THE ‘INVOLVED’ FATHER: NARRATIVES OF GENDER, POWER AND KNOWLEDGE IN THE TRANSITION TO FATHERHOOD

by

Kimberley Fink-Jensen

BMR-PT, University of Manitoba, 1993

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

The Faculty of Graduate Studies

(Anthropology)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

April 2009

© Kimberley Fink-Jensen, 2009
ABSTRACT

Over the past few decades, North America has seen a shift in the cultural expectations placed upon fathers. Men no longer pace the waiting room while their partners give birth; they are expected — and expect themselves — to be nurturing and supportive prenatally, during labour, and after the baby arrives. This thesis seeks to understand what changes in cultural expectations mean for fathers during pregnancy, at birth and in parenting, and to demonstrate how fathers’ stories hold the key to understanding how men adjust to and direct these changes. Data collection in this study was guided by two overarching questions: (1) What is the male experience of alternative birth and prenatal care? (2) How does the male experience intersect with the experience of women? In the course of this study I observed and conversed with thirty-three couples as they participated in prenatal classes, and participated in a partners-only birth preparation class with eight of the fathers. I then interviewed four couples about their experiences with pregnancy and birth using an open-ended, semi-structured format. The data collected help to demonstrate that identifiable cultural models of birth and father involvement exist and that these impact the experience of pregnancy and birth for expectant fathers. It also demonstrates the ways in which key ideologies about pregnancy and birth work to reinforce one another and structure authoritative knowledge. Findings from this study suggest these models leave traces in themes which recur in fathers’ narratives of pregnancy and birth. During the transition to fatherhood, activities of ‘couvade’ help to develop fathers’ subjective experience of pregnancy and of their baby, assisting them to form their identities as fathers. Dimensions of gender performance influence the role men take during pregnancy and at birth and limit their authority and choices of how to participate in birth. As a consequence, these fathers narrate a desire to be involved to a much greater degree than is generally culturally expected.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Background and Context</td>
<td>3</td>
</tr>
<tr>
<td>Involved Fathers</td>
<td>3</td>
</tr>
<tr>
<td>Authoritative Knowledge in ‘Dominant’ and ‘Alternative’ Birth Models</td>
<td>4</td>
</tr>
<tr>
<td>Rites of Passage and Narratives of Transition</td>
<td>8</td>
</tr>
<tr>
<td>British Columbia Birthing Context</td>
<td>12</td>
</tr>
<tr>
<td>Subjects and Methods</td>
<td>14</td>
</tr>
<tr>
<td>Limitations and Directions for Further Research</td>
<td>16</td>
</tr>
<tr>
<td>Primary Research Questions</td>
<td>17</td>
</tr>
<tr>
<td>Interview Subjects</td>
<td>17</td>
</tr>
<tr>
<td>Data and Analysis</td>
<td>20</td>
</tr>
<tr>
<td>The ‘Involved’ Expectant Father: Activities of Couvade in Alternative Birthing Culture</td>
<td>20</td>
</tr>
<tr>
<td>“I want to be involved”</td>
<td>21</td>
</tr>
<tr>
<td>“Be informed”</td>
<td>21</td>
</tr>
<tr>
<td>“Ensure your partner is healthy”</td>
<td>22</td>
</tr>
<tr>
<td>“Attend every prenatal appointment”</td>
<td>23</td>
</tr>
<tr>
<td>“Connect with your baby”</td>
<td>25</td>
</tr>
<tr>
<td>“Be involved in making decisions”</td>
<td>26</td>
</tr>
<tr>
<td>“Attend prenatal classes”</td>
<td>28</td>
</tr>
<tr>
<td>[His] Stories of Birth: ‘Alternative’ Models and the Place of Fathers in Birth</td>
<td>31</td>
</tr>
<tr>
<td>“Birth is painful”</td>
<td>32</td>
</tr>
<tr>
<td>“Birth is dangerous”</td>
<td>33</td>
</tr>
<tr>
<td>“Partners are there for support”</td>
<td>35</td>
</tr>
<tr>
<td>“Birth is ‘natural’ and ‘normal’”</td>
<td>36</td>
</tr>
<tr>
<td>“Midwives deliver”</td>
<td>37</td>
</tr>
<tr>
<td>“Home Sweet Home”</td>
<td>39</td>
</tr>
<tr>
<td>“No Interventions (Except by Choice)”</td>
<td>40</td>
</tr>
<tr>
<td>Conclusions</td>
<td>42</td>
</tr>
<tr>
<td>Notes</td>
<td>47</td>
</tr>
<tr>
<td>References Cited</td>
<td>48</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

First and foremost, I would like to thank the couples who took time to share their thoughts and experiences with me in the course of this research, and to the prenatal classes and their instructors who allowed me into their midst. Without them, this thesis would not have been possible.

I offer my gratitude to the faculty, staff and my fellow students at the UBC, who have inspired me to be creative and daring in the pursuit of knowledge. I owe particular thanks to Dr. Judy Segal whose questions and viewpoint taught me to question more deeply and inspired me to follow my instincts.

I thank Dr. B. McKellin and Dr. V. Kamat for seeing me through endless drafts and changes in topic. Their comments have helped make this thesis what it is today.

Special thanks are owed to my husband Chris, who has supported me in so many ways throughout my years of education, and to my children Katelin and Kieran who have heard too often “Not now. Mommy is working on her thesis”. All my love to them for their patience and tolerance.

Finally, in the course of my Master’s program I have been fortunate to be supported by a Canada Graduate Scholarship from the Social Science and Humanities Research Council of Canada (SSHRC), and by a Graduate Entrance Scholarship from the University of British Columbia. I thank them both for their generous support.
Introduction

Over the past few decades, North America has seen a shift in the cultural expectations placed on fathers. Men no longer pace the waiting room while their partners give birth; they are expected — and expect themselves — to be nurturing and supportive prenatally, during labour, and after the baby arrives (Reed 2005). This thesis sets out to understand what changes in cultural expectations mean for fathers during pregnancy, at birth and in parenting, and to demonstrate how fathers’ stories hold the key to understanding how men adjust to and direct these changes. Richard Reed (2005) opened up anthropological studies of reproduction to include male experiences of hospital birth in the United States. He has demonstrated that the concept of authoritative knowledge in childbirth is useful to understand the accepted place of fathers in the delivery room. In order to expand upon this, I have chosen to focus on fathers’ participation in ‘alternative’ births. By attending prenatal classes, conversing with fathers and interviewing couples as they became parents, I found that identifiable cultural models of birth and father involvement exist. The data collected help to demonstrate the impact of cultural models on the experience of pregnancy and birth for expectant fathers and the ways in which key ideologies work to reinforce one another and structure authoritative knowledge. These models also leave traces in the themes that recur in fathers’ narratives of pregnancy and birth, showing not only the models they follow, but also serving to illuminate tensions between competing models. During the transition to fatherhood in some societies activities like ‘couvade’ help to develop fathers’ subjective experience of pregnancy and of their baby, assisting them to form their identities as fathers. Dimensions of gender performance influence the roles men take during pregnancy and at birth, and limit their authority and participation in
birth. As a consequence, these fathers narrate a desire to be involved to a much greater
degree than is generally culturally expected. Finally, prenatal care is recognized as a
primary method of cultural transmission of birth models and gender roles.

‘Alternative’ care providers make claims of being more family-centred and
inclusive of fathers². However, the male experience of ‘alternative’ care has not yet been
widely recognized or explored. Birth and birth narrative research has largely focused on
the stories of women³. In many societies, fathers do not have much opportunity to tell
their stories of parenthood. This comes in stark contrast to the wealth of opportunities
given to women. For men to tell their birth experiences is just as important as for women,
both for themselves, and for researchers to develop a fuller understanding of their role in
birth. Telling their stories helps men assimilate a life-changing event and find comfort
with their new social identity. Their stories also provide a male perspective in the female-
dominated realm of child birth and birth stories. This thesis demonstrates how stories that
are told and heard during the transition to fatherhood form expectations of and
satisfaction with the birth experience. It is through stories that cultural models of birth are
transmitted and knowledge is shared.
Theoretical Background and Context

Involved Fathers

In alternative and dominant birthing culture, there is increased awareness that a family-centered approach to care helps to ensure positive outcomes for mothers and babies (Health Canada 2000; Portela and Santarelli 2003). This research includes recognition of the importance of fathers providing support in pregnancy, birth and parenting to the overall health and mental well-being of mothers and babies. Men are increasingly taking up this new role. Indeed, according to Statistics Canada, the proportion of men taking a leave of absence following the birth or adoption of a child has increased from 37.9 percent in 2001, to 55.2 percent in 2006 (Beaupré and Cloutier 2006). A recent survey on Canadian maternity experiences found that 94.6 percent of women have their husband or partner with them during labour, and 92.3 percent of women have their husband or partner with them during birth; the majority are very satisfied with the support they receive from their partner (Public Health Agency of Canada 2009). With a few notable exceptions (e.g. Cabrera, et al. 2000; Cabrera and Peters 2000; Lamb 1987; Reed 2005) there has been little or no research into the possible impacts on fathers that increasing involvement entails. However, the ‘involved father’ is a regular feature in popular parenting magazines, websites and books (see Frank and Livingston 1999; Gonzales 2009; Herbert 2008), and prenatal classes increasingly address the needs of fathers.

Even female-centred alternative publications such as Mothering Magazine now recognize the importance of including articles for and about fathers (O'Mara 2008).

Brigitte Jordan (1993), Robbie Davis-Floyd and Carolyn Sargent (1997) discuss the cultural dimensions of female experiences of birth, and negotiations of gender, power
Authoritative Knowledge in ‘Dominant’ and ‘Alternative’ Birth Models

Authoritative knowledge is any system of ‘knowing’ which is given cultural power to be valid or true, and which delegitimizes other modes of knowing (Jordan 1993). Authoritative knowledge is the “knowledge that counts, on the basis of which decisions are made and actions are taken” (Davis-Floyd and Sargent 1997:4). In childbirth, there are two primary systems of ‘knowing’ which correspond to the two primary cultural models of birth. These are the ‘dominant’ biomedical/technological model, and the ‘alternative’ natural/holistic model (Davis-Floyd 1992; Davis-Floyd and Sargent 1997; Jordan 1993; 1997; Viisainen 2001). Although parallel systems of knowledge can coexist, a hierarchical pattern tends to emerge where systems or models come into contact.

In the ‘dominant’ model, pregnancy and birth is viewed as a risky biomedical event best managed by technology (Davis-Floyd and Sargent 1997; Jordan 1997). As a result of this view, the obstetrician becomes the ultimate authority, followed by other doctors and then nurses. Their power and authority is marked by the ownership of technology and the ability to perform technical procedures, supported by a cultural belief in biomedical science and objective measures provided by medical technology (Jordan 1997:61). In this biomedical and technological context, the midwifery or ‘alternative’ model of care is a parallel but unequal system of ‘knowing’, and as such, midwives’ authority in hospitals is subordinate to that of physicians. Within the ‘dominant’ model,
a mother’s intuitive bodily knowledge, such following the urge to push or allowing
herself to freely vocalize and change positions during birth is subject to control by care-
providers and hospital policy (Jordan 1997:66-67). In her paper on women’s choices and
control during childbirth, Ellen Lazarus (1994) observes that the dominant view of birth
as biomedical event to be managed by technology constitutes a medical hegemony over
birth. She states “the relationship between doctor and patient and the authority of medical
institutions constrain women's choices and, consequently, their control [over their
births]” (Lazarus 1994:25). Most of the women in her study about childbirth attitudes
believed that a high-tech birth in hospital was their choice, even though other options
were not seen as possible (Lazarus 1994:39).

Fathers in this model are afforded the least authority and the least recognition.
Morris and McInerney (2009:25) noted that in media portrayals “the experience of
pregnancy and birth is not shown to be as important for the men involved” and supports
the “dominant view of masculinity” that men are independent and strong, and are there
to solely to support their wives or girlfriends. Their emotional responses to becoming
fathers are underemphasized to the point of irrelevance. Reed notes that as fathers come
to participate in birth, they must submit to the authority of those in charge and perform a
role which has been predefined by the medical establishment, usually taught to them in
prenatal classes (2005:218). Unless conflicts arise, this takes place unconsciously and
willingly. Jordan states that power dynamics are invisible “because it seems natural,
reasonable, and consensually constructed” (1997:57). They may be invisible, but can
contribute to a feeling of dissatisfaction with the birth experience, and conflicts of
authority in the birth room. In this model of birth, medical authority supersedes the
authority of lay participants in birth, in particular fathers, while controlling women by virtue of their gender status.

Portrayals of birth in popular culture and the media which privilege the biomedical model contribute to the acceptance of high-tech birth. In an analysis of reality television shows about birth, Morris and McInerney (2009) found that programs tend to focus on highly medicalized births. Their treatment of ‘alternative’ birth also supported biomedical birth as the birth of choice by portraying ‘non-conventional’ approaches as dangerous. Where women were shown to be labouring without medication, they were shown to be “out of control” (Morris and McInerney 2009:22), as if birth without medication was ill-advised and the female body was not to be trusted. That this is the dominant cultural model and birth experience is born out in statistics about birth in Canada. According to a new study of Canadian maternity experiences, 58.1 percent of women in Canada receive their prenatal care from an obstetrician/gynecologist, 99.8 percent had at least one prenatal ultrasound, 97.9 percent gave birth in hospital, and 90.8 percent had external foetal monitoring at some point in labour (Public Health Agency of Canada 2009). 89 percent of first time Canadian mothers had an epidural (Kennedy 2003), and in British Columbia in 2002, the Caesarean rate was 27.9 percent (Kendall 2003:8). This percentage has since risen.

The ‘alternative’ natural/holistic model often defines itself in opposition to the ‘dominant’ biomedical/technological model of birth (Davis-Floyd 1992; Viisainen 2001). Whereas the ‘dominant’ model views birth as a potentially dangerous biomedical event best managed by technology, the ‘alternative’ model is based the view that birth is a ‘natural’ and ‘normal’ physiological and social event. The model trusts the female body’s
ability to give birth without need for intervention (Cheyney 2008; Davis-Floyd 1992; Jordan 1993; Viisainen 2001). The choice of home birth has been recognized as the ‘gold standard’ of ‘alternative’ birthing culture. In fact, the choice of home birth and midwifery care has been recognized as a ‘system-challenging praxis’\(^1\), a way of healthcare consumers directly challenging high-tech hospital birthing environments and male-dominated systems of knowledge (Cheyney 2008; Rapp 2001; Viisainen 2001; Zadoroznyj 2001).

Within the ‘alternative’ model female knowledge and authority are foremost, and the biomedical model of birth is delegitimized. The midwife is the primary authority. Her authority is supported by her birthing knowledge gained through experience in helping women birth. She works together with the mother’s intuition and body knowledge to guide her through the birth experience in a non-interventive manner (Jordan 1997).

An important question is whether the position of fathers in this female-dominated system of authoritative knowledge is different from that of fathers in a hospital setting. In the ‘alternative’ model men also submit (willingly, consciously or not) to the authority of care providers, the authority of his partner’s bodily knowledge and intuition, and to the authority of female-based knowledge. The male role, defined by alternative prenatal classes and interaction with alternative care providers, is perhaps no less scripted than that of fathers in more mainstream birthing environments. However, the rhetoric of ‘alternative’ care is more inclusive of fathers in the experience of birth. The Midwives Association of British Columbia website describes the midwifery model of care as “Family-centred care that welcomes spouses, family members, and siblings in the childbearing process” (Midwives Association of British Columbia 2007).
Rites of Passage and Narratives of Transition

Men’s presence at birth in North America is a relatively recent development. Lamaze first wrote about the role of trained fathers as birth assistants to mothers as a method to ensure a natural, pain-free birth in the mid 1950’s (Reed 2005). It was not until the 1970’s that the movement to get fathers into the birthing room began gaining momentum. That said men have always had a role to play at birth, whether it is standing vigil in the waiting-room or holding his wife’s hand while directing her to breathe. Birth ritual has also been a long-standing component of anthropological study, but in the past, this has been primarily limited to the study of birth practices in non-western cultural contexts. The phenomenon of couvade, or ritual involvement of men in birthing activities, has been described in anthropological literature since Sir Edward Tylor’s writings in the nineteenth century (Reed 2005:14). Van Gennep, in his classic work The Rites of Passage argues that “rites of pregnancy and childbirth must be viewed as having considerable individual and social importance; rites of protection or those intended to facilitate delivery (often performed by the father), and those involving transference of roles (couvade and pseudo-couvade)... assure to the future mother and father an entrance into a special segment of society” (Van Gennep 2004 [1977]:49). It has been argued by Reed (2005) and Davis-Floyd (1992), among others, that birth and its attendant activities in North America and other ‘western’ cultures serve as a ritual rite of passage for men and women into parenthood, just as much as in ‘other’ societies. Although the concept of ‘couvade’ may be an “interpretive generalization”, a collection of “local practices that can be interpreted as ritual precautions [for fathers-to-be]” (Sperber 1996:49, emphasis added) it is still a useful concept to locate clusters of behaviour surrounding a key life event. Although
biologically a man will become a father when his child is born, his social acceptance as a ‘good’ father requires certain social roles to be fulfilled. As long as we remain aware of the limitations, the concept of ‘couvade’ may assist us in discovering the social dimensions of fatherhood.

Reed (2005:35) utilizes ‘couvade’ to refer to “fathers’ subjective participation in pregnancy and birth”. While traditionally the term has been used to refer to ritual activities of transference and an empathetic tie to the mother, usage of the term with Reed’s re-conceptualization more accurately captures the prenatal and birth experiences of men in North American and other Western contexts. It highlights a direct relationship of father to child and encompasses a wider range of activities than a focus on ritual allows. What remains unchanged by this definition is the social importance of couvade in the transition to fatherhood.

As defined by Van Gennep, rites of passage include three stages: separation, transition and reincorporation (2004 [1977]). Within these stages, identity is disrupted as one moves from self to an in-between self, and emerges as a new and altered self. Narratives of life transitions follow a similar basic episodic pattern to Van Gennep’s stages of the rites of passage. Narrators describe the events and feelings of disruption [separation], a period of ‘limbo’ [liminality or transition], followed by a period of adjustment and reorganization of life [reincorporation] (Becker 1997:2). With regard to the middle period of transition or ‘liminality’, Victor Turner observed that “liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention and ceremonial” (1995 [1969]:95). The movement into such a position in society is experienced as a disruption in continuity of
identity and of life, because the purpose or resolution of liminality is not yet known. Expectant fathers are liminal entities, and their stories can be expected to follow the general pattern of life transition narratives and rites of passage.

In her book *Disrupted Lives*, Gay Becker discusses how people undergoing periods of transition “organize stories of disruption into linear accounts of chaos that gradually turns to order” (1997:6). Narratives can be used to create a sense of order when there has been a permanent disruption to identity, role or way of life (Becker 1997), and as such, can be used to provide a sense of purpose. Mattingly and Garro (2000:1) state “narrative is a fundamental human way of giving meaning to experience. In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable action and states of affairs”.

Numerous benefits have been recognized for women to tell their birth stories, which support the importance of narratives in times of transition. An article in the Journal of Obstetric, Gynecologic, & Neonatal Nursing states:

> [b]enefits of sharing birth stories include the opportunity for integration of a major event into the framework of a mother’s life; the opportunity to share a significant life experience; the opportunity to discuss fears, concerns, “missing pieces” or feelings of inadequacy or disappointment; the opportunity for the woman to gain an understanding of her strengths; and the opportunity to connect with other women (Callister 2004:508).

Potentially, the same benefits exist for men to share their version of events, yet birth is primarily considered the experience of women. Lamaze International, a major advocate for the inclusion of fathers in birth states that “birth is about women’s lives, women’s wisdom, women’s bodies, and the empowerment of women” (Callister 2004:508, emphasis added). As the member of the birthing team who is neither a birth professional
nor the birthing individual, fathers are not afforded the same opportunities to validate their experiences.

Narratives serve a purpose, not only in helping to organize experience, but to function rhetorically as a vehicle of expression for public values (Segal 2005), and as sociolinguistic markers of identity (Tannen 2005:3). Arthur Frank argues that “people tell stories not just to work out their own changing identities, but also to guide others who follow them” (in Segal 2005:62). In this way, stories function as a transmission medium for knowledge, socialization and the development of cultural models.

Our knowledge is organized in culturally standardized and hence familiar event sequences…These “stories” include prototypical events, prototypical roles for actors, prototypical entities, and more. They invoke, in effect, whole worlds in which things work, actors perform, and events unfold in a simplified and wholly acceptable manner…“cultural model[s]”… [have a] dynamic role in guiding expectations and actions and [have] shared possession by the bearers of a culture (Holland and Quinn 1987:19).

The collection of narratives of given experiences or topics becomes useful to reveal aspects of a society or culture, as well as of individual lives and experiences. Cultural understandings and models leave “traces” in narratives through “what narrators highlight, elaborate, leave unsaid, mark with counter-examples and comment on in affective propositions” (Holland and Quinn 1987:17). Sociolinguistic anthropology and discourse study recognizes that “when people talk they communicate not only information, but images of themselves” (Tannen 2005:3) This includes dimensions of class, gender, social position, geographical location, ethnicity, and other aspects of identity. Miller (2000) demonstrates how image and cultural models interact in the analysis of women’s birth narratives and their transition from woman to mother. She notes that “striving to make sense of the intensely private experience of becoming a mother, within the context of
public expectations, is both challenging and potentially baffling. Difficult experiences may remain unvoiced, and social action may remain regulated” (Miller 2000:321).

Women wish to communicate and validate their new social position through telling acceptable narratives. Women (and men) are exposed to many narratives prior to the experience of birth, which shape their own experiences and ways of telling. These include metanarratives of cultural expectations, public or professional narratives, and individual or lay narratives (Miller 2000:312), which form the ‘scripts’ and ‘themes’ of cultural models. ‘Traces’ of cultural models are visible within narratives of the transition to motherhood and this serves as a useful starting point to analyse the case studies presented here.

**British Columbia Birthing Context**

In the Province of British Columbia, midwives provide a full range of antepartum, intrapartum, postpartum and newborn care for women (and families) whose pregnancies are considered to be low risk. The choice to deliver at home or in hospital is made by the client and her midwife, based on a policy established by the College of Midwives of British Columbia (CMBC). CMBC is the regulatory body which oversees the practice of midwifery in the province under the Midwives Regulation (BC 1995), Health Professions Act, and CMBC bylaws. Midwives must pass written, oral and practice examinations set by the CMBC in order to become registered, and must meet annual education and practice volume standards in order to continue registration. Midwives have community-based practices and function either independently or in practice groups. According to CMBC midwifery practice standards, midwives must maintain hospital privileges in order to provide their clients with continuity of care regardless of birth place (College of
Midwives of British Columbia 2009). Their services are covered through a midwifery plan funded by the Ministry of Health Services (Janssen, et al. 2002:316). Approximately 78 percent of midwifery clients plan to birth in hospital, while the remaining 22 percent plan for home birth (Janssen, et al. 2006). 6.1 percent of women in Canada receive their prenatal care with a midwife, and 4.3 percent of Canadian births are attended by a midwife; 1.2 percent of births in Canada take place at home (Public Health Agency of Canada 2009). According to the Midwives’ Association of British Columbia, the Midwifery Model of Care is based on the development of a relationship between caregivers, women and their families which supports informed choice (including choice of birth place), trust in the female body’s ability to give birth, and evidence-based ‘non-interventive’ maternity care (Midwives Association of British Columbia 2007).

Although it is not required, prenatal education is strongly recommended by all midwives to their clients and partners. Recommended prenatal educators are listed in written packages given to clients and in links on midwifery practice websites. The content and style of education from recommended educators tends to reinforce the midwifery model of care. Educators are frequently doulas, lactation consultants, midwives or maternity nurses with special training in childbirth education. Typical prenatal education consists either of a weekly series which runs for seven weeks, or ‘weekend intensives’ which run Friday evening and all-day Saturday and Sunday. Approximately two-thirds of couples expecting their first baby attend prenatal education (Public Health Agency of Canada 2009), usually in the third trimester of pregnancy.
**Subjects and Methods**

I gathered data for this study by engaging in participant observation in ‘alternative’ prenatal classes in British Columbia’s Lower Mainland and conducting interviews with volunteer couples from these classes. In the course of this study I observed and participated in prenatal classes offered by three different female prenatal education providers, attending two classes at each location, and one “partners only” class led by a male. In addition, I also participated in a “weekend-intensive” prenatal class with one of the providers, and was invited to attend one prenatal class reunion. These providers were selected based on their support of alternative birthing philosophies, their recommendation on midwifery websites in the Vancouver area, and their and their classes’ consent to allow observation. Two of the observed classes were provided by a local non-profit birthing society and the remainder were privately taught by certified ‘Birthing from Within’ mentors. The location of these classes included a ‘neighbourhood house’ community centre, an instructor’s private home, a midwifery clinic and a holistic health centre. The partners’ only class took place in a café.

During these sessions, patterns of conversational interaction between instructors, couples, and among class participants, presentation styles and topics covered by the prenatal instructors, and written materials distributed to the class were observed. Through these observations, patterns of gender and authority became evident, as discussed below. I also engaged in conversations with class participants and instructors during the breaks to provide context and clarification of what was observed. I wrote field-notes following each of the observation sessions to capture what I had observed and to guide future observations.
I recruited volunteer subjects for interviews by giving a brief oral description of my research to the observed prenatal classes, with prior approval of their instructors. Couples participated in two open-ended, semi-structured interviews, once during the third trimester of pregnancy, and once within six weeks following birth. In order to reduce the influence of partners on answers, fathers and mothers were interviewed separately. Questions were broad and open-ended to allow each interviewee a chance to direct the content of their answers and included asking them to describe their experiences with pregnancy and with birth, decisions that had been made about care, and their feelings about birth and parenting. Each interview was recorded with a digital audio recorder and then transcribed. Prior to the second interview, I reviewed each individual’s first interview in order to follow up on previous responses. Between interviews, responses were reviewed in order to refine the interview guide for subsequent interviews. With the exception of one interview with a mother that took place in a park, interviews took place in the couples’ homes.

Subjects were first time parents under the care of midwives. It was anticipated that those couples who had selected a midwife as primary caregiver would intend to follow an ‘alternative’ birth model. In order to limit confounding factors in the data, preference was given to couples who had been in a committed relationship for a minimum of one year, and the mothers’ were between twenty-five and thirty-five years of age. Although there are increasing numbers of women having their first child after age thirty-five, the age limit was set in order to reduce the likelihood of including births that involve obstetric or neonatal complications and interventions. Given the small number of participants in this study, the age limits were set in order to allow greater comparability.
of the data collected\textsuperscript{13}. Ethical approval for this study was granted by the University of British Columbia Behavioural Research Ethics Board.

Three couples completed both prenatal and postnatal interviews. A fourth couple gave birth shortly before our scheduled prenatal interview. They completed a postnatal interview which combined questions from the two interviews. For all of the couples, the first interview took place after I participated in two of their prenatal classes. I was in contact by e-mail and had spoken with them during the breaks and small group exercises in their classes. This enabled me to develop some rapport with each of the participant couples prior to their interview. Additional information comes from conversations and observations at prenatal classes. Thirty-three couples participated in the prenatal classes I observed, and eight fathers participated in the partners-only class. The size of classes varied from six to thirteen couples.

Although it was the intent of this research project to interview couples planning for hospital birth as well as for home birth, three of the four couples were planning home birth and the fourth, although undecided, preferred home birth as well. This apparent ‘volunteer bias’ meant the couples who volunteered for the study were in the minority, even among ‘alternative’ births\textsuperscript{14}. An exploration of the meaning of this bias helped to inform the development of my questions.

**Limitations and Directions for Further Research**

Limitations to this study were the small sample size, that only couples planning for home birth chose to participate, and that the sample consisted of well educated, middleclass participants. As a consequence, this thesis does not explore cultural models of birthing which would reflect other ethno-cultural and class based conceptualizations and practices.
of prenatal care and birthing. The sample also was selected to reduce the likelihood of maternal and neonatal complications and therefore does not capture the full range of birthing experiences for fathers. In future studies, a larger sample size would allow for the inclusion of couples planning hospital birth with a midwife, and couples who participate in the biomedical model of birth under family physicians and obstetricians. Including a comparative set of interviews and observations with couples participating in ‘dominant’ biomedical models of birth would allow a comparison between care types and to see relationships between models of care, ideologies of parenthood and experience of birth.

**Primary Research Questions**

Data collection in this study was guided by two overarching questions: (1) What is the male experience of alternative birth and prenatal care? (2) How does the male experience intersect with the experience of women? Within these broad questions, I asked: How does alternative care address the needs of fathers and fathers-to-be? How do men negotiate the empowered female environment of midwife assisted birth? What role does the concept of being an ‘involved father’ play in fathers’ conceptualization of reproductive and immediate postpartum care? What is the connection ‘alternative’ birth and ‘alternative’ masculinities and definitions of fatherhood? How do male narratives of birth reinforce or counter dominant themes in birth stories? Do their stories differ from those told by women?

**Interview Subjects**

*Father #1*: Marc is a 43 year old businessman and has been together with his wife, Stephanie, for eight years. Stephanie is a 32 year old nurse and former professional
athlete with professional obstetrical experience. Both were born and raised in Western
Canada, are very physically active and fit, and are motivated by pursuing new
experiences. I met Marc and Stephanie in their first prenatal class. They attended a style
of prenatal education known as “Birthing From Within” which focuses on birth as a rite
of passage for both partners. The classes combine instruction in pain coping practices
with self-discovery exercises for both moms and dads (Birthing From Within 2009), and
has less of a focus on biomedical information about pregnancy and birth than most
prenatal classes. All of the couples in the class had midwives as their primary care
providers and at least half were planning for home birth. Marc and Stephanie planned for
and accomplished birth at home.

Father #2: Sundeep is a 30 year old university professor. He and his wife Anisa have
been together nine years. Anisa is also 30 years old and works in design and
communications and is a former journalist. Both were born in India. They moved to
Canada two years ago after pursuing their education in the United States. They are social
activists, and this informs many of the choices they made during their prenatal care and
birth. Sundeep and Anisa’s baby arrived sooner than planned, so a decision had not been
made about where to give birth. Although they desired a home birth, they were leaning
toward hospital birth for the comfort of other family members. Their son was born at
home after a fast labour. As a result of giving birth sooner than planned, Sundeep and
Anisa attended only four of seven “Birthing from Within” classes in their series.

Father #3: Steve is a 29 year old carpenter with a degree in psychology and has
completed some additional anthropology courses. Tracey is a 29 year old PhD candidate
in neurophysiology. They have been together for 11 years. Steve has wanted to be a dad
for a long time. Tracey joked with me that of the two of them, Steve got the maternal instincts. Both were born and raised in Saskatchewan, and plan to return there after Tracey completes her degree. The couple attended prenatal classes with a doula which provided biological information about birth and pregnancy as well as practical tips for coping with labour. Classes included couples with a mix of care-provider types, from obstetricians to midwives. Of their class, Steve and Tracey were the only ones planning a home birth. A complication in labour resulted in an unplanned hospital labour and birth.

**Father #4:** Craig is a 39 year old professional musician and amateur cyclist. He and his wife Tanis have been together 16 years. Tanis is 35 years old and is a PhD candidate and part-time professional musician. Her research is related to pregnancy and foetal development; she is very well informed about pregnancy and birth options. Craig was born and raised in Alberta, and Tanis in Manitoba. Craig has “always wanted to be a dad”, and was thrilled when “they” became pregnant. Craig and Tanis attended “Birthing from Within”, in a class where all of the participants had midwives as primary caregivers, and half were planning home births. Their classes included a partners-only class lead by a male instructor trained in the “Birthing from Within” mentorship program. They planned a home birth in a birthing pool, but a complication discovered in labour resulted in a hospital birth for their son.
Data and Analysis

I have divided the presentation of data and analysis which follows into two phases based on cultural models of behaviour for expectant fathers and cultural models of birth. In each phase, I will briefly present the key features of the cultural model, followed by a thematic cross-case analysis, including observations at prenatal classes where applicable. Through this I will demonstrate how fathers use cultural models and expectations to form the skeleton of their narratives and to validate their new social identity as fathers.

The ‘Involved’ Expectant Father: Activities of Couvade in Alternative Birthing Culture

The cultural model of behaviours expected of ‘involved’ expectant fathers can be viewed as a form of ‘couvade’, as they assist expectant fathers in the subjective experience of pregnancy. The cultural model of involvement, or of important ‘couvade’ activities, leaves ‘traces’ in the narratives that follow through what fathers choose to highlight as important aspects of their experience of pregnancy. The sections below are themes which emerged during my analysis of interview transcripts, the content of prenatal classes and in web-based resources for fathers. Very briefly, these are becoming informed about pregnancy, birth and early parenting, ensuring your partner is healthy physically and emotionally, attending every prenatal appointment, developing a connection to your baby, being involved in decision-making, and attending prenatal classes. Expectant fathers participate in these activities in order to subjectively feel a part of pregnancy, and to assure a successful transition through the liminal period of the ritual transformation into fathers.
The desire for a subjective experience of pregnancy and birth is evident in fathers’ narratives in their expressed wishes for inclusion and involvement.

Craig: I think most… or many, many more fathers that I know want to be more involved in things [prenatally and at birth]. You know, of course (laughs), there’s only so much you can do from the guy’s side of things. Or from the partner’s side of things… but what I think is important is for fathers to have the opportunity and feel supported in their explorations of how to be involved in the process as much as they like, so that there are no barriers. If someone says ‘I want to do this,’ then no one will say, ‘no you can’t do that, you’re just the dad’.

Marc: My involvement [in prenatal care]? Well yeah, actually I would like to be — even though I know that with most of the midwife stuff the focus is on the mother — I would like to be actually, just a little more acknowledged as a part of the process.

When I first introduced my study to the four prenatal classes I participated in, the reaction was immediate and similar in all locations: “Finally, something for the dads! Someone is on our side!” As Craig pointed out, there is “only so much” that men are able to do during the prenatal period and birth, as they are biologically limited from direct experience of gestation. As a result, couvade activities take on even greater significance to foster a sense of involvement and connection.

Marc: [I’m] learning [as much as I can] about pregnancy and reading. I bought a book on pregnancy to understand the transitions over time … Learning about and just seeing the things that Stephanie was going through and trying to be a supportive husband … learning about [pregnancy related fatigue], how I had to adjust some of my behaviour to accommodate that… watching the changes that she’s going through… tonnes of learning.

Steve: I’ve been reading The Birth Partner… this book has really helped me just be mentally prepared [for] what’s going to be happening.

Sundeep: [I have been] reading and talking to the midwife and a few others who were in similar stages of pregnancy and so on… we had a lot of discussions with our midwife and her partner… and a whole bunch of reading. We probably
watched a couple of movies along the way, and then speaking with some others that we met because of classes and the friends that are also currently pregnant at the same time [to learn from their experience].

Craig: Tons of reading. Just talking with my other friends who are fathers… lot’s of reading, lot’s of talking… going up and down the street and feeling happy to chat with my neighbours who’ve had their children in the past 6 months and talk to them about their experiences, things like that. Just trying to be open to gathering the experience of others, wherever, whatever direction that might come from.

The preceding excerpts demonstrate the importance these fathers placed on gathering information about pregnancy, birth and parenting through a variety of sources. Reading was a key activity to gain knowledge, followed by conversations with midwives and others with experience in birth and parenting. Information allows fathers to build a sense of connection with the events their partner is experiencing, as seen in Marc’s excerpt above, and to feel prepared for their role in birth. Demonstrating that they are building a knowledge base about birth and pregnancy is also important to establish their authority to be involved in decision-making. That all of the fathers chose to highlight learning activities in their discussion of prenatal activities and preparations for birth supports that being informed is part of cultural expectations for expectant fathers. Reading and talking to others also exposes expectant fathers to culturally shared ideas about fatherhood, pregnancy and birth, and helps socialize them in their new identities as fathers. This mutually supportive cycle aids in reinforcing the cultural models which support culturally desired behaviours and goals.

“Ensure your partner is healthy”

Based on the fathers’ narratives, one of the things that fathers learn is the importance of their role in keeping their partner healthy through pregnancy. They learn the importance of good nutrition, to balance rest and activity, and to manage stress and provide
emotional support for their partner. As an aspect of the cultural model, this role serves the purpose of providing a close ally to monitor and support the development of healthy babies and mothers. It also allows fathers subjective involvement in providing the best start for their baby, and to develop a supportive connection with their partner. The fathers’ narratives provide evidence that this role has been internalized.

Steve: I think my main worry is making sure that Tracey is well nourished and eating properly and getting enough sleep and trying to keep her de-stressed, from being stressed, you know, that’s the main job I think… I cook every night and make sure we have groceries and easy breakfasts in the morning for her.

Marc: [My role is] just making, helping to make sure Stephanie is healthy both mentally and physically.

Craig: My primary role I think really has been to make sure that she’s happy and healthy. Well rested… Keeping her well fed….there was a time when she really needed more protein in her diet, so that was easy to do and then I just needed to make sure she was eating her vegetables as well. Because that was something she was tending to leave to the wayside. She didn’t have that need to have vegetables so I was just making sure that everything was well balanced.

Sundeep: [I was involved] in making sure she got enough to eat and trying to go out on walks and so on with her. Anisa hasn’t been the exercising kind… so we would go out on walks and then she started yoga and most of it was just, um, trying to make sure that her day to day environment didn’t seem very different and that she could be comfortable even though she was internally going through a lot of changes… I was mainly making sure that she got enough rest and enough food and occasionally to reassure her that everything was going alright.

“Attend every prenatal appointment”

Part of ensuring a healthy pregnancy is regular prenatal care. Attending prenatal appointments with their partner helps fathers to experience a primary activity of pregnancy for women and to demonstrate their support for their partner. It also supports gaining a similar knowledge base about pregnancy with their partner, allows them to develop a relationship with the caregiver responsible for the birth of their child, and to be involved in decision-making during pregnancy. All of the fathers interviewed had
attended all or most of their prenatal appointments. The importance of participating in prenatal appointments was highlighted by the justifications spontaneously offered for having missed appointments.

Steve: Yeah [I’ve been attending prenatal appointments]. I missed one last week…Just…I misjudged time…I really wanted to be there, but there were other things I had to take care of…so [I missed it].

Marc: [I went to] all of them…I think all of them. If I missed one it wasn’t by choice. No, I went to all of them, yeah.

Craig: I’ve attended all of our midwives appointments, except for one where I was out of town and therefore couldn’t.

At the conclusion of one of the larger prenatal classes I attended, a father concluded that he had been missing something major by not attending prenatal appointments with his partner. As a consequence, he now planned to attend the remainder of the appointments in order to develop a relationship with their caregiver and feel more prepared for the coming birth. He stated “I’m so glad I talked to other dads here. I didn’t realize what I had been missing”.

Often, activities which take place during prenatal appointments and developing a relationship with their care-giver became mentioned as highlights of pregnancy.

Steve: The highlights, um…*when we went to the midwives* to hear the heart, that was pretty special.

Craig: Right from the start I was flabbergasted at how many times we get to walk through the doors of the midwifery clinic and sit down with someone for an extended period of time and discuss and chat and *build a relationship* that ultimately I will entrust with the welfare of my family. I think that’s a really, really powerful thing.

Sundeep: So what was interesting was we did hear his heartbeat with the stethoscope and the um, monitor at one of the *regular check-ups with our midwife*. That was interesting but in a sense we already knew that there was a life inside and it was interesting to hear but it was not like it was so surprising or
suddenly changed the way we approached the pregnancy, but that was a
highlight.

Marc: The midwife visits just kind of gave the information that I needed to feel
comfortable and then also gave a base for Stephanie and I to discuss things on the
same level… The midwives were definitely a memorable part. I love our
midwives.

“Connect with your baby”

Attending prenatal appointments also allows fathers to develop a sense of connection
with their baby prior to birth, through hearing the heartbeat or seeing the baby on
ultrasound. Since they do not have the mother’s bodily experience of the baby’s
movements, hearing the heartbeat, seeing ultrasound images and externally feeling their
baby’s movements helps fathers to experience the reality of pregnancy (Draper 2002),
and to develop their identities as fathers. Developing a connection and sense of their baby
as a person prenatally was important, as seen in the narrative excerpts below.

Steve: The first kicks [were] amazing and I spend a lot of time just kinda listening
to the belly, you know, and (laughs) thinking that I hear things in there you know.

Marc: I want to see my baby. That’s the thing I’m most looking forward to, yeah.
I want to see this little critter that’s been [growing inside her]… we’ve seen baby
images through an ultrasound, you know, and I want to meet this person.

Craig: Then we went and had the ultrasound, just saw that image… tears
everywhere. We’ve just been… the overall feeling of this pregnancy has just been
really positive, really warm, really loving. We’re anticipating this child so much
and just really glad that it’s soon going to be in our hot little hands.

Sundeep presented an exception to the fathers’ narratives above. However, in explaining
that a connection after the child was born was important to him demonstrates his
recognition that development of a connection prenatally was the expectation. His
experience also differed from the other fathers as he and his partner chose not to do
prenatal testing or ultrasound. The choice not to have a prenatal ultrasound unless there is
a medical indication for one is made very infrequently, and the following excerpt is also partly a justification of that choice.

Sundeep: We didn’t do any of the ultrasounds or any of these other tests for us to say “oh we can see the baby move, etc”… but it didn’t seem to make as much a difference to me personally that you need to have that immediate connection because I knew he was going to come out and then you could play with him and everything… the remarkable thing [for me] was how [Anisa] dealt with all of this, with all the changes and I think we had a great time in those months leading up to the birth.

“Be involved in making decisions”

Having developed a knowledge base about pregnancy and birth, getting involved in ensuring a healthy pregnancy, developing a connection to their baby, and attending prenatal appointments prepares fathers for further investment in the pregnancy and birth. There are many decisions that are made during the course of pregnancy and birth, including whether or not to undergo prenatal testing, type of care-provider and planned birth location, and other elements of the birth plan. As mentioned above, authoritative knowledge structures are evident where decisions are made and action is taken. The decision making process is revelatory of the authority given different forms of knowledge. The above elements of ‘couvade’ all help to establish fathers’ knowledge, but does this grant them authority in the decision-making process? Overall, the fathers told me they felt “absolutely” included in decision making.

Craig: [The midwives have] been also including me in discussions and decision making… never, never felt like I was in the wrong place for being in the room and part of the discussions … Tanis and I don’t differ very much in our opinions I feel like we’ve approached [decisions] as a unit rather than her opinion and then mine and we’ll figure out which one is the winner.

There was, however, a subtle sub-text in the following reflections.

Marc: I think our decisions were mostly between Stephanie and myself… I mean a lot of the decisions are really directed by Stephanie because I believe that she’s
most impacted by the decisions we’re making… if she had made choices that we haven’t made, you know, for the most part I would have supported everything… pretty much every decision we have made along the way have been consultative… talking over it and then deciding what the best approach for us would be.

Sundeep: We spoke among ourselves a whole lot… [but] being the outsider, I mean, I am not the person who is actually delivering… It was still Anisa’s decision [whether or not to have a home birth], I felt. That’s why I never wanted to force that we should.

Steve: Tracey could have said, “No [to home birth], I want to do it in the hospital” and I would have been 100% okay with that… I don’t think that [pain medication is] for us by any means. If Tracey when the time comes and if Tracey is insistent on having the pain dealt with through medication then so be it you know I’m fine with that.

All of the fathers expressed very strong opinions about what they hoped for in the birth, but as the above excerpts demonstrate, they state they are willing to accept if their partners were to decide otherwise. Although it is also their baby and their birth, it is in their partner’s physical body. As a result, they were willing to grant authority to her bodily experience and knowledge. A deeper probing proves that the ultimate source of knowledge and authority for decision-making are midwives and in most cases, medical technology. Midwives are seen as a prime source of information and for direction in decision making, and for some of the fathers, technology can be used to corroborate.

Marc: Technology doesn’t replace the human element that the midwives are providing but is there to provide additional information to help us make decisions, decisions that we need to make in terms of tests that are taking place, in terms of the health of the baby… um it’s also there to provide just basic diagnostic information as to the health of the baby and the mother… technology is there to support the mother’s decision.

Steve: I think [the midwife is] really there to reassure us and to, to be there to answer our questions… about what’s happening and how things are progressing [so we can make decisions].
Craig: I think the most important thing [for midwives] is being a source of information, a source of experience and a source of support… I’m sure the inclusion of technology and things like that is something that can be beneficial.

Sundeep: At that point it would have been a more considered decision [about where to give birth] using [the midwife’s] input as well because I did not want to be the one [to make that decision].

The choice of care-provider then becomes a major decision, as their model of care and ideology greatly impacts the direction subsequent decisions will take. As a general rule, women and their partners tend to choose a care-provider (and therefore model of care) which most closely reflects their personal ideology (Viisainen 2001).

“Attend prenatal classes”

Marc: Well I’m doing the prenatal course… just learning about how I can best support Stephanie during the birth… One of the reasons for taking this prenatal course was so that I could at least get some insight into some doula-like support that can be provided during the birth.

For the remaining fathers, prenatal classes were so taken-for-granted as part of their preparation, that mention of the classes were limited to phrases such as “of course I’m taking prenatal classes” in amongst the discussion of other forms of preparation17.

By the time couples attend prenatal education, most have already experienced seven or eight months of pregnancy and have come with certain expectations about what prenatal education will include. By this time, they have already chosen a care-provider and have at least some idea of their birth plan and ideals. Reed (2005:136-137) notes that as a part of ‘couvade’ prenatal education serves a ritual purpose, to help develop men’s identities as fathers. The classes remove men from their everyday contexts and help them to focus on impending fatherhood by further developing a connection to the baby, redefining their relationship with their partner, and defining their relationship with
members of the birthing team. They learn what to expect and what they can do during birth, and the behaviours of expectant fathers are further reinforced.

The classes also serve to reinforce the structure of authoritative knowledge in ‘alternative’ child birth, where female-based and experiential knowledge is prioritised. In the classes I observed, the first class began with introductions. The instructor introduced herself and gave her background. All of the female instructors I observed were also doulas and highlighted their years of experience, how many births they had attended, and how many couples participate in childbirth education with their organization each year. Two of three of the females had children themselves, and described their birth experiences in order to demonstrate their range of personal experience with birth. Essentially the message was they had done or seen it all in birth. Once her authority through experience and knowledge was established, the couples introduced themselves. Introductions included first names, who was their care provider, where they plan to give birth and their due date. Typically, the details were provided by the female of the couple. It was interesting to note that where men provided the answers, they always hedged their response with “I think it’s…” or other ways of checking the information with their partner. They were never wrong, but their answers were always met with laughter, and a patronizing pat on the knee with a “very good” from their partner, as if it was surprising that he managed to get it right. As further evidence of male’s lack of confidence and authority in this context, questions during class from the men were frequently prefaced with “This may be a dumb question, but…”.

By contrast, in the partners’ only class, the male instructor began by giving his experience as a father who participated in the births of his two children, with a brief
mention of his mentorship training from “Birthing from Within” and his experience in facilitating partners’ only birth exploration classes. What he emphasised was that he was “just a dad” like them. In this context, the authoritative structure was much more horizontal.

Although it had been just over five years since I had attended prenatal classes with my partner in preparation for the birth of our daughter, I noted a definite shift in emphasis in prenatal classes. Instructors consciously included partners’ needs, both physical and emotional, when discussing labour preparations. These included discussions of things to include for dad in the labour bag, provisions for partners to get rest during prolonged labours, and journaling and ‘birth art’ activities which encouraged fathers to think about their fears and desires for their birth experience. While all of the fathers wished to be involved, they were hard pressed to come up with concrete answers about what they hoped for themselves. In one class, the group was divided into mothers and partners, and were asked: What do I need for support during labour and birth? I went with the partners, who immediately began to answer the question from the perspective of the mother. They could not perceive of themselves as having needs in the birth, and could only think of their supporting role. I had to prompt them that the instructor wanted them to think of their own needs. This was met with prolonged silence. Eventually there was consensus among the eight fathers that what they needed most was clear communication and access to information before and during the birth, in order to “not screw up” and to provide the support in the way that their partner would want.

In the partners-only class that I attended, the male instructor asked the dads to consider their fears about birth. What if they had difficulty coping themselves? What was
their plan? This was met with uncomfortable silence. One lone father stated that men should be free to experience birth on their own terms and that one of the reasons they hired a doula for their birth was to allow for the possibility that he may be in need of support. That in general few men were able to consider their own needs points to the power of cultural models of birth which defines the male role as supporter.

**[His]Stories of Birth: ‘Alternative’ Models and the Place of Fathers in Birth**

The excerpts from birth narratives that follow point to two overlapping models of birth which influence the manner in which birth narratives are constructed. The first is formed of cultural expectations for the experience of birth, and the second is the ‘alternative’ natural/holistic model of birth introduced previously. To briefly review, the ‘alternative’ model of birth is based the view that birth is a ‘natural’ and ‘normal’ physiological and social event. The model trusts the female body’s ability to give birth without need for intervention. The model is frequently defined in opposition to the ‘dominant’ or biomedical model, and as a consequence, home birth is seen as the ideal. The key personnel in ‘alternative’ birth are the midwife, the mother and the partner, occasionally including doula/family members/close friends, and informed choice/decision making is presented as a core value.

Cultural expectations for birth are often shared between the ‘dominant’ and ‘alternative’ models, as they are formed by the wider shared-cultural or ‘common’ knowledge and showed up as themes during analysis of the fathers narratives. They are heavily influenced by the ‘dominant’ model of birth, and are a point of tension between models. These are that birth is painful, birth is potentially dangerous, and that birth partners have a supportive role to play. The interpretation of these cultural expectations
varies by the birthing model context in which they are experienced, and influences the decision making process.

“Birth is painful”

Marc: I really don’t want to see my wife in pain, so there’s that fear… and then there’s just the fear of how I’m going to be, how effective I’m going to be to help Stephanie and how well I’m going to be able to deal with birth and the role that I’m supposed to be there for.

Craig: I’m apprehensive about seeing Tanis in pain, but I know that she’s strong and can do anything she sets her mind to. I’m reminded of a friend of mine who after the birth of his first child he went home, his wife was in hospital, he went home and he cried all night long just because of processing what he’d seen his wife just do.

Steve: …my role is just to really support Tracey and try to keep her focussed on less pain… I’ve been trying not to focus on the fears.

During two separate prenatal classes, couples were asked to rate what the pain of childbirth would be like on a scale of one to one-hundred. Male estimations of labour pain were consistently higher than females (some rated it as high as one-hundred, “the most excruciating pain imaginable”), and females who had not given birth rated it higher (seventy-five to eighty-five) than women who had (as low as forty-five). None of the classes’ instructors claimed that birth was not painful, but emphasised that pain was ‘normal’, ‘functional’ (it was progressing you closer to birth) and ‘manageable’. Couples could work together to cope with labour. Although medical options for pain relief were discussed, the focus of the classes was on non-pharmacological options which rely heavily on partners. These methods include breathing and relaxation techniques, positioning, therapeutic touch including acupressure, and use of physical modalities such as water, heat and ice. Men had an inflated perception of the pain of childbirth which, in the context of ‘alternative’ birth, put great pressure on them to help alleviate it through
‘natural’ methods. One prenatal instructor informed fathers-to-be that once they started something like therapeutic touch to aid their partners in coping with pain “Don’t stop. Whatever you do, if it is working, don’t stop. You are her epidural”. It is a father’s (or birth companion’s) job to be his partner’s coping resource and defender, and if his job is done well, they will accomplish the ideal of a medication and intervention-free birth. This contributed to one of their major expressed fears about birth, as shown above, and became one of the measures of their success during birth.

Steve: I couldn’t believe how much pain she was in… The pain was so intense she was just kinda staring. But I mean I knew that I was doing something, not that she was ever saying anything or much to me, you know. But I knew that I was doing something because like I said, every time she kinda started to look away… as soon as I brought her back to look at me she would start to breathe again with me, so, I knew that I was doing something… It was just focussing on helping her deal with the pain and doing what we had to, to have a successful birth.

Marc: I don’t like seeing [Stephanie] in pain and there were times when she wasn’t sure she could do it, just talking her through that, you know, just trying to send her as much energy as I could. A lot of wishing I could take on some of the pain, take it away from her, but that’s not possible.

Craig: Tanis was moaning and hollering. It turned out that the little stinker had turned in an unfortunate way and it was causing more discomfort hence the greater intensity of contractions… Through all of that the thing that really struck me, I spent most of the time at her head supporting or trying to support her, I was really struck by how physically powerful she was [handling the pain]. It seemed like every eyelash was flexing to be able to squeeze him out of that opening and just all of the, every ounce of energy that she had was directed toward delivering him. I described it like being really close to a freight train; this completely unstoppable force that I thought was really unique to be so close to.

“Birth is dangerous”

The expected pain of childbirth is very closely tied to the concept of birth as a dangerous and potentially life-threatening event. Both contribute greatly to feeling of fear and apprehension, prior to and during birth. That birth is a dangerous event is one of the primary justifications for the medicalization of birth, and is a fear that those participating
in ‘alternative’ home birth must overcome. This tension is seen in narratives, as the fathers express either their fears of “something going wrong” or in their emphasis of birth as safe.

Steve: You obviously want your baby to be healthy and there’s no complications and your wife to do well… you know, no harm to your baby or your partner. (Long pause) But yeah, I’ve been trying not to focus on fears. Stay positive. If something happens then it happens and we can deal with it then, but I think everything will be alright.

Marc: when the day comes and there is going to be a fair amount of chaos… There is a fear of things going wrong, although I don’t really dwell on that so much, but definitely if I were to really think about it…It’s a pretty traumatic event so, for both the mother and the baby; something could potentially go wrong for both.

Craig: I don’t really have any fears. I know that things are going to be challenging but I said, I promised my self right off the bat that I am going to be okay, that we are going to be okay in the end, as a family. And I think that’s all you can really hope for and promise yourself, so… so that’s how I address the issue of fears and apprehensions.

Sundeep: I have this notion that well, millions if not billions, I mean billions of people have gone through this over the years and sure it’s going to be painful or hard or however… everyone goes through it and at some level… So I was definitely more confident in it being a natural process and that everything would work out fine, so I wasn’t as perturbed about the concept of delivery itself…Maybe I was over confident in that sense, that “yeah, nothing is really going to go wrong, why get paranoid about it”? … In retrospect I could say was over confident, because you know you hear about people saying it could have gone [wrong] that way or the other way but it didn’t.

Postnatally, a few fathers reflected that birth was less of a traumatic experience than expected, reflecting the expectation that birth is something to be feared.

Craig: I don’t think I was quite prepared for how it actually went, though, in terms of just… I think I wound up feeling a lot more calm than I anticipated I might.

Marc: [Birth was] less freaky than I thought it was going to be.
“Partners are there for support”

This theme has emerged in several of the sections above. Fathers in prenatal classes viewed their primary role to be a support for their partner and as a defender of the birth plan. These roles were reinforced by the teachings themselves, in reading fathers had been doing in preparation for birth, and in popular cultural representations of birth. It has also emerged in the section on pain, where they spoke of their role in helping the mother to cope with it, and expressed fears of their ability to support them through the pain. Most fathers had difficulty in perceiving a role for themselves outside this very strong cultural role model for men to support and be strong for their partners at birth. That theme carried forward into their descriptions of birth.

Steve: *It was so emotional you know* like it was… ah, *I couldn’t do much to help, you know, it was kinda out of my hands and I had to just go with it.* *Looking back I but I didn’t give in to any of those emotions, I knew I had kind of to be present with her and help her and kinda focus on her all the time …It was always about her* so I didn’t… you know, *I could tell the adrenaline was pumping, it wasn’t about me, it was totally about Tracey and the baby* so it was um I didn’t have many thoughts you know about, about anything really. *It was just focussing on helping her deal with the pain* and doing what we had to *to have a successful birth.*

Marc: I was pretty *nervous coming into it that I would be able to supply the support that she needed*… I was pretty much with Stephanie almost the whole time. *At that point I was more there for support*, holding her hand and doing whatever she needed and ah, a lot of it there really wasn’t much that I could do, just being as supportive as I could. … *I think it was a big deal for her, in fact she said it was, so I know it was… And for myself? I don’t know. Things I did for myself? I can’t remember.* I can’t remember thinking about that much. I don’t know if I…I think that for myself it was just being part of the experience, that was pretty, that was, you know, my little selfishness there, was just being a part of it.

Craig: I was maybe expecting that I was going to need, that I was going to be more stressed-out about things in a way and that I would need to calm myself down more, that I would need to find more strength maybe, maybe my idea of what strength is was just inaccurate because I think I was able to be strong for myself and for Tanis and for [the baby].
Sundeep: I was just trying to get her to breathe easily. I was just trying to get her to come into the water because I thought that would be good, that it might relax her a little, but she didn’t want to do that… I was just telling her to stay calm. I thought she might need to be held, or something like that, but she didn’t really need to… [Anisa] seemed like she knew what she was doing… [It ended up that] I was just there to make sure in case she needed something that I could go and get it right away.

In the last excerpt, Sundeep wants to be involved and provide support. However, his wife laboured very independently, leaving him more of a spectator at the birth. The authoritative knowledge of his partner and her intuition of what she needed to birth overruled his knowledge of and role in birth.

The cultural role model for partners impacts the expectations of care givers and influences the frequency at which deviations are seen.

Craig: I remember being encouraged that we could reach down and touch his head as he was starting to emerge. Tanis did that I think a little more matter-of-factly. I reached down and touched his head and was surprised to find out later on from our doula that most… I had not thought that it would be so rare for a father to reach down and touch his child before he was born, but she said that she sees that so rarely, that apparently all the girls in the room were crying.

“Birth is ‘natural’ and ‘normal’”

One of the key premises of ‘alternative’ birth is that birth is ‘natural’ and ‘normal’, one of the key arguments against the ‘dominant’ biomedical model of birth. This concept also runs contrary to the idea that birth is dangerous seen about. It becomes an important theme for organizing fathers’ narratives about pregnancy and birth, and the terms ‘natural’ and ‘normal’ appear frequently. It is used as a justification for many decisions which are made, including place of birth. It is particularly interesting the way the following excerpts demonstrate the fathers’ use of ‘natural’ to define their involvement in the birth. This legitimates their involvement in birth by co-opting a key premise of the model.
Marc: [Home birth was] just in terms of the environment, it just felt *so natural that it was a no-brainer*. I would absolutely do it again… I couldn’t imagine not being that involved in the birth anymore. Like it just felt totally, just so, I don’t know, just felt *so natural*.

Craig: I felt it was entirely *natural* to do the things that I needed, to see the things I saw, and to help out in ways that needed to have my help and ah…and so in that way it actually perhaps I could say that it seemed that [my participation] was in many ways *more natural than I was expecting*.

Sundeep: The highlights of the whole thing… just going through with this experience [of being involved in pregnancy and birth] being *something really natural* and having the right kind of support to deal with it.

Another way the concept is used is as a way to legitimize and make sense of their experience. This is particularly evident in the excerpt below. Steve’s wife had a particularly long and difficult labour which included many things they had hoped to avoid.

Steve: In the middle of it all I was like, “*Is this normal? Is this the way it should be? Is this natural?*” but looking back on it, *it seems so natural* and such… you know the process happened *exactly the way it should*, but in the middle of it I was kinda questioning things, you know… You couldn’t have really done anything to prepare me for that. We felt like we prepared for it, no, we, I mean I had no idea what I was in for. Like I *said it seemed like it wasn’t natural* and it shouldn’t be like this at the time and looking back on it now it was just an amazing experience and *it’s completely natural* and things just went extremely well and I couldn’t be happier with it.

*“Midwives deliver”20*

From the concept that birth is natural and normal flows the decision to have a midwife as care provider for prenatal care and birth. In North America, the ‘alternative’ and ‘midwifery’ model of birth are virtually synonymous, and choosing one supports the other. It has been shown that people tend to choose care providers whose ideology closely matches their own in order that their decisions will be respected and validated (Gillisen, et al. 2005). Believing that a care giver’s beliefs match one’s own also aids in
the development of trust when recommendations from the care giver are given, and
allows a seamless transference of authority to the care giver.

Craig: I think there were a couple of times [during the birth] where we just kinda
looked at each other and said “well if that what he needs yeah, go” and ah, a lot of
that probably came from having a real sense of trust with both our midwives and
with our doula and they were there to really help advocate on our behalf and help
steer us.

Marc: Once the midwife showed up it was just a matter of more or less following
her lead.

The ‘alternative’ model is often defined in opposition to the ‘dominant’ model, so to, is
the decision of midwife versus physician. Fathers also had the important perception that
their needs were better addressed by midwives.

Steve: I think I’m more involved with the interaction between Tracey and the
midwife and I feel like I wouldn’t have that with a doctor… I’d kinda just be
sitting in the corner and we’d have a 10 minute appointment and the questions
wouldn’t be asked.

Craig: I feel like [the midwives] really are there for my benefit as opposed to
them just being there for Tanis’s benefit and I’m there kind of as a slightly side
issue …I don’t know whether I would expect a different kind of treatment in a
different environment. I don’t know. I just don’t have that experience to be able
make any kind of comparison. In general I’ve been really happy with my
experience.

Marc: You know I really like the midwife decision that we made, I am quite
happy with the way almost everything has gone so far. I am very pleased that we
have chosen to go the midwife route… [it’s] a, probably more a holistic
approach, not just about the mother, okay, and her needs, but about all the people
that are directly involved with the birth process or basically the family.

The importance of midwives to the ‘alternative’ care package can also be seen in
justification that Steve made for the involvement of physicians in their birth, those
physicians were “nice” and “thoughtful” and gave them time to make decisions. Craig, on
the other hand, highlighted intrusions by physicians and nurses into the birthing
environment they were trying to maintain and the tension between the medical team, their midwives and their doula.

Craig: When we went in originally, um, there was not a sense of calm a lot of it coming from the obstetrician coming in and immediately flicking on all of the fluorescent lights and I was glad that I had the courage for myself to ask, you know, “can we turn those lights off?” … [and then] the paediatrician who took her cell phone call in the middle of it all or the number of times we had to go and close the door to the delivery suite so that we could have some privacy instead of them being stuck open and all that kind of stuff… we accepted the scalp clip monitor on [our baby], we weren't happy about it. I was glad that we had our doula and midwives there to encourage us that it was in fact an okay thing to do and would give the rest of the hospital staff the reassurance that they needed that he was okay and didn’t need more drastic help at the time… [when] he was born, was placed very quickly and somewhat rebelliously [by the midwife] on Tanis’ tummy, and then he was whisked away to the paediatric team.

Evidence of these conflicts demonstrates the medical hierarchy of authority which takes precedence once birth is moved into the hospital setting.

“Home Sweet Home”

Home birth is the birth setting seen to most closely reflect the ideals of ‘alternative’ birth. This choice of birthing location is often a conscious choice in opposition to the ‘dominant’ biomedical model of birth (Cheyney 2008; Viisainen 2001). As seen above, the translation of an ‘alternative’ model into a biomedical setting is not necessarily an easy one, as primary ideologies of birth differ greatly. The presence of medical authority and conflicting policies can direct events of the birth against the wishes of the couple. Home birth represents a greater control over the birthing environment, and supports the ideal of maintaining a natural birth without interventions (Viisainen 2001).

Marc: After being in a hospital to visit a friend that gave birth there it certainly reinforced the decision about having a home birth and not being in that kind of environment.
Steve: [We were] sold on the home birth because its very familiar surroundings and [Tracey] wants to be able to focus on her and not have, you know, a million people running around, you know, in the hallways, and an unfamiliar bed.

Craig: I think just, what we want is an environment that is going to be warm and glowing and loving and receptive; whatever we can do in that way to ease this transition of this little one into the air world...[the delivery suite is] a rather cold looking surgical room.

Sundeep: It seems so natural to have a home birth...Anisa and I feel we’ve made everything [about pregnancy and birth] too systematic... [you] don’t need that level of monitoring... We were brought up in a generation where birth meant hospital...[but] having done some reading we knew it was safe...The medical industries essentially just are trying to make money off people. It would be immensely satisfying to have a home birth. It seemed very natural, it seemed safe and I’ve always felt that...for everything that runs counter to the mainstream thought [you should] take the actions that would be consistent with what you feel.

“No Interventions (Except by Choice)”

Control and choice are two powerful ideologies in the ‘alternative’ birth model. By defining itself in contrast to the biomedical model of birth, the ‘alternative’ birth model makes the use of monitoring and interventions in birth a matter of choice and control over birth rather than matters of biomedical routine; avoiding unnecessary monitoring and interventions keeps birth ‘natural’ and ‘normal’. It is important to note that ‘interventions’ have become synonymous with medical procedures and do not refer to the techniques of midwives and doulas which are seen as ‘non-interventive’. ‘non-intervention’ also supports putting trust in the mother’s body knowledge about birth. These aspects of the model greatly influence the fathers’ narratives around the use of interventions, as seen below.

Craig: I think [that an intervention is] something that is there that can be used as a tool if it’s necessary rather than it being implemented as a default. So I think there should be the basic idea that women can have happy and healthy babies and then provide the support structure so that women have the confidence to explore that. And then have all the other stuff available because it provides great benefit but it’s not needed in a lot of cases, so why impose it if it’s not truly necessary?
Sundeep: I think the main thing would be the way Anisa went through [the birth] … you know, I think it really showed her determination and her confidence in knowing her own body, and that was fantastic to watch and understand [that nothing was needed]… [Anisa] seemed to know what she was doing.

For the two births at home where no medical interventions were used, things went “according to plan”. Where interventions were used, they are justified by emphasising that it was their choice and that they were in control of the decision to follow medical recommendations. In the excerpts below, although actions were based on the authority of midwives and doctors, the fathers maintain that they remained in control of decisions.

Steve: [Tracey] didn’t want any interventions so she was really receptive to [the midwives suggestions]… So the midwife would come to me and say well we should do this or we should do that so in between contractions I would say Tracey, maybe we should do this… [however the doctors] were suggesting the use of oxytocin… We decided yeah, we’d give it another hour and see where we were at then and then we’d go with the oxytocin. So the hour passed and they came in with the oxytocin and hooked her up to it….I felt like we controlled it all. And I don’t regret any decisions we made and we took our time… they kind of let us do our thing and let us make the decisions, you know. So we felt like we did control how things went …

Craig: I think obviously they can’t tell you to make the decisions that you’re going to make but they gave us good clear reasons why that allowed us really quickly to come to the decisions that we did [to allow interventions].

By maintaining a rhetoric of control and choice these fathers simultaneously submit to the structures of authoritative knowledge through consent to interventions, and support the value of informed choice advocated for in the ‘alternative’ model of care. In the end, it does not matter whether their accounts of the decision-making process accurately reflect authoritative influences on their actions, what matters is their perception of their actions as fitting within the ‘alternative’ model. By consulting with midwives, the key authoritative figure in the model, and making an informed and ‘independent’ decision, even things that are most ‘to be avoided’ in the model can become acceptable.
Conclusions

Although every story presented above is different, common themes are readily apparent that illuminate the internalized model of involvement these expectant and new fathers acquired. The cases share these commonalities; the fathers had a deep commitment to be involved in the prenatal care of their partners, in the birth of their child, and in child care following the birth. Their commitment included attendance at all or most of their partner’s prenatal appointments, participation in prenatal education, various practices to prepare for labour, greater involvement in household activities and food preparation, assisting their partners in having a healthy pregnancy, direct involvement in their partner’s labour, and rearrangement of work schedules in order to participate more in childcare after birth. As such, they exemplify the movement toward ‘involved fatherhood’, and in fact, a conscious intent to be involved was noted in each of the fathers’ narratives. Based on conversations with fathers and observations made at prenatal classes, this degree of involvement was typical for the participants. Through their narratives, the men simultaneously reformulated their identities from men to involved fathers, legitimized a shift to a more nurturing role, described the locations of authority and authoritative knowledge, and justified deviations from ideal birth and parenting as contained in the cultural model or ideal they chose to follow.

This thesis set out to understand what changes in cultural expectations mean for fathers, and to demonstrate how fathers’ stories hold the key to understanding how men adjust to and direct these changes in expectations. It confirmed that cultural models of birth ‘make familiar’ a prototypical role and prototypical event sequence which guides expectations and actions of expectant fathers. Cultural models also provide the
framework for transmission of knowledge through stories, as shown by the themes which organized fathers’ narratives. By attending prenatal classes, conversing with fathers and interviewing couples as they became parents, I found that ‘dominant’ and ‘alternative’ cultural models of birth and father involvement exist. The ‘dominant’ model is influenced by a biomedical view of pregnancy and birth and traditional definitions of masculinity. This limits father involvement to a supportive role at birth. The ‘alternative’ model focuses on pregnancy and birth as a natural and normal event, and has a wider definition of masculinity that allows greater involvement of fathers. The above data help to demonstrate the impact of cultural models on the experience of pregnancy and birth for expectant fathers and the ways in which narratives are constructed. It also demonstrates how key ideologies work to reinforce one another and structures authoritative knowledge. Models also leave ‘traces’ in the themes which recur in fathers’ narratives of pregnancy and birth, showing not only the models which they are following, but also illuminating tension between competing models. During the transition to fatherhood, activities of ‘couvade’ help to develop fathers’ subjective experience of pregnancy and of their baby, helping them to form their identities as fathers. This study also revealed a dimension of gender performance which influences the role men take during pregnancy and at birth and which limits their authority and choices of how to participate in birth. As a consequence, these fathers narrate a desire to be involved to a much greater degree than is generally culturally expected. There appears to be a connection between a desire for greater involvement as fathers and the choice of ‘alternative’ care. Finally, prenatal care was seen to be a primary method of cultural transmission of birth models and gender roles.
Morris and McInerney (2009) note that the dominant cultural view is that men are not interested or involved in pregnancy and birth. As noted in the discussion of prenatal classes, men are not expected to have knowledge about even their own partner’s pregnancy or plans for birth. In the ‘alternative’ birth movement, the knowledge and authority of females is stressed, both in the experiences and expertise of female care providers, and in the bodily intuition and knowledge of pregnant and birthing mothers. Based on their gender, men are expected to play a role to support their partner in birth and parenting, but not to experience an emotional reaction or be deeply involved. Miller states that “counter narratives” are narratives that are constructed by “those who find that their (collective) experiences are not accommodated within more mainstream narratives” (2000:311). The role the fathers I interviewed enacted does not match the culturally expected role for fathers prenatally. Therefore, their narratives function as counter narratives to mainstream models of fatherhood.

That ideas of birth and gender are intricately entangled for women has been well recognized (Rapp 2001), however, they are equally entangled for men. Men in birth are to embody the qualities of masculinity, just as women are to embody the qualities associated with femininity. The activities which fathers are expected to take care of include responding to caregivers and relaying their messages, defending birth plans against care givers and women’s own ‘irrational’ requests in the heat of the moment, and remaining objective and supportive while seeing their partner in pain sets men up for a difficult task. In the end, this makes it difficult for them to experience the deep emotions of the birth of their child. Where women are encouraged to follow their ‘natural’ bodily instincts in ‘alternative’ birth models, the primary model for men is to remain in control.
Pregnancy, labour and birth become a powerful performance of gender because it seems only ‘natural’ to divide the experience based on biology; after all, it is her body that is pregnant. This gendered division defines the accepted masculine role as well as the expected performance of females at birth. Feminist childbirth activists have fought hard to bring women their power in childbirth, to de-medicalize the process, but until the masculine counterpart is recognized, the job of liberation of reproduction is incomplete. While the supportive role of men assists in demedicalizing the birth process for women, it is equally important that the experience of birth be humanized for men. Men need to be allowed the full range of bodily and emotional experiences of birth without ideas of gender constraining his experience. Masculinity must be defined to include nurturing and emotional qualities and not be constrained to being rational, strong and objective.

The role of fathers defined in traditional prenatal classes is rather stereotyped, and gives fathers little authority in defining their place in parenthood and birth. Traditional or ‘hegemonic’ masculinity is defined as the “most desired form of masculinity, one that usually aligns itself with traditional masculine qualities of being strong, successful, capable, reliable, in control. That is, the hegemonic definition of manhood is a man in power, a man with power, and a man of power” (Doucet 2006:35, emphasis original). In her book *Do Men Mother?*, anthropologist Andrea Doucet questions what the relationship is between hegemonic masculinity, which is “largely associated with a devaluation of the feminine” (2006:38), and masculinities which can include the more ‘feminine’ practices of care. She states “caregiving is undeniably a female-dominated profession that builds on what are considered traditionally feminine practices and identities…[There is a] need to provide space for men’s narratives of caregiving and to resist the impulse to measure,
judge and evaluate them through maternal standards” (Doucet 2006:28). She goes further to say that “In the same way that feminists have exercised caution about the ways that we understand the voices of one gender against a landscape designed by the other, so too these cautions must be brought to bear when we study men in female-dominated domains of social life” (Doucet 2006:28). Although hers is a study of fathers who are primary or sole caregivers for their children, her points about gender and masculinities are applicable to the role of fathers in birth and in ‘involved fatherhood’ where mothers still play a major role. This is particularly so in the context of ‘alternative’ birth where the feminine viewpoint is paramount and constrains men to a ‘masculine’ role. This is not to say that feminist activism which has created space for ‘alternative’ birth models in North America (Rapp 2001) was not important, but to caution against judging and defining male roles in birth by contrast to solely female criteria. There is also a need to provide space for men’s narratives of birth and to allow them to experience birth through male eyes.
Notes

1 By ‘alternative’ I mean maternity care outside the cultural norm of physician attended prenatal visits and hospital birth. In the cases presented here, this means care provided by a team of midwives (with or without doulas) with the option of home birth, and participation in prenatal education outside the hospital setting.

2 For example, see [http://www.bcmidwives.com/midwiferymodel.htm](http://www.bcmidwives.com/midwiferymodel.htm).

3 (see Callister 2004; DiMatteo, et al. 1993; Miller 2000; Viisainen 2001; Zadoroznyj 2001 for examples of women's birth narrative research).

4 ‘Family-centred care’ is a holistic approach to healthcare which includes building relationships with patients and their family members based on dignity and respect, providing psychosocial support, sharing unbiased information and involving family in decision-making and care (Johnson, et al. 2008).

5 ‘Involved fathers’ are men who have daily, active involvement in care of their children including handling daily routines, providing comfort and play, and having a direct and close relationship with their child (Frank and Livingston 1999). This extends to bonding with their child during pregnancy through touch, reading, and playing music for the unborn child and participating in prenatal care (Gonzales 2009).


7 “Partners only” classes are becoming more common in prenatal education, and were available in two of the four classes I participated in. Birthing From Within, a form of childbirth education, offers training for male instructors to lead these classes.

8 Such as external foetal monitors.

9 Although respect for the profession of midwifery is growing, their authority in the hospitals in which they work is still a site of negotiation. There are no stand-alone birthing centres in British Columbia at this time.

10 A “systems-challenging praxis,” explicitly attempts to unmask sources of social inequities and to advocate for permanent changes in the alignment of social power. Systems-challenging praxis converts medical problems into social and political issues” (Cheyney 2008:255)

11 Segal states “in general, we praise people for embodying what we value, and we blame them for embodying what we deplore” (2005:61)


13 In addition to interviews and participant observation, self-reflection formed an integral part of this research project. As a mother of two children born at home under the care of midwives, I draw on my own and my partner’s experiences as participants in alternative birth. I have also drawn upon my work experiences with the Maternity Care Research Group at the Centre for Community Child Health Research, Child and Family Research Institute in Vancouver, and my participation on the Maternity Care Discussion Group list-serve.

14 As mentioned above, seventy-eight percent of couples under the care of a midwife in British Columbia plan to give birth in hospital (Janssen, et al. 2006).

15 All names have been changed to ensure the privacy of the participants in this study.

16 For example, see the popular ‘involved dad’ website [www.dadlabs.com](http://www.dadlabs.com) for ways in which these behaviours are encouraged in expectant fathers.

17 This passing reference may have been due in part to having met me at their prenatal class. They knew I had prior knowledge of their participation in classes and what the content of their classes included.

18 Two of the four classes I participated in for this study were taught by the same organization whose classes I attended for my prenatal education.

19 ‘Birth art’ is spontaneous or directed acts of creativity which take place during the prenatal period. All of the classes I attended included some form of birth art, from drawing fears and hopes about labour or what came to mind when thinking about pregnancy and birth to various directed journaling activities.

20 This section is named for a bumper-sticker I once saw on a midwife’s car. Here it is used not only to refer to the midwives professional role of delivering babies, but also to refer to the cultural expectation that midwives will ‘deliver’ or support the key features of alternative birth.

21 For example, use of and external foetal monitor which interferes with freedom of movement is to be avoided, but intermittent auscultation with a stethoscope or Doppler is fine. Use of oxytocin to induce or augment labour is an intervention, but nipple stimulation and coitus are not.
References Cited

Beaupré, Pascale, and Elizabeth Cloutier

Becker, Gay

Birthing From Within

Cabrera, Natasha, Catherine S. Tamis-LeMonda, Robert H. Bradley, Sandra Hofferth, and Michael E. Lamb

Cabrera, Natasha, and H. Elizabeth Peters

Callister, Lynn Clark

Cheyney, Melissa J.

College of Midwives of British Columbia

Davis-Floyd, Robbie E.

Davis-Floyd, Robbie E., and Carolyn F. Sargent, eds.

DiMatteo, M. Robin, Katherine L. Kahn, and Sandra H. Bey

Doucet, Andrea
2006 Do Men Mother? Fathering, Care, and Domestic Responsibility. Toronto: University of Toronto Press.

Draper, Jan
2002 'It was a real good show': the ultrasound scan, fathers and the power of visual knowledge. Sociology of Health and Illness 24(6):771-795.

Frank, Robert, and Kathryn Livingston

Gilliesen, A, R Van den Broek, MC Klein, R. Liston, L. Saxell, and R Ottenheijm
2005 Do women attending family physicians, obstetricians or midwives see birth differently. North American Primary Care research Group (NAPCRG), Quebec City Quebec, 2005.

Gonzales, Heidi

Health Canada

Herbert, Glen
Public Health Agency of Canada

Rapp, Rayna

Reed, Richard K.

Segal, Judy

Sperber, Dan

Tannen, Deborah

Turner, Victor Witter

Van Gennep, Arthur

Viisainen, Kirsi

Zadoroznyj, Maria