. He still came really early. So it was just really
wanting to give him that opportunity to develop as much as he possibly could. (p. 45-
46)
Jamie: … And I do very much believe that we were created and that God made us to be able to do it – so that probably steered me in that direction too, so. (p. 46) …You know, like they said, it’s not until your body’s ready. (p. 54)

Judy: I think we’re made to do this. So, our bodies are meant to have babies. (p. 47)

Alice: I didn’t really want to have a c-section, so I was trying to let my body do whatever it was going to do. And I wanted to go as long as I could before getting an epidural, just to see, for curiosity, how far I could go. Because there’s some women that can do it all without. And I was honestly just curious how far I could go, how far I could go without getting an epidural….Um, I didn’t think I would need one. Like I guess I just didn’t want to have to go through the whole surgical and recovery aspect of it. Unless it was absolutely necessary. So I wanted to try it. Most of you know, our bodies were built to labor and give birth, so I wanted to try and have him without having a c-section. (p. 58-59)

Lisa: I think of full-term when you go in labor on your own, mainly. I’ve never – I’ve only done that one time, went on my own, and that was my first one. (p. 105)

Jamie: I think that’s why it’s important not to induce. Because the baby knows when it’s okay. You know they say it’s something the baby secretes that starts the labor process, when their lungs are mature and so, just let the baby decide. And if it’s something seriously life threatening, well then the baby probably will be okay at 36 or 37 weeks and if it you’re going to die well that’s fine. But if there’s not a good reason so, just let the baby decide… (p. 52)

Andrea: I just figured I’d go whenever it came. (p. 28)

Kathy: I mean the baby will come when the baby’s ready to come, you know, even if it’s 41 weeks …. Well, until you go into labor. Until God choses to put you labor. I mean minimum of 39, but there’s nothing wrong with 40 and 41. You know. I mean, you know we’re so focused on 39, but it should really be 40, 41. People consider themselves overdue at 40 weeks, but really 42 weeks is overdue but how many people go to 42 weeks? (pp. 81-82)

Marcia: But the baby is going to come when it’s ready. (p. 135)

Monica: I know that they frequently will schedule a c-section at 38 weeks or something, you know, saying that that’s considered full term but I wouldn’t agree. I think when your body starts labor, then you know you’re full term. (p. 165)

Abby: I mean I think if your body naturally goes into labor at 37 weeks, it’s trying to tell you something. …There’s a difference between somebody taking the baby. (p. 165)…You want them to cook as long as possible…Until your body says it’s ready to come. (p. 171)

Other Women’s Stories

Judy: My grandmother had her babies at home until the last two. And she did everything at home, like naturally. And then my mom was in the hospital, but waited a long time to have the drugs. (p. 47)
Allison: I was a member of Café mom for a while, and they – when I started wanting to – researching um home birth, I joined – just joined the group because most of those women have home births and a lot of them are midwives so I got a lot of information and good tips from them (p. 48)

Carrie: Finally about the third was when I started, you know, meeting more people and reading more and learning more on how you know technically you shouldn’t have had to go through that. (p. 45)… It was kind of like, right about when my, duh, really it was when my second child was older was when I really started getting into like – more of trying to do things more naturally. … ever since then I just knew like that was best, to let it go naturally. Just from reading and just from hearing others that did it. It was like, yeah, my body should be able to do this. So. That’s all. (p. 46) …Mine was through it’s mainly like the Internet group, kind of the social media type thing. It’s people that I know but they just live far away so we keep in touch and specifically one close friend that had her babies at home – but at least attempted to most of them, one of them … and through her and talking to her and seeing what she you know how she talked about birth and all that – then there’s a few other women through a group that I was apart of that just talked about natural child birth and just gave their stories and like. …And that’s really what, because I knew that ladies that were in it personally. You know, so that they helped. They were just – they live in other states. (p. 49)

Judy: Well, I had friends who are, who had babies and totally without drugs and wait until the babies are there. (p. 50)

Kim: . . . I think my mom had to do a lot with the way I wanted my birth. Because she had me natural. She didn’t have any epidural. I was actually born in a bathtub. So, it was very natural. (p. 61)

Leslie: I’d go on Facebook all the time, and I do have friends that were pregnant prior to me, and that I would talk to. They would tell me about their experience….Just like leave messages on walls, and then they would write back. Because no one is usually at it at the same time. (p. 63)

Maggie: It’s funny too, because a friend of mine, who owns a graphic design company started this publication … So I learned a lot of information from her, because she did natural childbirth … She had no Pitocin, no epidurals, no anything. She had the midwife and the doula and the doctor and had an absolute natural childbirth in the hospital, in case there was any problems. So. And I didn’t know that existed. (laughs)….It was kind of like cookie cutter. Like you come in, and everything, and this is how you’re going to do it. You’re going to take this at this time, and you know – in a way, it was great – it was painless. They’re looking out for the best interests of the mom, and you know, it may not be the best interests of the baby, but I guess it’s dependent on how you look at it – I was thinking at the time, my doctor was looking at the best interests of the baby because maybe you know, because maybe, he needed to come out for whatever reason. But now looking back it probably wasn’t. (p. 115)

Holly: My mom had all three of us natural and, um, I just hope to be able to do it without an epidural or a c-section, because I’m really scared about a c-section. (p. 17)
Jessica: Okay, my goal is to also go natural. My mom had, I’m one of seven too, the last three of us, natural. I was born with a midwife at home, so I looked for a while for a midwife. (p. 17)

Andrea: … we always talked about what our birth plan was. And Clacie had a really good story about the first time she gave birth. It wasn’t a great experience. And after that I was pretty set on going natural. (p. 29)

Jamie: Um, my mom had all of us naturally, without any drugs or induction or anything. And so I guess I just grew up knowing that it can happen. You know most people these days think you can’t do it without the doctor there to you know fix you and make everything happen right. I just knew that she could do it – so I was really interested in birth. I just am fascinated by it. I would like to work in the field one day. Actually, really before we even started trying, a couple years before we started trying, I just was reading for fun about it. You know reading books and Internet research – and just I couldn’t get enough information. And, so just kind of wanting to do it naturally lead me to authors and sites that supported natural things and the more I read the more I believed in that – so I guess that’s kind of how I got to that point. And I do very much believe that we were created and that God made us to be able to do it – so that probably steered me in that direction too, so. (p. 46)

Judy: My grandmother had her babies at home until the last two. And she did everything at home, like naturally. And then my mom was in the hospital, but waited a long time to have the drugs. And then I think that really what steered me that way was just reading. Like I read, lots and lots of information, and I read about the drugs that they give you and um how like my doctor said they give you – if they give you these drugs then they’re going to give the baby a drug to wake them up at the end, and um – again, I think we’re made to do this. So, our bodies are meant to have babies. (p. 47)

Monica: And then I have a friend who, she actually had a home birth with a midwife and a doula and so she was telling me about her experience (p. 157)

Jennifer: I had a friend that is a doula, and she had tried to convince me all my previous two pregnancies, come on, come on; I’m like, no, no, that’s fine. So this third one I said, okay fine, I’ll give you this pregnancy. Because she’s like, I’ll be your doula for free. I’m like, fine, you’ll be my doula, I’ll have a natural birth, I’ll try it, I’ll see what it is you know. I’ve had two babies before; the trouble that that has been trouble you know it should be fine, it should be you know a piece of cake. I dilated pretty easy; the other ones were 8-9 hours of labor. I’m like, yeah we can do this. (p. 154) … And I think that I have the same thing actually because my mom is an ob/gyn, it’s so much easier for me to pick up the phone and say, hey today I have this, this and that. (p. 163)

Foundation of Information

Jessica: I googled a lot. I think Babycenter.com and was one of the ones I went to for information. And then I watched a couple of videos on my Netflix, off the Internet, um the Business of Being Born, um I watched Pregnant America. But the Business of
**Being Born** – it was a lot about natural births and midwives and it just lets you see how the women could do it. And it didn’t seem like – it was it’s not going to kill them. So I really, um, liked watching that video. Because I was scared before that, but after that, even though I had seen a few births from that video. I was just like, oh, I think I can do that. So I like, go online. YouTube, Also. (p. 5)

Barbara: … And then I got pregnant with her. I started looking up on the Internet, how many different ways you can have a baby at home, have a baby without pain medicine and everything. So I want to do that. (Switches into baby talk) (p. 31)

Mary: I did a lot of YouTube, and the Babycenter. The Babycenter had videos. They had a water birth video. There was a medicated childbirth, an unmedicated childbirth. And there was even a home birth. And so those were really pretty interesting to watch. And the *Business of Being Born* – it’s empowering. Watching all the other women, did it, and they didn’t die. So you know I could have done it. So that’s what was, what was cool. (p. 5)

Diana: Just in reading like you know the Baby center emails that you can sign up for and just reading about c-sections, um, and reading about when it’s believed to be the safest to deliver babies, it was more just trusting the doctors and trusting the information that I read that the longer we wait the better off we are and um you know I would be okay at 38 weeks (laughs) ‘cause I wouldn’t be pregnant much farther in the week, but basically, I really just trusted the doctors more or less that, um, you know, if they think it’s safe to deliver, then do it. And there’s not been a discussion over, you know, 39 weeks, so I haven’t really. … It’s because of the weeks falling on Saturday, like she was going to try to schedule, like a Thursday or a Friday, if we could, just to make it as close to 39 as we could. But, um, in fact, um, at the very beginning, I had gestational diabetes with the first two, and, um, we’ll find out next week if I have it with this one, but she had said if you have gestational diabetes I have no problem doing a 38-week c-section. … I got the impression that if we started talking about 37 week delivery (voice rises) or obviously before that we would start having discussions over the safety for the baby, um, but it hasn’t really seemed – it seems just to be a given that at 38 and 39 weeks the baby is going to be – we have no reason to believe that the baby wouldn’t be fully developed at that point. (p. 128)

Diana: With my first one, I, um, religiously read, um, *What to Expect When Your Expecting*, but as I went through it the first one I was anticipating what was it going to say next. And then by the second one, that’s just a bunch of hooey. (laughter). Some of it’s good information, but you know and this one I haven’t even bothered to really read any – I do have an app that I have on my iPhone – we’ve upgraded technology in the last three years. I do have an app – and actually my girls are into it. They’re 2 ½ and 5, and um I got this app that um was like a $1.99 or something, and it shows pictures of the baby at each week, and then, um, it tells kind of what’s going on with a woman’s body and the baby, just like little advice things to be thinking about and like there’s things like, um, uh, tips for like you and your partner like oh now would be a really good time for a get-away before you get too uncomfortable. But now it’s just
more of a fun thing. Oh what’s the baby look like now, versus, trying to get information. (p. 130)

Julie: I had friend of mine had given me an older copy of the *What to Expect Book*, with my first one, and I found it helpful to just be like – oh okay this is what’s going on, oh, okay that’s cool. It had, you know –like things to be concerned about, things not to worry about, oh okay that’s cool. That’s helpful. Oh this is normal. All right, good. Um, but I did not – I don’t like going online. And I’m kind of guarded talking with other moms because one, pregnant women, or moms tend to get really bitchy. They get really territorial. Kind of what Diana was saying about you know, (voice) Oh well c-section is just horrible or well you have to be breast feeding your kid because they’re just going to be absolute idiots if you formula feed them – they get really territorial. It turns into, if you’ll pardon my French, a dick-measuring contest with women, this thing of, oh well I was able to have natural childbirth, so I’m so much better of a woman than you, oh and it just… Part of me wants to say, you know, it’s hard enough having a kid, why do you want to get into this prideful thing of you know, I did it better than you. You know what, you had a kid, it’s healthy. Who cares. (pp. 131-132)

Monica: So it was just kind of this culmination of you know what I would read on the internet and you know when I would discuss it with the doctor and you know. (p. 157)

Kate: I had originally planned you know, oh well get induced, we’ll do you know the epidural, until I started researching it. …And I really started thinking about it. And being a special ed teacher, I’m like Jennifer here, I don’t have, my friends who want to you know, however they want to have their babies, that’s wonderful. I think that’s you know your decision, your, what you have to be happy with and I think that’s great. But I’m a special ed teacher, and I read all the stuff about the learning disabilities, and I’ve always got that in the back of my head, the autism, and you know we don’t know where autism’s coming from and it’s chemicals and you know and it just hit me in the middle of my pregnancy, and my husband thought I was absolutely crazy because I was for a home birth, and I had a doula. And then he convinced me out of the home birth, which thank God he did. So, but it just hit me; it hit me right in the middle of my pregnancy that that was the way we should go. …My sister-in-law was the pediatrician, did give me some books. I forget; some of them, one of them was *Birthing Within*. I read several research-based books. And then I did a lot of my own Kate research on the Internet. (p. 160)

Foundation of Information and Importance of 40

Stacey: All of the –part of the reason I struggled with it -- most of the websites that I would see online that did the week-by-week pregnancy. Once you hit 37 weeks, they start using the word viable and healthy. And this that and the other, and you’re like, whohoo, okay so. That’s 37 weeks. So even if you went to the doctor 5 days later or two weeks later, and you’re doctor says okay let’s induce – that viable is going to ding in your head and you’re like okay it’s fine. And you may be nowhere near 40 weeks. (p. 52)
Judy: Because when you get your little updates – you know, I signed up for this thing, where it sends you updates every week. You know they look perfectly normal by 35 weeks. They look just like a baby. Just smaller. And so I don’t think anybody would guess there’s that much difference. (p. 57).

Lisa: You can’t do nothing until 37 weeks. That’s the magic number. (laughs)
S: And where did you get this idea of 37 weeks? Where did it come from?
Lisa: Through our doctor too, and then I was reading when I’d done our daughter too and then online. …Like when I’ve had her book. She has like every doctor visit I went and I saw where I had her at 37 weeks and 2 days, so. And I did read online where 37 weeks they’re developed, and um …Where did I go? Oh. There’s a pregnancy.com one –
S: Pregnancy.com. Is it like Baby Center?
Lisa: I’ve seen, been into Baby Center (garbled) like either 123 pregnant. I had it bookmarked, but after you have the baby, you’re like pfft. (laugh) …And then What to Expect When You’re Expecting, of course. You have that book. I bought that book for every pregnancy. And we give it away. Here you go. (laughs). Whoever gets pregnant. Here you go. (pp. 102-103)

Maggie: … Because sometimes you’re – the dates that you could be off from the beginning. It’s what I’ve always heard. That 36 to 40 weeks or 41 weeks or whatever, it may not have been right – you may have got the date a week off or whatever – just kind of like a … I think on BabyCenter or whatever. Through the Internet and people talking and things like that. So. (p. 120)

Uncertainty and Information Seeking

Lisa: You know, pregnancy, you know information. That’s what you’d Google and then they’d give all these sites and then you mainly just have to pick the sites because some cites are just stupid. (laughs) And you have to look them on and it’s like okay. And then you just look at them, see what’s interesting. Most of them are just like, that’s stupid. (laughs) …The book, the book, What to Expect when You’re Expecting because you can ask my husband because it was in the bathroom and we knew the bathtub, and wherever I went when I had a question, you know I’d look it up. (p. 104)

Maggie: We used it, yeah. It was mainly like on products, like things that you’re going to need. Like we’d look all of that stuff up. My husband is adamant about like products we’re going to need, which ones were the best and that kind of stuff. Um, and then we just got the weekly emails. And I would look up, you know, certain things that were going on with me, like if I had really bad heartburn or whatever, aches and pains or weird feelings – I would have, I would like, okay, is this normal? And looking that up and stuff like that. (p.116)

Marcia: Like I want know how c-sections work, because I don’t know. I want to know what the epidural’s supposed to do or something they – have something else. Or is there like alternative methods to that, like natural childbirth. I have no idea. They have under water birthing too at (hospital name), so that’s definitely an option. Because with natural birth, they said it goes a lot easier. Baby just kind of swims out. (laughs)
That sounds good, doesn’t it? (p. 125) … My mom, my sister, my nanny, my doctor. (laughs) Babychat on line. I mean I don’t know what’s going on. I really don’t. This is the most confused I’ve ever been in my life. (p. 128)

Monica: During one of our meetings she said, oh so you’re going to have a c-section again. And I said, no I don’t want another c-section unless, you know, unless I have to. But I don’t want that to be like upfront decided that that’s how that will be. You know, and she sighed and, well I don’t know. So I met with her again, same thing; you know, oh so you’re going to have a c-section. I went, no and like maybe it’s not in your chart or something. And she kept saying, well you know the risks or uterine rupture, don’t you. And I said, yeah. And of course I didn’t but you know I just, you know I wanted to sound like I knew what I was doing. So, but I went back and that’s when I started studying that whole thing, because I did have a c-section before and you know she brought it up. (p. 149) … But her, just her coming to that conclusion so quickly without even discussing it with me kind of like put me off and you know I’m like, you know no and you know we haven’t even thought about that yet. I went, I just basically went back and did a lot of research; thankfully for the Internet, you know you can…..I just started looking up; I went to ICAN…..I mean I kind of you know wiggled through the Internet but I ended up at ICAN which is the International Caesarean Awareness Network…Which promotes you know VBACs and vaginal births…. Mybestbirth; you know Ricki Lake; she’s got, I don’t know if you know that but she does have a website. (p. 157)

Importance of Brain Development – Knowledge During Pregnancy

Samantha: I understood it, and this actually stuck with me. I saw it every time that I came here for my appointments, and I think this is one of the reasons why that I wanted to wait for him to reach 40 weeks, or at least really close. And, um, it makes sense that the brain is not developed enough until then. So that did stick with me, about that. (p. 14)

Holly: They show pictures of the brain of a 36-week-old and a 40-week-old. And it’s a massive difference. So yeah. (p. 23)

Mary: All the exam rooms I was ever in, there’s always posters say that it’s best to stay pregnant until 39 weeks because of brain development and everything. (p. 9)

Carrie: I remember thinking, I remember seeing this, and then I had a friend from high school that was pregnant after me and she was like she was trying have him come out two months early, and I was like scratching my nose a little. Please stop talking about that. And I was like did she not get that paper?…So yeah, in my mind I felt a little bit, this would help those people who were trying to have a baby you know by Christmas when they’re due in February. (p. 57)

Lisa: All I know is when you’re pregnant it starts developing real early (p. 109)

Importance of Brain Development – the March of Dimes Brain Card
Leslie: Reading this. Like knowing this now and 40 weeks – that they don’t forget to breathe. And like I’m so scared now from the whole SIDS situation and if I would have had him taken out early, you know, he may have had a greater chance of that – because his brain has not been developed, and he forgets to breathe at night. (p. 73)

Judy: Right, because when you get your little updates – you know, I signed up for this thing, where it sends you updates every week. You know they look perfectly normal by 35 weeks. They look just like a baby. Just smaller. And so I don’t think anybody would guess there’s that much difference. (p. 57)

Maggie: I probably would have been like, hey what’s up with this? Like, this is what we want right here (points to second brain picture).

S: Why do you think it’s important?

Maggie: Well, I mean, obviously, you want your baby to be the best – you know like have the best chances for everything, so you want to do everything you can as a mom. And if staying in the oven a little longer to keep all of brain capacity you can –

S: Yeah.

Maggie: Yeah. Definitely. (Looks again.) Wow. The SIDS too. Wow. Interesting. Yeah they don’t have this on the doctor’s office wall. ….And I mean, I’m fine. It’s just it is – it is a little bit concerning. Like, wow. You know, so, I would definitely tell other moms to try to wait as long as you can. I just didn’t go and do research like this. And I just don’t think a lot of people do. (pp. 121-122)

Julie: I did not know that. 35 weeks it is half the size it will be at 40 week. I did not know that. Holy cow. It doubles in size. (p. 141)

Marcia: So my question is, if you have a 35-week baby, I mean is all of this still going to develop? The way – you see all these little circuits and connections in here – is this still going to develop even if the child’s born? (p. 141) …You know, reading this about the breathing. I do remember seeing that, um, babies born earlier do have a higher risk of SIDS, and this would make sense because they forget to breathe. Like at 35 week versus? (p. 142) …One of the things I would be curious about would be to see the brain at each week from between 35 and 40 – just to see, like how much – not that I question that there is a difference, but what is the difference from 39 weeks to 40. What is the difference from 38 to 39? And just to see you know, like if I had – if I went in to labor or for like some reason had to have a baby at 38 – you know, just to be informed, what would my baby’s brain look like at that point? (p. 145)

Julie: Especially if 37 is the criteria a lot of doctors will use. Oh you’re at 37 weeks – because for me, just seeing that okay at 35 weeks the brain is about half the size it will be at term – so in five weeks, it’s going to double in size, that’s really big.

…Especially if that’s the benchmark the doctors are going to look at, giving mom something that says – okay, if your doctor says 37 weeks, (p. 145-146)

Diana: Well, I was going to say, I think all of us would agree, duh, at 35 – we don’t even want to think about it. …Even the stuff online, I think even What to Expect When You’re Expecting app that I have – it all says 37….I think when you start getting anxious – like I mentioned, anxious to see that baby and you know the baby is healthy,
and this kind of helps me to chill out a little bit. Like okay, I’m anxious, I’m uncomfortable, and that’s okay, because like I want what’s best for my baby. So I can be mature enough, and the adult in this situation to wait – because I want to give my baby all the benefits that I can. Um, so like this actually helps take away some of that anxiety of – over, I want to see my baby, I want to hold my baby, I want to see what he looks like – and this, I was like, you know it’s okay to wait another week or two. (p. 146)

Julie: I know that one of the biggest fears of any parent that has a newborn is SIDS. Because there are things that we connect – oh this could cause it – but we don’t know definitively what is going to cause it. And to just say, oh, babies born just a couple of weeks early – have a huge risk for SIDS (p. 146)

Diana: That makes me go (mock yell), “Forty weeks sounds great.” (p. 146)

Monica: Just reconfirms that you really need to you know wait as long as possible for that baby to finish developing…I mean it’s just, I know there’s more than just the brain issue and then like you said the lungs but it’s just, it’s striking you know like the difference in their brain from here to here what 5 more weeks or 4 more weeks can do (p. 182).

Abby: It’s just 5 weeks; that’s what I was thinking… There’s a reason why you gain, well not me but you, but most, a lot of women gain a lot of weight in their third trimester is that things are really happening…Things are really speeding along like in the first trimester so… I mean it’s amazing just what a week, a couple of days (p. 182-183)

Monica: Well for me, I’m drawn more to the pictures than the words…I mean visually, I mean that’s, I always go straight for the pictures, and maybe other people here go straight for the words but maybe if even there were you know a middle picture of the 37½ (p. 187)

Jennifer: You know but I’ve been hearing all of them and I see that there’s some ob’s out there that are you know more relaxed and they go, oh it’s fine, but I also see other ob’s that are not so having, you know I could picture myself sitting in a waiting room waiting or even in a patient room waiting for my ob to come, just I always read their signs…I don’t know; I’m bored there, I’m sitting there doing nothing….So I start looking and if I saw this picture, I don’t think I would need to hear anything from ob, you know what I’m saying….This would you know, I don’t care what they said, if you’re going to put this on your wall (p. 187)

Meanings of Preterm

Molly: I think of premature. Like below 34 weeks. (p. 9)

Samantha: Like unhealthy and small. (p. 9)

Molly: Small. (p. 9)
Samantha: Have to have help instead of being able to be on their own. (p. 9)

Mary: I think before 37, but that’s just because… (p. 9)

Molly: You think of little, bitty (p. 9)

Heather: I’ve got some friends who had like, premies. Like preterm to me is definitely before, in my mind, um, like it was the doctor waiting 37 weeks. You know, definitely before that. It’s when you’re really worried about significant issues, mortality being a huge one. Um, I have a friend who gave birth to her oldest at 24 weeks, and thankfully, she made it, and she’s a great little 5-year-old now – she’s tiny. (laughs)

But I mean preterm to me is definitely.. Little babies and ones that you still worry about those milestones and just being healthy. (p. 68)

Alice: I don’t know that they would call 37 to 40 weeks full term but I feel like there’s a term – preterm is before 36, 37 and full term is closer to 40. I think there’s a term between like 37 and 40 – but I can’t quite remember what it is. I feel like maybe it’s pre-preterm, preterm and then full term. I feel like that 37, 40 weeks there’s another term that they have for births that happen in there. Because you’ve gotten through so many of those milestones that are important for the baby that there’s, the risk is less in that period – but they’re not really considered full-term yet, because they’re not 40 weeks or 41 weeks. (FG5, p. 68)

Maggie: … I guess 36 weeks is preterm, but I just didn’t think that I was preterm. And I know that sounds crazy, but I think of twins when they’re like 22 weeks. Like I think preterm before even 36 weeks, and it’s just scary. (p. 118).

Marcia: Pray. (p. 118).

Julie: Tiny little babies…Yeah, the ones that are just a little bit bigger than the size of your hand. (p. 138)

Tammy: A preemie. (p. 22)

Holly: I put low weight. (p. 22)

Tiffany: The first thing that comes to mind is NICU. But I’ve experienced it. You know 2 ½ weeks of tubes and needles, and all kinds of stuff that’s not fun to go through. (p. 22)

Beth: Small. (p. 22)

Clacie: A really small baby. (p. 34)

Barbara: In an incubator. (p. 34)

Judy: My niece was preterm because my sister had preeclampsia, and, um, it was very scary. She was in – we were scared she was going to be unhealthy. We weren’t sure that her lungs were fully developed. And she was so tiny…. (p. 53)

Jamie: Fragile, tiny, NICU, frightening, and precious. You know, when you see that little baby. It’s just like – it’s amazing, um, but it’s scary. And fragile is just the word I think of like you know. They say it’s so touch and go. And it’s just so – they’re health is just so fragile. (p. 53)
Liz: I guess you think about the little bitty tiny ones (p. 95)
Monica: NICU. (p. 168)
Abby: Low birth weight. (p. 168)
Monica: Learning disabilities. (p. 168)
Abby: Lungs…. Immature lungs. (p. 168)
Kate: Brain development. (p. 168)
Abby: When you think of, if you think about a preterm baby, I think what instantly pops in your head is a baby born at 24-30 weeks who you know weighs a couple of pounds….Is in the NICU…. You know you don’t think about the baby that was born at 36 weeks who actually is really healthy looking, that may weigh more than a term birth…Because of the genetics…They’re bigger babies anyway so….And so I don’t know which is the, I’m just going on my soapbox, which is a problem, because people don’t think of the 37 weeks babies so they schedule it to come out early, or they make themselves go into labor, and I’m like, that’s still an early, you know, it’s still early…You want them to cook as long as possible….Until your body says it’s ready to come. (p. 171)

Causes of Preterm Birth (Risks)
Jessica: Many things can cause preterm birth… I mean bad oral hygiene. Um, infections. High blood pressure. And a lot of sugars. All kinds of stuff. (p. 10)
Molly: There’s a lot of stuff. (p. 10)
Kim: Something that they kept reminding me of was do not get stressed. Because stress is going, is going make you make that baby come early. (p. 69)
Leslie: Environmental. Something you eat could cause you to go into labor, or something your doing. (p. 70)
Alice: For a while I was seeing a high-risk doctor, and they were doing a study on, I think it’s short cervix. I don’t remember the details, because I didn’t qualify, obviously. But, um, in terms of a real medical reason, there are some medical things that differ from female to female. Some females just have a higher risk of going into early labor because of the way their bodies are built. (p. 70)
Beth: I have no clue. (p. 22)
Tiffany: Oral problems can cause it. Infections, like UTI. Bacterial infections. All those can actually cause premature labor. And there’s something else – I don’t remember what it was. I have no clue. (p. 22)
Clacie: I don’t know. I guess I really don’t know. Because a friend of mine had hers 3 weeks early, and I just have no idea. She seems really healthy and everything. And there wasn’t a problem so I just don’t know. (p. 36)
Barbara: Um, I think stress on your body. Infections. Anything like that. Um. Sometimes it just happens. Sometimes there’s no real explanation for it – sometimes it just happens. I think stress and infections, mostly. (p. 36)

Liz: Absolutely no, no idea. (p. 95)

Lisa: Nothing really, because I never had one…. I’ve even heard if you’re around a lot of smoke, if you smoke, you could have preterm. You know smoking or diabetic or you know something health-wise for you. (p. 106-107)

Maggie: Smoking? I’m just guessing. (p. 119)

Abby: Tobacco use. (p. 169)

Kate: No, I don’t know…. Well I think any kind of complication in the pregnancy can be a risk factor for…. The gestational diabetes. (p. 169)

Monica: Stress. (p. 169)

Abby: Diabetes, injury and age. (p. 169)

Jennifer: I don’t know if any traumatic might be. (p. 169)

Abby: Preeclampsia…. There’s a lot. (p. 169)

Getting to 40 Weeks

Stacey: It’s just a number. I mean, you’re pregnant. And you’re like, it’s exciting for a while, for a long time. And then you get to the end and you’re like okay, I can’t breathe. I can’t walk. And so I mean from the beginning you just focus on your due date. That’s just – everybody does that. No matter who you are, you focus on your due date. That’s all there is to it. So to stick any kind of number to it – really just – even if you’re prepared to go 40 and 41 and 42 weeks, if you know, like if we were told that it was safe to go to 42 weeks or if we were told it was safe to go to 40 weeks – whatever number was – that would stick in our mind, you know? No matter how informed we were, we went to the doctor and we knew, okay, like you said 39 weeks, baby’s healthy at 39 weeks, ready to go. It may actually still influence us no (p. 51)

Allison: It’s awful. Because I was prepared to go a long time. Especially, my middle son was a c-section that’s what influenced me to do the home birth, so I was prepared, my midwife prepared me because my body had done labor with my first who was six, but hadn’t done labor the last time. So your body might have stop and go. You might be pregnant until 42 weeks. I was prepared. But it didn’t make that last few weeks any easier. And yeah, if they start saying 39 weeks, women are just going to – oh it’s okay. 37 weeks, that’s close enough. 36 weeks, that’s close enough. Cause it is a number that people will focus on. (p. 51)

Alice: When we were getting closer, they thought that my daughter was going to be big, and so my doctor and me had been talking about 38 weeks. She said we’ll talk about induction at 37, we’ll talk about doing it at 38, see how things are going, talk about doing it at 38. And we hit 37, and there wasn’t any talk of it. And we hit 38, and she was like, you know, if I do her early, you’re not showing any signs, if I do it
earlier, the likelihood of c-section is going to go up, so we’re just going to wait. I’m like, uh. Because in my head, for a long time, it’d been 38 – 38- 38 – and then I get there and it’s like no, we’re going to wait. And I’m like oh my god, two more weeks. That’s a long time to be pregnant in the summer, in August, September when it’s really, really hot. Because in my mind, I had 38. That was the number. And then I get there and it’s like no… It was very much like,  (loud sigh) I’m still pregnant, I’m still pregnant. I’m just waiting pretty much. (p. 70)

Kathy: If I had wanted a natural birth and not wanted a c-section, if I had been as head strong on wanting a vaginal birth as I was on a c-section, I would have never scheduled at 39 or probably even 40 because I would have know that would have been a failed induction and ended up a c-section. If I had been as head strong opposite, that would have been very influential. (p. 87)

Heather: Yeah, well, 37 is generally they won’t induce you unless it’s medically necessary. They will not take the baby before 37 weeks. Um, unless it’s something very serious is my, um, I guess general knowledge of it. (p. 66)

Meanings of Early

Molly: That’s why I’ve always heard that you can go two weeks early or two weeks late, because it’s not exact. (p. 8)

Samantha: Well, I mean, I don’t know. Like 40 is like the number that everyone says, but I think that 2 weeks early is okay. They say that usually by then they’re pretty developed and everything. They’re good (p. 9). Um, I didn’t want to plan, like get induced or plan that or anything, or schedule or anything because I felt like if I did that then he wasn’t really ready. And it would have put more stress on me. And I would have been worried about what if it’s too early. What if he’s not ready and then he’s born, and he has to be in the NICU. Then I would think that it’s my fault, because I had him come early. (p. 13)

Beth: Now my boys, like I said, I had one 7 days early and the other one 14 days early. Um, they were about the same. One was 6’ 15” the other was 7’ 6”. And they were healthy. They didn’t have any problems. (p. 20) … Early birth to me, my sister, she just had her little boy, and she had her little boy a week early. That’s what I think of, you know, just a week or two early. (p. 22)

Nancy: They always say you need to stay pregnant until you’re 38 week mark, because two weeks early, the baby’s going to be fine. Anything before that, they can have any kind of problems. (p. 33)

Andrea: I think they could always be off on you’re due date, so if you went a little early or a little late, it would be okay. (p. 33)

Clacie: I don’t know. I guess I really don’t know. Because a friend of mine had hers 3 weeks early, and I just have no idea. She seems really healthy and everything. And there wasn’t a problem so I just don’t know. (p. 36)
Barbara: If they say 39 is good enough, or, you know, 40. People are going to say well if 39 is good enough I can go a week early. I can go 38. If 38 is good enough, then I can go a little earlier. (pp. 42-43)

Carrie: With him? He came actually on his due date. Um, the second one she came a week early – the same thing happened. Water broke, and they induced me. (FG4, p. 45) … Because I knew how much development happens in the last weeks and I just wanted to make sure that he was not going to be – and it was really early. He still came really early. (p. 46)

Jamie: I think with those typically, it’s not going to work unless your body’s ready anyway. So, yeah. And I wouldn’t do it early. (p. 54)

Heather: With my second, he came three weeks early. So he was born at 36 weeks and 6 days, something like that. (p. 50)

Alice: I guess I would have to ask for clarification when you say early – put in the preterm, full term - - in-between so that it’s more a familiar term that I’m used to hearing, … I would need to clarify early birth – are we talking about preterm, full-term, in-between. I’m guessing early birth means anything before 39/40 weeks, but I’m just guessing. (p. 69)

Kathy: ….Now, about 36, 37 weeks I started trying to whine her out early and that’s when my doctor was like no, no, no. (p. 76)

Liz: Yeah, I’d think of more along the 36, 37, 38 – to me that’s early. Because they’re supposed to go to at least 40 weeks or 41. So yeah, I would just think of that as early. (p. 95).

Lisa: It may be where she’s not walking, her balance that could be where she may have been born early. (p. 110)

Tiffany: I know my son was born at 35 ½ weeks gestation. He was early. He spent 2 ½ weeks in the NICU. (p. 20)

Diana: … as a mom, I would just be like I can deal with a learning disability over losing my baby, because it was born too early, um but I would like just like have questions, does the baby have any physical disabilities as a result of being born earlier. Um, but if it’s an early birth and not preterm, um, I think I would just be asking what was the weight of the baby? Just out of curiosity. I think I would be concerned if it was an early birth… (p. 140)

Jennifer: I would consider my birth an early birth because it came at 37 weeks….Or if I came, like my other two babies, I always say they came before, between my 38 and 39 weeks. (p. 170)

Abby: I mean I guess when I’m describing. When people say, when did your baby come at, and I have said, oh he and, and because of them came at 38 weeks; I said, he came early. (p. 170) … people don’t think of the 37 weeks babies so they schedule it to come out early, or they make themselves go into labor and I’m like, that’s still an
early, you know it’s still early…You want them to cook as long as possible…Until your body says it’s ready to come. (p. 171)
References


Vita
Sarah C. Vos
December 21, 1974
Bowling Green, Kentucky

Academic Degrees
Calvin College, B.A., May 1997    Major: English Literature/Minor: German Language

Professional experience
Freelance Writer – Lexington, Kentucky 2009-2010
  Public Health Reporter
  Enterprise Reporter
  Metro Enterprise Reporter
Concord Monitor – Concord, New Hampshire 2001-2004
  Crime Reporter
  Regional Reporter
  Assistant Editor
  Research Assistant
  Editorial Intern
Editors At-Large – Grand Rapids, Michigan 1997
  Writer

Honors and Awards
• Tall Grass Farm Fellowship, Institute for Rural and Community Journalism, 2011
• Fellow, Knight Center for Specialized Journalism, September 2008
• Journalism Fellow in Child and Family Policy, University of Maryland, 2005
• First place, General News Story, Kentucky Press Association, 2005
• First place, Business News Story, Kentucky Press Association, 2005
• First place Breaking News, New England Press Association, August 2004
• First place General News, New England Press Association, August 2004
• Second Place, Breaking News, New Hampshire Press Association, August 2003

Juried Presentations
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Juried Presentations
Sarah C. Vos
Student’s signature

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