THE EXPERIENCE OF PRECIPITATE LABOUR

by

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THE EXPERIENCE OF PRECIPITATE LABOUR

BY

CATHERINE RIPPIN-SISLER

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

DEDICATION

To my husband Jeff for always believing,
and my children Rebecca, Daniel, and Julia
for opening my eyes to the world of
maternal-child nursing.

THE EXPERIENCE OF PRECIPITATE LABOUR

The experience of giving birth is an important life event for a woman. Despite abundant research on psychosocial factors related to childbirth, no studies have focused on the specific phenomenon of a precipitate labour. A descriptive-exploratory study was conducted to investigate the experience of precipitate labour.

Semi-structured interviews were conducted with twelve subjects, who also completed the "Childbirth Perceptions Questionnaire", the "Labour Agentry Scale", and the "Satisfaction with Childbirth Experience Questionnaire".

The conceptual framework used was adapted from the work of Janis which suggests that satisfaction with childbirth is related to how the event is experienced relative to expectations of the event.

Qualitative analysis resulted in three themes: Anticipating Birth, Experiencing Birth, and Reviewing Birth. Categories within the themes included forming expectations and rehearsing (Anticipating Birth); physical and psychological experiences, and external factors (Experiencing Birth); and feelings and actions (Reviewing Birth).

Quantitative analysis yielded moderately high to high scores on all instruments, suggesting women who experienced precipitate labour perceived the experience

positively, felt they were in control, and were satisfied with the experience. Comparisons of these scores to those of a more heterogeneous childbearing population indicated that subjects in this study scored in the same range, or higher on all instruments.

The results of data analysis suggest that women who experience a precipitate labour are, in retrospect, satisfied with the experience, and view it positively.

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CHAPTER 1

Purpose of the Study

The intent of this descriptive-exploratory study was to examine what the experience of precipitate labour is like for a woman. Two variables, postpartum satisfaction and prenatal expectations were examined within the context of the birth experience using qualitative and quantitative methodology.

Statement of the Problem

It is surprising, given the emotional impact of childbirth in a woman's life, that most research pertaining to the birth experience has focused on the measurement of "hard" data, such as mortality rates for mothers and infants (Lomas, Dore, Enkin, & Mitchell, 1987; Oakley, 1983). Only in the past ten to fifteen years has attention been directed toward the psychosocial outcome of birth, that is, the dimensions of women's mental, emotional and social well-being following childbirth. Two commonly studied

psychosocial variables are prenatal expectations for birth and postpartum satisfaction with childbirth. The importance of examining psychosocial variables such as expectations and satisfaction lies in understanding the consequences of unfulfilled expectations and dissatisfaction. Failure to meet prenatal expectations and/or to experience satisfaction with birth has resulted in the perception of failure in childbearing for some women. This in turn may result in postpartum guilt, anger, depression, loss, disappointment and dissatisfaction (Erb, Hill & Houston, 1983; Knight & Thirkettle, 1987; Konrad, 1987; Laufer, 1990; Lipson & Tilden, 1980; Mercer, 1981; Oakley, 1980; Oakley, 1983; Sandelowski, 1984).

Studies that have examined maternal expectations and satisfaction frequently have evaluated women comparatively according to variables such as type of delivery,ie., caesarean section or vaginal birth (Bradley, 1983; Bradley, Ross, & Warnyca, 1983; Clark, 1975; Erb et al., 1983; Kearney & Cronenwett, 1989; Lipson & Tilden, 1980; Seguin, Therrien, Champagne, & Larouche, 1989; Stolte, 1987), parity (Clark, 1975; Kartchner, 1950; O'Connell, 1983), age (Meisenhelder &

Meservey, 1987), or level of prenatal education (Crowe & von Baeyer, 1989; Willmuth, Weaver, & Borenstein, 1978). To date, no study has been published that considers length of labour as a variable in evaluating psychosocial outcomes. When examining factors that may have an impact on a woman's evaluation of her childbirth experience, length of labour is an obvious consideration. A short labour may be viewed differently from an average or lengthy labour. Labour and delivery requires great physical and emotional endurance. The general public commonly equate "shorter" with "better" in reference to the labour experience. A common wish of parents is a short labour and delivery (Shearer, 1987). However, an inordinately short labour compresses and intensifies the experience for the woman and "sensory overloading" may occur due to the barrage of stimuli (Affonso, 1977).

Extremely short labour is referred to as precipitate labour. It is described as labour that occurs with undue rapidity (Miller & Keane, 1978) and is considered abnormal (Acker, Gregory, Sachs, & Friedman, 1988; Clayton, Fraser, & Lewis 1972; Friedman, 1978). Approximately 15 percent of all

labours can be categorized as precipitate, that is completion of the first and second stages of labour in three hours or less. By contrast, although there are no absolute values for "normal" length of labour, within a normal range, nulliparous women may take 30 hours and multiparous women 22 hours to complete the first and second stages (Bobak, Jensen & Zalar, 1989; Doenges & Moorhouse, 1994).

Precipitate labour can cause a number of physical complications for mother and baby including uterine rupture, lacerations, postpartum hemorrhage, and neonatal intracranial trauma. The psychosocial ramifications of having precipitate labour are not known.

The complete dearth of scientific studies addressing the subject of precipitate labour is reason enough for examining the phenomena. Additionally, given that it occurs in 15% of births, it is an event worth exploring. More important however, is the need to understand how the experience is perceived by women so that nurses and other care providers can attempt to meet the individual needs of clients both during the intrapartum and postpartum periods. Evaluating

prenatal expectations and postpartum satisfaction with childbirth, specifically with women who have experienced a precipitate labour, will provide information that will facilitate the development of individualized care for these women.

Research Questions

To examine the phenomena of precipitate labour in depth, the following research questions were developed:

1. What expectations do women have for the birth experience?
2. How is the birth experience perceived by women who experience a precipitate labour?
3. What factors contribute to a positive precipitate labour experience?
4. What factors contribute to a negative precipitate labour experience?
5. In retrospect, how do women feel about the experience?
6. How do measurements of psychosocial outcomes of childbirth compare between women who experience

precipitate labour and a heterogenous sample of postpartum women?

Conceptual Framework

The conceptual framework for this study is based on the work of Janis (1958). Janis was interested in psychological stress, specifically in the stress that develops when a person is facing severe physical danger. Using hypotheses generated from his study of hospitalized patients facing surgery, he attempted to predict how people will react before, during, and after exposure to any crisis involving actual or potential danger of body damage. Of particular relevance to this study was one question Janis posed in his research: What are typical attitudes and expectations that develop preoperatively and how do they affect the likelihood that the patient will feel elated or depressed postoperatively? This question can be applied to childbirth by substituting "prenatal" for preoperative, and "postpartum" for postoperative. It is an appropriate substitution since the prenatal/preoperative periods both involve anticipation

of a major life event that will cause pain and possibly damage body integrity, and the postpartum/postoperative periods include physical recovery from a stressful event as well as emotional integration of the stressor.

Janis was conducting psychoanalytic research and became interested in this area after working with one patient who was undergoing psychoanalysis. During her therapy, the patient required unexpected surgery. Her preoperative reaction to the impending surgery and postoperative emotional state during psychoanalytic sessions were recorded by Janis, who then realized that he had learned a great deal about the emotional changes induced by surgery (Janis, 1958).

Acting on this new knowledge, Janis proposed a number of hypotheses. One of these addressed the role of conscious anticipation in development of reactive elation, and was stated as follows:

> At the termination of an episode of stress impact, the affective status of the person (on a continuum of euphoric versus dysphoric mood) will depend upon whether the amount of perceived suffering and loss (victimization) is more or less than had consciously been

> expected before the onset of the stress episode: If the amount of victimization is more than had been expected, the mood will tend to be dysphoric; if less than had been expected, the mood will tend to be euphoric (provided that no further impact of severe danger or deprivation is anticipated in the near future) (Janis,p. 143).

Janis postulated that the greater the discrepancy between the "victimization" that is expected (Ve) and the "victimization" that is perceived to have occurred (Vo), the greater the degree of post-stress euphoria or dysphoria. This discrepancy factor can be represented symbolically:

$$Ve - Vo$$

The greater the positive discrepancy, the greater the intensity of euphoria, and conversely the greater the negative discrepancy, the greater the intensity of dysphoria.

Utilizing Janis' theory of psychological stress, Levy and McGee (1975) tested a number of hypotheses with a population of childbearing women. They postulated that a woman's evaluation of childbirth as

favourable or unfavourable would be related to the perceived stress which she had experienced relative to her expectation of stress. Stated in terms of this research project, a woman's satisfaction or dissatisfaction with childbirth may be related to how the event was experienced relative to her expectation of the event.

Effective resolution of stress such as that experienced in childbirth may depend upon whether the amount of perceived suffering (victimization in Janis' terminology) is more or less than was consciously expected before the event. If the event was worse than expected (more suffering than anticipated), the woman will feel dysphoric and dissatisfied; if the event was better than expected (less suffering than anticipated), the woman will be euphoric and satisfied. An underlying assumption of this framework is that such emotional reactions will be apparent in a woman's evaluation of her childbirth experience (Levy & McGee, 1975).

Levy and McGee tested their hypothesis on a convenience sample of 60 women and found support for the hypothesis. A correlation of .78 was found between

the subjects' evaluation of labour and delivery and their experience of delivery in relation to expected stress. In a similar study, Knight and Thirkettle (1987) recruited 98 primiparous women and evaluated their expectations and experiences of pregnancy and delivery before and after birth. Results were consistent with Levy and McGee's earlier findings. How favourably a women evaluated her birth experience was best predicted by the prenatal expectations she expressed (Knight & Thirkettle, 1987).

Bramadat (1990) studied ninety-one women to determine maternal expectations, perceptions, and satisfaction with childbirth in women undergoing induction, augmentation and spontaneous labour. Results support the previous findings of Levy & McGee. Women who have a childbirth experience that is better than expected were more satisfied with the birth experience than women who had a childbirth experience that was worse than expected (Bramadat, 1990).

Janis' conceptual framework is applicable to the present research project because the occurrence of precipitate labour can not be predicted and therefore, can not be entirely expected. Whether such

unpredictability leads to dysphoria or euphoria based on the differential between expected and perceived "victimization" is the question to be addressed.

Conceptual Definitions

In this study, the following definitions will be used.

Expectations - preconceived ideas or opinions with regard to what is likely to take place, developed through anticipatory thinking about the childbirth event prior to its occurrence. Expectations may be formulated clearly, or be vague in nature, and may evoke positive, negative or mixed emotions (Stanton, 1990).

Event - the childbirth experience, beginning with the woman's perception of regular uterine contractions and ending with completion of the second stage of labour. In this study, the time frame for the event is 3 hours or less between first regular contractions and delivery of the baby.

Satisfaction - a feeling of fulfilment and happiness with the childbirth event. In this study, it was

operationalized as statements by the subject indicating contentment with specific aspects of the labour experience as well as the entire childbirth experience.

Assumptions Underlying this Study

In this research study, the following assumptions were made:

1. the length of labour was recorded accurately in the hospital record.

2. subjects recalled the birth experience and were able to verbalize their memory of the event.

3. subjects were open and candid when recalling their labour and delivery experience for the interviewer.

Summary

Although there are increasing numbers of studies that examine women's psychosocial response to childbirth, none focus on the population of women who experience precipitate labour. Janis' conceptual framework suggests that prenatal expectations may

influence postpartum response to childbirth. Given that precipitate labour can not be predicted, and therefore not expected, it is important to examine women's psychosocial response to this experience.

CHAPTER 2

Review of the Literature

A literature review was conducted using both computerized and hand searches. Topics included in the search were precipitate labour and psychosocial outcomes of labour and delivery. Specific psychosocial factors sought were expectations of and satisfaction with childbirth. Finally, the consequences of negative psychosocial outcomes relative to birth were examined.

Precipitate Labour

Precipitate labour occurs unpredictably and rapidly, with very strong, frequent uterine contractions (Clayton et al., 1972; Cunningham, MacDonald, Gant, Leveno, & Gilstrap, 1993; DeLee, 1913; Friedman, 1978; McLennan & Sandberg, 1970), and concurrent abdominal contractions (Cunningham et al., 1993; DeLee, 1913; Friedman, 1978). Lack of resistance of maternal pelvic soft tissue may contribute to precipitate labour (Clayton et al., 1972; Cunningham et

al., 1993; Curtis, 1933; Friedman, 1978; McLennan & Sandberg, 1970; Oxorn, 1980). Curtis (1933) assigned a time frame of completion of labour and delivery in less than five hours for precipitate labour. More contemporary sources cite three hours or less (Friedman, 1978; McLennan & Sandberg, 1970; Oxorn, 1980), although this time period is recognized as being arbitrary (Friedman, 1978).

Multiparous women are more likely than nulliparous women to experience precipitate labour (Clayton et al., 1972; Curtis, 1933; Friedman, 1978; Oxorn, 1980). As well, once a woman has experienced precipitate labour, subsequent precipitate labour is more likely (Oxorn, 1980).

Friedman (1978) used cross-sectional sampling of 10,293 primigravid women in a study designed to examine duration and shape of dilatation and descent patterns during the active phase of labour. He compared a cohort of mothers who experienced precipitate labour with a group who experienced an "ideal labour" (Friedman, 1978). Factors such as maternal age, prematurity, birth weight, malposition, and rupture of membranes did not differ appreciably between the

precipitate group and the average group. In contrast, Lehman and Chism (1987), in their retrospective chart audit of 183 patients, found precipitate labour to be significantly more common among women who were forty years of age or older. In comparing the findings of these two studies however, the great difference in sample size must be taken into consideration.

Maternal complications with precipitate labour include postpartum hemorrhage (Cunningham et al., 1993; DeLee, 1913), uterine rupture (Cunningham et al., 1993), and cervical, vaginal, vulvar, and/or perineal lacerations (Clayton et al., 1972; Cunningham et al., 1993; Curtis, 1933; DeLee, 1913; McLennan & Sandberg, 1970). Rarely, an amniotic fluid embolism can occur (Cunningham et al., 1993). Clayton et al. (1972) suggest that "mental upset" from a very rapid labour is a significant concern.

Risks also exist for the fetus in these circumstances. At the extreme is the possibility of neonatal death due to an unexpected birth in an inappropriate setting (DeLee, 1913). More recent sources suggest a rapid and unexpected birth may be unattended and a fetus may be injured by falling during

birth because the mother is not in a recumbent position (Clayton et al., 1972; Cunningham et al., 1993; McLennan & Sandberg, 1970). Perinatal mortality and morbidity may also be increased due to poor oxygenation of fetal blood secondary to strong uterine contractions with negligible intervals of relaxation (Clayton et al., 1972; Cunningham et al., 1993; Garrey, Govan, Hodge, & Callander, 1974; McLennan & Sandberg, 1970). Intracranial trauma may occur (Cunningham et al., 1990; McLennan & Sandberg, 1970).

Precipitate labour has been cited as a contributing factor in Erb-Duchenne Palsy. Acker and colleagues (1988) conducted a retrospective chart review and found the incidence of precipitate labour was 31.8 percent among infants diagnosed with this neurologic complication. Additionally, this labour phenomenon has been identified as a risk factor in the development of symptomatic intracranial haemorrhage in term infants (Sachs, Acker, Tuomala & Brown, 1987).

Contrary to the above findings, Oxorn (1980) suggests that the dangers of rapid labour are no greater for mother and child than the average labour. The information cited is based on "recent studies", but

no details of the studies are given.

Psychosocial Outcomes of Labour

Over the past ten to fifteen years, psychosocial outcomes of birth have been popular variables for investigation. Two variables in particular - postpartum satisfaction with childbirth and prenatal expectations of birth - have been extensively investigated.

Satisfaction

Satisfaction is one of the most common variables examined (Green, Coupland & Kitzinger, 1990), and according to one source, the most important (Lomas et al., 1987). But satisfaction is a complex, subtle, and ever changing concept (Bramadat & Driedger, 1993; Lumley, 1985) that is exceedingly difficult to measure (Green et al., 1990).

Using a questionnaire, Seguin and colleagues (1989) surveyed a random, stratified sample of 938 women who had delivered a live baby four to seven

months previously to determine what affected a woman's satisfaction with maternity care. Results indicated that this multidimensional construct has at least five identifiable features: 1) the experience of delivery, 2) medical services, 3) nursing services, 4) the information received and participation in decision making, and 5) the physical environment.

Despite the difficulty in defining and measuring satisfaction, numerous studies claim to have identified specific factors that contribute to satisfaction with childbirth. These include participation in treatment decisions, and provision of information regarding procedures used, ie., some degree of control over the situation (Drew, Salmon & Webb, 1989; Driedger, 1991; Green et al., 1990; Humenick & Bugen, 1981; Sequin et al., 1989; Sullivan & Beeman, 1982). Green and associates (1990) state that what matters most to women appears to be the belief that the right thing was done, rather than whether a specific intervention did or did not occur. This prospective study of 825 women found a strong negative relationship between number of procedures and feelings of not being in control, and overall satisfaction. This was observed for both minor

(eg. shaves, episiotomies) and major (eg. forceps delivery, cesarean section) procedures. The effects were cumulative with increased numbers of interventions leading to increased loss of control and decreased satisfaction.

Drew and colleagues (1989), found that avoiding specific obstetric interventions such as episiotomies and inductions was relatively unimportant to mothers. This study was conducted on postnatal wards in a specialist obstetric hospital. The sample of 183 women completed questionnaires 18-96 hours after delivery. The location and timing of data gathering is a limitation of this study as the subjects were captive and may have feared retribution or neglect if they chose not to participate (Lumley, 1985). As well, the immediate postpartum period is often one of exhilaration and the view of the birth experience might become more critical as time elapses (Lumley, 1985).

The use of pain-relieving drugs also has been related to satisfaction. Women who use no medication report the highest level of satisfaction, followed by those who only use gas and air (Entonox) (Driedger, 1991; Green et al., 1990; Sullivan & Beeman, 1982).

Self-control is a factor affecting satisfaction. Green and colleagues (1990) report that subjects who did not feel in control of themselves were least satisfied. In contrast, Driedger (1991) found that having a sense of control increased subjects' satisfaction. Women expect to have some degree of ego control during labour, and primary satisfaction with birth may be derived from being in control (Butani & Hodnett, 1980). Satisfaction with birth also increases when good rapport develops between the caregiver and the patient (Sullivan & Beeman, 1982).

Prenatal Expectations

A second method of examining psychosocial outcomes of birth involves reviewing prenatal expectations and evaluating whether or not they were met. Expectations may include such variables as a woman's actions during labour, the degree of pain experienced, sex and characteristics of the baby, the kind of help available from her physician, hospital personnel, partner and/or coach, and the number and type of procedures that may be used during labour and delivery (Beaton & Gupton,

1990; Stolte, 1987). Such expectations may be formed through discussions with the physician or midwife, family, and friends. Additionally, information from antenatal classes and the mass media may influence expectations. Finally, the experience of pregnancy prior to labour may alter the expectations women form (Clark, 1975; Knight & Thirkettle, 1987).

Knight and Thirkettle (1987) evaluated a convenience sample of 98 women to explore the relationship between prenatal expectations of birth, actual experience and transient postpartum depression. They determined that women who found childbirth unpleasant had not expected this to occur. Clark (1975) found that realistic expectations led to more positive evaluation of the experience, and conversely, that unrealistic expectations led to negative evaluations. Seguin and colleagues (1989) also concluded that birth is a personal experience whose evaluation is related to prior expectations of it.

Butani and Hodnett (1980) interviewed a convenience sample of fifty women who had recently experienced labour and found thirty-two women stated labour was not as they had expected. Reasons stated

included length of labour, degree of difficulty of the labour, and amount of pain experienced.

Stolte's (1987) study comparing perceptions of actual events with expectations of labour and delivery yielded similar results. This exploratory study involved the use of a semistructured interview 24 to 72 hours postpartum. As shown in the following table (Table 1), subjects' expectations were unmet in a number of areas:

Table 1

Events	% Responses "not like expected"
Procedures	7%
Support person	8%
Ability to cope	14%
Anaesthesia	15%
Infant	16%
Help from MD/RN	17%
General impression	21%
Analgesia	53%

(Stolte, p. 101)

Such evidence suggests that many childbearing women experience dissatisfaction and unmet expectations. One must reflect on the implications this has for the affected woman.

Impact of Negative Psychosocial Outcomes

It might be assumed that surviving labour and the birth of a live, healthy infant are reason enough for a woman to feel satisfied with the experience. However, research suggests otherwise. The fact that all consumers are not satisfied points to the importance of the experience as well as the outcome (Sullivan & Beeman, 1982). As well, what may appear to caregivers to be "routine" childbirth may be perceived by the mother as humiliating, mutilating, or dehumanizing (Laufer, 1990). Failure to realize idealistic expectations of birth may lead some women to a perception of failure. This in turn may influence how a woman views both herself, and her baby (Butani & Hodnett, 1980). A sense that one has failed can result in postpartum guilt, anger, depression, loss, disappointment and dissatisfaction (Erb et al., 1983; Knight & Thirkettle, 1987; Konrad, 1987; Laufer, 1990; Lipson & Tilden, 1980; Mercer, 1981; Oakley, 1980; Oakley, 1983; Sandelowski, 1984).

A woman who repeatedly expresses feelings of shame and guilt, or feels unable to deal with some of the

events of her labour is at risk for "self-esteem disturbances" (Konrad, 1987). Decreased self-esteem can make a woman feel incapable of mothering (Laufer, 1990). Before a woman can take on the role of mothering, she must integrate the labour and delivery experience, and in some circumstances, work through a grieving process that involves relinquishing prenatal expectations of herself. Failure to do so may impede her ability to focus on and attach to her infant (Laufer, 1990; Mercer, 1981).

Affonso (1977) introduced the concept of "missing pieces" to describe the phenomena of reconstructing the birth experience. By conducting postpartum interviews, she found almost 90 percent of subjects could not remember details of their labour and delivery, and wished they had more information. Emotions experienced in relation to the presence of "missing pieces" included frustration, anger, and behaviours such as crying. Reconstructing the birth experience may be necessary to allow for a woman to move on to other tasks of mothering and to feel positive about the experience of childbirth (Affonso, 1977).

Of particular relevance to this study was

Affonso's finding that women who have precipitate labour may be at increased risk for experiencing "missing pieces". Rapid labour and delivery may create missing pieces because events happen so quickly that the woman has difficulty integrating and remembering events in a logical order or comprehending why they are occurring. Less information about progress may be provided because of staff preoccupation with preparing rapidly for imminent birth (Affonso, 1977). Women who experience "missing pieces" during labour do not feel their expectations of birth were fulfilled.

Historical Development of Prenatal Expectations

A number of factors have led to the development of high expectations for childbirth. Until the 1940's, childbirth related accidents and complications and catastrophes were the focus of maternal health caregivers. Maternal and infant mortality occurred at alarming rates due to infection, haemorrhage, and birth trauma. However, in the following decades, dramatic improvement in maternity care and public health resulted in markedly decreased maternal and perinatal

mortality rates (Sandelowski, 1984). Survival of childbirth became an expectation.

Additionally, this was a time in history when people were putting the experience of war and economic depression behind them and searching for meaningful experiences in the home and family. The result was a pursuit of pleasure and meaning in the birth process (Sandelowski, 1984).

This period of history also saw increased advocacy and concern for women's emotional well-being. Grantly Dick-Read suggested exercises to relax and prepare mothers emotionally to cope with labour. His work now forms the basis for much of current childbirth preparation (Kitzinger, 1984). Frederic Leboyer advocated an approach to delivery sensitive to what he felt were the baby's needs, including dim lights, quiet atmosphere, and warm water massage (Kitzinger, 1984). Michel Odent expanded on Leboyer's ideas and espoused a philosophy that allows a woman "to be herself, and in tune with her body in an atmosphere of peace and love" (Kitzinger, p. 235). Birth, Odent argued, should be not a medical task, but one that values what a woman wants.

Certain sectors of the public have embraced these alternative beliefs and practices and demand their inclusion in obstetrical practice. Sullivan and Beeman (1982) cite the number of books and mass media articles published on maternity care issues as evidence of growing unrest with traditional maternity care. Titles such as The Rights of the Pregnant Parent, Birth Without Deception, and Home Birth suggest an aggressive stand on the subject of the socialization and expectations of birth (Sullivan & Beeman, 1982). The alternative maternity care addressed in this literature and advocated publicly by feminist and parent groups involves greater parental choice and control (Seguin et al., 1989; Sullivan & Beeman, 1982).

The result of improved maternity care, decreased mortality, and increased emphasis on the psychosocial issues of childbirth has been the assumption by some women that they will have a physically and psychologically "perfect" birth. Expectations for childbirth have been raised to unrealistic heights (Sandelowski, 1984). The fulfilment of childbirth expectations and attainment of maximum satisfaction have become to some as crucial to safe pregnancy

outcomes as the prevention of haemorrhage and trauma (Ellis, 1983; Sandelowski, 1984).

Summary

For many childbearing women, it is apparent that the "process" of birth is as important as the "product". Psychosocial complications may result from a birth that does not meet prenatal expectations, and does not leave the mother with a feeling of satisfaction. Women who experience precipitate labour may be at particular risk for unmet expectations and dissatisfaction because the brevity of the experience was unforeseen.

CHAPTER 3

Methodology

The intent of this research study was to explore and describe the experience of precipitate labour from a woman's perspective. This chapter will address the research design, sample, data collection methodology, instruments, data analysis procedures, and ethical considerations for the study.

Research Design

A descriptive-exploratory design was used for this study. A descriptive design examines a phenomenon as it exists within a population while an exploratory design functions to explore and describe a phenomenon (Brink & Wood, 1989).

Both qualitative and quantitative data were collected. In considering the research question at hand, it was apparent that a mixed qualitative-quantitative approach was most appropriate because the research question asked for data regarding a personal

experience. Indeed, the meaning of postpartum ratings of satisfaction are more likely to be understood when qualitative approaches are used as opposed to quantitative (Shearer, 1983). However, areas of inquiry can be enriched through the judicious blending of qualitative and quantitative data. The combining of these two approaches in a single study is complementary; they represent words and numbers, the two fundamental languages of human communication (Polit & Hungler, 1991).

Sample Selection

Purposive sampling was employed to establish a sample of 10 to 15 subjects from an accessible population of 25. Purposive sampling is a nonprobability sampling method in which subjects are selected by the researcher based on personal attributes. In this study, subjects were selected on the basis of their obstetrical histories (for example, parity). Thus, a sampling bias existed in subject selection. However, purposive sampling is appropriate when subjects with a specific experience are required

and it is considered a method of choice for qualitative studies. With qualitative research, the sample of subjects used to generate data is typically small because the intent is to study some phenomenon intensively, rather than extensively (Polit & Hungler, 1991).

Study subjects met the criteria of having completed the first and second stages of labour in three hours or less, having a vaginal delivery of a healthy, term infant, and being able to speak and read English. These criteria were selected for the following reasons: 1) three hours is the most common time frame associated with precipitate labour, 2) if subjects who experienced the birth of a compromised neonate were included, the question of whether or not the experience of having a "sick baby" confounded their precipitate labour experience would arise, 3) psychometric instruments were in English, as well as the interview, and a thorough understanding of English was necessary to ensure that accurate responses were given. The theoretical sample that was most desirable for this study included subjects who had a wide range of obstetrical histories, thus ensuring that the sample

was as representative as possible. This sample therefore was selected to include: primiparous women, multiparous women, those with and without a past history of a precipitate labour, women whose labour was induced, and those who intended to deliver in hospital but did so before their arrival.

Potential subjects were found by examining the hospital delivery log book on the Labour and Delivery Unit at a major teaching hospital. Details of each birth are entered in the log book. Although the log book did not give exact information about length of labour, it did give clues about women who might meet the selection criteria of completion of first and second stages of labour in three hours or less. Charts were reviewed on those women who might meet study criteria (Appendix A), and therefore be considered for the sample. A letter, signed by Dr. P. F. Hall, Head, Department of Obstetrics, Gynecology, and Reproductive Sciences, was sent to potential subjects (Appendix B). Women who were contacted were asked to call a specified number if they did not wish to participate in the study. Names of the persons who did not call to have themselves excluded from the study were released by the

department to the researcher. The researcher then contacted the potential subjects by phone and explained the study verbally (Appendix C). The researcher arranged to meet those potential subjects who gave verbal consent to participate in the study. At the beginning of the meeting, the researcher reviewed the explanation of the study as outlined on the telephone, and read the subject a disclaimer (Appendix D).

Meetings occurred at a time and place convenient to the subject, three to four months following the birth experience. A time period of this length between the birth experience and the interview was chosen because it allowed the subject to recall the experience more realistically. Interviews immediately following birth tend to result in intense, exhilarating responses that swamp every other reaction (Lumley, 1985). As well, the physical exhaustion and recovery required of a newly delivered woman are such that interviews within the first six weeks postpartum hardly seem fair. It was hoped that leaving interviews until three to four months after the fact would lead to data that more accurately reflected the subjects' true feelings.

Data Collection

The researcher met with each subject at a mutually agreeable time and place for the purpose of data collection. The quantitative portion of the data collection involved the subject filling in a demographic sheet (Appendix E), the "Childbirth Perception Questionnaire" (CPQ) (Appendix F), the "Satisfaction with Childbirth Experience Questionnaire" (SCEQ) (Appendix G), and the "Labour Agentry Scale" (LAS) (Appendix H). Qualitative data were gathered through one in-depth interview with each subject using semi-structured questions. Additionally, the researcher made observations throughout the interview regarding the subject's non-verbal communication. Interviews were recorded on a microcassette recorder once permission to do so was obtained from the subject. Observations were jotted down immediately following the interview once the researcher had left the subject.

The use of multiple approaches of measurement is a strength of this study. Using participant observation, and administering the CPQ, the SCEQ, and the LAS in addition to conducting interviews provides pragmatic

validation in the research design because triangulation occurs.

Instruments

Demographic Sheet

The demographic sheet was developed to collect information that enabled the researcher to describe the sample and allow for comparisons between subjects.

Childbirth Perception Questionnaire

The CPQ postpartum questionnaire used by Bramadat (1990), evolved from the prenatal "Childbirth Expectations Questionnaire" originally developed to assess prenatal childbirth expectations (Beaton & Gupton, 1990; Gupton, Beaton, Sloan & Bramadat, 1991). The CPQ retrospectively measures women's perceptions of their birth experience. The questionnaire is made up of 36 items representing four subscales: coping with pain, support from partner/coach, nursing support, and use of technological interventions. Subject response is measured on a five point Likert-type scale. The readability of this instrument has been judged to be

between the junior high and college level (Bramadat, 1990). The CPQ was used in a past research project with a heterogenous sample of women (Bramadat, 1990), and at that time construct validity was established by comparing the CPQ scores to another unidimensional questionnaire that measures perception of childbirth. Correlation between the scores of these two instruments was 0.50, a marginally acceptable indication that both questionnaires are measuring the same construct (Bramadat, 1990). Measurement of reliability coefficients (Cronbach's alpha) yielded results of 0.78 and 0.81 at two different times of administration.

Satisfaction with Childbirth Experience Questionnaire

The SCEQ was developed by Bramadat (1990), and is a direct measure of satisfaction using a 6-item, summated rating scale. Subjects are asked to rate their overall satisfaction with the birth experience as well as their satisfaction with coping with pain, support from partner/coach, nursing support, and use of technological interventions on a scale from "very satisfied" to "very dissatisfied". Internal consistency for the SCEQ was deemed adequate when

tested with Cronbach's alpha (0.73 and 0.80 at two different times of administration) (Bramadat, 1990).

Labour Agentry Scale

The LAS was developed by Dr. Ellen Hodnett and Daryl Simmons-Tropea to measure expectancies and experiences of personal control during childbirth. This 29-item summated rating scale has been used over 600 times, and the consistency of results suggests a high degree of reliability and validity as a measure of childbirth control. The alpha reliability coefficient, an index of reliability, ranged from 0.93 to 0.95 in various studies (Hodnett & Simmons-Tropea, 1987).

Permission to use the CPQ and SCEQ was granted by Dr. Bramadat, and Dr. Hodnett gave permission for the LAS to be used in this study.

Interview Guide

Open-ended questions were developed to enable the subject to relate her birth experience to the researcher in her own words. After introductions were completed and both the subject and researcher were comfortably seated, the interview began with the

following statement from the researcher:

"I am interested in studying how women who have experienced quick labours feel about their birth experience. Starting from the point that you first went into labour, tell me about your (last) birth experience."

This first question was followed when appropriate, by other questions:

2) What parts of your birth experience did you find satisfying?

3) What parts of your birth experience did you find dissatisfying?

4) Before labour began, what had you expected labour to be like?

5) In what ways were your expectations met?

6) In what ways were your expectations not met?

7) What factors contributed to a positive birth experience?

8) What factors contributed to a negative birth experience?

Throughout the interview, the researcher used communication techniques such as clarification, rewording, and perception checking to ensure that the

subject understood the questions, and that the researcher had correctly comprehended the subject's responses.

Data Analysis

The demographic sheets were analyzed for subjects' attributes and description of the sample population was completed. The CPQ, the SCEQ, and the LAS scores were each tabulated individually. The scores obtained were then compared to scores obtained using these three instruments on a larger, heterogenous sample. These scores represent part of the data gathered by Bramadat (1990). By comparing the researcher's subject scores using the CPQ, the SCEQ, and the LAS to a past population's scores, general inferences could be made with respect to where the present subjects' scores fall.

Interviews were transcribed verbatim as soon as possible following data collection. Participant observation notes that were jotted down following the interview were filed with the interview transcript.

Latent content analysis was used to analyze the

data. This refers to reviewing and categorizing data for the feeling and implied meaning of the spoken words (Wilson, 1989). All transcribed interviews were entered into the computer program Qualpro, which provided a means of organizing the data according to researcher generated classifications. The interviews were read over several times, and data were classified into preliminary categories according to the implied meaning of the data piece. An example of a preliminary category would be "satisfied with nursing care". Once all the data had been classified, all categories were reviewed, and were collapsed when more than one represented a similar idea (for example, "satisfied with nursing care" and "unsatisfied with nursing care" were collapsed into "nursing care"). Further review and revision of the generated categories continued until finalized categories were established. Broad themes which captured the essence of the categorized data were then established. The researcher's thesis chair also had access to the raw data and provided input throughout the period of data analysis. This second review of the way data were categorized helped to minimize errors in analysis (Marshall & Rossman,

1989).

Ethical Considerations

Ethical Review

Prior to beginning this study, approval was sought from the University of Manitoba Faculty of Nursing Ethical Review Committee. Approval to proceed with the study was granted on June 1, 1992 (Appendix I). Approval to access subjects from St. Boniface General Hospital was granted June 30, 1992 (Appendix J).

Informed Consent

Subject's participation in this research study was on a voluntary basis. All subjects were read a disclaimer (Appendix D) prior to their participation, and verbal consent to participate was obtained. Subjects were made aware of the study purpose and expectations of their participation verbally by telephone and again in person prior to commencing the interview. Subjects were given the opportunity to withdraw from the study at any point during the interview process. Subjects also were informed that they had the right to refuse to answer any questions,

should that be their wish.

Risk of Physical and Psychological Discomfort

Subjects completed the data collection instruments and participated in the interview at a time and place convenient to them. No experimental conditions were imposed on subjects that would cause specific physical or psychological discomfort.

The opportunity for a subject to recall her labour experience evoked many memories. Potentially, some of these might have been disturbing to the subject. In the event that this occurred, the researcher planned to stop the interview, offer support, use therapeutic communication, and suggest resources that might be of help to the subject (eg. subject's physician, Women's Health Counsellor, Youville Clinic Counsellor). This did not occur during any of the data collection.

Confidentiality

Only the researcher had access to the delivery log book for the purpose of identifying subjects for this study. As well, the researcher was the only one accessing subject's hospital charts. Subjects selected

for this study were referred to by a numerical code; the master code was kept in a locked drawer in the researcher's office. The researcher conducted all of the interviews. A secretary familiar with transcription of confidential material was hired to transcribe the interviews. All transcripts and instruments were identified by the subject's code only.

Analysis of data was done by the researcher. Input was also given by the statistician on staff at the Manitoba Nursing Research Institute, and the researcher's thesis chair. However, all data that was made available to these two people was labelled by the subject's code only.

Tapes, transcripts, and completed instruments were kept in a locked drawer in the researcher's office. They will remain secured for a period of seven years to allow for validation of research findings with raw data if necessary, and then will be destroyed.

Summary

Sample selection, data collection, methodology, instruments, data analysis procedures, and ethical

issues for this descriptive-exploratory study have been outlined. In the following chapter, findings for this study will be reviewed.

CHAPTER 4

Results

Demographic Data

Fifteen subjects were selected from an accessible population of twenty-five women on the basis of their obstetrical histories and were contacted by letter. One subject declined participation and two subjects could not be found at the addresses on record. Twelve subjects were interviewed, and filled out all questionnaires and surveys. Results from one subject were discarded when it was discovered that her infant had a low apgar score (3 at one minute, and 6 at five minutes), and had spent the first night in Neonatal Intensive Care.

Subjects' age, marital status, education, and work status prenatally were noted as well as characteristics of each subject's labour, namely length, sex of the newborn, Apgar scores, location of delivery and the attendant at delivery.

Mean age of the eleven subjects was 29.3 years, with a range of 25 to 37 years. All subjects were

married. Subjects were well educated women. All had completed high school; seven had continued on to trade/diploma education, and one had attended university. Prenatally, nine subjects were working outside the home, four full-time, and five part-time.

Length of the first stage of labour ranged from 43 minutes to 3 hours, with a mean of 1 hour, 44 minutes. The second stage ranged from 2 minutes to 1 hour, 1 minute, with a mean of 14.7 minutes. Total length of stages one and two ranged from 50 minutes to 3 hours, 2 minutes with a mean length of 1 hour, 58.6 minutes.

Eight newborns were female, and three were male. One minute Apgar Scores for the newborns ranged from 7 to 9. Five minute Apgar Scores varied from 7 to 10.

Ten subjects delivered their baby in either the Birthing Room or Case Room in the Labour and Delivery Unit. One subject delivered her child in the hallway leading to the Labour and Delivery Unit. Four subjects were delivered with the physician they had seen prenatally in attendance. Six babies were delivered by an obstetric resident or intern. One subject was assisted by a physician who happened to be close by when the delivery occurred.

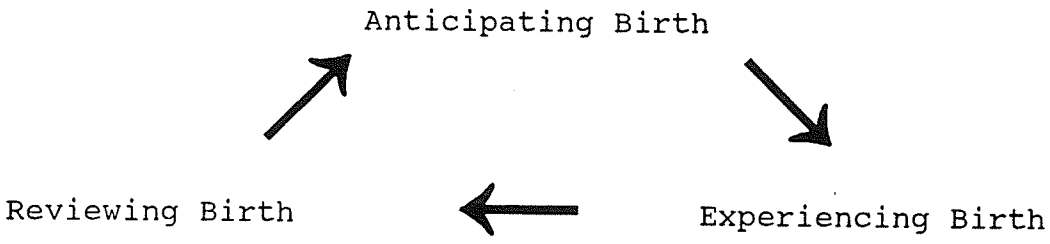
Qualitative Results

This part of the study focused on five questions:

1. What expectations did women have for the birth experience?
2. How is the birth experience perceived by women who experience a precipitate labour?
3. What factors contribute to a positive precipitate labour experience?
4. What factors contribute to a negative precipitate labour experience?
5. In retrospect, how do women feel about the experience?

The result of analysis of the qualitative material was the emergence of three cyclical themes:

Figure 1



Discreet, mutually exclusive categories arise from these three themes. They include forming expectations and rehearsing for the theme of anticipating birth; physical experience, psychological experience, and external factors for the theme of experiencing birth; and feelings and actions for the third theme, reviewing birth. Schematic representation follows:

Figure 2

Anticipating Birth

-Forming Expectations

-Rehearsing

Experiencing Birth

-Physical Experience

-Psychological Experience

-External Factors

Reviewing Birth

-Feelings

-Actions

ANTICIPATING BIRTH

The question that subjects were asked regarding their expectations for birth yielded the theme of Anticipating Birth. This theme reflected prenatal thoughts subjects had about their upcoming labour. Within this theme, two categories emerged: forming expectations and rehearsing.

Forming Expectations

This category involved prenatal acquisition of knowledge, attitudes, and values regarding labour and delivery which led to development of personal expectations for the approaching event.

Subjects highlighted a number of factors that affected development of expectations for their upcoming labour. These included personal experiences and knowledge gained from others.

Personal experiences that influenced development of expectations included not only past personal labour and delivery events, but also experiences in support of others' births. As well, experience during pregnancy itself was instrumental in forming expectations.

Multiparous women stated their previous birth experience was important in how expectations were developed. For some, "a previous birth makes it easier...because you know what's going on" (Subject #21). One subject stated that she gained confidence from past birth experiences that went smoothly. Some subjects expected duplication of previous labour experiences. "I kept thinking, well, if my water breaks, then I'll have time, you know, you think it's going to be like the first time around so I didn't really worry" (Subject #13).

Past labour and delivery experiences that were perceived negatively influenced subsequent prenatal expectations. One subject, who had failed to progress with her first labour had required a Cesarean Section. She expected "to have labour pains but then, to stop dilating at a certain point because I did with the first one" (Subject #5). Another subject also expected to duplicate negative aspects of her first labour. "I expected that I would be really exhausted and I expected pain from the episiotomy and those...sort of things" (Subject #21).

Expectations specific to labour length developed

as a result of length of past labours.

> My first one, even if I pushed for two hours, it was still a short labour. I think nine hours in all, so it's very short for a first one. So that was something that I was basically counting on, that it was not going to be very long. (Subject #21)

Another multiparous subject stated "I thought it was going to be the way it was, short and intense for a short amount of time and, that was it" (Subject #11).

Having the opportunity to support others in labour facilitated formation of expectations. One primiparous subject found participation in her sister's labour helpful in forming her own expectations. "I knew it was going to be painful...I was with my sister when she had her baby so I got to watch everything and I knew what to expect" (Subject #3).

Two subjects were registered nurses with experience in maternal-child nursing. They indicated that this helped them develop realistic expectations of labour and delivery. "I think because I'm a nurse in one way because I know, in a way you know what to expect and ...working in a hospital I know what it's

like" (Subject #11).

Expectations for labour and delivery also developed from experience of pregnancy. Subject #23 was unsure whether or not she would require Cesarean Section because her fetus was in breech presentation. "I think there was just so much anxiety built up about it (the labour) that all we kept thinking about was, let's get it over with, let it happen". Another subject had a "difficult" pregnancy.

> I was expecting twins and lost one of the twins at 13 weeks, but the other one stayed, so all the way through I had cramping and bleeding and, so I didn't know what was going to happen. (Subject #21)

Subjects formed expectations on the basis of knowledge from others. Sources of such knowledge included books and articles, prenatal classes, friends' stories, and family histories.

> I had never done it before (labour) so basically I took from everybody else and kind of thought 'well, mine could be like that, or mine could be like this, or'. But, yeh, I had expected it to be in the order that they

said in prenatal (classes). (Subject #10)

When information specific to labour length was presented, its focus was on lengthy labours. "I think what they mostly talk about is longer labours, how terrible the long labour is. I don't remember anything much on fast labours" (Subject #3).

Histories of short labours, in subjects' sisters and mothers, also influenced their expectations. "My mother had ended up having very short labours...my one sister with her last pregnancy, had just...a couple of hours as well (Subject #18).

While the majority who included family history in development of their expectations related stories of unusually short labours, one primiparous subject expected a long labour, in part based on her mother's experiences. "My mother had also had always, 12 to 18 hours (of labour)" (Subject #10).

Rehearsing

The second category in the theme of Anticipating Birth is "rehearsing". This category is defined as the active prenatal planning subjects do for all imaginable scenarios which they feel may occur once labour has

commenced.

For multiparous women who had past precipitate labours, rehearsing for another fast labour occurred. Rehearsing was particularly focused on finding caregivers for subjects' other children. Subjects expressed a sense that labour could go so quickly that if plans were not in place ahead of time, a stressful predicament would result.

> Deal with the labour and deal with, you know, trying to keep the kids kind of out of the way and worrying 'How am I going to get to the hospital?' and...my biggest thing was who was going to watch the kids if I had to rush out to the hospital during the day. (Subject #11)

When one subject's worst fears were realized because she went into labour at night when her husband was working, she found time spent rehearsing for that eventuality helped.

> Everything that possibly could have happened...we were ready for it. We had planned ahead and I guess that was a big plus. We knew what could happen and we were

ready for it. (Subject #8)

For subjects that did not rehearse for a specific situation that resulted, benefits of rehearsing were acknowledged postpartally.

> It was a quick experience but...afterwards you stop and think, 'Oh, if I had of known, I could have got here earlier, if I hadn't of stopped and left J. (her son) at my Mom's', it probably only took 5 minutes out of our way, if that, but 5 minutes was all I needed to get into the labour room. And sort of things like that, you wonder later on if I could have done things a little different. (Subject #7)

Primiparous subjects commented on how rehearsing would be important in subsequent pregnancies. "Next time as soon as I have a contraction we'll be up there 'cause they say the second one is usually a little bit faster" (Subject #3).

EXPERIENCING BIRTH

Subjects reflected at length on the second

research question regarding their perception of precipitate labour. Emerging from this question is the theme of Experiencing Birth which reflects what subjects were able to recall about their precipitate labour and delivery. Subjects also highlighted factors that contributed to a positive and/or negative birth experience; this information relates to research questions number three and four. Their memories included physical and psychological experiences, as well as external factors of Experiencing Birth.

Physical Experience

The physical experience of precipitate labour is defined as the subjects' perception of labour length, contraction quality, complications that resulted from speed of the event, and drugs and procedures used.

Length of labour included subject's perceptions, feelings, and attitudes regarding the duration of labour, from first regular uterine contractions to birth. Generally, overall length of labour from beginning of contractions until birth was perceived as shorter than what subjects expected prenatally. Subjects who were expecting "shorter than average"

labour due to their past obstetrical history or obstetrical history of female family members, commented that the end result was still shorter than anticipated. Labours "seem to be short in my family but I wasn't expecting it to be that short. I figured that maybe 8 hours kinda thing. I didn't expect it to go quite that fast" (Subject #3). Another subject stated:

> I didn't think it would be very long because J's (first baby) was only like 8 hours total, I guess. I figured she probably wouldn't be any longer than that, I've heard they get kind of shorter and I was figuring she would be shorter but sort of the normal. (Subject #7)

Positive reflections on precipitate labour occurred. Shorter labours were viewed as preferable to longer ones. This was primarily due to the period of pain and trauma being shorter.

> I think that one of the big bonuses (of) having a short labour (is) that you're not put through that much for that long. ... It was less painful, less traumatic for the period of time. (Subject #8)

Negative evaluations also occurred, predominately that precipitate labour did not allow the subject sufficient time to plan and feel prepared.

> I think the one big negative thing about quick labours is you don't have time to prepare yourself. Like you don't go into it gradually. It's just like, I woke up and bang! I was in labour...There is nothing gradual about it. I didn't wake up and, and there was one contraction and then, you know, 7 minutes later it, I had another one. It was just right away that they were strong, and you don't build up to it....And I think that's one of the biggest negatives about quick labours ...it's just all of a sudden you're just in real pain and it's like, wow, you can't believe how...you didn't feel anything beforehand. (Subject #8)

A second aspect of the physical experience of precipitate labour that subjects discussed was contractions, specifically physical sensations, primarily in the abdomen, pelvis, and lower back, associated with progressive dilation and effacement,

followed by birth.

Contractions were described as starting out as cramps, or lower back pain. They were not necessarily regular, and frequently, subjects did not think that they were indicative of true labour until after the baby was born and they recalled events leading up to birth. A couple of subjects chose to leave for hospital unsure as to whether they were in labour.

> I just woke up, I couldn't sleep because I was having mild contractions...I was just wondering what was happening - I didn't think I was in labour yet - I just wasn't feeling well so I couldn't sleep...I'm just kind of wondering what was happening....We headed for church and on the way there I was starting to think that this wasn't such a good idea because my cramps were getting a little bit stronger, but I still wasn't sure. (Subject #13)

Some subjects became aware that they were in true labour when contractions very quickly increased in intensity and frequency. They did not necessarily become regular. This period of labour was described as

"immediate transition" with contractions occurring "one on top of the other" with no time to rest in between. "My contractions...got to the point where they were just one on top of each other, I had no time in between" (Subject #3). "I didn't think it was humanly possible to start out with contractions close together" (Subject #23).

> All of a sudden the water broke and...then the contractions started immediately and they were like 2 minutes apart....The contractions were quite intense. What they reminded me of was immediate transition....With this labour, they were very intense immediately. (Subject #18)

Two subjects, one multiparous and the other primiparous, felt constant, low back pain and had difficulty distinguishing contractions. Neither had regular contractions that they could time.

> The low back pain was still there and the contraction sort of went away and then it came back and then it never left. It was like it was always there...just like one solid contraction" (Subject #7).

"It was almost a constant pain, I really couldn't tell the contractions apart" (Subject #10).

Another physical aspect recalled was complications. These were unexpected physical events related to childbirth, which required intervention, and were in the subjects' opinion, directly related to the precipitate nature of labour.

Two subjects experienced extensive perineal tearing and bruising. From their perspective, this complication required longer than average recovery and involved a great deal of pain.

> Half my pain was the tearing, I tore pretty badly, they said, I bruised pretty bad too 'cause she came so fast....I took a lot longer to recover from it I think 'cause it was so short and the bruising and the tearing was more. (Subject #7)

Three subjects experienced increased immediate postpartum bleeding. None required transfusion. Bleeding was controlled by massaging the uterus, an intervention the subjects found more painful than labour. Subjects found the bleeding disconcerting, and frightening.

> I had such a fast delivery they had trouble with my uterus, having it to contract to stop the bleeding....They kept massaging my stomach and it was just so painful...it was worse than the actual labour. (Subject #11)

The final physical component of Experiencing Birth related to drugs and procedures. A number of subjects recalled specific drugs and procedures used during their labour and delivery including Entonox Gas, and Demerol.

> The gas really doesn't do anything to take away the pain, it just kind of numbs your awareness of it I guess....It was just disappointing that the pain didn't go away, that I was just sort of feeling woozy. (Subject #18)

> I wished I wouldn't have had to have the Demerol....I was a little bit dopey for, just for the beginning, as soon as she started coming out that was it, I was awake, but just, I guess I would have been that little bit more aware at the time as to what was going on. (Subject #3)

Two subjects reflected on the procedure of episiotomy. One subject felt hers could have been prevented. "I had an episiotomy too, and I felt that he did it too quickly, he didn't give it a chance to go by itself...another couple of pushes and I probably wouldn't have needed it" (Subject #5). Another subject did not have an episiotomy, but felt she should have. "Having it (the length of labour) a little bit slower then I could have had an episiotomy because it heals so much faster...They never even asked me because it happened so fast" (Subject #10).

Psychological Experience

The psychological experience of birth included thoughts and feelings subjects remember having during labour and delivery. Components included an emotional trajectory of: 1) disbelief at how quickly labour began, 2) alarm that labour was proceeding so quickly, 3) panic about the possibility of not getting to hospital, and 4) relief at reaching the hospital. As well, fear for oneself and the baby, and sense of control over one's body and the situation were mentioned.

Subjects proceeded through the emotional trajectory to varying points. They expressed an initial feeling of disbelief related to the suddenness with which labour began, and the time that elapsed since labour had begun.

> (My husband asked) 'Should I go move the car?' and (the nurse) said 'Well I don't think you should, things could start happening pretty fast.' That shocked me because, like, we just got there so I didn't think it was going to go that quick...I didn't think it was happening that fast but before I knew it they had wheeled me into the delivery room...I couldn't believe it. (Subject #13)

Once subjects realized that they might be, or definitely were in labour, a sense of alarm occurred at the thought that labour was progressing so quickly. This was foremost in the minds of all subjects who were at home when labour began.

> You just want to get to the hospital...that was my main thing, I just worried about, what if I had this baby in the car? (Subject #7).

> I thought I was going to have the baby at home. I didn't think I'd make it to the hospital (Subject #8).
>
> The biggest concern was if I was going to make it to the hospital in time (Subject #23).
>
> (When my water broke), with my second labour that's when it went very quickly after that, so that's when I started getting a little stressed (Subject #22).

When subjects felt that labour was going to progress more quickly than their situation could accommodate, they experienced panic. "(I was walking down the street), then I felt a really low low push, like almost like the baby was starting to come out already and I panicked" (Subject #7).

> I panicked a bit, you know, like I was watching the clock saying, 'Where is he (husband)?', you know, 'It shouldn't be taking this long' you know, it's a 5 minute drive. (Subject #18)

Once subjects got to hospital, and were in the Labour and Delivery Unit, a sense of relief was

experienced at having arrived before the baby was born. "I felt a lot more secure once I was there. I felt that 'Oh, I made it'. That I wouldn't be in trouble, that I was in good hands, so I wasn't worried at that point" (Subject #8).

Subjects highlighted fears that were felt during labour which focused on their own well-being and that of their fetus. "I started feeling the pain and I thought, 'Am I going to make it through this?' you know, I was just kind of frightened about what was going to take place and if everything would really work out okay" (Subject #13). "I heard a couple times that, having such a quick labour wasn't good for the baby, that it was a shock to them almost. And that kind of worried me" (Subject #8).

Subjects frequently referred to the sense of control they experienced during labour. This characteristic of control involved both the degree of coping ability felt over their body as well as their sense of power to manage labour. Maintaining control was viewed positively. "I was in control and I knew I was in control...I was doing very well, and I was happy with myself" (Subject #8).

> The fact that I was in control. I felt very, very confident and it's such a huge thing...All of a sudden you go through it and you are in control all the way through...This time I could control it (the birth) and the level of pain was manageable. I remember thinking that every single woman in the world should have a birth like that. (Subject #21)

When subjects felt that they were not experiencing as much control as they would have liked, a more negative perspective was taken.

> I feel kind of uncomfortable about thinking what people must have thought of this screaming woman going down the hall in a wheelchair...I felt kind of uncool, I didn't handle that very well...I wished I hadn't been so loud about it and been able to be a little calmer. (Subject #7)

External Factors

The external factors of birth included those elements outside the labouring women's personal space, but influential in how the experience was perceived,

such as the support persons present, fetal outcome, and the hospital system.

Three types of support people were identified: husbands, nurses, and physicians. Each type will be discussed individually.

All subjects found the presence of their spouse valuable during labour. Prior to arriving in hospital, husbands acted in the role of support person, and were responsible primarily for getting the subject to hospital as fast as possible.

> And G. (subject's husband) was really really good, like he amazes me when I'm just totally panicked, he's the calmest...I just didn't want to sit and he's like, 'okay, come on, it's okay'...and he's very calm about the whole thing, not panicked at all. He may have driven like a crazy man through downtown....You know he was really calm and that really helped. (Subject #7)

Once in hospital, the primary reasons that subjects wanted their spouse present were to provide physical and emotional support, help with decision-making should it be necessary, and to witness the birth

of their child.

> I didn't want him to miss this exciting part. And maybe to make decisions that I couldn't handle. If I couldn't think straight, I wanted him to be there to make all these decisions...To make sure that things happened like the way I wanted them to. I think that's particularly why I wanted him there. (Subject #10)

Two husbands were not present for the birth. One had chosen to leave before the birth took place. Because this had been negotiated with the subject prior to labour, it was acceptable to her, although she expressed regret at what her husband missed.

> I didn't need him there to coach me...As far as I'm concerned, having someone sitting there...trying to encourage you, like lots of times they encourage you in the wrong way, like it just makes somebody angry...Just for his own sake I would have liked him to be there for the birth...but I can understand and accept the fact that he couldn't be there, that...he chose not to be there.

(Subject #18)

The other husband who missed the birth was still in Admitting when it occurred, while the subject was being wheeled down the hall to the Labour Unit. By the time he arrived, the hall had been cleaned and there was no sign of anything having happened. This was perceived by the subject as disappointing for her husband and herself.

> All of a sudden, she's born...and G.(husband) missed the whole birth experience and I feel kind of bad with that. He was there for the first one but he was a little too nervous the first time to really pay attention to what was going on and he was really prepared for this too so I guess I do feel a little bit...that he kind of missed out again.
>
> (Subject #7)

Nurses were perceived very positively in their contribution to the labour and delivery. "The staff, like that made a world of difference, just having a couple of nurses to back you up, you know to really encourage you" (Subject #13).

The nursing staff's ability to adapt quickly to

precipitate labour was also noted.

> I thought she was really organized 'cause all she did...was just bringing the table over and paging the doctor, it seemed like a lot was going on but now when I think back to it...she really was very organized and getting everything together really fast. (Subject #11)

Another subject commented:

> She was very calm. I could see that...she was working fast, like when I first got in there and she was filling out the form, she was more relaxed and then when I said I needed to push, then she sped it up a bit, 'We can fill out the form later'. But she was very calm. And, I think that helps. (Subject #18)

Nurses were instrumental in conveying information to subjects to keep them informed about what was happening. "The knowledge that the nurses... gave me was a real help, I felt like I knew what was going on" (Subject #5). Nurses gave ongoing encouragement and guidance that was seen by subjects to be beneficial.

> They were just 'Okay, then you'll do this, and then you'll do this. Okay, here's the head coming'. They were very calm, they just helped me through very much. They didn't panic at all. (Subject #10)

The one negative aspect of nursing care some subjects perceived was not being believed when they felt they were ready to push.

> I was just slightly frustrated that she wouldn't check me right away, you know, but then I guess that she had stuff to do too and I guess maybe she wasn't expecting it to go so fast either. (Subject #18)

A second subject stated:

> Just too, them telling me that I couldn't start bearing down. You're not the one laying here - how do you know whether it's time to bear down or not? That part of it was frustrating. (Subject #3)

The third type of support from physicians, was viewed positively by subjects as well. Although all were aware that they were using a teaching hospital, and that their own physician would not necessarily be

present for delivery, two stated that it was important to them that their doctor be present. In both cases, those physicians were present and did the delivery. The other nine subjects were attended at birth by other physicians in their doctor's call group, residents, or in one case a doctor that happened to be nearby. This situation was not a problem for the subjects involved. "It didn't bother me (that her doctor was not present). I just figured they know what they are doing so it doesn't matter, as long as there's someone there to help me" (Subject #13). Another subject stated she did not know the attending physician. "Never seen him before. That was a little strange. Sometimes you really expect to see your doctor there, but it didn't really bother me too much" (Subject #8).

Interns and residents were seen as helpful when they participated in the event.

> The student doctors did a very good job. I remember S., she was just incredibly helpful, she was very friendly. Very encouraging. I felt very, very comfortable the minute I was with her...I don't remember what the guy was like. He didn't say much. I'm not sure if

> it was one of his first times, or he wasn't very familiar, but S. made me feel very, very comfortable. And she kinda instructed him in how he stitched me and everything. (Subject #10)

One subject experienced frustration with resident staff attending her.

> Probably the fact that I couldn't hardly understand the resident was probably the most frustrating for me...The first time around the resident made the difference, but this time...I sort of felt that he was there to learn too, so, he was using me. But it's something that you accept if you go to St. B., you know that it's going to be part of the whole process, so I was aware of that and I had accepted the fact that he was going to be there. But, when Dr. S.(the on call physician) walked in I knew the resident was there, but when Dr. S. walked in I totally relaxed. (Subject #21)

Another aspect of the category of external factors is the birth outcome, specifically status of the

infant. Birth of a healthy baby was seen by subjects as critical in viewing the experience positively. "When I realized that she was okay and everything was okay then, then the whole experience was, was perfect" (Subject #8).

Some subjects stated that, prenatally, they had a sex preference for the infant based on a desire for an infant of the opposite sex to the child or children they had previously. When this occurred, it made the experience exceptionally positive. "I was just so excited, first to see that it was a girl because that was basically what I wanted" (Subject #21).

> When they told me I had a girl I thought that was amazing because I was sure that she was going to be a boy because everybody else I knew had 2 boys...I didn't want to hope for a little girl, so it was just wonderful when they said it was a girl. (Subject #7)

The final external factor in Experiencing Birth was the hospital system as it affected the subjects. Subjects referred to two ways that the hospital system affected their perception of the event. First, the admitting process was stressful for some who worried

that they would have the baby in the Admitting Department.

> We were in admitting and I was making a mess there and the last time we went through so fast and this time it seemed to be so long...I figured I was going to have the baby in the admitting room. (Subject #23)

Alternatively, subjects were escorted to the Labour Floor while their husbands remained in Admitting to complete paper work. This arrangement was also stressful.

> My husband was admitting me into the hospital and I remember feeling 'Where is he, where is he?' because I couldn't see him. He was still admitting me and I was already in the delivery room...so I remember thinking 'Where is he?' 'cause he's not around. 'Cause it had gone so fast. I didn't want this to happen without him being there with me. (Subject #10)

As mentioned earlier, one husband missed his daughter's birth because he was delayed in Admitting. This was very disappointing for both the subject and

her husband.

> G. came upstairs just minutes later and the floor was all clean, he said, in the hallway so there was no sign that anything had happened. And he comes in and he's looking for me and he kind of got lost, and he finally make it to the room and they said, 'Oh, yes, your daughter's been born already.' And he's like, 'What, I missed it!' He missed the whole thing. (Subject #7)

The second way in which the hospital system affected subjects was in length of stay. Subjects revealed a sense that their time in hospital intrapartum and postpartum seemed fleeting.

> In going so fast I was in labour and delivery, like in the birthing room such a short time that it almost felt like it never happened. Like, I wouldn't have minded just being there a little more time just to, just to be there. I don't know why, but I think that would have...I had my baby and I got washed up and I went to the ward and I don't know. I stayed there two days and went home.

> It just seemed sort of like a blur because it went so fast. (Subject #22)

This reaction seemed to be exacerbated in subjects who were not cared for in birthing rooms during labour.

> One thing that bothers me about the birth experience is the setting...It seems that you're being bounced around from one bed to the next bed to the stretcher to the, you know you are being placed from here to here to here to here throughout the whole hospital...(I would) like it a lot better if you were just in one area and they just left you there. (Subject #8)

One subject articulated a sense of being "special" when she was a labouring patient. "They make you feel...like you're there, you're it sort of thing....And then it's all over and especially when it is short like that. Then it's all over" (Subject #11).

REVIEWING BIRTH

When subjects were asked how they felt in retrospect about their precipitate labour the final

theme of Reviewing Birth emerged. This theme encompasses ways in which subjects worked through personal thoughts with respect to their precipitate labour. Categories that emerged from this theme included actions and feelings.

Actions

This category included purposeful behaviour performed with the intent of aiding integration of the experience. Comparing was the primary action undertaken.

Subjects compared their experience to that of other women through conversation with friends and family after the fact and found this assisted them with the task of integrating birth.

Other women were described as feeling envy, jealousy, disbelief and frustration when subjects related their precipitate labour experience.

> A lot of people are envious. I think a lot of other mothers who had like longer labours feel that. Everybody seems to think that 'Oh, it was short so it was really easy'. (Subject #13)

Subjects were able to come to terms with such feelings by acknowledging that a long labour would be less desirable, but also asserted that the pain precipitate labour caused was no different than other labour pain, and thus not necessarily easier.

> You're lucky you didn't have to go through all that (lengthy labour). But all in all, it's probably the same. (Subject #5)
>
> As far as I'm concerned I must feel the same pain that they do. (Subject #8)

A second act of comparing occurred when subjects measured their experience to the "norm" identified in prenatal classes and books. One multiparous subject felt both her labours had been "different" than normal. Her first baby was born prematurely, and her second labour was precipitate, with delivery in the hall leading to the Labour and Delivery Unit.

> It was nice to have it over with quickly but you kind of miss the experience because it happened so fast...They've (other women) had the longer labour (and) they think, 'oh, you know, it's better to just get it over with.' But when you never really had a normal labour

> you wish you did have one just so you can remember more of the experience...I do feel like I missed out on the normal sort of event that was supposed to go on and knowing what was happening. Having someone come in and say you're 7 centimetres dilated. Like I have no idea if I woke up 10 centimetres, or I woke up 3 and fifteen minutes later I was 10, I don't know how. (Subject #7)

Feelings

The second category in the theme of Reviewing Birth is that of feelings. That is, postpartum emotional perceptions of the birth.

A few subjects expressed ambivalence with regard to length of labour. Although they were happy it was short, they wondered if prolonging it briefly might have improved the situation.

> It all happened so fast and that was good 'cause then it was over and done with...When it's going that fast I don't think you really need to focus that much. Maybe a little bit longer, there's always that Demerol. That

part (not using it) would have been better. (Subject #3)

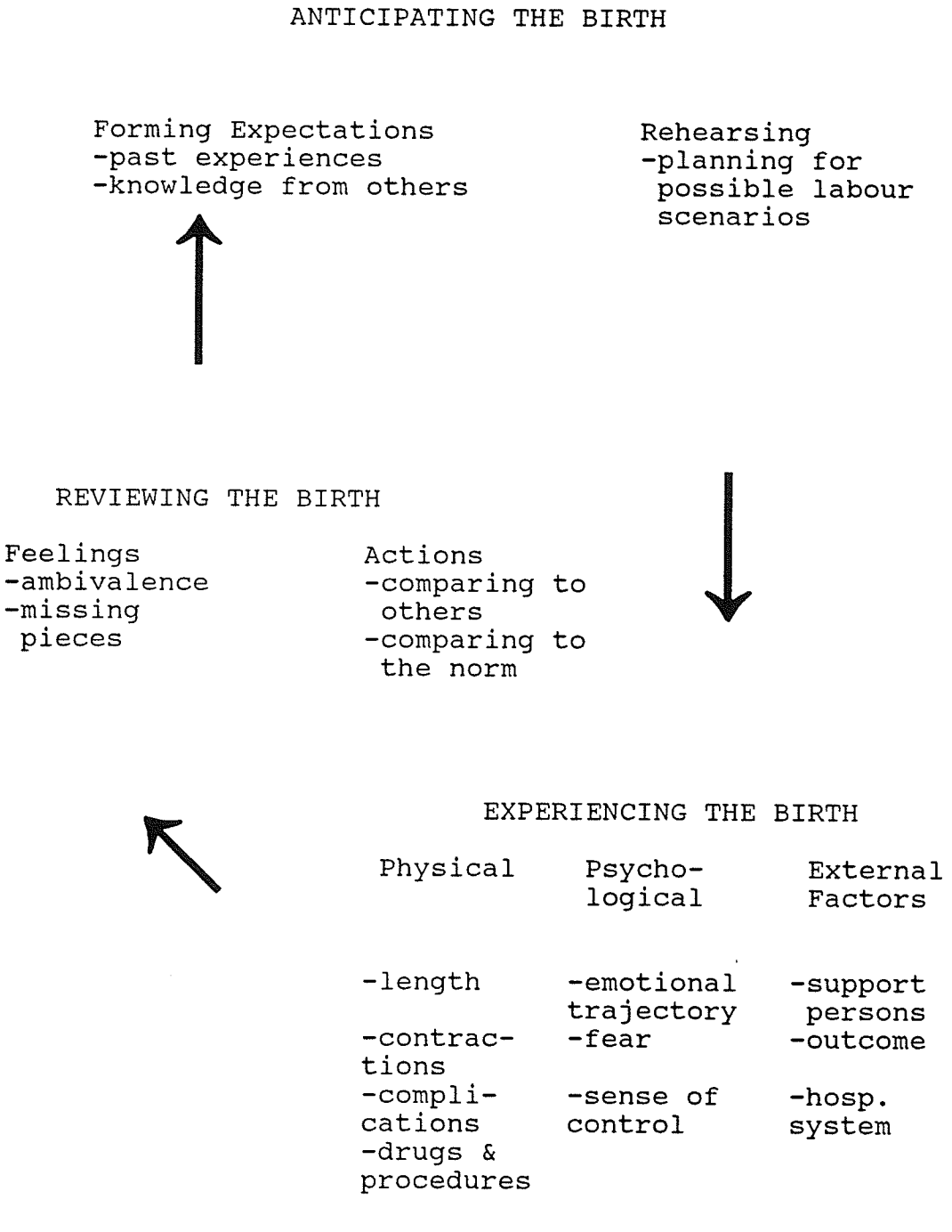
I guess after a while I have decided that being short is a lot better than being eighteen hours but I would have liked to have had a little bit more time, even like half an hour or an hour. (Subject #7)

One subject expressed feelings of "missing the experience" because of its speed. "It was nice to have it over with quickly but you kind of miss the experience because it happened so fast" (Subject #7).

Summary of Qualitative Results

Analyzing the qualitative data of subjects who experienced precipitate labour yielded three themes. Discreet, definable categories were generated from each theme. Schematic representation of the themes and categories is shown in Figure 3.

Figure 3


ANTICIPATING THE BIRTH
Forming Expectations
-past experiences
-knowledge from others
Rehearsing
-planning for possible labour scenarios
REVIEWING THE BIRTH
Feelings
-ambivalence
-missing pieces
Actions
-comparing to others
-comparing to the norm
EXPERIENCING THE BIRTH
Physical
Psycho-logical
External Factors
-length
-contrac-tions
-compli-cations
-drugs & procedures
-emotional trajectory
-fear
-sense of control
-support persons
-outcome
-hosp. system

Quantitative Results

The final research question was: How do measurements of psychosocial outcomes of childbirth compare between women who experience precipitate labour and a heterogenous sample of postpartum women? This section of the study focused on this question.

Subjects were asked to complete three psychometric instruments: the Childbirth Perceptions Questionnaire (CPQ), the Satisfaction with Childbirth Experience Questionnaire (SCEQ), and the Labour Agentry Scale (LAS). In order to satisfy the sixth research question, scores were compared between precipitate labour subjects and a heterogenous sample of postpartum women.

Subject Scores

Each questionnaire was scored and the mean, standard deviation, and 95% confidence interval for the mean were calculated. Scores for each of the instruments (and subscales) were standardized with percentage scores to allow for comparison.

Childbirth Perceptions Questionnaire

The range of CPQ scores was 118 to 153, with the highest possible score 180. The mean was 136.27, with standard deviation of 13.33 and a 95% confidence interval for the mean of 127.31 to 145.23. Scores were also calculated for the four CPQ subscales (coping with pain, support of significant other, interventions, nurse support). The highest possible score on the subscale of coping with pain was 55; the mean score for this sample was 38.18, suggesting subjects felt a moderate ability to cope with labour pain. The subscale support of significant other was comprised of eight items on the questionnaire, and therefore the highest possible score was 40. The sample's mean on this subscale was 27.73, indicating that subjects perceived a moderate amount of support. The third subscale, interventions, had a possible high score of 45. The mean score for the sample was 35.73. This high score suggests that subjects felt very positive about the type and amount of intervention they experienced during childbirth. The final subscale relates to nurse support. The sample's mean score was 34.64 out of a possible score of 40, suggesting a very

high perception of nurse support.

In order to allow for comparison between subscales with unequal value, the percentage scores for the CPQ were also calculated. The percentage total score mean was 69.63, with a standard deviation of 9.26 and a 95% confidence interval for the mean of 63.4 to 75.86. The percentage score for nurse support was highest (83.24), followed by support from significant other (74.03), interventions (64.32), and finally coping with pain (61.78). This suggests that subjects had the most positive perception regarding the support they received from nurses, and were least positive about their ability to cope with the pain of childbirth.

Table 2 summarizes subjects' mean CPQ scores, and Table 3 reflects the percentage scores for the CPQ.

Table 2

CHILDBIRTH PERCEPTIONS QUESTIONNAIRE
MEAN TOTAL AND SUBSCALE SCORES

Subscale	Mean	Standard Deviation	Confidence Interval 95%
Pain	38.18	7.4	(33.2,43.16)
Significant Other	27.73	3.35	(25.48,29.98)
Interven-tions	35.73	5.57	(31.98,39.48)
Nurse Support	34.64	4.15	(31.85,37.43)
CPQ Total Score	136.27	13.33	(127.31, 145.23)

Table 3

PERCENTAGE SCORES
CHILDBIRTH PERCEPTIONS QUESTIONNAIRE

Subscale	Mean	Standard Deviation	Confidence Interval 95%
Pain	61.78	16.91	(50.41, 73.15)
Significant Other	74.03	11.96	(65.99, 82.07)
Interven-tions	64.32	13.92	(54.96, 73.68)
Nurse Support	83.24	12.98	(74.51, 91.97)
CPQ Total Score	69.63	9.26	(63.4, 75.86)

The Labour Agentry Scale

The LAS was the second instrument used. Scores ranged from 119 to 194, with 203 the highest possible score. The mean was 160.91, with standard deviation of 27.30 and 95% confidence interval for the mean of 142.55 to 179.27. The percentage scores were tabulated. The percentage mean was 75.81, with standard deviation of 15.69. The 95% confidence interval for the mean was 65.26 to 86.36. These scores indicate that subjects felt a moderately high degree of control during their labour.

Satisfaction with Childbirth Experience Questionnaire

The final instrument that was completed by subjects was the SCEQ. Scores ranged from 33 to 42, out of a possible 42. The mean was 38.45, with standard deviation of 3.11 and 95% confidence interval for the mean of 36.36 to 40.54. The mean percentage was 90.15, standard deviation of 8.64, and a 95% confidence interval for the mean was 84.34 to 95.96. Results on this instrument were extremely high, suggesting subjects felt very satisfied with their labour.

Correlation Analysis

Correlation analysis, which indicates the magnitude of a relationship between variables, was done with the three instruments, CPQ, LAS, and SCEQ, as well as between labour length and each instrument. Two non-parametric tests were calculated: Spearman Correlation Coefficients and Kendall Tau b Correlation Coefficients. Relationships were shown to exist between instruments, and between labour length and individual instruments. Results were similar with both tests. Results for Spearman Correlation Coefficients, the more powerful correlation of the two, were used.

As indicated in Table 4, strong positive correlation exists between percentage scores of the CPQ and LAS, the LAS and SCEQ, and labour length and CPQ. Moderate positive correlation was present between the CPQ and SCEQ, labour length and LAS, and labour length and SCEQ. Scatter diagrams were developed to illustrate correlation between instruments, and between labour length and each instrument (see Appendix K).

Table 4

SPEARMAN CORRELATION COEFFICIENTS
FOR THE CPQ,LAS,SCEQ, AND
LENGTH OF LABOUR

	PCPQ	PLAS	PSCEQ
PCPQ	1.00000	0.90000	0.67288
PLAS	0.90000	1.00000	0.81575
PSCEQ	0.67288	0.81575	1.00000
L OF L	0.7904	0.6696	0.6553

PCPQ = Percentage Score for the CPQ
PLAS = Percentage Score for the LAS
PSCEQ = Percentage Score for the SCEQ
L of L = Total Length of Labour

Comparison of Results to a

Heterogeneous Postpartum Sample

In 1988, a convenience sample was recruited from women attending childbirth preparation classes at two large tertiary care teaching hospitals in a midwestern Canadian city (Bramadat, 1990). The research focus was comparison of maternal satisfaction with childbirth in women undergoing induction, augmentation, and spontaneous labour. Subjects completed questionnaires three times: during the third trimester, 24 - 48 hours postpartum, and 4 - 6 weeks postpartum. Results

obtained from the postpartum questionnaires were compared to results obtained from this study's precipitate labour sample. In Bramadat's study, eighty-five subjects completed questionnaires at the third point of testing, including the CPQ, the LAS, and the SCEQ.

Bramadat's sample was comprised of primiparous middle-class, English-speaking women ages 20 to 39 (mean 28.3 years). Most were married (89.2%), and 6.9% were living in common-law relationships. Subjects were well educated, with most having completed high school, and many continuing on to trade/technical training or university. All but five were working outside the home. The majority had no antepartum complications (Bramadat, 1990). Because of the very similar demography of Bramadat's sample to this study's precipitate labour sample, it is appropriate for comparison of results on the psychometric instruments used in both studies.

Childbirth Perceptions Questionnaire

A comparison of CPQ scores for the precipitate labour sample and Bramadat's sample was done. As

indicated in Table 5, statistically significant differences between the two samples existed in the subscale of intervention (precipitate sample mean = 35.73, Bramadat sample mean = 28.24), and CPQ Total Score (precipitate sample mean = 136.27, Bramadat sample mean = 123.95). This suggests that the precipitate labour population had a more positive perception of the interventions used during childbirth, and generally had a more positive perception of their experience. This may be because Bramadat's population contained some subjects who had unplanned Caesarean Sections, and that the very nature of precipitate labour prevents interventions by not allowing enough time for them to occur. No statistically significant differences existed between samples on the subscales of pain, support from significant other, or nurse support.

A comparison of percentage results for the two samples was also completed, with similar results. The difference between the intervention subscale percentage scores was statistically significant (precipitate sample = 64.32, Bramadat sample = 45.60), as was the CPQ percentage total score (precipitate sample = 69.63, Bramadat sample = 61.08). No other statistically

significant differences were found. Table 6 highlights the comparisons.

Table 5

CHILDBIRTH PERCEPTIONS QUESTIONNAIRE
COMPARISON OF THE PRECIPITATE SAMPLE RESULTS (P)
TO BRAMADAT'S (1990) SAMPLE RESULTS (B)

Sub-Scale	Mean		Standard Deviation		Confidence Interval 95%	
	P	B	P	B	P	B
Pain	38.18	31.85	7.4	7.5	(33.2 43.16)	(30.21 33.49)
Sig. Other	27.73	28.9	3.35	4.4	(25.48 29.98)	(27.94 29.86)
Inter-vention	35.73	28.24	5.57	4.4	(31.98 39.48)	(27.28 29.2)*
Nurse Support	34.64	34.96	4.15	4.3	(31.85 36.43)	(34.02 35.9)
CPQ Total Score	136.27	123.95	13.33	12.8	(127.3 145.2)	(122.0 126.7)*

* = significant at α = .05 level of significance

Table 6

CPQ PERCENTAGES
A COMPARISON OF THE PRECIPITATE LABOUR SAMPLE (P)
TO BRAMADAT'S (1990) SAMPLE (B)

Sub-Scale	Mean		Standard Deviation		Confidence Interval 95%	
	P	B	P	B	P	B
Pain	61.78	47.38	16.91	17.08	(50.41 73.15)	(43.65) 51.11)
Sig. Other	74.03	78.32	11.96	15.82	(65.99 82.07)	(74.78 81.68)
Inter-vention	64.32	45.60	13.92	11.09	(54.96 73.68)	(43.18 48.02)*
Nurse Support	83.24	84.26	12.98	13.51	(74.51 91.97)	(81.31 87.21)
Total Score	69.63	61.08	9.26	8.87	(63.4 75.86)	(59.14 63.02)*

* = significant at α = .05 level of significance

Labour Agentry Scale

LAS results were compared between the two samples; no statistically significant differences were found. Results are outlined in Table 7. Although precipitate labour sample scores are higher, confidence intervals for the means overlap, suggesting that the scores are similar.

Table 7

LABOUR AGENTRY SCALE
COMPARISON OF THE PRECIPITATE LABOUR SAMPLE (P)
TO BRAMADAT'S (1990) SAMPLE (B)

	Mean		Standard Deviation		Confidence Interval 95%	
	P	B	P	B	P	B
Raw Score	160.91	147.76	27.30	31.41	(142.55 179.27)	(140.9 154.6)
% Score	75.81	65.98	15.69	18.0	(65.26 86.36	(62.05 69.91)

Satisfaction with Childbirth Experience Questionnaire

Results for the SCEQ were compared, and are summarized in Table 8. The precipitate labour sample displayed higher satisfaction than Bramadat's sample.

Table 8

SATISFACTION WITH CHILDBIRTH EXPERIENCE
QUESTIONNAIRE: COMPARISON BETWEEN
PRECIPITATE LABOUR STUDY (P) AND
BRAMADAT'S (1990) STUDY (B)

	Mean		Standard Deviation		Confidence Interval 95%	
	P	B	P	B	P	B
Raw Score	38.45	33.98	3.11	6.25	(36.36 40.54)	(32.62 35.34)*
% Score	90.15	77.53	8.64	16.16	(84.34 95.96)	(74.0 81.06)*

* = Significant at α = .05 level of significance

Summary of Quantitative Results

The precipitate labour population scored moderately to very high on all questionnaires. Quantitative analysis suggests that the sample of women studied felt positive about their childbirth (CPQ), felt moderately high control (LAS), and were highly satisfied (SCEQ).

Correlation analysis suggests a strong positive relationship between the percentage scores for the CPQ and LAS, the SCEQ and LAS, and the labour length and CPQ. A moderate positive relationship existed between the percentage scores of the CPQ and SCEQ, labour length and LAS, and labour length and SCEQ.

In comparison to a demographically similar sample surveyed with the CPQ, LAS, and SCEQ in an earlier study, there were significant differences in only the CPQ total score, the CPQ Intervention Subscale, and the SCEQ. In these three situations, the precipitate labour sample scored higher than the more heterogeneous sample of postpartum women. Women who experienced precipitate labour felt more positive about their childbirth, the interventions that occurred during and

it, and more satisfied with the experience.

Findings Viewed Within The Context of the Conceptual Framework

The conceptual framework for this study was based on the work of Janis (1958). Janis symbolically represented discrepancy between victimization expected (Ve) and victimization perceived to have occurred (Vo) with the following equation:

$$Ve - Vo$$

Euphoria will result when the discrepancy is positive, and dysphoria when the discrepancy is negative.

In this study, no exact values were placed on the Ve or Vo by individual subjects; instead, the researcher carefully read over subject's stated expectations and accounts of their actual experiences, and categorized them as positive, neutral, or negative based on the subject's reflection.

Seven subjects had a positive discrepancy factor. These subjects had expected a high degree of victimization, and found that they experienced minimal to no victimization. For example, Subject #8 described

herself as "panicking and totally out of control" during a previous labour. She expected to behave in a similar fashion, and found this behaviour embarrassing. As well, she knew her physician gave routine enemas on admission to the Labour Floor, and this she found very distasteful. Finally, because her first labour was three hours long, she was expecting a shorter labour this time and did not know if she would make it to the hospital before delivery. This thought distressed her. Based on these expectations, subject #8 was rated by the researcher as expecting a high degree of victimization. In reality, subject #8 experienced minimal victimization, because she made it to the hospital prior to delivery, there was no time for the enema, and she experienced a much greater sense of control during labour. Thus, when subject #8's Vo (victimization which was perceived to occur) was subtracted from the Ve (victimization which was expected), a positive discrepancy factor results. This according to Janis' work would leave the subject feeling euphoric. Subject #8 did feel very positive and satisfied about her experience: "The whole experience was perfect" (Subject #8).

Two subjects expected no victimization and perceived none during their labour and delivery. Their discrepancy factor was deemed to be neutral. One subject was a multipara whose first labour was shorter than average for a first delivery (8 hours total), and the other subject, a primiparous client, expected a shorter than average labour because "it ran in the family", and had been a labour support person for her sister. Both subjects described their experience as being exactly as expected.

The final two subjects expected less victimization than they experienced, and thus their experiences appear to have a negative discrepancy factor. Subject #13 was a multipara with a past history of a faster than average labour. She had experienced spontaneous rupture of membranes four and one half hours prior to the onset of contractions with her first labour experience. She expected this labour experience to duplicate her last one, and so she was not worried about having enough time to reach hospital. This time she had a labour that was one hour and eight minutes in its entirety, and she experienced a great deal of anxiety during labour because she was not in the

hospital until just before delivery. The other subject, also a multipara, expected a shorter than average labour based on her last labour, but expected to be in hospital. She delivered her baby in the hall leading to the Labour and Delivery Unit.

Findings from the qualitative data support Janis' theory of the relationship of expectations and post-event mood. Those subjects who expected a worse experience than was actually perceived to have happened were very happy and satisfied. Subjects who found the experience as they expected were satisfied, but less so based on their verbal accounts. Finally, subjects who experienced more victimization than they expected were the least satisfied of all.

It is important to note that even the two subjects who experienced more victimization than expected still rated the experience as happy and satisfying, although they were markedly less animated in their descriptions, and more careful to balance their remarks about satisfaction with some that indicated dissatisfaction.

Summary of Results

Qualitative results suggest that subjects felt positive about precipitate labour overall. Most were able to articulate factors that made the experience positive; many had difficulty identifying negative aspects. Quantitative results supported this conclusion. All subjects scored high on psychometric measurements indicating a positive perception of their birth experience.

The CPQ subscale describing "support from significant other" received a high score from subjects. In the qualitative data, subjects referred to their husbands as the "significant other" involved in labour, and emphasized the importance of that role. This would appear to support the inclusion of "significant other" as a CPQ subscale.

As well, the CPQ subscale of "interventions" was measured. Subjects scored highly on this indicating positive opinions about interventions received. Qualitatively, few spoke negatively about interventions during labour and delivery. This lends support to validity of this CPQ subscale.

The concept of control was measured quantitatively by the LAS. Although control did not emerge as a qualitative category the concept was mentioned by all subjects. When control was seen to be present, it was viewed positively. When control was not present, its presence was missed. That all subjects spoke spontaneously of presence or absence of control suggests that it is a pivotal concept worthy of measurement and evaluation.

When qualitative and quantitative results were woven together, the following impressions emerge. Women who experienced a precipitate labour relied on support from their husbands, experienced minimal interventions, and felt the need to be in control was important. The summary experience of precipitate labour was positive for the eleven subjects studied.

CHAPTER 5

DISCUSSION

Six questions served as a focus for this study of precipitate labour. The results reported in Chapter 4 will be discussed within the context of these questions, followed by a discussion of the findings in relation to the conceptual framework. Finally, limitations of the study and its implications for nursing practice and areas needing further research will be addressed.

Question #1: What expectations do women have for the birth experience?

Qualitative studies require the researcher to ask open-ended questions, and allow subjects to set the agenda for the ensuing discussion. When subjects were asked to describe their expectations for birth, most had difficulty articulating them apart from general comments such as "I expected it to go pretty much as it did", or "I didn't know what to expect". Inevitably, subjects focused discussion on factors in their lives

that had influenced their expectations. This discussion led to the development of the theme Anticipating Birth, and two categories: forming expectations and rehearsing.

Forming Expectations

Women formed expectations for their upcoming labour on past personal experience and knowledge gained from others. Past personal experience included past labours, work experience in Labour and Delivery, and acting as a labour coach. Knowledge gained from others included material learned in prenatal classes, by reading, and from female friends' and family members' stories.

Multiparous women expected impending labour to duplicate, or be similar to previous labours. Understandably, primiparous women depended more on information gathered from other sources. All subjects tempered their expectations with information from female relatives, specifically from the labours described by their mothers and sisters.

These findings are supported in the literature. Beaton and Gupton (1990) found that multiparae focused

on "whether their second experience would be like their first with regard to such specifics as length, (or) time of rupture of the membranes" (p. 135). Other studies also have demonstrated that multiparas' expectations for labour are based on the nature of their past births (Bassett-Smith, 1988; Stolte, 1987). Knight and Thirkettle (1987) reported that primiparas' expectations for labour were based on antenatal class information, events during their pregnancy, and their mothers' recollection of pregnancy.

Subjects had difficulty remembering and/or describing specific prenatal expectations. Most stated that, in general, they had expected things to go the way they did. Subjects reported expectations of pain, exhaustion, and an intense labour, and in reality those expectations were met. Infrequency of unmet expectations may be explained by the retrospective measurement of a sample limited to women who had delivered healthy newborns quickly at term. It is possible that a "Halo Effect" took place. Subjects had survived birth with minimal complications and delivered a healthy newborn which may have blinded them to unmet expectations and highlighted those that were.

> The joy surrounding the arrival of a healthy baby...creates a favorable halo. This undoubtedly results in an upward bias in the expressed level of satisfaction. (Sullivan & Beeman, p.327)

One unmet expectation was labour length. All subjects found labour shorter than anticipated, even when short labour was expected. Labour length was measured against each psychometric instrument by correlational analysis. A strong positive correlation was found between labour length and the CPQ, suggesting that as the length of labour increased, subjects had an increasingly positive perception of the experience. However, one must keep in mind the sample size of eleven when considering this correlation.

Rehearsing

The second category that emerged out of the theme of Anticipating Birth was "rehearsing". To cope with potentially negative expectations, some subjects rehearsed possible actions they would employ in certain situations. Rehearsing involved prenatal planning for all imaginable scenarios once labour commenced. Those

who did not rehearse suggested that they now realized rehearsing might be beneficial. Knight and Thirkettle (1987) suggested that coping abilities may be strengthened by prenatally rehearsing possible negative features of labour and delivery.

Hall and Carty (1993) studied eight women prospectively to understand their experience in an early discharge programme. Taking control was the primary means of coping. That process involved, among other things, organizing and preparing for impending birth by arranging for others to assist the family as needed. Such preparation increased subjects' confidence that they would be ready for early discharge. One subject who had not prepared adequately saw the benefit of it retrospectively, and intended to prepare more carefully for subsequent pregnancies (Hall & Carty, 1993). The described process of taking control through preparation is similar to the rehearsal described by precipitate labour subjects. That action is a tangible means of exerting some control over their upcoming, largely unpredictable, labour experience.

Mackey (1990) studied sixty-one married, multigravidae to describe their preparations for

childbirth. Qualitative analysis of taped interviews suggested subjects' preparation included reviewing past birth experiences, gathering information, and planning for labour. Mackey's findings support this study's categories of "forming expectations" (reviewing past childbirth experiences and gathering information) and "rehearsing" (planning for labour).

Question #2: How is the birth experience perceived by women who experience precipitate labour?
Question #3: What factors contribute to a positive precipitate labour experience?
Question #4: What factors contribute to a negative precipitate labour experience?

Due to the nature of qualitative inquiry, subjects' response to questions 2, 3, and 4 became entwined. When relating their labour experience, subjects reflected on what had happened, as well as what had made the experience positive and/or negative. For this reason, these questions will be discussed together.

Subjects were able to describe their precipitate labour experiences clearly. Their reflections yielded the theme of Experiencing Birth, and its three categories: physical experience, psychological experience, and external factors.

Physical Experience

The physical experience was described as short, with painful contractions occurring "one on top of the other". Subjects felt unprepared for the suddenness and intensity and found the rapid build-up of contractions difficult to manage. The physical experience also encompassed complications felt to be directly related to the precipitate nature of the birth, including perineal bruising, tearing, and increased postpartum bleeding. The remaining component of the physical experience included drugs and procedures used, specifically Entonox Gas and Demerol, and episiotomy.

The sparse literature on precipitate labour is descriptive rather than based on research trials. It suggests that contractions associated with precipitate labour are very rapid, and very strong (Clayton et al.,

1972; Cunningham et al., 1993; Curtis, 1933; DeLee, 1913; Garrey et al., 1974; McLennan & Sandberg, 1970), which is consistent with subjects' descriptions.

Increased complications, such as lacerations and postpartum hemorrhage can result from precipitate labour (Clayton et al., 1972; Cunningham et al., 1993; DeLee, 1913; McLennan & Sandberg, 1970). This is congruent with what some subjects described. Fetal complications may result, primarily from hypoxia associated with the strong unremitting contractions or unattended birth (Clayton et al., 1972; Cunningham et al., 1993; Garrey et al., 1974; McLennan & Sandberg, 1970). In this study, because a positive fetal outcome was required as an entry criterion, this did not occur.

A few subjects chose to use Entonox Gas and/or Demerol to cope with labour. Such use was not viewed positively by subjects, primarily because they did not completely block the pain, and left subjects feeling "dopey". Stolte (1987) interviewed 70 postpartum women to compare their birth experience with their expectations. Fifty-three percent found their experience of analgesia was not as expected; analgesics were less effective than anticipated. Driedger (1991)

interviewed women to determine components of satisfaction with labour. The majority that used analgesics did not find them satisfactory.

The only procedure that subjects discussed was episiotomy. One subject had an episiotomy and wished that she had not; another did not have one and wished that she had, presuming that her perineal healing postpartum would have been faster had one been carried out. Perhaps these opposing opinions are best explained by viewing the subjects as both experiencing the sense that what they felt was the right action in their situation was not carried out. Green and colleagues (1990) suggested from prospective study of 825 women that

> what matters to the woman is less the experience of the interventions per se, and more the belief that the right thing was done (p. 21).

Drew and colleagues (1989) found that avoiding obstetric interventions such as an episiotomy was relatively unimportant. What was critical was that procedures should be explained and that women should be adequately involved in choosing them. The two subjects

with contrasting opinions perhaps did not feel they had input into the decision that was made, and thus remained unconvinced that the right thing was done.

Psychological Experience

The second category, the psychological experience of precipitate labour, encompasses an emotional trajectory of disbelief, alarm, panic, and relief, as well as feelings of fear and the concept of control.

The first stage of the emotional trajectory, disbelief, was experienced by all subjects and related to a sense that the suddenness of what seemed to be labour was impossible; insufficient time had passed for the physiological processes they were feeling to occur. Alarm was experienced once subjects realized that they were indeed in labour, and that it was proceeding rapidly. Panic set in when subjects felt that labour was progressing more quickly than their current situation could accommodate. The primary focus of panic was whether or not the subject would arrive at the hospital before the baby was born. Clark (1975) identified "not getting to the hospital in time" as one fear experienced by multiparous women. The final

component of the emotional trajectory was relief, experienced as subjects reached the Labour and Delivery Unit, and felt they were in competent hands.

The emotional trajectory was experienced to varying degrees by all subjects. How far subjects progressed through its stages depended on their own recognition of labour, and on their location when this occurred. Those who left for hospital unsure of whether or not they were in labour experienced disbelief when hospital staff assessed their labour as well advanced. Because they were in hospital before the proximity of birth was identified, they did not experience feelings of alarm, or panic. In hindsight, they expressed relief that they had chosen to go to hospital when they did.

Subjects who realized labour had begun and started out for hospital, progressed through the trajectory to different stages, depending on their circumstances. Those able to reach hospital relatively quickly experienced disbelief, alarm, and minimal panic before feeling relief at having arrived at hospital. Subjects who did not get to hospital quickly because of distance, or having to wait for transportation

expressed panic following the initial feelings of disbelief and alarm. As well, their sense of relief on arrival was great. One subject who did not make it to the Labour and Delivery Unit before delivery experienced extreme alarm and panic in addition to initial disbelief. She did not experience relief, primarily because the delivery occurred outside the Labour and Delivery Unit.

Similar emotional processes have been identified in the literature. McKay (1989) found that the psychological experience of spontaneous abortion was comprised of three properties: dealing with the unexpected, assessing the possibility, and acknowledging the reality. The first property included feelings of shock and disbelief, and for some subjects, symptoms were recognized only in hindsight. This property is very similar to the disbelief stage of the emotional trajectory in Experiencing Birth. Assessing the possibility, McKay's second property, involves evaluating the degree of threat. Similarities exist between this and the precipitate labour study's emotional trajectory steps of alarm and panic. These stages all involve acknowledging the event, whether

spontaneous abortion or precipitate labour.

Fear was a second component within the psychological reaction to precipitate labour. Fear was focused on subjects' well-being as well as that of their baby. Such fears are not unique to precipitate labour. Mackey (1990) found that prenatal multiparas described fear so intense that they were terrified, petrified, or panic-stricken. Fear was associated with lack of understanding of what was happening as labour progressed. Given the speed and intensity of precipitate labour, women with that condition may not have time to understand what is happening. Precipitate labour may be a specific stressor that can amplify fears during labour.

The final psychological component of precipitate labour is control. Whether or not subjects felt they were "in control" during precipitate labour appeared to be very important. This included both the degree of coping ability felt over their body as well as the sense of power subjects perceived they had to manage the labour situation. Correlational analysis indicated a strong positive relationship between the LAS (measure of control) and the CPQ (perception of birth) and the

LAS and SCEQ (measure of satisfaction); this suggests that as subjects experienced an increased sense of control, they also perceived their labour more positively and were more satisfied. Mackey (1990) found that her prenatal, multigravida subjects interpreted managing labour and delivery well as being in control during those events, and that these later implied active decisions about what behaviours and actions to exhibit and being able to follow through on those decisions (Mackey, 1990). Schlatter (1990) found that a sense of ability to make decisions during labour will influence a woman's degree of satisfaction with that experience.

Precipitate labour subjects who maintained control felt positively about their actions, whereas those who did not feel they were in control expressed negative feelings. Loss of control was listed by Butani and Hodnett (1980) as one of the most unpleasant aspects of labour, and others have identified loss of control with decreased satisfaction (Drew et al., 1989; Green et al, 1990; Humenick & Bugen, 1981; Sequin et al., 1989; Stolte, 1987; Sullivan & Beeman, 1982).

External Factors

External factors, the final category in the theme "Experiencing Birth", incorporates support persons, fetal outcome, and the hospital system as factors that affect the labouring woman.

Support persons, including husbands, nurses and physicians were extremely important to subjects. Husbands' presence during labour in particular was very important. All subjects' spouses had intended to be present during labour, and all but one planned to remain during birth. Two husbands - one by prearrangement and one by unforeseen circumstances - missed the deliveries. Primarily, husbands were seen by subjects as supporters, decision-makers, and witnesses. Sullivan and Beeman (1982) found in their study of satisfaction with maternity care that women had a great desire for a childbirth coach, usually their husband. Mackey (1990) found women credited their husbands with helping them manage labour and had difficulty managing labour if their husband was absent. She noted that in describing the ideal experience, women related how they wanted to witness and enjoy the delivery with their husbands (Mackey, 1990). Stolte

(1987) discovered that subjects felt "the support person did not necessarily have to coach; mere presence was supportive" (p.102).

Nurses were the second support specified by subjects. Nurses had an overwhelmingly positive impact because of their support, information and encouragement. Green and colleagues (1990) found that women who felt they had been given the right amount of information in a clear way were most satisfied and fulfilled with their birth experience.

Nurses' competence in adapting to a quickly changing situation was also seen by subjects as a benefit. When nurses did not perceive that the situation was changing as quickly as it was (for example, when a patient had to push and the nurse told her it was not possible yet because insufficient time had passed), patients expressed frustration. Mackey and Flanders Stepans (1994) conducted intensive interviews with postpartum women to determine how they evaluated labour and delivery nurses. Qualitative analysis yielded the following favourable qualities of Labour and Delivery nurses: participation, acceptance, information-giving, encouragement, presence, and

competence (Mackey & Flanders Stepans, 1994).

The final support person mentioned by subjects was the physician. Generally, physicians were viewed positively. All subjects were aware that the hospital they had chosen to deliver in was a teaching hospital, thus the presence of residents, interns, and students was inevitable. Subjects found residents and interns helpful when they actively participated in the event, and did not appear to view the subject's delivery as simply another learning experience. Bradley (1983) suggested that greater emphasis should be placed on the interpersonal helping relationship by attending physicians as well as nurses during birth. Specifically, improved communication, increased empathy and greater positive reinforcement during labour and delivery would be beneficial (Bradley, 1983).

The second characteristic of "external factors" is birth outcome. Birth of a healthy term infant was an entry criterion for this study. In effect, this guaranteed that all subjects had the happy outcome of an uncompromised infant. Having a healthy baby seemed to be subject's major focus when they recalled labour. It is not surprising that a healthy infant is ranked as

the most important factor in women's determination of satisfaction with childbirth (Drew et al, 1989). Sullivan and Beeman (1982) state that a "healthy baby legitimizes the entire pregnancy experience" (p. 327). For a number of subjects in this study, the outcome was viewed as exceptionally positive because the baby's gender was the one desired prenatally. Ramona Mercer (1981) highlighted the need for a mother to reconcile the baby she has borne with her fantasy infant; this allows her to identify herself as the infant's mother. When the baby has the same characteristics (for example gender) as the fantasy baby, reconciling is much easier (Mercer, 1981).

The final "external factor" of Experiencing Birth was the hospital system's effect on the labouring woman. This occurred in two ways: the admitting process, and shortened length of stay.

Hospital procedures required patients to complete the entire admitting process in the Admitting Department. Time spent there provoked increased anxiety, as it delayed arrival on the Labour and Delivery Unit, and the consequent sense of relief at being in "safe hands". If a subject was judged to be

in advanced labour in the Admitting Department, she was taken up to the Labour and Delivery Unit while her husband remained to finish paper work. Usually this separation of the husband from his labouring wife was short and provoked anxiety only temporarily. In one situation, it led to the husband missing critical parts of the birth. In light of the evidence cited earlier for importance of husbands' presence to labouring women, this practice of separating labouring women from their support person for document completion should be reviewed.

The hospital system affected subjects also by length of stay. Subjects found length of stay exceptionally short, primarily because they did not spend much time in hospital prior to birth. When subjects laboured in a labour room, then moved from delivery room to recovery room to Postpartum Unit, their sense of having an overly abbreviated hospital stay was exacerbated. For subjects, admission was seen as a time that they felt "special". A short experience simply meant less time to experience that positive sensation. In developed countries,

> after a baby is born...all the attention

> shifts from the mother to the baby....Many mothers...(feel) a profound sense of loss and abandonment by their medical caregivers and their families. In general there (is) little acknowledgment of what these women (have) been through, both physically and emotionally, by giving birth. (Kendall-Tackett & Kaufman Kantor, 1993, p.74-75)

It would appear that in this era of shortened hospital stays for healthy parturient, allowing such women to stay longer during postpartum is unlikely. However, single room maternity care for such women, and recognizing the importance of their feelings would help women come to terms with precipitate labour when it occurs.

Question #5: In retrospect, how do women feel about the experience?

This fifth question led to the identification of the theme Reviewing Birth. The categories of actions and feelings emerged from this theme.

Reviewing the events of childbirth, reflecting on

how they differed from expectations, and integrating the experience is the first task of assuming motherhood. Only when the birth has become as a cognitive whole can it become a part of the woman's "self" (Mercer, 1981). Failure to come to terms with the events of birth may inhibit a mother's ability to focus on and attach to her newborn (Laufer, 1990; Mercer, 1981).

Actions

The primary action employed by subjects in Reviewing Birth was comparing their personal labour experience to other labour experiences, whether their own, or those of other women, or the "established norm" found in pregnancy literature. Mercer suggested that reviewing events of labour and delivery, and evaluating them in relation to other significant womens' experiences is one of the first tasks a mother must undertake to integrate birth (Mercer, 1981).

Feelings

The second category of feelings surfaced when subjects reflected upon their precipitate labour.

Predominately, they expressed ambivalence. No subject wished for a long labour. However, some felt that another 30 to 60 minutes would have benefited them by adding enough time to do things that did not get done (for example, have the husband present), or avoid things they wished they had not had (for example, Demerol). Subjects appeared to wish they had more time to allow them to gain control over how the birth evolved.

One subject felt that the speed of the experience was such that she could not cognitively keep up with it; this led to feelings that she had missed parts of the experience. This response is congruent with "missing pieces" described as components of the birth experience that have been forgotten or repressed because the flood of stimuli during labour creates sensory overload and obstructs integration of the birth (Affonso, 1977). Rapidly occurring births can be overwhelming to women who describe being swept away with a resulting sense of temporary helplessness, and missing portions of the experience because of inadequate time to process events (Kendall-Tackett & Kaufman Kantor, 1993). The absence of portions of the

experience will delay integration of the birth (Mercer, 1981).

Question #6: How do measurements of psychosocial outcomes of childbirth compare between women who experience precipitate labour and a heterogenous sample of postpartum women?

Using three psychometric instruments, the precipitate labour sample was compared to a heterogenous sample of postpartum women studied by Bramadat (1990).

The CPQ

Differences in the CPQ scores were found at a 0.05 level of significance for the total score of the instrument, as well as the "intervention" subscale. This suggests that the precipitate labour sample felt more positively about childbirth than Bramadat's sample. Precipitate labour subjects scored higher on the intervention subscale, indicating positive perceptions about the interventions they received. This may be explained by the fact that the precipitate

sample experienced few interventions as time was insufficient to allow them, while Bramadat's sample included subjects who experienced inductions, augmentations of labour, Cesarean Sections and spontaneous deliveries.

The LAS

No statistically significant differences in LAS scores occurred between the two samples. The mean percentage scores for both samples were moderately high, indicating a moderate sense of control during labour.

The SCEQ

Results on SCEQ suggest higher satisfaction with birth among the precipitate labour sample than among the heterogenous group. This difference may be a result of less unexpected occurrences in the precipitate sample than in Bramadat's sample, such as inductions and augmentations of labour.

Relationship of Findings to the Conceptual Framework

The conceptual framework for this study was based on the work of Janis (1958). Janis symbolically represented discrepancy between victimization expected (Ve) and victimization perceived to have occurred (Vo) with the following equation:

$$Ve - Vo$$

Euphoria will result when the discrepancy is positive, and dysphoria when the discrepancy is negative.

Results presented in Chapter 4 indicate how specific subjects' expectations and experiences were preliminarily measured according to Janis' equation. Seven subjects had a positive discrepancy factor, two subjects had a neutral discrepancy factor, and two subjects had a negative discrepancy factor.

As with the studies by Levy & McGee (1975), Knight & Thirkettle (1987), and Bramadat (1990), these results support Janis' theory of the relationship of expectations and post-event mood. Subjects who expected a worse experience than was perceived to have happened were very happy and satisfied. Subjects who

found the experience as they expected were satisfied, but less so based on their verbal accounts. Subjects who experienced more victimization than they expected were the least satisfied of all.

Further substantiation of Janis' theory occurs because of emergence of prenatal rehearsal as an important concept. As Levy and McGee (1975) explain, a "psychological inoculation" effect appears to occur when rehearsal of events occurs. The subject becomes "inoculated" against adversity of stress by being better able to understand and control events (Levy and McGee, 1975).

IMPLICATIONS FOR NURSING

This study has several implications for nursing. During the prenatal period, nurses should encourage the action of "rehearsal", with the objective of helping pregnant women plan for any eventuality with their impending labour. As well, prenatal classes and teaching should include brief mention of precipitate labour, given that it occurs in approximately 15% of

births. While this percentage does not suggest extensive teaching need be done, at least mentioning it as a possible outcome can help women prepare and cope with this type of labour, should it occur.

During labour, it is imperative that nurses follow up on client cues that may suggest labour is proceeding in an unexpected manner. Providing personalized, organized, and caring nursing interventions is paramount. Understanding the alarm and panic often experienced during precipitate labour is important so that the nurse can offer appropriate intervention and reassurance. Given that control is important to labouring women, nurses must create an environment that encourages clients to participate in decision-making when feasible, and in which clients' choices are honoured wherever possible.

Once the precipitate labour client has arrived in hospital, it is important to include and not exclude her support person. Admitting paperwork should be done after arrival in Labour and Delivery, or at another time that does not require separation of the client from her support person. In this study, subjects stressed that even a brief separation provoked anxiety.

While it is difficult for nurses to influence length of hospital stay, nurses can help decrease the sense of haste by promoting the use of Single Room Maternity Care as opposed to traditional multiple transfer style care. Although the length of stay in hospital might not be affected, fewer transfers would assist the precipitate labour client to assimilate the experience, because it would all take place in one environment.

During the postpartum period, nurses can help the precipitate labour woman integrate her experience by encouraging her to review and compare her experience to others she has heard or read about. Clients should be given permission to feel ambivalence about their short labour. If the client is experiencing the phenomenon of "missing pieces", the nurse can attempt to fill in relevant details by talking with the staff who were in attendance at the delivery, and reviewing the client's hospital chart. Imperative throughout the entire precipitate labour experience is the need for all staff to be attentive to the psychological aspects of the event as well as the physical.

LIMITATIONS

This study's major limitations are its retrospective nature and small sample size. With a retrospective design, it is possible that emotions and reactions to the labour situation have changed.

Purposive sampling was used, thus a sampling bias may exist. Subjects who did not make it to the hospital before delivery or chose not to go to hospital were not included, because the sample was drawn from the hospital's delivery log book. Also, the researcher had to rely on subjective comments entered in the delivery log book by nurses to select possible subjects; it is possible that potential subjects were missed because no comments were present.

Although the sample size is acceptable for qualitative research, it is too small to draw confident conclusions for quantitative research. Subjects were homogenously well educated, married women who sought medical attention for their pregnancy, and delivered in one hospital setting. Therefore, quantitative results of this study cannot be generalized. And one must keep in mind that generalizing results is not the goal of

qualitative studies (Morse, 1989).

Use of a comparison group of heterogeneous postpartum women may have strengthened this study's conclusions. However, subjects in the comparison group delivered approximately four years prior to the subjects in this study, at two tertiary care hospitals. During the interceding years differences in the kind of care labouring women received may have occurred. As well, differences in care between the two hospitals may be present. This could influence responses to psychometric instruments. Given these limitations, results of this study must be accepted with caution, and cannot be generalized.

RECOMMENDATIONS FOR FUTURE RESEARCH

Future research into precipitate labour needs to employ a stronger research design. A large, prospective study of pregnant women would allow for a better understanding of the emotions women feel prenatally, as well as during immediate and more distant postpartum periods. While it is impossible to choose a precipitate labour population prospectively, a

large sample size would likely yield some appropriate candidates. In addition, a large sample studied prospectively would allow for more representative comparisons between precipitate labour clients and those with other types of birth experiences.

Research focused specifically on the emotional trajectory is essential. Given the description of similar emotional responses among women experiencing other types of crises, there may be a place for study of "emotional reaction to maternity related crisis".

In the hospital setting, comparative research should assess the differences between client's response to being cared for in single room settings versus traditional maternity rooms.

Further study should highlight the response of the precipitate labour client's support person. During this quick-paced, anxious event, the support person may have unique or extreme reactions, and understanding them would assist care providers in dealing with them.

Additional research could focus on attitudes of health care workers towards precipitate labour to determine the degree of congruence between workers' attitudes and womens' perceptions of the experience.

SUMMARY

This descriptive-exploratory study has attempted to illuminate the experience of precipitate labour from a woman's perspective. Literature searches yielded no studies that have focused on this topic.

Qualitative analysis led to development of three themes: Anticipating Birth, Experiencing Birth, and Reviewing Birth. Categories for those themes included: forming expectations and rehearsing (Anticipating Birth); physical, psychological, and external factors (Experiencing Birth); feelings and actions (Reviewing Birth).

Women highlighted importance of specific details during the antepartum, intrapartum, and postpartum phases of pregnancy. Antepartum, women depended on information from significant women in their life as well as formal literature and prenatal classes to assist them to form expectations of their upcoming labour. Rehearsing for possible labour situations was paramount prenatally. Intrapartum, making it to the Labour and Delivery Unit prior to delivery was critical. Until this occurred, women experienced

various degrees of disbelief, alarm, and panic. The presence of husbands was crucial during the experience. Health care workers who were perceived as supportive and involved were favourably viewed. The hospital system negatively affected women's perceptions when it forced husbands to stay behind in Admitting to complete paperwork. As well, when traditional maternity care rooms were used, this accentuated the rapidity of the experience for subjects. During the postpartum phase, women found that reflecting on the experience and comparing it to others assisted them in coming to terms with it. Despite expressing generally positive comments about the experience, women did feel some ambivalence, specifically about labour length.

Quantitative analysis revealed positive perceptions regarding birth, as measured on the CPQ, a moderately high sense of personal control during childbirth (measured on the LAS) and a high degree of satisfaction as measured on the SCEQ. Comparison of the precipitate labour cohort's responses to those of a more heterogeneous group indicated significant differences between samples in only three areas (CPQ total score, the Intervention Subscale of the CPQ, and

the SCEQ). In these three scores, the precipitate sample scored higher, suggesting they felt more positive about the whole childbirth experience, more positive about the interventions used during birth, and were more satisfied with the birth experience.

This study suggests the women surveyed were in retrospect, satisfied with the experience, and viewed it positively.

The implications for nursing are many, and were reviewed. As well, the limitations to the study were discussed, and suggestions for further research were identified in hopes that future studies with more rigorous design will be conducted.

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APPENDIX A

Chart Information Form

Chart Number_____

Patient Name_____

G___P___

Length of First Stage_____

Length of Second Stage_____

Total _____

Maternal complications noted:

Newborn

Sex_____

Apgar Scores_____

Newborn complications noted:

APPENDIX B
Letter from Dr. Hall to Potential Subjects

(DATE)

Dear

I am writing today to introduce you to a research study that will soon be conducted. From hospital records, you have been identified as a possible subject for this study.

Cathy Rippin-Sisler is a Master's of Nursing student at the University of Manitoba. She has been a registered nurse for eleven years, and her area of interest in nursing is childbirth, and women's feelings about this event.

Soon, she will be conducting a study with women who had short labours to explore how they feel about their experience. Because your labour was less than three hours long, you are being invited to participate in her study.

If you decide to participate in the study, you will be asked to fill in three questionnaires that will take about 20 minutes to complete. Then Cathy will interview you about your birth experience. The interviews usually take about 1 to 1 1/2 hours. The questionnaires and the interview can be completed in a location most convenient to you, including your home if you like, and will take place at a time convenient to you.

All information collected from you will be kept confidential, and will be stored in a locked drawer in Cathy's office. Results from the study will be published as part of her Master's Thesis, and possibly a journal article, but no personal information will be given that could identify you in any way.

If you do not wish to be considered for this study,

please call Marilyn McGurkin, secretary, Maternal-Child Nursing Office, at 237-2776 within 7 days and ask her to remove your name from the list.

If you do not call and ask that your name be removed from the list, Cathy will call you in the next few weeks to talk to you about the study.

If you have further questions about this study at this time, Cathy would be most pleased to talk with you. She can be called at 256-2549. As well, her thesis advisor, Dr. Ina Bramadat can be called at 474-6222 with any questions.

Thank-you for your time in considering this request.

Sincerely,

P.F. Hall, M.D., B.Sc.Med., FRCSC
Professor and Head
Dept. Obstetrics, Gynecology and
Reproductive Sciences

APPENDIX C

Telephone Explanation of Study to Potential Subjects

Hello. My name is Cathy Rippin-Sisler. About a week ago, you received a letter from Dr. Philip Hall regarding a study that I want to do. Did you receive that letter?
(answer no) I will ask him to send out another copy to you. What is your current address?
(answer yes) Good.

I am currently doing a study on women's views of their labour experience. Specifically, I want to explore how women feel about their labour experience when it is very short. I understand that your labour was less than three hours long.

At this time, I would like to invite you to participate in this study. First of all, I would like to tell you how the study will be conducted, and what would be expected of you if you choose to participate.

You will be asked to fill in four questionnaires which will take about twenty minutes to complete. The first questionnaire covers personal information such as your age, marital status, and level of education. The second questionnaire involves 36 questions that will give me information on how you felt about your last labour experience. The third questionnaire asks 6 questions about how satisfied you were with your labour experience. The last questionnaire asks 29 questions about your feelings of control during childbirth. Following these questionnaires, I will interview you for about 1 to 1 1/2 hours. The purpose of the interview is to get an idea about how you felt your labour experience went. At anytime, you may refuse to answer a question on the questionnaires or in the interview. As well, you can withdraw from the study at any point.

Filling in the questionnaire and completing the interview can all take place at one time, and can be arranged for your convenience in terms of when and where it takes place.

I will be tape-recording the interviews and then copying the recordings on to paper. Your name will not appear on any of the questionnaires or the copy of the interview. I will be identifying all of the papers with a code and only I will know how the code works. All tapes and completed papers will be kept in a locked drawer in my office. By following these steps, no one will know how you answered questions.

The study results will be part of my Master's Thesis, and may be published in a journal article. The results that would be included would be group results only, or comments from the interviews that would not identify you.

I will be most happy to share the results of my study with you. If you would like, a meeting of all subjects will be arranged and the results can be discussed in a group setting. It will also be possible to receive a written form of the results individually.

Would you like to take part in this study?
(Answer No) Thank-you very much for your time today. Good-bye.
(Answer Yes) Thank-you for agreeing. Would it be convenient for us to meet at your home? When would it be convenient for me to come over? I will see you on _____ (day) at _____ (time). Good-bye.

APPENDIX D

DISCLAIMER

Women's Experience of Precipitate Labour

You are being invited to voluntarily participate in the above-titled research project. The purpose of this project is to gain an understanding of what a very short labour is like for a woman.

If you agree to participate, you will be asked to fill in four questionnaires that will take about 20 minutes, and participate in an interview with the researcher that will take about 1 to 1 1/2 hours.

The questionnaires and interview will be about your (most recent) labour and delivery experience. You will not have to answer any questions that you do not want to. The interview will be tape-recorded, and the researcher will copy the interview onto paper from the recording.

You are free to withdraw from this study at anytime. There is a slight risk that talking about your labour experience could be upsetting for you. Should this happen, the interview will be stopped immediately, and the researcher will offer you help.

Questionnaires and copies of the interview will be kept confidential. All completed questionnaires, interview tapes, and written copies of the interviews will be kept in a locked drawer in the researcher's office.

The researcher's advisors will have access to written copies of the interview and the questionnaires, but these copies will be identifiable by a code only. Only the researcher can decode the code number.

You will be offered the chance to meet with other subjects as a group to discuss the study results once they are available. If you prefer, a written copy of the results could be made available to you individually.

You may telephone Cathy Rippin-Sisler any time if you have questions regarding your participation in the

study. Her telephone number is 256-2549. Her thesis supervisor is Dr. Ina Bramadat, and she may also be called at her office. Her number is 474-6222.

APPENDIX E

code___

Demographic Data

Please answer the following questions. This information will be used for the purposes of this research project and any written material about the project.

1. Age (in years)____

2. Education - Please circle the last year of education completed at each level

	Number of Years Completed
A) Grade School/High School	1 2 3 4 5 6 7 8 9 10 11 12 13
B) Trade/Vocational School or Community College	1 2 3 4
C) University	1 2 3 4 5 6 7 8 9

3. Were you working outside the home before the birth of this baby? Yes___ No___

If yes, were you working full-time____ or part-time____?

4. Present Marital Status
   Single, never married _____
   Married/Common Law _____
   Separated _____
   Divorced _____
   Widowed _____

5. Was this your first pregnancy?_____
   If not, how many pregnancies (including this one) have you had?_____
   How many children do you have?_____

6. With your last baby, how long was your labour, from the first regular contraction until the baby was born?_____

7. Where did the delivery take place?_____

8. Who delivered the baby for you?_____

APPENDIX F

code___

Childbirth Perceptions Questionnaire

This questionnaire is designed to describe women's perceptions of their labour and delivery experience. Your opinions along with those of other new mothers will be used to learn more about women and childbirth.

The questionnaire contains a number of statements, each of which says something different about your labour and delivery. I am interested in knowing what the labour and delivery experience was like for you. For each statement, decide how you agree or disagree with the view expressed. Think about the statement. Beside each statement, you will find five words used to describe your experience. There are no right or wrong answers. Your response is a matter of your personal opinion. The information you give will be completely confidential.

Thank you for your time and your help. Below are examples that may help you in completing the questionnaire.

EXAMPLES

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
A. I was very confident during labour and delivery	1	2	3	4	(5)
B. I needed to know more about labour and delivery than I possibly could	1	2	(3)	4	5

The answer to Example A, "Strongly Agree" indicates that you are quite certain that you were confident during your labour and delivery.

The answer to Example B, "Neutral" indicates that you cannot quite decide whether to agree or disagree with this statement.

CIRCLE the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my last labour and delivery experience, I found that:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My partner/coach was happy and excited.	1	2	3	4	5
2. The nurses were kind to me.	1	2	3	4	5
3. I avoided seeking help from the nurses.	1	2	3	4	5
4. I was immobilized by the pain of labour.	1	2	3	4	5
5. I was able to cope with labour.	1	2	3	4	5
6. I felt reassured by the nurses' presence.	1	2	3	4	5
7. The nurses spent little time with me.	1	2	3	4	5
8. My plans for birth were ignored by the nurse.	1	2	3	4	5
9. My partner/coach felt quite helpless	1	2	3	4	5
10. I was required to have routine procedures even if I didn't want them.	1	2	3	4	5
11. I asked my partner/ coach for help.	1	2	3	4	5
12. I worried about the severity of labour pain.	1	2	3	4	5

CIRCLE the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my last labour and delivery experience, I found that:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
13. There was little chance that I would end up having a cesarean section.	1	2	3	4	5
14. Lots of medical equipment and machinery were used.	1	2	3	4	5
15. I was afraid of panicking.	1	2	3	4	5
16. I experienced discomfort but not unbearable pain.	1	2	3	4	5
17. I felt comforted by the presence of my partner/coach.	1	2	3	4	5
18. I felt intense pain.	1	2	3	4	5
19. I had a childbirth free from medical intervention.	1	2	3	4	5
20. I was up walking around for most of my labour.	1	2	3	4	5
21. I wanted to have fetal monitoring.	1	2	3	4	5
22. I was afraid of being a coward.	1	2	3	4	5

CIRCLE the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my last labour and delivery experience, I found that:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
23. I was able to relax during labour.	1	2	3	4	5
24. The nurses offered me encouragement.	1	2	3	4	5
25. There was little chance that forceps would be used.	1	2	3	4	5
26. The pain of labour was agonizing.	1	2	3	4	5
27. I received personal attention from the nurses.	1	2	3	4	5
28. My partner/coach told me what was going on.	1	2	3	4	5
29. The nurses allowed me to be an active participant in decision making.	1	2	3	4	5
30. I was scared when I thought about the pain of labour.	1	2	3	4	5
31. I could have refused to have any procedures I thought unnecessary.	1	2	3	4	5

CIRCLE the number under the word(s) which come closest to your own opinion.

PLEASE BE SURE TO MARK EVERY STATEMENT

With regard to my last labour and delivery experience, I found that:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
32. My opinion or that of my partner/coach was sought for all major medical decisions.	1	2	3	4	5
33. I used anesthetics and/or pain killing drugs.	1	2	3	4	5
34. The doctor made most of the decisions.	1	2	3	4	5
35. I avoided telling my partner/coach what I was feeling.	1	2	3	4	5
36. I was embarrassed by my behaviour.	1	2	3	4	5

APPENDIX G

code___

Satisfaction with Childbirth Experience Questionnaire

Please place an "X" at the point on the line that most clearly indicates your satisfaction with your birth experience:

1. How satisfied are you, overall, with your labour and delivery experience?

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

2. How satisfied are you with how you coped with the pain of labour and delivery?

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

3. How satisfied are you with the amount of control you had over your labour and delivery experience?

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

4. How satisfied are you with the amount of help you received from your partner/coach during labour and delivery?

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

5. How satisfied are you with the amount of intervention that were done during your labour and delivery?
(intervention refers to use of anesthetics, medical procedures like episiotomy, use of forceps, electronic fetal monitoring, and procedures such as I.V., enema and/or shave prep., etc.)

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

6 How satisfied are you with the support you received from the nursing staff during your labour and delivery?

very dissatisfied___:___:___:___:___:___:___very satisfied
1 2 3 4 5 6 7

APPENDIX H

LABOUR AGENTRY SCALE

INSTRUCTIONS code___

Just as no two women are exactly alike, no two women have exactly the same experiences during labour. Please try and recall your labour as vividly as you can. Now rate the quality or nature of your experience during this time on the following scales. Of course, you probably had many different feelings, but try to remember what it was generally like for you during this time. Here is how to use these scales:

If you feel that what you experienced during labour was VERY MUCH related to one end of the scale, you should place you "X" as follows:

Almost Always X : ___ : ___ : ___ : ___ : ___ : ___ Rarely
1 2 3 4 5 6 7

OR

Almost Always ___ : ___ : ___ : ___ : ___ : ___ : X Rarely
1 2 3 4 5 6 7

If you feel that what you experienced during labour was QUITE CLOSELY related to one end of the scale (but not extremely), you should place your "X" as follows:

Almost Always ___ : X : ___ : ___ : ___ : ___ : ___ Rarely
1 2 3 4 5 6 7

OR

Almost Always ___ : ___ : ___ : ___ : ___ : X : ___ Rarely
1 2 3 4 5 6 7

If you feel that what you experienced during labour was ONLY SLIGHTLY related to one end of the scale, you should place your "X" as follows:

Almost Always ___:___:_X_:___:___:___:___ Rarely
1 2 3 4 5 6 7

OR

Almost Always ___:___:___:___:_X_:___:___ Rarely
1 2 3 4 5 6 7

If you feel that what you experienced during labour was NEUTRAL on the scale, (that is, both ends of the scale are equally related to your experience), you should place your "X" in the middle space:

Almost Always ___:___:___:_X_:___:___:___ Rarely
1 2 3 4 5 6 7

Please try to respond to each scale independently of how you responded to the other scales. And please be frank! There are no right or wrong answers.

1. I felt awkward.

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

2. I experienced a sense of active striving

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

3. I felt good about my behavior during labour

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

4. I felt someone or something else was in charge of my labour

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

5. I had a sense of perspective on what was happening

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

6. I experienced a sense of success

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

7. I experienced complete awareness of everything that was happening

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

8. I felt fearful

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

9. I felt relaxed

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

10. I did not know what to expect from one moment to the next

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

11. I felt adequate

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

12. I felt victorious

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

13. Everything seemed wrong

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

14. I felt powerless

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

15. I experienced great anxiety

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

16. I experienced a sense of being with others who care

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

17. I felt very responsible

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

18. I felt competent

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

19. I had a feeling of constriction and of being confined

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

20. Everything made sense

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

21. I was dealing with labour

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

22. I had a sense of not being in control

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

23. I experienced a sense of conflict

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

24. I felt open and receptive

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

25. I felt incomplete and like I was going to pieces

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

26. I felt important

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

27. Everything seemed unclear and unreal

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

28. I felt incapable

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

29. I felt secure

Almost Always ___:___:___:___:___:___:___ Rarely
1 2 3 4 5 6 7

The University of Manitoba

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#92/19

Proposal Title: "The experience of a precipitate labour."

Name and Title of Researcher(s): Cathy Rippin-Sisler
Graduate student, Faculty of Nursing, U of MB

Date of Review: June 1, 1992

APPROVED BY THE COMMITTEE: June 1, 1992

Comments:

Date: June 3, 1992

Linda J. Kristjanson, PhD, RN — Chairperson
Associate Professor
University of Manitoba Faculty of Nursing

Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Revised: 92/05/08/se

Hôpital général St-Boniface General Hospital

June 30, 1992

Ms. Cathy Rippin Sisler
34 Corton Place
Winnipeg, Manitoba
R2N 1W6

Re: Access to SBGH for research

Dear Ms. Rippin Sisler

I am pleased to inform you that access has been approved for your thesis research project entitled:

Study of women with precipitate deliveries

You may proceed with data collection as outlined in your proposal.

Please feel free to contact me if the services of the Nursing Research Space at SBGH can be of help to you, or if I can facilitate your project in any way.

Congratulations on your interesting project. When it is finished, would you provide us with two summaries of your final report, one version being a scientific summary, and the other being in lay language for the general public? We will look forward to hearing your findings.

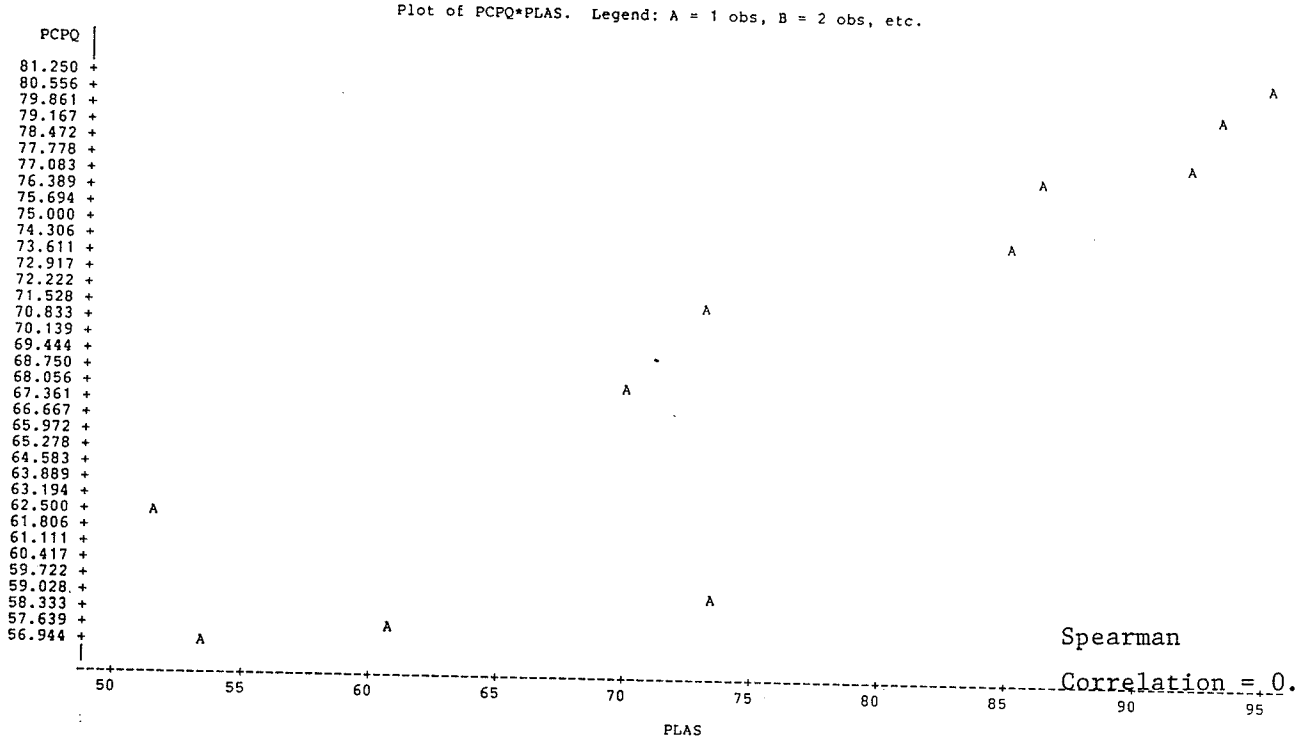
Sincerely,

Eleanor J. Adaskin, RN, PhD
Director of Nursing Research
Tel. [illegible]

EA/mj

PRECIPITATE LABOUR
FREQUENCY TABULATIONS FOR SELECTED VARIABLES

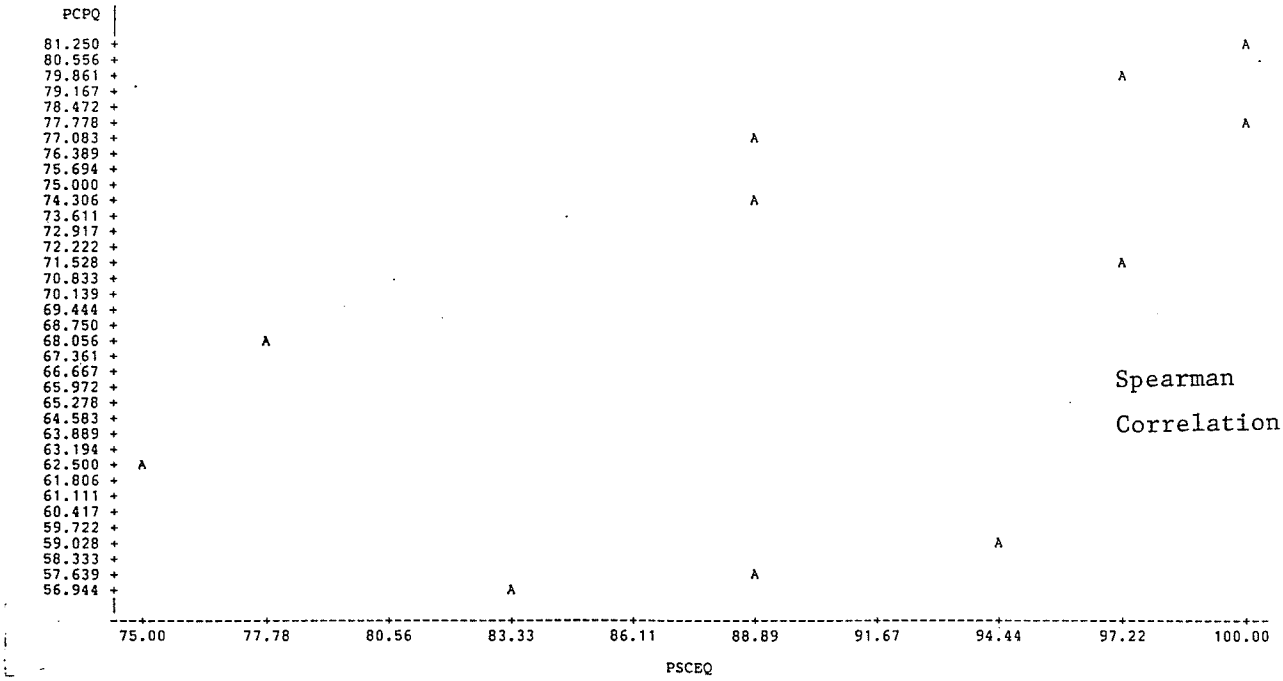
Plot of PCPQ*PLAS. Legend: A = 1 obs, B = 2 obs, etc.



Spearman
Correlation = 0.9000

PRECIPITATE LABOUR
FREQUENCY TABULATIONS FOR SELECTED VARIABLES

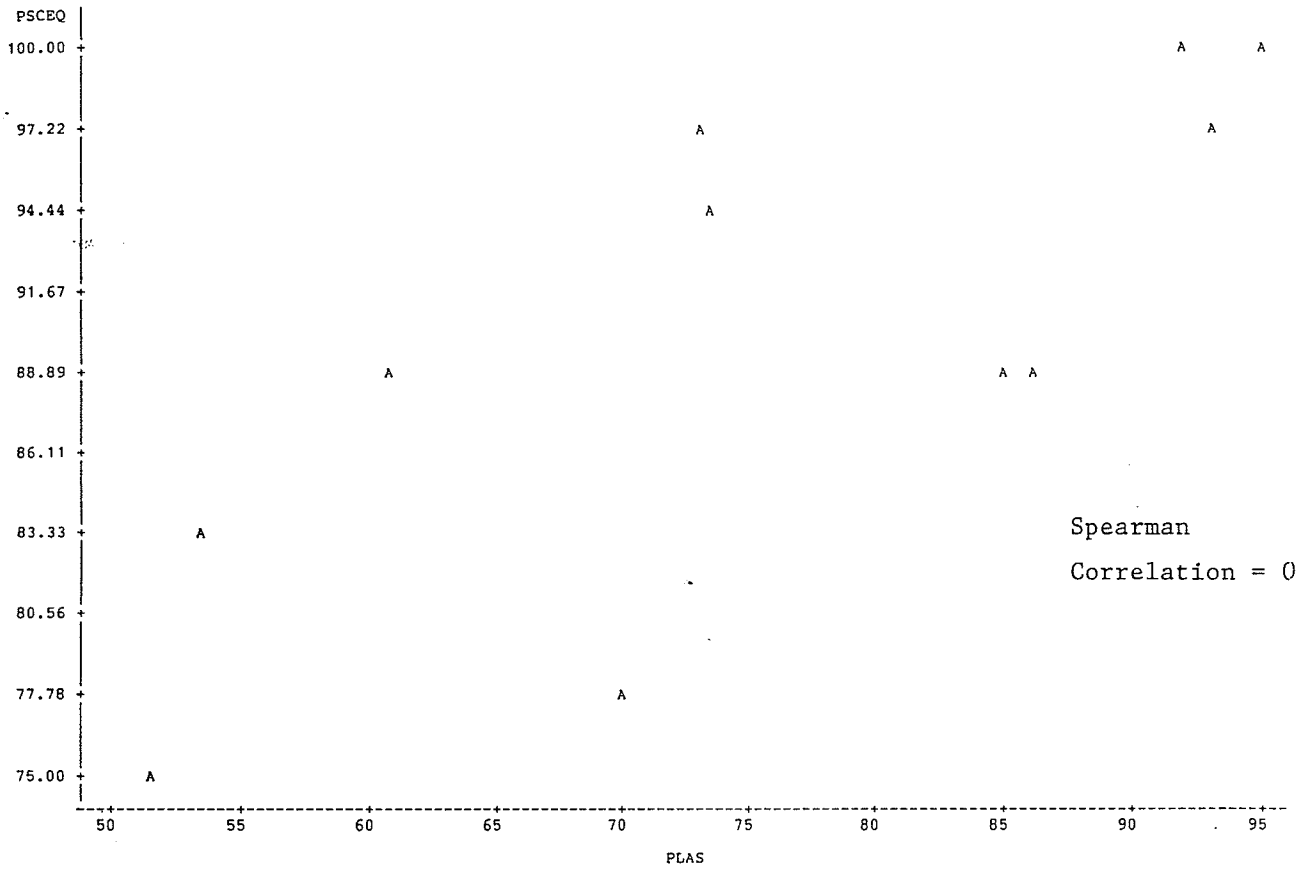
Plot of PCPQ*PSCEQ. Legend: A = 1 obs, B = 2 obs, etc.



Spearman
Correlation = 0.672

FREQUENCY TABULATIONS FOR SELECTED VARIABLES

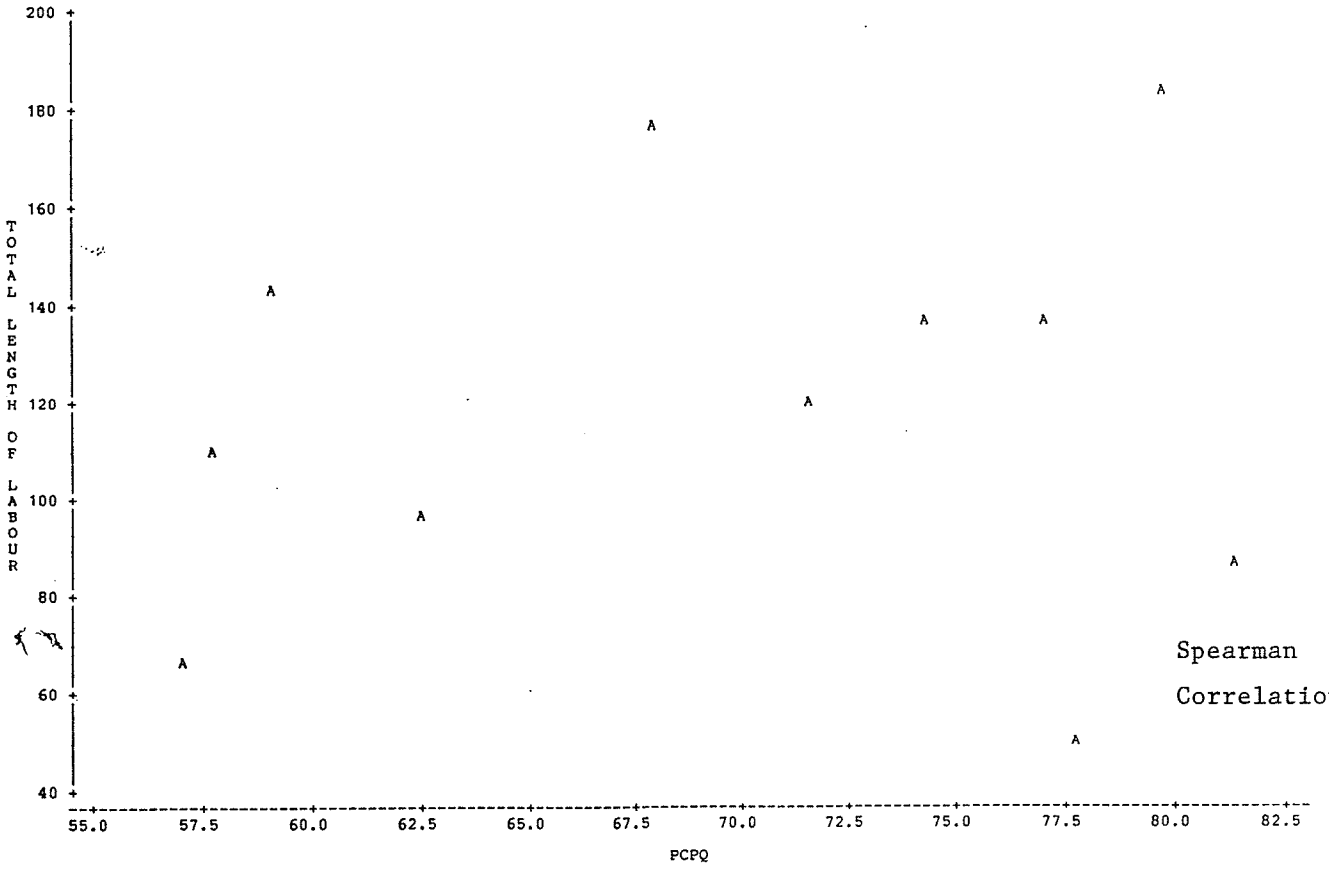
Plot of PSCEQ*PLAS. Legend: A = 1 obs, B = 2 obs, etc.



Spearman
Correlation = 0.81575

PRECIPITATE LABOUR
FREQUENCY TABULATIONS FOR SELECTED VARIABLES

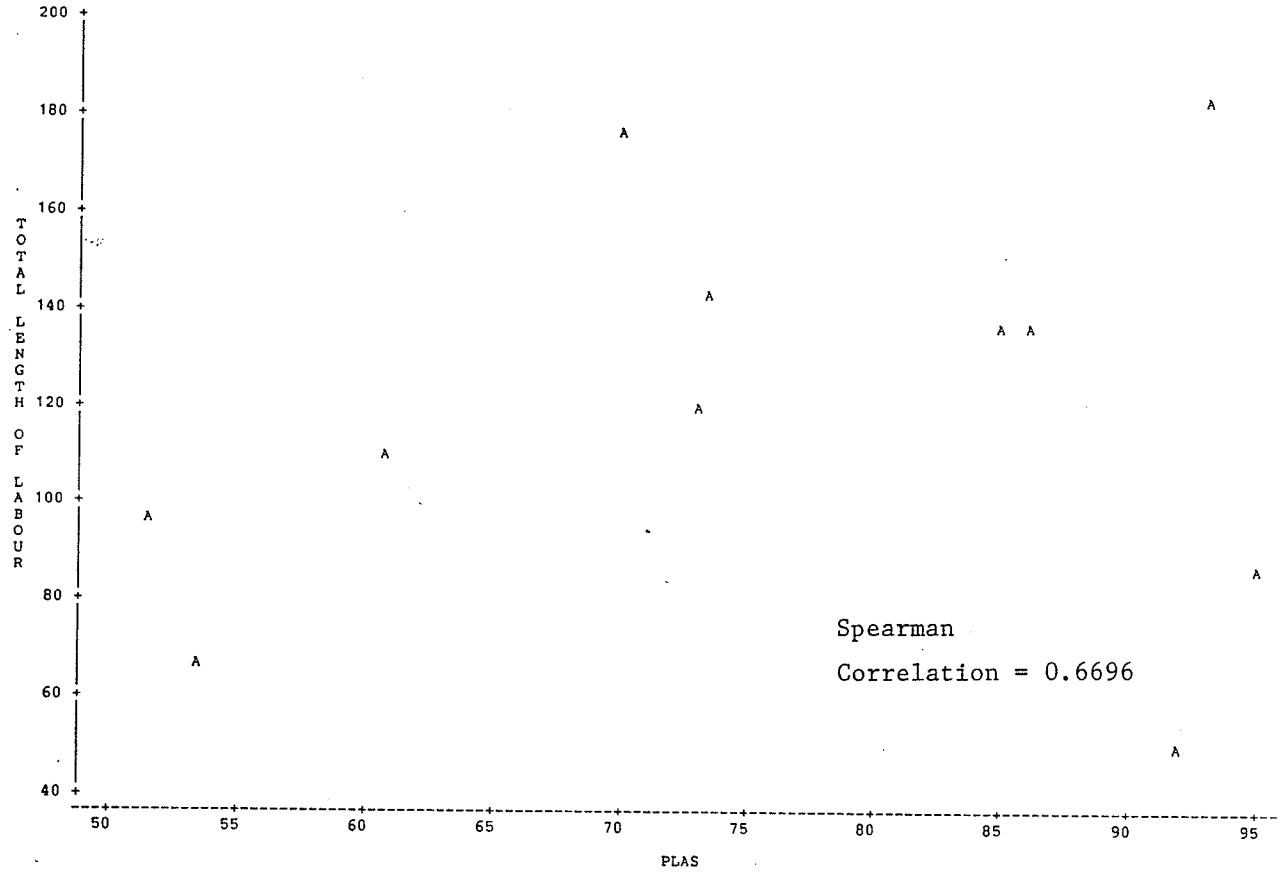
Plot of TOTAL*PCPQ. Legend: A = 1 obs, B = 2 obs, etc.



Spearman
Correlation = 0.7904

PRECIPITATE LABOUR
FREQUENCY TABULATIONS FOR SELECTED VARIABLES

Plot of TOTAL*PLAS. Legend: A = 1 obs, B = 2 obs, etc.



PRECIPITATE LABOUR
FREQUENCY TABULATIONS FOR SELECTED VARIABLES

Plot of TOTAL*PSCEQ. Legend: A = 1 obs, B = 2 obs, etc.