SELF-EFFICACY FOR CHILDBIRTH:
A QUALITATIVE STUDY OF PREGNANT WOMEN PLANNING HOMEBIRTH

by

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ABSTRACT

This study identified themes in the lives of pregnant women and proposed relationships to developing childbirth self-efficacy. Ten women planning midwife-attended homebirth took the Childbirth Self-Efficacy Inventory (CBSEI) (Lowe, 1991a) before life-history interviews were conducted. Only one had a high self-efficacy score, but the CBSEI was determined not to be valid with the sample. Using Spradley's ethnographic analysis technique (1979), three major domains emerged: "difficult times in life and/or turning points," "deciding to have a homebirth," and "dealing with labor." The themes of "Walking with God" and "Family and Home as Central" linked the three domains. The women developed a spiritual core, either in childhood or later, which helped them plan and deal with birth and other difficult times.
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CHAPTER I

INTRODUCTION

Building confidence in pregnant women has been a focus in the nursing and childbirth education literature since the 1950s. Childbirth education advocates such as Dick-Read (1959) and Lamaze (1976) recognized long ago the importance of building confidence for childbirth by educating pregnant women about birth and teaching them coping strategies for labor. Independent and hospital-based childbirth educators practice in most communities. Childbirth preparation classes of various orientations are well-accepted and attended by many pregnant women and their support persons.

Despite the continuing efforts of childbirth education proponents, many pregnant women seem to have little confidence in their ability to give birth without interventions other than emotional and physical support. These women fear the experience of childbirth and do not explore the use of coping techniques. They may also approach childbirth fully expecting to require analgesia, regional anesthesia, delivery assisted with forceps or vacuum extractor, or even Cesarean birth.

Women who enter labor with unresolved fears, encounter multiple interventions, and describe their childbirth in negative terms may not derive much
psychological satisfaction or elation from the experience. Also, some interventions encountered by women during childbirth increase the possibility of complications and the need for additional interventions (Thorp et al., 1991, 1993; Thorp, Parisi, Boylan, & Johnston, 1989). In order to optimize psychological satisfaction with birth and lessen the possibility of iatrogenic complications, nurses and childbirth educators must find ways to maximize or facilitate their pregnant clients' development of confidence or self-efficacy. This study will focus on the development of self-efficacy for childbirth as a necessary factor for the use of coping behaviors in labor.

Self-efficacy has recently been proposed as a theoretical framework to study women's confidence in their ability to cope with labor (Lowe, 1991c), and to construct and evaluate childbirth education programs (Broussard & Weber-Breaux, 1994). Research has indicated that self-efficacy or confidence for childbirth is a significant predictor for persistence in use of coping techniques, increased control during childbirth, decreased childbirth pain, and increased satisfaction with birth (Butani & Hodnett, 1980; Crowe & von Baeyer, 1989; Davenport-Slack & Boylan, 1974; Lowe, 1987, 1989; Manning & Wright, 1983). Lowe (1993) has developed an assessment tool to measure outcome expectancies and self-efficacy expectancies for coping with childbirth.
Self-efficacy is the deductively-derived construct originally developed by Bandura (1977, 1982) as part of his Social Cognitive Theory. This construct explains and predicts why different forms of psychological treatments result in psychological changes. Self-efficacy is defined as a person's judgment that he or she can effectively perform actions to deal with a particular situation, and that, given a responsive environment, desired outcomes will result (Bandura, 1982). Researchers in nursing and other disciplines have discovered that self-efficacy is a useful theory for explaining, predicting, and influencing behaviors (Crabtree, 1986; Utz, 1990).

In self-efficacy theory, a distinction is made between outcome expectations and efficacy expectations. Outcome expectations are defined as "a person's estimate that a given behavior will lead to certain outcomes" (Bandura, 1977, p. 193). Efficacy expectations are defined as "the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977, p. 193).

Outcome and efficacy expectations, along with adequate incentive and appropriate skills, are necessary for an individual to attempt a coping behavior. Self-efficacy expectations may vary according to the difficulty of the task, and may range in strength from weak to strong. The strength of self-efficacy determines the expenditure of
effort and the persistence of the effort in spite of obstacles.

Four major sources of information create self-efficacy expectations (Bandura, 1982):

1. Performance accomplishments or enactive attainment, the most dependable source, means that one learns from successful past experiences that one is able to perform a difficult task.

2. With vicarious experience, observing others successfully perform the task persuades the individual that she or he should also be able to do so.

3. Verbal persuasion from others that one is capable of successful performance may increase self-efficacy to some degree.

4. Emotional or physiological arousal while either anticipating or performing the task may be interpreted as vulnerability and decrease an individual's self-efficacy.

Bandura indicates that "the impact of information on efficacy expectations will depend on how it is cognitively appraised" (Bandura, 1977, p. 200). He states that there are a number of contextual factors that enter into the cognitive appraisal of self-efficacy information. Cognitive processing concerns learned cues and rules that people use to integrate self-efficacy information from its different sources. People vary among themselves as to the cues and rules they have learned to use to integrate self-efficacy
information. Some people are able to integrate self-efficacy information well and develop high levels of self-efficacy. Others are not as able and develop lower levels of self-efficacy. Similarly, some pregnant women develop very high levels of self-efficacy for childbirth, and others have very low levels (Lowe, 1993).

Bandura (1986) has found that it is possible to produce enduring and generalized increases in self-efficacy in people with firmly-held low judgments of self-efficacy. However, it requires "powerful confirmatory experiences in which people successfully manage task demands that far exceed those commonly encountered in their daily lives" (Bandura, 1986, p. 401). Successfully managing childbirth could be the powerful confirmatory experience that may lead to generalized increases in self-efficacy in women who may have lacked high levels prior to childbirth.

Self-efficacy appears to be a concept integral to the psychological preparation of pregnant women for childbirth. Though it deserves continued study, no research was found that specifically traced the development of self-efficacy in women preparing for childbirth. Moreover, there are no systematic studies of the life experiences that impact the positive development of self-efficacy for childbirth.

Purpose

The purpose of this research was to identify recurring themes in the lives of pregnant women with self-
efficacy for childbirth, and to propose relationships between these recurring themes and the development of self-efficacy for childbirth. Lowe's suggestions for further study included conducting qualitative as well as quantitative studies to determine whether self-efficacy is a state or trait phenomenon (Lowe, 1991c). Identifying key correlates of confidence for childbirth would refine self-efficacy theory as applied to childbirth. The intended outcome of this qualitative research study was an increased understanding of how life experiences impacted the development of self-efficacy for childbirth in this sample.

Research Questions

The research questions that guided this study were:

1. Do the participants have high levels of self-efficacy for childbirth as measured by Lowe's tool (Lowe, 1993)?

2. What life experiences can be identified through life history interviews as similar in the lives of pregnant women with self-efficacy for childbirth?

Definition of Terms

For the purposes of this study, the major terms were defined and used as follows:

1. Outcome expectancy, also called outcome expectations

   Theoretical - "the belief that a given behavior will enhance coping with labor" (Lowe, 1991a)
Operational - the participant’s Outcome-Active Labor and Outcome-Second Stage subscale scores on the Childbirth Self-Efficacy Inventory (Lowe, 1991a)

2. Self-efficacy expectancy, also called self-efficacy or efficacy expectations (Bandura, 1977; Lowe, 1991c)

Theoretical - "a personal conviction that one can successfully perform specific behaviors during labor" (Lowe, 1991a)

Operational - the participant’s Efficacy-Active Labor and Efficacy-Second Stage subscale scores on the Childbirth Self-Efficacy Inventory (Lowe, 1991a)

3. Pregnant woman

Theoretical - a female human being who has conceived either in vivo or in vitro, and has been diagnosed by a health care worker as carrying one or more viable embryos or fetuses

Operational - an adult female 21 years of age or older who is receiving prenatal care at the time of the first interview, and is in the 28th week or more of pregnancy. At the point of entry into the study, she will also be planning to give birth in an out-of-hospital
setting

4. Nullipara

Theoretical - "a woman who has not given birth at more than 20 weeks' gestation" (Olds, London, & Ladewig, 1992, p. 317)

Operational - a pregnant woman (as defined above) who has not previously given birth at more than 20 weeks' gestation

5. Multipara

Theoretical - "a woman who has had two or more births at more than 20 weeks' gestation" (Olds et al., 1992, p. 317)

Operational - a pregnant woman (as defined above) who has "previously given birth" (Lowe, 1993, p. 145) at least once at more than 20 weeks’ gestation

Assumptions

This study operated under two assumptions:

1. Pregnant women have varied life experiences. Consequently, they have learned varied cues and rules for integrating self-efficacy information about their anticipated childbirths.

2. The responses from study participants were honest, candid, and complete.

Limitations

Although the ability to generalize to other
populations is not considered an essential outcome in qualitative inquiry, some researchers regard this as a limitation (Marshall & Rossman, 1989). The sample was purposive, and was limited to ten pregnant women planning homebirths. Therefore, generalization to larger or other populations of pregnant women should be done cautiously. Germain, however, argued that if the participants studied are representative and typical of their group, "a case may be made for some degree of generalization to other specimens of a similar type" (1986, p. 160).

Also, only three of the nine post-birth interviews occurred within the first month after birth, with the other six interviews taking place at eight or more weeks postpartum. Beyond the first month, memory lapses could have occurred and distant events could have seemed less important than more recent events (Redmond, 1991).

Significance of the Study

Understanding the life experiences that may impact the development of self-efficacy for childbirth is essential to health care providers who work with women preparing for childbirth. Childbirth educators could use this increased understanding to modify their approaches to conducting childbirth education classes. Nurses involved in providing prenatal care could use this knowledge to improve the psychological and emotional support they provide to pregnant women. In addition, individuals who make policies that
affect the life experiences of women, (and consequently their development of self-efficacy for childbirth), could utilize this increased understanding in their policy-making decisions.

Health care reform anticipates that costs for health care will be contained through various strategies (Shugars, O’Neil, & Bader, 1991). Two potential strategies for the care of low-risk pregnant women are utilization of: (a) caregivers such as midwives, who can economically offer maternity care; and (b) out-of-hospital birth sites, which have been shown to be less costly (Scaer, 1993).

Care by non-physician caregivers in non-hospital settings usually precludes the administration of most anesthetics and analgesics. In the near future, pregnant women who are low-risk may be expected to handle childbirth with minimal pharmacologic intervention. These circumstances may call for maximum self-efficacy in regard to childbirth. It is crucial that caregivers and policy makers more thoroughly understand how self-efficacy for childbirth develops and how to facilitate and enhance its development.
CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature was conducted to organize information about the current knowledge base related to confidence or self-efficacy for childbirth. This literature review begins with a brief examination of selected studies that support the importance to women of maintaining control or experiencing mastery in childbirth. Clinical studies on confidence in the childbearing experience are presented next. Bandura’s work on self-efficacy is examined as a theoretical framework for exploring the development of maternal confidence in the ability to cope with childbirth (Bandura, 1977, 1982, 1983, 1985, 1986; Bandura, Adams, Hardy, & Howells, 1980; Bandura, Reese, & Adams, 1982). Finally, this review examines the studies on self-efficacy for childbirth.

Studies on Control and Mastery

One of the earliest research studies on the concept of control in labor is from Davenport-Slack and Boylan (1974). They found that the following factors predicted a positive and rewarding childbirth experience for the 75 female subjects: (a) attendance at childbirth preparation classes, (b) positive attitude toward pregnancy and birth, (c) desire to participate in the birth and have the husband present, (d) higher levels of education, (e) lower degrees
of general reactivity to pain, and (f) expectation of lower
degrees of analgesia use. The common denominator for these
factors was identified as "self-reliance, self-control, and
independence" (Davenport-Slack & Boylan, 1974, p. 222).
Although the measures used for some of the predictor
variables seem either unsophisticated, unidimensional, or
poorly described, this study was one of the first to explore
the impact of psychological factors on childbirth.

Further evidence for the importance to women of
control during childbirth was provided by Willmuth (1975),
who performed a content analysis of postpartum birth reports
of 145 women who had attended prepared childbirth classes.
The analysis revealed that the reason for the women’s
positive assessments of their experience was their ability
to stay in control during childbirth. Three meanings of
control were noted: most commonly (a) control of decision-
making in interpersonal relationships with the staff, and
(b) self-control of behavior, with (c) control of pain
perception, occasionally mentioned. Only a small number of
women credited pain reduction as the primary reason for a
positive childbirth experience.

Similar results occurred in another study (Butani &
Hodnett, 1980) in which 50 postpartal women were asked open-
ended questions to determine what contributed to a positive
birth experience. Personal control during labor was
important to the majority of their sample (39 women).
Based on increasing research evidence, Humenick (1981) proposed mastery in childbirth as a new model to replace the pain management model of childbirth satisfaction. Her review of research literature supports the viability of the mastery model, which is that mastery of the task of childbirth requires preparation for active participation and development of a support system. Mastery is the key factor influencing satisfaction in childbirth, assuming that pain is managed by the woman at an acceptable level.

This model was tested (Humenick & Bugen, 1981) on 33 primigravidas. The results of the data analysis partially supported the model. The women’s prenatal attitude about active participation (confidence) predicted their positive evaluation of the childbirth experience (satisfaction), and their perceptions of their ability to control childbirth (mastery) predicted increases in instrumentality from antepartum to postpartum. Instrumentality is a concept which includes "decisiveness, confidence, and ability to stand up well under pressure" (Humenick & Bugen, 1981, p. 84). The study was limited by small sample size and convenience sampling, limiting generalizability of the results.

Hodnett and Simmons-Tropea (1987) developed an instrument, the Labour Agentry Scale (LAS), to measure expectancies and/or experiences of personal control during
childbirth. Each of the two alternate forms contains 29 seven-step Likert-type statements relating to feelings of mastery or control during birth. Results of psychometric testing indicated good reliability and validity, and a factor analysis indicated that the single common factor underlying all 29 items was personal control in childbirth.

Hutton (1985) had administered the LAS to 48 postpartal women, and found significant positive correlations between perceived human support in childbirth and levels of experienced control, and between control and measures of satisfaction in childbirth. An inverse relationship occurred between use of pain-relieving drugs and control experienced in childbirth.

And lastly, a recent prospective study (Green, Coupland, & Kitzinger, 1990) of 825 women further emphasized the importance of control and its impact on psychological outcomes of childbirth. Women in this study who expected to be in control during birth were more likely to achieve control, to use no pain-relieving drugs, and to have higher levels of satisfaction and feelings of emotional well-being postpartally.

Abundant evidence exists of the importance of control in labor to positive postpartal psychological outcomes. Some of the reviewed studies provide indications that achievement of control or mastery during birth requires that women perceive themselves to be capable of dealing with
birth, and willing to be active participants in birth. The next section will address confidence in the childbearing experience.

**Clinical Studies on Confidence in the Childbearing Experience**

Seven clinical studies were identified that addressed confidence as an important psychological construct for childbirth. Five studies were performed to determine the psychosocial predictor variables for labor pain and distress. Three of these five studies were performed by Lowe (1987, 1989, 1991b), and led to her later research about confidence or self-efficacy for childbirth. The last two studies did not focus primarily on confidence for childbirth, but nonetheless augment understanding of this variable.

**Studies of Psychosocial Predictor Variables for Labor Pain and Distress**

**Lowe's studies.** Lowe (1987) studied 50 women with term singleton pregnancies as they entered the hospital in labor. She administered the McGill Pain Questionnaire (MPQ), an established instrument with good reliability and validity (Melzack, 1975), to women in early labor, active labor, transition, and second stage. The Self-Evaluation in Labor Questionnaire (SELQ), a 21-item, 4-point Likert-type scale (E. Lederman, R. Lederman, & Kutzner, 1982), was administered in early and/or active labor to measure the
psychological predictor variables of state anxiety, concern about labor outcome for self and baby, fear of labor pain, and confidence in ability to cope with labor.

Correlational and multiple regression analyses were performed to determine the relationships among the variables. The higher the level of confidence in the ability to cope with labor, the lower was the level of pain during early and active labor. The only variable that contributed significantly to variation in early labor pain proved to be confidence in the ability to cope with labor (62% of the variance). State anxiety and fear of pain, as measured during early labor, explained 53% of the variance in active labor pain. The only significant variable measured during active labor was confidence in the ability to handle labor (predicting 31% of the variance of active labor pain). In addition, other data reported in the study suggests that confidence in ability to cope with labor was highly associated with postpartal reporting of control during labor (Lowe, 1987).

Lowe repeated this study with a larger sample of 134 low-risk women, with the instruments administered only during active labor (Lowe, 1989). The same relationship was found between confidence and labor pain. Of all the predictor variables, confidence was the most highly correlated variable to the sensory, evaluative, and affective subscales of the MPQ (0.306, 0.360, 0.603), with
significance levels of \( p < .001 \). The correlation between confidence and total MPQ scores was .508, with the next highest correlation being between fear and total MPQ scores (.373), with significance levels at \( p < .001 \). Because of the multicollinearity that existed among some of the independent variables, a reduced regression model was produced by stepwise regression. The only variables which explained significant amounts of the variance in pain were confidence, childbirth preparation, and frequency of contractions, with confidence explaining 26% of the variance in total MPQ scores. Lowe acknowledged the lack of generalizability of her findings and recommended replication in other populations, investigation of prenatal and intrapartal interventions to enhance confidence, and exploration of the impact of previous childbirth experiences on confidence.

Lowe's third study (Lowe, 1991b) again replicated her 1987 study, but with a larger sample of 151 women, with measurement of additional predictor variables for labor pain, and with the use of a modified pain measurement instrument (Short-form McGill Pain Questionnaire or SF-MPQ, which includes sensory and affective subscales only) (Melzack, 1987). Validity data for the SF-MPQ was reported, along with acceptable reliability estimates for this study. The results were essentially the same: stepwise regression analysis revealed that the most significant predictor of affective pain in early, active, and transitional labor, as
well as sensory pain in early and active labor, was lack of confidence in the ability to cope with labor. In combination with one or two of the other variables such as cervical dilatation, length of labor, fetal station, severity of menstrual pain, and/or parity, confidence explained from 21% to 39% of affective or sensory pain during each of the various phases of labor. Analysis of the data on transition pain in the 43 subjects who had no epidural anesthesia indicated that the three predictor variables of confidence, frequency of contractions, and severity of menstrual pain explained even more variance (46.5% of the variance in sensory pain score and 50% of the variance in affective pain score).

Crowe and von Baeyer's study. Crowe and von Baeyer (1989) administered questionnaires to 21 primigravidas prior to and after prenatal classes to evaluate six psychosocial variables as predictors of childbirth pain and other birth outcomes. The variables were: knowledge of childbirth, fears about childbirth, locus of control, state anxiety, expectations of pain during birth, and confidence in ability to control pain. Within 24 to 48 hours after childbirth, pain was measured retrospectively via the McGill Pain Questionnaire (MPQ) (Melzack, 1975) and a 10-centimeter Visual Analog Scale (VAS) (Huskisson, 1983).

Stepwise multiple regressions with forward inclusion were used to identify significant preclass and postclass
predictors. Greater preclass confidence predicted less pain as measured by the MPQ ($r = -.52$). Postclass confidence predicted less pain as measured by both the MPQ ($r = -.37$) and the VAS ($r = -.53$). Significance levels for all three correlations were $p < .05$. Additionally, the postclass variable of more knowledge about childbirth was a significant predictor of less childbirth pain, whether measured by MPQ ($r = -.52$) or VAS ($r = -.79$), with significance levels of $p < .01$.

Weaknesses of the study included lack of reliability and validity information on each of the instruments used, small sample size, and the threat to validity posed by a possibly differential loss of 9 subjects from the original convenience sample of 30. In addition, the MPQ may have been inappropriately administered for several reasons. The MPQ was described as consisting of "20 groups of pain descriptors from which subjects choose one word" (Crowe & von Baeyer, 1989, p. 60), but the instructions for the MPQ are for subjects to choose a word from a group only if it applies to their pain experience (Melzack, 1975). Also, no reliability estimates were reported, although the MPQ was adapted to measure preclass expectations of childbirth pain.

Witchik, Hesson, and Bakal’s study. The responses of 115 low-risk primigravidas during the last trimester and during labor were analyzed to examine the ability of designated prenatal variables to predict labor pain and
coping or distress-related thoughts during labor (Wuitchik, Hesson, & Bakal, 1990). The women took the Prenatal Self-Evaluation Inventory (for which reliability and validity data are given) during the last trimester, providing seven subscale scores, including fear of pain and helplessness. In addition, nine-point Likert scales were administered on admission to the hospital in labor in order to assess frequency of practice of prepared childbirth techniques and degree of confidence in their ability to use them.

Pain during each phase of labor was determined via administration of the Present Pain Intensity scale (PPI) of the McGill Pain Questionnaire (Melzack, 1983). Also, during each phase of labor, thoughts about coping and/or distress were elicited, coded, and scored. Women who had high fear of pain and helplessness also had more intense pain and distress-related thoughts in each phase of labor. Women who were confident in their ability to use relaxation during labor had less intense pain in the latent phase and fewer distress-related thoughts in active labor.

Stepwise multiple regressions indicated that 7% of the variance in latent labor pain was predicted by confidence in the use of relaxation. The predictor variable of concern for self and baby contributed significantly to pain in the active and transition phases. The authors suggest that with the move into active labor, the basic anxieties about the baby’s welfare and possible labor
complications become apparent, and start to impact pain and distress in labor, despite the confidence women may have felt at the beginning of labor.

Studies Which Augment Understanding of Confidence for Childbirth

Two other research studies address confidence as an issue in childbirth though it is not the primary focus of the studies. Sakala (1988) formally studied the practices of independent midwives in Utah in order to evaluate their approaches for potential benefits to their clients. These midwives believe that fear is a significant source of childbirth pain. During the prenatal period, they emphasize the involvement of the woman’s husband, the resolution of any conflicts the woman may have which could be a source of stress, and "the woman’s own empowerment through knowledge and confidence" (Sakala, 1988, p. 1147).

Morse and Park (1988) designed a post-hoc comparative study in which 149 homebirth mothers and 102 hospital-delivered mothers compared the intensity of their childbirth pain with eight other painful events. The hospital-delivered women rated pain in childbirth significantly higher than those who delivered at home (as the second most painful type of pain versus the seventh most painful event).

The authors suggested that prenatally the homebirth mothers may have used the psychological technique of bolstering to justify their decision and to downplay or
devalue the expected childbirth pain. The authors speculated that bolstering "may give the mother enough confidence to lower her anxiety and thus reduce pain" (Morse & Park, 1988, p. 178).

An alternate or additional explanation was not explored by the authors: it may have been that the homebirth mothers (more of whom were multiparas than in the hospital-delivered group) possessed higher levels of self-efficacy or confidence for childbirth, resulting in confidence and persistence in the use of coping techniques in labor, and less pain as a result. One weakness in the study, therefore, was the failure to control the variable of parity, or even to report the exact numbers of primigravidas and multigravidas in the homebirth and hospital groups. It would have been interesting to see the statistical analyses performed on the scores of the primigravida homebirth mothers as compared to the primigravida hospital birth mothers, as well as the scores of the multigravida homebirth mothers as compared to the multigravida hospital birth mothers.

Theoretical Perspectives on Self-Efficacy

Self-efficacy is the construct developed by Bandura (1977, 1982, 1983, 1985, 1986) as part of his Social Cognitive Theory to explain how cognitive processes mediate the relationship between knowledge and performance of skilled activities. Bandura has demonstrated that, to
function competently, one must not only possess the appropriate skills, but also judge oneself capable of performing them. Possessing self-efficacy allows the individual to be actively engaged in challenging tasks, to expend effort, and to persist in overcoming barriers. Self-efficacy has been found to be a better predictor of future behavior than is past behavior (Bandura, Adams, Hardy, & Howells, 1980). Self-efficacy also may generalize from one activity to other similar activities (Bandura, 1977).

A distinction is made between self-efficacy expectancy, defined by Bandura (1986, p. 391) as "judgments of one's capability to accomplish a certain level of performance," and outcome expectancy, defined as a "judgment of the likely consequence such behavior will produce" (Bandura, 1986, p. 391). An individual can possess outcome expectancies without possessing self-efficacy expectancies.

The approach taken in self-efficacy research has been to develop measures that are tailored to the particular tasks of interest (Bandura, Reese, & Adams, 1982). This strategy allows the researcher to determine the degree of congruence between self-efficacy expectancies and performance of the particular task (Bandura, 1986). It should be noted, however, that some researchers believe a generalized self-efficacy construct exists and have developed an instrument to measure it (Tipton & Worthington, 1984).
Self-efficacy is based on four sources of information: (a) performance attainments or enactive attainments based on actual mastery experiences; (b) vicarious experiences in which the mastery experiences of others are observed or visualized; (c) verbal persuasion and similar kinds of social influences; and (d) physiological states such as autonomic arousal, fatigue, and pain, which inform the individual of his or her own degree of vulnerability (Bandura, 1985). Efficacy indicators, examples of which are described below, exist for each of the four sources of self-efficacy information. In addition, Bandura has found that this information is not automatically accepted, but rather cognitively appraised for selection, weighting, and then integration into an individual's self-efficacy judgment (Bandura, 1986). A number of factors such as "personal, social, situational, and temporal circumstances" (Bandura, 1986, p. 401) affect cognitive appraisal. Examples are that a "perceptual set" will affect how individuals interpret "what they see and hear" (Bandura, 1985, p. 91), and depressed affect can decrease personal judgments of self-efficacy (Bandura, 1986).

Serving as indicators of self-efficacy for performance accomplishments are: (a) success at a difficult rather than an easy task, (b) success attributed to personal capability rather than external aid, and (c) expenditure of minimal effort for a successful performance. Performance of
difficult tasks with much effort under ideal conditions contributes more to self-efficacy than failure under the same conditions. Continued improvements at task performance with periodic failures increases self-efficacy more effectively than continued success with a leveling off of performance (Bandura, 1986).

Examples of efficacy indicators for vicarious experience which are most effective in increasing self-efficacy are as follow: (a) vicarious viewing of effortful rather than effortless behavior, (b) similarity of the models to the viewers rather than dissimilarity, (c) diversity of models rather than a single model, and (d) depiction of outcomes that are rewarding (Bandura, 1977). Modeled behavior that stresses predictability and controllability of threats to successful performance enhances self-efficacy (Bandura, Reese, & Adams, 1982).

Efficacy indicators for verbal persuasion include the "perceived credibility of the persuaders, their prestige, trustworthiness, expertise, and assuredness" (Bandura, 1977, p. 202), all of which enhance confidence in the persuader (Bandura, 1986) and increase the impact of verbal persuasion. Other factors that enhance both confidence in the persuader and self-efficacy from this information source are the perceptions that the persuader has extensive evaluative competence and a thorough understanding of task difficulty (Bandura, 1986).
Efficacy indicators for physiological arousal include attribution of physiological reactions to external factors or to positive emotions, or interpreting them as commonly experienced by competent people. These contribute more to self-efficacy than attribution to personal weakness or inability (Bandura, 1986). Generally, moderate levels of physiological arousal facilitate skill performance, and high levels obstruct performance. Past experience with physiological arousal as either facilitating or debilitating will affect the impact of this information on self-efficacy (Bandura, 1986).

Studies on Self-Efficacy for Childbirth

Four studies have used self-efficacy theory as a framework for studying self-efficacy for childbirth. Manning and Wright (1983) were the first to use self-efficacy theory as a framework to study confidence for childbirth. After Lowe's initial studies involving confidence for childbirth (Lowe, 1987, 1989, 1991b), she thoroughly explored self-efficacy theory for its applicability to the study of confidence for childbirth (Lowe, 1991c), and then developed and used an instrument to measure outcome expectancies and self-efficacy expectancies for coping with childbirth (Lowe, 1993). Broussard and Weber-Breaux (1994) used self-efficacy along with the Health Belief Model to construct a model for the design, conduct, and evaluation of childbirth education classes.
Manning and Wright's Study

Manning and Wright (1983) developed an unnamed instrument to measure self-efficacy expectancy for childbirth, outcome expectancy, and the importance of this outcome to the subject. Self-efficacy expectancy for childbirth was defined simply as "anticipated ability to control the pain of labor and delivery without pain medication" (Manning & Wright, 1983, p. 424). It was assessed for 5-hour intervals of a potential 25-hour labor, using a "yes/no" response and a 6-point Likert scale for degree of certainty.

Outcome expectancy was similarly measured using a 6-point Likert scale indicating degree of agreement. Subjects responded to the statement, "The techniques for controlling pain which are taught in Prepared Childbirth classes will make it possible for a woman to go through labor and delivery without pain medication for X hours" (Manning & Wright, 1983, p. 425). Importance of the outcome, defined as a medication-free labor and delivery, was assessed with a 7-point Likert-scale.

Manning and Wright's instrument was administered to 52 primigravidas at three different times: (a) at the conclusion of a childbirth education class series (Phase 1), (b) while in early labor (Phase 2), and (c) several days after delivery (Phase 3). Phase 3 data concerned the subject's expectancies regarding her next childbirth
experience. Test-retest reliability for relevant self-efficacy expectancy scores from Phase 1 to Phase 2 (corresponding to the five-hour time period in which the delivery actually occurred) was found to be .64. The test-retest reliability for relevant outcome expectancy scores was .77. Test-retest reliability for importance of the outcome scores from Phase 1 to Phase 2 was reported as .82. Evidence was presented for criterion-related (predictive) validity, construct validity, and discriminant validity of the instrument.

Manning and Wright found that the use of medication in childbirth was negatively correlated with self-efficacy expectancy \( r = -.47, p < .001 \), outcome expectancy \( r = -.39, p < .01 \), and importance of the outcome \( r = -.31, p < .03 \). Percentage of time in labor without pain medication was found to be positively correlated to the three predictor variables of self-efficacy expectancy \( r = .42, p < .01 \), outcome expectancy \( r = .38, p < .01 \), and importance of the outcome \( r = .35, p < .05 \). As expected, possession of self-efficacy expectancies contributed more to the prediction of persistence in pain control without the use of medication than did outcome expectancy or importance of the outcome.

Although this study was important for several reasons, there have been criticisms of its narrow focus on medication-free labor and delivery as the outcome (Lowe, 1991c) and on its misconstruing outcome expectations "as the
effectiveness of a technique" (Bandura, 1986, p. 392). Bandura states: "Means are not results. An efficacious technique is a means for producing outcomes, but it is not itself an outcome expectation" (Bandura, 1986, p. 392).

Lowe's Studies

With the results of her earlier studies indicating that much of the variance in labor pain could be explained by a woman's confidence in her ability to cope with labor, Lowe sought a theoretical framework for her continued study of confidence for childbirth. As did Manning and Wright before her, Lowe found that self-efficacy theory was well-suited to her research needs.

Lowe's examination of self-efficacy as a framework for evaluating confidence for childbirth. Lowe (1991c) first thoroughly explored self-efficacy theory for its applicability to the study of women's confidence about coping in labor. The main tenets of self-efficacy theory were described and applied to women anticipating childbirth. For example, Lowe provided evidence from various studies that pregnant women derive self-efficacy information about coping with childbirth from the four sources of self-efficacy information described by Bandura (1977, 1982). Information is also given to support the contention that self-efficacy expectancies for childbirth may vary in magnitude, strength, and generality, and that pregnant women can differentiate between outcome expectancies and self-
efficacy expectancies for childbirth.

Lowe (1991c) concluded with implications for childbirth educators and maternity nurses for understanding self-efficacy as applied to pregnant women and childbirth education, and with suggestions for further study. Lowe’s recommendations for further study were to conduct qualitative as well as quantitative studies to determine whether self-efficacy is a state or trait phenomenon, and to identify key correlates of confidence for childbirth in order to refine self-efficacy theory as applied to childbirth.

Lowe’s development of a tool for measuring self-efficacy for childbirth. Before proceeding with her research, Lowe developed a valid and reliable instrument based on self-efficacy theory (Lowe, 1993). The development, pilot testing, revision, and further detail about psychometric evaluation of Lowe’s Childbirth Self-Efficacy Inventory (CBSEI) is reported in Chapter III.

The final form of the CBSEI (Appendix A) is comprised of four subscales, each with 15 or 16 items. Each item has a 10-point Likert response scale (Lowe, 1993). There are two subscales for outcome expectancies and two subscales for self-efficacy expectancies.

The two subscales for outcome expectancies, Outcome-Active Labor and Outcome-Second Stage, measure how helpful the pregnant woman feels the indicated behavior could be in
coping with childbirth. Outcome-Active Labor (AL) is a subscale of outcome expectancies for 15 coping behaviors that can be used during active labor. Outcome-Second Stage (SS) is a subscale of outcome expectancies for 16 coping behaviors that can be used during second stage (pushing).

The two subscales for self-efficacy expectancies, Efficacy-Active Labor and Efficacy-Second Stage, measure the woman's degree of certainty about her ability to use the indicated behavior to cope with childbirth. Efficacy-Active Labor (AL) is a subscale of self-efficacy expectancies for the same 15 coping behaviors for active labor. Efficacy-Second Stage (SS) is a subscale of self-efficacy expectancies for the same 16 coping behaviors for second stage.

Outcome-AL and Efficacy-AL scores can each range from 15 to 150, and Outcome-SS and Efficacy-SS scores can each range from 16 to 160. Total CBSEI outcome and self-efficacy expectancy scores can range from 31 to 310. The higher the score, the higher the individual's outcome expectancy and/or self-efficacy expectancy for active labor or second stage.

The CBSEI was completed by 351 women attending childbirth education classes (Lowe, 1993). Four other instruments were also administered: (a) the Generalized Self-Efficacy Scale (Tipton & Worthington, 1984), (b) the Self-Esteem Scale (Rosenberg, 1965), (c) the Multidimensional Health Locus of Control Scale (K. Wallston,
B. Wallston, & DeVellis, 1978), and (c) the Learned Helplessness Scale (Quinless & Nelson, 1988).

The CBSEI was found to be sensitive to a wide range of both outcome and self-efficacy expectancies for childbirth in nulliparas and multiparas. As predicted by self-efficacy theory and the impact of previous actual mastery experiences with childbirth, mean Efficacy-AL, Efficacy-SS, and Efficacy-Total scores for multiparas were significantly higher than those mean scores for nulliparas, according to independent t tests (t = 3.21, 2.69, and 3.12, respectively, with a significance level of p<.008). For both nulliparas and multiparas, self-efficacy expectancy scores were significantly lower than outcome expectancy scores for both active labor and second stage (p<.001), indicating that respondents could differentiate between potential helpfulness of coping behaviors for labor, and certainty about their own personal ability to utilize these behaviors.

Reliability was evaluated by estimating internal consistency, which varied between .86 to .95 for the four subscales of the CBSEI (Lowe, 1993). Test-retest correlations were all significant at p<.01. The results of factor analysis supported construct validity of the CBSEI. Low-magnitude positive correlations were found between the self-efficacy scales (Efficacy-AL, Efficacy-SS, and Efficacy-Total) and the Generalized Self-Efficacy Scale, the
Self-Esteem Scale, and the Internal-Health Locus of Control subscale, thus providing evidence of criterion-related validity. As predicted, the self-efficacy scales were negatively correlated to a significant degree with the Learned Helplessness Scale. Lowe concluded that the CBSEI demonstrated good psychometric properties and could be used to test hypotheses about the development of self-efficacy in childbirth.

Broussard and Weber-Breaux’s Study

The purpose of this study (Broussard & Weber-Breaux, 1994) was to integrate self-efficacy theory and the Health Belief Model (HBM) (Rosenstock, 1974) into a framework for the design, conduct, and evaluation of childbirth education classes. The HBM proposes that psychological readiness to perform health-related behaviors (such as coping behaviors in childbirth) is at least partially determined by the simultaneous presence of four sets of factors: (a) perceived susceptibility to a health-related problem, (b) the perceived severity of the problem, (c) the predominance of perceived benefits of taking health-related action in relation to the perceived barriers to action or costs of action, and (d) cues of sufficient strength to trigger action. For health-related actions to occur, the perceived benefits must outweigh the perceived barriers or costs of taking action such as physical, economic, psychosocial, environmental, and other considerations. Cues of sufficient
strength to trigger action could include internal cues such as physical sensations, and external cues such as advice from others or the media. Demographic, psychosocial, and structural variables are recognized as having the potential to influence individual perceptions and thus impact health-related behaviors.

Broussard and Weber-Breaux acknowledged that self-efficacy theory and the HBM seem to be interrelated and complementary. One example given is that the original HBM does not explicitly acknowledge the importance of an individual's feeling capable of performing health-related tasks (self-efficacy). Also, an individual who possesses self-efficacy for a task must also: (a) possess the incentive, (b) feel susceptible, (c) perceive some benefits to performance of the task, (d) overcome or minimize any perceived barriers, and (e) perceive cues (elements of the HBM), in order to perform. Each component of the Childbirth Belief-Efficacy Model (CBEM) is examined with application to the pregnant woman preparing for childbirth. Implications for childbirth educators are described.

Summary

The literature seems to support mastery or control during childbirth, as well as decreased perception of childbirth pain, as a function of self-efficacy or confidence for childbirth. Satisfaction in the childbirth experience and other positive outcomes are the results. It
is important to understand what factors impact the development of self-efficacy for childbirth. No research within the self-efficacy framework was found that specifically traced the development of self-efficacy for childbirth in pregnant women. Nor were there any systematic studies of life experiences that impact the development of self-efficacy for childbirth in women who possess it.
CHAPTER III

METHOD

The research design was qualitative in nature, befitting the study of a concept that has not been thoroughly investigated (Field & Morse, 1985; Marshall & Rossman, 1989). This section describes the sample and settings for this research and the instruments used. Data analysis is also discussed. And lastly, issues of rigor in qualitative research are addressed.

Sample

A purposive sample of 10 pregnant women planning homebirth was obtained (Field & Morse, 1985). All of the participants happened to be multiparas. Participants were selected for their ability to "illuminate the phenomenon being studied" (Sandelowski, Davis, & Harris, 1989, p. 79), that of self-efficacy for childbirth in pregnant women. The sample was collected over a seven month period, and included every pregnant woman within a one-hour driving radius who met the study criteria and with whom the researcher could schedule an interview prior to childbirth. Although Field and Morse (1985) recommend maximizing diversity in qualitative research samples, the population from which to sample in this study was limited. Therefore, it was not possible in the later stages of the study to purposefully maximize diversity by choosing participants that were
different in their socioeconomic or cultural characteristics from the initial participants.

Participants were women over 21 years old, who were in their third trimester of pregnancy at the time of the initial interview (28th week or beyond), and who were anticipating homebirth. All participants were able to speak and read English. Participants were identified through the researcher’s contacts with licensed midwife practitioners (LMPs) in Lafayette and Baton Rouge. LMPs are licensed to practice in the State of Louisiana by the Louisiana State Board of Medical Examiners. The LMPs obtained permission from the pregnant women for the researcher to make the initial telephone contact.

During the telephone contact, the researcher briefly explained the study to each participant. In addition, the researcher informed each participant that interviews would be tape-recorded, that she could refuse to answer any question or stop the interview at any time, and that she would remain anonymous to others (Field & Morse, 1985).

Once verbal phone consent from each participant was obtained, the researcher established a convenient date and time during the last trimester of pregnancy for initial data collection. The participants had uncomplicated homebirths, except for one woman who was admitted five weeks preterm to the hospital in labor and had an unmedicated, uncomplicated birth there.
The researcher scheduled second, follow-up interviews within the first few months after birth. Because of scheduling problems, it was not feasible to perform all of the second interviews within the first month after birth, as originally planned. Three interviews were performed within the first month postpartum, but six interviews took place between 8 and 13 weeks after birth. If clarification had been needed, a third interview could have been requested, but this was not regarded as necessary for any of the participants.

Nine of the ten participants were interviewed a second time. The woman who had the preterm birth in the hospital was not interviewed again, because she would not have been able to provide any information or insights about the actual experience of homebirth. Her pre-birth interview data was utilized because it was considered valid and relevant in that she was anticipating a homebirth at the time of the initial interview. She also had met the other subject inclusion criteria at this time.

Because of the nature of the research design, it was not possible to state the exact number of participants to be interviewed prior to data collection. However, it was anticipated that between 10 to 20 women would be interviewed (Lincoln & Guba, 1985). After ten participants were interviewed and 19 interviews analyzed, the researcher evaluated the progress of data collection and analysis.
Data saturation had occurred, meaning no new themes were derived from the data and repetition of data was occurring, so the decision was made to cease sampling. Callister indicated that about 20 interviews "are necessary to elicit major repetitive themes of the topic under study" (1994, p. 16).

Nine participants chose to be interviewed in their own homes. Research studies conducted in the participant's own environment "create less risk" for the participant because the setting is under the control of the participant and not the researcher (Morse, 1988, p. 214). One participant preferred to be interviewed in the home of the researcher, because the location was convenient and allowed fewer interruptions than her own home. The researcher made efforts to provide privacy and comfort and to minimize interruptions and distractions (Field & Morse, 1985).

Instruments

Two quantitative instruments were utilized with each participant. The researcher completed a demographic data sheet and then administered the Childbirth Self-Efficacy Inventory (CBSEI) (Lowe, 1991a) to each participant. The researcher then conducted the life history interview.

Demographic Data Sheet

The researcher completed a researcher-designed demographic data sheet (Appendix B) to gather data about a number of demographic characteristics. The data sheet
required information on the age, educational background, employment history, race, and ethnic group of each participant and her significant other, as well as family income range and relationship of participant to significant other. In addition, the following information was elicited: maternity history, information on current pregnancy, information about childbirth classes, and type of caregiver.

**Childbirth Self-Efficacy Inventory (CBSEI)**

The CBSEI was used in an attempt to establish empirically the expected high levels of self-efficacy of the participants. Permission was obtained from the author of the tool for use in this research (see Appendix C). The development, pilot testing and revision, and further detail about psychometric evaluation of the CBSEI are described below.

**Development.** Semi-structured interviews were conducted with 23 primiparas and 25 multiparas within 48 hours of uncomplicated vaginal birth to elicit perceptions of coping behaviors for labor. Content analysis of the audiotapes resulted in the generation of 56 items for the tool. The 56 items were sorted into eight categories of behavior and one category labelled "uncategorized", each with 2 to 10 items. Six content experts judged each item on a scale of 1 to 3 as having from "little to no information" (1) to "maximum information about self-efficacy for labor" (3) (Lowe, 1993, p. 143). Items with little to no
information were deleted, reducing the item pool to 33 items and seven categories, each with 1 to 8 items. These 33 items were examined for redundancy, resulting in a tool with 20 items and seven categories, with 1 to 6 items in each category (Lowe, 1993).

The 20 items were ordered randomly. The instructions for the tool were for the respondent to indicate (with either "yes" or "no") which behaviors they expected to perform in labor, and the strength of their expectancies on a 10-point scale. The items were used first for early labor, repeated for active labor, and then for second stage expectations, producing a 60-item tool. Minor changes followed evaluation by three measurement experts, resulting in a tool for pilot testing with a reading level for grade 7 or grade 8 (Lowe, 1993).

Pilot testing and revision. The CBSEI was distributed to 96 healthy pregnant women in their third trimester who were enrolled in childbirth education classes. The instrument was completed and returned in the mail by 76 (79%) of the women (Lowe, 1993).

Cronbach's alpha coefficients of internal consistency ranged from .67 to .81 for the three subscales. Examination of responses and the statistical analyses established the need for four revisions: (a) removal of five items from the active labor subscale and four from the second stage subscale because they had item-total correlations below .3;
(b) elimination of the early labor subscale because the participants were unable to discriminate well between the early labor and the active labor subscales; (c) dropping of the "yes/no" response, since the participants invariably indicated "yes" for expectation of using behaviors in labor; and (d) addition of measures of outcome expectancies for each coping behavior (Lowe, 1993). The final form of the CBSEI was described in Chapter II.

Psychometric evaluation. Some information about psychometric evaluation of the CBSEI was introduced in Chapter II. Additional information is presented here. Cronbach's alpha coefficients for each subscale were .86 for Outcome-Active Labor, .93 for Efficacy-Active Labor, .90 for Outcome-Second Stage, and .96 for Efficacy-Second Stage. Item-total correlations were above .30 for all items. Between subscale correlations were .71 for Outcome-Active Labor and Outcome-Second Stage, and .79 for Efficacy-Active Labor and Efficacy-Second Stage. Correlations between Outcome and Efficacy subscales were moderate for both active labor ($r = .48$) and for second stage ($r = .50$).

Two-week test-retest correlations on 69 randomly-drawn participants were all significant at $p < .01$: .56 for Outcome-Active Labor, .76 for Efficacy-Active Labor, .46 for Outcome-Second Stage, and .69 for Efficacy-Second Stage. The equivocal nature of some test-retest correlations was attributed by Lowe (1993) to self-efficacy for childbirth
being a state phenomenon rather than a trait phenomenon, and to the potential effect of ongoing attendance at childbirth education classes.

Four separate principal axes factor analyses with orthogonal and oblique rotation were used to examine the structure of the four subscales and determine construct validity. For each of three subscales (Outcome-Active Labor, Efficacy-Active Labor, and Efficacy-Second Stage), one factor with eigenvalue > 1.0 was extracted, accounting for 35-55% of the variance in each subscale. For the fourth subscale, Outcome-Second Stage, three factors were extracted with eigenvalues > 1.0, but the first and second factors, explaining 48.4% of the variance, "were theoretically and empirically uninterpretable" (Lowe, 1993, p. 147). In addition, since the third factor was very brief (two items), it could not be used as a subscale, and it was decided that Outcome-Second Stage would remain as a unidimensional subscale in the CBSEI (Lowe, 1993).

Criterion-related validity was established with low-magnitude positive correlations between CBSEI subscales and the criterion variables of generalized self-efficacy, self-esteem, and internal health locus of control (see Table 1). Self-efficacy subscale scores were negatively correlated with chance health locus of control and helplessness scores (see Table 1). All correlations were statistically significant at p<.002 (Lowe, 1993).
Table 1

Pearson Product Moment Correlations Between CBSEI Efficacy Scores and Criterion Scores

<table>
<thead>
<tr>
<th>Scales</th>
<th>Efficacy-AL</th>
<th>Efficacy-SS</th>
<th>Efficacy-Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generalized Self-Efficacy</td>
<td>.29</td>
<td>.28</td>
<td>.30</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>.18</td>
<td>.22</td>
<td>.21</td>
</tr>
<tr>
<td>Internal-Health Locus of Control</td>
<td>.22</td>
<td>.25</td>
<td>.25</td>
</tr>
<tr>
<td>Chance-Health Locus of Control</td>
<td>-.18</td>
<td>-.20</td>
<td>-.20</td>
</tr>
<tr>
<td>Helplessness</td>
<td>-.16</td>
<td>-.17</td>
<td>-.17</td>
</tr>
</tbody>
</table>

Life History Interviews

Life history interviews were performed because of their potential for identifying a set of common themes in the lives of the participants (Field & Morse, 1985), and also because of their potential for understanding how self-efficacy is expressed in their lives. This identification was the purpose of this research. A life history is a more or less comprehensive account and analysis of a person's life. In contrast to earlier life history studies (Mandelbaum, 1973), the life history interviews in this
study were focussed, but not exhaustive. In more recent life history studies, either large numbers of participants were interviewed (Mercer, Nichols, & Doyle, 1988), or interview time for each of the six to eight participants totalled 1½ - 6 hours across two to three interviews (Bramwell, 1984; Redmond, 1991). In this study, each of the 19 interviews generally lasted about 1 - 1½ hours, with a few interviews taking as long as 2 - 3 hours to complete.

Life history has been an important technique in ethnographic anthropology since at least the 1920s (Dollard, 1935; Langness & Frank, 1981). It has been advocated for use in qualitative research (Marshall & Rossman, 1989), and has been recommended and utilized more frequently by nurse researchers in recent years (Bramwell, 1984; Hagemaster, 1992; Mercer, Nichols, & Doyle, 1988; Redmond, 1991). Marshall and Rossman (1989) indicated some of the advantages of the life history, including a vicarious view of the life of an individual, production of many hypotheses for future research, and, when multiple life histories are studied in comparison, insights into adaptive processes. Hagemaster (1992) found the life history appropriate to nursing’s holistic view of the individual.

One of the goals of ethnographers and others who use the life history method is to "present the insider’s view of a culture" (Langness & Frank, 1981, p. 29). Ethnographers are concerned with psychologically embedded norms "which
guide the actions of individuals in a specific culture" (Field & Morse, 1985, p. 22-23). Mandelbaum (1973) indicates that the life history process emphasizes the individual's experiences and requirements in coping with society. Moreover, life history can emphasize the ways in which individuals differ from others in their own culture (Hagemaster, 1992).

Life history was an appropriate data collection method for this research study. Women who plan home or out-of-hospital birth may have had life experiences that affect their development of self-efficacy for childbirth. They seem to cope by constructing their own environment or culture for birth.

A key issue for life history interviews is the ability of the interviewer to establish rapport with participants (Langness & Frank, 1981). Rapport was facilitated via several strategies, including attention to dress, personal behavior, and interview style, and to the values of honesty and mutuality. The researcher dressed in a low-key fashion, with no obvious signs of professional stature or position (e.g., lab coat) that could distance her from the participants. Her personal behavior was straightforward, pleasant, and courteous.

The interview style involved body language reflecting active non-judgmental listening and avoidance of interrogating (Morse, 1988) or interrupting the participant.
Also, a relaxed, reflective approach (Hagemaster, 1992) was used to communicate to each participant the importance of her responses.

Another purpose of this interview style, which discourages "interviewer dominance and respondent acquiescence" (Mishler, 1986, p. 54), was to promote honest, meaningful (and thus, trustworthy) (Lincoln & Guba, 1985) responses rather than responses perceived by the participant as desired by the researcher (Hall & Stevens, 1991). Participants shared very intimate and sometimes painful details of their lives with the researcher. For one participant, the first interview proved to initiate a therapeutic catharsis of a sort, helping her deal with unresolved issues. After telling the researcher her whole life story of abandonment, abuse, and struggle, she divulged this at length and with great emotion to her midwife during her early labor. As a result, their relationship is closer, and the participant voluntarily assists in the midwife's prenatal clinic. Oakley (1981) reported similar therapeutic effects when interviewing women.

The relationships that developed were felt to be non-exploitative and non-hierarchical or egalitarian in nature (Hall & Stevens, 1991; Oakley, 1981). Most of the participants, upon the completion of the interview, asked questions about the researcher's background and her future plans. Many of the participants commented that they had
really enjoyed being interviewed. Knowing that the researcher had not personally observed any homebirths, one participant invited the researcher to be present at her labor and birth. Two other participants enthusiastically agreed to their midwife's suggestion that the researcher be invited to their births. One woman felt that the interview was important to her, because it allowed her to share her experiences with others and perhaps was God's way for her to become involved in helping women in a larger way. Several participants hugged or kissed the researcher at the conclusion of an interview or birth. Oakley noted that "personal involvement" of the researcher with study participants should not be considered "dangerous bias," but rather "is the condition under which people come to know each other and to admit others into their lives" (1981, p. 58).

The initial interviews were nondirective or open-ended, as recommended by Langness and Frank (1981), in order to promote spontaneity and provide insight into the aspects of their lives perceived as important by the participants. The interview was initiated with the following question: "I know that you're planning to labor and have your baby at home. Would you tell me about how you made your decision to have a home birth?"

Subsequent questions were asked, as appropriate, to open topics for discussion, clarify meaning, redirect when
necessary, and encourage elaboration and narrative responses. Probe questions to empower the participant and encourage storytelling and richly detailed responses included those related to the participant’s birth plan, such as: "Who will be helping you with your labor?," "What kinds of activities do you see yourself doing in labor?," "Where will you be for the birth itself?," and "What will your children be doing while you’re in labor?"

The researcher was prepared to open topics for discussion. It is appropriate with some qualitative research methodologies such as ethnographic life history to pursue "hunches" about what has previously been observed in the field. Aamodt commented that the goals of her ethnographic interview protocol were "discovering and documenting what practicing nurses had had hunches about but what had not yet been recorded in the nursing literature" (1986, p. 165).

The researcher’s years of experience with childbearing women constituted a long period of participant observation (Spradley, 1980), during which many observations were made about self-efficacy for childbirth. Her clinical experience and subsequent ethnographic studies seemed to indicate that the following factors would be among those that could influence the development of self-efficacy for childbirth: philosophy or beliefs about childbirth held by the pregnant woman’s own mother; the pregnant woman’s
general beliefs about her body's capabilities; a religious or spiritual orientation that directs the woman to find meaning in her life experiences; and successful resolution of previous crises in a pregnant woman's life.

In seven of the initial interviews, one or more of these topics came up in the natural evolution of the interviews, during discussions that followed the introductory question and subsequent probe questions about the birth plan (see p. 48-49). Cultural knowledge that is easily articulated by informants is called "explicit cultural knowledge" (Spradley, 1979, p. 8). In contrast, knowledge that cannot easily be expressed in direct ways is called "tacit cultural knowledge" (Spradley, 1979, p. 9). Whether knowledge is explicit or tacit, the researcher makes inferences about the meaning (Spradley, 1979, p. 7-9). When participants did not bring up the topics themselves, the following probe questions were used to explore these areas of potential tacit knowledge:

1. Can you tell me how your mother approached childbirth or what her beliefs about childbirth were?

2. What are your general beliefs about your body's capabilities?

3. Can you tell me a little about the role religion plays in your life, if any?

4. Have you had any difficult experiences in your life that you were able to handle successfully?
Participants were encouraged to discuss any life experiences that may have even remotely impacted on their development of self-efficacy for childbirth. To foster complete expression and prevent unnecessary interruption, the researcher noted topics that arose during the course of the interview to which she could return later in the same interview or during the follow-up interview.

Procedure

Prior to the initiation of data collection, each participant signed the consent form (Appendix D). The researcher then completed a demographic data sheet (Appendix B). In addition, the researcher administered Lowe's Childbirth Self-Efficacy Inventory (CBSEI) (Appendix A) prior to the life history interview in order to avoid any sensitization to the tool as a result of discussion of related topics that arose during the interview process.

Interviews were audiotaped, transcribed, and analyzed. Data analysis was concurrent with data collection. Follow-up interviews on the same woman and initial interviews of subsequent participants that occurred later in the data collection period became more structured or directive (Hagemaster, 1992; Langness & Frank, 1981; Lincoln & Guba, 1985; Sandelowski et al., 1989). With one exception, tapes were erased after transcription and analysis; the participant who experienced a preterm birth requested her audiotape as a memento.
Field notes were made after the interview to document participants' non-verbal behavior, environmental factors, and other researcher observations. Analytic notes were also kept to document progress in the researcher's processing of the data.

Data Analysis

The methods of analysis of data resulting from completion of the demographic data sheet, the Childbirth Self-Efficacy Inventory (CBSEI), and the life history interviews will be discussed here.

Demographic Data Sheet

Descriptive statistics were used to summarize the demographic characteristics of the sample. Included among the demographic characteristics for both participants and significant others were: age, education and employment background, race, ethnic group, and family income. Characteristics of the participant that were summarized were: gravida, parity, weeks of gestation, time at which decision was made for out-of-hospital birth, attendance at childbirth classes, previous out-of-hospital births, and relationship to significant other.

Childbirth Self-Efficacy Inventory (CBSEI)

Although Lowe or others have not categorized scores on the CBSEI in any way (e.g., score ranges representing low, moderate, and high levels of self-efficacy), it seemed reasonable to create categories for the following reasons.
The potential participants for the study were expected to have at least some demographic characteristics in common with the women in Lowe's study: mean age of 28.5 years, 91% Caucasian, 92% married, 75% having some college education, 60% having income greater than $40,000, and all attending childbirth classes (Lowe, 1993). Additionally, Lowe reported in her study (1993) that Total Self-Efficacy Expectancy scores were normally distributed. Normal distribution allows for trichotomization of scores into ranges (Hinkle, Wiersma, & Jurs, 1988, p. 93). The Total Self-Efficacy Expectancy scores can be trichotomized to establish low, moderate, and high score ranges based on the division of the area under the normal curve into equal portions (33%, 34%, and 33%). The z score for 0.17 (17%) of the area on either side of the mean is ± 0.43 (Hinkle et al., 1988, p. 646). Thus, the cutoff score for the low scoring group is 0.43 standard deviations less than the mean and the cutoff score for the high scoring group is 0.43 standard deviations greater than the mean.

For multiparas in Lowe's study (1993), the Total Self-Efficacy Expectancy mean was 222.6 and the standard deviation was 44.8, resulting in the following ranges for this study: low = 31 to 203, moderate = 204 to 241, high = 242 to 310. Thus, multiparas in this study who scored in the 242 to 310 range on Total Self-Efficacy Expectancy scores were to be regarded as having high levels of self-
efficacy for childbirth, those who scored between 204 and 241 were to be regarded as having moderate levels, and those scoring between 31 and 203 were to be regarded as having low levels.

The researcher consulted Lowe for her recommendations for categorization. The researcher devised the categories for low, moderate, and high ranges of Total Self-Efficacy Expectancy scores, as well as three other options for categorization of scores (Appendix C), but the first schema was regarded by the researcher and Lowe as being the most viable and theoretically sound option (Appendix C). Lowe re-examined her own data to see how this categorization schema would work to distribute the women in her sample into low, moderate, and high self-efficacy groups (Appendix C).

Scores for the present study were found to vary considerably. Only one woman fell into the high-scoring group, and the others unexpectedly fell into the moderate and low-scoring groups. Comparison of the qualitative interview data of women from the different scoring groups could have been accomplished via matrix display tables. Matrix displays could have been used not only to identify relationships between Total Self-Efficacy Expectancy scores and the sociocultural context (goal of completeness), but also "to demonstrate similarity or convergence of two different measures of a single construct" (goal of confirmation) (Breitmayer, Ayres, & Knafl, 1993, p. 241).
It was determined, however, that the CBSEI was not an appropriate or valid instrument to have used to measure self-efficacy for childbirth in this sample of childbearing women (Chapter V). Therefore, the use of matrix display tables to demonstrate methodological triangulation was not appropriate in this study.

**Life History Interviews**

Spradley’s ethnographic analysis technique (1979) was used to analyze the data for recurring themes in individual lives and in the group as a whole. This technique has been used in nursing research for analysis of data resulting from multiple life histories (Redmond, 1991). The ultimate aim of this technique was to discover common patterns or themes in the data.

In order to arrive at thematic analysis, however, the researcher first had to discover the domains or categories of meaning embedded within the data. Three major domains were discovered. The minor domains that were discovered were subsumed into the major domains (e.g., the domain "beliefs about pregnancy and childbirth" was subsumed into "deciding to have a homebirth"), left undeveloped because of their limited scope (e.g., "persons mentioned by woman"), and/or considered tangentially in the analysis (e.g., "kinds of decisions," such as the decision to breastfeed). The researcher named each domain with a "cover term" under which she listed all the examples of the domain located within the
data (Spradley, 1979). The second step in the technique was to perform a taxonomic analysis for subcategories of organization within each domain. Taxonomic analysis continued through to the end of data analysis, as new insights were developed about the organization of the data within the domains.

Componential analysis was expected to be the next step in the data analysis. Componential analysis is the "search for the attributes that signal differences among symbols in a domain" (Spradley, 1979, p. 94). Spradley presents seven types of contrast questions (1979, p. 160) to use in eliciting differences among terms in a domain. However, asking these kinds of repetitive questions (e.g., differences between various pairs of turning points in the participants' lives) did not seem productive in this study. Therefore, componential analysis was not used.

Lastly, to discover cultural themes, the researcher employed a combination of several strategies suggested by Spradley. The researcher became immersed in the data, made a list of cultural domains and reread the interview data to find the relationships among the domains, and identified a domain that seemed to organize a great deal of information and to which the other domains could be easily connected. Spradley indicated that theme analysis "invites the most experimentation on the part of the ethnographer" (1979, p. 190). Within the three major domains, two themes recurred
that constituted the relationship among these domains (Spradley, 1979).

Data analysis was to be facilitated via the use of a computer program for textual analysis called MARTIN (Diekelmann, Lam, & Schuster, 1991). MARTIN uses Microsoft Windows to design a figurative desk top. The interview data can be transferred to "index cards" for annotation. Analytical notes can be attached to the passages being studied, and later removed if needed. As "index cards" are compiled, they can be arranged with other cards that are similar. As associations develop and patterns emerge, cards that are related can be joined more formally by moving them into a hierarchy of folders and groups of folders.

Because the taxonomic analysis by which categorization of data via MARTIN would occur was in revision until the end of data analysis, it was decided not to use MARTIN to facilitate data analysis. Review of the interview transcripts and use of the "Search" function of the word processing program to locate key words in the interview files, as well as the researcher's memory, allowed the researcher to organize and analyze the data.

Issues of Rigor in Qualitative Research

A number of strategies to ensure rigor have been described, including purposive sampling, comfortable setting and establishment of rapport during the interview process, and a well-structured analytic scheme. A purposive sample
of informants is "likely to provide the most useful information about the topic of inquiry" (Sandelowski et al., 1989, p. 79). Thus, purposive sampling ensured the collection of data that was valid in terms of an investigation into the development of self-efficacy for childbirth.

Additional strategies to ensure rigor in this qualitative research relate to credibility, fittingness, and auditability (Sandelowski, 1986). Credibility, a measure of the truth value of the research, means either that the description or the interpretation of a human experience is faithful enough to be recognized by those having that experience, or that having read the description or interpretation, one would recognize the experience (Hall & Stevens, 1991; Sandelowski, 1986). Fittingness, a measure of the applicability of the research, means that the themes are well-grounded in the data or that they "fit" the data well (Sandelowski, 1986).

As data collection continued, the emerging themes or patterns were validated with subsequent participants in interviews that were more structured. Sharing the results was another way to establish credibility and fittingness in this study, while protecting participant anonymity and sensitive information. A licensed midwife practitioner, a maternity nursing educator who is also a graduate faculty member, and the researcher's major professor were asked to
independently judge the credibility and fittingness of the researcher's analysis. After their recommendations were incorporated, their final judgement was that the standards for credibility and fittingness, as defined above, had been met.

Auditability, a measure of the consistency of findings in a study, means that another investigator can follow the "decision trail" of the researcher (Sandelowski, 1986). The first step in establishing auditability was to write a research proposal that clearly delineated the purpose and direction of the research (Sandelowski, 1986). Auditability was further established as the chairperson of the researcher's dissertation committee read the interview transcripts, the analytic memos, and the final report, and was able to follow the logic used by the researcher (Sandelowski, 1986).

Summary

Life history studies were conducted on ten multiparous women preparing for homebirths. Open-ended interviews were conducted initially, followed by directive interviews. Each initial interview was preceded by the administration of Lowe's Childbirth Self-Efficacy Inventory (Lowe, 1993) to attempt to establish empirically the existence of relatively high levels of self-efficacy for childbirth and to allow for methodological triangulation. Demographic data was summarized via descriptive statistics,
and interview data was analyzed via Spradley's (1979) ethnographic analysis technique.
CHAPTER IV

RESULTS

In this chapter, the results of the study are presented. First, descriptive statistics are used to summarize the demographic characteristics of the sample. Then results of the administration of the Childbirth Self-Efficacy Inventory (CBSEI) are reported. Lastly, the ethnographic analysis of the interview data is described.

Description of the Sample

A summary of the personal information, maternity information, information on significant other, and reported family income is presented below. In addition, the characteristics of the sample are compared to those reported by Lowe for her study sample (Lowe, 1993).

Personal Information

The mean age of the 10 participants was 31.6 years, with a range of 23 to 36 years. Their education ranged from General Equivalency Diploma (two participants) to a Master’s degree (one participant). Altogether, seven of the 10 women had at least some college education. All had been employed in the past, mostly before marriage and/or motherhood, with only one participant currently employed outside the home (on a part-time basis).

All 10 participants were Caucasian. When asked if they were members of particular ethnic groups, seven women
said "No" or "White-American," one identified herself as Hispanic (originally from Mexico), one as Cajun, and one as third-generation Italian-American. Nine participants were married at the time of the interviews; one participant was divorced, but planning to return to her ex-husband.

Four women identified themselves as Catholic during the interviews, and one as Presbyterian. The other five women stated that they were "Christian" or attended a non-denominational Christian church. The women lived in four different cities, and their midwives stated that none of them knew each other or belonged to the same church or social group.

**Maternity Information**

All 10 women were multiparas. One woman had had a previous Cesarean birth. Information relating to the maternity histories given at the time of their first interviews is summarized in Table 2. None of the viable pregnancies involved multiple fetuses. Five women had pregnancy losses (mean of two each), and five had not had any losses. Six of the 10 participants had three biologic living children each. One participant also had an adopted child, and one woman had a child who had died of Sudden Infant Death Syndrome.

The means and ranges for the weeks of pregnancy at the time of the first interviews are given in Table 3. Information about the timing of the pre-birth and post-birth
Table 2

Means, Medians, Modes, and Ranges of Gravity, Parity, Pregnancy Losses, and Living (Biologic) Children of Sample (N = 10)

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gravity</td>
<td>4.8</td>
<td>4.5</td>
<td>4, 6</td>
<td>2-8</td>
</tr>
<tr>
<td>Parity</td>
<td>2.8</td>
<td>3</td>
<td>3</td>
<td>1-4</td>
</tr>
<tr>
<td>Pregnancy Losses</td>
<td>1</td>
<td>0.5</td>
<td>0</td>
<td>0-4</td>
</tr>
<tr>
<td>Living Children</td>
<td>2.7</td>
<td>3</td>
<td>3</td>
<td>1-5</td>
</tr>
</tbody>
</table>

Table 3

Means and Ranges for the Weeks of Pregnancy at the Time of the First Interview, and Weeks Before and After Birth that Interviews Occurred

<table>
<thead>
<tr>
<th>Relationship of Time of Interview to Pregnancy or Birth</th>
<th>Mean</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks of Pregnancy at the Time of the First Interview (N = 10)</td>
<td>36</td>
<td>32-39</td>
</tr>
<tr>
<td>Number of Weeks Before Birth that Pre-birth Interviews Occurred (N = 10)</td>
<td>3.65</td>
<td>1-8</td>
</tr>
<tr>
<td>Number of Weeks After Birth that Post-birth Interviews Occurred (n = 9)</td>
<td>7.14</td>
<td>1.3-13</td>
</tr>
</tbody>
</table>
interviews in relation to the date of the actual birth is also provided in Table 3. Six of the 10 pre-birth interviews occurred at 3½ - 4 weeks before birth, and five of the nine post-birth interviews occurred at 8 - 10 weeks after birth.

When asked about the progress of the current pregnancy, all characterized it in a positive way, except for one participant who indicated that she was experiencing more fatigue than usual. Another participant felt tired in the evening after taking care of her two young children all day.

Each of the 10 participants had her first baby in a hospital setting under a physician's care. Four participants subsequently had homebirths and two had out-of-hospital births in a birthing center. Although five of these six participants indicated that there was no question that their next birth would be at home, one woman considered the issue with each pregnancy in case there are problems that would preclude a homebirth. She decided on homebirth during this pregnancy at four or five months, when she heard that her midwife was back from a sabbatical.

Of the remaining four participants, one woman decided to have a homebirth before this pregnancy began, based on her experience of having a Cesarean birth in a hospital with her first pregnancy. The other three participants decided in their first trimesters to have homebirths.
All 10 participants received prenatal care from licensed midwife practitioners based either in Lafayette or in Baton Rouge. None of the 10 participants attended childbirth classes during the current pregnancy. Six participants had attended childbirth classes of some kind during past pregnancies, usually during their first pregnancies.

Three participants reported family income in the $10,000-20,000 range, and three others reported a $20,000-30,000 range. Four participants indicated a range of $30,000-40,000.

**Significant Others**

Nine participants identified their significant other as their husbands, and one participant identified her boyfriend and her ex-husband, both of whom were present at her subsequent homebirth. However, she gave information for significant other only on her boyfriend. Their mean age was 35.6 years, with a range of 24 to 42 years.

The educational background of the significant others ranged from sixth grade to completion of a Master’s program. One significant other had a sixth grade and one a ninth grade education, and two were high school graduates. Of the six significant others who attended college, one had attended for two years, two had baccalaureate degrees, one had "almost" a Master’s (except for thesis), and two had completed Master’s degrees. For two of these significant
others, their college education took place in a Bible college or seminary school.

Nine significant others were currently employed. The man who was unemployed had been disabled for 16 years.

All were Caucasian. According to the participants, three significant others would identify themselves as Cajun, one as Hispanic, and the other six indicated that their significant others would not identify themselves with any particular ethnic group.

Comparison to Lowe’s Sample

With a mean age of 31.6 years, this sample is slightly older than the women in Lowe’s study (1993), in which the mean age was 28.5 years. The range of ages for the present study was 23 to 36 years, and the range in Lowe’s study was 18 to 42 years.

In this study, seven participants (70%) had at least some college education compared to 75% in Lowe’s study. All participants in this study were Caucasian compared to 91% in Lowe’s study.

Nine (90%) of the participants in this study were currently married, and 92% of the subjects in Lowe’s study were married. Unlike Lowe’s study, where 60% of the subjects had incomes above $40,000 per year, all of the 10 participants had incomes below $40,000 per year.

All the women in this study are multiparas, whereas in Lowe’s study, only 25% were multiparas. None of the
participants in the present study were currently attending childbirth classes, whereas all of the participants in Lowe's study were.

To summarize, these 10 participants have a similar educational level and marital status as the women in Lowe's sample. However, they are slightly older and age-homogenous, are more racially homogenous (Caucasian), and have lower family incomes. While Lowe's sample included primarily nulliparas who were attending childbirth classes, the participants in the present study were all multiparas who were not attending childbirth classes.

The above differences in sample characteristics need to be taken into consideration when interpreting the results of the Childbirth Self-Efficacy Inventory in the next section. An additional factor to be addressed is that, to Lowe's knowledge, all of the women in her samples delivered in hospitals, including both those women who participated in the original development of the tool and those women who provided psychometric data (Appendix C).

Results of CBSEI Administration

The first research question was: Do the participants have high levels of self-efficacy for childbirth as measured by Lowe's tool (Lowe, 1993)? The participants all paid close attention to the standardized instructions given by the researcher for taking the Childbirth Self-Efficacy Inventory. The researcher attempted to be consistent in
responding to questions that a few participants asked to clarify the directions. No participant was haphazard or careless in completing it and each seemed to take the time needed to finish it to her satisfaction. Most of the women commented verbally about individual CBSEI items while they were completing the instrument or later during the interview; when they commented during instrument administration, the researcher responded in a neutral way.

Four participants scored in the low range and five in the moderate range for Total Childbirth Self-Efficacy Expectancy score. Only one participant scored in the high range. The participants as a group did not have high levels of self-efficacy for childbirth as measured by Lowe's tool (Lowe, 1993).

Ethnographic Analysis of the Interview Data

The second research question was: What life experiences can be identified through life history interviews as similar in the lives of pregnant women with self-efficacy for childbirth? Following administration of Lowe's tool (1993), the pre-birth interviews were conducted. Three major domains emerged from the data: "difficult times in life and/or turning points," "deciding to have a homebirth," and "dealing with labor." From these three major domains, two themes in the lives of each of the ten individual women and of the group as a whole were identified: "Walking with God" and "Family and Home as
Central."

The taxonomic analyses for the three major domains are presented in Appendices E, F, and G. Illustrative data from various parts of each domain will be described, and then the two themes will be explicated.

**Difficult Times in Life and/or Turning Points**

The researcher's previous studies and experience with pregnant women seemed to indicate that a successful resolution of previous crises in a pregnant woman's life positively influenced the development of self-efficacy for childbirth in many women. The probe question "Have you had any difficult experiences in your life that you were able to handle successfully?" was used when necessary to elicit information in this area (Appendix E). Also, other questions were used to clarify the meaning of "turning points," once that topic was introduced by a participant.

**Early difficult periods.** Five participants, half of the total sample, had some very difficult periods early in their lives. One participant prefaced her lengthy response detailing early sexual activity, self-hate, numerous suicide attempts, and hospitalization with the following summary: "I've had a lot of difficult experiences in my life -- I've had a hard life, a very hard life." Another woman who was abandoned by her mother at age seven and went to live with a series of relatives stated, "At the age of 15, I moved [to live] by myself, and it was a big decision to make. And I
started working at 13 years old.... that's how I finished my high school." A participant who described difficult parent-child relations and had had to drop out of college for counselling admitted that "I had a lot of freedoms ... and ended up going out drinking, even on the week nights, and just partying and not studying, and going to work late, and skipping classes, and was very irresponsible." Another woman answered the question by saying:

My parents were divorced and ... my father went to prison and my mother ... would have different men that lived with us. And so I guess that was pretty difficult for me ... as a child especially. I would say that was the major thing in my life, my total adolescent years.

Yet another participant described having an alcoholic father who left the family and died when she was eight years old. She was also an out-of-control adolescent who had had two abortions, abused drugs and alcohol, and later became a single mother.

For these five participants, the difficult time in life either constituted or was followed by a "turning point," in which the outcome was a positive personal change. Four of these women described well-defined religious or spiritual experiences as turning points. For example, one participant explained,
... I was a drug addict, and an alcoholic ... and that was probably the most major turning point in my life.... And I went through a Christian drug rehab, and met the Lord, and I was ... almost 19, and ... it set my foundation ... and I knew what I needed to do with my life.

A second woman declared that: "I had a major religious experience, I guess you'd call it, whenever I was 18, where I ... gave my life to the Lord. And just started serving God." Another woman said:

Probably the biggest turning point was when I came to know the Lord ... when I was in college. I started going to ... a non-denominational church on campus ... and a girl befriended me there and really shared about the Lord with me and shared with me how I could have a relationship with God.

During a suicide attempt, one participant seemed to have a near-death experience that involved a spiritual element. After hospitalization and discharge home, she visited with a neighbor, who talked to her about God:

It meant something to me all of a sudden and I grabbed ahold of it. And there was no big prayer or anything, but whatever he told me about God and Jesus and the Holy Spirit ... I received it. I said "This has got to be for me."... From that point on, God directed my paths of my life.
The fifth participant in this group found that she drew strength from a deepening relationship with God to overcome her difficulties: "One time, I was very rebellious.... but then, I started getting closer to Him [God]. It's not that He left me, you know, it's that things [difficulties] happen.... He always was there for me, you know."

The subsequent lives of the five women were shaped by these difficult experiences and turning points. They were aware that the inadequacy of their own parenting, family life, and/or early spiritual or religious background had long-term negative effects on them. One participant elaborated:

'It's taken awhile for me to kind of recoup ... and get self-confidence back because ... a child is really torn apart by different things going on with their parents ... and it's taken me awhile to get restored in that area but ... I'm still not perfect ... I'm a lot better than I was back then.

A woman described her reaction to her parents' authoritarian style by saying that:

We were supposed to respect ... authority, regardless of what happened, regardless of whether the words matched up with actions or anything else. And that's very hard to deal with. It's hard to deal with when you're little, and it's hard to deal with as an adult, looking backward.
Another woman indicated that she had experienced a spiritual vacuum during her early life, and finding God was "what I'd been missing all my life." The participant who had had early sexual activity and suicide attempts explained that although she had very good, loving, and protective parents, they had "a lack of knowledge" in regard to the spiritual realm:

> It was ... not a religious home at all, just your all American type ... You finish with school, you go to college and ... then you either have a career or you raise a family.... You would never think that there were any problems.

These five participants have made conscious decisions to parent their children differently than they themselves were parented. The woman whose parents were authoritarian recounted that she began thinking about different parenting styles in college, when she talked about it with her sisters. She very clearly described her own parenting style that seemed to be democratic rather than authoritarian, and her concept of mutual respect between parents and children:

> One thing that I think my parents were dogmatic about was authority, and I am to a degree, but I know that I don’t have this high and mighty authority stand just because I gave birth to S. [daughter] ... I feel like I need to continually earn her respect, that I don’t just naturally get it ... I need to respect her, and love
her, and praise her for the things that she does that are good.

Another participant said, "I always knew in my heart that when I had children, that's when I would be the best I could be. Because I would never let them down like my parents let me down ... never in a million years." The woman who had been abandoned by her mother remarked, "I always try to be a better mother, a better person. I don't want to be, you know, like ... my mom -- she wasn't there for me, but I want to be [there] for my children." Another woman, who made the decision to drop out of nursing school to stay home with her young child, recollected, "I always came home to an empty house ... because she [her mother] had to work.... I feel like my family comes first."

Only one woman in this study was employed outside the home, and they all expressed strong feelings about their responsibilities in their mothering role. Other decisions were made based on the desire to develop very close relationships within the family. For example, decisions about husband's work:

My husband ... started his own business ... and he brings us everywhere with him ... Most husbands don't want to.... They get up in the morning and leave and don't really have too much to do with their family.... In his new business ... he just packs us up and brings us, and it's kind of like a family deal.
Another woman talked about setting priorities to strengthen family bonds: "We do everything as a family. We have like a family outing once a week. We’re getting more toward that, where a family is coming even before his [husband’s] job."

Another participant explained her decision to return to her ex-husband as being mostly for the children’s benefit:

I’m willing to do whatever it takes for my children to grow up ... well balanced.... And I don’t think without a father that it’s healthy. I grew up like that and ... it’s a lot of pressure trying to do it yourself.... So ... that’s one of the reasons, because it is important ... in every area in their life. I just think it is an awesome responsibility.

These five women also had made decisions to provide a solid religious or spiritual foundation for their children. An example is the woman who reported, "with the knowledge that I have now, the way I raise my children ... is from the spirit realm." One woman made the decision to homeschool her child in order to share her Christian values with him (a decision made by most of the women in the total sample).

She stated:

I feel like someone else would be raising my child [if she sent her child to public school]. He would be with them from ... 7 til 3 ... and that person would be teaching him all their values. Because when you teach them, I guess you ... intermingle some of your beliefs
into what you’re teaching.

Another participant indicated that she was teaching her children to trust in God and put Him first in their lives. A woman whose children were actively involved in their church, and who was a church youth leader with her husband prior to their divorce, stated: "I devoted my life ... to God ... and I know that I can’t raise them successfully without His influence." She used a Christ-centered homeschool curriculum, as did other women in this study.

Another participant acknowledged, "Almost every answer that I give S. [her daughter] to the questions that she asks me, has to do with God ... [e.g.] ‘God gave us the rain’.... ‘It’s so that all living things will grow’." She continued to illustrate this integration of God into her parenting role during the interview: "I have told her [daughter] ... it’s God’s decision whether this is a boy or a girl and it’s God’s decision when it’s time for the baby to be born."

Later and/or less severe difficult periods. The other five participants were also able to identify difficult times in their lives and/or turning points. However, these participants had more stable or satisfying childhoods and three participants were especially positive about how they were raised. The events related to turning points for these five participants either occurred after childbearing had
begun (e.g., death of a participant's mother, having a miscarriage, and dealing with a husband's disability) and/or seemed to the researcher not as severe in nature (e.g., living in a foreign country, and rejection by a high school boyfriend).

As with the first five women described, these five women had difficult experiences or turning points that they often portrayed as religious or spiritual in nature. All of these women indicated that they coped with life crises by drawing strength from their faith in God. Asked if she would consider her late resolution of a painful high school relationship as a turning point in her life, one woman answered:

Well, it was the consequence of a turning point. I was really coming to grips with my Christian convictions and the Lord ... growing in my relationship with the Lord. It was as a result of the turning that was taking place that I dealt with that relationship.

Another woman described the religious or spiritual aspects of two turning points in her life. First, she and her husband realized that being materialistic and making high salaries was not "God's purpose" in their lives. They sold all their possessions to do missionary service work overseas, and planned to continue that life in order "to live out Matthew 25, how Christ tells us to live our lives" [The Last Judgment: "I was hungry and you gave me to eat"].
About adopting their first child, which this participant identified as a second turning point, she remarked:

I really feel that ... it was just absolute intervention that God wanted him to be in our family, because there was so many coincidences with this adoption, that the moment that I called the agency and was inquiring ... his birth mother ... was interested in putting him up for adoption. And then the adoption worker told us that we should think of a name for him, and we had selected the name N., and that was his name given at birth.

Commenting on the difficult experiences in her life, another woman said:

I think my faith life has just brought me away from bad coping behaviors ... to much better ones.... I always had faith -- in a way, when you’re a child, it’s not very mature. And I never lost sight of God but I didn’t rely on Him like I should’ve. And I didn’t obey His laws.... If I had been doing that, I wouldn’t have been in the troubles that I had.

One Catholic woman attributed positive changes in her family life to attendance at two church-sponsored events, which she identified as turning points:

Cursillo [a personal retreat] was like a personal walk with Christ for me, and when he [husband] went, it was his own personal walk. And in the Marriage Encounter
it kind of like combined the two walks together. So now we’re able to have our own personal walk, but still have the God-centered marriage that we’re supposed to have.

The last woman was sad when reflecting upon her mother’s death, but described it as a turning point. Although she did not directly depict this event as having a spiritual aspect, during the interview she expressed an interest in reading biographies of people who survived life’s difficulties, and identified human resilience as a God-given trait.

Three of these participants indicated a high level of satisfaction with the parenting and religious or spiritual upbringing they received. Each one alluded to being raised in and observing a specific religious faith, and continuing in their adult lives to develop their religious faith and spirituality. They recognized the long-term positive effects derived from their stable family and religious foundation. These women seemed to be reproducing for their own children the spiritually and emotionally rich and stable family lives they themselves had enjoyed.

For example, when questioned about the source of her inner strength and general self-confidence, one participant responded:

The idea of just having that security of a mother being there, which my mother was. She was at home with us.
And provides ... this security foundation that they mentioned over and over in the research ... that babies and infants and children who don't have that are kind of always looking for that security.

She also indicated, "Parents who are happy in their marriage just convey the most security a child can have. And that was definitely the case.... I never ever heard them fight or anything."

A second participant, who expressed great satisfaction and serenity in her role as mother and wife, was asked how she had made her choice to stay at home with her children:

I guess I grew up in a traditional family with a stay-at-home mom, and that shaped a lot of it.... when I grew up I did play with dolls and I was the mommy and I played house.... When I got older, I chose a profession. I chose teaching. And I started my degree. I never did finish it, but I actually did teach in a private school. It was kind of an extension of that traditional female role. I didn't choose construction engineer or ... more of a masculine role. So I guess I was raised very traditionally and I just kept going that route.

The same participant was asked what influences from her childhood encouraged her development of confidence:

My parents did everything to see that we were
encouraged. If we showed an aptitude for something, they did everything that they could to help us reach goals that we had set.... they insisted on behavior patterns. We were not allowed to live wild lives. We had to obey our parents. We had to help with the house. In order to earn privileges ... we had to show that our grades were up and that we were responsible enough to do our daily chores.... And I think having a life style that encourages you to do right and rewards you with privileges, makes you confident that you can reach goals.

The third of these participants was asked to characterize her childhood, and responded in a positive way:

It was very nice.... I had a happy childhood. I went to good schools and was raised in a nice neighborhood with good friends that I’ve maintained friendships with ’til today. My family’s been very involved with church and with our activities and our school. We haven’t had any major problems in our family. So, I mean, no violence, no addictions. It’s just been a very nice, loving, supportive family.

She remained close to her parents and one sibling who lived in the same town, and who were supportive and actively involved with her children.

The other two participants seemed satisfied with some aspects of their upbringing, and did not characterize their
parents as negligent in any way. However, they felt that they had certain personal shortcomings to overcome or correct as a result of deficiencies in their background. One woman attributed her insecurity and early lack of confidence as a child to her mother who had "a hard time relating to people" and who was not as loving a mother as she was a grandmother, and to the fact that her father was gone often because he was in the military. The other woman commented that her parents did not foster family togetherness or activities, and did not encourage their children to engage in extra-curricular activities. She stated, "I don’t remember having that strong of a structured spiritual life as a kid," and felt that she developed more confidence in herself later in life "after we changed and we really became more spiritual."

The women in this group were more aware than their own parents were of the subtleties of spiritual and character development in raising their children. Some participants expressed an awareness of their children's perceptions about this issue. An example is, "They see the spirituality, how better off they are than most other kids." Comments such as the following were typical: "I don’t think it was negligence on our parents’ part or anything like that. It’s just we’re more aware of it [character development] than they were." One woman summed up her awareness very concisely:
We do a lot of work on character development, which a lot of moms who home school do.... a lot of us are saying their religious and their character development are probably the two more important things than anything else we'll do, because ... that's what will get them through life.

Deciding to Have a Homebirth

The researcher was interested in the factors that led the participants to plan homebirths. Each initial interview began in this way: "I know that you're planning to labor and have your baby at home. Would you tell me about how you made your decision to have a homebirth?" In addition, the following questions, when asked, elicited tacit cultural knowledge that was included in this domain: "What are your general beliefs about your body's capabilities?," "Can you tell me a little about the role religion plays in your life, if any?," and "What adjectives would you use to describe your personal attributes?" or "How would you describe yourself?"

Factors in deciding to have a homebirth were multiple and complex (Appendix F). The participants examined personal and vicarious experiences with birth in different settings, pragmatic factors, and feasibility and social support. Minimization of any disturbance in home routine was important to these women, as were issues of safety and control. Basic to their homebirth decisions were underlying
beliefs about the human body, God, and their own personal attributes in relation to birth. In every case, the decision for homebirth seemed to have been made with careful consideration, prayer, and evaluation of the alternatives.

**Beliefs in the human body, and about God and self in relation to childbirth.** Participants held certain beliefs that allowed them to even consider the prospect of homebirth. Included were beliefs about the human body, about God in relation to childbirth, and about their own personal attributes in relation to birth. The following probe questions were used to elicit this data: "What are your general beliefs about your body's capabilities?" and "Can you tell me a little about the role religion plays in your life?"

General beliefs about the body included beliefs of a religious or spiritual origin. Examples were: "our body is a temple of the Holy Spirit," "it's not our body -- it's God's -- and we're supposed to glorify Him in our body," and "your spirit tells your mind, and your mind tells your body [what to do], and God has designed the three in one in you."

Participants spoke of the dependability and strength of the body: "the human body can endure a lot of stress or hardship ... and it'll bounce right back," "your body heals itself," "your body will take care of itself," "our bodies are very strong," "the things that your body can physically do are really very amazing," and "if you listen to your
body, it tells you your limits. It lets you know how far,
you can go and when you need to slow down, and when you need
to rest." One participant expressed this belief in the body
when she stated that the right reason for women to have
homebirths was because "they believed in their body."

Participants generally believed that they needed to
take care of their bodies with proper exercise, nutrition,
and abstinence from harmful substances such as alcohol and
tobacco. Many of the women stated that they avoided
medication when possible, and were not people who "run to
the doctor for every single thing." Some participants
favored natural healing methods or substances instead.
Three women practiced Natural Family Planning because of
concern about the effect of other contraceptive methods on
their bodies.

When asked for general beliefs about their bodies,
some participants immediately focused on beliefs about their
female biological identity and experiences. One woman
expressed her thoughts about her body this way: "I think of
my body in terms of femininity and in terms of what I’m
supposed to do with my body . . . in terms of giving birth,
nursing a baby, but also that body used in service to my
family."

All of the participants except one had nursed their
older children as babies. The participant who had bottlefed
her five older children felt that her decision to breastfeed
for the first time was based on a new and improved understanding of God’s plan: "He’s asking me to breast feed ... if He sends you a baby, He’s going to send the means to feed it also, and I was just the one that wasn’t taking the means that He was providing."

Many other beliefs were expressed about God in relation to the female biological experience of childbirth. Some beliefs centered on childbirth as a normal body function, not a sickness: "If I think how God fix[es] everything ... how your body knows when it’s ready ... that it’s the best machine"; "God made all the animals and every day, animals are having babies.... I think we were made to have babies"; and "Our bodies were made by God ... and they will function efficiently, including giving birth."

Only one participant seemed adamantly negative in her views about physician-directed hospital birth. She said:

If He [God] can form it [the baby], He sure can deliver it without medication and help from some man that thinks he knows everything.... [some doctors think] they’re God, and they take the place of God, and I just think that ... it’s natural ... what did they do before they had hospitals?

One of the most prevalent and pervasive beliefs was that God was present and in control during childbirth and that women have to trust in God that the birth will proceed smoothly. "God is gonna be there with me" and, "I know that
He is taking care of me for this.... And I know that no matter what happens, I’ll be OK" were typical statements made by the participants. One woman depicted homebirth as:

.. God’s way.... you don’t need so much medical [intervention] and sterilization to do what comes natural since the beginning of time. And if something has to happen, it’s because that’s His will. There’s nothing I can do about it, or stop it, or change it if I was in a hospital or not. It’s just whatever His plan is, it’s going to happen no matter where.

This same participant attributed her confidence for birth to her trust in God:

My confidence for birth has to go back to trusting.... that God does what He wants to do and there’s nothing I can do to change that. And it’s just being in acceptance with what He sends ... I know He’ll never send something that’s going to hurt me. So it makes me more confident in birth.

Another participant (interviewed during her fourth viable pregnancy) had had two deliveries in the hospital under epidural anesthesia, and during the next pregnancy, she prayed to God to give her a painless birth. She had just two contractions that she could identify as labor contractions, followed by a precipitous birth with only her husband to attend her at home, with the midwife arriving soon after. She explained that she and her husband
performed the correct maneuvers during the birth and that she and the baby experienced no difficulties because "God ... really had control over us." Her trust in God and her positive experience with her first homebirth led her to decide to also have her next baby at home.

Other beliefs centered on purpose: "God wants us to have babies"; "He intended for us to go through labor and to give birth and to be aided by ... people who are there to support you"; and "God made woman to have a baby." Asked how she developed her beliefs about her body for childbirth, one participant responded: "It just makes sense, once you have the foundational belief that God made your body and He made it this way, and He made it this way for a purpose." Another said that:

Childbirth is something God gave us to do, and so it's just a natural consequence of the natural law, the way God made things to be, and I guess that’s why I feel the way I do about childbirth, that it needs to be as close to the way that God intended it to be as possible.

Others depicted childbirth as a spiritual experience. One woman spoke of the spiritual meaning of childbirth:
That kind of imagination to think that someone can grow another person inside of them ... can only be God.... I’ve really taken the conception and the forming of the baby and the birth of the baby as a very holy and
sacred event.... the actual birth itself is just such a loving spiritual experience, the life-giving part of it.

Another woman described birth as an important life event, as evidenced by the genealogical chronology of Jesus' family in the Bible, and said later in her interview that "it is a very significant day, because at that point you go from being ... a couple, to being a family."

Lastly, beliefs about their own attributes in relation to birth seemed to have an impact on the women's decisions to plan homebirth. These women described themselves in relation to childbirth as "strong" and having self-will and self-control: "I have a strong self-will that if I'm going to do something, then I'll do it. And if it's up to me ... I see myself being able to do it, handle it, and not go out of control."

They also saw themselves as being accountable for the outcomes of pregnancy and childbirth. One participant criticized people who do not take responsibility for their health:

People ... fall into the hands of the medical profession, and then they make all their decisions for them. All of which may not be for their best interests, because only you know (not that you know best -- you need the advice of other people who know more than you do) ... you have to weigh it out and make
decisions.

Many participants stated beliefs that reflected a general confidence in their ability to give birth naturally, e.g., "I’m anticipating a fast one [labor]"; "you have all that you need [to give birth] ... unless there’s something very unusual"; and "I don’t believe it’s [birth] an illness, and I think hospitals are for sick people, basically." One woman who felt strongly that her confidence developed because of the way she was parented said: "I’m just a confident person ... it just carries over into the childbirth."

Having overcome some difficult life experiences and experienced a turning point of a spiritual nature, another participant felt that "all your life experiences lead to building character and making you be able to handle or not be able to handle a situation." One participant saw overcoming life’s difficulties as a choice: "It can make you stronger, or it can make you weaker, you know. That’s why you have to choose."

Experience. In making the decision for homebirth, participants considered their previous personal experiences with hospital, out-of-hospital, and/or home births. They also evaluated the experiences or opinions of others who had had or were familiar with hospital or home birth.

The participants had had a variety of experiences in the hospital. At one end of the continuum were experiences
that were satisfying and met most of the women’s expectations. At the other end, however, were experiences such as a Cesarean birth classified by the woman as "a difficult time in her life": "I had a section, and it was horrible. I thought it was the worse thing ever ... it was really traumatic to me." For this woman, resolution lay in the "turning point" of her subsequent homebirth. The disapproving comments of a number of participants centered around caregivers, hospital routines, and uncomfortable feelings provoked by being in the hospital.

Seven participants felt that hospitals were appropriate for complications of childbirth, but not for normal birth. Typical descriptions of the hospital were: "So cold and lonely," and "a place that I really don’t feel good at." One participant stated that "hospitals ... make you feel so sterile and detached from the world." Another participant summed up her feelings like this:

I feel like this [childbirth] is a natural part of life, and I don’t want to be made to feel like I’m sick. Maybe that’s the struggle I have with the hospital and childbirth. If I have complications, I’ll be the first one to run to the hospital.... I don’t have anything against that at all.

The women were affected by the sights and sounds of the hospital. One participant spoke of "the harshness of the hospital," and another woman mentioned "all the lights, the
nurses running in and out." One participant remembered the laboring woman in the next room screaming, which "made me a little nervous, you know, scared." In labor with her first child, she asked herself at the time, "I'm going to have to go through that?"

Caregivers included maternity nurses and doctors, sometimes "too many doctors, too many nurses." Lack of control over choice of birth attendants and lack of continuity of care were upsetting. According to one participant: "Nothing against maternity nurses, but there's one in and one out, and shift changes and ... you don't know who they are really." Another complaint about caregivers was their dependence on technology. One woman stated that the nurses who were uncomfortable with requests for less use of technology "don't quite know how to react ... without all their gadgets."

Communication patterns that excluded the woman were criticized:

The way the nurses and the doctors would talk about me without me being a part of the conversation, because I can remember one nurse ... had checked me, and another one came in and said "Has she voided yet?" And I was kind of like, "Well, you can ask me ..." You know? I just felt like I wasn't in the room and like ... I wasn't a part of the conversation ... I felt like ... I was an object at that moment.
And:

You know how when two people have a secret joke and they kind of mention it and you feel like you’ve been left out of the joke and you don’t know what’s going on? It was almost like they knew their own little language and their own little numbers and terms and they ... did their own thing.

Hospital routines were described as being frustrating to those women who wished "to do things we wanted to do ... things that we knew would help it [labor] progress." Particularly mentioned were "all the things that confine you to the bed." One common complaint was that "they put you in your labor room, and you’re just strapped to all of these things." One woman described the effect of the hospital routines:

It makes you feel more like ... a surgical process that’s going on ... instead of life.... It takes the meaning away of birth. It’s like it’s ... just a procedure, more or less like they’re opening you up to take out an appendix or something: "Oop, here it is!" And not centering so much on this is a baby; this is life; this is something new; this is a new little human being.

Another participant’s hospital birth "wasn’t a bad experience, because I didn’t know better, but it wasn’t fulfilling either." She stated that it was "kind of generic
... you're just part of a procedure," and explained that "you don't have a choice."

The four participants who had had one or more previous homebirths reflected on the specific reasons they enjoyed homebirth, and hoped that their next homebirths would be similar. They focussed on the comfort that they found in their own homes, as well as their ability to control the physical environment, social milieu, activities surrounding childbirth, and caregiving strategies. Nine participants compared their hospital and home birth experiences. One woman commented:

... the hospitals, it's like you're just a patient, and with the midwife, I felt more like a person ... expecting a birth.... It [being in the hospital] was just like a procedure.... an everyday routine, and this [homebirth] just makes it more special for you.

Several women who had had a homebirth described their sense of self-gratification, increased self-esteem, and fulfillment characterized as a self-actualizing experience, and included these factors in making the decision to have one again. Of her first homebirth experience, one participant said, "It took everybody to try to keep me down. For three months after that I was on a high." Another participant, still feeling the effects of her difficult experiences in life, said of her homebirth:

The reason that ... God put into my heart to have a
home birth and the reason that I stuck to that and everything came out okay, is because it just totally basically lifted my self-esteem. It gave me confidence in my ability to be a woman.... And I think that God used that to help me to feel like I have worth ... just in every area ... I feel more confident about everything.

Some participants had had previous easy, short, and uncomplicated labors and births, whether in the hospital, birthing center, or the home, and took this fact into consideration when making the decision for homebirth. For example, one woman stated, "I had all my other kids natural so there really was no reasons [sic] why I couldn’t go through it ... and my labors aren’t that long." Others made the decision for homebirth in spite of previous experiences with labor and/or birth that they regarded as difficult or painful. They felt that the benefits of homebirth outweighed the difficulties or pain involved.

Those participants who had not had a homebirth before relied heavily on "hearsay" about homebirth. "Hearsay" included reading about homebirth and considering that relatives, friends or others in their cultural group had homebirths. The following was a typical expectation based on hearsay: "I just kind of like that cozy idea of a home birth, and the family atmosphere and having your family there with you." This woman felt that childbirth was
"natural and spiritual" and could "just take place in a quiet, peaceful environment."

Women also questioned their prospective midwives to gather information about the reality of homebirth. One participant was pleased to find that the midwife would be "really there for you the whole time, helping you through it, which is not the case in the hospital."

However, as one woman participant acknowledged, "There are a lot of people that think we're totally crazy." It was not surprising that participants searched for stable characteristics among the women with whom they talked. One participant who only casually knew women who had had homebirth felt relieved to discover that they were not necessarily "weird or strange people ... [or] uneducated people ... [or] people who had never heard of a doctor ... That gave it some legitimacy."

In some cases, the decision for homebirth was influenced by actual observation of other women they knew giving birth at home: "Seeing that homebirth just convinced me of the difference, and how much better it could be at home, and how much easier it was on the baby. I mean the differences were just stark." For one woman, the information she gathered about birth from viewing childbirth videos and observing births in a hospital setting helped her make the decision for homebirth.

One participant had a hospital birthing center
available to her. However, her doctor, who understood her needs well, told her that it was "mostly just nice wallpaper." The woman explained that "their [doctors’ and nurses’] method of doing things still has not changed and behind all that is all their technology that they’ll whip out."

**Feasibility and social support.** Participants considered access to an acceptable caregiver essential to committing to the decision for a homebirth. They also stated a need to receive support from their husbands or significant others. Comments about husbands included that "his confidence in me being able to do it was high" and "he’s really ... gung-ho about it." One participant, who was young and unmarried for her first child, had decided against her home for that birth, saying "I didn’t have someone there to support me like I felt I needed."

**Safety.** Participants had concerns about safety in the hospital as well as home settings. A common belief was that hospital births have been made unnecessarily complicated by what happens in hospitals. One woman stated, "Some of the hospital policies, I think, and practices cause as many problems as they help." A few women made reference to being exposed to micro-organisms in the hospital to which the mother and baby would have no immunity.

Concerns about complications in the home setting were alleviated by realizing that complications do not
necessarily develop because birth takes place in the home, and by having questions answered about how complications would be handled at home if they were to occur. All participants felt reassured that they had ready access to a back-up physician and a hospital, for complications that their midwife could not handle.

It was helpful to participants knowing that the midwife took precautions to ensure safety, such as screening for high-risk factors and bringing in equipment such as oxygen. Being told by the doctor or midwife that they had no high-risk factors was also reassuring to the women.

Pragmatic factors. Pragmatic factors included costs, access, and previous birth experiences (see Appendix E, p. 171-172). Cost of hospitalization was an issue to four participants, one of whom said, "We didn’t have maternity insurance at the time and so that was part of it, although ... if I hadn’t felt really drawn to it, I’d have been too nervous to try it." Another participant declared that "I’m a very frugal person. We’re able to pay our bills and ... feed our children ... but I don’t like spending two and three thousand dollars that I don’t have to."

One woman explored homebirth because she did not have access to an out-of-hospital birth center. Also, she became convinced that homebirth was entirely acceptable: "After the midwife left [after a home visit], it was like, why wouldn’t we want to do this? There was no reason I could think of,
that we would not want to do this."

Another participant did not want to drive one hour to her former caregiver in another city, did not have an acceptable hospital or out-of-hospital birth center available, and regarded homebirth as the only realistic alternative. And last, another pragmatic consideration was the participants' previous birth and postpartum experiences. If the participants had already experienced uncomplicated births and postpartum recoveries that were relatively easy and uneventful, then they more easily made the decision for homebirth.

Minimization of disturbance in home routine. All of the participants felt that they would be more comfortable in their homes than in a hospital atmosphere. One woman stated very succinctly "I’m a home person. I like to be in my environment." They also liked knowing that at home, they knew where everything was located. Participants described looking forward to being able to stay home instead of having to get dressed, pack up, and drive to the hospital. One participant spoke wistfully of homebirth: "I think it would be nice." She then reminisced rather dreamily about her first labor prior to a hospital birth:

I remember last time ... I was sitting in that chair [pointing to a chair in her living room], and I was just so comfortable, and I said "I’m just not moving, just tell the doctor to come here".... I was just
relaxed, and that's just how I wanted to stay.

One participant mentioned another aspect of homebirth, that "it doesn't have to be something real complicated and real difficult, but it can be something quite extraordinary and simple at the same time."

Participants valued the home setting because it offered an earlier opportunity for their older children to bond with the newborn. One woman remembered her first two homebirths:

When I had my little girl, my little boy was sleeping, it was early, early in the morning ... And when he woke [sic] up, the baby was here. And the same thing happened with the second one ... my little boy and my little girl ... were sleeping, but they wake [sic] up and ... [there was the baby for them to see].

One woman recounted with delight her two daughters' participation in her precipitous birth:

The kids are screaming, "Daddy, the head is out! The head is coming! The head is coming!".... They never shut up the whole time. They're laughing, and crying, and jumping on each other, and they're jumping in the bed.... They're just like super excited. And P. [husband] looked at them, "Will y'all just shut up for a minute, so I can take care of this?".... it was so exciting. The adrenaline was going like crazy!

Three of the women planned for their older children
to actively participate in the birth event, and realized that extensive sibling participation might not be as likely in hospital settings. One woman allowed her three daughters, ages five to eleven, to witness the birth and help with the initial care of their baby sister. The oldest child cut the cord, the middle child put on the first diaper, and the youngest one dressed the baby. She later commented on her children’s behavior at the birth: "They all did great! ... they’re great with her -- it’s like we had her.... that’s what’s neat about homebirth ... that the family is involved."

Three of the women appreciated being able to continue caring for their older children’s needs with minimal disturbance in their children’s routines. A participant who started labor at five in the morning and gave birth at midday addressed this concern:

If I would go to the hospital, to leave them, it would be real hard for me ... 'cause I’m too close to them. And I think for them, too.... like that morning, I fix [sic] their uniform ... I was able to send them ready to the next-door neighbor, they just took them to the school. In the afternoon, my husband went and picked them up.... When they came, they went straight and see [sic] the baby and everything.

That they were able to continue with their own normal home activities during labor and early postpartum was an
advantage to some women. Even the home routine of pet care was significant to one woman who appreciated being able to "take care of my own things that I wouldn't have been able to take care of if I went to the hospital -- my little bunnies and stuff like that." Another participant expressed delight that she was able to bake brownies for a "big sister party" for her two older daughters on their new little sister's actual birthday.

**Issues of control.** All of the women were concerned about the issues of control over choices of activities in labor, over what would be done to them during labor and birth, over the extent of technology used, and over newborn care. The participants understood that homebirth offered them more control in these areas.

One of the activities they were most adamant about was being mobile and able to walk. The home environment seemed to free some participants from inhibitions and allow them to "do their own thing." One woman said this about her first hospital experience: "I didn't know what my rights were ... what I was able to do or not do, to where I was intimidated." In contrast, one woman anticipating a homebirth decided to dance from room to room as a way to cope during labor: "I turned on music and did my little jig around the house. I really would have been too self-conscious to do that in the hospital, and I really think that [jig] was what got my labor going." Participants also
wanted to bathe or shower, and eat and drink freely.

They wanted to avoid routine procedures, such as IV (intravenous) fluids and drawing blood for lab values, unless specifically needed. The participants wanted input into decision-making about procedures performed in labor (e.g., artificial rupture of amniotic membranes and episiotomy), and expected to have their permission asked beforehand. Significant use of technology was not expected, except for periodic checks of fetal heart tones. A characteristic belief was expressed by one participant: "Once they [doctors and nurses] step in and try to intervene at a point that may not have been necessary, [it] usually leads to more and more and more intervention."

Being able to have family present during the birth and have control over the number of people there were other concerns. Some of the participants objected to even small numbers of people around them and preferred to spend parts of their labors alone, with family and midwife nearby. Others' laboring styles required the simple passive presence of, or active interaction with, large numbers of family and friends. In the three births witnessed by the researcher, the number of non-caregiver individuals present in the room at the actual time of birth ranged from one to nine people.

Immediate breastfeeding and continuous, close contact with the newborn were considered to be the norm by the participants. "Just being able to have your baby after the
birth, without fighting somebody for the baby" was appreciated by one woman. They presumed that, in the home, family members would be allowed to interact with the newborn sooner after the birth and would have easier access to the newborn than in the hospital.

Knowing their caregiver well offered a measure of control to the women. In addition, knowing that the midwife would be there the whole time meant to some participants that their own biological timetable would be honored. A woman who had to stop pushing and wait for the physician to arrive for her last hospital delivery explained that:

My midwife's going to be here while I'm in labor and she's not going to leave. She's not going to have standing orders for the staff nurses that say, "Don't call me until the baby crowns." She's going to already be here. I won't have to wait [to push], and that's a big deal. That's a very big deal!

In the pre-birth interview, a participant mentioned control as a reason for choosing homebirth. In the post-birth interview, she interpreted this as meaning control "about my fate, whether or not I was going to have a C-section." She had a successful VBAC (vaginal birth after a Cesarean) at home, and a healthy baby. However, prior to labor, her back-up physicians wanted her to allow a Pitocin induction for postterm pregnancy:

They told me I was putting my baby in jeopardy. I
could feel myself getting in this position where ... I’m no longer in control of my birth.... I almost felt like they were going to put me in prison.... I was scared to death to go up there and get my biophysical profile 'cause I thought, "Well, they are just going to take me and ... induce me."

It was important to all of the participants to consciously "let God be in control" during the labor and birth. The woman who applied the word "generic" to hospital birth said of her homebirth, in comparison: "The difference for me is that I can let God be in control as much as I want Him to here at home and that’s what’s important to me, that I get the fullness of Him." This woman’s birth was far from generic as she and her husband tailored it to their spiritual and family needs. In a heartfelt ceremony shared by friends and family, they raised their newly-swaddled newborn up to the heavens to dedicate him to God in thanksgiving for his safe birth. The consequences of her letting God be in control were fulfillment and a self-actualizing experience: "When God does something for me, it’s lasting. It never leaves me.... I’ll grow from it forever." When asked "Might [that] not happen in the hospital setting?," this participant responded: "No, because you’re under kind of their rules.... They have a lot of people to tend to and there’s a procedure involved and it’s kind of step 1, step 2."
Dealing with Labor

The following probe questions were asked in the pre-birth interviews: "What kinds of activities do you see yourself doing in labor?," "Who will be helping you with your labor?," "Where will you be for the birth itself?," and "What will your children be doing while you’re in labor?" Questions also were asked to clarify which of the activities they thought would help them to cope with labor, and to help the researcher understand their responses to the CBSEI. In post-birth interviews with each participant (except for the woman who delivered preterm), the researcher asked for birth stories, including the ways in which the participants actually dealt with labor.

Among the wide variety of ways of dealing with labor (Appendix G) were preparatory activities prior to labor, arranging for the presence or absence of certain people, support techniques, and environmental factors. Also, a number of self-coping mechanisms and strategies were discovered, including physical activities, emotional/psychological techniques, and spiritual activities.

Activities prior to labor. The women prepared themselves in different ways for labor. Pro-active and avoidance-type activities were included, and some activities had elements of both.

Pro-active types of activities consisted of attending Lamaze classes (in past pregnancies), reading about
childbirth, and talking to women who had given birth naturally. Choices of reading materials were often books and magazines which were very supportive of natural childbirth and homebirth. Another pro-active approach was to think during the pregnancy about putting the pain of birth in perspective: "It's not the worst pain in life."

Other ways of dealing with labor that were pro-active had a spiritual base. One woman decided not to moan and groan in her upcoming labor because the Lord went through His trials "and He never lashed back." They prayed that God would take care of them in labor or allow them to have an easy labor (e.g., "I need to know that You can help me through this and give me the easiest birth that I could possibly have"). They trusted enough in God to accept whatever kind of labor He would send. One woman indicated:

God does what He wants to do and there's nothing I can do to change that. And it's just being in acceptance with what He sends ... I know he'll never send something that's going to hurt me. So it makes me more confident in birth.

Avoidance-type activities included refusing to dwell on "really difficult birth stories" or on potential childbirth complications. One woman stated, "If you dwell on all the things that could go wrong, you would reduce your confidence."

Some activities could be construed as having either
pro-active or avoidance-type elements. One woman recalled her first pregnancy:

I didn’t spend a lot of time thinking about what it was gonna be like, because I didn’t want to exaggerate a fear, that everybody’s gonna have some kind of fear, anyway, about first-time childbirth, it just seems obvious. But I was busy doing the things I need to do everyday.

Another woman reported that:

The only ones that I’ve kept it from [her planned homebirth] are my mom and my mother-in-law.... They both are worriers.... I don’t want to deal with it. It would cause me stress. I don’t have stress not telling them, and if I tell them after the fact, they can’t do anything about it.

Presence or absence of people. The simple presence of certain people (e.g., husband, other women) was comforting to the participants, and helped them deal with labor. One woman explained, "I wouldn’t say that there was anything that he did that ... made me more comforted, like emotionally, just that he was there." Even women who preferred to labor by themselves wanted their husband’s presence: "They [midwife and her assistant] pretty much let me [be] by myself, and I feel better like that. My husband ... was with me, you know. But I feel better like that."

Of her first birth in the hospital, when no visitors were
allowed to be with her, one participant remarked: "That was why the birth was so hard, I think - we had no support."

The presence of a particular number of people was a way for some women to deal with labor. While some participants preferred not having many people around or even being alone, others felt that having large numbers of people present was beneficial for coping with labor. One woman said:

I just prefer having a lot of people around when I'm having a baby. I don't like being alone, and I think it's because ... I'm not going to let anybody know ... how bad it is or could be.... I'm not going to let them see me out of control.

Knowing that the midwife was going to be there the whole time, helping the woman through labor, was comforting and helped the women deal with labor. The midwife's particular role in ensuring the safety of the woman and her baby was mentioned by several participants. In addition, one woman described the assistant to the midwife as "a friend of mine, so I knew her, and that made a big, big difference."

For the majority of the women, having their older children taken care of or occupied during the labor helped them deal with labor. This need was expressed well by one woman:

I'm afraid that the children will be an added burden to
me because I’ll be worried about them.... their responses and their needs and I’m afraid that ... a part of me may get distracted.... I just need to let them do their own thing and I’ll do my own thing at this point.

This woman’s in-laws took her older children to their home the morning her labor began. She remarked, "It allowed me a lot more ability to relax, not worrying that my children were not being well taken care of."

**Support techniques.** Support persons used physical activities, emotional/psychological techniques, and general activities to help the women deal with labor. Physical activities included the use of touch, such as rubbing or lightly touching the woman’s back, legs, feet, or stomach ("it takes your concentration away from the pain") or simply holding her hand. Some women found it helpful to have their breathing coached, or have someone tell them to start their breathing technique when a contraction was about to begin. One participant commented, "It didn’t bother me as much" when her breathing was coached this way.

Some of the support techniques were emotional or psychological in nature. Having verbal support was important to women. Examples included getting encouragement from the husband ("it was reassuring just to be able to tell him ... that I was discouraged and just to have him there to listen to me"), being told that she was making progress.
"that really makes a big difference. I'm always afraid they're going to say, 'Oh, you're only four centimeters. You've got a long way, honey.'"), and especially being assisted by women who have given birth themselves ("the encouragement helped a lot ... S. and T. and C. most of all, because the three of them have experienced this before").

Other forms of verbal support included being asked how they felt, being verbally walked through procedures, being told labor would be over soon, and having someone count to help the woman through the contraction or with pushing.

The midwives purposefully performed cervical exams more infrequently in slow labors because hearing about slow progress would discourage the woman. Being told that the fetus was fine also helped women to deal with labor. Some support persons knew not to expect responses from the laboring woman during contractions; for example, one participant said, "Noise doesn't bother me, as long as I know they don't expect me to answer."

Having support persons who were sensitive to the woman's subtle behaviors helped some women cope. One woman described that her birth attendant "just picks up cues that aren't even intended to be given.... I was asking for the sheet once [after a vaginal exam] and sort of groping for it, and she's like, 'You're still a lady, D. Don't worry.'"

General activities included "having a lot of help to get through" and having someone in the room praying for or
with the woman during labor:

That's part of what I do to help me cope, is having somebody there, besides my husband, who I know is praying.... It just helps my attitude, I guess, more than anything.... Once I get into labor, I don't think about something going wrong or anything, and I would attribute, at least part of it, to knowing that there's somebody there praying.

Another woman said, "I had a friend of mine that got there [to her bedroom for the birth] and I saw she was praying the rosary and so that I knew ... I was in good hands there. So that all goes to kind of help me to ignore the [contractions]."

**Environmental factors.** The environment of their own homes helped these women to deal with labor. Just the fact of being at home seemed to affect women who "get stressed out just thinking about going to the hospital" or who feel that "there's no more loving and secure environment than your home." Asked about the personal meaning of homebirth, one woman responded: "I'm kind of a homebody. And I love to be at home.... I'd much rather be at home than anywhere else." From her own experience of three homebirths, one participant summarized: "I think home birth, what makes it easier and different is being in your home ... being comfortable with your surroundings. I think that has a lot to do with the speed of your birth, the labor. I really
Knowing where things were in their environment was facilitated at home. Also, an appropriate setting was sometimes accomplished in special ways (e.g., "He [husband] had some candles lit and music on.... it was just a real peaceful, peaceful setting. That helped a whole lot"). Having the lights dimmed and listening to Christian music was also mentioned by several women. A woman who wanted a more relaxed, light-hearted approach to coping with labor felt freer to do so at home: "More than in the hospital, we were probably able to set the stage a little bit more [for a more carefree mood].... since it was our home."

**Self-coping techniques.** Techniques or activities that participants utilized to deal with labor were physical, emotional or psychological, and spiritual in character. Some activities featured two of these elements; for example, some physical activities possessed an emotional or psychological component as well. One illustration was the participant with slow early labor who decided to turn on some music and dance around the house. When asked how music helped her cope with labor, she said: "You can ... dance along with it, it's a little bit more fun ... it makes time go a little bit faster."

Another way for time to go faster seemed to be by performing the usual everyday activities. A woman who usually went beyond her due date stated that "when labor
does come, I ignore early labor and I do all of whatever I have to do. I've gone to church in the past. I have gone shopping, done ... the housework and taken care of the children." One participant "was busy and ... animated in conversation" while she was doing dishes with her sisters-in-law, then decided to take a shower, after which she realized that she had progressed to active labor (she usually had "an hour or two" of active labor).

A number of activities with positioning or movement seemed to help these women deal with labor. When asked about coping in labor, the majority of the participants mentioned walking first. Many said simply "I walk," "I walk around," "I feel better walking. I stop when the contraction [starts], but after the contraction, I keep walking," and "I don't like to be in bed.... I can go with the contractions better if I'm walking." For many, walking was a way to deal with labor and also to speed labor up. A participant who was not emotionally prepared to be in labor (she was 11 days early) put off walking until she was ready: "For me walking does it. I mean, if I walk, that's it -- bam, I'm gone."

Other positioning and movement activities that helped women deal with labor included being on "all fours", semi-reclining, kneeling, sitting, bending over in a standing position, and making rhythmic movements such as rocking in a chair or while standing. One woman said that her
contractions "weren't as painful" when she was squatting, and another felt that "my body just wants to do that.... I squat and it seems to help a little bit." Two participants preferred lying down, at least during active labor.

Preferences for breathing techniques ranged from "Lamaze -- I don't like it -- I like just to breathe regular, and just concentrate on the breathing" to "the only thing that I did to cope was the [Lamaze] breathing." The women who performed breathing techniques did so for pain control: "Deep breathing really helped me this time. I take really deep, deep breaths, and that seemed to relieve even a little bit of the pain ... at least in the early part."

Other physical activities for coping were to maintain a comfortable body temperature, and eat and drink as desired ("that's just a miserable feeling to feel dehydrated"). Various forms of skin stimulation entailed placement of a heating pad to the back for back labor, baths or showers ("I took a bath a couple of times, because it was just so comforting ... the warm water was relaxing"), and self-massage ("rubbing my stomach ... always helps a little"). And last, although some women hoped to remain quiet and uncomplaining during childbirth, others found it helpful to make noises such as moaning during transition or groaning with the pushing efforts during birth: "It just felt good to make noise.... That's what relieved the pressure."

Emotional or psychological strategies were used as
well. Maintaining self-control was one strategy. Participants developed certain attitudes for maintaining self-control: "You just have to grin and bear it." They paced themselves by handling one contraction at a time ("I didn’t anticipate the next one with fear or anything -- I just got through one at a time") or handling longer periods of time ("I kind of take it in chunks of time ... I say, okay, I can handle this for 15 more minutes").

Participants alluded to their total preparation for maintaining self-control: "I guess because I was emotionally and physically and spiritually prepared ... keeping myself in control wasn’t a problem." For some participants, conscious effort was necessary to maintain control: "I just keep telling myself, you got to wait and relax, because if you start tensing up, it’s going to make it harder." Some used positive self-talk to maintain self-control: "At the end, I was saying, I think I can - I think I can. I remember thinking ... I can do this - I can do this."

Another helpful emotional or psychological strategy was to focus on outcomes. Some outcomes were short-term, such as trying to "think about the uterus contracting ... rather than ‘this hurts’" and even just knowing that each contraction would end. Some focused on the final outcome of the end of labor, as exemplified by one woman who said, "The one thing that did help was K. [midwife] rubbing my back, saying ‘It’s gonna be over soon.’ Just thinking it’ll
be over soon helps." Another woman found herself "focusing in on the baby and she'll or he'll be here soon."

Activites such as getting out of bed, even though it was not helpful in decreasing pain for some women, helped them deal with labor because of the potential outcome. One woman said, "Mentally that was a good thing getting up ... because I was just convinced once I stood up this baby was just going to be born." One woman started squatting: "I knew that if I'd squat during the contraction that it would speed things up, and that's when the contractions went from seven minutes [apart] to three minutes, right away."

Emotionally or psychologically accepting labor as it occurred was a strategy some women described. "Mostly we just talk and I just let it happen ... you can't stop it" was a typical comment. Another participant said, "I just try to let everything take its course and not get in the way by being afraid or something. You know, just let it go," and another commented that she was "just very relaxed and just kind of went with the flow of the contractions."

Either focusing on, ignoring, or suppressing stimuli helped some women deal with labor. Women used photographs of their older children as focal points, visually focussed on the person assisting, or listened to conversations in the room. One participant mentioned that she ignored stimuli between contractions in order to sleep. Several women were able to achieve self-control and induce an altered state of
consciousness by suppressing stimuli: "I was sort of blocking everything out, which was a little bit different than before. This time ... the pain was so intense, I just sort of ... everything around me was sort of like a dream, a fog." Another woman stated: "I was really just able to ... kind of put myself in this trance."

The researcher noted that throughout the interviews, the participants found many occasions to laugh. It was not unexpected, then, that use of humor or a light-hearted attitude was a way to deal with labor. One participant described joking, "having fun and laughing" with her husband as they were walking during labor. The participant whose labor was slow to progress until she walked said, "I make jokes. I think that's what helps me.... K. [midwife] said something about 'we're not in a hurry' and I said 'well, maybe you're not in a hurry, but I'm in a hurry!'"

Reminding themselves that childbirth was a universal experience was a helpful strategy. During labor, one participant thought of her friends who had had natural childbirth and told herself, "You're not the only one who's had to go through this."

Spiritual activities also were identified. All participants generally felt that God was in control, and that they had to trust in Him. One participant who had had two hospital births with regional anesthesia and then two homebirths indicated the extent of her dependence on God: "I
am probably the worst candidate for a home birth.... if it wasn’t for God." They believed that God would take care of them in labor. Examples were women who admitted that "I had 100% confidence in God, so I knew I was being taken care of" and "believing in the supernatural and that God is going to take care of me, then that’s what keeps me calm." Trusting God required a surrendering of fears about labor for some women. One woman explained, "When you trust in God, it’s always against your flesh. It always goes against your grain, because when you trust in something, you’re completing capitulating. I’m completely, totally surrendering and it’s like a courageous thing."

Another participant found that prayer during labor was comforting, "knowing that the Lord ... is in control of it and that we were leaving it up to Him -- we were putting it in His hands and that we were trusting Him." Women prayed during labor in widely different ways. They thought of childbirth pain as a sacrifice: "I do a lot of mental prayer.... I offer up my pain a lot for like the souls in purgatory." They used visual images such as a crucifix to pray: "I would try to meditate on Jesus’ pain on the crucifix.... I knew He would have never inflicted me with more pain than what He endured on the cross." Prayer was used for coping during difficult contractions: "When I’d have a contraction, I would start praying and my focus was on God." Some women wanted to pray with others: "A.
[friend] came in and she laid her hands on the bottom part of my stomach and she was just praying with me.... That was a lot of relief." One woman described achieving an altered state of consciousness through prayer: "When I’m praying ... I move into another place. I escape. I go into my own little world with Him ... and I can relax.... I escaped the pain."

Other activities that can be construed as spiritual in nature included listening to Christian music and "praying in spirit." One woman thought about God’s promise to her for a painless birth and "listened to encouragement from the Holy Spirit."

Walking with God, and Family and Home as Central

The purpose of this research was to identify recurring themes in the lives of pregnant women with self-efficacy for childbirth. From the three major domains of "difficult times in life and/or turning points," "deciding to have a homebirth," and "dealing with labor," two themes were identified. The themes "Walking with God" and "Family and Home as Central" linked the three domains and seemed to be themes in each of these women’s lives as a whole, not just in relation to childbirth. Their lives were very consistent with God, family, and home as integral to their everyday existence and inextricably linked.

"Walking with God" relates to the way many of these women used the terms "walk" and "walking" both in speaking
of their spiritual beliefs and of these beliefs applied to childbirth. They talked about "walking the Christian walk," which means being "in tune with God, and just trusting Him, that He knows what He's doing, and He knows where He's leading us." Another participant said of Christ's example, "Jesus always walks before you, just follow Him.... I know that He goes through it before you go through it, that whatever He allows you to go through, it's for a reason.... I just know that it [pain in childbirth] won't last forever." Another woman described the source of her calm during childbirth: "If I have enough Word [Bible study] in me in the area that I'm walking out, if I have enough faith in that area, then that faith will change my natural situation."

The theme "Walking with God" refers to the women's spiritual beliefs and experiences which occurred in all three domains. Regarding the first domain, five participants had what they identified as spiritual rebirths or born-again (Christian) experiences that were turning points in their lives. For four of these women, the turning points occurred after the participants had some very difficult early life experiences. The other five women either had a well-developed spiritual core from early in life or developed a mature spirituality as adults.

In deciding to have a homebirth (the second domain), the factor that seemed most basic to their decisions was
their belief system about the human body, God, and self. Beliefs about the human body, God, and childbirth were often expressed as being interrelated.

Some of the ways in which they dealt with labor (the third domain) were to pray, to call upon their inner resources or inner strength which they attributed to God, and to trust that God would take care of them in labor. One of the participants even reflected that religion "plays a very big part [in my life], probably the biggest part as far ... as the home birth aspect, too."

"Family and Home as Central" as the second theme relates to the focus of the participants on home and family life. One woman stated: "My family -- my children and my husband -- that is my life."

In describing difficult times in life and/or turning points (the first domain), seven participants identified dissatisfaction of some degree (from slight to total) with their families of origin, and were seeking to establish a stronger, more spiritual base in their own nuclear families. The other three women described their childhoods and early lives in very positive terms, and seemed to be duplicating the same kind of stability within their own homes and families.

In deciding to have a homebirth (the second domain), participants acknowledged their feelings about home as an environment in which they could relax more completely and
act more spontaneously during labor and birth. It was also important for participants to experience birth more fully as a family event with minimal disturbance in home routines.

In dealing with labor in their own homes (the third domain), the women were able to design birth plans that would meet their own needs and those of their families, whether that was to include or exclude their children and other family members in all or part of the birth event. Environmental factors that facilitated coping, a subdomain of "dealing with labor," were greatly dependent on being in the home setting.

Some of the participants in the study were given the opportunity of identifying themes in their lives themselves. Not all of the women could articulate themes concisely:

When you're a child, I think life just kind of happens.... and your decisions are basically made. Once you get old enough to start making your own choices, I guess, then maybe you can find a little theme. I don't know what it would be, though. I think I wouldn't know how to put it into words.

At the post-birth interview, this same participant found the words when asked the same question. She admitted thinking about themes after the first interview ("I've searched through myself a little bit for ... a theme in my life"), and produced the following: "My home ... and my family are central and ... all of my decisions ... are based around how
will it affect my family, my home, and how God sees that we should do things."

Others who could articulate a theme were often brief (e.g., "My vocation is motherhood," "Let go and let God," "I would hope that it would be that I would be here to serve God and to reflect His love toward others"), but occasionally more expansive:

My theme is to do what God wants me to do.... He made me this way to handle this type of nutrition, He made me this way to have a baby naturally ... and He gave me my child because I'm supposed to raise him ... so all these things kind of fit under that. That would be the theme.... everybody should feel like they have a point in life.... Most people that don't have any kind of goal are swaying about ... so I think that's really the most important thing right there.

As this participant continued to explain:

God made us.... He put us here so that we would ... reflect the image of His son. And we do that by having faith in Him, and trusting that our hard times or trying times are to test us to strengthen our faith.... the theme of my life is that I'm a faithful steward and servant with what I'm given.

Asked about how she made important decisions and to consider whether she had a theme that might govern her decisions, one participant said:

...
What governs just about every decision we make is our faith in God and I'm continually trying to discern how did He intend for things to be, before everything got so crazy?..... 'cause things were so pure at one point.... That's kind of my governing thing, that I try to think 'What did God intend?' and what's the most natural way to do something.... my definition of natural is what did God intend for it to be, how did God make it originally?..... "natural" and "God" really go together for me.

The women's belief about childbirth, that God is in control during the woman's birth and that women have to trust in God that the birth will proceed smoothly, reflects their general belief that God is in control of their lives, and that they need to trust God. One woman described God as a "focal point" or "centerpiece" in her and her family's life now, whereas earlier in her life she described herself as "still doing my own thing and then sort of tacking on God at the end." Decisions these women made in every part of their lives were made for the good of the family and in obedience to God's laws or what they perceived as His will. For example, one reason given for homeschooling was "to maintain a family identity."

In conclusion, these women "birth as they live." They live out their philosophy of life through these two major themes and act on their beliefs. As one participant
explained, "I don't think you can separate the way that we live from the way that we believe."

Another purpose of this study was to propose relationships between the recurring themes and the development of self-efficacy for childbirth. One theme identified in this study was "Family and Home as Central." A stable family of origin which promoted spiritual development offered several women in this sample a base from which to develop confident feelings about the self. Two of the women consciously ascribed their self-confidence for birth to their general self-confidence developed during childhood. Overcoming difficult or flawed early family and life circumstances through spiritual or religious turning points, or through a maturing and sustaining belief in God, seemed to offer other women strengths to deal with future difficult or challenging life circumstances. Also, the women's self-awareness allowed those with flawed early family experiences to fashion for their own nuclear families more ideal family situations. Because of or despite their early life experiences with home and family, the meaning of home and family to these women was this: home and family constituted an appropriate milieu in which to plan for and deal with childbirth. Being in the home with ready access to family during labor and birth seemed to contribute to their confidence.

The other theme identified in this study was "Walking
with God." A spiritual or religious core seemed to offer the women in this sample inner resources or strength from which first to plan homebirth and then deal effectively with labor and birth. Miller (1995) wrote that "the influence of spirituality on one's self-esteem ... may partially explain its role in sustaining valued health behavior" (p. 258). For some of the women, the basis for their spiritual core was established early in life and they continued to mature in their spirituality. For others, religion or spiritual development was not a significant part of their upbringing; these women experienced events of a religious or spiritual nature as turning points in their lives. Miller (1995) points out that the "order and timing" of spiritual maturation "is individualized" (p. 258). Whether their spirituality developed early or later in life, the participants drew from their spiritual core to plan homebirth and to deal with childbirth and other difficult times in their lives.

Summary

The results of the study were presented in this chapter. First, descriptive statistics were used to summarize the demographic characteristics of the sample. The sample was compared to Lowe's sample (1993), and results of the administration of the Childbirth Self-Efficacy Inventory (CBSEI) were reported. Then the ethnographic analysis of the interview data was described. The following
three domains were identified and illustrated along with their taxonomic analyses: "difficult times in life and/or turning points," "deciding to have a homebirth," and "dealing with labor." "Walking with God" and "Family and Home as Central" were described as the two themes which linked the three domains. Relationships between the themes and the development of self-efficacy for childbirth were explained.
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

In this chapter, the results of the research will be discussed and conclusions will be drawn. Then recommendations will be made for nursing practice and nursing education. Suggestions for further research will also be made.

Discussion and Conclusions

The purpose of this research was to identify recurring themes in the lives of pregnant women with self-efficacy for childbirth. A further purpose was to propose relationships between these recurring themes and the development of self-efficacy for childbirth. One intended outcome of this research was an increased understanding of how life experiences impacted the development of self-efficacy for childbirth in this sample of women.

Discussion of CBSEL Results

Only one participant scored in the high range for Total Childbirth Self-Efficacy Expectancy score, with five in the moderate range, and four in the low range. Lowe applied this researcher’s categorization scheme for Total Childbirth Self-Efficacy Expectancy scores to her sample (Appendix C). The distribution of multiparas in Lowe’s group among the Total Childbirth Self-Efficacy Expectancy score groups is significantly different from the
distribution of multiparas in this sample. The distributions are displayed in Table 4. A frequency distribution of Lowe’s multiparous group would be negatively skewed (to the left), while that of the present sample would be positively skewed (to the right).

The mean Outcome and Self-Efficacy Expectancy scores for both Parts I and II, as well as the mean Total Childbirth Outcome and Self-Efficacy Expectancy scores, were all lower for the present sample than the mean scores for the multiparous group in Lowe’s study (Table 5). In addition, the present sample has narrower ranges (more clustered around the mean) for each of the above scores than Lowe’s sample.

The possession of self-efficacy for childbirth by this sample of homebirthing women could not be determined empirically through the administration of the CBSEI (Childbirth Self-Efficacy Inventory). These unexpected outcomes can be explained in several ways.

First, each participant verbalized doubt about the helpfulness (outcome expectancy) of one or more of the coping behaviors on the CBSEI. Lowe recognized her underlying assumption, in the construction of the CBSEI, of an additive effect. She assumed that “women who express confidence in using more behaviors to cope during labor have a higher self-efficacy for labor and will therefore cope better during labor and birth” (Lowe, 1993, p. 149), and
Table 4

Distribution of Samples of Lowe and Present Study Among CBSEI Total Childbirth Self-Efficacy Expectancy Score Groups

<table>
<thead>
<tr>
<th>Total Childbirth Self-Efficacy Expectancy Score Groups</th>
<th>Lowe's Sample</th>
<th>Present sample of multiparas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total sample</td>
<td>Nulliparas</td>
</tr>
<tr>
<td></td>
<td>N=360</td>
<td>n=271</td>
</tr>
<tr>
<td>Low (31-203)</td>
<td>42%</td>
<td>46%</td>
</tr>
<tr>
<td>Moderate (204-241)</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>High (242-310)</td>
<td>26%</td>
<td>22%</td>
</tr>
</tbody>
</table>

stated that this was an untested assumption. For example, eight participants indicated that to "Think about others in my family" would not be helpful during labor or birth. "Concentrate on an object in the room to distract myself" was generally not done by these women, most of whom closed their eyes and turned inward to deal with contractions. "Concentrate on thinking about the baby" was less helpful to these women during active labor than during the second stage of labor. Even the well-accepted breathing techniques taught in childbirth education classes ("Use breathing during labor contractions") were not used by some of the women, who indicated that they just breathe normally during contractions. Lowe acknowledged that the CBSEI needed to be administered "in more diverse demographic samples and in women unexposed to childbirth education" (1993, p. 149).
Table 5

Means and Ranges of CBSEI Scores in the Samples of Lowe and Present Study, and Differences Between the Samples

<table>
<thead>
<tr>
<th>CBSEI Scores</th>
<th>Lowe's Study (Mean and Range)</th>
<th>Present Study (Mean and Range)</th>
<th>Differences Between Means of CBSEI Scores in Lowe's and Present Study (and %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I-Active Labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Expectancy</td>
<td>127.7 (88-150)</td>
<td>112.7 (78-137)</td>
<td>15 (10%)</td>
</tr>
<tr>
<td>Self-Efficacy Expectancy Scores</td>
<td>109.4 (55-150)</td>
<td>102 (78-134)</td>
<td>7.4 (4.9%)</td>
</tr>
<tr>
<td>Part II-Second Stage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome Expectancy</td>
<td>128.5 (34-160)</td>
<td>120.2 (88-152)</td>
<td>8.3 (5.2%)</td>
</tr>
<tr>
<td>Self-Efficacy Expectancy Scores</td>
<td>113.3 (34-160)</td>
<td>108.6 (88-131)</td>
<td>4.7 (3%)</td>
</tr>
<tr>
<td>Total Childbirth Outcome Expectancy Scores</td>
<td>256.2 (34-160)</td>
<td>232.9 (88-152)</td>
<td>23.3 (7.5%)</td>
</tr>
<tr>
<td>Total Childbirth Self-Efficacy Expectancy Scores</td>
<td>222.6 (89-310)</td>
<td>210.6 (166-265)</td>
<td>12 (3.9%)</td>
</tr>
</tbody>
</table>

A close examination was made of how each participant scored her individual self-efficacy expectancy items in comparison to her respective outcome expectancy items. Most of the time, when a participant circled a low number for outcome expectancy, she also scored a low or lower number for self-efficacy expectancy. In both Lowe’s sample and the present sample, the means for self-efficacy expectancy scores are lower than their respective outcome expectancy scores (Table 5). It would be expected that women would
feel uncertain about performing coping behaviors that they do not regard as helpful.

Second, the differences between the mean outcome expectancy scores of Lowe's sample and the present sample (e.g., for Part I, 127.7 versus 112.7, a difference of 10%) are about twice as great as the differences between the mean self-efficacy expectancy scores of Lowe's sample and the present sample (e.g., for Part I, 109.4 versus 102, a difference of just 4.9%) (Table 5). Though the homebirth sample felt less strongly than Lowe's sample did about the helpfulness of the coping behaviors listed, the homebirth sample's certainty of their ability to use the coping behaviors that they did feel strongly about was relatively higher.

Third, all ten participants described, in one or both of their interviews, coping behaviors that were not listed in the CBSEI. Walking, praying, eating and drinking, taking a bath or shower, using a heating pad on her back, "going with the flow," making jokes, listening to music, and even dancing around the room are examples of behaviors that women in this sample found helpful for coping with labor. One participant even commented as she was taking the CBSEI, "I need to do my own thing like this right here [develop her own questionnaire], write my own ideas."

Lowe was informed and consulted about these observations. She responded that the women on whom the
CBSEI was normed "were all women whose ideas of birthing behavior have been molded by a very interventionist medical model," and to her knowledge had all given birth in hospitals (Appendix C). Also to be considered is that all of the women in Lowe's sample were currently in childbirth classes, were familiar with the standard coping strategies listed in the CBSEI, and may have had higher retest scores because of ongoing attendance at childbirth education classes (Lowe, 1993). The present sample, in contrast, did not attend childbirth education classes during the current pregnancy, and only six had attended classes in past pregnancies.

There are demographic differences as well as differences in birthing behaviors between Lowe's group and this sample. In addition, all of the women in the present study, except for the participant who delivered preterm, gave birth in their homes, whereas the women in Lowe's study gave birth in hospitals. Therefore, the CBSEI was not an appropriate instrument to have used to measure self-efficacy for childbirth in the population of homebirthing women, and thus its reliability and validity for this sample is questioned. Lynn (1987) argued that "the general acceptability and appropriateness" of an instrument is greatly enhanced when its construction incorporates "use of the experiences and terminology of persons similar to those to be studied" (p. 206).
Despite the lack of empirical evidence of self-efficacy for childbirth via Lowe's research instrument, the researcher concluded that other evidence supported the existence of self-efficacy in these women. This evidence was amassed from the qualitative analysis of the pre-birth and post-birth interview transcripts as well as the researcher's observation of three participants during their unmedicated labors and births.

Discussion of Ethnographic Analysis

One of the major findings of this study was the importance to the participants of their religious or spiritual lives. Spirituality and/or religion has been recognized as providing "a ready resource for coping with life" (Miller, 1995, p. 257). Defined as a search for meaning in life and applied to childbirth, a developed spirituality may allow a woman to seek her own personal meaning of childbirth and to enact, unconsciously or not, her own life themes (e.g., centrality of family and home) in her choice of sociocultural milieu for childbirth. There has long been a connection between homebirth and religion; certain religious groups such as Jehovah's Witnesses (DeVries, 1992), Seventh-Day Adventists, Christian Scientists, and Mormons (Mitford, 1992) seek out the services of midwives for homebirth. Callister (1992) reported that Mormon women in her study "endowed childbirth with a profound spiritual dimension and drew an inner
strength from their religious beliefs" (p. 55).

Not all women who choose homebirth are necessarily religious in their orientation. In some communities, they constitute a relatively small group; for example, in the homebirth practice of a Northern California midwife, only 15% fall into this category (Mitford, 1992). Other groups who prefer homebirth are variously described as middle-class Caucasian women who advocate alternative life-styles "stressing feminist health practices" (Mitford, 1992, p. 12), and others in alternative lifestyles such as "seriously health conscious people, [and] hippies" (M. Penn, LMP, personal communication, January 24, 1995). These women choose homebirth for different philosophical, but perhaps no less spiritual, reasons. Indeed, Davis-Floyd (1992) stated that 3 of the 100 mothers in her study identified explicitly with "New Age ideology," defined as "a wholistic, systems-oriented vision of reality in which the individual creates or attracts to herself the life experiences she most needs to further her spiritual growth" (p. 201-202).

From whatever orientation homebirth is chosen, these groups seem to be in marked contrast to other women such as the group of 31 pregnant professional women studied by Davis-Floyd (1994). Those women, all "in positions of power and authority" (p. 201), tended to see their bodies as imperfect and out-of-control during pregnancy and childbirth, and made conscious decisions to accept obstetric
technology "as a liberation from the tyranny of biology" (p. 222). It is interesting to note that the women in the present study ascribe to very conservative traditional values, and they deeply value their roles as wives and mothers. One of the women, the only woman who worked outside the home (part-time as a social worker), was asked for her views on feminism, and very astutely responded:

These same women who will stand up to defend ... these cases in court, those who work for large corporations ... when they get in the doctor's office and he tells them 'oh, you're small; you'll have a C-section.' And they say 'oh, okay' ... and go along with him ... women have not been very assertive in taking health care and birthing in their own hands, and having that confidence that they have at their workplace in their own selves.

Homebirthing women from various orientations have all rejected what has been labelled the "medical model of birth" (Martin, 1987), dominant in most hospital settings, in which the laboring woman's body is regarded as an imperfect machine needing to be controlled and managed. Others have called this model the "technocratic model of birth" (Davis-Floyd, 1992), and believe that it reflects the dominant American culture.

The opposing "wholistic" model is espoused by women who plan homebirth. In this model, birth is regarded as a natural process, women are felt to have an innate ability to
give birth in an environment of their choice with attendants of their choice, and birth occurs unfettered by unnecessary intervention (Davis-Floyd, 1992). The family, according to this model, is "the significant social unit" and "birth rituals should affirm ... the unity and integrity of the family" (Davis-Floyd, 1992, p. 156).

A model of birth is generally based on the particular cultural paradigm or world view held by the group in question. Herberg (1989) states that "all beliefs and values regarding health are derived from a person's basic world view" (p. 22). Three major world views exist: scientific, holistic, and magico-religious. Although most people choose beliefs from all three world views to explain and deal with life events, usually one world view predominates (Herberg, 1989, p. 22).

Women who embrace the medical model or technocratic model of birth have a scientific world view. In this world view, life can be controlled, manipulated, and reduced to component parts such as separate mind and body (Cartesian dualism). The scientific world view "disavows the metaphysical" (Herberg, 1989, p. 28), and asserts that human beings are "nothing more than the consequence of our anatomy and physiology" (Dossey, 1982, p. 222). This world view dominates in the United States today, and regards pregnancy and childbirth as an "incipient disease state" (Greener, 1989, p. 95). One example of this is an obstetrician who,
on a local television call-in program, referred to "the minefield of labor and delivery."

Women who plan homebirth seem to possess beliefs emanating from holistic and magico-religious world views. In the holistic world view, "the whole person is viewed in the context of the total environment" (Herberg, 1989, p. 34). This view looks beyond biomedical health to environmental, sociocultural, and behavioral aspects of wellness. The holistic world view seems to be altogether consistent with the views of women for whom environment and family are so important to their birthing process.

Within the magico-religious world view, "supernatural forces dominate" and human fate depends on the action of God (Herberg, 1989, p. 26-27). Illness, in this view, may be interpreted as giving the person an opportunity to resign oneself to God's will (Herberg, 1989). Women in the present study believed that "God was in control" and that whatever kind of labor they had was the will of God, for whatever purpose He ordained.

These conclusions need to be related to self-efficacy theory in order to refine this theory for application to childbirth. Bandura identified four sources of self-efficacy information. He indicated (1977) that "the impact of information on efficacy expectations will depend on how it is cognitively appraised" and integrated (p. 200). For this sample of women, their holistic/magico-religious world
view and their consequent "wholistic" model of birth constituted the cognitive matrix through which they appraised self-efficacy information. Since information on active, non-interventionistic birth was consistent with their world view, this information was accepted and integrated into their thinking and belief system about birth, and a high level of self-efficacy for childbirth resulted. Women with lesser affinity to this type of world view, when confronted with a technocratic environment or routines that may be less than supportive of holistic practices, may not be able to sustain coping behaviors in childbirth, and align themselves more closely with the scientific world view (Davis-Floyd, 1992). A woman's cultural world view seems to be a major factor in the development of her self-efficacy for birth and her ability to sustain coping behaviors through childbirth.

Recommendations for Nursing Practice and Education

The research findings and conclusions foster numerous recommendations for nursing practice and education. In addition, some recommendations may apply to nurses who are childbirth educators. First, maternity nurses (both practicing nurses and nursing students) need to identify and be aware of their own cultural world views and models for birth in order to give culturally-sensitive care to women who may not share the same world view and birth model.

When assessing pregnant women, nurses need to be
aware that women's cultural world views or religious/spiritual orientation may have an impact not only on their choice of birth site and birth attendant, but also on the strength and persistence of their self-efficacy expectations. Miller (1995) advised maternity nurses to "make a formal assessment of the ways in which each woman brings her spirituality to bear on health behavior issues" (p. 261). She further counselled that "if the client's cultural/spiritual systems and the professional health care culture are at odds," the nurse can help "to resolve conflicts between them" (p. 261). Resolution may consist of acting as an intermediary between client and institution to communicate desires and expectations, compromise between the client and the health care system, or redirection of the client to an alternate health care system that meets her needs more fully.

The nurse can assist the client to fully explore her cultural world view in regard to childbirth, to resolve any inconsistencies within it, and to examine and develop her spiritual resources. When a pregnant or laboring woman is found to possess spiritual resources, the nurse can encourage the woman to call upon these resources.

Maternity nurses can seek to make changes in hospital birth environments, practices, and nurse-client communications in order to provide care that meets clients' psychological/emotional/spiritual needs as well as physical.
For example, nurses can make the environment conducive to relaxation, include the client in all conversations about her care, and minimize the use of technology when appropriate for those women who cannot comfortably incorporate this into their belief systems. Nurses can also encourage consideration of the family as a unit when communicating with pregnant women and devising hospital policies and procedures.

New systems for providing intrapartum care could be devised. For example, the pregnant woman anticipating admission to a certain institution could meet and get to know her potential labor nurses prior to labor (e.g., during hospital birth classes, tours of the maternity unit, in extended and meaningful encounters), and not experience lack of control from facing a "community of strangers" (McKay, 1991, p. 284). Some nurses may need to become more comfortable with use of touch in other than a procedural context (McKay, 1991). Changing the cultural milieu from one that supports the medical model to one that supports the wholistic model of birth is another fertile and challenging area for practice.

Another implication for nursing is that some parents may need more guidance in regard to childrearing practices. Practices that encourage the development of confidence in children may need to be taught or modelled. Parents may need to be presented information on parenting styles and
their potential long-range effect on children. Also, parents may need more assistance in regard to the spiritual development of their children.

Nursing educators have been placing more emphasis in recent years on cultural factors in nursing care, considering the changes in population demographics in this country. Educators can help to make maternity nursing students aware that subcultural groups in the childbearing population may not be visibly identifiable and that cultural assessment may require more than a cursory inspection. Students need to understand the concept of cultural world view, how health care models derive from world view, and how culturally-sensitive care can be given based on this understanding.

Suggestions for Further Research

A similar study using a larger, more heterogenous sample of homebirth participants could be conducted. The results of such a study would be more generalizable.

The CBSEI (Childbirth Self-Efficacy Inventory) would not be recommended in the present format for use in this population of homebirthing women. A research tool to measure self-efficacy for childbirth in homebirth populations, analogous to the CBSEI, could be developed and tested for psychometric properties, and then used in studies of homebirthing women.

This study involved only multiparous women. Similar
studies on nulliparous women planning homebirth could be performed to establish differences between nulliparous and multiparous homebirth populations in the development of self-efficacy.

The relationship between spirituality/religion and health has not as yet been firmly established in empirical studies (Miller, 1995), nor has the spiritual dimension of nursing care been given much attention by nurse scholars until recently (Henry, 1995). Studies could be performed to further explore the links between religion/spirituality, world view, and self-efficacy for childbirth.

The home environment could be further studied for the elements that support the "wholistic" model of birth. These elements could be reproduced in hospital and other institutional environments, and research performed to detect differential effects on women during labor and birth between the two environments.

And lastly, health care reform and its emphasis on cost-containment may change the way maternity services are provided. Increased use of caregivers, such as midwives, and out-of-hospital birth sites may develop. Approaches will need to be created to assist women to adjust to the differences in expectations between the medical model for birth and the wholistic model they would encounter in an out-of-hospital site or with midwives. Research can be performed to determine which approaches are the most...
effective or satisfactory.

Summary

In this chapter, the results of the research were discussed and conclusions were drawn. It was concluded that the CBSEI (Childbirth Self-Efficacy Inventory) was not an appropriate instrument for use in this population. The researcher described her understanding of how the life experiences which influenced the development of the two themes impacted the development of self-efficacy for childbirth in this sample of women. Recommendations were made for nursing practice, education, and research.
REFERENCES


Appendix A

CHILDBIRTH SELF-EFFICACY INVENTORY (CBSEI)
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Nancy K. Lowe, RN, PhD
College of Nursing
The Ohio State University

Scoring Instructions

The CBSEI is a self-report measure of outcome expectancy and self-efficacy expectancy for labor and birth. In the framework of self-efficacy theory (Bandura, 1982), outcome expectancy for labor and birth is defined as the belief that a given behavior will enhance coping with labor, while self-efficacy expectancy is a personal conviction that one can successfully perform specific behaviors during labor. This distinction is important because a woman may believe that a certain behavior could help a woman cope with labor, but feel incapable of personally performing the behavior during her own labor.

Part I of the CBSEI measures outcome expectancy and self-efficacy expectancy for active labor, while Part II measures the same constructs for second stage or birth. Scale scores are computed by summing the item responses as follows:

Outcome Expectancy Active Labor (Outcome-AL): items 1 through 15
Self-Efficacy Expectancy Active Labor (Efficacy-AL): items 16 through 30
Outcome Expectancy Second Stage (Outcome-SS): items 31 through 46
Self-Efficacy Expectancy Second Stage (Efficacy-SS): items 47 through 62

A Total Childbirth Outcome Expectancy Score (Outcome-Total) is computed by summing the Outcome-AL and Outcome-SS scale scores. A Total Self-Efficacy Expectancy Score (Efficacy-Total) is computed by summing the Efficacy-AL and Efficacy-SS scale scores.
Childbirth Self-Efficacy Inventory (CBSEI)

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Nancy K. Lowe, R.N., Ph.D.
College of Nursing

Subject ID ________  Date ________
CBSEI: Part I (Labor)

Think about how you imagine labor will be and feel when you are having contractions 5 minutes apart or less. For each of the following behaviors, indicate how helpful you feel the behavior could be in helping you cope with this part of labor by circling a number between 1, *not at all helpful*, and 10, *very helpful*.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Not at all helpful</th>
<th>Very helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relax my body.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>2. Get ready for each contraction.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>3. Use breathing during labor contractions.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>4. Keep myself in control.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>5. Think about relaxing.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>6. Concentrate on an object in the room to distract myself.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>7. Keep myself calm.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>8. Concentrate on thinking about the baby.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>9. Stay on top of each contraction.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>10. Think positively.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>11. Not think about the pain.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>12. Tell myself that I can do it.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>13. Think about others in my family.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>14. Concentrate on getting through one contraction at a time.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>15. Listen to encouragement from the person helping me.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>
Continue to think about how you imagine labor will be and feel when you are having contractions 5 minutes apart or less. For each behavior, indicate how certain you are of your ability to use the behavior to help you cope with this part of labor by circling a number between 1, not at all sure, and 10, completely sure.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Not at all sure</th>
<th>Completely sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Relax my body.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>17. Get ready for each contraction.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>18. Use breathing during labor contractions.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>19. Keep myself in control.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>20. Think about relaxing.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>21. Concentrate on an object in the room to distract myself.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>22. Keep myself calm.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>23. Concentrate on thinking about the baby.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>24. Stay on top of each contraction.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>25. Think positively.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>26. Not think about the pain.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>27. Tell myself that I can do it.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>28. Think about others in my family.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>29. Concentrate on getting through one contraction at a time.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>30. Listen to encouragement from the person helping me.</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>
Think about how you imagine labor will be and feel when you are pushing your baby out to give birth. For each of the following behaviors, indicate how helpful you feel the behavior could be in helping you cope with this part of labor by circling a number between 1, not at all helpful, and 10, very helpful.

31. Relax my body.
32. Get ready for each contraction.
33. Use breathing during labor contractions.
34. Keep myself in control.
35. Think about relaxing.
36. Concentrate on an object in the room to distract myself.
37. Keep myself calm.
38. Concentrate on thinking about the baby.
39. Stay on top of each contraction.
40. Think positively.
41. Not think about the pain.
42. Tell myself that I can do it.
43. Think about others in my family.
44. Concentrate on getting through one contraction at a time.
45. Focus on the person helping me in labor.
46. Listen to encouragement from the person helping me.
Continue to think about how you imagine labor will be and feel when you are pushing your baby out to give birth. For each behavior, indicate how certain you are of your ability to use the behavior to help you cope with this part of labor by circling a number between 1, *not at all sure*, and 10, *completely sure*.

<table>
<thead>
<tr>
<th></th>
<th>Not at all sure</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Completely sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. Relax my body.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>48. Get ready for each contraction.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>49. Use breathing during labor contractions.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>50. Keep myself in control.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>51. Think about relaxing.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>52. Concentrate on an object in the room to distract myself.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>53. Keep myself calm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>54. Concentrate on thinking about the baby.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>55. Stay on top of each contraction.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>56. Think positively.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>57. Not think about the pain.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>58. Tell myself that I can do it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>59. Think about others in my family.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>60. Concentrate on getting through one contraction at a time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>61. Focus on the person helping me in labor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>62. Listen to encouragement from the person helping me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
Appendix B

DEMOGRAPHIC DATA SHEET

DATE: ___________ NUMBER OF PARTICIPANT: _____

SITE OF INTERVIEW: ____________________________________________

PERSONAL INFORMATION

  Age: ______
  Educational Background: ________________________________
  Employment History: ________________________________
  Race: _____ Member of particular ethnic group: ______
  Marital status: ___________________________

MATERNITY INFORMATION

  Gravida: _____ Parity: ____________
  Expected date of birth: ___
  # weeks pregnant now: ______
  Progress of this pregnancy: ________________________________
  When did you decide to have an out-of-hospital birth?: ________________________________________________
  Type of caregiver: ________________________________________
  Attendance at childbirth classes: ___________________________
    ________________________________________________________
  Type of childbirth class: _________________________________
  Material covered in class so far: ____________________________
    ________________________________________________________
SIGNIFICANT OTHER

Relationship of significant other to you:___________

Age:_______

Educational background:__________________________

Employment history:____________________________

Race:_____ Member of particular ethnic group:_______

FAMILY INCOME PER YEAR

_____ under $10,000

_____ $10,000 to $20,000

_____ $20,000 to $30,000

____ $30,000 to $40,000

____ above $40,000
November 2, 1992

Anne B. Broussard, RNC, MSN, ACCE
Assistant Professor, College of Nursing
The University of Southwestern Louisiana
Lafayette, Louisiana 70504-2490

Dear Ms. Broussard:

Thank you for your interest in the Childbirth Self-Efficacy Inventory (CBSEI). I am enclosing a copy of the tool, scoring instructions, and an abstract of its development. I am also enclosing reprints of several relevant papers which you may find useful in your work. The paper describing the development of the CBSEI is in press in Research in Nursing & Health and should appear in the spring of 1993 (second or third issue).

If you decide to use the CBSEI in your dissertation research, you have my permission to do so providing the following conditions are met:

1) The instrument is not altered in any way and will be duplicated from the original.

2) An abstract of your study will be sent to me on its completion.

3) Psychometric data will be sent to me on the instrument including reliability estimates, any relevant validity information, and results of a factor analysis, if done.

4) You will inform me of your decision to use the instrument prior to data collection.

I am delighted to hear that another nurse is interested in the concept of self-efficacy for labor and I wish you the best in the conduct of your research. Please do not hesitate to contact me if I can be of any further assistance [redacted].

Sincerely,

[Redacted]

Nancy K. Lowe, RN, PhD
Assistant Professor

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November 30, 1993

Nancy K. Lowe, RN, PhD
Assistant Professor, College of Nursing
Department of Life Span Process

Dear Dr. Lowe:

I am a doctoral student who wrote to you a year ago to obtain your Childbirth Self-Efficacy Inventory for possible use in my doctoral research. Thank you for your prompt reply and for the reprints. I've read your latest publication (the report on the development of the CBSEI in a 1993 issue of Research in Nursing & Health) and am interested in using your tool.

Presently, I am at the dissertation proposal stage and am deciding on my research design. My interest is in exploring the factors that lead pregnant women to selectively heed self-efficacy information for childbirth (I know this selectivity occurs: a pregnant woman recently described to me her search for the "right" people to tell her their positive birth stories and her discounting of the frightening birth stories she heard, yet I know that some women would readily incorporate negative portrayals of birth). In my childbirth education practice, I focus on facilitating incorporation of self-efficacy information from the four sources, but I realize that this may have minimal impact on some women. I have had some contact with women who decide on home birth, and am intrigued by their development early in pregnancy (and prior to their attendance at childbirth education classes) of high levels of self-efficacy for childbirth. I want to conduct life history studies on about 10 of these women in order to identify the life experiences and influences that are significant in the development of their self-efficacy for childbirth.

The women in my area who have home births seem comparable demographically to the women in your study. The CBSEI could be used to establish empirically their (assumed) high levels of self-efficacy, and/or as part of a triangulation design. Do you have any data that I could use in regard to what you
would consider to be high, moderate, and low Total Self-Efficacy Expectancy scores? I see four options for categorization of scores:

1. You stated in your article that the Total Self-Efficacy Expectancy scores were normally distributed. I trichotomized the scores to establish high, moderate, and low score ranges based on the division of the area under the normal curve into equal portions (33%, 34%, and 33%). The z score for 0.17 (17%) of the area on either side of the mean is ±0.43. Thus the cutoff score for the low scoring group is 0.43 standard deviations less than the mean and the cutoff score for the high scoring group is 0.43 standard deviations greater than the mean:
   For nulliparas ... 31 to 185 = low  
   186 to 225 = moderate  
   226 to 310 = high  
   For multiparas ... 31 to 203 = low  
   204 to 241 = moderate  
   242 to 310 = high

2. Another option is to assume that Total Self-Efficacy Expectancy scores above your mean could be considered "high", and scores below the mean could be considered "low":
   For nulliparas ... 31 to 205 = low  
   206 to 310 = high  
   For multiparas ... 31 to 222 = low  
   223 to 310 = high

3. A third option is to divide the possible range of Total Self-Efficacy Expectancy scores (31 to 310) into three equal ranges of 93 to 94 points:
   For nulliparas and multiparas ... 31 to 123 = low  
   124 to 217 = moderate  
   218 to 310 = high

4. The last option I can think of is to establish categories differentially according to the ranges of scores in your study:
   For nulliparas (31 to 310)... as above  
   For multiparas (89 to 310)... 89 to 162 = low  
   163 to 236 = moderate  
   237 to 310 = high

I would welcome any and all comments and advice you may have on my concerns about the use of the CBSEI. Please let me
know if you or others have published or will soon publish any additional data using the CBSEI.

Sincerely,

Anne B. Broussard RNC, MSN, ACCE
Assistant Professor, College of Nursing
Doctoral Candidate, Louisiana State University Medical Center School of Nursing, New Orleans, LA
April 15, 1994

Ann B. Broussard, RNC, MSN, ACCE

Dear Ann,

Thank you for your letter of April 2, the reprint of your article, and the copy of the letter you sent me before Christmas. Congratulations on a fine application of self-efficacy theory to childbirth education. I am so glad that you resent the letter, because I had lost your original letter before I got it answered and could not remember who it was from! I usually don't loose things like that but this time I did and felt badly that whoever had written to me was wondering why I had not responded. So, first let me apologize for not responding in December.

I am pleased that you will be using the CBSEI for your dissertation research and the questions you raise about using the scores to place women categorically into low, moderate, and high levels of self-efficacy are very interesting. Simply from a sensitivity standpoint, I would favor a 3 category designation (option 1, 3, or 4) over a two category designation above or below the mean (option 2). I also agree that option 1 is most sound since the decisions are based on empirical data from a large sample. As long as your sample is similar demographically to my sample used for the psychometric test of the CBSEI, I feel that would be a rational way to go. I am going to hold onto your letter in a place where I will not loose it, and when I have time later this summer I will look at my data to see how option 1 works in terms of distributing the women in my sample into low, moderate, and high groups. I will let you know what that looks like.

Again, thank you for your persistence in writing to me a second time and best wishes for the completion of your doctoral research. Please do not hesitate to write or call

Sincerely,

Nancy K. Lowe, RN, PhD
Associate Professor
March 21, 1995

Anne B. Broussard, RNC, MSN, ACCE

Dear Anne:

Thank you for your letter informing me of the progress on your dissertation research and your decision to use the CBSEI in your study. I am delighted you are using the instrument and look forward to your results. Enclosed is a table which describes the percentage distribution of scores for my total sample, nulliparas and multiparas using the high, moderate and low score ranges you described. As expected the ranges you are using fit the multiparas most closely.

The women in the sample who provided the psychometric data, to my knowledge, all delivered in hospital. In addition, the women who were interviewed to develop the items for the instrument also all delivered in hospital. It is interesting that you describe different coping behaviors for your home birth woman. Actually the behaviors of praying and walking were in the original pool of items but were eliminated from the instrument during the expert review and pilot test. Showering and making jokes were never part of the item pool. You have raised an interesting point and one that has bothered me from the beginning about the instrument. The women from whom it was developed and on whom it was psychometrically tested were all women whose ideas of birthing behavior have been molded by a very interventionist medical model. There are no hospitals in Columbus which promote an active approach to labor with walking and hydrotherapy for example, and the in bed, continuous EFM, NPO, IV, epidural approach is VERY pervasive. Please keep track of all these insights into what is missing on the instrument related to this different population of women. I will be very interested in what you feel is lacking.

Thank you again for your letter and progress report. I look forward to hearing the results of your study.

Sincerely,

Nancy K. Lowe, CNM, PhD
Associate Professor
## Total Self-Efficacy Expectancy Score Ranges
from psychometric test sample for CBSEI
Nancy K. Lowe, 1995

<table>
<thead>
<tr>
<th>Range</th>
<th>Total sample N=360</th>
<th>Nulliparas N=271</th>
<th>Multiparas N=89</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-203 low</td>
<td>42%</td>
<td>46%</td>
<td>29%</td>
</tr>
<tr>
<td>204-241 moderate</td>
<td>32%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>242-310 high</td>
<td>26%</td>
<td>22%</td>
<td>39%</td>
</tr>
</tbody>
</table>
Appendix D

LOUISIANA STATE UNIVERSITY MEDICAL CENTER IN NEW ORLEANS

CONSENT FORM

1. STUDY TITLE: Self-Efficacy for Childbirth: A Qualitative Study of Pregnant Women

2. PERFORMANCE SITES: Homes of the participants, or other sites convenient for and agreeable to the participants

3. NAMES AND TELEPHONE NUMBERS OF INVESTIGATORS:
   Principal investigator:
   Anne B. Broussard, RNC, MSN, ACCE
   Doctoral Student, LSUMC School of Nursing Graduate Program
   24-hour phone access via:
   [Redacted]
   [Redacted]
   Supervising professor:
   Patricia L. Lane, RN, PhD
   LSUMC School of Nursing Graduate Program
   [Redacted]

4. PURPOSE OF THE STUDY: The purpose of this research study is to help health professionals understand how pregnant women develop confidence for childbirth. Only pregnant women will be included in this study.

5. PARTICIPANT INCLUSION CRITERIA: The participants will be: (a) over 21 years old, (b) pregnant, and (c) anticipating an out-of-hospital birth. About ten to twenty women will be included in the study.

6. PARTICIPANT EXCLUSION CRITERIA: Women under 21 years old, not pregnant, and/or anticipating a hospital birth do not meet all the inclusion criteria.

7. DESCRIPTION OF THE STUDY: Demographic data (background information, such as age, education, and employment history) will be requested first, and then the participants will be asked to complete a questionnaire about confidence in childbirth (The Childbirth Self-Efficacy Inventory). These two forms will take about 20 minutes to complete.

   Information about life experiences that helped in the development of confidence for childbirth will be requested through one interview that will occur before the birth and one interview that will occur after the birth. A third interview may be requested in some cases if clarification is needed. Each interview is
LSUMC in NO - Self-Efficacy for Childbirth

anticipated to take between 1½ - 2 hours. The
interviews will take place in an area where the privacy
of responses can be maintained.

A tape recorder will be used during the interviews
and the tape will be erased after the information has
been typed from the tape. Participants can ask to
review and change any part of the tape.

8. BENEFITS TO PARTICIPANT: The opportunity to share
perceptions of developing confidence for childbirth may
be beneficial to participants.

9. RISKS TO PARTICIPANT: There are no known risks to
participants or to their unborn babies by participation
in this study. Thoughts and emotions arising from the
process of interviewing may be uncomfortable for some
participants. Participants will be offered referral
for counselling if desired.

10. ALTERNATIVES TO PARTICIPATION IN THE STUDY: (N/A)

11. SUBJECT REMOVAL: (N/A)

12. PARTICIPANT'S RIGHT TO REFUSE TO PARTICIPATE OR
WITHDRAW: Individuals may refuse to participate or
withdraw from the study at any time without
jeopardizing their medical treatment, in any way, in
the future. Should significant new findings develop
during the course of the research which may relate to
participants' willingness to continue participation,
that information will be provided to participants.

13. PARTICIPANT'S RIGHT TO PRIVACY: Information from this
study will be used in a graduate school dissertation
and the results will be published and presented at
conferences. The privacy of participants will be
protected and they will not be identified in any way.

14. RELEASE OF INFORMATION: (N/A)

15. FINANCIAL INFORMATION: Participants will not be paid
for participation in this study nor will participation
result in any financial charges.

16. This study has been discussed with me and all my
questions have been answered. I understand that
additional questions regarding the study should be
directed to investigators listed on page 1 of this
consent form. I understand that if I have questions
about participants' rights, or other concerns, I can
LSUMC in NO - Self-Efficacy for Childbirth

contact the Chancellor at [REDACTED] I agree with the terms above and acknowledge I have been given a copy of the consent form.

Signature of Participant ______________________  Date __________

Signature of Witness ______________________  Date __________

The study participant has indicated to me that she is unable to read. I certify that I have read this consent form to the participant and explained that by completing the signature line above the participant has agreed to participate.

Signature of Reader ______________________  Date __________
Appendix E

Taxonomic Analysis

Kinds of Difficult Times in Life and/or "Turning Points"

Experiences that occurred in childhood through young adult period
1. Experiences related to family of origin
   a. Being abandoned by her mother
   b. Living with a series of relatives
   c. Living by herself at young age
   d. Difficult home life (e.g., divorced parents, father in prison, mother with different boyfriends, alcoholic father who left them)
   e. Not having a close family life
2. Experiences related to becoming independent
   a. Starting work at young age
   b. Working and going to high school
   c. Not being able to go to college
   d. Time of partying and drinking too much
   e. Having to drop out of college and get counselling
3. Experiences related to relationships
   a. A painful or stressful experience that was relationship-oriented
   b. Major rejection by a boyfriend
   c. Difficulty communicating with authoritarian parents
   d. Sexually active at age 12 and not being able to say no to a series of boyfriends
4. Miscellaneous experiences
   a. Unnamed difficulties that seemed really horrible at the time
   b. A time of bad coping behaviors
   c. Going through alcohol and drug rehabilitation
   d. Living in a foreign country
   e. Being suicidal and hospitalized

Experiences that were related to religion or spirituality
1. Rebellious or not obeying God's laws
2. Becoming a Christian
3. Going from being Catholic in name only to putting God first in their lives (effect of going to Cursillo & Marriage Encounter)
4. Doing missionary service work
5. Feeling that God directly intervened to bring them their first (adopted) child
6. Realizing that what she needed in her life was God/being "born again"
7. Leaving one church and letting God bring her into a small ministry
Experiences that were related to marriage and family
1. Getting married
2. Childbearing experiences
   a. Going through labor
   b. Having a Cesarean section (hospital and home recovery) for her first baby
   c. Accomplishing her goal of having a homebirth/a vaginal birth
   d. Having a miscarriage
3. Becoming a mother/adopting a child
4. Dealing with illnesses and deaths in the nuclear family
   a. Losing a baby to death
   b. Adjusting to and living with her husband’s disability
5. Owing a large amount of money
Appendix F

Taxonomic Analysis

Factors in Deciding to Have a Homebirth

Beliefs in the human body, God, and self
1. General beliefs about the human body, e.g., the body is created by God
2. Beliefs about childbirth related to God or religion, e.g., God is in control and will take care of the woman in labor
3. Beliefs in own personal attributes in relation to birth
   a. Beliefs reflecting general confidence in women’s ability to give birth
   b. Strength
   c. Self-control
   d. Self-will
   e. Accountability for outcomes of pregnancy and birth

Experiences
1. Previous personal experience with birth
   a. Personal experience in hospitals
      i. Caregivers
      ii. Hospital routines
      iii. Uncomfortable feelings provoked by being in the hospital.
   b. Personal experience with home birth
      i. Enjoying a previous home birth, e.g., having the focus be on the baby as new life, and not on the birth as a procedure
      ii. Realizing that the next home birth can’t be more difficult than the previous home birth
      iii. Feelings of self-gratification, increased self-esteem, and a sense of fulfillment (described as a self-actualizing experience)
   c. Previous births were all natural and labors and births were not long, difficult, or complicated
2. Vicarious experience
   a. "Hearsay" about homebirth
      i. Reading about birth and homebirth
      ii. Considering that relatives or friends had homebirths
      iii. Knowing that many other women in your culture have homebirths
      iv. Hearing positive reports about the homebirths of friends or others
      v. Realizing that people who have homebirths are not necessarily weird, strange, or uneducated
      vi. Talking to the midwife about homebirth
b. Actual observation of a birth
   i. Observing or assisting with a friend's homebirth
   ii. Observing births in a hospital setting
   iii. Watching childbirth videos

c. "Hearsay" about hospital birth
   i. Hearing that the hospital birthing centers are pretty, but treat childbirth the same as hospitals do

Feasibility and social support
1. Access to caregiver
   a. Being told about doctor or midwife who does homebirth
      i. Believing that the caretaker has the necessary knowledge
   b. Talking to the midwife about what is involved in homebirth
   c. Being able to spend a good bit of time with the midwife who answers her questions and eases her fears

2. Having husband's support for having a homebirth
3. Receiving encouragement from others to have a homebirth

Safety
1. Concerns about safety in the hospital setting
   a. Knowing that some hospital births have been made unnecessarily complicated by what happens in hospitals
   b. Knowing that you and the baby can be exposed to micro-organisms in the hospital that you have no immunity to

2. Knowing that doctor or midwife takes all the precautions for safety
   a. Knowing that the midwife does not take high-risk clients
   b. Being told by the doctor or midwife that you have no high-risk factors
   c. Knowing that the midwife brings in equipment such as oxygen

3. Concerns about complications in the home setting
   a. Realizing that complications don't necessarily develop because birth takes place in the home
   b. Having questions answered about how complications are handled at home
   c. Ready access to a back-up physician and a hospital for complications

Pragmatic factors
1. Decreased cost of home birth/no hospitalization insurance/not wanting to pay for "luxury" when her needs could be met at home
2. Not having a birth center available as an alternative to hospital birth
3. Not wanting to drive 1 hour for prenatal visits with previous caretaker, and entertain her first 2 children during drive and while in waiting room
4. Not being able to think of a reason not to have a home birth
5. Believing that postpartum recovery need not be extensive and can take place at home
6. Feeling that she would not need medical intervention because previous births had been uncomplicated

Minimization of disturbance in home routine
1. More comfortable at home than in hospital atmosphere
2. Opportunity for siblings to bond with newborn and/or participate actively in the birth
3. Able to continue to care for older children's needs with minimal disturbance in their routines
4. Able to continue with normal home activities
5. Keeps birth simple and uncomplicated

Issues of Control
1. Having control over her choice of activities in labor
2. Having control over what is done to her during labor and birth
3. Having control over the amount of technology that is used
4. Being able to have family present
5. Not feeling self-conscious at home/feeling free to "do her own thing"
6. Knowing your caregiver and that she will be there the whole time
7. Letting God be in control (in home setting as opposed to hospital, where the experience is kind of "generic")
8. Having control over her fate (Cesarean delivery versus vaginal birth)
9. Not having to wait to push, since the midwife will be there the whole time
10. Having control over what is done with the baby once it's born
Appendix G

Taxonomic Analysis

Ways of Dealing with Labor

Activities prior to labor
1. Pro-active types of activities, e.g., praying to God to take care of her in labor or allow her to have an easy labor, feeling prepared by having been to Lamaze class
2. Avoidance-type activities, e.g., not hearing really difficult birth stories
3. Activities that could have either pro-active or avoidance-type elements, e.g., staying busy with everyday activities during pregnancy so as not to spend a lot of time thinking about labor

Presence or absence of people
1. Having certain people present, e.g., husband, other women
2. Knowing that the midwife is really there for you, helping you through labor/ensuring the safety of you and the baby
3. Having your children taken care of or occupied during the labor/birth
4. Presence of a particular number of people, e.g., not having lots of people around her/being by herself/being left alone versus having a lot of people around

Support techniques
1. Physical activities
   a. Touch, e.g., having your back, legs, feet, or stomach rubbed or touched lightly
   b. Having your breathing coached/having someone tell you to start your breathing technique because contraction is about to begin
2. Emotional/psychological techniques
   a. Having verbal support, e.g., getting encouragement from husband
   b. Infrequent cervical exams by midwife because hearing about slow progress would discourage her
   c. Being told the baby (fetus) is fine during labor
   d. Not having her support persons expect conversational responses from her during contractions
   e. Having support persons who are sensitive to her subtle behavioral cues
3. General activities
   a. Having a lot of help to get through
   b. Having someone in the room praying for you or with you during labor
Environmental factors
1. Listening to Christian music/other music
2. Having the lights real dim
3. Having candles lit
4. Feeling that the setting was peaceful or comfortable
5. Knowing where things were in her environment
6. Being in your own home
7. Being more free in the home to "set the stage" for a more light-hearted approach to coping with labor

Self-coping techniques
1. Physical activities
   a. Performing usual everyday activities/ignoring early labor
   b. Positioning and movement, e.g., walking or walking as long as possible
   c. Breathing techniques/just breathing regularly
   d. Eating and drinking as desired
   e. Maintaining comfortable body temperature
   f. Skin stimulation, e.g., rubbing her own abdomen, putting a heating pad to her back, showering or bathing
   g. Moaning or making noise during transition and pushing contractions

2. Emotional/psychological techniques
   a. Maintaining self-control, e.g., by pacing through one contraction at a time
   b. Focussing on outcomes, e.g., thinking that labor will be over soon
   c. Accepting labor as it occurs, e.g., "going with the flow"
   d. Either suppressing or focussing on stimuli, e.g., photo of older children
   e. Keeping a light-hearted attitude/making jokes
   f. Remembering that childbirth is a universal experience

3. Spiritual activities
   a. Believing that God is in control and will take care of her
   b. Trusting God
   c. Praying
   d. Listening to Christian music
   e. Praying in spirit
   f. Thinking about God’s promise to her for a painless birth
   g. Listening to encouragement from the Holy Spirit
VITAE

Anne Bienvenu Broussard

Professional Education

1983 MSN, Area of Specialization: Maternal-Newborn Nursing, Teaching
University of Mississippi Medical Center
Jackson, Mississippi

1972 BSN, The University of Southwestern Louisiana
Lafayette, Louisiana

1967 Diploma in nursing
The Johns Hopkins Hospital School of Nursing
Baltimore, Maryland

Professional Experience

10/67 - 5/68 Charge nurse on medical-surgical unit at Our Lady of the Lake Hospital, Baton Rouge, LA

6/68 - 7/68 Staff and charge nurse in the Intensive Care Unit at Lafayette General Hospital, Lafayette, LA

8/68 - 5/69 Charge nurse in Cardiac Care Center at Hermann Hospital, Houston, TX

6/69 - 8/69 Staff nurse in float pool at Our Lady of the Lake Hospital, Baton Rouge, LA

9/69 - 6/70 Charge nurse at St. Martin Infirmary, St. Martinville, LA

10/76 - 6/79 Charge nurse in the Intensive Care Unit and evening supervisor at Iberia Parish Hospital, New Iberia, LA

6/74 - 7/74 Staff development instructor in Intensive Care Unit nursing at Iberia Parish Hospital, New Iberia, LA

8/79 - 5/82 Staff nurse, assistant head nurse, acting head nurse on OB-GYN floor at Iberia General Hospital and Medical Center, New Iberia, LA

8/83 - present Instructor and Assistant Professor, College of Nursing, University of Southwestern Louisiana, Lafayette, LA

6/86 - 9/88 Part-time staff nurse in labor and delivery at Women’s and Children’s Hospital, Lafayette, LA

7/86 & 6/87 Independent nursing consultant to nurse practitioner in Mexpa, San Luis Potosi, Mexico

5/89 - 8/89 Part-time staff nurse in high-risk nursery at University Medical Center, Lafayette, LA

5/91 - 8/94 Part-time staff nurse and consultant, Our Lady of Lourdes Regional Medical Center Family Maternity Unit, Lafayette, LA

11/77 - present Independent childbirth educator