

INTEGRATING THE VOICE OF THE DYAD: LISTENING TO THE BIRTH STORIES OF  
BOTH PARENTS

by

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ABSTRACT

This study explores how partners make the transition to parenthood together. Men's and women's experiences were examined, as well as the couple together. Using a grounded theory approach, the research aims to elevate men's voices while considering the couple as a dyad. Participants were eight heterosexual couples who had a baby in the last year. Semi-structured interviews were conducted with each individual and the partnership for a total of 24 interviews. Although societal narratives emphasize women's roles in pregnancy and childbirth, men's participation in childbirth has been shown to strengthen family bonds and contribute to positive outcomes for all members of the new family. By applying grounded theory, this study develops a framework that incorporates both parents' experiences, highlighting the differences in how men and women process childbirth and its impact on the couple's dynamic. The study emphasizes the importance of considering both partners' attachment needs during this transition. It underscores the significance of supporting both mothers and fathers, the latter whose needs are often overlooked. The findings offer clinical implications for therapists and medical providers to improve support for both parents and the dyad during childbirth.



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by

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## CHAPTER 1: INTRODUCTION

Becoming a parent is often considered a major life change (Cowan & Cowan, 2000). To this point, the decision to enter parenthood has been described as either the most fateful or important decision a couple makes (Cowan & Cowan, 2000). Once parenthood is embarked on, it lasts for the rest of an individual's life (Nomaguchi & Milkie, 2020). Though parenting has many rewards, it also has many demands, the results of which can have negative consequences for individuals and couples (Nomaguchi & Milkie, 2020). Research has shown some of the negative consequences can be decreases in relationship satisfaction (Cowan & Cowan, 2000; Gingras et al., 2021; Nomaguchi & Milkie, 2020; Zhang et al., 2024), marital intimacy (Cowan & Cowan, 2000; Durtschi et al., 2017), sexual satisfaction (Cowan & Cowan, 2000; Durtschi et al., 2017), and leisure time (Durtschi et al., 2017). Conflict can also increase (Cowan & Cowan, 2000; Durtschi et al., 2017). Research has shown that upon transitioning to parenthood, there are also significant changes in personal identity and roles (Cowan & Cowan, 2000; Gingras et al., 2021). Accompanying those negative changes are worries about adequacy and preparedness on many dimensions of parenting (Cowan & Cowan, 2000).

Despite the progress society has made in gender equity, parenthood research—especially surrounding childbirth—tends to focus primarily on the mother (Cabrera, 2019; Nomaguchi & Milkie, 2020). There are presumably many reasons for this. When a woman becomes a mother, she undergoes great changes. She changes biologically, psychologically, socially, and some would even say spiritually. Fox (2009) said:

Motherhood changes a woman's body, her relationships with her family and friends, and especially her partner, her work and responsibilities, her control over time, her

relationship to her home and community, the meaning of marriage and family for her, her earnings, and even her feelings about herself (p. 4).

Parenting tends to be gendered (Nomaguchi & Milkie, 2020), with more couples falling into traditional gender roles as their children age (Cowan & Cowan, 2000; Fox, 2009; González et al., 2018). A central tenet of sensitive parenting—a current parenting ideology—is “intensive mothering” which highlights the dominant societal narrative that good parents are mothers (Hays, 1996; Nomaguchi & Milkie, 2020).

Shapiro et al. (2020) point out that men are viewed more often as breadwinners or helpmates than parents or caretakers, though this narrative is beginning to change (Cabrera, 2019). When men participate in childbirth, family bonds may be strengthened (Jouhki et al., 2015). Additionally, fathers’ participation during labor and delivery can increase paternal attachment, which may lead to the increased well-being of the child, academic gains, and cognitive, emotional, and social development (Uncu et al., 2024). Despite the positive outcomes observed when men are part of the childbirth experience, research has largely ignored men’s experience during labor and delivery (Sansiriphun et al., 2015; Xue et al., 2018). It is interesting to note that in America, while women are traditionally celebrated before giving birth with a baby shower, men, at best, are given a cigar at the hospital. Men do not receive nearly the level of pomp and circumstance as they make the transition to fatherhood as women do upon entering motherhood.

Because men’s experiences during labor and delivery have been largely overlooked, some researchers have suggested new parents be studied as a dyad instead of studying only the mother (Cowan & Cowan, 2000; Iles et al., 2011). Iles et al. (2011) found that men and women

process the experience of childbirth differently and those differences matter. Attachment theory is one lens through which to view these differences (Iles et al, 2011). In considering a more systemic approach to studying childbirth experiences, Tohki et al. (2018) delineate the delicate line that must be walked when involving men in the childbirth space to avoid disempowering women in one of few spaces in which women in patriarchal societies enjoy autonomy.

While attachment theory offers valuable insights into the differing experiences of men and women during childbirth, a grounded theory approach provides an additional framework for exploring these differences, particularly by elevating men's voices without diminishing the experiences of women. Grounded theory is a qualitative method of research that allows theory to emerge from the data (Glaser & Strauss, 1967). It is frequently employed when researchers are studying a new area, trying to understand a major process, illuminating voices not previously heard, developing policy, and informing professional practice (Charmaz & Thornberg, 2021). Because researchers have not focused on men's voices about childbirth, a grounded theory approach can serve to create a new theory incorporating men's experiences during childbirth. Additionally, including the voice of the dyad will shed light on how men and women experience and process childbirth differently and also how the couple as a unit does. The purpose of this paper, therefore, is to use a grounded theory approach to study experiences in childbirth, as it allows for the development of a new theory grounded in the lived experiences of men while still preserving women's voices and integrating the perspective of the dyad.

## CHAPTER 2: LITERATURE REVIEW

Grounded theory is a type of qualitative research. It was originally developed by Glaser and Strauss (1967) as a research approach in which data is collected and analyzed simultaneously. It is an incredibly flexible research methodology that allows for endless possibilities in data sources, methods, and generated theory (Birks & Mills, 2023). A grounded theory approach is generally selected when a researcher wants to study a given phenomenon and generate new concepts to better understand it (Charmaz & Thornberg, 2021; Glaser & Strauss, 1967). It is an interplay between inductive, deductive, and abductive logic processes (Kennedy & Thornberg, 2018). To undertake this methodology correctly, a researcher must be open to being surprised by the data (Kennedy & Thornberg, 2018). In order to be “surprised by the data,” reflexivity must be utilized (Birks & Mills, 2023).

Reflexivity, formerly known as bracketing, is when the researcher develops insight into and openly acknowledges the influence she/he has on the study at hand (Birks & Mills, 2023; Tufford & Newman, 2012). Said well, “Researchers are a sum of all they have experienced” (Birks & Mills, 2023, p. 17). Grounded theory researchers must accept that, though it is important to try, it is impossible to suspend all the selves of the researcher (Birks & Mills, 2023). Researchers must be honest and critical throughout the entire grounded theory study about how they are showing up in the research (Birks & Mills, 2023). To employ reflexivity, the following section will outline some of my experiences that influence the current study.

### **Self of the Researcher**

Qualitative research requires the researcher to introspect and reflect on their prejudices and biases to see how these may affect the results. The following section examines how my past history, present experiences, and future expectations permeate this grounded theory study.

### ***Personal History***

When I was pregnant with my first child, my husband and I attended a prenatal appointment together. At the time, I was about halfway through my pregnancy, educating myself and exploring what I wanted for labor and delivery. As a couple, we had been reading about the Bradley Method, which is a guide for husband-coached childbirth (Bradley & Montague, 1996). When we asked our obstetrician for his professional opinion, he told us that if we used the Bradley Method during labor and delivery, we would likely end up getting divorced. This was a pivotal moment for me. I believed and trusted my body was capable of giving birth naturally and that our marriage could withstand the event. Knowing I would not have the support of my obstetrician for an unmedicated delivery, I switched my provider to a midwife at a freestanding birth center. I was able to give birth naturally, with my husband as my biggest supporter. He provided the physical, mental, and emotional support I needed during labor and delivery. Our marriage was made stronger as we transitioned into parenthood together.

Years later, while living in Japan, I became a childbirth doula. I had just given birth to my fifth child and had community members asking for my help navigating labor and delivery in a Japanese hospital. These military wives had heard horror stories of how a failed epidural or the language barrier resulted in traumatic birth experiences. They wanted someone to support them so they could have a better outcome. When I assisted these women, I heavily encouraged their partners to help. I taught the husbands massage techniques, laboring positions, and positive affirmations to support their wives throughout the labor. While none of the outcomes of my work was quantified, I watched families in creation and saw husbands and wives entering into it together.

### ***Present Experiences***

In recent years, I have volunteered as a doula at a local hospital. The hospital specializes in care for high-risk pregnancies. My experience has been very different due to the multiple medical interventions typically utilized with these patients. Every laboring woman I have assisted has been hooked up to several machines and monitors, vastly reducing the freedom she has to move around and her partner to help. Instead of labor being an interactive process, like a dance between partners (Jouhki et al., 2015), mom is typically lying in the hospital bed while dad either plays on his phone or watches television in the corner. When delivery is imminent, the room fills with medical personnel, and the baby's father is pushed to the periphery. Most of the time, all attention is on mom and baby and no one pays any attention to dad unless he is wanted to cut the umbilical cord. Families are still being created in these instances, but it does not always feel like the partnership is an important part of it.

During the past few months, in casually mentioning my thesis topic to people, multiple women have told me that their partner's lack of support during labor and delivery was a huge point of contention in their relationship. One even went so far as to tell me that she was divorcing her husband for that exact reason. As I have pondered these events, I have often wondered if better support for the male partner would have resulted in better outcomes for the female partner and the couple together.

### ***Future Expectations***

As I compare my personal birth experiences and those of my clients in Japan to those I have had recently, the differences are stark. Throughout the time spent recently at the local hospital, I frequently found myself getting frustrated that I was the one massaging backs, helping with position changes, and providing affirmations for my laboring patients while the dads just played on their phones, slept, or went outside to smoke. Did they not understand what Bohren et

al. (2017) found, that continuous support for laboring women was incredibly beneficial for both mom and baby? Did they not realize that support for their partner during labor and childbirth had such positive benefits for the entire family, themselves included (Xue et al., 2018)? Did they not know about the attachment injuries that are so prevalent during times of extreme stress like childbirth (Gingras et al., 2021; Iles et al., 2011; Johnson, 2007)? My biases are clear that I do believe every member of the family benefits when dads are an active part of the labor and delivery process. These biases reflect some of my power, privilege, culture, and values, and may not be the same as participants in this study. It is important to be reflexive about my biases to ensure the participants' voices are the ones that are heard and not mine (Birks & Mills, 2023). Now that my personal experiences have been discussed, a literature review will follow.

Birks and Mills (2023) state that a review of the literature in grounded theory research can be contentious and misunderstood. They state if one engages too much in the literature, there is a risk of contaminating the data as codes and concepts emerge. Conversely, if one fails to understand what any of the current literature contains, the risk of duplicating others' work or repeating others' mistakes is likely. The same researchers recommend an informed approach to the literature at the outset of a grounded theory study. A literature review helps to justify the need for a particular study and also enhances theoretical sensitivity (Birks & Mills, 2023; Charmaz & Thornberg, 2021). Theoretical sensitivity to the data allows a researcher to identify and extract elements that have relevance to the grounded theory study (Birks & Mills, 2023; Charmaz & Thornberg, 2021). The following section will outline the literature surrounding the transition to parenthood and women's and men's experiences during childbirth.

## **Literature Review**

Though recent years have shown a decline in birth rates around the world, it is estimated that 80-90% of adults eventually become parents (Gingras et al., 2021; Livingston, 2024). The entry to parenthood is considered a significant life event (Zhang et al., 2024). As Cowan and Cowan (2000) stated, “Becoming a parent is irrevocable” (p. 32). In this literature review, there are many references to the work by Cowan and Cowan based on their ten-year longitudinal study documenting men’s and women’s experiences throughout pregnancy and into early childhood. That book was, and still is, considered seminal on this topic.

### ***Transition to Parenthood***

When partners become parents, many relational changes may occur (Cowan & Cowan, 2000; Fox, 2009). In heterosexual couples, some of the positive changes can include increased marital trust (Zhang et al., 2024), strengthening of familial relationships (Jouhki et al., 2015), couple growth (Cowan & Cowan, 2000), and a revitalized relationship (Cowan & Cowan, 2000). Among the negative relational changes are decreased relationship satisfaction (Cowan & Cowan, 2000; Gingras et al., 2021; Nomaguchi & Milkie, 2020; Zhang et al., 2024), marital intimacy (Cowan & Cowan, 2000; Durtschi et al., 2017), sexual satisfaction (Cowan & Cowan, 2000; Durtschi et al., 2017), and leisure time spent together (Durtschi et al., 2017). For many couples, interpersonal conflict also increases (Cowan & Cowan, 2000; Durtschi et al., 2017). The good news for parents and parents-to-be is that many of the negative changes reported during the transition to parenthood show a U-shaped pattern over time (Gingras et al., 2020; Nomaguchi & Milkie, 2020). This means that measures such as relationship and sexual satisfaction that drop in the beginning, will likely increase as the new family adjusts to the changes caused when a baby is born (Gingras et al., 2020; Nomaguchi & Milkie, 2020).

As individuals become parents, they may experience individual growth (Cowan & Cowan, 2000) and an increased sense of purpose and meaning in life (Johansson et al., 2015; Nomaguchi & Milkie, 2020). Existential thoughts about the fragility and deeper meaning of life are common (Johansson et al., 2015). It is also likely a person will experience significant changes in identity and roles as they become a parent (Cowan & Cowan, 2000; Epifanio et al., 2015; Gingras et al., 2021). The changes in roles and relationships do not just occur for the new parents; Cowan and Cowan (2000) point out that when a baby is born, there is a three-generational shift in roles and relationships as parents become grandparents and children become parents. It is interesting to note that for many parents-to-be, impending parenthood leads to reflection on how they were parented, with many making conscious decisions to either be the same as or different from their parents (Cowan & Cowan, 2000). Becoming a parent may stir up childhood issues and cause adult children to differentiate from their parents again (Cowan & Cowan, 2000).

In heterosexual couples, as the birth of their baby approaches, both men and women may worry they will not be prepared for or capable of parenting once the child is born (Cowan & Cowan, 2000). Those who did not experience what they perceived as good parenting growing up may worry they cannot provide what they never received. Shifting feelings of safety and vulnerability can also occur (Cowan & Cowan, 2000). New parents often worry whether their baby will be healthy; both partners may also worry whether the mother will survive childbirth (Cowan & Cowan, 2000). In the United States, this worry is frequently augmented for mothers and babies of color due to increased adverse birth outcomes affecting people of color (Markin & Coleman, 2023).

### ***Focus on the Mother***

Parenting research has traditionally focused on the mother (Cabrera, 2019; Nomaguchi & Milkie, 2020). It is not difficult to understand why; from the moment of conception, a woman's body begins to transform to accommodate the growing fetus (Berk, 2022). During the approximately 40 weeks of pregnancy, a woman's body undergoes significant physical changes (Berk, 2022). These include changes in weight, shape, and hormone-endocrinological balance (Cowan & Cowan, 2000). Common distressing physical symptoms of pregnancy may include nausea, backache, indigestion, fatigue, shortness of breath, painful intercourse, swelling, leg cramps, and urgent urination (Cowan & Cowan, 2000). During labor and childbirth, a woman experiences changes in her hormonal physiology as well as substantial pain and discomfort (Bohren et al., 2017).

In addition to the physical changes during pregnancy and childbirth, a woman often experiences psychological changes (Cowan & Cowan, 2000). The same researchers suggest examining the interaction between physiological and psychological changes to better understand the emotional experiences of women during pregnancy and childbirth. Anxieties about the viability of the fetus, the birth of a healthy baby, coping with labor and delivery, and being a good enough mother are common during this time (Cowan & Cowan, 2000). Epifanio et al. (2015) go so far as to say that in becoming a mother, women must allow for a new mental arrangement for new priorities, values, interests, and mothering. Further stated, during this time, women may "perceive a sense of inadequacy and loss of faith in their own abilities, reduced mood, agitation, anxiety, and significant loss of interest in routine activities" (Epifanio et al., 2015, p. 41).

Women also experience many social or relational changes throughout pregnancy and childbirth (Fox, 2009). Relationships with partners, family, friends, coworkers, and even

acquaintances change when a woman becomes a mother (Fox, 2009). As partners enter the “protective cocoon” of pregnancy, they frequently become each other’s primary support system which places a huge strain on the partnership as each member relies on the relationship to meet all of her/his needs (Cowan & Cowan, 2000, p. 49). The strain continues after the baby is born, as parents are often deprived of contact with the outside world. This may result in increased difficulty for the partnership “that is already vulnerable to disappointment from within and pressure from without” (Cowan & Cowan, 2000, p. 29). Research has shown that as pregnancy progresses through childbirth and the child ages, most parents take on more traditional gender roles (Cowan & Cowan, 2000; Fox, 2009; González et al., 2018). This means that all women, and especially those who had careers before motherhood, may experience a shift in their relationship with the world around them when their baby is born (Cowan & Cowan, 2000).

### ***Barriers to Fatherhood Involvement***

Like women to motherhood, some men experience the transition to fatherhood as a “physical, emotional, psychological, and spiritual journey” (Sansiriphun et al., 2015, p. 460). However, it is interesting to note that in research, the entry to fatherhood is described on the one hand as “transformative” (van Vulpen et al., 2021, p. 3) and, on the other, as “variable” (Fox, 2009, p. 5). These two opposing views illustrate the wide range of views on fatherhood. Cowan and Cowan (2000) pointed out that men regularly describe the childcare work they do as babysitting or helping, instead of simply, parenting. Despite societal improvements in gender equality and roles, men are still viewed more often as breadwinners than nurturing or sensitive caretakers (Cabrera, 2019; Shapiro et al., 2020).

When men play an active role during childbirth, research shows they may have positive feelings about the birth, adopt the role of father better, and family bonds can be strengthened

(Jouhki et al., 2015). Additionally, when fathers attend childbirth, paternal attachment can increase (Uncu et al., 2024), feelings of confidence may increase (Sansiriphun et al., 2015), and health improvement may be observed for every member of the family unit (Uncu et al., 2024; van Vulpen et al., 2021). Some of these gains last as children age, leading to increased well-being of the child, as well as improved academic achievement and cognitive, emotional, and social development (Uncu et al., 2024). Research by González et al. (2018) suggests that the more egalitarian a partnership is during pregnancy, childbirth, and later, the happier both partners are. However, it is important to note that correlation does not imply causation. While the act of a father being involved during childbirth is associated with positive outcomes, this involvement may be more reflective of a broader pattern of engagement in childrearing. Involvement over time, both during and after pregnancy, is likely a more significant contributor to these outcomes, rather than the single event of being present at childbirth itself.

Despite the abundance of positive outcomes observed when the father is involved in childbirth, research primarily fails to include men as a prominent member of the laboring couple or consider their experiences during labor and delivery as important (Johansson, 2015; Sansiriphun et al., 2015; van Vulpen et al., 2021; Xue et al., 2018). Notwithstanding these limitations, the common themes about men and childbirth that do show up are disconcerting. During pregnancy and childbirth, men have reported feeling like outsiders, marginalized, and undervalued (Jouhki et al., 2015). Feelings of distress, overwhelm, panic, and fear are also common (Iles et al., 2011; Johansson et al., 2015). Societal messages lead men to believe that during labor and delivery, they should be calm, strong, and a reassuring companion (Johansson et al., 2015). Paradoxically, Johansson et al. (2015) also state, “For men to be truly present

during labour [sic] and birth they need to shed the traditional masculine values of power and control” (p. 16).

Unsurprisingly, literature also states that men do not frequently talk about their feelings regarding childbirth or parenthood, though may benefit from doing so (Howarth et al., 2019; Iles et al., 2011; Johansson et al., 2015; Jouhki et al, 2015). The present author notes the irony in messages about fatherhood: be an involved father though society does not believe involvement is masculine; help around the house even though housework is a woman’s job; be strong for your partner but shed your masculinity to do it; do not talk about your feelings even though it would help; let fatherhood transform you but do not celebrate your journey.

### ***Strength of the Dyad***

Both men and women often suffer from opposing and seemingly impossible messages about successful parenting—beginning with pregnancy and childbirth and lasting well beyond. Men’s experiences during pregnancy and childbirth have been largely overlooked (Johansson, 2015; Sansiriphun et al., 2015; van Vulpen et al., 2021; Xue et al., 2018). This exclusion must be rectified if a greater understanding of the process of childbirth and transition to parenthood for a couple is to be gained.

Research shows that during times of fear, anxiety, or distress, such as pregnancy and childbirth, attachment is activated (Gingras et al., 2021; Simpson & Rholes, 2018). Attachment theory suggests that humans have a primary, biological need for emotional connection, which is often activated during times of threat or uncertainty (Cassidy & Shaver, 2016; Johnson, 2007). Bowlby (1988) believed that this need for attachment is particularly pronounced during the entry to parenthood, as the inherent stress of this life change can trigger memories of childhood and activate attachment processes. During times of perceived threat, such as the transition into

parenthood, individuals often seek comfort and reassurance from those they are close to, and once they receive this support, feelings of distress are calmed (Cassidy & Shaver, 2016; Gingras et al., 2021). Romantic attachment, which is based on patterns of interactions with caregivers during childhood, transfers to romantic partners in adulthood (Simpson & Rholes, 2018). Secure attachment within a romantic partnership allows each partner to soothe the other during moments of activation, fostering emotional support and reassurance during times of stress (Simpson & Rholes, 2018).

During pregnancy and childbirth, both parents may experience attachment activation and need to process the experience differently (Iles et al., 2011). Iles et al. (2011) stress the importance of adequate social support in successful cognitive processing of traumatic events like childbirth. As partners provide support for each other during times of stress, both can reap the benefits (Iles et al., 2011). Studying parents as a dyad would allow an understanding of both partners' experiences during childbirth and the transition to parenthood while correcting the omission of the father's perspective.

### **Rationale for This Study**

As mentioned, literature is somewhat scarce on the involvement of men during pregnancy and childbirth (Cabrera, 2020; Xue et al., 2018). The existing literature is fragmented, with most reviews focusing on specific countries of origin with little to no exploration of which factors influenced father involvement (Xue et al., 2018). Tokhi et al. (2018) posit one of the reasons researchers may not have involved men in the childbirth space may be to avoid disempowering women. They suggest that any intervention designed to include men “must be carefully designed and implemented in order to support women’s autonomy and avoid reinforcing unequal gender relations” (p. 11). In patriarchal societies like the U.S., the childbirth space is one of few spaces

where women typically enjoy autonomy and a degree of authority. Giving men power in a new domain may prove detrimental to women in the future (Tokhi et al., 2018).

One of the ways to study childbirth inclusively, without disempowerment of any group, may be to study both parents as individuals and in the dyad instead of studying either the father or the mother alone (Iles et al., 2011). Because men and women experience and process childbirth differently (Iles et al., 2011; van Vulpen et al., 2021), these inherent differences should be explored to better understand childbirth from the perspective of all participants. A grounded theory approach will allow study of experiences in childbirth to give men an elevated voice while still preserving women's voices. Additionally, by integrating the voice of the dyad into childbirth research, a new perspective can be gained to understand how partners transition to parenthood together.

## CHAPTER 3: METHODS

Childbirth is a complex process and one that typically marks a period of transition for partners (Cowan & Cowan, 2000; Johansson et al., 2015). Understanding how heteronormative individuals and couples navigate this transition is not something that can be easily understood by simply examining the relationship between single variables using quantitative methods (Greenstein & Davis, 2020). Many types of qualitative research seek to describe and explore phenomena as well as understand the meanings, interpretations, and experiences of individuals (Birks & Mills, 2023; Greenstein & Davis, 2020). Grounded theory is a type of qualitative research that goes further to explain the phenomenon being studied with the intent to generate a new theory (Birks & Mills, 2023; Glaser & Strauss, 1967). This method of data collection allows a variety of different experiences and voices to come to light while also seeking to understand a major process (Charmaz & Thornberg, 2021; Thornberg & Charmaz, 2014).

Grounded theory uses an iterative process to collect and analyze data while maintaining adequate checks in the research along the way (Charmaz & Thornberg, 2021; Glaser & Strauss, 1967; Thornberg & Charmaz, 2014). Theoretical explanations of the experience being studied emerge as the researcher uses memos, repeated coding, and comparison of the data (Birks & Mills, 2023; Charmaz & Thornberg, 2021; Glaser & Strauss, 1967). This process aims to reach “theoretical saturation of the emerging conceptual categories” that will lead to the new theory (Charmaz & Thornberg, 2021, p. 309). As this grounded theory methodology was applied, I have gained a better understanding of how partners transition to parents together.

### **Sampling**

Sampling, in quantitative research, is based on studying a portion of the population that is, ideally, representative of the entire population (Rapley, 2014). The aim of this is to allow

findings to be generalized to individuals outside of the research. In qualitative research, there is a focus on specific people, situations, or sites, which means a representative sample is not always desired. That is not to say that a given sample should be homogenous, but rather that participants are specifically chosen for their particular perspective (Rapley, 2014).

The number of participants in a grounded theory study is not predetermined, instead, as data is collected and analyzed along the way, participants are added until theoretical saturation is reached (Birks & Mills, 2023; Rapley, 2014). This means that sampling is “emergent, progressive[,] and inductive” (Rapley, 2014, p. 59). A researcher knows theoretical saturation has been reached when new data no longer produces fresh theoretical insights, categories, or concepts (Thornberg & Charmaz, 2014). Based on the iterative and emergent process of grounded theory research, there was no preset number of participants to be recruited for this study. However, using past studies as an estimate, it was anticipated between 10-15 couples would be interviewed. When the current study was completed, eight couples were interviewed.

### ***Recruitment***

One of the challenges of trying to access this population is finding places where new parents visit. To increase the likelihood of finding parents who have given birth in the last year, specific efforts were made to locate centers that provide services to new parents. The primary researcher had contacts at the Nancy Darden Child Development Center (NDCDC) at East Carolina University and the Seymore Johnson Child Development Center at Seymore Johnson Air Force Base (AFB) in Goldsboro, NC. Each of these locations have infant rooms that provide services for children under 1. Recruitment flyers were distributed in both of these locations. Many of the families at the NDCDC likely gave birth at the local hospital and were being recruited to provide perspective on a more traditional birth experience. Families at Seymore

Johnson AFB were being recruited with the hope of including the military voice since their experiences might provide a unique outlook. A flyer was also distributed to Bella Donna Midwifery at La Vita Bella Birth Center in Jacksonville, NC to include the voices of families who chose to give birth at home or at a birth center. In addition to the locations named above, participants were also recruited using digital flyers distributed to personal contacts and through Facebook contacts of the primary researcher.

### ***Selection Criteria***

The following guidelines were used to determine participants' eligibility in this study:

- 1) Biological parents (one biological male, one biological female) of a baby born in the past year. Since the focus of this study was to examine how partners experience childbirth together, the event of childbirth needed to be something that has been experienced in the semi-recent past. Because the ability to recall details is compromised as time passes (Lew et al., 2016), the goal was to try and capture the experience as close to the birth of their child as possible.
- 2) Individuals in a committed heterosexual relationship with the baby's other parent. Again, because this study was focusing on how partners experience childbirth together, participants must be in a partnership.
- 3) Each partner must speak English fluently. Interviews were conducted in English so the research could understand what was being said to collect and analyze the data appropriately.
- 4) Individuals must be at least 18 years old.

- 5) Individuals participating virtually must have an email account to receive the Webex link, consent form, demographic form, and assessments. They must also have a mobile device with a camera.

## **Procedures**

Those who were interested in participating in the study responded to the flyer by email. They were then contacted via phone to schedule an interview time. An initial screening was done to ensure participants were eligible for inclusion in the study. All participants were interviewed virtually through Webex. In order to help with transcription, all interviews were recorded through Webex. Because participants needed to be able to speak openly and freely about their experience during the birth of their child, participants were interviewed separately and then together.

As the interviews began, informed consent was obtained and participants were given the opportunity to ask any questions they had. Once consent was obtained, one individual began their interview. During that time, the other partner was in a different room completing the demographic questionnaire and four assessments. Upon completion of the first interview, participants traded places and the second interview was conducted while the other partner completed the demographic questionnaire and four assessments. When both individual interviews were completed, the couple was then brought together for the joint portion of the interview. Individual interviews lasted approximately 30-45 minutes each, and the couple interviews lasted approximately 20-30 minutes. All individuals who completed the interviews and questionnaires were compensated for their time with a \$10 Amazon gift card.

## ***Measures***

As part of the interviews, participants were sent a link from RedCAP and asked to complete a demographic questionnaire and four assessments. Although these instruments are quantitative in nature, given the size of the sample, the purpose of collecting this data was not to run statistical analyses. Instead, this data was being collected to help provide additional information to help provide descriptive information about the participants and their birth story. The first form consisted of demographic information about the individual and the birth of their child (i.e., type of birth, place of birth, time of birth, etc.). Traditional questions regarding age, gender, race/ethnicity, education, and income were also included (See Appendix G). In addition to demographic information, participants were asked to complete four assessments.

***Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987).*** The EPDS is a 10-item self-report scale used to screen for postpartum depression symptoms (i.e., I have been anxious or worried for no good reason, I have been so unhappy that I have been crying; Cox et al., 1987). Each item is scored on a four-point scale from 0 to 3 (Cox et al., 1987). These items are then summed for an overall score. Unlike other common depression screeners, the EPDS excludes somatic symptoms like fatigue and change in appetite that are common occurrences during the postpartum period (Murray & Cox, 1990). It was originally designed to measure postpartum depression in women; however, this assessment tool has been validated for use with both mothers and fathers (Epifanio et al., 2015; Iles et al., 2011; Massoudi et al., 2013). Despite somewhat varied results for paternal assessment, researchers agree the EPDS does identify major depression and distress in new fathers (Epifanio et al., 2015; Massoudi et al., 2013). The EPDS has long been used as a quick assessment tool to identify postpartum depression in women with a Cronbach's alpha of .87 (Cox et al., 1987; Murray & Cox, 1990). Using the EPDS identified

women and men in this study who exhibit symptoms of postpartum depression. Understanding their current relationship with depression helped provide additional information surrounding their childbirth experiences and any resulting depression.

***Dyadic Adjustment Scale-4 (DAS-4; Sabourin et al., 2005).*** The DAS-4 is a brief version of the original Dyadic Adjustment Scale (DAS) designed to measure relationship satisfaction in marriages and other cohabitating couples (Sabourin et al., 2005; Spanier, 1976). The DAS-4 is made up of four items answered on Likert scales; three items (i.e., “In general, how often do you think that things between you and your partner are going well?”) are rated on a six-point scale from 0 (all the time) to 5 (never) and a fourth item is rated on a seven-point scale from 0 (extremely unhappy) to 6 (perfectly happy; Gingras et al., 2021; Sabourin et al., 2005). Responses are then summed for a total of 25 possible. This assessment has good internal consistency of  $\alpha=.87$  (Gingras et al., 2021). Including this assessment was helpful because it provided descriptive information on an individual’s satisfaction with the relationship to deepen the understanding of how the childbirth experience may be related to relational satisfaction (Gingras et al., 2021).

***Brief Accessibility, Responsiveness, and Engagement Scale (BARE; Sandberg et al., 2012).*** The BARE is a 12-item scale that measures how accessible, responsive, and engaged an individual views themselves and their partner (i.e., I listen when my partner shares her/his deepest feelings, It is hard for me to get my partner’s attention). Items are scored on a 5-point Likert scale ranging from 1 (never true) to 5 (always true). Scores are then totaled for up to 36 possible. This assessment tool was designed to measure attachment behaviors and couple bonding (Sandberg et al., 2012). Cronbach alphas range from .66 to .85 for all self and partner scores of accessibility, responsiveness, and engagement (Sandberg et al., 2012). Childbirth and

the period that follows can be distressing and isolating for a couple (Cowan & Cowan, 2000). The BARE is another scale that helps determine how satisfied a person is in their relationship, and how comfortable they feel turning to their partner when they are feeling distressed or isolated (Sandberg et al., 2012). Information from this scale was used descriptively to gain a better understanding of relational dynamics between the couple and how accessible, responsive, and engaged they experience their partner.

*Experiences in Close Relationships Scale-Short Form (ECR-S; Wei et al., 2007).* The ECR-S is a 12-item assessment adapted from the 36-item Experiences in Close Relationships Scale (ECR; Brennan et al., 1998) designed to measure adult attachment (i.e., It helps to turn to my romantic partner in times of need, I do not often worry about being abandoned; Wei et al., 2007). Items are scored on a 7-point Likert scale between 0 (strongly disagree) and 6 (strongly agree) for each question with higher scores reflecting the presence of anxiety or avoidance insecurities (Wei et al., 2007). Anxiety and avoidance measures are summed separately and divided by 6 to provide an average on each measure. The assessment has good levels of reliability and validity with Cronbach's Alpha statistics ranging between .90 and .94 for men and women (Iles et al., 2011; Wei et al., 2007). To benefit from support, like what is needed during childbirth and after, "individuals must be able to form close relationships and depend on others" (Iles et al., 2011, p. 521). The ECR-S was included in this study because it allowed the author to use this information descriptively to help provide additional information about participants and their attachment behaviors within their relationships.

### ***Interviews***

At the beginning of the interview, participants were asked to select a pseudonym for themselves. Once that was completed, the interview began. Participants were given as much time

as necessary to fully answer all questions. At times, they were asked to clarify or expand their answers. The stance of the interviewer was open with the primary job of listening to provide cues to encourage participants to continue their explanations. During this time, the interviewer paid close attention to incidents, which is “an umbrella term for recurring actions, characteristics, experiences, phrases, explanations, images, and/or sounds” (Birks & Mills, 2023, p. 165).

**Individual Interviews.** The following is a list of questions that were used in the individual interviews:

- 1) Please tell me the birth story of your child.
  - a. What, if anything, did you love about the birth of your child?
  - b. What, if anything, would you have changed?
  - c. What emotions did you experience?
  - d. What emotions did you observe your partner experiencing?
- 2) Please tell me about times, if any, throughout your prenatal care and during labor and delivery that you felt like your voice was heard.
  - a. Conversely, please share times, if any, when you felt like your voice was dismissed.
  - b. Please share times, if any, when you felt like your partner’s voice was heard throughout your prenatal care and during labor and delivery.
  - c. Conversely, please share times, if any, when you felt like your partner’s voice was dismissed.
- 3) What relational impact did your baby’s birth have on you and your partner?
  - a. What relational impact, if any, did your baby’s birth have on any of your other relationships (i.e., family, friends, coworkers, etc.)?

**Couple Interviews.** The structure of the couple interviews proceeded similarly to the individual interviews. Couples were given adequate time to share any stories or experiences that emerged from participating in the individual interviews. Though some of the questions are similar, the goal of the interview was to obtain the participants' experience during the birth of their baby and how it continues to impact them now. Here is a list of the questions that were used during the joint interviews:

- 1) Together, tell me the story of your baby's birth.
- 2) How has your partnership changed since your baby was born?
  - a. If you have other children, how, if at all, did adding this new baby change your partnership?
- 3) What, if anything, did you learn about yourself during the birth of your child?
  - a. What, if anything, did you learn about your partner during the birth of your child?
  - b. What, if anything, did you learn about your relationship as your baby was born?
- 4) Having gone through the experience of your baby's birth as a couple, what advice would you share with other couples?

### ***Interview Memos***

Before each interview, I printed off a piece of paper with the interview questions on it with space to record my memos. On these papers, I wrote notes of any thoughts or impressions I had during the course of the interviews. These memos, along with the transcripts from the interviews, served to create the codes and categories that emerged during the research.

### **Data Analysis**

Thornberg and Charmaz (2014) stated, “Grounded theorists gather data and conduct analysis in parallel throughout the entire project” (p. 156). When interviews began, informal data analysis began as well. This allowed future interviews to be guided by the data collected in the past. For example, I found that in the individual interviews, partners told roughly the same birth story, emphasizing slightly different aspects. Because of this, in later interviews, when I asked the couple to tell me the story of their baby’s birth again, I asked them to share a shortened version, only highlighting parts of the birth story they wanted to add that hadn’t been shared before.

### ***Coding***

Once all interviews were completed, the formal coding process began. When referencing coding, Thornberg and Charmaz (2014) posited:

Coding helps researchers to see the familiar in a new light; gain distance from their own as well as their participants' taken-for-granted assumptions; avoid forcing data into preconceptions; and to focus further data collection, including the potential of leading the researchers in unforeseen directions (p. 159).

Several levels of coding took place throughout this grounded theory study. Throughout the coding process, I utilized data from all 24 interviews. The most salient information about the process of labor and delivery emerged from the individual interviews. The individual and relational changes couples recognized since their baby was born emerged more from the couple interviews.

**Initial Coding.** Initial coding was the first phase of analysis and consisted of comparing data, line-by-line, and breaking it down into short and simple codes (Birks & Mills, 2021; Thornberg & Charmaz, 2014). Line-by-line coding was a reflexive activity where the researcher

used constant self-interrogation and began to take ownership of their data (Birks & Mills, 2021). Initial coding helps grounded theorists to comprehend “participants’ experiences and perspectives” (Charmaz & Thornberg, 2021, p. 308). During this time, the researcher can code with gerunds (noun forms of verbs that end with -ing) and/or in-vivo codes (participants’ words that capture a broader concept) to discover and remain attentive to the process and action taking place (Birks & Mills, 2021; Thornberg & Charmaz, 2014). Questions such as: “What is this data a study of?”, “What category does this incident indicate?”, and “What is actually happening in the data?” are useful at this time (Glaser, 1978, p. 57). Initial coding, along with constant comparative methods, led to the sorting and grouping of initial codes (Thornberg & Charmaz, 2014).

**Focused Coding.** The second phase of analysis was focused coding. Focused coding follows initial coding (Birks & Mills, 2021). During focused coding, initial codes are explored and decisions are made about which codes best capture what is happening in the data (Thornberg & Charmaz, 2014). These codes are then raised up to “tentative conceptual categories” which are then given conceptual definitions and the relationships between them are analyzed (Thornberg & Charmaz, 2014, p. 162). Constant comparative methods continue to be utilized to generate and refine categories (Thornberg & Charmaz, 2014).

**Theoretical Coding.** The final phase of coping to take place is called theoretical coding. Theoretical coding involves the analysis of how codes and categories previously fashioned from the data might be related to each other (Thornberg & Charmaz, 2014). These relationships are then explored as hypotheses that can be integrated into a new theory. Thornberg and Charmaz (2014) stated:

Initial and focused coding generate data-driven and empirical codes and categories by building on constant comparisons of data, data and codes, and codes and codes. In contrast, theoretical codes consist of ideas and perspectives that researchers import to the research process as analytic tools and lenses from outside, from a range of theories (p. 163).

In addition, the “theoretical codes must work, have relevance, and fit the data and generated and refined categories” (Thornberg & Charmaz, 2014, p. 165). The most salient theoretical codes to emerge were then integrated into the emerging grounded theory.

### **Trustworthiness and Credibility**

In grounded theory research, it is important to address and adopt quality criteria to establish trustworthiness and credibility for readers (Charmaz & Thornberg, 2021; Kennedy & Thornberg, 2018; Thornberg & Charmaz, 2014). Glaser (1998) presented four criteria necessary for judging the quality of a grounded theory study: workability, relevance, fit, and modifiability. Thornberg and Charmaz (2014) illustrate that questions guiding the judgment by Glaser include:

(1) Does the theory *work* to explain relevant behaviour [sic] in the substantive area of the research? (2) Does it have *relevance* to the people in the substantive field? (3) Does the theory *fit* the substantive area? (4) Is it readily *modifiable* as new data emerge? (p. 167).

In addition to the criteria named above, trustworthiness and credibility are strengthened by use of memos, auditors, and participant feedback.

### ***Memos***

Memoing is defined as “the recording of thoughts, feelings, insights, ideas, and actions in relation to a research project” (Birks & Mills, 2021, p. 247). The use of memos permeates grounded theory research and is used during every phase of the study (Birks & Mills, 2021).

Memo writing allows grounded theorists to “step back and ask, ‘What is going on here?’ and ‘How can I make sense of it?’” (Thornberg & Charmaz, 2014, p. 165). Additionally, memos permit researchers to get the ideas out—in whatever language desired (Glaser, 1978).

Throughout the interviewing and analysis processes of the current study, memos were written to record thoughts and insights into what the participants were sharing. The first memo written highlighted the importance of support. This is an example of a memo that helped to guide theory formation.

### ***Auditors***

It is common practice to use an internal auditor (i.e., a committee member specializing in methodology) to read over interview transcripts to assist in validating themes that emerge.

During the past several months, regular meetings were held with my internal auditor to ensure the process being used to understand the data was valid. As suggestions were made, I went back into the data to look for more in-depth explanations and made changes as necessary. An external auditor was also asked to review transcripts, post-interview notes, and other material related to the study to ensure a logical path was being followed. This helped to increase the dependability of the study.

### ***Participant Feedback***

Corbin and Strauss (2008) recommended that researchers using grounded theory methodology incorporate participant feedback in the data analysis. As such, once I summarized each individual and couple interview, I sent copies of the individual and couple summaries to each participant. They were encouraged to read each summary to correct anything inconsistent with their experience and add anything they felt necessary. While all were encouraged to provide feedback, responses were received for almost half of the individual interviews (n=7) and just

over half of the couple interviews (n=5). Most participants reported no changes were necessary. Nicole corrected a small transcription error in her document. Hannah requested a phone call to discuss the interviews and the positive result of participating. All feedback given was incorporated into the continuing analysis. To receive feedback on the entire model, six of the eight couples were asked to read the results section of the manuscript to provide feedback on whether they felt the model being described captured the experiences shared. The results were shared with six couples, and feedback was received from four. They were asked to do this because a grounded theory approach always seeks to elevate the voices of those studied, not the researcher. Once again, the feedback given was integrated into the emerging theory.

## **Conclusion**

Becoming a parent is a considerable event—and the beginning of a journey that lasts a lifetime (Cowan & Cowan, 2000; Zhang et al., 2024). There are many inherent joys and challenges in parenthood (Nomaguchi & Milkie, 2020). Research on parenthood, especially around pregnancy and childbirth, has largely overlooked the experiences of fathers despite the many benefits fathers bring to the pregnant mom and future family (Johansson, 2015; Sansiriphun et al., 2015; van Vulpen et al., 2021; Xue et al., 2018). To this end, a grounded theory study sought to illuminate and expound on the experiences of fathers, mothers, and the dyad during childbirth. From this study emerged a new theory of the way partners enter parenthood together and suggestions for new ways to support the family during this transitional time.

## CHAPTER 4: RESULTS

### Participants

The following table focuses on participants and some of their most salient demographic features provided for this study. Although each individual is unique, there are some commonalities shared by all participants. For example, all female participants had a vaginal birth, and all partners are the biological parents of their child. See Table 1 for an overview. For a summary of participants' demographic information as well as a summary of their most recent birth experiences, see Appendix M.

**Table 1**

*Demographic Information for Participants*

Participant	Race/Ethnicity	Living Children	Type of Relationship	Length of Relationship in Years	Birth Facility
V (1F)	White/Hispanic	3	Married	5	Hospital
Cirus (1M)	Black/Hispanic	3	Married	5	Hospital
Nicole (2F)	White/Black	4	Married	8	Hospital (triage)
Sam (2M)	White/Hispanic	4	Married	8	Hospital (triage)
Mary (3F)	White/Hispanic	1	Married	5	Hospital
Bilbo (3M)	White	1	Married	5	Hospital
Jane (4F)	White	1	Married	1	Home (planned)
Jaguar (4M)	White	1	Married	1	Home (planned)
Mercedes (5F)	White	2	Married	4	Home (unplanned)

Lincoln (5M)	White	2	Married	4	Home (unplanned)
Shantell (6F)	Black	1	Married	1	Hospital
Anderson (6M)	Black	1	Married	1	Hospital
Jasmine (7F)	Black	3	Married	12	Car (unplanned)
John (7M)	Black	3	Married	12	Car (unplanned)
Hannah (8F)	White/Hispanic	1	Dating	1	Hospital
Charlie (8M)	Other/Hispanic	1	Dating	1	Hospital

### *Contextual Factors*

Once individual and dyadic data were analyzed, a new conceptual model emerged (see Figure 1). This model has three main categories: uncertainty, support, and impact. However, while talking with participants, it became clear that to understand the experiences encompassed by the three categories, one needed to understand how certain contextual factors influenced their experiences, both individually and as a couple. Therefore, before defining each category with its affiliated subcategories, this section will highlight the contextual factors that participants described as important elements playing a role in their childbirth experience. Neblett (2013) stated, “We are the sum total of our experiences. Those experiences—be they positive or negative—make us the person we are, at any given point in our lives” (para. 11). A person simply cannot be removed from their context. When contextual factors are clarified, it becomes easier to understand the model that emerged from the data. Participants reported that past experiences and current belief systems were some of the contextual factors that influenced the recent birth experience the most.

**Past Experiences.** Throughout the interviews, participants often described past experiences and how they influenced their current birthing story. These past experiences seemed to center around three factors: pregnancy losses, negative experiences with medical providers, and previous births.

Regarding pregnancy losses Bilbo, whose wife had two miscarriages before having their baby, said, “It [referring to their two losses] was pretty tough on us...I mean, it still is, I won't lie.” Speaking of their previous losses, Mary said:

We had to do fertility treatments to get pregnant in the first place. We had a loss after our third IUI, and the other two didn't take anyway. Then we lost our son at 20 weeks and that was really hard. Because of that I was really anxious [while] pregnant.

Half of the couples had already given birth to one or more babies. For these participants, they reported feeling more experienced. V said, “She's my third [baby]. I was relieved. I'm experienced. I know what I'm doing, and I know what my body's going through.” V said her husband Cirus “reminded me, ‘This is your third time. You got this.’” Based on their previous birth experience, Mercedes and Lincoln discussed at length what she wanted for her labor and delivery. Because of this, she shared that her partner “knew exactly what I wanted. He knew exactly how I wanted things to go, what I would decide if something was going wrong.”

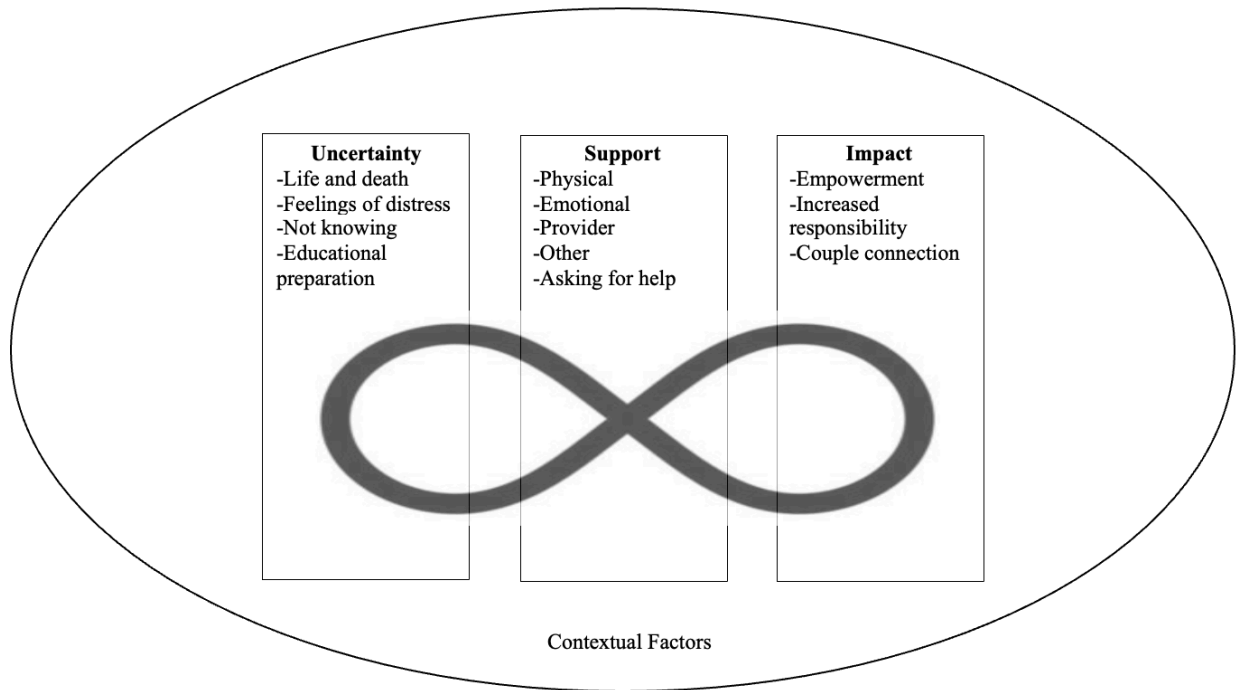
Some of the current experiences with birth, according to participants, were shaped by their past experiences. Previous loss, negative experiences with medical providers, and past births seemed to influence participants' thoughts and behaviors in areas such as preparation, expectations, and decision-making. Previous negative experiences with the medical community were mentioned by some of the participants. Jasmine, who gave birth to her most recent baby in the trunk of her car, said she was hesitant to go to the hospital “because it's not the first time I've

been dismissed [by medical providers] as far as pregnancy.” Sam named some of the negative experiences Nicole had during previous pregnancies. He said, “She had negative interpersonal interactions with other providers. [During] the C-section she had to put up with people talking about their fishing trips while they were sewing her up. The second birth she went in for follow-up [care] and the ob/gyn [said], ‘I don't even remember your baby.’”

**Current Belief Systems.** Some participants mentioned how their current belief system affected their labor and delivery. Anderson said that in preparation for their baby’s delivery, “We prayed about it. We’re gonna put it in God’s hands.” For Jane, “there was a lot of exercising my faith.” Others mentioned how creating a family or becoming a parent was something that they had looked forward to for a long time. Hannah shared that throughout her pregnancy, she knew “the moment that I was longing for and praying for and asking for was right around the corner.” Anderson, referring to his wife’s desire to have a child, said, “This is something that she always wanted...when the time was right and this was the right time. She always wanted a family of her own.” For these participants, current belief systems, such as faith in God or the desire for a child, were crucial throughout labor and delivery. For many participants, it seems these belief systems helped provide them with the hope and motivation to persist when labor was difficult. With pertinent contextual factors noted, the theoretical model will follow.

### **Theoretical Model**

While the model will emphasize three main categories, and each will be described independently, it is important to note that these three categories do not appear to be independent. Rather, they appear to be interdependent, and as a result, there seems to be continual movement (represented by the infinity symbol) between all three categories, with one category influencing the others. The model is as follows:



**Figure 1**

*Visual Diagram of the Theoretical Model*

***Uncertainty***

The first main category to emerge from the data is uncertainty. While feelings of uncertainty were reported by nearly all of the participants, how these feelings manifested themselves was different. Subcategories identified when describing uncertainty were life-or-death experience, feeling distress, not knowing, and attempts to educate themselves. Attempts to educate appeared to be a way participants tried to mitigate some of the uncertainty that comes with childbirth. Each of these subcategories will be described in greater detail.

**Life and Death.** Thirteen of the 16 participants mentioned the uncertainty of life and death that accompanies the birthing process. Bilbo said, “The miracle of life is something where we can do the best we can, but we really don’t have a choice what happens.” For him, this uncertainty was likely heightened because of the previous losses he and his wife had

experienced. Several participants alluded to the possibility of death for both the mother and the baby. Jane said, “There is not just a concern for your body, but your baby's body, too. We all know at some point it's not guaranteed for them to be okay.” Anderson recognized this same fragility of life. He said, “There's obviously a lot of traumatic experiences where the baby or the mom doesn't make it.” His wife, Shantell, echoed the same sentiment in her interview. She said, “...because not all women make it through [childbirth].”

Sam, a physician who is familiar with the health disparities often faced by marginalized populations, acknowledged that this reality is not the same for everyone. Speaking to some of the health disparities that exist, he said, “Maternal morbidity, mortality in the United States is worse compared to other developed countries...Nicole is Black, so there's like an increased risk there too.” Hannah had some underlying health conditions that made pregnancy a little riskier for her. Because of this, she had to have conversations with both her partner and family beforehand and was clear that “if we ever had the situation, if it would be life or death between me or my son...I would a thousand percent want...my son to be the one to come out.”

**Feelings of Distress.** Although uncertainty was a common experience shared by most participants, the level of intensity seemed to vary. Common feelings associated with uncertainty were nervousness, fear, and anxiety, though participants often mentioned many different emotions concurrently. Fifteen of the 16 participants expressed these types of feelings. First-time parents expressed more of these feelings, and in greater intensity, than did those who had already given birth to a child.

For Hannah, the nervous feelings increased as she got closer to her due date. She said she was “getting more and more nervous as his arrival was approaching.” Her partner, Charlie, expressed he felt similar feelings during her labor and delivery. He said, “[I] was very nervous.

[I] was nervous and scared because [I] didn't expect, or really understand how much a mother goes through during birth, as well as labor, to bring a child into the world.” Shantell said, “Every little thing was just making me nervous because I was panicking and I was afraid.” Her husband, Anderson, recognized those same feelings in himself, as well as in his partner. He said, “I was very, very, very nervous when I was in the room. I was by her bedside the whole time. She was very nervous too, again, cause this is her first child...she was very, very nervous, just dealing with the not knowing if she was gonna have to have a C-section or if we could have the vaginal birth like we put on our birth plan.”

Mary shared that these feelings existed throughout her pregnancy and during labor and delivery. She said, “I was really anxious pregnant, so I went to the emergency room six times or more.” These feelings increased during her labor and delivery. She said that while she was in labor, “I had a panic attack. I couldn't control my body. I freaked out as soon as I started having any contractions. I was crying. I was hysterical.” Her partner, Bilbo, shared that he also experienced strong feelings. He said, “I think we were really nervous to the point where it was affecting the way we think and how we act.”

Jane and Jaguar are first-time parents who chose to have a home birth. Unlike the other first-time couples, they reported very few feelings of fear or anxiety. The only feeling of distress Jane reported was that she called her midwife at the outset of her labor, “just to make sure that there [was] nothing going wrong.” Jaguar said, “There was one scare” with the baby that was rectified quickly. Those are the only two instances in which either member of that partnership reported feelings of distress during pregnancy and throughout labor and delivery. In their case, the uncertainty of being first-time parents, something that often leads to more intense feelings of

uncertainty, seemed to be offset by the fact that Jane has been a midwife assistant for almost 9 years. As a result, she had a lot of experience with the birthing process and what to expect.

While uncertainty tended to be less intense for parents who had multiple children, that uncertainty increased if elements of their birthing plan were unexpected/unplanned. Jasmine and John reported feeling the most distress among couples with multiple children. Jasmine described herself as “a deer in headlights” and said her husband “looked like he saw a ghost.” John described his feelings about his third baby’s birth as “the only one I truly was freaked out about.” He said he felt “fear, that we're gonna lose our child or had already lost her. [A] majority [of] fear and anxiety.” A large portion of this fear centered around the fact that they ended up having an unplanned and unassisted delivery.

Mercedes and Lincoln, who also had an unplanned, unassisted delivery, reported some feelings of distress. Mercedes said she felt “apprehensive.” Lincoln reported he felt “good anxiety” during his son’s birth, though he did say he wished he “wasn’t as panicked” in the moments after his son was born.

**Not Knowing.** In addition to the feelings of distress named, thoughts of not knowing what to do or what was going on were voiced by nine of the 16 participants. Both women and men expressed this uncertainty, though fewer women expressed their own uncertainty. V, one of the women who expressed some not knowing, shared some of her thoughts with the nurse. She said she told the nurse, “Let me know what’s happening.” Shantell said, referring to the labor process, “I didn’t know what to expect.” Two women reported observing that it was their partners who did not know what to do. Jasmine said her husband felt “helpless because it's like he didn't know what to do. He's not medically inclined whatsoever.” Shantell said her husband “didn't know what to expect.”

While not knowing was present for some of the women, it appeared to be a major factor in the experiences of the fathers, especially those going through the process for the first time. Feelings of not knowing were expressed by four out of four first-time fathers. This suggests that first-time fathers may experience higher feelings of not knowing than those who have already gone through the experience before. Bilbo voiced his thoughts very clearly. He said when they arrived at the hospital, his thoughts were:

What needs to happen next? What do we need to do? What is the plan? You need to tell me the plan so I'm not in the dark. As long as that happens, I'm good cause I know what to do. I kind of know what to expect. I tend to find comfort in the knowns.

Anderson expressed similar thoughts, noting that his inexperience in this situation was contributing. He said:

It was just me being a first-time dad, there was a lot of things that...I didn't know about a lot of things. I was fearful because I was just not in the know of what's gonna happen, what the future holds and different things like that.

This feeling of not knowing was not just limited to the birthing experience. Charlie, also a first-time father, voiced how his not knowing also extended to the future. He said, “[I] wasn’t sure if [I] had what was necessary to provide a good future for [our baby].”

**Educational Preparation.** One step it seems that partners took to reduce their feelings of uncertainty was to prepare for labor and delivery by gaining knowledge about childbirth. Levels of preparatory knowledge, especially for the male partner, appeared to influence participants’ experiences. Lincoln shared that he’d “done enough preparation and [taken] quite a few first aid certification classes, so I wasn’t worried about anything really going wrong.” Hannah said she loved “how prepared my partner was to advocate for me.” Shantell, speaking about her husband,

stated, “I knew he was ready, and he was well prepared because we took the classes and we knew all the questions to ask.” For participants, the educational preparation they or their partners had engaged in before delivery was invaluable to their experience.

The first category described by participants was uncertainty. A majority of the participants described feeling quite nervous and anxious about the birthing experience. These feelings seemed to be more intense for first-time parents and parents who had an unanticipated complication surrounding the birthing process. Also, while many participants described feeling uncertain about what to expect, especially around the fact that birth was potentially a life-or-death situation, fathers specifically expressed uncertainty about not knowing what to do. This was a feeling described by both the male participants and shared by many of their female partners. It appeared that they, in particular, were looking for guidance on what to do in order to be useful. While participants clearly acknowledged their uncertainty, and the lack of control they truly felt, many of the participants did what they could to help reduce their felt anxiety. This included taking classes and other educational measures to feel as prepared as possible.

### *Support*

The second category to come from the data was support. In the present study, 15 of 16 participants referred to the support they either gave or received. According to participants, this support centered around four specific types of support: physical, emotional, provider, and others. Support appears to be so vital during this transition that 11 of the 16 participants mentioned support explicitly. In total, the word “support” was named over 50 times in the 24 interviews conducted. The ability to receive support seemed to also be influenced by participant’s ability to ask for support, which some were able to do more openly than others.

**Physical Support.** Some of the moms talked about the physical support their partners provided for them. Jane said her partner's job was to "keep me hydrated, bring me lots of food, [and] lots of broth." Mercedes talked about how Lincoln used a "shoulder release, so it would cue my body to relax during labor." Mercedes said that Lincoln also used "a little bit of counterpressure" on her hips during her contractions to help ease her pain. V said her husband Cirus was "like one of those birthing coaches, cause he was with me in every contraction. Every time I called him over, he would come, he'd hold my hand, and he'd breathe with me."

**Emotional Support.** Many of the moms also mentioned the emotional support their partners offered. Shantell recalled her partner saying to her, "I'm gonna let you go through your emotions. I'm here; you need me, I'm here." Speaking of the support her partner gave her, Hannah said, "He was very observant and he was very much present. It was very reassuring that he was like that during my labor and delivery." Jane said her husband was "right there with me the whole time."

Seven of the eight dads talked about the support they gave to their partners. Bilbo, one of the first-time fathers, wanted to support his wife during her labor but was unsure how to proceed. He said:

I didn't know what to do. I was asking a nurse, what does everybody else do in this situation? And she said, honestly, most of the men sit over there and go to sleep because they're so tired. I was like, there's no way I'm sleeping. So, I was helping push, or helping her do her thing, or whatever she's doing.

Anderson, another first-time dad, said, "I was very, very supportive of my wife...I had to just tap in and be her support system during this time."

For Cirus, it was important to provide continuous support to his wife throughout her labor and delivery. He said:

I'm talking to her the entire time. I didn't stop, I can't stop, and I told her that I wouldn't stop. It's a matter of breathing with her, being with her in that moment. You have to have the same heart rate. You have to have the same breath. You have to run out at the same time. You have to bring it on at the same time. You can't just wait til one cues it on and then act like you want to hop on in. You're on the same frequency the entire time.

**Provider Support.** Providers were also pivotal sources of support, with 11 of the 16 participants mentioning favorable interactions. At one point during her labor, Mary felt ready to quit and asked if her doctor could just cut her baby out. Mary said her doctor supported her. She said:

[The doctor] talked to me and treated me like a person. [She] didn't go in there and say, no, you're crazy or anything. I just felt like even there, I didn't get what I wanted, but I felt like she actually heard me out [and] treated me kindly.

Nicole had providers that supported her desire to give birth vaginally even though she had a previous C-section. She said her providers told her, "Whatever you want, ma'am" rather than forcing her to follow a preset course of action. Mercedes mentioned a similar sentiment from her providers. Her providers told her, "We're here to help, here to support you."

As a young first-time mom, Hannah reported she was supported because "my questions were being answered by the doctors. Any questions or concerns that I had, they would answer, and they would guide me through the whole process and what to expect." Jaguar spoke highly of the support given to him and his wife by the midwife and her assistant. He said, "The team did a good job at being able to respond and [be] helpful."

Though most of the participants reported positive interactions with providers, three of the women spoke about providers' behaviors that were not supportive. Shantell hated the cervical checks her providers insisted on conducting. She said, "I didn't like them [to] keep putting their fingers in to check me." When Mercedes arrived at the hospital in shock after giving birth at home unintentionally, one of her midwives shamed her and said, "Well, you didn't follow the rules. We tell you not to wait to come to the hospital." That was "a little off-putting" for Mercedes since the midwife had never given specific instructions on when to come. Jasmine felt like she had to fight for support for the kind of prenatal care and birth that she wanted. She said her provider was "rude and offsetting" and used a "scare tactic" to force interventions Jasmine did not want. Jasmine said:

[My provider] was upset about not doing cervical checks. I'm just like, I don't need [a] cervical check in order for my baby to be fine or [be] delivered. I feel fine. The baby's fine. And I just felt very dismissed. What put it over the edge was the constant nit-picking about me being induced when I'm fully healthy.

When asked if her feelings of provider dismissal led to her delay in coming to the hospital, Jasmine responded, "Absolutely."

It is important to note that all three of the Black women in this study reported some of what Sam referred to as "negative personal interactions" with their providers. For Nicole, these interactions occurred during a previous pregnancy. Jasmine said she avoided going to the hospital for the very reason that she had been dismissed during a previous pregnancy and her most recent one. Shantell hated the cervical checks her providers insisted on conducting. This data implies that the Black women in this study may have been affected by racism, which affects the type and quality of healthcare Black women receive (Markin & Coleman, 2023).

**Other Support.** Four of the participants spoke about support that came from others. V's mom was able to attend her birth and V loved that she was there. V, speaking about her partner, nurse, and mom, said, "It was the people that were there for me. I need those people. To push me through the pain and through the experience. I had the people that I needed while I was giving birth." Jasmine's husband was at work until just before she delivered, but her mother-in-law was on the phone with her, supporting her. Jasmine said, speaking about her mother-in-law, "She's timing my contractions. She's breathing with me over the phone." Two participants spoke about support that came from a higher power. Shantell said, "God saw me through everything." Lincoln reported he could feel a "spiritual presence there to help" that was "calming me."

**Asking for Help.** The support received was influenced by the ability to ask for help. The four multiparous women mentioned the concept of help differently than did the rest of the participants. V was clear with her nurse about the help that she wanted and needed. She said, "Please, don't go. Please, can you just stay here and let me know what's happening?" V reported that her nurse's response was, "I will not leave this room, okay? I'm gonna stay here with you until you don't need me anymore." V asked for help from her husband as well. She said, "Every time I called him over, he would come. He'd hold my hand and he'd breathe with me." Mercedes was also clear about the help that she needed from her husband. She went into labor in the middle of the night while her husband was sleeping. She said, "I woke up Lincoln, and said, 'We're having a baby today. I need your help.' He woke up half delirious and he started supporting me through contractions with counterpressure."

Jasmine had a different experience. Her husband is in the military and was at work when she went into labor. He mistakenly thought there was more time before his wife would deliver and did not come home when she asked him to. Because he did not come home when she asked,

they left too late for the hospital, and she delivered in the trunk of the car. Her statement to him about this was, “You had one job, get to the house when I called you the first time.” Her request for help was not met in a timely manner.

Nicole arrived at the hospital minutes before she delivered, barely making it into the triage room before her baby was born. Her husband is a resident physician and is not often home due to his busy work schedule. Though he was present for the birth, she did not report asking him for help at that moment. She said, “he helped make this baby, but it was really me doing most of the work, which is like perfectly fine by me. It's my show.” She said, “I learned that I could just push out a baby because I didn't really need much help from anybody.” Of these four women, three of them asked for help. Two received the help requested, but one did not. The fourth woman did not ask for help and did not receive help.

Participants described the importance of support. They specifically described the importance of physical and emotional support they received from their partners, the medical providers, and others. While this level of support was described by several participants, there were a few who did not receive the support they needed, either from their partner or the medical providers. Women (and couples) who had been through the birthing process before seemed to feel more confident asking specifically for what they needed. As they were able to make those requests more clearly, either to the partners or the providers, it helped others respond in a way that was consistent with their needs, thus creating this positive cycle of support because they felt their needs were being met.

A good example of this positive cycle of support was shared by Mercedes and Lincoln. Mercedes shared how she asked for Lincoln's help. She said that while she was laboring, her partner “was running around the house. I'm telling him what to pack between contractions and

then I'm shouting downstairs, 'I need you. There's another one coming.' And he just [came] right up and I was very, very appreciative of that." Lincoln emphasized how he tried to support his wife with what she asked of him. He said, "My wife did a good job listening to her body, and I tried to do a good job listening to her."

### ***Impact***

While many of the participants acknowledged that the baby had changed their schedules or cadence of life, including lack of sleep, there were two impacts that were specifically mentioned by several of the couples. The first messages centered around the individuals. For women it was an increased feeling of empowerment and for men it was an increased feeling of responsibility. Second, was an increased couple connection that helped bring the couple closer together as they worked together as a team.

**Empowerment.** Seven of eight women reported positive individual impacts after giving birth. Six of eight females said they felt stronger or more empowered. V said she learned, "It's strength...I am strong." Hannah reported she learned, "I'm a lot stronger than what I had perceived myself to be beforehand." Shantell said, "I would say, compared to my younger self, the woman I am today, it doesn't even compete with my younger days. I'm much stronger, much wiser, [and I have] more compassion." Mary learned, "I can do hard things even when I want to quit." Jane spoke about the "sense of accomplishment" she felt after having her baby. She said, "Now there is that experience no one can take away that I share now with mothers."

This level of strength seemed to be magnified to a level of empowerment when the women were forced, through circumstances, to deliver their babies without medical intervention. Nicole, who went to the hospital hoping for pain relief, did not make it in time. She said, "That's kind of empowering. I had that baby. No doctor [was] needed to catch my kid." Mercedes, who

unexpectedly delivered her baby on the toilet at home, said, “There’s truly nothing more empowering than catching your own baby.”

**Increased Responsibility.** While a common expression for the mothers was empowerment, the prevailing message from the dads was increased responsibility. Many of the fathers talked about feeling the need to be more responsible now that they are a father. This was especially true of the first-time fathers.

All four of the first-time dads reported a change in their feelings of responsibility. Charlie said he has a “bigger responsibility now than it was back then [before my son was born].” Jaguar reported he and others now view him as an “adult-adult” because he is a dad. Bilbo said:

Having a baby is great. Having a family is awesome, but it’s work. It is real, actual, hard work, both physically and emotionally. Not only with your child but with your spouse...But, definitely, if you're willing to put in the work, it’s worth it.

Anderson said he has learned about:

...being a leader. Knowing that there's a bigger purpose here other than myself. It was the wife first, but now [it's] the baby I'm caring [for], and I have to be a great father [and] a great leader for both of them.

In addition to individual impacts, the relationship of the dyad changed as well.

**Couple Connection.** Six of the eight couples reported positive relational impacts since having a child, though most of those also reported a difficult period of transition. Words like “closer”, “solidified”, “bond”, and “team” were used to describe the positive changes. Mary said, “I felt really bonded after the labor part. I just feel like we were really close, closer, through the experience.” Mercedes shared how their son’s birth “solidified just how much of a team we are.” In response, her husband Lincoln said, “I agree with that...teamwork, and being able to trust

each other too.” Cirus shared some beautiful words about the impact of his daughter’s birth on his relationship with his wife. He said, “I would say [our daughter’s birth] acted as a very, very good cure for our relationship. Think of [an] adhesive and [how] it cures itself over time...A lot of that can help solidify [a] long-term relationship.”

Both the mothers and fathers discussed some important changes that occurred in their lives as a result of the birthing experience. The mothers focused heavily on the individual strength they felt as they completed the physically and emotionally difficult task of giving birth. Many even mentioned how empowered they felt. Fathers, on the other hand, seemed to emphasize the increased responsibility they felt as they became even more of an “adult.” Both partners discussed their relationship and how much stronger it was as they survived this experience together.

### ***Interrelated Connection between Categories***

While it is important to understand each category independently, the experiences described by the participants suggested an interrelated nature between these variables. Thus, the visual diagram of the model (see Figure 1) shows an infinity symbol to capture the continuous flow between variables. Though it is easy to understand the interconnected nature of the categories of uncertainty and support, it may be useful to zoom out to better understand how the category of impact is also integrated. When one broadens the context of the impact of a baby’s birth on the relationship, one can see that for some couples, talking about the birthing experience may help to decrease relational uncertainty and increase support for each other all of the time, not just during the birth of a child.

For participants, the higher the level of uncertainty they experienced throughout pregnancy and during labor and delivery, the greater the need for support. It seems that the more

support both women and men received, the more positive the experience was. When the experience was positive, the impact on the individual and the couple was better. Those who felt more supported were able to more clearly state their needs, and as a result, it was more likely that their needs were met, also making the experience more positive. This seemed to be especially true with first-time parents who often reported not knowing what to expect. The more support they received from each other, and the medical providers, the better prepared they felt and the less anxiety as well.

Fathers seemed to especially feel a level of responsibility for their partners and wanted to be present for them in a meaningful way. However, often, they did not know what to do and appreciated any guidance that was provided, either by their partner or the providers. This quote was previously shared but illustrates well the guidance first-time fathers seek from medical providers. When Bilbo and his partner arrived at the hospital, he asked the providers:

What needs to happen next? What do we need to do? What is the plan? You need to tell me the plan so I'm not in the dark. As long as that happens, I'm good cause I know what to do. I kind of know what to expect.

For Bilbo and his partner, the medical providers provided the support they both needed in their time of uncertainty.

While many of the participants reported a positive birthing experience, there were a few who did not. Participants who had a less positive experience still experienced moderate levels of fear and uncertainty. However, for these couples, they either expressed a need and it was not met or they did not feel comfortable enough to even express their need. For these couples, the female partner did not feel support, either from the partner ("He helped make this baby, but it was really me doing most of the work") or the medical providers ("It's not the first time I've been dismissed

[by medical providers] as far as pregnancy.”). These women may have felt some of the individual strength associated with completing an amazingly difficult experience, but they did not report the same level of positive relational change expressed by others.

This may be further illustrated by comparing two couples who differed significantly in the support provided. V’s partner, Cyrus, spoke of the continuous support he provided. He said, “I’m talking to her the entire time. I didn’t stop, I can’t stop, and I told her that I wouldn’t stop. It’s a matter of breathing with her, being with her in that moment.” For Jasmine, her partner John was not there for her. She said to him, “You had one job, get to the house when I called you the first time.” Of this experience, he said, “I realized the time I thought we had [until the baby was born] had already passed while I was at work. By the time that realization was made, [our] baby was already here.” When asked what he loved about the birth of his child, he said, “nothing” because he didn’t get to see his baby’s birth.

Contextual factors also seemed to influence the participants and the experiences they had. First-time parents appeared to feel much higher levels of uncertainty and, therefore, needed higher levels of support (van Vulpen et al., 2021). This was also true for participants who had lost a baby previously or had other negative experiences with medical providers. Ironically, mothers who had been through the experience before, were able to ask more directly for their needs to be met. This may be because they knew what to expect or were not experiencing as much uncertainty. Now that the results have been presented, a discussion of the findings will follow.

## **CHAPTER 5: DISCUSSION**

The purpose of this chapter is to connect the emerging theory with existing literature and to formulate provisional hypotheses based on the findings. Completion of these steps is necessary to develop a theory that is grounded in both the literature and data from this study. Once these steps are completed, the remainder of the chapter will focus on clinical implications for marriage and family therapists, implications for medical systems, including providers, the strengths and limitations of the current study, and directions for future research.

### **Existing Literature**

Early research on childbirth focused primarily on the mother (Cabrera, 2019; Nomaguchi & Milkie, 2020). A shift was later made to include the voices of fathers (Cabrera, 2019).

However, as some researchers have stated, because the entry to parenthood is something that usually happens to both members of a partnership, it is important to include the voices of both parents as well as the couple (Cowan & Cowan, 2000; Iles et al., 2011). Dyadic data about childbirth is rare and one of the primary contributions this study makes. By incorporating the voices of both the male and female partner, as well as the couple together, the transition to parenthood can be more readily understood (Cowan & Cowan, 2000; Iles et al., 2011).

To help understand the findings of the current study, it might be helpful to consider this model from an attachment perspective. Attachment theory suggests that humans have a primary, biological need for emotional connection (Cassidy & Shaver, 2016). This attachment need is often activated during times of threat or uncertainty. When attachment processes are activated, humans seek comfort and reassurance from those they are close to. Once individuals receive this comfort and reassurance from an attachment figure, they are soothed, and feelings of distress are calmed (Cassidy & Shaver, 2016; Gingras et al., 2021). As participants in this study described,

the transition to parenthood is a period that is replete with uncertainty, anxiety, and fear. From an attachment perspective, moments of uncertainty often activate attachment needs (Cassidy & Shaver, 2016; Gingras et al., 2021). Based on the feelings shared by participants, it is likely attachment needs of both women and men were activated during pregnancy and especially throughout labor and delivery.

Life transitions are often times of uncertainty, and few other life transitions carry the uncertainty that childbirth does (Cassidy & Shaver, 2016; Halchuck et al., 2010). These feelings of uncertainty were expressed by nearly all of the participants in the current study. Both women and men felt uncertainty about the lives of both the baby and the mother. Participants shared this uncertainty manifested in feelings of distress such as nervousness, anxiety, and fear. For dads, this was compounded by added uncertainty. In the current study, this feeling manifested as not knowing. New fathers worried they would not know how to meet the needs of their partner during labor and delivery. Many understood the physical and emotional significance of this event for their partner and were worried that they would not be there sufficiently for their partner. Additionally, they worried that they would not be able to sufficiently provide for the baby or the new family unit. These worries likely stem from societal messages men receive about needing to be good providers. This is reflected in the added responsibilities men shared that they felt.

Because nearly all participants reported feelings of distress, it is safe to assume, as mentioned above, attachment needs were activated in all partners. Attachment theory helps provide some insight into how people respond when their attachment needs are activated (Cassidy & Shaver, 2016). Past experiences play an important role in the response people have. Those with negative experiences either become anxious or avoidant, whereas those who are secure are easily comforted and reassured (Cassidy & Shaver, 2016). Several participants in this

study mentioned past experiences, whether it was previous losses or negative experiences with the medical system, that increased their uncertainty during childbirth. These past experiences increased the level of support needed by participants.

In childbirth literature, it is clear that women benefit from support (Bohren et al., 2017). What the current literature does not say as clearly is that men need support as well (Iles et al., 2011). One of the things that makes childbirth so difficult for a partnership is that everyone knows the woman needs support and wants to provide it for her. This can be challenging for her male partner, though, because he is often activated also and does not know how to help her nor how to help himself. This is important because, as was shared by the participants, the birthing process is a critical time where multiple attachment-based needs are occurring simultaneously. Uninformed couples can often unintentionally have attachment miscues that potentially create harm by misunderstanding one another's needs.

Not knowing how to respond or being afraid to fail was a clear message shared by these fathers. These concerns are likely informed by societal messages about traditional masculinity men often receive about the need to be self-reliant and competent. (McDermott et al., 2019). However, it comes at a time when their partners are overwhelmed by their own physical and emotional needs. As a result, partners may not have the physical or emotional bandwidth to acknowledge the male partner's attachment needs. Fathers' needs, often ignored during the birthing process, may lead them to deal with their own attachment activation by withdrawing or avoiding. This may result in him not being present for his partner. These feelings can often be magnified during medical visits and the birthing process because medical providers often do not actively create space for the father or try to understand his responses (Johansson et al., 2015). This sentiment was captured potentially by one father who mentioned a nurse told him that most

fathers were asleep in the corner. Since the primary focus is on the mother's well-being, the medical system, as well as the partner, often misinterprets the male partner's responses as being uninvolved or unavailable.

In this study, fathers reported that medical providers who stepped in and provided clear guidance on how to most effectively help their partner helped them feel less uncertain and, therefore, more confident in their ability to be present. Additionally, when the female partner was able to ask for the kind of support she needed, this also helped the male partners to feel needed and more successful. It appears that when male partners know how to help, it increases their ability to remain actively present for their female partners, and a positive systemic interaction occurs. This often results in the female partner being soothed because she does not feel alone in her pain and suffering. When the pair are actively working together to get through the birth, positive individual and relational impacts are seen.

Participants seemed to note this as well. Cirus likened the experience of going through childbirth with his wife to adhesive for their relationship. Many of the participants reported the experience strengthened or solidified their bond. What these participants shared suggests that responsiveness during a critical, intense time can be bonding and strengthen or deepen the attachment already there. This is especially true when the partnership feels similar support from medical providers. When the birthing partnership is viewed and treated systemically, everyone benefits.

While many of the experiences shared resulted in increased strength for the female partner and increased connection for the couple, it is important to discuss the few experiences that did not. Attachment injuries are a concept that describes what happens when an attachment figure is not available during a person's pivotal time of need. These injuries often result in

partners developing a “never again stance” (Johnson et al., 2001, p. 145), often refusing to be vulnerable because they lack confidence that their partner will be there for them. These injuries can often be difficult to process and become a new internal working model for self and others (Cassidy & Shaver, 2016; Halchuk et al., 2010). Two of the experiences described in this study could potentially be classified as attachment injuries. Nicole did not report asking for help and ended up sharing that she gave birth by herself. Jasmine shared how her partner failed to do his “one job,” and as a result, she was alone as she birthed her baby in the back of her car. As a result, she did not share the same positive outcomes described by other participants.

Given the central role of the mother in the birthing process, it is likely easier for clinicians and other professionals to properly identify potential attachment injuries surrounding her experience. This research, however, acknowledges two types of attachment injuries that might be harder to recognize. First, attachment injuries may not be isolated to romantic partners. Several females described how they waited to seek medical care because they did not want to be “that girl.” This resulted in one participant having an unexpected home birth because she was not able to make it to the hospital in time. Negative past experiences with the medical community led to distrust or apprehension to reach out for fear of being turned away. As was highlighted previously, all of the Black female participants described negative experiences they had with medical providers that contributed to their current birthing experience. Similar to their experiences with their partners, some of the participants shared their needs with the medical providers but felt those needs were either ignored or not met. The lack of responsiveness to their need reaffirmed feelings they had already felt, and decreased the level of support they felt from others.

Another important consideration is the possibility that fathers may be experiencing silent attachment injuries. Due to the central focus on the female partner, many men might have attachment-based needs that go unacknowledged. However, since the focus tends to be primarily on the partner, they likely do not feel it is appropriate to express those needs. These feelings might be reinforced or magnified by the lack of recognition by the medical community. Couples and providers might benefit from understanding these dynamics better so they can increase their attachment-informed responses and provide the necessary support that might decrease the number of attachment miscues that can potentially lead to attachment injuries.

### **Provisional Hypotheses**

Once the emerging theory is embedded in existing literature, provisional hypotheses can be formed. In this case, five tentative hypotheses will be presented. Though these hypotheses are closely intertwined, they will be described independently. These are the five hypotheses:

1. Not knowing is a common feeling new parents experience.
2. First-time parents experience more uncertainty and, therefore, need more support all around.
3. Parents who have experienced previous loss (i.e., miscarriage, stillbirth) need more support than those who have not.
4. As parents know how to state their needs and ask for help, the likelihood of having their needs met increases.
5. When partners are able to meet each other's needs, there are positive individual and relational impacts. Conversely, those who do not receive the support they need are more likely to experience an attachment injury.

As is true with many theories, the process is not linear. The following is one possible way these hypotheses may be interrelated.

Many of the participants shared their feelings of uncertainty, including not knowing. For the women, it was more about not knowing what to expect or how they would handle the process of labor and delivery. For men, they were more uncertain of how to meet the needs of their partner. Additionally, men expressed more feelings of not knowing if they would be able to continue to meet the needs of their partner, as well as provide for their new child. Because new parents have never navigated this process before, more uncertainty may be present for both. This means they need more support from outside sources, relying heavily on people who have been through this process before (i.e., medical providers), as they navigate childbirth together.

The level of uncertainty, anxiety, and fear appears to be much higher for parents who have experienced previous loss or had negative experiences with the medical community. Because of this, they need increased support from medical providers throughout pregnancy and during labor and delivery. Lower levels of uncertainty and fear were reported by parents who have previously birthed a child. Knowing what to expect allowed them to know what they needed during the perinatal period and ask more specifically for those needs to be met. By asking for specific help, their partners and providers were often able to better meet their needs. When partners were actively present and successfully met one another's needs, more positive individual and relational impacts were identified. These feelings were greatly enhanced when the couple jointly felt supported by the medical community. In the few instances when partners expressed their needs and those needs were not met, less positive impacts were felt.

### **Clinical Implications**

The purpose of this study was to further understand how partners transition to parenthood together and provide some guidelines for marriage and family therapists who work with couples navigating this transition. There are three lessons clinicians can learn from this study, and applying attachment theory may help clinicians conceptualize the process of each.

Attachment theory stresses the importance of emotional attunement between partners (Cassidy & Shaver, 2016). This is especially important when one or both partners are experiencing an activation of their attachment needs. Because both partners likely have needs activated throughout the course of the perinatal period, clinicians can teach couples the importance of attuning to each other. What often happens during this period is that because the woman is the one who is pregnant, both partners prioritize meeting her needs. Though this is important, it often means the male partner has needs that go unmet. This is not to say we should stop meeting the pregnant woman's needs, but rather, expand our view of care for the entire family system. Often, the male partner simply needs to feel like he is an important part of the process. Women can aid this by asking for what they need and giving their partners specific tasks to complete. Clinicians can assist couples with this by facilitating open conversations about what the partnership (not just the woman) wants throughout the perinatal period, focusing especially on labor and delivery.

After their baby is born, couples may also benefit from discussing their birthing experience with each other. In a post-interview call, Hannah shared how meaningful the interview had been for her and her partner. During their interview, Charlie called Hannah a "warrior" for what she endured during the labor and delivery. The couple had not ever processed the birth of their child to the level done in the interview. When Charlie highlighted the strength he saw in his partner, it helped to solidify the empowerment Hannah felt. Hannah also reported

that the interview led to deeper conversations between her and her partner, which helped to improve their communication and gave them a push to move their relationship forward. Hannah recommended all partners be able to talk about their birth story in the same manner. Clinicians are in a position to facilitate conversations like this with clients to help them process their birthing experience. By doing this, partners can both become more aware of the other's needs and strive to meet those needs to the best of their abilities.

For couples who have recently given birth and may be struggling to navigate the transition to parenthood, it can be helpful for clinicians to be mindful of attachment injuries that may have occurred during pregnancy or childbirth. Attachment injuries are common during life transitions, and the transition to parenthood is no different (Cassidy & Shaver, 2016). An example of this may be Jasmine and John, who gave birth in the trunk of their car. Jasmine asked for her partner to come home when her contractions began, but he did not come right away and, as a result, missed being an active part of the birth. Both Jasmine and John independently expressed their frustration over the situation. By identifying an attachment injury in struggling couples, a clinician can help them resolve the injury using the Attachment Injury Resolution Model (Sandberg & Schade, 2012). It is important for clinicians to remember that resolving the injury does not just mean helping the victim find healing, but, once that is done, also enabling the victim to see how they may have hurt their partner as well (Sandberg and Schade, 2012). For Jasmine and John, resolution would mean that John is able to meaningfully apologize to Jasmine for not coming home in time, but also that Jasmine could apologize for her behavior that subsequently hurt John.

### **Medical Implications**

In addition to recommendations for clinicians, this study suggests three implications for individuals working as medical providers or in medical systems that serve individuals during the perinatal period. Some of the participants discussed avoiding the hospital because of potential embarrassment or shame about being turned away because they were not in active labor. Providers who work in triage services could do more to improve sensitivity to women who come to the hospital with symptoms they believe are indicative of impending childbirth. This is understandably a difficult task, given that medical systems are often understaffed and overworked (Suran, 2023). One way to mitigate this a bit may be for midwives and ob/gyns to be more explicit and detailed about what symptoms warrant coming to the hospital. This is especially pertinent information for first-time parents who have never been through the birth process before and carry a lot more uncertainty about childbirth than do experienced parents.

The uncertainty first-time parents often feel also means they frequently need more support from medical providers (van Vulpen et al., 2021). Partners who have experienced previous loss are susceptible to this increased uncertainty as well. This uncertainty often manifests during labor and delivery when both women and men likely arrive at the hospital unsure of what to do or what the birthing process looks like. Nurses are often the providers who spend the most time with these patients and are best poised to provide this added support (Bohren et al., 2017). Participants in this study shared that it was most helpful when nurses patiently answered all of their questions, honored their birth plans, and stayed by their side when labor became intense. This may be another difficult task for providers, especially in situations when nurses are assigned to care for more than one patient at a time (Bohren et al., 2017).

A final recommendation for medical providers is to include the father as an important member of the birthing team. Alluding to this, Mercedes said her husband was “very much

recognized as a partner in the whole thing, and not just a ‘baby daddy.’” Research shows that men often feel marginalized or left out of the birthing process despite wanting to play an active role (Jouhki et al., 2015). If nurses, midwives, and doctors could slow down their interactions just enough to focus on both of the parents individually, instead of just the mom, dads may feel like they perform a vital role instead of just warming a chair while they wait for their partner to give birth. Helping providers become more attachment-informed may help them understand the importance of expanding their definition of “patient” and treat the entire system together. This may open space for the male partner to be even more engaged in the room, thus creating more positive outcomes for the mother and for the couple.

### **Strengths and Limitations**

This study has a number of strengths that allow it to contribute to the body of literature about partners transitioning to parenthood. First, all participants were interviewed individually and as a partnership. As has been mentioned previously, qualitative data that includes the voices of both mothers and fathers is rarely found in the current body of literature. Second, participants were from a variety of racial and ethnic backgrounds. The percentage breakdown was as follows: Black 25%, White (Hispanic or Latinx) 31%, White (not Hispanic or Latinx) 31%, Black/White 6%, and Black/Hispanic or Latinx 6%. Third, half of the women were nulliparous; the other half were multiparous. Fourth, participants’ relationships varied. Seven of the couples were married, and one was dating. The length of these relationships varied as well, spanning from one year to 12. Fifth, participants also had a wide array of birth experiences. Types of birth by percentage were: planned hospital birth 62.5%, unplanned home/other 25%, and planned home birth 12.5%. Lastly, 37.5% of participants delivered their child in a manner that was much different than what they had originally planned (i.e., triage, home, car).

Notwithstanding the strengths of the current study, there are limitations to be aware of. The number of participants in the study was small. Only 16 individuals and eight partnerships were interviewed. Typically, a grounded theory study would aim for at least 10 partnerships in a study like this, bringing the total number of interviews up to 30. This study only conducted 24. Additionally, a large percentage (87.5%) of the sample was taken from only one geographic location, though none of the babies were born in the same facility. Also, all of the women volunteered to participate gave birth vaginally without instrumentation. Several attempts were made to include women who had C-sections or instrumental births (i.e., forceps, vacuum) but none agreed to participate. Finally, all couples were in heterosexual relationships with the other biological parent of their child. None of the participants interviewed identified as members of the LGBTQ+ community. Because of these limitations, one should be cautious in assuming the generalizability of the findings to all people who make the transition to parenthood.

### **Future Research**

Even though theoretical saturation was achieved in this study, the theory that emerged is still tentative and needs further validation. Several limitations exist and must be addressed before this theory is complete. The first two are shown in Table 2.

**Table 2**

*Different Types of Deliveries*

	<b>Typical delivery</b>	<b>Delivery with unexpected difficulties</b>
<b>Positive experience</b>	5	1
<b>Mixed experience</b>	0	1
<b>Negative experience</b>	0	1

The biggest limitation of this study that requires further research is that none of the participants had a C-section or instrumental delivery. Unplanned C-sections and vaginal deliveries with vacuum or forceps are typically utilized only when something has gone wrong with either the mother or the baby, and the baby must be delivered immediately. In these situations, there is likely an increased amount of fear and uncertainty because either the baby's or mother's life is in danger. Though there were unexpected difficulties with some of the participants' deliveries, none were emergent situations. It is possible that when emergencies arrive, partners may have different needs and require a different kind of support than what this current theory proposes.

Because five of the partnerships had typical deliveries and reported favorable outcomes, this emerging theory is incomplete. Additional research is necessary in order to increase the voices of those who had typical deliveries but mixed or negative experience. It is possible that those who had mixed or negative experiences did not want to share their birth stories and, therefore, did not volunteer to participate. Further research is needed to address this gap and verify the theory fits with all experiences.

A final limitation and suggested area for future research is incorporating the birthing experiences of the LGBTQ+ community. Individuals who are members of sexual and/or gender minorities often desire to bear children and are frequently marginalized or erased in perinatal spaces (Griggs et al., 2021; Kukura, 2022). Marginalized populations often experience stress due to their status as a minority, and this stress sometimes manifests in health disparities (Everett et al., 2019). Additionally, medical providers do not always meet the needs of these individuals, either because they are unaware of how to do so or choose not to (Kukura, 2022). As future

studies address the gaps left by the current study, the emerging theory can be better adapted to address childbirth for all parties.

## **Conclusion**

This study provides valuable insights into the complexities of the transition to parenthood, particularly by emphasizing the importance of considering both partners' experiences and attachment needs. The inclusion of both partners contributes to a deeper understanding of the process of childbirth for men and women. Attachment theory has proven to be a useful framework in helping to conceptualize how both mothers and fathers experience activated attachment needs during this period of uncertainty and stress. This research underscores the significance of providing support not only to the mother but also to the father, whose needs are often overlooked despite their vital role in the process.

Despite the limitations of the current study, this research provides important clinical implications for marriage and family therapists, as well as medical providers. Clinicians can apply the findings to foster greater emotional attunement between partners and help them navigate attachment injuries that may arise during childbirth. Medical providers, particularly nurses, midwives, and ob/gyns, can also use these insights to improve support for both parents. By continuing to explore and validate the emerging theory, future research can further enhance understanding of the transition to parenthood and the support needed to ensure a more positive experience for all involved.

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## APPENDIX A: INSTITUTIONAL REVIEW BOARD APPROVAL



**EAST CAROLINA UNIVERSITY**  
**University & Medical Center Institutional Review Board**  
Willis Building · Mail Stop 682  
600 Moyer Boulevard · Greenville, NC 27834  
Office 252-744-2914 · Fax 252-744-2284 · [rede.ecu.edu/umcirb/](http://rede.ecu.edu/umcirb/)

### Notification of Initial Approval: Expedited

From: Social/Behavioral IRB  
To: [Annelise Billings](#)  
CC: [Andrew Brimhall](#)  
Date: 11/8/2024  
Re: [UMCIRB 24-002110](#)  
Integrating the Voice of the Dyad: A Tentative Grounded Theory into the Birth Stories of Partners

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) occurred on 11/7/2024. The research study is eligible for review under expedited category # 6,7. The Chairperson (or designee) deemed this study no more than minimal risk.

As the Principal Investigator you are explicitly responsible for the conduct of all aspects of this study and must adhere to all reporting requirements for the study. Your responsibilities include but are not limited to:

1. Ensuring changes to the approved research (including the UMCIRB approved consent document) are initiated only after UMCIRB review and approval except when necessary to eliminate an apparent immediate hazard to the participant. All changes (e.g. a change in procedure, number of participants, personnel, study locations, new recruitment materials, study instruments, etc.) must be prospectively reviewed and approved by the UMCIRB before they are implemented;
2. Where informed consent has not been waived by the UMCIRB, ensuring that only valid versions of the UMCIRB approved, date-stamped informed consent document(s) are used for obtaining informed consent (consent documents with the IRB approval date stamp are found under the Documents tab in the ePIRATE study workspace);
3. Promptly reporting to the UMCIRB all unanticipated problems involving risks to participants and others;
4. Submission of a final report application to the UMCIRB prior to the expected end date provided in the IRB application in order to document human research activity has ended and to provide a timepoint in which to base document retention; and
5. Submission of an amendment to extend the expected end date if the study is not expected to be completed by that date. The amendment should be submitted 30 days prior to the UMCIRB approved expected end date or as soon as the Investigator is aware that the study will not be completed by that date.

The approval includes the following items:

Name	Description
Annelise Billings Thesis Draft for IRB	Study Protocol or Grant Application
BARE	Surveys and Questionnaires
Birth Stories Recruitment Flyer	Recruitment Documents/Scripts
Consent Form AB Long	Consent Forms
DAS 4	Surveys and Questionnaires
Demographic Questions	Surveys and Questionnaires
ECR S	Surveys and Questionnaires
EPDS	Surveys and Questionnaires
Follow up email	Recruitment Documents/Scripts
Interview Questions	Interview/Focus Group Scripts/Questions
Master Key	Data Collection Sheet
Participant Feedback Questions	Surveys and Questionnaires

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

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IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418  
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

## APPENDIX B: INSTITUTIONAL REVIEW BOARD AMENDMENT APPROVAL



**EAST CAROLINA UNIVERSITY**  
**University & Medical Center Institutional Review Board**  
Willis Building · Mail Stop 682  
600 Moye Boulevard · Greenville, NC 27834  
Office 252-744-2914 · Fax 252-744-2284 · [rede.ecu.edu/umcirb/](http://rede.ecu.edu/umcirb/)

### Notification of Amendment Approval

From: Social/Behavioral IRB  
To: [Annelise Billings](#)  
CC: [Andrew Brimhall](#)  
Date: 1/2/2025  
Re: [Ame1\\_UMCIRB 24-002110](#)  
[UMCIRB 24-002110](#)  
Integrating the Voice of the Dyad: A Tentative Grounded Theory into the Birth Stories of Partners

Your Amendment to update this study according to the revised human research regulations (as of January 21, 2019) has been reviewed and approved using expedited review on 12/20/2024. It was the determination of the UMCIRB Chairperson (or designee) that this amendment does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a Final Report application to the UMCIRB prior to the Expected End Date provided in the IRB application. If the study is not completed by this date, an Amendment will need to be submitted to extend the Expected End Date. The investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Document	Description
EPDS(0.02)	Surveys and Questionnaires

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

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IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418  
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

## APPENDIX C: GREENPHIRE EXCEPTION APPROVAL

### Account/Department

\*Student

### Service

Accounts Payable / Greenphire Exceptions Database

### Source

Client Portal

### Workflow

✓ Exception Request Approval

### Created

Tue 10/29/24 1:06 PM by [Annelise Billings](#)

### Last Modified

Tue 10/29/24 2:29 PM

### Name of Study

Integrating the Voice of the Dyad: A Tentative Grounded Theory into the Birth Stories of Partners

### PI's Name

[Annelise Billings](#)

### Amount per Payment

10.00

### Number of payments to be made to an individual in a calendar year

1

### Justification for requesting the exception

Each participant is only receiving a one-time compensation of a \$10 Amazon gift card. Because the amount of compensation is only one time and for less than \$50, Greenphire is not the preferred method of payment.

### FOAP Number

using personal funds

### What data are you collecting from the participants?

Full Name (Required)

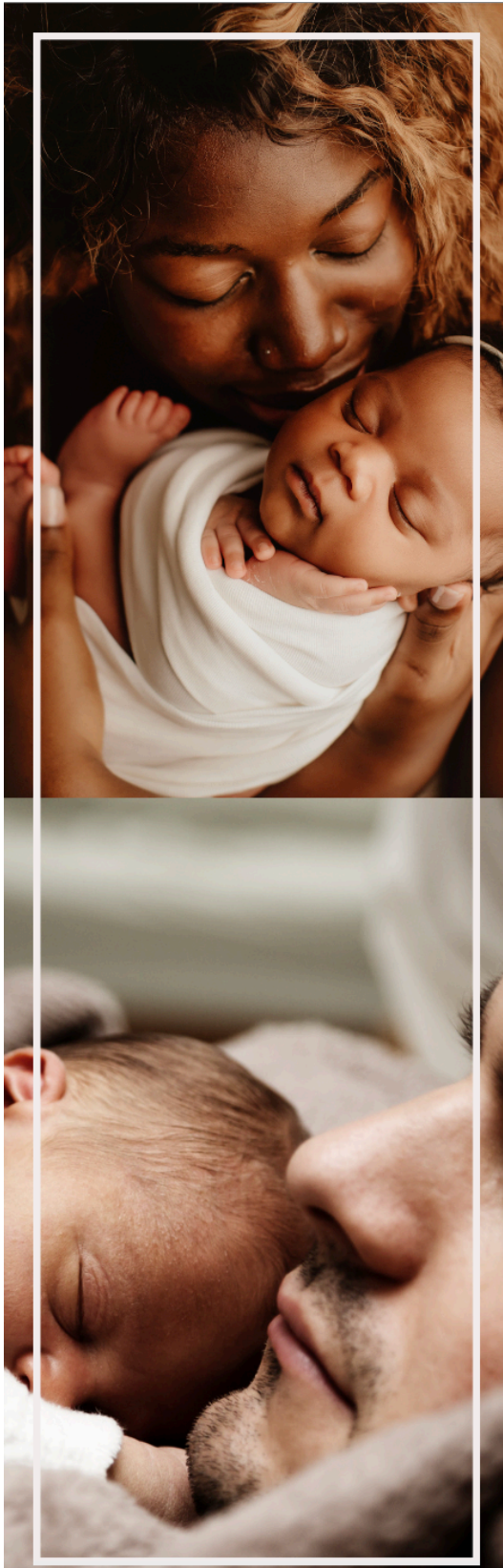
Email Address

Phone Number

## Description

Each participant in my study will be compensated for their time with a one-time payment in the form of a \$10 Amazon gift card. Participants will receive this gift card after completing an individual interview, a couple interview, and a series of questionnaires administered through Redcap. All interviews and questionnaires will be completed during a two-hour time slot and compensation will be sent digitally after that.

## APPENDIX D: RECRUITMENT FLYER



# Share your birth story!

## *Volunteers Needed*

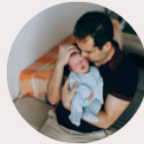
When partners become parents, it is often a big transition. This transition is sometimes misunderstood as the experiences of both partners aren't often considered.

### We want to hear from you \_\_\_\_\_



Who: You are eligible if you

1. Had a baby in the last year
2. Are in a committed partnership with your baby's other parent
3. Can speak English fluently



What you'll be asked to do: Participate in this research study by sharing your experience of childbirth as a partnership during an interview.



What you will receive: Each partnership will receive 2 \$10 Amazon gift cards for participating



How to sign up: Contact the primary investigator via the email below.

### Contact \_\_\_\_\_

We want to learn about the birth of your baby and how your relationship has changed since you have become a parent.

Primary Investigator:  
Annelise Billings  
Email:  
[birthstories.ecu@gmail.com](mailto:birthstories.ecu@gmail.com)

## APPENDIX E: RECRUITMENT EMAIL

Email sent to interested participants who email [birthstories.ecu@gmail.com](mailto:birthstories.ecu@gmail.com)

Hello,

Thank you for your interest in participating in this study!

My name is Annelise Billings. I am currently in my second year of the Marriage and Family Therapy masters program at East Carolina University. When partners become parents, it is a period of transition. This transition is sometimes misunderstood as the experiences of both partners are not often considered. I'm completing a research study geared toward understanding the process of birth for both men and women, as well as the impact this experience has had on partners' relationships. Therefore, I am seeking new parents who are in a committed relationship and have had a baby in the past year to participate in this research. To be included in this research, you must:

- both be biological parents (one biological male, one biological female) of the new baby
- be in a committed relationship
- both must be able to converse in and understand English
- be at least 18 years old
- both have access to a mobile device with a camera

The title of this research study is Integrating the Voice of the Dyad: A Tentative Grounded Theory into the Birth Stories of Partners. This study will include some questionnaires about your mental health, your relationship, and the birth of your baby. It will also include an individual interview and interview with your partner. The total participation time is approximately 2 hours. Interviews will be conducted at Reddit House at East Carolina University or online via Webex where I will ask you about the birth of your child and some of the impacts you've noticed since your baby was born. Once interviews are completed, both partners will each receive a \$10 Amazon gift card. After the interviews, you will be contacted twice over the next four months to provide brief feedback on the analysis taking place.

If you are still interested in participating, please send an email with your phone number and a good time to reach you to Annelise Billings (Primary Investigator, Email: [birthstories.ecu@gmail.com](mailto:birthstories.ecu@gmail.com)), and I will contact you to answer any questions you have and schedule your interview time.

Thank you so much for your help with furthering this research!

Annelise Billings

*She/Her* || M.S. Marriage and Family Therapy Candidate '25

**Email:** [birthstories.ecu@gmail.com](mailto:birthstories.ecu@gmail.com)

## **APPENDIX F: CONSENT FORM**

### **Informed Consent to Participate in Research**

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Integrating the Voice of the Dyad: A Tentative Grounded Theory into the Birth Stories of Partners

Principal Investigator: Annelise Billings

Institution, Department or Division: East Carolina University, Human Development and Family Science

Address: 112 Rivers Bldg

Telephone #: 910-478-5773

Study Coordinator: Annelise Billings

Telephone #: 910-478-5773

Researchers at East Carolina University (ECU) study issues related to society, health problems, environmental problems, behavior problems and the human condition. To do this, we need the help of volunteers who are willing to take part in research.

#### **Why am I being invited to take part in this research?**

The purpose of this research is to investigate how the birth of a child affects a romantic partnership. You are being invited to take part in this research because you are at least 18 years of age, you are the biological parent of a baby born within the last year, and are in a committed relationship with that baby's other biological parent. The decision to take part in this research is yours to make. By doing this research, we hope to learn how partners experience the birth of their child and how their relationship is affected when a baby is born.

If you volunteer to take part in this research, you will be one of about 30 people to do so.

#### **Are there reasons I should not take part in this research?**

I understand I should not volunteer for this study if I am under 18 years of age, am not the biological parent of a baby born in the last year, or am not in a committed relationship with my baby's other parent.

#### **What other choices do I have if I do not take part in this research?**

You can choose not to participate.

#### **Where is the research going to take place and how long will it last?**

The research will be conducted by a graduate student at East Carolina University. You will need to come to Reddit House at East Carolina University or participate virtually through the Webex platform one time during the study. The total amount of time you will be asked to volunteer for this study is approximately two hours over the next four months. We will also be contacting you two times following the interviews to request brief feedback from you.

#### **What will I be asked to do?**

You will be asked to do the following:

1. Complete basic demographic information about yourself and brief information about the birth of your child
2. Complete the Edinburgh Postnatal Depression Scale which is a common instrument that measures symptoms of postnatal depression in both men and women
3. Complete the Dyadic Adjustment Scale-4 which is a 4-item instrument that provides descriptive information about relationship satisfaction
4. Complete the Brief Accessibility, Responsiveness, and Engagement Scale which is a 12-item instrument that measures relationship dynamics among partners
5. Complete the Experiences in Close Relationships Scale-Short Form which is a 12-item instrument that measures attachment behaviors in a partnership
6. Complete an individual interview lasting approximately 45 minutes about the birth of your child which will be recorded
7. Complete a partnership interview about the birth of your baby, with your baby's other parent, which will last approximately 30 minutes and be recorded
8. Soon after the interviews have been transcribed, you will be provided with a summary of your interviews to provide feedback in case you want to add or change anything.
9. Toward the end of the study, you will be contacted again to provide more brief feedback about the results of the study in case you want to add or change anything.

Only the primary researcher will have access to the video recordings. Once interviews have been transcribed, the researcher will change all mentioned names to pseudonyms, and then the recordings will be deleted.

**What might I experience if I take part in the research?**

We don't know of any risks (the chance of harm) associated with this research. Any risks that may occur with this research are no more than what you would experience in everyday life. We don't know if you will benefit from taking part in this study. There may not be any personal benefit to you but the information gained by doing this research may help others in the future.

**Will I be paid for taking part in this research?**

We will be able to pay you for the time you volunteer while being in this study. At the completion of the interviews, each participant will receive a \$10 Amazon gift card sent to the email address on file.

**Will it cost me to take part in this research?**

It will not cost you any money to be part of the research.

**Who will know that I took part in this research and learn personal information about me?**

ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Any agency of the federal, state, or local government that regulates human research. This includes the Department of Health and Human Services (DHHS), the North Carolina Department of Health, and the Office for Human Research Protections.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff have responsibility for overseeing your welfare during this research and may need to see research records that identify you.
- The principal investigator and members of the research committee

**How will you keep the information you collect about me secure? How long will you keep it?**



**APPENDIX G: DEMOGRAPHIC INFORMATION QUESTIONNAIRE**

No.	Question	Answer
1	Please choose a pseudonym you'd like to be referred to in this research	
2	How old were you on the day your most recent baby was born?	_____ years old
3	What is your gender? <i>Select gender with which you identify</i>	Female Male Nonbinary Transgender Other (specify): _____ Prefer not to respond
4	What is your race? <i>Select all that apply</i>	American Indian or Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White Other (specify): _____ Prefer not to respond
5	What is your ethnicity? <i>Select only one</i>	Hispanic or Latino Not Hispanic or Latino Prefer not to respond
6	What is your highest degree or level of school that you have completed? <i>Select only one</i>	Less than high school degree High school degree or equivalent (i.e., GED) Some college but no degree Associate degree Bachelor degree Graduate degree (i.e., Masters, PhD, M.D.)
7	Which of the following categories best describes your employment status? <i>Select only one</i>	Employed full-time Employed part-time Out of work but looking for work Out of work but not currently looking for work Homemaker Student Military Retired Disabled Other (specify): _____

8	What is the primary language spoken in the home? <i>Select only one</i>	English Spanish Other (specify): _____
9	What was your combined household income in the last year? <i>Select only one</i>	\$0 - \$19,999 \$20,000 - \$34,999 \$35,000 - \$49,999 \$50,000 - \$74,999 \$75,000 - \$99,999 \$100,000+
10	Using a few words, please describe the nature of your relationship with your baby's other parent.	
11	How long have you been in a relationship with the other parent of your baby? <i>Please specify length of the relationship at the time of your baby's birth</i>	_____ years and _____ months
	The remainder of these questions are to be answered only by the birthing parent	
12	Where was your baby born? <i>If born in the U.S., please provide state, if born outside of the U.S., please provide country</i>	State: _____ Country: _____
13	What type of facility was your baby born in? <i>Select only one</i>	Hospital Freestanding birth center Home birth (planned) Home birth (unplanned) Other (specify): _____
14	What type of birth did you have? <i>Select only one</i>	Vaginal delivery Vaginal birth after cesarean (vbac) Cesarean section (planned) Cesarean section (unplanned) Other (specify): _____

15	<p>What types of interventions were used during labor and delivery?  <i>Select all that apply</i></p>	<p>IV fluids  Induction of labor  Augmentation of labor  External fetal monitor  Internal fetal monitor  Artificial rupture of membranes  IV pain medication  Epidural anesthesia  Episiotomy  Assisted vaginal birth: forceps  Assisted vaginal birth: vacuum  General anesthesia  Cesarean section  Water birth  Continuous labor support  Laboring while up and/or moving around  Other (specify): _____</p>
16	<p>Please provide the month your baby was born  <i>Select only one</i></p>	<p>January  February  March  April  May  June  July  August  September  October  November  December</p>
17	<p>What time of day was your baby born?  <i>Select only one</i></p>	<p>Morning 6:00am -11:59am  Afternoon 12:00pm – 5:59pm  Evening 6:00pm – 11:59pm  Night 12:00am – 5:59am</p>
18	<p>Please choose a pseudonym you'd like your baby to be referred to in this research. If you do not want your baby identified by a name, simply write "baby"</p>	

## APPENDIX H: SAMPLE TRANSCRIPT

I

Please tell me the birth story of your child.

Jag

Ok Yeah, it was just really simple. like, Jane said, it, you know, 40 weeks we're ready to have a baby, like, at least not prevent it. Because it was too early and then, so we just yeah, at four at 40 weeks, we just, uh, uh we're ready to have a baby, so whenever she started contracting, um, just went with a flow.. like Jane has talked about, you know, sleep is really important. So we just made sure we slept and and uh just ate well and rested a lot. um and then, you know, her team eventually came over and um just did kind of what I had expected, just uh set everything up, to carry Jane and watched shows until baby was ready to come out. um, yeah, that it was really simple, and then once they, uh once we got to um Jane actually pushing for that one hour, um, um, that was just it went by very quickly. I barely remember it because it was just like very in the moment the whole time, just yeah, very in the moment. and um yeah, um, her team was good. uh we had a lot of trust in everyone that was working there. So, uh, not really worried about anything they said, because I knew that whatever was happening, it would take care of it. um so like there was one scare where the baby who has not breathing well after birth for like ten seconds and uh and but they handled it and uh baby was perfectly fine and went on her mom's chest and from there it was just um clean up and they all left and Jane and I just slept. So that's pretty much it, yeah.

I

What role do you feel like you played during her labor and delivery?

Jag

I don't know what the right word for it would be, a support or backbone. I don't know, just someone that was just there to do, you know, this yeah, I I guess it just support, you know, just that I was there, it was just to be there just to help whatever was needed, just listening. um, so um yeah, I I that's pretty much it, just a support role, like that's just, you know, I it's just with with her the whole entire time, so,

I

Okay, wonderful.. What if anything did you love about the birth of your child? So if you could just pinpoint maybe one or two things, what did you specifically love about Ray Ray's birth?

Jag

I think the simplicity of it that it really is like birth at it's basic level doesn't have to be. so difficult and complex and tiring and and stressful. It just was the simplicity of it, so that's one and the second would probably be uh just a joy to see, um, like just all that time, you know nine months and for the baby to finally be there, so, just the joy of actually seeing our baby.

I

Okay. What if anything would you have changed?

Jag

Not really, I not really anything, like the duration is expected. I'm the kind of person who wants things done quick. So, yeah, great. she could have had a baby in and under a day and like fantastic. by otherwise, like I kind of knew, like it would it could take a little while, so, like, I don't really have anything I would change. Like, if you could change speed, go for it, but like, you can't really change speed. So no, yeah nothing to change.

I

Okay. What emotions did you experience during Jane's labor and delivery?

Jag

Not much, honestly. I like, I was like, I'm an emotional person, but also in that time, I just knew what I needed to be, which is just support, which was really just me focusing on her, I didn't really think about myself. So, um, I think, you know, once the baby was born, there was relief and joy uh again, and other than that, like that's pretty much it. Like, I was just there and present for her and then baby was born and it was joy and just relief that everything went well and baby seems healthy and Jane's healthy and it went well.

I

Okay. What emotions did you observe your partner experiencing?

Jag

I'm... not...kind of normal Jane, honestly. um you know, I think there was annoyance of it taking as long as she thought it would take. She wanted her midwife to go home because it was taking too long, she didn't want to waste their time. Um, so I think it was just a feeling of annoyance of it taking how long it was taking. um, you know, not getting the contractions closer. Um yeah, and excitement. excitement for the baby. There's pretty much it.

I

Okay. Please tell me about times if any throughout your partner's prenatal care and during labor and delivery that you felt like your voice was heard.

Jag

Yeah, like the whole time. I didn't really talk a lot at all, and when I did they replied and answered and it was straightforward and asked if I had anything else to say, and I turned it to Jane.

I

Okay. Were there any times during prenatal care and labor and delivery that you felt like your voice was dismissed?

Jag

No.

I

Okay. So then same two questions about your partner, though. So were there times when you felt like your partner's voice was heard throughout her prenatal care and labor and delivery?

Jag

Yeah, I don't remember any time that she had said something and it just didn't feel like it was like, yeah, I think I think everything was said and she didn't feel dismissed and yeah, the team did a good job at being very able to respond and helpful.

I

Okay, great. All right, so then just two questions left. Uh, the first one is what relational impact did your baby's birth have on you and your partner?

Jag

I'm not sure, like, uh, like hey, of course, like, I think it was just like that we had something we have to take care of together now, so it's not just that we want to take care of each other and love each other. It's now that we have a baby to take care of, so I feel like it put us on, um um it may it showed us it just made us have to be even more intentional than we already are with the baby and with our marriage, because the baby does make it hard to find time. So, I I just think it made it more intentional with our time and and um and our efforts to care for each other and the baby. cause it's not just, again, it's not just each other now it's the baby that needs to see how we treat each other, so..

I

Would you say that you've noticed, um I mean, if you could pinpoint just some of the differences that I guess you've said being intentional. So I guess I'm I'm looking for kind of more behavioral things. Like, are there things that are different that you would say that you you are labeling intentional? Am I making sense?

Jag

Yeah, I just I think that difference is just quality time together, like, there is just less time, I feel like in the day, cause there is less time, because there's a baby to take care of. So I guess the difference would be just time. like we're all slowed down. Like we were able to run, run, run. but now it's like, you know, walk, because you have a baby that has to be taken care of and that's a very big difference in our life, you know, accounting for more time, when we go places to nurse or to change a diaper or to just get in the car and get a carrier, so I just speed, you know, like we're not as fast. We're slower, and um but it take, you know, that's a difference. Like that's obviously there that's that's for me that's a negative difference, I guess, but it's also a positive difference. being slowed down is really positive in the sense that it gives me more time to think about the things that, like, I should think about, which is yeah, just not being so quick. I think it's important to not be so quick.

I

Okay. What relational impact if any did your baby's birth have on any of your other relationships? So this could be family, friends, coworkers

Jag

I'm not sure, honestly. I think, uh I think everyone's really the same, mostly. I mean the fact that, like, they um like, I'm a dad, so it's more like they treat me more like an adult, unless I feel like I

wasn't really not treated like I was an adult before, but I feel like it's even more like an adult. Like you have a child, it's not just like you're married and you're 23, it's like you have a child, and that's like, so they treat you a little differently in that respect. um but I think that's the biggest thing. It's just like it's like we have a child, so like, therefore, we are like "adult adults." So uh that's what I think about, that's probably just that. That's how I feel a little bit.

I

Adult adult, I like that. I like that. Okay. Is there anything else that you can think of?

Jag

Not necessarily, no.

## APPENDIX I: SAMPLE CONDENSED TRANSCRIPT

### **Please tell me the birth story of your child.**

Jaguar reported his baby's birth was really simple. Jaguar reported they just went with the flow. Jaguar reported when the team came over they did what he expected. Jaguar reported he had a lot of trust in everyone working there and he wasn't really worried about anything. Jaguar reported that after the baby was born, there was a bit of a scare, but it was handled and the team cleaned up and left him and his wife to sleep. Jaguar reported that his role was to be a support or backbone, to help whatever was needed, and to listen. Jaguar reported he was with her the entire time.

*Jaguar-It was just really simple...at 40 weeks, we just, we're ready to have a baby, so whenever she started contracting, **just went with the flow**... sleep is really important. So we just made sure we slept and just ate well and rested a lot...Her team eventually came over **and just did kind of what I had expected**... Once we got to Jane actually pushing for that one hour...it went by very quickly. I barely remember it because **it was just like very in the moment the whole time**... her team was good. We had a lot of **trust in everyone that was working there**. So, **not really worried** about anything they said, because I knew that whatever was happening, they would take care of it. So, like, there was **one scare** where the baby was not breathing well after birth for like ten seconds and...they handled it and, baby was perfectly fine, and went on her mom's chest and from there it was just clean up and they all left and Jane and I just slept.*

*Interviewer-What role do you feel like you played during her labor and delivery?*

*Jaguar-A **support or backbone**...I was there...just to **help whatever was needed**, just **listening**...I, it's, just **with her the whole entire time**.*

### **What, if anything, did you love about the birth of your child?**

Jaguar reported he loved the simplicity of his baby's birth. Jaguar reported birth doesn't have to be so complex and stressful. Jaguar reported loving the joy of actually seeing their baby.

*Jaguar-I think the **simplicity of it** that it really is like **birth at it's basic level**. **Doesn't have to be so difficult and complex and tiring and stressful**. It just was the simplicity of it, so that's one. And the second would probably be, just a joy to see, like just all that time, you know nine months and for the baby to finally be there, so, just the **joy of actually seeing our baby**.*

### **What, if anything, would you have changed?**

Jaguar reported if he could have made things go quicker, that would have been nice, but he knows that's not possible so he wouldn't have changed anything.

*Jaguar-Not really anything...I'm the kind of person who wants things done quick...I kind of knew...it could take a little while...if you could change speed, go for it, but like, you can't really change speed. So, no, yeah **nothing to change**.*

### **What emotions did you experience?**

Jaguar reported he didn't experience many emotions because he was just focusing on being present and a support for his wife. Jaguar reported that after the baby was born and everyone was healthy and it went well, he felt joy and relief.

*Jaguar-Not much, honestly...I'm an emotional person, but also in that time, **I just knew what I needed to be**, which is just **support**, which was really just **me focusing on her**, I didn't really think about myself...Once the baby was born, there was **relief and joy** again, and other than that, like that's pretty much it. Like, **I was just there and present for her** and then baby was born and it was joy and just relief that everything went well and baby seems healthy and Jane's healthy and it went well.*

**What emotions did you observe your partner experiencing?**

Jaguar reported he thinks his wife felt annoyance because labor was taking too long and she wanted her midwife to go home. Jaguar reported he also saw his wife feeling excitement for the baby.

*Jaguar-Normal Jane...I think there was **annoyance** of it taking as long as she thought it would take. She wanted her midwife to go home because it was taking too long, she didn't want to waste their time...**Excitement** for the baby.*

**Please tell me about times, if any, throughout your prenatal care and during labor and delivery that you felt like your voice was heard.**

Jaguar reported he felt like his voice was heard the whole time. Jaguar reported he didn't talk a lot and would often turn it over to his wife.

*Jaguar-The whole time. I didn't really talk a lot at all, and when I did they replied and answered and it was straightforward and asked **if I had anything else to say, and I turned it to Jane.***

**Conversely, please share times, if any, when you felt like your voice was dismissed**

*Jaguar-No*

**Please share times, if any, when you felt like your partner's voice was heard throughout your prenatal care and during labor and delivery**

Jaguar reported his partner didn't feel dismissed and the team did a good job responding and being helpful.

*Jaguar-I think everything was said and she didn't feel dismissed...**the team did a good job at being very able to respond and helpful.***

**Conversely, please share times, if any, when you felt like your partner's voice was dismissed.**

Did not ask because was previously answered

**What relational impact did your baby's birth have on you and your partner?**

Jaguar reported he and his partner have something to take care of together now. Jaguar reported they have to be more intentional because there is less time. Jaguar reported the cadence of their lives has slowed down and he views that as both negative and positive.

*Jaguar-I think it was just like that we had something we have to take care of together now, so it's not just that we want to take care of each other and love each other. It's now that we have a baby to take care of... it showed us it just made us have to be **even more intentional** than we already are with the baby and with our marriage, because the baby does make it hard to find time... it's not just each other now it's the baby that needs to see how we treat each other...Quality time together, like, there is just less time...So I guess the difference would be just time. Like we're all slowed down. Like we were able to run, run, run. but now it's like, you know, walk, because you have a baby that has to be taken care of and that's a very big difference in our life...that's a negative difference, I guess, but it's also a positive difference. Being slowed down is really positive in the sense that it gives me more time to think about the things that, like, I should think about, which is yeah, just not being so quick. I think it's important to not be so quick.*

**What relational impact, if any, did your baby's birth have on any of your other relationships (i.e., family, friends, coworkers, etc.)?**

Jaguar reported his relationships are mostly the same. Jaguar reported he is treated like an “adult adult” or more of an adult now that he has a child.

*Jaguar-Everyone's really the same, mostly...I'm a dad, so it's more like they treat me more like an adult...**It's just like it's like we have a child, so like, therefore, we are like “adult adults.”***

## **APPENDIX J: PARTICIPANT FEEDBACK QUESTIONS**

After interviews were transcribed, an interview summary was created and emailed to participants. Participants were then asked to complete the following questions:

1. Do you feel this interview summary accurately portrays your birth experience?
2. Is there anything you would like to correct?
3. Is there anything you would like to add?

After the results section of my study was completed, some participants were emailed a copy of the results chapter. Participants were then asked to complete the following questions:

1. Do you feel these results accurately portray your birth experience?
2. Is there anything you would like to correct?
3. Is there anything you would like to add?

**APPENDIX K: SAMPLE OF PRE-ANALYSIS/OPEN CODING**

Participant	Birth Story	Loved	Changed	Emotions	Partner Emotions
Jane/4	<p><i>it was really fun</i></p> <p><i>It was really hard, the hardest thing we've ever done</i></p> <p><i>sense of fun to it</i></p> <p><i>work task</i></p> <p><i>just holding my hand</i></p> <p><i>right there with me the whole time</i></p> <p><i>fun to be on the receiving end of care</i></p>	<p><i>I love the timing of her birth</i></p> <p><i>exercising my faith</i></p> <p><i>God had the perfect timing for her birthday</i></p> <p><i>it's gonna work out</i></p> <p><i>a sense of accomplishment with it all</i></p>	<p><i>fighting your body</i></p>	<p><i>good calm</i></p> <p><i>sense of accomplishment</i></p> <p><i>dedicated to the process</i></p> <p><i>excited</i></p> <p><i>exhausted</i></p> <p><i>very satisfying</i></p>	<p><i>super calm</i></p> <p><i>task oriented</i></p> <p><i>looking forward to the completion of our labor</i></p>
Jaguar/4	<p><i>just really simple</i></p> <p><i>just went with the flow</i></p> <p><i>what I had expected</i></p> <p><i>trust in everyone that was working there</i></p> <p><i>not really worried</i></p> <p><i>A support or backbone</i></p> <p><i>help whatever was needed</i></p> <p><i>just listening</i></p> <p><i>just with her the whole entire time.</i></p>	<p><i>the simplicity of it</i></p> <p><i>birth at it's basic level. Doesn't have to be so difficult and complex and tiring and stressful.</i></p> <p><i>the joy of actually seeing our baby.</i></p>	<p><i>nothing to change</i></p>	<p><i>I just knew what I needed to be</i></p> <p><i>really just me focusing on her, I didn't really think about myself</i></p> <p><i>relief and joy</i></p> <p><i>present for her</i></p>	<p><i>Annoyance</i></p> <p><i>Excitement</i></p>
Mercedes/5	<p><i>pretty confident</i></p> <p><i>but also, I'm not for sure</i></p> <p><i>I had my plan</i></p> <p><i>familiar with supporting unmedicated, and supportive</i></p> <p><i>labor at home... to minimize any sort of interventions</i></p>	<p><i>all of it</i></p> <p><i>I got to go unmedicated</i></p> <p><i>had all of the sensations</i></p> <p><i>fast</i></p>	<p><i>there's truly nothing more empowering than catching your own baby.</i></p>	<p><i>excited and relieved</i></p> <p><i>very loved and supported</i></p> <p><i>pride in delivering him</i></p> <p><i>apprehensive</i></p>	<p><i>Tired</i></p> <p><i>Discouraged</i></p> <p><i>Happy</i></p> <p><i>Shocked</i></p> <p><i>Patient</i></p>

**APPENDIX L: SAMPLE OF ACROSS DATA SUMMARY**

**Uncertainty**

Participant	Self	Partner
V	<p><b>Nervous</b>                      ...can you just stay here and <b>let me know what's happening?</b>                      Ride the roller coaster</p>	
Cirus	<p>Take what you can get because someone else didn't get it.</p>	
Stinky Buffalo	<p><b>Worry</b>                      Worried I wasn't going to bond  <b>Uncertainty</b>                      Am I going to like this kid?  <b>Nervousness</b>                      I, like, want some more information {about VBAC}                      I just feel like something's wrong with this baby {lip tie}                      I didn't want to be like, one of those people that, like go to the hospital and the hospital's like, why are you here? Go home.</p>	
Sam	<p>I also <b>worry</b> about side effects                      She didn't wanna look like the girl...that thinks she's having contractions</p>	
Mary	<p><b>Really anxious</b> pregnant                      I went to the emergency room like six times or more                      I was <b>really afraid</b>                      I had like a <b>panic attack</b>                      I couldn't control my body                      I <b>freaked out</b> like as soon as like I started having any contractions                      I like was crying I was like <b>hysterical</b></p>	<p><b>Freaked out</b></p>
Bilbo	<p>...a lot of times <b>I didn't know, you know, exactly what she wanted or how to, you know, make her feel better</b>  <b>Nervous</b> given our last experience {previous loss}                      We <b>didn't know what to expect</b>                      Is this really happening?                      It was affecting the way we think and how we act  <b>Nervousness</b>  <b>Anxiety</b>  <b>What needs to happen next?</b>  <b>What do we need to do?</b>  <b>What is the plan?</b>                      You need to tell me the plan...so I'm not in the dark...as long as that happens, I'm good cause I know what to do. <b>I kind of know what to expect.</b>                      I tend to find comfort in the <b>knowns</b></p>	

	The miracle of life is something where we can do the best we can, but we really don't have a choice what happens	
Jane	just <b>make sure that there is nothing going wrong</b> , It's not guaranteed for them to be okay	
Jaguar	there was one <b>scare</b>	
Mercedes	Pretty confident, but also, I'm not for sure I wasn't necessarily worried <b>Apprehensive</b> The full gamut	<b>Shocked</b>
Lincoln	<b>I wish I would have known</b> that the baby was okay, so I wasn't as <b>panicked</b> and I could have enjoyed the moment a little bit more Good <b>anxiety</b> All the emotions Calmer than I expected to be I <b>knew</b> what, like needed to be done to help I had done everything that I could You might have to do some things and you need to know what's happening with your wife, you need to try to understand what's happening with your wife	<b>Shock</b>
Shantell	<b>Every little thing was just making me nervous</b> <b>Panicking</b> <b>Afraid</b> I think I <b>stressed myself out more</b> than I needed to...I made myself <b>paranoid</b> for no reason. <b>Nervous</b> Little <b>scary</b> I <b>didn't know</b> what to expect	<b>Scared</b> because he <b>didn't know what to expect</b>
Anderson	<b>... first-time dad, there was a lot of things that, you know, I didn't know</b> What the future holds <b>Scary feeling</b> . I was <b>very, very, very nervous</b> Stay off of Google...All you're doing is scaring yourself right now	
Jasmine	<b>Stressed</b> , but not stressful Stressful I felt like <b>I was a deer in headlights</b>	Completely stressed Every emotion <b>Helpless</b> <b>He didn't know what to do</b> He wants to help, but in this case, there's nothing for him to do

John	Freaking out Truly was freaked out Not knowing what to do in this situation Anxiety Fear Gonna lose our child or had already lost her	
Hannah	I was very nervous I was very scared Getting more and more nervous as his arrival was approaching Nervousness Nobody knows the outcome	Nervous
Charlie	Scared A lot of fears He wasn't sure if he had what was necessary to provide a good future for {our baby} Trying to stay calm Shock Nervous	

Nervous 7  
 Scared 5  
 Anxious 4  
 All the emotions 3  
 Panic 3  
 Shock 3  
 Fear 2  
 Freaked out 2  
 Stressed 2  
 Worried 2  
 Paranoid 1  
 Apprehensive 1

**High Intensity:** Panic, Freaked out, Shock

**Moderate to Strong Fear/Anxiety:** Fear, Scared, Anxious, Apprehension

**Moderate to Low Intensity:** Stress, Nervous, Uncertainty, Worried

**Low Intensity:** Paranoid

## APPENDIX M: PARTICIPANT SUMMARIES

### *Couple 1: V and Cirus*

**V.** V is in her mid-twenties and completed high school. V is White with Hispanic or Latinx heritage. She currently works full-time and is a military reservist. V reported 2.66 avoidant and 4.16 anxious on the ECR. V and Cirus are married and have been together for five years. They have three children.

**Cirus.** Cirus is in his mid-twenties and completed high school. Cirus is Black with Hispanic or Latinx heritage. He currently works full-time and is a military veteran. Cirus reported 1.83 avoidant and 4.33 anxious on the ECR.

**Recent Birth Experience.** V delivered their third baby at a hospital. V was induced at 40 weeks. Throughout her labor and delivery, she utilized no pain interventions. The couple reported having a very positive birth experience.

### *Couple 2: Nicole and Sam*

**Nicole.** Nicole is in her late twenties and has a college degree. Nicole is Black and White but not Hispanic or Latinx. She currently stays home full-time with her children. Nicole reported 1.66 avoidant and 3.16 anxious on the ECR. Nicole and Sam are married and have been together over eight years. They have four children. Nicole had a C-section with her first birth. Nicole reported some negative experiences with her medical providers during her other pregnancies.

**Sam.** Sam is in his thirties and has a college degree. Sam is White with Hispanic or Latinx heritage. He is employed full-time as a resident physician. Sam reported 2.66 avoidant and 4 anxious on the ECR.

**Recent Birth Experience.** Nicole delivered their fourth child at a hospital. However, the couple arrived just shortly before their baby was born. Nicole's water broke in the lobby of the

hospital and the couple had been in the triage room for only two minutes before their baby was born. Because of this, no medical interventions were utilized. The couple reported both positives and negatives about their recent birth experience.

***Couple 3: Mary and Bilbo***

**Mary.** Mary is in her mid-thirties and has a college degree. Mary is White with Hispanic or Latinx heritage. She currently stays home with her child. Mary reported 2.16 avoidant and 4.16 anxious on the ECR. Mary and Bilbo are married and have been together for over five years. The couple has one child. Mary had two previous pregnancy losses, one in the first trimester and one at 20 weeks gestation.

**Bilbo.** Bilbo is in his late thirties and has a college degree. Bilbo is White with no Hispanic or Latinx heritage. He is employed full-time. Bilbo reported 2.83 avoidant and 3.5 anxious on the ECR.

**Recent Birth Experience.** Mary delivered their child at a hospital. Mary was induced and received an epidural for pain relief. The couple reported significant anxiety throughout Mary's pregnancy and during labor and delivery.

***Couple 4: Jane and Jaguar***

**Jane.** Jane is in her mid-twenties and has a college degree. Jane is White with no Hispanic or Latinx heritage. She currently works part-time as a midwife assistant. Jane reported 1.66 avoidance and 3.66 anxious on the ECR. Jane and Jaguar are newly married and have been together just over a year. The couple has one child.

**Jaguar.** Jaguar is in his mid-twenties and has attended some college. Jaguar is White with no Hispanic or Latinx heritage. He is employed full-time. Jaguar reported 1 avoidance and 1.5 anxious on the ECR.

**Recent Birth Experience.** Jane delivered their child at home with a midwife and a midwife assistant. Though the midwife utilized some minor interventions, Jane and Jaguar reported a very positive birth experience.

***Couple 5: Mercedes and Lincoln***

**Mercedes.** Mercedes is in her late twenties and has a college degree. Mercedes is White with no Hispanic or Latinx heritage. She currently stays home with her children. Mercedes reported 1 avoidance and 2.5 anxious on the ECR.

Mercedes and Lincoln are married and have been together for over four years. The couple has two children. Mercedes reported some negative experiences with her medical providers during her other pregnancy.

**Lincoln.** Lincoln is in his late twenties and has a college degree. Lincoln is White with no Hispanic or Latinx heritage. He is employed full-time at a hospital, though not in a medical capacity. Lincoln reported 2 avoidance and 3.33 anxious on the ECR.

**Recent Birth Experience.** Mercedes delivered their child at home while sitting on the toilet. The couple had planned to deliver at the hospital, but by the time Mercedes realized the baby was about to be born, it was too late to go to the hospital. Lincoln provided simple medical care, like suctioning, for the baby at birth. After the delivery, Mercedes' body went into shock, and she had to be rushed to the hospital in an ambulance for help delivering the placenta. When the couple arrived at the hospital, their midwife shamed them for not coming to the hospital in time to deliver. The couple reported a very positive birth experience despite it being an unplanned, unassisted home birth.

***Couple 6: Shantell and Anderson***

**Shantell.** Shantell is in her late twenties and has a college degree. Shantell is Black with no Hispanic or Latinx heritage. Shantell is employed full-time. Shantell reported 1 avoidance and 1.66 anxious on the ECR. Shantell and Anderson are newly married and have been together for three years. The couple has one child.

**Anderson.** Anderson is in his early thirties and has a college degree. Anderson is Black with no Hispanic or Latinx heritage. Anderson is employed full-time. Anderson reported 1.5 avoidance and 2 anxious on the ECR.

**Recent Birth Experience.** Shantell delivered their child at a hospital. Shantell went into labor naturally but had her labor augmented when it was not progressing quickly enough. Shantell received an epidural for pain relief. The couple reported a very positive birth experience.

#### ***Couple 7: Jasmine and John***

**Jasmine.** Jasmine is in her mid-twenties and has some college. Jasmine is black with no Hispanic or Latinx heritage. Jasmine is a student. Jasmine reported 3.66 avoidance and 5.83 anxious on the ECR. Jasmine and John are married and have been together for over twelve years. The couple has three children. Jasmine reported both previous and current negative experiences with medical providers during pregnancy. Jasmine reported this pregnancy was unplanned, and she did not find out she was pregnant until her second trimester.

**John.** John is in his late twenties and has some college. John is black with no Hispanic or Latinx heritage. John is currently employed as full-time, active duty military personnel. John reported 15 on the EPDS. He is the only participant whose score on the EPDS was moderate. John did not complete the ECR.

**Recent Birth Experience.** Jasmine delivered their baby in the trunk of their car en route to the hospital. Jasmine called John while he was at work and asked him to come home because she was in labor. John stayed at work to finish some things up, thinking he had more time before the baby would be born. By the time John arrived home and the couple headed to the hospital, the baby was born within 10 to 15 minutes. Jasmine was pleased that she did not have any interventions for her birth. John reported that he loved nothing about the birth because he missed it because he was driving and was very fearful for the baby's life.

***Couple 8: Hannah and Charlie***

**Hannah.** Hannah is in her early twenties and has a college degree. Hannah is White with Hispanic or Latinx heritage. Hannah is a student. Hannah reported 3.5 avoidance and 4.5 anxious on the ECR. Hannah and Charlie are dating and have been together for over a year. The couple has one child. Hannah reported some early concerns about early viability of her pregnancy.

**Charlie.** Charlie is in his early twenties and completed high school. Charlie reported he has Hispanic and Latinx heritage. Charlie is employed full-time. Charlie reported 3.66 avoidance and 2 anxious on the ECR.

**Recent Birth Experience.** Hannah delivered their baby at a hospital. Hannah was induced and received an epidural for pain relief. The couple reported having a positive birth experience.

