POSTPARTUM WOMEN'S PERCEPTIONS OF SATISFACTION WITH CHILDBIRTH

by

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ABSTRACT

Childbearing women and their caregivers know little about satisfaction with childbirth, despite a remarkable daily birth rate. The purpose of this study was to explore and describe the meaning of satisfaction with childbirth from the perspective of postpartum women. Nine women, who delivered three to four months previously, were recruited to the study. Semi-structured interviews were conducted with a focus on: women's meaning of satisfaction with childbirth; contributory aspects of the birth experience to women's satisfaction and dissatisfaction with childbirth; and any perceptal changes about the birth experience (from the antenatal to the postpartum period). Content analysis was used to examine the interview transcripts. Results indicate: 1. childbearing women have difficulty defining the meaning of satisfaction with childbirth, yet, explicitly verbalized aspects of the birth experience that contributed to their satisfaction and dissatisfaction; 2. satisfaction with childbirth is associated with the various ways of "Being There" by significant others and caregivers; 3. the husband's physical presence is perceived as the key aspect of pyschological support and the key contributor to satisfaction with childbirth; 4. subjects expect caregivers to provide combined physical, psychological, and verbal informational support; 5. childbearing women go into labour with preconceived expectations about childbirth, and 6. although satisfaction with the birth experience depends on subjects antenatal expectations and congruency of the outcome, "remaining in control" of the experience was identified as a contributor to satisfaction with childbirth. This study adds to the conceptualization of satisfaction with childbirth from the perspective of postpartum women. The findings have implications for caregivers in their care of childbearing women and provide a basis for further research and development of nursing theory related to satisfaction with childbirth.

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Chapter One

Satisfaction with childbirth is a focus of growing interest in perinatal nursing. This interest has motivated a number of studies to determine women's satisfaction with the birth experience. Until recently, the "hard" measures of mortality and morbidity have been used to evaluate "satisfactory" childbirth outcomes (Oakley, 1983). This perspective was understandable at a time of high maternal and infant death rates. More recently, with decreased mortality and morbidity rates, interest has begun to focus on psychosocial outcomes as a measure of childbirth satisfaction.

Although childbearing women are still concerned with viable and healthy childbirth outcomes, the more recent feminist, natural childbirth, "back to nature" and consumerism movements have created a shift in the ideology of childbirth practices (Nelson, 1983). The "back to nature" movement advocates rejecting modern technology and returning to early twentieth century childbirth practices. Natural childbirth advocates also are eager to be more actively involved in childbirth, but differ from the "back to nature" supporters in their acceptance of professional (as distinct from technological) control over such an important event. The feminist movement advises parturients to "reject the authority of men in...female experiences [such as childbirth]" (Nelson, 1983, p. 295), to gain control over their own lives and bodies. Consumerism advocates urge that all attitudes toward any and all prevalent medical practices be questioned.

The above movements have led to the introduction of alternative birthing rooms or birthing centers, increased use of lay midwives and home deliveries (Littlefield & Adams, 1987). Evaluation of childbirth outcomes likewise has shifted in emphasis from mortality and morbidity to "soft" outcomes or psychosocial morbidity [mental,

emotional, social state] (Oakley, 1983). This ideological shift has both affected practice and heightened awareness of psychosocial morbidity issues. Until recently, declining childbirth mortality and morbidity has been a source of satisfaction for health care professionals. Lumley (1985), however, challenges the traditional perspective and asks "Whose satisfaction is in question?" (p. 141). She suggests that the satisfaction of the parents, not the health care professionals, should take precedence in any evaluation of the birth experience.

Conceptualization of Satisfaction

Mounting interest in psychosocial outcomes of childbirth has resulted in a flurry of research studies. The purpose of the majority of the studies has been to identify variables that contribute to childbirth satisfaction. This task, however, has been impeded by a major underlying problem - failure to clearly conceptualize patient satisfaction (Gutek, 1978; Linder-Pelz, 1982; Pascoe, 1983; Westbrook & Oliver, 1981). Researchers also use varied terminology when discussing satisfaction (Austin, 1986; Erb, Hill, & Houston, 1983; Norr, Block, Charles, Meyering, & Meyers, 1977) and indeed, investigators use various terms interchangeably within their own studies (Davenport-Slack & Boylan, 1974; Levy & McGee, 1975). Researchers in general have been intent on identifying sociodemographic correlates of satisfaction rather than clearly defining the underlying construct (Pascoe, 1983).

Other theorists (Hunt, 1976; Pascoe, 1983; Westbrook & Oliver, 1981), perceive satisfaction as an evaluation of an emotion, rather than an emotion per se. Hunt (1976) argues that to determine satisfaction requires divorcing oneself from the experience and then evaluating it. Without a priori 'stepping back' or distancing from the situation,

satisfaction would be identical to an affective response of pleasure or happiness created by the experience. From this perspective, satisfaction is not the enjoyment of the experience: rather it is an evaluation indicating that the experience matched the expectation (Hunt, 1976; Westbrook & Oliver, 1981).

While some theorists (Hunt, 1976; Linder-Pelz, 1982; Westbrook & Oliver, 1981) are preoccupied with defining satisfaction, others (Carlsmith & Aronson, 1963; Pascoe, 1983; Sherif & Hovland, 1961; Weaver & Brickman, 1974) have focused instead on the development of theoretical formulations of the relationship between satisfaction and other variables. Pascoe (1983) conceptualizes satisfaction as both a dependent variable and predictor of subsequent health related behaviours. He perceives knowledge of consumer satisfaction to be at the theory formation level.

Pascoe (1983) discusses two theories of patient satisfaction: discrepancy theories and fulfillment theories. Discrepancy theorists define satisfaction as the "difference between actual outcomes and some other ideal outcome" (Pascoe, 1983, p. 186). Prior expectations are seen as determinants of satisfaction and any deviations from the subjects perceived expectations are assumed to produce dissatisfaction. Pascoe (1983) points out, however, that deviations from expectations may lead to surprise rather than dissatisfaction. He maintains it is unlikely patients receiving more than they expected should be less satisfied than if they obtained what they anticipated. Fulfillment theorists, on the other hand view satisfaction as a function of the amount received from an event despite what one feels they should and/or want to receive. Fulfillment theorists are criticized for using outcome as the sole measurement of satisfaction, while neglecting to consider psychological standards involved in evaluating childbirth outcomes (Pascoe, 1983).

Three other patient satisfaction models are described in the consumer satisfaction literature: the contrast model (Weaver & Brickman, 1974), the assimilation model (Carlsmith & Aronson, 1963), and the assimilation-contrast model (Sherif & Hovland, 1961). The contrast model predicts satisfaction based on perceived discrepancy between an expectation and performance (Day, 1976; Weaver & Brickman, 1974). Anderson (1973) argues that consumers magnify the discrepancy between expectations and performance. Therefore, performances that are better than expected will be evaluated as satisfactory and those that are worse than expected as dissatisfactory.

In the assimilation model, satisfaction is reinforced when the consumer's perception of the outcome is adjusted so as to be more consistent with expectations (Carlsmith & Aronson, 1963; Day, 1976). Differences between expectations and performance result in psychological stress within subjects (Pascoe, 1983; Day, 1976). Subjects alleviate this stress by assimilating the difference between their perceptions of performance and expectations. Dissatisfaction is thus less likely since perceptions of performance will be adjusted to match expectations.

Expectation also is used as a standard to evaluate outcome in the assimilation-contrast model (Sherif & Hovland, 1961; Pascoe, 1983). Consumers are perceived to have latitudes of both acceptance and rejection, that is, if disparity between expectations and performance is small enough to fall into the consumer's latitude of acceptance, the difference will be assimilated to be more in line with the expectations than the performance justifies (Anderson, 1973). If the disparity between the consumer's expectations and perceived performance is beyond the latitude of acceptance, however, it falls into the zone of rejection. Contrast then prevails and the difference is magnified (Anderson, 1973; Day, 1976).

Research to date has provided little definitive support for any specific theory. Pascoe (1983) observes that despite worthy attempts to further theoretical knowledge of consumer satisfaction by developing models and theories, none of the above theories or models have strong empirical support. Lumley (1985) challenges knowledge of the satisfaction construct by asking "Is there such a thing as satisfaction?" (p. 141).

Operationalization of Satisfaction

The complexities encountered in the conceptualization of childbirth satisfaction also are reflected in its operationalization. While some researchers maintain that satisfaction must be clearly conceptualized prior to construct operationalization (Linder-Pelz, 1982; Westbrook & Oliver, 1981), many studies have proceeded directly to the measurement of childbirth satisfaction. Typically, the instruments used have been simple ad hoc measures, demonstrating neither reliability or validity (Westbrook & Oliver, 1981), the questionnaire being the most frequently used instrument. Alternative approaches within the questionnaire include: Likert scales (Littlefield & Adams, 1987; Lomas, Dore, Enkin, & Mitchell, 1987); the semantic differential technique (Humenick & Bugen, 1981; Levy & McGee, 1975); forced-choice questionnaires (Chute, 1985; Sullivan & Beeman, 1982); and open-ended questionnaires (Willmuth, 1975).

There are other methodological problems with the measurement of satisfaction. Use of forced-choice questions, for example, may have led to overestimation of satisfaction levels in many studies (Oakley, 1983; Shearer, 1983; Sullivan & Beeman, 1982). Subjects' eagerness to please caregivers may result in their giving answers they think investigators want to hear (Lumley, 1985). Many of the statements in childbirth satisfaction questionnaires lack relevance to laboring women (Lumley, 1985; Shearer,

1987). These limitations are evident in the Labor and Delivery Satisfaction Index (LADSI), one of the few tools designed to measure childbirth satisfaction. Lomas et al. (1987) developed the LADSI in an attempt to address the operational problems inherent in measuring satisfaction with childbirth and to assess the caring aspect of childbirth care. The LADSI consists of 38 items, each rating agreement or disagreement on a 6-point scale.

Shearer (1987) identifies four limitations to the statements in the LADSI that discourage subjects from expressing all their negative feelings about their childbirth experience. These limitations include: (1) failure of some statements to address postpartum women's own childbirth goals; (2) repetition of statements; (3) inclusion of items on which postpartum women are asked inappropriately to judge the quality of medical care; (4) and incorporation of overly narrow or broad statements. The latter limitation forces postpartum women into agreeing or disagreeing without having an opportunity to explain their answers. Shearer (1987) commends these investigators for making an important first step in measuring postpartum women's satisfaction with labour and delivery. Nevertheless, she argues that postpartum women's responses to the LADSI statements must be re-examined if this tool and its assumptions are to be used in measuring satisfaction with childbirth.

Fixed-scale questionnaire methods elicit fewer negative responses than do open-ended interviews (Lumley, 1985; Shearer, 1987). Such tools may prohibit postpartum women from fully sharing their responses to the childbirth experience (Shearer, 1987; Sullivan & Beeman, 1982). The forced-choice method cannot do justice to the range and complexity of the woman's feelings involved (Shearer, 1983). Researchers (Charles, Norr, Block, Meyering & Meyers, 1978; Kirke, 1980) have argued that the only reliable

way to determine how women feel about childbirth is for postpartum women themselves to evaluate the birth experience.

Chenitz and Swanson (1986) agree that nothing in the world - experiences, persons or objects - has inherent or intrinsic meaning in and of itself. Only through interaction with the experience and with self is the experience defined and meaning attached to it. "The meaning the experience has to the individual gives it a value" (Chenitz & Swanson, 1986, p. 5).

Several studies (Bennett, 1985; Erb et al., 1983; Oakley, 1983; Shaw, 1985) confirm that women express negative feelings of disappointment and frustration more openly several weeks or months after childbirth than they do at the time of birth. Immediate reactions to childbirth may be so intense that every other reaction is confounded until postpartum women have time to reflect on their childbirth experience (Bennett, 1985; Lumley, 1985). To fully internalize the meaning of childbirth satisfaction, and to assess whether their satisfaction and dissatisfaction with certain factors changed during the course of labour and delivery, postpartum women must be given time to distance themselves from the childbirth event.

Shaw's (1985) research raises further speculation about childbirth satisfaction. Shaw (1985) found that postpartum women had positive feelings regarding the birth experience while concurrently being negative about a transfer during labour from a birthing centre to a traditional labour unit and expressing disappointment at the childbirth outcome. Findings of this study suggest that postpartum women may be satisfied with some aspects of childbirth, while dissatisfied with others. This raises the question whether postpartum women also may be satisfied at one point in time during labour, yet, not at another. If so, can an overall measure of satisfaction with the birth

experience adequately represent the complexity of childbirth satisfaction?

To determine what childbirth satisfaction or dissatisfaction means, postpartum women themselves have to share their perspectives. In-depth interviews should be conducted to move beyond superficial responses regarding childbirth satisfaction (Gutek, 1978; Lumley, 1985). Interviewing permits women to clarify the entire range of childbirth feelings rather than agreeing or disagreeing with given statements.

In summary, the multiple complexities encountered in the conceptualization and the operationalization of childbirth satisfaction may account for the controversy over the nature and knowledge level of this construct. To determine postpartum women's perception of their satisfaction with childbirth will require methodological changes including an approach other than forced-choice questionnaires. A method is required that will permit postpartum women to give personal accounts of their childbirth experience. Childbearing women themselves must identify what is satisfying or dissatisfying about the birthing experience.

Purpose of the Study

The purpose of this study was to explore and describe childbearing women's satisfaction with the childbirth experience. The following questions guided the study. From the perspective of childbearing women:

1. What does it mean to be satisfied with the birth experience?
2. What factors in the birth experience contribute to childbirth satisfaction?
3. Does a childbearing woman's satisfaction with the birth experience change during the course of labour and delivery, and if so, how does it change?

Conceptual Framework

The conceptual framework for this study is based on Symbolic Interactionism. Symbolic Interactionism is a social theory about human behaviour that focuses on the meaning experiences have for individuals (Chenitz & Swanson, 1986). As an approach to studying human behaviour, Symbolic Interactionism focuses on how people define experiences and on how they act in relation to their perceptions. The meaning of the experience, therefore, is created by individuals and leads to actions and consequences of action (Chenitz & Swanson, 1986).

As a framework for analyzing human behaviour, Symbolic Interactionism is based on three premises: 1) individuals act toward things on the basis of the meaning these things have for them, 2) meanings of things in life are developed through social interactions with others, 3) and individuals handle and modify meanings through an interpretative process, that is, individuals point out meaningful things to themselves and transform these meanings in relation to the experience (Blumer, 1969).

A central tenet of Symbolic Interactionism theory is that psychological or inner aspects of human behaviour are based on the intricate interaction between specific events or experiences and their attached meanings (Chenitz & Swanson, 1986). Chenitz and Swanson (1986) argue that, through socialization, humans learn definitions and meanings of objects, events and people. The self-concept is central to Symbolic Interactionism. Therefore the meaning of events or experiences may vary from one individual to another. Blumer (1969) claims experience changes self and consequently behaviour. Through interaction, people and phenomena are subject to redefinition and meanings, that is, as a consequence of continual transactions between individual and societal values and expectations, both individuals and societies changes over time.

These conditions would apply, for example, to the study of the childbirth experience. Symbolic Interactionism, therefore, as the conceptual framework for this study, enabled the researcher to examine aspects of labour and delivery that created childbirth meaning and satisfaction for childbearing women.

Basic Assumptions

The study was based on the following assumptions:

1. Postpartum women can recall and verbalize their lived childbirth experience.
2. Postpartum women will give a truthful account of their birth experience to a nurse.
3. The researcher is able to comprehend the postpartum woman's perspective of the childbirth experience and analyze the data objectively.

Significance of the Study

The major significance of this study is its contribution to clarification of the patient satisfaction construct and our to understanding of the meaning of childbirth satisfaction. A review of the related literature pertaining to patient satisfaction (Fox & Storms, 1981; Locker & Dunt, 1978); job satisfaction (Lawler, 1971), and consumer satisfaction (Anderson, 1973; Day, 1976; Hunt, 1976; Westbrook & Oliver, 1981) indicated little consensus on conceptual or measurement issues. The goal of this study was to explore the various dimensions of patient satisfaction.

This study also has significance for health care recipients. The consumerism movement has precipitated an interest in measuring patient satisfaction and dissatisfaction (Day, 1976; Linder-Pelz, 1982). Although the past several decades have seen dramatic improvements in maternal and child mortality rates, health care

consumers contend that hospitalized care is dehumanizing and impersonal (Cirz, 1978; Sandelowski, 1984). Instead, women are demanding family centered perinatal care with active participation in childbirth, that is, they are asking to be allowed to "give birth" rather than to be "passively delivered" (Doering, Entwisle & Quinlan, 1980, pp. 12-13). Efforts to "humanize" childbirth are evident in the emerging alternative birthing practices (Nelson, 1983). Active participation in the birthing process has been positively associated with childbirth satisfaction (Davenport-Slack & Boylan, 1974). Satisfaction may, therefore, be the predictor of both future care and consumer use of the health care system.

In summary, before valid measures of 'satisfaction' can be developed and interpreted, or associations between variables made, clarification of the construct is required.

Organization of the Thesis

This thesis is organized into five chapters. Chapter one presents the current level of conceptualization and operationalization of the construct satisfaction, the purpose of the study, conceptual framework, assumptions and significance of the study. Chapter two provides a review of the current literature, focusing on various aspects of satisfaction with childbirth, including theoretical models of satisfaction. Chapter three includes a discussion of the methodology. In chapter four the findings of this investigation are presented. Chapter five presents a summary of the findings as well as the relevance of these findings in relation to the current literature. Implications of the findings for nursing practice, education, theory, and research recommendations provide the conclusions to this thesis.

Chapter Two

LITERATURE REVIEW

Childbirth is an intense physical and emotional experience (Astbury, 1980; Leifer, 1980). For some women childbirth is positive and satisfying (Doering et al., 1980; Humenick, 1981; Willmuth, Weaver & Borenstein, 1978); for others it is a negative and dissatisfying experience (Cranley, Hedahl & Pegg, 1983; Levy & McGee, 1975; Lunenfeld, Rosenthal, Larholt & Insler, 1984). How can childbirth pose such a dichotomy? Why do women experience childbirth so differently? What factors contribute to these differences? The review of the literature will focus on the conceptualization and operationalization of satisfaction with childbirth, and on the variables associated with satisfaction during the birth process.

In the literature review, various aspects of satisfaction with childbirth will be examined, including: theoretical models of satisfaction, terminology and definitions proposed by various authors, and the many variables contributing to satisfaction. Operationalization or measurement of satisfaction with childbirth also will be discussed.

Conceptualization of Satisfaction with Childbirth

Most patient satisfaction studies have been conducted without an explicit definition or conceptualization of satisfaction and without systematic consideration of its determinants and consequences (Gutek, 1978; Linder-Pelz, 1982; Pascoe, 1983). Pascoe (1983), in reviewing the literature, noted that researchers were more preoccupied

with identifying sociodemographic correlates of satisfaction than defining satisfaction. Westbrook and Oliver (1981), however, argue that before consideration is given to measuring the satisfaction construct, priority attention must be directed toward the conceptualization of satisfaction and its relatedness to other theoretical frameworks.

Gutek (1978) advocates "exploring the cognitive meaning of satisfaction for respondents" (p. 44). She identifies four approaches to use in studying client satisfaction and concludes that one question remains unanswered: "What does satisfaction really mean?" (Gutek, 1978, p. 53). Gutek (1978) suggests that contrast effects may increase consumers' reported levels of satisfaction. For example, a childbearing woman's childbirth experience may be positive in comparison to her initial expectation and consequently she reports being satisfied. Fox and Storms(1981) suggest placing emphasis on "understanding the central fact of satisfaction" (p. 559).

"People are satisfied" is a basic finding in most research studies investigating consumer satisfaction (Fox & Storms, 1981). For example, Woolley, Kane, Hughes and Wright (1978) found that 92 percent of the subjects in their study expressed satisfaction with their care, even though they failed to regain their usual functional status after an acute illness. An awareness of this finding is essential when investigating satisfaction with health care, because the idea that everyone is satisfied with care, can "block understanding of satisfaction with health care" (Fox & Storms, 1981, p. 559). These investigators also argue that being "Faced with a dependent variable with little variance (everybody's happy), researchers may focus on dimensions of satisfaction rather than explain the central fact of satisfaction" (Fox & Storms, 1981, p. 559).

The Linder-Pelz Model is viewed (Pascoe, 1983) as a major exception to the lack of psychological theory-building in patient satisfaction research. Linder-Pelz (1982)

characterizes patient satisfaction as a positive attitude, where attitudes are affective or evaluative. She differentiates between the affective and cognitive, claiming perceptions are cognitive in nature. Implicit as well in Linder-Pelz's (1982) definition of satisfaction is the recognition that satisfaction data, like any social psychological data, are limited by their subjective nature. Additionally, satisfaction is always relative, changing as standards of comparisons or expectations change, even though the object of evaluation remains constant (Pascoe, 1983).

The Linder-Pelz model has methodological and conceptual problems, the more fundamental problem being at the conceptual level (Pascoe, 1983). First, satisfaction is conceptualized as an expectancy-value attitude. In other words, satisfaction is likely to include a range of prior expectations, health care values, and a sense of entitlement to care. Pascoe (1983) argues that consumer satisfaction with health-care services is more likely to be influenced by immediate experiences than values and expectations.

A second conceptual problem is the assumption of a multiplicative relationship between determinants of satisfaction (Pascoe, 1983). Linder-Pelz (1982) maintains that "an attitude such as patient satisfaction is based on...belief strength and attribute evaluation" (p. 578). In other words, an attitude toward an object is related to one's belief that an object possesses certain attributes and how one evaluates those attributes. A multiplicative relationship is established by multiplying both the number of attributes an object possesses, evaluating these attributes, and summing their products (Linder-Pelz, 1982). Therefore the greater the number of attributes and the more favorable the evaluation, the more satisfying the experience.

Evaluation is a comparison of salient characteristics of the consumer's health care experience to a given subjective standard (Pascoe, 1983). Assumptions regarding

the comparison process include two interrelated psychological activities: a cognitively based evaluation of, and an affective or emotional response to, the structure, process and service outcome (Pascoe, 1983). Pascoe (1983) argues that instead of being dependent upon one another, perceptions and attitudes may represent independent predictors of satisfaction and be classified according to individual consumer differences.

Two alternatives to value-expectancy models of satisfaction are discrepancy and fulfillment theories (Pascoe, 1983). Fulfillment theorists define satisfaction as the difference between desired and received outcomes (Linder-Pelz, 1982; Pascoe, 1983). These theorists take into account the mere "difference between what occurs and what should be and was expected ... [or] was desired" (Linder-Pelz, 1982, p. 579). Such an approach assumes satisfaction is determined exclusively by objective outcomes, and neglects consideration of psychological standards such as expectations, desires, wants, or perceptions (Pascoe, 1983).

Discrepancy theorists define satisfaction as the variance between what a subject desires and what occurs (Linder-Pelz, 1982; Pascoe, 1983). Implicitly, the discrepancy approach has been most commonly used in patient satisfaction studies (Pascoe, 1983). Discrepancy theorists' perceptions, however, differ in relation to which occurrences are compared, that is, they may focus on either what is desired, expected, important, or should be, that is, what one is entitled to (Linder-Pelz, 1982). Linder-Pelz (1982) argues that discrepancy formulae are more useful than fulfillment formulae, because discrepancy theorists initially take into consideration the amounts desired, expected or valued. Discrepancy approaches compare outcomes to some psychological standard, and they assume deviations from the expected result in dissatisfaction (Pascoe, 1983). Pascoe (1983) contends deviations from the expected may lead to surprise, but not

inevitably to dissatisfaction. It is doubtful that subjects would be less satisfied if more was received than was anticipated.

Consumer satisfaction researchers have investigated various types of expectations and their roles in determining satisfaction. Miller (1977) argues that to state that satisfaction depends on one's expectations, requires that types of expectations be specified. This investigator described four different expectation types: ideal, minimum, expected, and deserved. Consumers use one of the four types as a subjective standard to assess a product or service. The ideal expectation represents a maximum, whereas the minimum is the least acceptable level. The expected type is based on past averaged experience, and the deserved expectation is based on the consumer's subjective sense of what should be the accepted level (Miller, 1977). Therefore, to measure satisfaction, it is essential to establish which type of expectation is held by the consumer (Pascoe, 1983). Patients have increasingly become viewed as consumers of satisfaction, yet investigators of patient satisfaction have not attended to the conceptual and methodological strategies of marketing-based models of consumer satisfaction (Friedman & DiMatteo, 1979; Reeder, 1972).

Pascoe (1983) conceptualized patient satisfaction at two levels: 1) as a consumer reaction to specific aspects of an experience, and 2) both as a dependent variable and predictor of health-related behaviours. Consumer and patient satisfaction research findings evidence a dyadic conceptualization of patient satisfaction. At the first level of conceptualization, patient satisfaction is defined as a consumer's reaction to specific aspects of an experience, such as context, process, and outcome. In other words, patient satisfaction is an evaluation of the services received. Expectations serve as a standard for assessing a commodity or service. Therefore, patient satisfaction is characterized as

an evaluation comparing directly received service to a given subjective standard (Pascoe, 1983).

At the next level, satisfaction is conceptualized as both a dependent variable and a predictor of subsequent health-related behaviour (Pascoe, 1983). Satisfaction is therefore a dependent measure of structure, process and service outcome when the degree of satisfaction is viewed as a continuum, that is, from either totally satisfied to totally dissatisfied. As a predictor of ensuing health-related behaviour, the degree of satisfaction is perceived as contributing to resultant patient commitment to and compliance with recommended treatment. These activities may modify the consumer's subjective standard(s) and experience over time, and result in changed health related behaviour. Pascoe (1983) also argues that satisfaction is a dynamic process involving the psychological activities of assimilation and contrast. A wide latitude of acceptance would lead to assimilation of the experience and consequently to a sense of satisfaction. Conversely, experiences more positive or negative than the subjective standard would produce a contrast effect and likely dissatisfaction (Pascoe, 1983).

Pascoe (1983) perceived knowledge of patient and consumer satisfaction to be at the theory formation level. More recently, however, Lumley (1985) challenged the basic satisfaction construct by asking, "Is there such a thing as satisfaction?" (p. 144). She questions whether at some point during labour and delivery women may perceive certain aspects of the experience unsatisfactory, while concurrently perceiving other aspects as satisfactory (Lumley, 1985).

To compound the issue of conceptualizing the satisfaction construct, not only is there the difficulty of dealing with the discrepancy of whether satisfaction is at the construct or theoretical formation level, but there are also incongruencies in its

definition. Hunt (1976) argues that satisfaction is not an emotion, but an evaluation of an emotion. He claims that to determine satisfaction one has to step away from the experience and then evaluate it. Without stepping away, one would be referring directly to an emotion such as, happiness, pleasure, or to a warm feeling evoked by the situation or object. Thus, satisfaction is not the pleasureableness of an experience, rather it is an evaluation of the experience against a given subjective standard. Therefore any discussion of satisfaction or dissatisfaction has an implied "compared to what" (Hunt, 1976, p. 460) attached to it. Investigators thus are obligated to give implicit attention to perceived alternatives.

Conversely, Linder-Pelz (1982) perceives satisfaction as an affective response. Westbrook and Oliver (1981) view consumer satisfaction as an evaluative response to either subjective standards, ideally desired outcomes, or outcomes barely deemed acceptable. They argue that affect is central to the satisfaction construct. Therefore, as a result of their outcome evaluations subjects may experience varying degrees of emotion or feeling such as: happy or pleasant feelings with favorable outcomes; or regret, unhappiness or irritation with unfavorable outcomes. Regardless of the evaluative standard used, the more favorable the perceived outcome, the greater the satisfaction (Westbrook & Oliver, 1981).

Additional conceptualization difficulties arise from the diverse terminology researchers use to describe satisfaction with childbirth. Alternative terminology used includes: positive birthing experience (Austin, 1986); satisfying birth experience (Erb et al., 1983); enjoyment of birth (Norr et al., 1977); positive and rewarding childbirth experience (Davenport-Slack & Boylan, 1974); favorable childbirth (Levy & McGee, 1975); and positive outcome (Clark, 1975). Not only are researchers diverse in their

choice of terminology, they may in fact use the different words interchangeably within their own studies (Davenport-Slack & Boylan, 1974; Erb et al., 1983; Levy & McGee, 1975).

In summary, inconsistencies in defining satisfaction, use of diverse terminology, and controversy over the level of conceptualization of satisfaction, all add to the complexity of trying to understand what postpartum women perceive as satisfaction or dissatisfaction with childbirth. The complexities encountered in the conceptualization of satisfaction, in all probability, result in inherent difficulties with the operationalization of measuring satisfaction.

Operationalization of Satisfaction with Childbirth

Measurement of satisfaction has been problematic. There is little agreement regarding the most appropriate method of measuring consumer satisfaction (Pascoe, 1983; Westbrook & Oliver, 1981). Typically studies have measured consumer satisfaction by means of a few broad questions about satisfaction or by using unstandardized single item subscales that elicited responses to only a few dimensions of health care (Linn & Linn, 1975; Stamps & Finkelstein, 1981).

Typically, instruments have been simple, ad hoc measures, demonstrating neither reliability nor validity (Westbrook & Oliver, 1981). Without evidence of reliability and validity, interpretation and synthesis of research are hindered and likely to result in imprecise assessment of the levels of satisfaction.

Linder-Pelz (1982) argues that "to identify determinants and consequences of satisfaction, associations between the variables should be sought not only on an ad hoc

basis but also on the basis of a priori hypotheses derived from previous theoretical and empirical studies" (p. 577). This appears a difficult order considering the present level of conceptualization of childbirth satisfaction.

Sullivan and Beeman (1982) also identified methodological problems inherent in measuring satisfaction with maternal care. They found that postpartum women were reluctant to criticize their caregivers. Additionally, women were found to be even less critical of their maternity care if they had given birth to a healthy baby (Sullivan & Beeman, 1982). In other words, a healthy infant tends to cloud negative experiences and create a favorable environment for subsequent care evaluations. Lumley (1985) argues that the most unreliable data is generated when researchers are also the caregivers. Possible reasons why postpartum women might provide unreliable data are: to report dissatisfaction with the childbirth experience would mean making explicit personal criticisms (Lumley, 1985); mothers may give socially desirable replies because they aim to please (Lumley, 1985; Shearer, 1987); and some women may guess the presuppositions and strive to have them confirmed (Lumley, 1985). Therefore it is unlikely that hospitalized postpartum women will report dissatisfaction while receiving nursing service.

Another methodological problem identified was that women base their perceptions of satisfaction with care on measures such as: caregiver conduct - including emotional support, technological competence, and communication (Butani & Hodnett, 1980; Sullivan & Beeman, 1982). Studies show these dimensions are highly correlated and that rapport with the caregiver largely influences how postpartum women perceive technical competence (DiMatteo & Hays, 1980). Further, satisfaction with childbirth was found to be greatly enhanced when the quality of communication improved through

explanation of procedures and fulfillment of labouring women's preferences and wishes. Lack of communication was perceived as a likely reason why parturients did not actively participate in decision making during childbirth, nor maintain control during labour and delivery (Kintz, 1987; Mercer, 1985; Sullivan & Beeman, 1982). Hence, they experienced dissatisfaction with childbirth.

Based on these findings, Sullivan and Beeman (1982) hypothesized "that the better the rapport and the greater the fulfillment of choice, the higher will be the level of satisfaction [with childbirth]" (p. 322). To test the hypothesis, Sullivan and Beeman (1982) studied 1900 postpartum women. The purpose of the study was to determine, on a statewide survey, women's level of satisfaction with maternity care in relation to: 1) communication patterns between caregivers and postpartum women, and 2) specific clinical procedures used during labour and delivery, and 3) whether or not women had wanted these procedures (Sullivan & Beeman, 1982). The clinical procedures examined, included: presence of a childbirth coach; encouragement to use breathing and relaxation; freedom to move around; use of a fetal monitor; presence of a family member; choice of atmosphere; use of medication to assist the women in labour; and medication to put the woman out for delivery (Sullivan & Beeman, 1982).

Three communication measures were used to study the relationship between the quality of communication and the overall levels of satisfaction: 1) enough time was spent discussing problems, 2) staff used words the woman could understand, 3) staff tried to understand how the woman (subject) felt. Each of the three measures had a statistically significant relationship with women's satisfaction with both their prenatal and labour and delivery care (Sullivan & Beeman, 1982).

The strongest associations were found between subjects perception of the time

caregivers spent discussing their problems and being sensitive to their needs, and the level of expressed satisfaction with care (Sullivan & Beeman, 1982). In other words, the stronger these associations, the greater the level of satisfaction. The extent to which preferences were or were not honored influenced the level of satisfaction. Of all the labour and delivery preferences stated by women "those surrounding uses of medication seem most salient for level of satisfaction" (Sullivan & Beeman, 1982, p. 329). When preferences were not honored, the reported level of satisfaction declined significantly (Sullivan & Beeman, 1982). Other research supports these findings (Doering & Entwisle, 1975; Marut, 1978, Willmuth, 1975).

A final methodological problem implicit in measuring women's satisfaction with their perinatal care, is that women do not realize that there are alternate choices of care (Sullivan & Beeman, 1982). Conversely, most women expect caregivers to advise them as to the care they will have during childbirth. In an ethnographic study, Danziger (1979) found that nurses and physicians frequently offered arbitrary, uniform, as well as inappropriate responses to birthing women, rather than providing them with information about the options available to them. Danziger's (1979) findings suggest that maternity care must be redesigned so that alternative choices of care are presented objectively. To measure postpartum women's satisfaction with maternity care, subjects' must probe their childbirth experience when telling investigators about their experience.

To meet the need for a more detailed assessment of child- birth satisfaction, Lomas et al. (1987) developed the Labor and Delivery Satisfaction Index (LADSI). The authors' intent in designing the LADSI was to measure postpartum women's satisfaction with childbirth. Shearer (1987), however, views the LADSI as having four major inadequacies. First, the statements do not all relate to women's goals and objectives -

without which their satisfaction cannot be measured. Secondly, items are redundant and are likely to elicit "mechanically repetitive answers" (p. 130). Third, the statements do not all relate to satisfaction, but instead ask women to assess the quality of medical care. This deficiency may result in low internal consistency. The final limitation of the LADSI is that it contains statements that are "overly narrow or broad, so that parents are forced into simplistic agreement or disagreement. They cannot single out a sub-area within the statement" (Shearer, 1987, p. 130).

Shearer (1987) argues that the combined effect of the four inadequacies elicited mainly positive responses, rather than encouraging postpartum women to express negative feelings about their childbirth experience. Shearer (1987) also observed that the LADSI may have elicited mainly positive responses because caregivers administered the instrument.

A decision investigators continually face is whether to use forced-choice, quantifiable questionnaires or open-ended, qualitative interviews. Both approaches have been used to determine which variables contribute to satisfaction with childbirth. Despite the fact that forced-choice questionnaires and Likert scales elicit fewer negative responses than open-ended interviews (Shearer, 1987), researchers have widely utilized the more structured instruments (Hodnett, 1982; Humenick & Bugen, 1981; Kieffer, 1980; Mercer, 1985; Willmuth et al., 1978). Only a few investigators have used open-ended interviews (Lipson & Tilden, 1980; Stolte, 1987).

The inadequacy of a forced-choice questionnaire was apparent in Sullivan and Beeman's (1982) study of consumer satisfaction. A 60 - statement forced-choice questionnaire was administered to 1900 postpartum women. Only nine percent reported any dissatisfaction, while 91 percent reported satisfaction. Of special interest and

significance were 500 unsolicited consumer comments made on the questionnaire. These comments included both very positive endorsements and highly negative remarks. Yet, many women, despite highly negative comments, rated their overall evaluation of labour and delivery care as satisfactory. These findings strongly suggests that to elicit childbirth responses from the perspective of postpartum women, an approach other than forced-choice questionnaires must be used (Sullivan & Beeman, 1982).

Other research pointed out the inadequacies noted in Sullivan and Beeman's (1982) study (Charles et al., 1978; Gutek, 1978). Gutek (1978) argues that if we are truly interested in more than superficial answers to questions about satisfaction, we will have to do in-depth interviews. Charles et al. (1978) claim that a woman's subjective evaluation of an event is the only reliable way to determine how women feel about an experience. These authors maintain that an objective evaluation by an observer cannot accurately represent another's lived experience.

Kirke's (1980) study of postpartum women's perception of their obstetrical care supports this argument. Two hundred and ten postpartum women and 22 physicians who worked in obstetrical units were interviewed using structured questionnaires. The questionnaire administered to physicians was designed to obtain information about attitudes to physician-patient communication. The data revealed discrepancies between women's and physicians' reports regarding their communication during labour and delivery. Seventy - seven percent of physicians felt they had explained forth coming procedures well. Only 25 percent of the women, however, reported receiving explanations (Kirke, 1980). These varied findings explicitly demonstrate the incongruities that may result when two different groups of individuals evaluate the same event. Therefore, to determine what for women is satisfying about their childbirth

experience, data must come from postpartum women themselves.

Kirke (1980) further argues that lack of communication between health care consumers and caregivers is the basic cause for dissatisfaction with medical care. The investigator also contends that health care professionals must recognize communication as integral to satisfaction with childbirth (Kirke, 1980). Only through communication - verbal and/or non-verbal - can caregivers know what women want and expect. It is imperative then, that postpartum women communicate to caregivers what they perceive as necessary elements for satisfaction with the childbirth experience (Kirke, 1980).

Variables Contributing to Satisfaction with Childbirth

A number of studies have examined associations between variable(s) and their contribution to satisfaction with the childbirth experience. Several studies have focused explicitly on satisfaction with childbirth. Three studies examined the relationship between childbirth satisfaction and a Mastery Model of Satisfaction that included: active participation, self-reliance, self-control, independence, and internal locus of control (Humenick & Bugen, 1981; Littlefield & Adams, 1987; Willmuth et al., 1978). A fourth study investigated the level of satisfaction with maternity care during labour and delivery and whether satisfaction was linked to consumer and caregiver communication patterns (Sullivan & Beeman, 1982). A fifth study examined postpartum women's perception of, and satisfaction with, their labour and delivery nursing care (Shields, 1978).

All three studies classified under the Mastery Model examined the relationship of childbirth preparation classes and locus of control to childbirth satisfaction.

Humenick and Bugen (1981), utilizing the "Mastery Model", studied 37 primigravid women who had attended Lamaze childbirth preparation classes. Two questionnaires were administered to the women after they had completed a series of classes. The first questionnaire, the Childbirth Participation Scale, included ten statements related to the woman's perception of the extent to which she could control her childbirth. The second, a Personal Attributes Questionnaire (PAQ) measured both instrumentality (self-assertion, self-protection, self-expansion) and expressiveness (a concern for merging with the needs of others).

Three weeks after childbirth, the latter questionnaire was readministered during a postnatal home visit. During the same visit, women also completed a Childbirth Experience Ratings instrument - consisting of three separate scales (Humenick & Bugen, 1981): (1) the Labor and Delivery Evaluation Scale, a ten item semantic differential scale rating postpartum women's recent labour and delivery experience, (2) the Labor Agency Scale (LAS), and (3) the Delivery Agency Scale (LDS). The LAS and LDS, adapted from Oliver's (1972) questionnaires, measured postpartum women's perception of control during labour and delivery.

Childbirth Participation Scale scores correlated with the Labor and Delivery Evaluation Scale and the LDS, but not with the LAS. The findings partially support the hypothesis that a prenatal woman's attitude significantly predicts the evaluation of her labour and delivery experience (Humenick & Bugen, 1981). This finding was not supported by a study conducted by Levy and McGee (1975), who found that "anticipation of labour and delivery...was not related to the woman's evaluation of her actual delivery experience" (p. 171).

Littlefield and Adams (1987), in a second "Mastery Model" study, examined

women's participation, satisfaction, and change in health locus of control after delivering in an alternative birthing room. Investigators point out that, prior to this study, over 1000 studies and reviews of literature had examined the construct of locus of control in health behaviours. The dominant theme in earlier research was that maintaining control or mastery was closely associated with satisfaction (Littlefield & Adams, 1987; O'Connell, 1983; Willmuth, 1975; Willmuth et al., 1978).

Littlefield and Adams (1987) chose a quasi-experimental two-group design, using a convenience sample of 99 postpartum women. Two instruments were administered to both groups: (1) 21 women who chose alternative perinatal care, and (2) 78 women who chose conventional care. The first instrument, the Multidimensional Health Locus of Control Scale (MHLC), was an 18-item, six-point Likert Scale with Form A for prenatal women and Form B for postnatal women. Women completed Form A at 30-32 weeks gestation and Form B two to three days postnatally. The MHLC measured internal, powerful others and chance scores both pre- and postnatally, and was employed to determine alternative or conventional birth score changes.

The second instrument, The Patient Participation and Satisfaction Questionnaire (PPSQ), a five-point, Likert type scale, was given to postpartum women two to three days postnatally (Littlefield & Adams, 1987). The PPSQ was administered to collect demographic data and information on subjects' satisfaction with their prenatal caregiver; their intrapartum and postpartum nursing care; their childbirth preparation class instructor; and the degree to which they felt their preferences regarding care were honoured. Other information about satisfaction obtained by using this tool included: data on satisfaction with the birthing room environment; safety; delivery performance compared to subjects' expectations of childbirth; postpartum experience and the overall

satisfaction with their birth experience (Littlefield & Adams, 1987).

Statistically, parents who delivered in the alternative birthing room were older and more likely to be multiparas (Littlefield & Adams, 1987). Women in both groups scored high on internal health locus of control, yet, scored low on the powerful other scale. Women in the conventional group relied more on health care providers and health care institutions than the alternative group. Differences between groups in age, parity, and powerful other scores may have influenced alternative and conventional group comparisons for the outcome of the study. Pearson correlational analyses, however, indicated these variables were not related to the outcome variables of satisfaction or participation in care.

Littlefield and Adams (1987) used three subscales to examine women's satisfaction with perinatal care. First, satisfaction with direct care represented how the antepartal caregiver and in-patient nursing care were evaluated. Next, total satisfaction scores included women's evaluation of direct care plus satisfaction with hospital experiences, prenatal classes, hospital environment and safety. Third, comprehensive satisfaction included both satisfaction with direct care and total satisfaction, plus, satisfaction with the degree of perceived participation in care (Littlefield & Adams, 1987). Women in both groups reported being very satisfied with labour and delivery and postnatal nursing care. Mean scores were within less than five points of the top score on the nursing care Labour and Delivery Satisfaction Scale (possible range being 18-90). A low significant negative relationship was found, however, between labour and delivery and total satisfaction, yet, was not found between direct care or comprehensive satisfaction (Littlefield & Adams, 1987).

Women who delivered in the alternative group experienced a greater sense of

satisfaction than those in the conventional care group, especially when the experience matched their expectation. These findings support the hypothesis that alternative approaches to perinatal care are related to increased satisfaction (Littlefield & Adams, 1987).

Littlefield and Adams (1987) also examined the impact complications might have on childbirth satisfaction. A low significant relationship ($p < .05$) was found between labour and delivery complications and total satisfaction for the entire sample. No association was found between complications and satisfaction with direct care or comprehensive satisfaction. In other words, when there were childbirth complications "they [complications] decreased aspects of women's satisfaction, but not the degree of participation or their perception of the quality of direct care" (Littlefield & Adams, 1987, p. 145). In other studies, labouring women's active participation was found to be the underlying factor associated with a satisfying childbirth experience (Davenport-Slack & Boylan, 1974; Chute, 1985).

A significant positive relationship was found for antepartal women in the conventional group, that is, the more antepartal complications, the greater the women's satisfaction. These investigators view the increased satisfaction of the conventional group as related to increased visits to the office and to physicians spending more time with the antepartum women (Littlefield & Adams, 1987). While most interesting, this finding is contrary to what one would expect to find among prenatal women in the Western world. That is, increased time with their own physician also would contribute to women's satisfaction, however, complications would not be the reason they would choose for increased visits to the Office, nor increased time spent with their physician. Contemporary women want a healthy infant, as well as an uncomplicated pregnancy.

Additionally, findings showed that an alternative birth experience generally increased postpartum women's sense of participation, and therefore was associated with childbirth satisfaction (Littlefield & Adams, 1987). Conversely, the alternative birth experience did not change women's internal scores on the Multidimensional Health Locus of Control Scales. In this study, women's reliance on powerful others increased post delivery, but was not related to satisfaction with childbirth (Littlefield & Adams, 1987).

In 1975, Willmuth conducted a content analysis of questionnaires that had been completed by childbirth prepared women during the postpartum period. Control or a sense of being in control was an important correlate of satisfaction. This finding is strongly supported by other research (Humenick, 1981; Littlefield & Adams, 1987). Willmuth (1975) also found that some women reported high satisfaction with their labour and delivery experiences.

Cognizant of these earlier findings, Willmuth et al. (1978), in a "Mastery Model" study, examined the probability of a positive association between satisfaction with the experience of prepared childbirth and the sense of personal control (internal locus of control). These investigators speculated that childbirth preparation classes might be predictive of childbirth evaluative differences such as high satisfaction or unpleasant dysphoric experiences (Willmuth et al., 1978).

Willmuth et al. (1978) used the Rotter Scale to measure women's expectancy of locus of control. The Rotter Scale was administered to 118 women at their first childbirth preparation class. The Rotter Scale and a postpartum questionnaire (PPQ) also were administered to 98 women while still hospitalized. Subjects were asked to rate their satisfaction with the childbirth experience on a four-point scale (very satisfied -

very dissatisfied) by evaluating physician care and nursing care, and the overall experience. The hypothesis that satisfaction with prepared childbirth is related to the woman's locus of control was supported. For non-class attenders however, no association was found between locus of control and satisfaction (Willmuth et al., 1978).

Willmuth et al. (1978) contend there is the possibility, depending upon women's locus of control, that preparation classes may directly affect how postpartum women perceive childbirth satisfaction. In other words, satisfaction of "internal" women may be enhanced by preparation classes - whereas for "external" women classes may lower satisfaction. Rationale for this conclusion is that preparation classes stress being an informed participant during labour and delivery. For internally oriented subjects this attitude is congruent with their personal values. Conversely, for externally oriented individuals this position is incongruent with their value system, because they do not value being in control, but expect to be advised (Willmuth et al., 1978).

The above findings support the contention that childbirth preparation classes and control contribute to childbirth satisfaction. Other studies indicate that postpartum women perceive control to be the key factor associated with a positive and satisfying childbirth experience (Chute, 1985; Doering et al., 1980; Humenick, 1981; Humenick & Bugen, 1981; Mercer, 1985; Marut & Mercer, 1979; Willmuth, 1975). Although satisfaction with prepared childbirth appears to be related to the individual's locus of control, Willmuth et al. (1978), argue that is only one factor, and as an isolated variable, locus of control cannot be used to predict the outcome of childbirth satisfaction. Other investigators also contend that maintenance of control seems to depend upon multiple factors (Butani & Hodnett, 1980; Doering et al., 1980).

The remaining two studies that measure satisfaction with childbirth both focus

on postnatal women's perceptions of satisfaction with care during childbirth (Shields, 1978; Sullivan & Beeman, 1982). Sullivan and Beeman (1982) administered a 60 question consumer satisfaction questionnaire to 1900 postnatal women to examine the association between communication, choice of specific labour and delivery procedures, and satisfaction with maternity care. Three measures were used to examine prenatal caregiver communication: 1) staff spent enough time discussing problems, 2) staff used words the women could understand, and 3) staff tried to understand how the woman felt. Each of the three communication measures had a statistically significant relationship with satisfaction. The strongest associations were with caregiver empathy and time spent discussing postpartum women's problems. Conversely, if caregivers showed less empathy and spent less time discussing problems, postpartum women reported lower levels of satisfaction. These findings were supported by later research (Bennett, Hewson, Booker & Holliday, 1985; Norr et al., 1987).

Satisfaction also declined significantly when preferences were not honored (Sullivan & Beeman, 1982). The most reiterative and popular theme in the media is that women desire a more personalized childbirth experience. In other words, women want their preferences honored or fulfilled during the birthing process. This desire also is described in terms of better rapport with caregivers, more flexibility in procedures, and greater influence and participation in decision making. These aspects of the experience allow women increased control over their labour and delivery and facilitate a higher level of childbirth satisfaction.

A final study examined postpartum women's perception of, and satisfaction with, labour and delivery nursing care (Shields, 1978). Shields' (1978) study was the only research identified that utilized an interview-questionnaire to examine the subjective

needs of women in labour. Through interviews, 80 postnatal women described their nursing care during labour and delivery. On a five point scale (very satisfied - not satisfied), subjects rated their satisfaction with labour and delivery nursing care. Chi square analyses were used to identify seven categories of nursing care: physical care only, supportive care only, medications only, and various combinations of the three.

A significant correlation was found between the type of nursing care described and subjects' satisfaction scores ($p > 0.025$). Postnatal women perceived supportive care as more satisfying than exclusively physical care. Subjects' most satisfying nursing care however, was a combination of supportive and physical care. Interestingly, only 27 of the 80 women in the study reported receiving combined physical and supportive care - just marginally more than the 25 that reported receiving physical care only. Labouring women were very satisfied with combined care. Supportive care, however, was the decisive factor in the way postnatal women perceived their nurses and nursing care (Shields, 1978).

The element in supportive care that postpartum women referred to most frequently was the nurse's ability to be a sustaining presence, that is, to recognize and respond to the patient's need for her presence (Shields, 1987). Other studies produced similar results (Kintz, 1987; Roberts, 1983). Conversely, in the Shields' (1978) study, nurses' insensitivity to either physical or supportive care resulted in decreased patient satisfaction with nursing care. Nurses non-supportive behaviour, for example, those who were "nasty", "short", or "bossy", was particularly reflected in lower satisfaction scores.

The significance of these findings to labour and delivery staff is two - fold. First, combined physical and supportive care during the birthing process seems to be most contributory to childbirth satisfaction. Second, the element within supportive care

most influential in contributing to childbirth satisfaction is nurses' sensitivity to the needs of labouring women (Shields, 1978).

Conclusion

Care of the laboring woman involves an intricate plan of care delivered in an environment laden with the tension of potential crisis. Compared to the experience of pregnancy with its many subtle and gradual physiological and psychological changes, labour and delivery is rapid and abrupt (O'Connell, 1983). Childbirth is the universal process that terminates pregnancy. Postnatal women, however, may view different aspects of the experience as contributing to their satisfaction with childbirth.

Until recently, health care given to women during labour and delivery was basically directed toward safety for both mother and baby. The technological approach used to ensure a safer childbirth, fostered a sense of maternal powerlessness (Willmuth et al., 1978). More recently, women have demanded less technology, more active participation and greater control in their childbirth experience.

Willmuth et al.'s (1978) study suggests that to enhance women's satisfaction with childbirth, caregivers must pay more attention to prenatal women's childbirth expectations and preferences. Additionally, studies have shown that only after women's expectations and preferences are assessed and communicated, can caregivers provide the support necessary to foster childbirth satisfaction. Further research is needed to learn, from women themselves, which variables contribute to childbirth satisfaction. Only postpartum women's subjective childbirth perceptions can accurately represent their experience (Charles et al., 1978; Kirke, 1980).

From the review of the literature, two major complexities were identified: 1) conceptualization of the satisfaction construct, and 2) operationalization of childbirth satisfaction. Several studies examined mastery or locus of control as a factor likely to influence childbirth satisfaction. In other research, postpartum women's perception of, and satisfaction with, labour and delivery nursing care were investigated. In the latter studies, two factors were examined: 1) postnatal women's level of satisfaction with labour and delivery nursing care, and 2) whether women's childbirth satisfaction was linked to consumer and caregivers communication patterns. No studies that addressed women's definitions of childbirth satisfaction were identified. The purpose of this study was to examine the meaning of satisfaction with the childbirth experience from the postpartum woman's perspective.

Chapter Three

RESEARCH METHODOLOGY AND PROCEDURES

The purpose of this study was to explore and describe the meaning of satisfaction in childbirth from the childbearing woman's perspective. In this chapter, the research design, the procedures used in data analysis, study participants, the instruments used in data collection and ethical considerations are described.

Research Design

Wilson (1985) argues that qualitative research methods and designs must be used when: 1) an investigation raises questions about people's experiences under natural conditions, 2) an investigator is dealing with a study question about which very little is known, or 3) the intent of the study is to gain insight about a particular group of people. The purpose of qualitative research designs is to generate and describe new observations where little or no prior information exists (Seaman, 1987; Wilson, 1985). Qualitative research methods aspire to capture what other people and their lives are about, without preconceiving the categories into which information will fit (Wilson, 1985).

Little is known about satisfaction in childbirth. The intent of this study, therefore, was to gain insight into how postpartum women perceive childbirth satisfaction. To understand others, the qualitative analyst or researcher tries to discern how other people feel, think, act and behave. Wilson (1985) argues that to know about

people is not enough; rather, face to face knowing is essential to understanding another's world to the fullest.

Descriptive and explorative designs include both comparative designs that compare and contrast cases and classification designs that put observations and descriptions into categories (Seaman, 1987). In this study, the qualitative techniques of exploration and description were utilized to collect and present rich and diverse accounts of nine postpartum women.

Qualitative research generates an abundance of data. This is one of the most prominent disadvantages of qualitative data analysis (Polit & Hungler, 1989; Treece & Treece, 1986, Woods & Catanzaro, 1988). A systematic, objective procedure is required to analyze such massive amounts of material. Content analysis, a procedure for analyzing unstructured qualitative data was used in this study (Wilson. 1985).

Content Analysis

Definition

Content analysis is a method of both qualitative data collection and data analysis (Holsti, 1969; Seaman, 1987; Treece & Treece, 1986). Other researchers define content analysis as a method of handling narrative, qualitative data (Polit & Hungler, 1989; Wilson, 1985) or as a process by which data is scanned for themes and categories that describe the essential meanings (Kovacs, 1985; Robert & Burke, 1989). Polit and Hungler (1989) contend that "the most useful unit for nurse researchers are themes, which embody ideas or concepts, and items, which refer to the entire message" (p. 325).

Purpose of Content Analysis

"Coding is the process whereby new data are systematically transformed and aggregated into units which permit precise description of relevant content characteristics" (Holsti, 1969, p. 94). Treece and Treece (1986) also state that "content analysis is used to make a descriptive statement concerning an attitude, a word or concept frequency...[or] a social condition..." (p. 349). Seaman (1987) however, views the purpose of content analysis to be that of analyzing semantic content or establishing "the meaning or intent of the content" (p. 334). In this study, the researcher used all three approaches to delineate categories that would represent a precise description of the content characteristics of the material that was analyzed. To determine the categories, the researcher had to decide what should be coded and how it should be coded. In other words, "the meaning and intent of the content is a judgment made by the researcher" (Seaman, 1987, p. 334).

Types of Content Analysis

The qualitative research process can utilize one of two types of content analysis: latent content analysis and/or manifest content analysis. The latter type has numerical objectivity, that is, responses are simply coded and counted, hence it also has procedural reliability. This approach, however, is likely to lack validity because the richness and content of the data are not considered (Treece & Treece, 1986; Wilson, 1985; Woods & Catanzaro, 1988). In this study little emphasis was given to numerical objectivity, although in a few incidents the number of responses with regard to satisfaction and/or dissatisfaction in childbirth were counted and coded.

Latent content analysis was utilized more consistently throughout the study. In this approach, each passage of the textual material was viewed within the context of the entire transcript. When using latent content analysis the investigator "goes beyond what was said directly to infer the meaning of something" (Wilson, 1985, p. 408).

The researcher using latent content analysis is concerned with the meaning within each passage of the data. To determine the meaning in this way requires that the investigator code an incident for a category and then compare it with the previously coded data in the same category (Treece & Treece, 1986). The
significant outcomes of such a comparison are the identification of a category's dimensions, the conditions under which it is least or most likely evident, its major consequences and its relation to other categories (Treece & Treece, 1986). Further, each time the category or a word pertaining to it is mentioned, the researcher must determine if the usage is consistent with previous discussions and with the meaning of the emerging theme (Treece & Treece, 1988). This process of constant comparative analysis was utilized throughout data collection and data analysis. Closure to data collection took place when data analysis no longer produced new categories.

Steps in Content Analysis

Content analysis has been identified as useful both in collecting and analyzing data. As a procedure for analyzing a large amount of unstructured narrative material, content analysis requires that the investigator set certain guidelines. Several steps were used in this study.

First, a decision was made about the unit of analysis. It is important this choice be made so that the "recording unit - the specific segment of content" can be placed

in a given category (Holsti, 1969, p. 116). Five units of analysis were available for selection: 1) single words or symbols - generally the smallest unit used in content analysis research, 2) themes - as single assertions about a subject, 3) sentences, 4) paragraphs, which usually do not lend themselves to classification into a single category, and 5) items, used when an entire article, film, book, or other object is characterized.

Words have been identified as the smallest unit used in content analysis (Holsti, 1969). Further, words are considered easy to work with and are "indicators of more abstract concepts" (Woods & Catanzaro, 1988, p. 438). Therefore, the data initially was scanned for the words "satisfaction" and "dissatisfaction" or words subjects used to describe the meaning of satisfaction or dissatisfaction. In this study, very few responses included the words "satisfaction" and "dissatisfaction" or words that defined the meaning of satisfaction and dissatisfaction.

Next a search was made for themes which might answer the study question. Holsti (1969) contends that, for most purposes, the theme is the "most useful unit in content analysis" (p. 116). Polit and Hungler (1989) claim that the search for themes involves not only the discovery of commonalities across subjects, but also natural variation of the data. Woods and Catanzaro (1988) view themes as propositions or sentences about some fact, and point out that "themes have more meaning than words alone, but are more difficult to analyze reliably because of their complexity" (p. 430).

Holsti (1969) identified two disadvantages of coding for themes: 1) to code for themes is usually very time consuming, and 2) boundaries are not as easily identified as when the unit of analysis is a word, sentence, paragraph or item. Holsti (1969) further argues that the researcher may need to refer to the context in which the

recording unit appears. The recording unit in this study was the theme. Holsti (1969) defines the context unit as "the largest body of content that may be searched to characterize a recording unit" (p. 117). The context unit in this study was the childbirth experience from the postpartum woman's perspective.

Next, categories were developed, based on themes appearing in the data. In this study the categories were extracted from the data rather than borrowing them from existing theory. Wilson (1985) calls the extraction of categories from data "Unfolding Tributary", a method consisting of two steps. First, all the data must be coded into one of two major categories; in this case, the categories of satisfaction and dissatisfaction. Second, the data must be re-read repeatedly. By repeated scanning, the coded data was separated into more precise codes until a degree of precision was achieved. That is, the overall theme ("Being There") and the categories and sub-categories of "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling) summarized the meaning of satisfaction with childbirth. Categories must be mutually exclusive and collectively exhaustive (Kovacs, 1985; Wilson, 1985). The categories in this study are perceived as meeting both criteria.

The tedious task of analyzing qualitative data has been identified as a major disadvantage of qualitative research (Polit & Hungler, 1989; Treece & Treece, 1986; Woods & Catanzaro, 1988). Analysis in this qualitative study, indeed was a time consuming task and a taxing exercise.

A third step in content analysis is to develop rationale and illustrations to guide the coding of data into categories or theme validation. Polit and Hungler (1989) note

that some researchers use a procedure known as quasi-statistics to validate thematic analysis. Quasi-statistics "involves a tabulation of the frequency with which certain themes or relations are supported by the data (Polit & Hungler, 1989, p. 332).

The final step in the analysis process required the researcher to weave the thematic strands together into an encapsulating theme which answered the study question. In this study the thematic strands of "Doing For", "Doing With" and "Doing To" all supported the overall theme of "Being There" which described the birth events and/or interactions that had meaning for the subjects and ultimately contributed to their meaning of satisfaction.

Study Participants

Prior to data collection, the researcher met with ten City Public Health Nurses and their supervisor to discuss criteria for eligible subjects, to explain the methodology, and to solicit assistance in finding eligible and diversified subjects. Some Public Health Nurses had difficulty finding subjects who met the criteria and who were willing to be study participants. There was no attrition of subjects, however, once they had consented to participate.

Initial contact with the City Public Health, Director of Nursing, was with regard to recruiting postpartum women from their general roster. Secondly, a formal request for access to postpartum subjects was made after the research proposal was approved by the University of Manitoba, School of Nursing Ethical Review Committee. To be included subjects were required:

1. To have delivered three to four months prior to the interview, to allow for

subjects physical and psychological recovery, as well as having adjusted to the "mothering" role.

2. To be able to read, write and speak English; for purposes of communication.
3. To live within the perimeter of the city of Winnipeg to allow for ease of contact.
4. To have a telephone for purposes of arranging the interview.

The convenience sample of women who agreed to participate included nine postpartum women who had delivered in four of the five facilities that attend to deliveries in a major Canadian city. The sample included: single and married women; both young and older primiparas and young and older multiparas; women who had spontaneous vaginal deliveries and one subject who had a cesarean section. Subjects were attended to in delivery by obstetricians, family physicians, residents, and a nurse. The overall rating for four women was that of satisfaction; five reported an overall rating of dissatisfaction.

Participant Selection

All women who met study criteria were initially contacted by the Public Health Nurse to obtain permission to release the participant's name to the researcher (Appendix G). Women who consented to having the Public Health Nurse release their name were then contacted by telephone and a meeting time was arranged to distribute written materials (Appendix D). Eligibility criteria for subjects interested in participating were reconfirmed. Additionally, subjects were assured of their rights with regard to withdrawing from the study anytime they wished and their right not to answer any questions. Confidentiality of the subjects names and interview data also was

emphasized.

Data collection was carried out in each subject's home, at a time mutually convenient for the subject and the researcher.

Instruments

Two instruments, an interview guide and a demographic tool, were developed for purposes of data collection.

Interview Guide

Several open-ended questions (Appendix A) were developed to enable subjects to describe the childbirth experience from their perspective without imposing pre-existing ideas about childbirth. The questions were directed by the researcher's experience with childbearing women, the purpose of the study, and the literature review.

Prior to data collection, the interview guide was evaluated by three professionals who had experience in the methodology and in instrument development. Two postpartum women who met the study criteria were interviewed. These interviews served as pilot tests of the interview guide. After the second interview, the interview guide was modified to include a more explicit statement of the purpose of the interview, that is, to learn from subjects about what contributed to their satisfaction and dissatisfaction with childbirth.

Further, subjects were asked whether their feeling toward childbirth had changed from the pre-labour to the postpartum period, and if so, what had happened to bring

about these changes. The revised interview guide proved more efficient in encouraging subjects to share information regarding the phenomenon of interest. Data from the pilot interviews were not included in the findings of this study.

Demographic Tool

Demographic data (Appendix B) were collected to assist in data interpretation.

Ethical Considerations

The research proposal was approved by the Ethical Review Committee of the School of Nursing, University of Manitoba and the City Public Health Agency.

Informed Consent

Subjects consenting to participate in the study were provided with written explanation of the study in their homes prior to the interview (Appendix D). Their role as study participants also was clarified prior to the interview. The consent form (Appendix E) was explained to the subjects. Women who agreed to participate in the study were asked to sign duplicate copies of the consent form (one for the subject and one for the researcher) prior to participation. Subjects were also offered the option of receiving a summary of the study after its completion (Appendix F).

Participants Comfort - Physical and Psychological

The one hour interviews took place at a time and location convenient for the subject. It is not known whether subjects suffered any ill effects as

a result of their involvement in this study. The occasion to freely talk about the birth experience may have helped some subjects to put the childbirth experience into perspective. One subject commented that she had told a friend that finally there was someone who was interested in hearing about her childbirth experience. Subjects were informed that they were at liberty to withdraw from the study at any time. Subjects also were informed that it was their privilege and right not to answer certain questions if they so decided.

Confidentiality

Confidentiality was maintained for all interview information. The researcher transcribed all audio-taped interviews. Code numbers were used to label audio-tape recordings and transcripts. Accessibility to the transcripts was restricted to the researcher and her advisor. Tapes and transcripts were kept in a locked filing cabinet. The researcher erased the tapes upon completion of the study.

Limitations

Limitations of this study include:

1. With the exception of one subject, all participants were Caucasians. All subjects also were well educated, middle class women. While the sample size was reasonable for the allotted time frame, a larger group of women would be required to substantiate the findings of this study.
2. The retrospective design of this study required subjects recall an experience of three to four months previously. A further limitation of recall, in the birth

situation, is that of recalling an event that occurred when the subject was under the influence of one or more medications, as well as pain, stress, and an unfamiliar environment.

Conclusion

In this chapter, the research methodology of content analysis and the procedures utilized in the investigation of this study were presented. Nine subjects were recruited from a general City Public Health postpartum roster and interviewed with respect to their childbirth experience three to four months earlier. Closure to this investigation took place when succeeding interviews no longer produced new categorical dimensions.

Chapter Four

PRESENTATION OF THE FINDINGS

In this chapter, findings of the study are presented. First, biographical information about the interviewees is summarized. Secondly, women's definitions of childbirth satisfaction and dissatisfaction are presented. In subsequent sections of the chapter, findings that emerged during transcript analysis are organized under the overall theme "Being There", and the categories and sub-categories of "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling). Finally, subjects' perception of changes in attitudes toward childbirth from the prenatal to the postnatal period are summarized.

Biographical Information

Three primiparous and six multiparous women were interviewed. Eight of the nine subjects were Caucasian, ranging in age from 20 to 35 years, with a mean age of 28 years. Eight of the nine women were married. The interviewees were well educated women. Two women had a baccalaureate degree and a third was completing a degree; three women had obtained vocational and technical certificates. Three subjects had not completed high school. Only one woman was presently employed full-time outside the home. Three others worked part-time and five were homemakers with no intention of returning to the work force at the present time.

One subject required a cesarean section. The other eight subjects had

spontaneous vaginal deliveries without any assistance. The study participants delivered in four of the city hospitals with maternity units. In summary, the subjects were well-educated women in their prime reproductive years, two-thirds of whom had experienced previous births.

The Meaning of Satisfaction With Childbirth

During each interview, participants were asked what satisfaction with childbirth meant to them. Two types of responses were obtained. For some women, satisfaction and its converse, dissatisfaction, meant experiencing an affective response or feeling about childbirth. Six of the nine postpartum women had difficulty defining the meaning of childbirth satisfaction. Instead, participants described aspects of the birth experience that they perceived as contributing to childbirth satisfaction. An interesting finding was that, while all nine subjects identified the baby as the most satisfying aspect of the birth experience, not one mother referred to the baby as a determinant of satisfaction with childbirth.

The one exemplar, common to the three subjects who defined the meaning of childbirth satisfaction was: "I'm happy." Another subject defined childbirth satisfaction as a state of feeling content.

> I would have to say being content afterwards with the way everything was - having happy thoughts, happy feelings - happy thoughts - just the way everything went.

For a fifth subject, experiencing satisfaction meant:

> To look back and be....Just a warm feeling that you get. When I think about it....now, oh I'm so happy.

One subject described satisfaction with childbirth as a goal or point of achievement in life:

> I felt complete...I felt really good. I had fulfilled what I wanted. I don't know - fulfillment - I just felt complete.

Subjects faced an equally difficult task in defining childbirth dissatisfaction, as they did in defining childbirth satisfaction. For two primiparas, dissatisfaction was a negative feeling of discomfort:

> Getting a negative feeling about something and just not feeling comfortable with it or with that aspect of it. I'd have to say that when everything is going nice and smooth and then something happens and you right away just feel that you don't like it - you start to feel uncomfortable.

I felt so uncomfortable and I was scared.

One multipara also viewed childbirth dissatisfaction from an affective orientation, and expressed her feelings in the following way:

> What I wasn't happy with. What I wasn't pleased with when I look back at it. What didn't make me feel warm about it. Just something that I wasn't - when I look back, what I'm not fond of - what I'm not pleased with, that I wish didn't happen. To me that's what it [dissatisfaction] means.

Most subjects, when asked what childbirth satisfaction and dissatisfaction meant to them, described instead, specific aspects of the childbirth experience that contributed to their response. The overall theme that emerged from content analysis of their responses was the theme "Being There." Within this overall theme, several categories or ways of "Being There" were identified: 1) "Doing For" (sub-categories: nurturing, advocating, supporting), 2) "Doing With" (sub-categories: togetherness, sensitivity) and 3) "Doing To" (sub-categories: intervening, controlling).

BEING THERE

For study participants, the theme of "Being There" centered on the presence of significant others and/or caregivers. When the presence of significant others and/or

caregivers met subjects' birthing process needs, it led to satisfaction with the childbirth experience. Conversely, when subjects' needs were not met by significant others and/or caregivers this contributed to subjects' dissatisfaction with the birth experience.

Study participants identified events where the physical "Being There" of a mother, a husband, an infant, and/or caregivers led to childbirth satisfaction. Subjects repeatedly verbalized circumstances of "Being There" that involved their significant others and/or caregivers and what it meant to them. Two women described the importance to them of their husband's presence. For Mrs. K., her husband's "Being There" meant:

> Just being with me when ___[baby] arrived. Just being with us all the time....I think everybody needs someone like him....He was really good.

Mrs. L.'s husband, however, could not be present throughout the whole childbirth experience for reasons beyond their control. Nonetheless, she described the significance of her husband's presence while he was with her.

> Oh, it was very great. It meant everything I think. That's why I think it really bothered me that he wasn't there [during the actual cesarean section], that he at least didn't get to see this....for him to be there and know what was happening - because I didn't.

For two other women their husband's physical presence during the birthing process did not meet their expectations. Consequently they expressed dissatisfaction with their spouses. Mrs. A. expressed her ambivalence about wanting his presence, but, being unable to tolerate physical contact or touch:

> I love my husband dearly, but he just didn't cut it. He did to a certain point....I had said to my husband earlier on, when I was in labour, "Breathe with me" and he goes, "I am" - "No, you're not. Get out of this room - you're not doing anything. You're useless. Get lost!" So he went out and calmed down....In one sense you want him [husband] there so bad and in another it is like "Get away from me. Don't touch me. Stay away from me." But the minute they leave "How dare you leave me. Where the hell are you? You got me pregnant. You got me into this situation - if it wasn't for you I wouldn't be here." I think it is just an emotional thing in one sense.

Mrs. S.'s husband also was present physically. She, however, expressed dissatisfaction with his behaviour "toward the end [of labour] when the pain was getting bad":

> At one point I almost told him off - I was having back

> labour and we had cream and he was rubbing my back - but he'd found a Time magazine and by the time he could tear himself away from the magazine, get the cream on his hands to rub my back, the contractions would be finished!...So sometimes you know he would rub my back and then he would turn to go back and sit down and I'd be grabbing at him and say "No, no."...Maybe it was because I had my back to him too that he couldn't see my face - so I had to keep reaching over sort of waving at him you know. I was afraid I would scream if I opened my mouth.

For three study participants, the presence or "Being There" of their caregivers during labour and delivery, was perceived as contributing to childbirth satisfaction. Mrs. W. was totally satisfied with her physician:

> She [physician] was there the whole time....she broke the water, she did all the stuff....she just kept coming back and forth, back and forth....She's wonderful. I'm just one of the biggest advocates of her around.

Mrs. T. described what the nurses' "Being There" meant to her:

> They talked me through it [labour and delivery], they were right there. It was the first time I've had staff who did that. Staff who were right there. Instead of being busy with other things - like taking your blood pressure, monitoring your temperature and all those things she sat with me. As soon as a contraction came she checked the monitor - because you're always hooked to those and she'd say "Oh, I see another contraction is coming." She'd sit down at the edge of my bed, hold my hand, rub my back, talk to me and just get me through it, which I thought was really helpful....She stayed with me while I was in labour. Yes, she was in there the whole time....So that was nice.

Another subject responded to the nurse's "Being There" during labour in the following way:

> It was very meaningful to me that she stuck with me - you know because they were there in the morning and she sat and talked with me all day long....we were sitting in the labour room - and all day long we were laughing and joking around - talking to each other about this and the other thing. Too, it went very well. There wasn't time to think about - that is one

> thing she did very well - she kept my mind off worrying about why the baby wasn't here yet and things like that....and that she stuck around until the baby was born.

Although two participants identified the best and/or most exciting part of the birth process to be their active involvement, the climax of the whole experience was that of giving birth to their baby. That is, the eventuality of the baby finally "Being There" contributed most to their satisfaction:

> I think that was the highlight - when he was finally born. Probably that was the most satisfying.

For another subject, her active involvement had a direct impact on baby's "Being There":

> The best part was probably when I was pushing and then she was born. Maybe it was because I had the epidural at the time and there wasn't a lot of pain - so everything was - I didn't have to deal with all this pain as well, so I was just focusing on pushing and getting her out. Having her there.

Other subjects also focused on the baby's "Being There." Mrs. W. derived

satisfaction from immediately having the opportunity to hold her baby:

> Them giving me ___[baby] immediately....[last time] I wanted to see the placenta....this time it was having ___[baby] delivered. I guess they suctioned him and then handed him to me guck and all. There he was and I remember looking at this funny looking thing and that was like "WOW!" You know, the cord was still attached, he still had the electrode on his head, he was right from me to me! And I think that was something that I, in retrospect - I wish I'd done with ___[first child].

Mrs. K. described the climax of her childbirth experience:

> When it was over. Honestly, when he was out and the afterbirth was out, I was stitched up and I was holding him.

Subjects' physicians not "Being There" for the actual delivery contributed to women's dissatisfaction with the birth experience. One study participant described how her physician's absence affected her:

> I knew that [my physician would be away on vacation] ....I was apprehensive about that....and disappointed,

because I really like my doctor and I really wanted
him to be there.

For another subject her physician not "Being There" meant:

Well, it [physician being absent] was a little scary
you know. I counted on him being there.

Nurses not "Being There" during labour basically was found to contribute to childbirth dissatisfaction. Ms. V., however, did not consider the nurses' absence in early labour contributed to her dissatisfaction with the birth experience:

Well, it didn't bother me that much because I knew
there was other people in there. I was by myself in
one room, but it was the labour ward where there is
a bunch of rooms - and you can hear everyone else
screaming for nurses so they can't always be with
me - there is someone else who needs them too.

For Mrs. T., the fact that a certain physician from her obstetrical group was not present, contributed to her satisfaction with childbirth:

I'd had one of the other doctors for one of my
other deliveries. I just prayed that I wouldn't get

him and I didn't! I found him very abrupt and rude.

Four subjects described what "Being There" of their significant others during childbirth meant to them. Mrs. K. described what having her husband present meant to her:

> I can't ever imagine going in there [delivery room] alone by myself without having my husband or someone close to me there....Other than just having him there - it was comforting to have someone there - just someone that you feel close to and that - like a family member. Rather than just being there alone or someone that you didn't necessarily know....Yes [he was present] right from the time we got there until the end. He took her [baby] at the end and went with her to the nursery. He carried her there. Then he came back and stayed with me for a while.

Mrs. M. shared what her husband's presence meant to her:

> He would do the breathing exercises with me, he'd give me back massage or hold my hand, you know just everything. It was just wonderful to have somebody that I loved there, because all these other people were

> strangers to me and you don't want to go through something like that alone. You want somebody you know there with you.

At least one woman resorted to extreme behaviours to keep her husband with her:

> I had his head in a headlock and everything. He wasn't going anywhere. He tried to watch ___[baby] being born but I kept screaming "I need you now, I need you now, don't leave me, don't leave me." [Husband] "I'm not going anywhere." [Subject] "I know you're not going anywhere." That is when I grabbed him and put him in a headlock....He got his head around and he pulled himself up, he got his head around and watched ___ [baby] being born.

Only one study participant's mother was physically present for part of the birth process. Mrs. M. described what it meant for her to have her mother present during labour:

> It felt so good to have mom there, because you know yourself mom's are irreplaceable. You feel your worst and you always say "Oh, mom where are you?" So in

that sense it was really nice to have her there. I know at the very end when I was in the case room delivering ___[baby] I was saying "O, mama mia!" in Italian. So I mean you're always calling for your mom and I did. So it was good to have her that way.

In summary, "Being There" referred to the physical presence of subjects' significant others, their newborns, and/or their caregivers. Subjects responses indicate that they expected psychological support from husbands and caregivers, in addition to physically "Being There." When "Being There" met subjects needs and expectations it led to satisfaction with childbirth. Conversely, when needs and expectations were not met, it led to dissatisfaction. On further analysis it was evident that there were many ways of "Being There."

DOING FOR

In this study, "Doing For" referred to significant others and/or caregivers providing holistic care to childbearing women. That is, subjects were physically, emotionally, and informationally (verbally) supported by caregivers. For participants "Doing For" whether nurturing, advocating and/or supporting, was perceived as a significant contributor to childbirth satisfaction. That is, when study participants perceived the "Doing For" by significant others and caregivers to meet their expectations it contributed to satisfaction with the birth experience. Conversely, when experiences were not met it led to dissatisfaction.

Nurturing

In this study, nurturing refers to the qualities commonly attributed to or associated with taking care of another person: lavishing care on, providing for, looking after, giving encouragement, demonstrating love, and being attentive to the labouring woman's needs. Participants experienced nurturing from their husbands, caregivers (nurses, physicians), and in one instance, the subject's mother.

Additionally, the childbearing women also experienced satisfaction in childbirth when they were able to nurture their babies through the act of breast-feeding.

Two study participants described how being nurtured by their husbands contributed to satisfaction with their childbirth experience. Mrs. K. described how her husband's nurturing affected her during childbirth and expressed her satisfaction with his nurturing as follows:

> He's just really good....Holding___[baby] for the first time - I was very happy. Just breast-feeding for the first time [he helped with that]....He tried very hard. When he didn't know he'd ask me and say "What can I do to make you feel better?" He was really supportive, really supportive.

Mrs. S. stated that "For the most part my husband was good...he was okay." When asked to explain what "Okay" meant, she commented:

> He was there! He was there and rubbed my back you know and was where I could call him. He tried to keep me laughing and that - being humorous....he was holding my hand....He [also] helped me undress when I got there [hospital].

Study participants also identified instances when they received nurturing from caregivers that contributed to satisfaction with the birth experience. Conversely, failure on the part of caregivers to provide nurturing, contributed to childbirth dissatisfaction. In this study physicians included both male and female obstetricians, residents, interns and anesthetists. Three women described the nurturing they received from nurses. For Mrs. L. nurturing by a nurse included:

> She was always there and held my hand a lot - she was very positive in her reinforcement, talking [assertively], and she was really trying to do that and she did it good.

Ms. V. described aspects of nurturing provided her by caregivers:

> They [nurses] brought me the warm sheets when I was cold. One nurse gave me a massage on my back when the pain was getting to be a little bit too much. During

the hard labour the one nurse was holding my hand - so it was all right.

For Mrs. W. nurturing was provided through "hands on" care:

They [nurses] bundle you up in nice warm blankets, they gave me a sponge bath and I just sort of lay drowsy and they brought ___ [baby] to me within the hour and he nursed very well. So it was very nice. It was only 7:30 at night but they had the blinds down. To me that was a very - I often think of how relaxing that was....that relaxation - the warm cozy cocoon feeling. Also the feeling of being taken care of. Right now you can't do anything - we'll get you this and that.

Mrs. M. was the only subject whose mother was present for part of the birth process. When asked how it was different to be nurtured in labour, by your mother rather than your husband, Mrs. M. commented:

It was a bit conflicting the way I was feeling....I guess you're always a little bit closer to your mom so in that way I think probably it felt really good to have my mom there. Although my mom wasn't as helpful

because she doesn't know the breathing exercises and stuff - it's different. They helped me in different ways. My mom I guess was the moral support and my husband did the breathing exercises with me.

Analysis of the interviews showed how significant others and caregivers play a unique role in contributing to satisfaction with the birth experience. Satisfaction associated with nurturing applied not only to study participants as recipients, but also to postpartum women in the nurturing of their newborns.

One of the most satisfying activities women were able to "do for" their infants was direct nurturing through breast-feeding. Subjects perceived breast-feeding to contribute to childbirth satisfaction if the experience went well. Conversely, when the baby had difficulty "latching on" it contributed to dissatisfaction with the birth experience.

Six interviewees breast fed their babies. With the exception of one mother, these subjects had planned to breast-feed immediately after giving birth. Of the five who planned to breast-feed immediately, only one subject had the opportunity to do so at the time of delivery. Two subjects described how they felt about nurturing their babies through breast-feeding.

...breast-feeding for the first time - I was very happy.

----[baby]...would...stroke the breast and it was such a wonderful warm cozy feeling....It was a very,

very comfortable feeling.

Mrs. T. had the opportunity to breast-feed her baby immediately after giving birth, she, however, chose to delay it for two hours. She described her experience:

I nursed him at that time and we did very well.

Mrs. M. stated that initially she did not experience the nurturing she anticipated from breast-feeding, in spite of providing nourishment to her baby. Not experiencing the anticipated nurturing contributed to Mrs. M.'s dissatisfaction with childbirth, until the problem was resolved:

He didn't take to me right away. It took like the third try...We had a bit of problems because he somehow - it seemed he just couldn't latch on to me for a while there....And when he finally got the hang of it, I was okay.

Study participants identified breast-feeding as a method whereby they could nurture their infants. Subjects, however, also expected to be nurtured by caregivers. Mrs. K. argued that physicians did not provide nurturing in that they were insensitive to her and her needs:

> I think that they become a little bit insensitive to a patient's needs after they've done so many [deliveries] in one time....You are just one out of how many? You're a statistic to them....I just thought that I was a nobody.

Nurturing, whether it meant study participants were the recipients or the givers, both contributed to satisfaction with the childbirth experience. Conversely, when subjects perceived the nurturing aspect to be inadequate, ineffective, or even absent, they experienced dissatisfaction with the childbirth experience.

Advocating

Advocating, as an aspect of "Doing For", included caregivers' willingness to support the childbearing woman verbally, and/or to intercede for her. In this study, two women identified their caregivers as advocates. For Mrs. K., the nurse's advocating on her behalf contributed to her satisfaction with the childbirth experience:

> She [nurse] was the one that was communicating between the two of us [physician and patient], telling her [physician] you know "she's [patient] feeling this and that" because I would tell her [nurse]. It was satisfying - I think the nurse was really good.

Mrs. S.'s physician was her advocate:

> My doctor came in and said....she likes her patients to have a choice - whether they want the stirrups or not....so she asked me "Which do you want?" I thought at the moment I didn't care. Then I decided that I'd prefer not to have them. So they took everything away ...I liked it....Dr. ___ held one leg and my husband held the other....So we had her [baby] like that. I really enjoyed it. I think it was more natural to have her that way....I had expected the stirrups. I didn't know that they would let you do it that way even. So I was very pleased....It turned out better than I had expected....It was very nice.

In each instance advocating was perceived as contributing to women's satisfaction with the birth experience.

Supporting

Supporting, as an aspect of "Doing For", refers to significant others and caregivers giving encouragement, help and assistance, physically, emotionally, and/or informationally (verbally) to labouring women. Two participants identified their husband as being very supportive. For Mrs. M., her husband's support during childbirth contributed to her satisfaction with the experience.

> I didn't think he could handle it [labour and delivery]....but he did. He really surprised me. He really came out for me and was really strong and he was very supportive and he was just great. I wouldn't have had it any other way.

Mrs. T. described her husband as being "a very supportive husband." Although her husband was present during the last delivery, her response emphasized how he was unable to stay with her during previous deliveries, to be supportive:

> He is a very supportive husband, but is one that cannot see me suffer excessively. With the other deliveries he always had to walk out when I got into transition. Now as I felt myself getting close to not being in control any longer and not knowing how I was going to behave if I had to endure the contractions much longer - I was thinking I would have to tell him to leave. But then the nurse said "His head is here!" and I knew I was about done. So ___[husband] stayed in and did well.

Mrs. S.'s response indicated why she perceived her husband not to be supportive during childbirth:

> I think mostly because he didn't pay too much attention when we were taking the...prenatal classes - he was always day dreaming, staring off into the distance and said "Oh, you won't really need it" I think because he day dreamed in class - he missed some of the things that he was supposed to be watching for.

Most subjects expressed satisfaction with the nursing care they received. The majority of women emphasized the psychological rather than the physical nursing care they received and how that aspect of care contributed to childbirth satisfaction. Ms. V. described the support the nurses gave her as follows:

> During the labour part you are quite emotional and you need all the support you can get. Then afterwards you have a crying baby on your hands, while you are tired. You need somebody to kind of be there for you while you are resting....I needed that time to recuperate....If I hadn't had anybody there to support me I would have been crying and going crazy. They were really nice, they brought me something to eat afterwards.

For Mrs. T., the supportiveness of the labour floor nurses included:

> The nurses that I had....helped walk me through my labour and so I didn't lose control of myself....He [nurse] rubbed my back and my legs [and] helped me with the breathing....she [another nurse] stayed with me....I wish more would do that.

Additionally, not only was Mrs. T. satisfied with the supportive nursing care, it was also because of this support during labour and delivery that she experienced a change in her apprehensiveness toward childbirth. The above response identified how nurses helped bring about this change for Mrs. T..

Mrs. S. also described how nurses' supportive care affected her:

> They were very nice - in good spirits and that, and that made me feel in good spirits. They were very open and friendly.

For Mrs. M. being supported by nurses included:

> When I first got there, she [nurse] put on these tapes of really soft music - which really helped...she was really friendly and tried to make my husband feel comfortable and whatever and she was just really good

....Then the other nurse that I really felt good with
was ___[nurse]. When I was in a real lot of pain I
said "I'm going to die, I can't take this anymore."
Then ___[nurse] would grab me and say "Look you're
doing wonderful work, we're almost there." You know
he [nurse] really encouraged me - so he was great....
Those two nursing staff, but even the other ones
were nice and very helpful and they did try to
comfort me and whatever.

Mrs. A. described the psychological care she received from the postpartum staff:

The care was good and everything....They were friendly
enough....The nurses on the ward were really good.
They were very helpful. They showed me things.

Mrs. B.'s, previous supportive nursing care had been a determining factor in choosing a hospital for this delivery:

They were great with ___[first child] and that is why
I chose to go back there again....They were the best.
They were the absolute best....They were wonderful
They were great....It was the absolute best! The
nurse that had started with me in the morning said I

had better have this baby before her shift was over at three o'clock and she stayed with me [until after the delivery], even [though the shift had ended].

As mentioned earlier, subjects perceived the presence of their own physician at the delivery, as supportive and contributing to satisfaction with the birth experience. One of the three subjects who did not have her own physicians present was, however, favorably impressed by the attending physician. This subject perceived the physician's competent care as contributing to her childbirth satisfaction and describes how she was affected by his care as follows:

He was an older man. Actually he was really good, he was wonderful. I'm glad it was him because you know he did - of all the other doctors that were there examining me I'm glad he was the one that did it.... I felt good. He was very experienced and that and with the complications I had he saved my baby.

Two subjects, however, did not perceive the attending physician to be supportive. One subject described the attending physician's care and how it affected her in the following manner:

When I had met this other [referral] doctor I liked him and I thought that if I had him it would be okay

....Then I ended up getting this other [On Call] doctor....I [had] just assumed that if he [my doctor] wasn't delivering he would come. He just wasn't on call....I had never really met the doctor that delivered me....I didn't know anything about her.... Then her coming in....it is like "Who are you? I don't know you. I don't want you here"....It just felt uncomfortable having her there....It was just not knowing what she was doing. I wasn't informed as to what was going on....I wasn't very happy with my delivery...I was very displeased with the doctor that was helping me.

A second subject did not feel comfortable with the attending physician and described her [the physician] as follows:

She [physician] didn't seem to know what she was doing....she wasn't familiar with the labour and delivery process....And it bothered me....more so after I had actually delivered him [baby]. They took forever to do the stitching...I don't know [how long] but, she had to give me three locals to finish off the stitching....I was getting a little annoyed.... I hope she doesn't make it as a doctor, because her

attitude didn't impress me.

For caregivers and/or significant others to merely "Be There" physically, but not nurturing, advocating and/or supporting the labouring woman, led to dissatisfaction with the birth experience. Study participants viewed nurses' inappropriate comments as non-supportive behaviour and as neither nurturative, advocative, or supportive. Mrs. L. recalled becoming very upset by a comment a nurse made to her just prior to going for the cesarean section:

> "What is your doctor going to do? He's going to watch!" I remember hearing that comment and I thought that wasn't very appropriate.

Mrs. A. described herself as ready "to get off the delivery table and wallop her [nurse]" when the nurse who was looking after her in labour said to her:

> "Listen, you've got your epidural - there's no painless delivery so give it up!"

Two other subjects found nurses' comments inappropriate:

> I remember the nurse saying "Don't yell with your mouth. Don't push with your mouth - push with your bum." I remember thinking what a stupid thing to say.

> This is one thing I had wanted to mention to them... When they yelled out "Stop - the cord is around the neck!" I was terrified....for the baby....I was going to talk to them that they should have a code for saying that [the cord is around the neck] or something.

Mrs. T. also perceived some of the nurses remarks to be non-supportive:

> Often it's like, "The Fourth!" I guess I had this with some of the...nurses. "Oh, your fourth already! We don't need to talk to you because you already know what you are doing."

Another means by which caregivers were perceived to be non-supportive was through not sharing information with the labouring woman. Mrs. S., for example, reported:

> I guess when she [baby] was getting close to coming out - I was beginning to wonder whether they were going to have me have her there [labour room] or would they move me to another room or not. I didn't know what to expect.

Mrs. S., however, perceived her husband to be the individual who could later support her with information about the childbirth experience and therefore, wanted him to "Be There" for the childbirth experience.

> At the time I was very foggy - so I think it was comforting to know that there was somebody there who knew what was going on. I didn't know what was going on.

Another participant claimed that although a physician attended to her physically, the manner in which care was given, was anything but supportive:

> This one female doctor, she was so rough - when she gave me an internal she really hurt me....She hurt me a lot and I was really mad. I didn't want her to touch me anymore.

Four study participants perceived withholding by caregivers of vital information about their baby's condition as non-supportive. One woman described her experience as follows:

> They [health care professionals] weren't telling me - maybe they were concerned about the baby or something because I was concerned that there was something wrong with him [baby]...they seemed to be concerned about

> something that they weren't telling me about....I just thought that there was something wrong - especially after he was born, he was just lying there and then finally they did something and it's like "Oh, you have a boy" and then they whisked him out of the room and I didn't even get to see him.

Another subject expressed how vital information was withheld from her by physicians:

> They [physicians made comments] to each other and the nurses....I can't remember any specifics what they said. I knew that they sounded like something was not right....So I was getting worried. I could feel a little bit of movement every once in a while, so I thought - what's the problem?

A third participant described how information about her baby was not communicated to her:

> I had him at 11:36 in the morning. I didn't even get to hold him....They whisked him off right away. They never gave me a reason....I didn't know what was happening - I thought something was wrong with him

....I just wasn't pleased with any of it.

A fourth woman described the fear she experienced because information was withheld:

> He had the cord wrapped around his neck so they had to cut the cord and then I could push again and he came out. They took him away - they didn't tell me "It's a boy or it's a girl or anything." With all the fear of what was going on all the time that I was in labour, I thought that he had died. I was so scared and they didn't tell me anything.

Four women also described how inadequate verbal informational preparation for an intervention was perceived a greater source for dissatisfaction than the actual procedure. Three subjects had an induction and one woman a cesarean section. One woman described her lack of knowledge regarding the induction as follows:

> I knew nothing about it [induction]. I had gone in and the nurses had examined me and everything. I was on the table at 20 after eight...and she said "Once we get you started up here, I think the baby will come pretty quick."...At 2:30 in the afternoon - Wow this is quick! I did it quicker on my own with the

> first one....When is this going to take place? I was waiting so much.

Another woman also was unfamiliar with the procedure, as well as unaware when the intervention was carried out:

> [I was] checked to make sure everything was okay. He broke my water....I didn't even know it at first. I believe he did [tell me what he was going to do] but I didn't quite hear him, but it didn't feel like anything had happened. After I moved around I could feel the water dribbling out every now and then....I suppose you are scared when you don't know what to expect. You hear so many stories and you try to visualize in your mind what it is going to be like, what the pains are going to be like - just things like that. Just the fact that you don't know what to expect.

A third subject was unprepared for the artificial rupture of membranes, nor was she informed about her baby's condition. The combination of not being informed about the induction and later learning about the precarious condition of the fetus, led to dissatisfaction with the childbirth experience.

> They broke my water and that, so by then they knew that he'd had a bowel movement and they didn't tell us....They attached the fetal monitor....What they knew and didn't tell me is that he had meconium - he'd had a bowel movement inside me and they didn't tell us that - so I didn't know.

Although Mrs. L. had an emergency cesarean section, she claimed "the circumstances of his [baby's] birth weren't important." She however, perceived the manner in which the cesarean section was carried out as follows:

> It upset me the way everything went....The speed and everything....I hadn't really been all that aware that it was that severe a problem with the heart rate dropping....I didn't realize that we were anywhere this close to taking this measure [cesarean section] ...[and] that [a cesarean section] was a possibility ...I think it would have been better if someone had said...you know heart rate dropping is not very good. It might mean...we...have to do something quickly... They didn't tell me...[nor] him [husband] - it all happened so very quickly - there was no time at all for mental preparation.

In summary, "Doing For" (nurturing, advocating, supporting) the childbearing woman by her significant others and/or caregivers led to satisfaction with the birth experience. Conversely, participants who perceived various behaviours by caregivers and/or significant others to lack these qualities, viewed the childbirth experience with dissatisfaction.

DOING WITH

In this study "Doing With", refers to the participant and her husband, and in one case the subject's mother, experiencing childbirth together. That is, not only are both of them present physically, but, also both are involved psychologically. "Doing With" included the sub-categories of "togetherness" and "sensitivity." Togetherness contributed to satisfaction with the childbirth experience. However, when togetherness was denied, it resulted in dissatisfaction with the experience. In this study, sensitivity denotes psychological feelings because a significant other is experiencing physical and/or psychological pain. Data supporting the sub-category sensitivity was limited and only (in its absence) perceived as a contributor to dissatisfaction with childbirth.

Togetherness

Analysis of the subjects' responses showed that in this study togetherness was identified in two types of situations. First, it referred to a couple mutually and simultaneously experiencing the birth of their child. Secondly, it signified mother-baby contact, which facilitated bonding with the newborn baby.

The eight married subjects' husbands were present throughout labour and delivery, with the exception of one husband who was not able to be present for the actual delivery. The majority of women found that experiencing the birth together, a "Doing With" their spouse, contributed to childbirth satisfaction. Mrs. L. explained:

> We intended the whole time to do it together, but as labour went on and everything, it became even more important to me that he was there.

Mrs. L. was further questioned in what way it became more important for her to have her husband "there as labour progressed." She responded in the following manner:

> Just to hold my hand through a contraction and things like that. Just really to think - thinking that you weren't alone in this.

For Mrs. B., satisfaction in childbirth was specifically related to her husband's presence. "Oh, it [childbirth] was one of satisfaction - especially because my husband was in the delivery room with me." When asked how her husband's presence accounted for her really feeling satisfied, Mrs. B. commented:

> Well, because he shared it with me. He was the one to say "It's a girl!"...It was something - he was

> holding my hands all the time and everything. He was so happy too. I looked at him and saw tears in his eyes. It is something you just don't go through with anyone else in life...It just wouldn't have been the same if he wasn't there. It's his child too and you've been waiting and waiting and waiting and waiting and you're all excited about it and everything. If he wasn't there to share the final moment with you it would seem a little more empty.

Mrs. W. admitted that during pregnancy she had told her husband "I don't need you in that room [delivery room] - you don't have to be with me there." In the end though, he was present for the whole birth process. Retrospectively, she perceived his presence at childbirth totally opposite to what she had anticipated his presence to mean for her prenatally:

> I don't think I would have wanted to have had just the nurses there. Even though I had said to him several times I don't need you in that room [delivery room] I was glad he was there, I guess. He was sort of in the background when I was labouring. During the delivery he was on one side and the nurse on the other and I was holding his hand. I just about broke it because I was squeezing so hard. I think after the

baby was born it was kind of nice to have somebody who I could ask questions of. The nurse is doing her thing, the doctor is doing the sewing and that. So ___[husband] was sort of checking out ___ [baby] and talking to me a bit. He actually could check the baby out and do an inventory and that sort of thing. He had 10 fingers and 10 toes, he's got this and that. So when I was being sewed up he stood there and talked with me....So it was nice to be able to share it with somebody....someone who's there you know and sometimes he can fill in the blanks for me ....I was glad that he was there.

The majority of participants found togetherness with their husbands contributed to their satisfaction with the childbirth experience. Mrs. L., unlike the other two women, could not experience togetherness with her husband because he was physically absent from the operating room. He had not been notified of her transfer to the operating room from the delivery room, where she had been taken to establish the epidural. For Mrs. L. the most dissatisfying aspect in childbirth was that of "Having the cesarean - alone." The reason why she was bothered by the aloneness was because neither she nor her husband knew the details regarding the cesarean section.

Only two of the nine subjects made reference to not initially experiencing togetherness with their newborn infants. That is, in spite of physical contact and providing care to their babies, two mothers felt no bonding or attachment to them.

Initially there was no emotional relatedness between mother and infant. Both women however, bonded with their sons a couple of days after being home with them.

Mrs. T. described her initial lack of togetherness with her son, and subsequent development of attachment as follows:

> I never want my babies right after they are born. It's like "I've done my job, don't give me that baby until I'm ready for it!" I know the nurse tried to talk me into having ___[baby] right after he was born, but I said "No! I don't want him now!" And fortunately she respected my request and didn't try and force the baby on me again at that point....After about two hours I was ready to have ___[baby]. I nursed him at that time and we did very well. I didn't bond with him initially. I had been home a couple of days when we became attached.

Mrs. L. also did not initially experience emotional togetherness with her son, in spite of physical contact with him. Her bonding however, paralleled that of Mrs. T.:

> The first few days it was just sort of - only a relationship in terms of - I had to care for him and there really wasn't very much else there. I wanted to be sure he was dry and fed and comfortable, but that's about it. A few days later is when it started to feel,

you know, there was some emotion there and a real caring....___[husband] was there all the time for that first week....That week really brought things together....I guess most important was to forget the labour and that sort of thing and getting to know him [baby] a little bit and getting a lot more emotional than just caring for a baby.

In summary, subjects' perceived togetherness, whether with their spouse during the birthing process and/or when bonding occurred with their newborn infant, as contributing to satisfaction with childbirth. Subjects, however, experienced dissatisfaction, when they were denied togetherness by caregivers during the birthing process. For example, one woman was denied her husband's presence during delivery. Others, despite physical contact with their babies, did not initially experience togetherness.

Sensitivity

Subjects' responses yielded only two examples that supported the sub-category sensitivity. These examples, however, were distinctive enough content to support the presence of an emerging sub-category. For purposes of this study sensitivity denotes feelings of psychological pain, concern, empathy, tenderness, sympathy and perceptiveness, because a significant other is experiencing physical and/or psychological pain. Sensitivity was identified in two situations: 1) as a reason why one subject's

husband was unable to stay with his wife during the actual delivery in previous births, and 2) as a subject's perception of her mother's response to the pain the subject was experiencing.

Mrs. T. explained why her husband had not been in on previous deliveries:

> He is a very supportive husband, but is one that cannot see me suffer excessively. With the other deliveries he always had to walk out when I got into transition.

Mrs. M. not only had her husband with her during the birthing process, but her mother also was in the hospital Waiting Room the entire time. The only time the mother stayed with her daughter, however, was when relieving her son-in-law, for example, for a lunch break. Mrs. M. shared how she perceived her mother's presence and how it affected her (Mrs. M.):

> It was really hard for mom. I mean it's hard for moms to see their kids go through a lot of pain and my mom suffered seeing me like that....I felt bad when my mom was there because I didn't want her to see me like that - in so much pain....I didn't want her to see me suffering like that.

In summary, because study participants suffered physical pain, their significant others suffered psychologically. Subjects, in turn suffered psychologically because they

observed their significant others expressing distress.

DOING TO

In this analysis "Doing To" refers to caregivers attending to some aspect of study participants' care in labour and delivery. "Doing To" included the sub-categories of "Intervening" and "Controlling." Interventions contributed to either childbirth satisfaction or dissatisfaction. Controlling, however, contributed exclusively to dissatisfaction with the childbirth experience.

Intervening

In this study, intervening referred to caregivers attending to the perceived needs of subjects, with or without informed consent. Three major types of interventions were reported: administration of analgesia, inductions and a cesarean section. In each instance, whether with or without informed consent, caregivers' "Doing To" labouring women contributed either to satisfaction or dissatisfaction with the childbirth experience.

The most common intervention experienced by subjects in this study was analgesic administration. Eight of the nine subjects received some analgesia; seven had demerol. While being the most commonly used analgesic, no subject used demerol exclusively. Two women had entonox (gas) with the demerol, three others had demerol plus fentanyl (an epidural), and another two received all three types of analgesia. One participant managed exclusively with the entonox, while another without any analgesia.

Study participants identified both satisfaction and dissatisfaction in response to the effects of analgesia. Seven women received demerol, yet, only one perceived it as a contributor to satisfaction with childbirth. This subject claimed "the demerol really did help me...I had control of my body." For the remaining six, the effects of demerol led to dissatisfaction. That is, they did not obtain the expected pain relief. Instead, they were cognitively impaired and therefore unable to remain in control of the experience.

Three of the five subjects who had fentanyl, perceived it as contributing to their satisfaction with childbirth, the other two to dissatisfaction. One subject initially perceived the effects of entonox to contribute to her satisfaction with childbirth. As labour progressed however, entonox was perceived to contribute to her dissatisfaction, as it did for four other subjects.

Study participants reported feelings of satisfaction related to favorable effects from the analgesia. Satisfaction as a result of favorable outcomes of analgesia included "Being in Control" and "Amelioration of Pain."

Being in control refers to women's perceptions that they personally were managing the labour experience. Two study participants experienced being in control in the sense that they were aware of what was going on about them. Because the analgesia allowed them to remain in control as a result of decreased pain, subjects perceived analgesia as a contributor to satisfaction with childbirth. Mrs. K. described how demerol affected her during labour as follows:

> I found that pain killers - well the demerol really
> did help me. It numbed out not my legs - I had control

> of my body parts - I wasn't as caught up in the pain
> that I couldn't push or that I couldn't do this or that
> - before I couldn't move. At least with this I was able
> to help. I could feel my muscles - I could do something.
> I'm glad that I had the little that I did have.

Mrs. S. perceived the epidural as a significant factor in allowing her to feel in control of herself and her body during childbirth. Further, the epidural enabled her to push effectively in late second stage:

> Maybe it was because I had the epidural at the time
> and there wasn't a lot pain - so everything was - I
> didn't have to deal with all this pain as well, so I
> was just focusing on pushing and getting her out.

Amelioration of pain refers to how much better or improved participants felt after having received some analgesia. Five participants received both demerol and fentanyl. Three subjects described how fentanyl [the epidural] affected them in childbirth. Ms. V.'s initial perception of how the epidural affected her included:

> After they gave me the epidural I went to sleep for
> two hours and it was great. As soon as I had the
> epidural....I was satisfied, because I wasn't
> feeling anything....Yes, I was very satisfied.

Mrs. S. attributed her satisfaction with childbirth to the epidural:

> The epidural worked great....I loved it! At the time I did - for the pain and everything....I think it really helped me relax. I felt it made me very drowsy.

One subject resisted the epidural as long as she could. Her response to its effect, however, was as follows:

> I was glad I did [have the epidural], because I felt a lot better. It even helped me sleep through some of those painful contractions....I didn't want it [epidural] and I was resisting, but he [husband] insisted I get it. So I was glad I did, because I felt a lot better.

Fentanyl was observed as having two effects on subjects. First, it relieved women of their labour pain. Second, because subjects were relieved of their discomfort, they relaxed and slept. Once the fentanyl took effect, subjects were very much aware of what was going on about them, in spite of having slept for an hour or two.

For another subject, the initial effect of the entonox was perceived as favorable and contributing to childbirth satisfaction:

> They gave me gas and that was my life saver....That gas mask just about saved my life because I swear I was going to die.

Although these subjects perceived the analgesia as contributing to childbirth satisfaction, others reported that it only contributed to their dissatisfaction. Several study participants claimed analgesia did not provide the expected pain relief.

In this study, "pain" refers to the unbearable discomfort of uterine contractions experienced by the nine study participants during the birth process. The following responses describe what pain "did to" the subjects and how analgesia did not relieve the discomfort. Mrs. M., for example reported:

> The pain wasn't too bad in the beginning - I could take it....But then they [contractions] started... getting so bad, I couldn't stand the pain....finally ...they gave me demerol and that didn't do anything - they might as well have given me nothing. By 4:30 in the afternoon they [contractions] were really bad and they put me on I.V....to get the baby moving....Then the pain started getting really severe....I just couldn't stand it anymore and my husband said "Enough is enough! Give her the epidural....I couldn't feel my legs at all, but I could still feel the pain.... All in all it was a very painful and scary experience.

Mrs. A., like Mrs. M., had both demerol and fentanyl, yet did not experience the anticipated relief:

> I had the demerol when I was about six centimeters ...I just said, "I just can't do this anymore...!" I didn't know how else to handle it [pain]. The contractions just hurt so much....I just screamed... The [demerol] didn't do anything for me. It didn't do a thing for me. If it did I don't know what kind of pain I would have been going through....They wheeled me in to give me the epidural....Just before I delivered, but it only lasted long enough till I hit the delivery table....I felt every bloody thing when I delivered that baby....No matter what drugs they gave me it hurt.

For other labouring women, demerol also did not provide the expected alleviation of discomfort from contractions:

> It [demerol] didn't work....I didn't notice any change in the strength of the contractions, in the pain. It might have made it just a little bit numb - the pain in the back. As for the pain in my back - my husband

rubbing my back helped more than the demerol did by far....I remember he [nurse] gave me it [demerol] and said that maybe that would take the edge off. Maybe about half an hour later he came by and said "Did that help?"...I said "I didn't realize it had worked yet."

They gave me demerol and that didn't do anything - they might as well have given me nothing.

Mrs. L. perceived the ineffectiveness of demerol in easing her pain as follows:

I had some demerol - which to me is a big mistake. I will never take that again. I felt it did nothing for the pain in terms of easing the pain. That stuff is useless. I said [to my husband] "It hasn't zonked me out and hasn't really helped the pain at all." If I had to do it again...I would refuse the demerol for sure....It didn't help for the pain....I was really disappointed in that....I thought it would do a little more for the pain. To me it did nothing for the pain ....it didn't lessen the pain of the contractions.

Five subjects had both demerol and fentanyl, two of which also had entonox. Two of the five subjects indicated that fentanyl did not provide the expected pain

relief.

Of the five study participants who had entonox, only two subjects' responses included descriptions of the effect entonox had on them. One subject reported that initially the entonox had given her pain relief and she had perceived it as her "life saver." As labour progressed she reported:

> I needed to hold on to that gas mask...The gas just isn't covering anymore, you guys. I was just sucking it in for the sake of sucking it in.

Another subject perceived the entonox as not meeting her need for pain relief:

> As the labour progressed I needed to hold on to that gas mask - gas wasn't doing anymore.

Study participants, despite receiving analgesia, did not experience amelioration of pain. Consequently, these subjects experienced dissatisfaction with the labour and delivery experience.

No subjects identified dissatisfaction with themselves for having 'given in' to having analgesia. Subjects, however, were dissatisfied when they experienced "Loss of Control" of the situation during childbirth. For the majority of subjects labour pain was so severe that agreeing to analgesia seemed to be their only recourse. Study participants' responses indicated that the unfavorable effects from the analgesia were perceived as contributing to their loss of control.

For some study participants loss of control meant being cognitively impaired. That is, labouring women perceived themselves unable to maintain their awareness and rationality during the birthing process, because of the effect demerol and/or entonox had on their senses. Mrs. L. described how demerol affected her in labour and contributed to her loss of control:

> All it did was sort of take away my senses that I had left....I was so disappointed in its effects....All it [demerol] did was make me feel very stoned - like out of control....At that point I lost a lot of it - awareness, control.

Mrs. L. already perceived herself as "stoned...[and] out of control" because of the analgesia. Then, when she was informed "we have to take the baby now", she further perceived herself in the following way:

> I was very upset with that, because I felt I knew that I had very little control of things at that point....I really felt that at least he [husband] should know what is going on because I didn't. I didn't feel that I had a good control on anything and I at least wanted him to know what was going on and to be making the decisions or whatever it takes, because I didn't trust myself to be making proper

decisions or anything.

When another subject, Mrs. S., was asked to explain how she felt she had lost control, she responded:

> I didn't feel I had control of my senses, because of the demerol. Not control of the situation, but control of my senses. I wouldn't really be aware of things. Sometimes I knew that there were people around me, but I really couldn't say who and things like that. I knew I was that much out of it. To me that was the biggest mistake. I might have been able to have better control if I had lost a bit of the pain....It [demerol] just zonked me out between contractions. Overall, I think that was something I would never, ever do again, that is, take demerol for something like that at least....I would never use it again in labour.

Another subject described a similar loss of control associated with analgesia:

> Emotionally I was fine till they gave me the demerol and that's when I went downhill. It hit me like a ton of bricks. It was like - I don't know how to explain it. It was like my spirit left my body - it is like I

could stand over and watch myself, I could feel the contractions but, they didn't hurt. I wasn't feeling no pain at all. I could feel my tummy tightening.... With the demerol I just lost it. I had no control. They kept telling me to relax. I said "I'm relaxed!", but I was just out of control. I didn't know how else to handle it. The contractions just hurt so much. And with the demerol I couldn't feel them.

The common perception regarding the use of entonox was one of dissatisfaction. Firstly, it did not effectively reduce the pain. Secondly, it impaired subjects' cognitive ability:

They gave me gas - that just made me tired and dizzy. I was really wiped out from all that gas. It was terrible....The gas it just made me very dizzy - very, very dizzy and each time they took it away I kind of blacked out for a minute. I felt very whoosy....The gas - it didn't help.

I felt as if I was bombed out of my mind. Then I didn't want it [entonox] anymore - it was sort of too distracting and I had to concentrate on getting this [delivery] over with. I couldn't breathe properly

because I was too wonky from the gas.

The second most common type of intervention experienced by participants was inductions of labour. For women in this study, induction was accomplished through amniotomy or rupture of membranes, a method of artificially inducing labour. As discussed earlier, this intervention contributed to three women's dissatisfaction with childbirth, because the procedure was carried out without providing adequate preparatory information. Cesarean section was a third type of intervention experienced by a study participant. As previously mentioned, Mrs. L., perceived lack of informational preparation regarding the cesarean section more of a contributor to dissatisfaction with childbirth than the actual surgical procedure.

In summary, subjects perceived "unbearable pain" as the reason for requesting analgesia. Although the effects of analgesia (demerol, fentanyl, entonox) contributed to both study participants satisfaction and dissatisfaction with the childbirth experience, the majority claimed they did not experience the expected pain relief. Analgesics, therefore, were perceived as a major contributing factor to subjects' loss of control during the birth experience. Subjects perceived loss of control to be related to two factors: 1) the analgesics impaired them cognitively, and 2) the analgesia was ineffective in ameliorating the pain.

In this study, medical interventions led to both satisfaction and dissatisfaction with the childbirth experience. Inadequate informational, physical and psychological preparation with regard to interventions was an underlying contributor to childbirth dissatisfaction.

Controlling

A second sub-category of "Doing To" was "Controlling." In this study, controlling refers to childbearing women being dominated or controlled by caregivers. That is, subjects perceived themselves subjected or pressured into a procedure or behaviour with which they did not agree or were not well informed about. The above identified behaviours of professionals were labelled as controlling. Sub-categories of controlling are: 1) "denying requests", 2) "intruding" on subjects privacy and dignity, and/or 3) "coercing" subjects into a behaviour without thoroughly informing them about the procedure. For study participants, controlling led exclusively to dissatisfaction with the birth experience.

Denying Requests

Caregivers refusal to grant childbearing women their expressed desires was labelled "Denying Requests." For subjects to be denied their requests without clarification, contributed to dissatisfaction with the childbirth experience. One study participant was deeply hurt psychologically because nurses refused to free her hand so she could touch her newborn baby:

> One part I really hated about the thing [cesarean section], that's when I realized that - I reached out to touch him [baby], but I couldn't - I was strapped down. And that really depressed me. I felt that not only had this [childbirth] not worked out the way it

> was planned [naturally] and I lost, or didn't know what was going on half the time and here I can't even touch my baby....That really hurt me....I even asked if I could have one hand free and they said "No" not until I was stitched up. That's when I realized that - so I said can't you at least untie me?..."No." I had to wait until I was stitched up.

For another woman, denial meant caregivers' enforcing their will, rather than being accommodating to the subject's request:

> I just didn't appreciate the attitude the hospital [personnel] had - it was like either you do it our way or telling you that we don't like what you're doing.

A third subject described herself as "really upset" because she was denied her request for comfort and analgesia during labour and coerced into a procedure without giving informed consent:

> Just the way they were - I was being told. Like I said I wanted to squat on top of the bed - so they started taking my bed apart and had me in like a standing position on this bed. Well, I wanted to just get up

on the bed and squat....I was just trying to be comfortable and it was like they weren't letting me do anything I wanted to do. At around seven o'clock I was begging them like "Please, give me another demerol." They were going "No, we'll give you an epidural." I said "I don't want an epidural....check with my doctor and see if I can have another shot of demerol"....They came back about half an hour later and said "We can give you another shot. I'll go get the needle and everything and be right back." That was about 07:30 - the nurse came back at nine o'clock and said "We'll break your water now." I said "Where is my shot?" They never came back and I wanted my shot. They had told me I was going to have it. I was looking forward to it - I was depending on it. "Where is it?" They said "Well, you can't have it now." I was really upset.

Mrs. M. described how she was denied a fentanyl "top up":

They gave me the first one [dose of fentanyl] around four when I just couldn't take the pain anymore. I think they gave me...two other doses - but what happened is I still felt the contractions and by the

time he [baby] was ready to be delivered, I was starting to feel the pains again and I wanted another one [dose of fentanyl], but they said "No, you are too close now - we can't give you another one."

A sixth participant recalled three specific requests she was denied:

I need something for this pain....I had to have something and they are going "You can't have anything" and I'm going "Well, I really need something"....So I finally got them to give me the gas.

Later on in the bathroom, nurses insisted that the subject return to bed before her contraction was completed:

...meanwhile I wasn't even finished the contraction. It was like I can't walk in the middle of pain here - let me just finish my contraction. Well, they started walking me back to the bed. The head was there. I wasn't even finished with the contraction. I was just in pain.

The third instance of denial prompted the woman to ask for early discharge:

> I wanted a semi-private, but they couldn't get me one so I was put in a room with 3 other ladies. I wanted privacy, but was kept up all night. I was released the next morning ....I wanted out. I would have stayed longer if I would have had a semi-private just for the rest.

Caregivers denied study participants their requests. Denial, as perceived by study participants contributed to their dissatisfaction with the birth experience.

Intruding

Caregivers imposing upon a childbearing woman's privacy and dignity, without her permission was labelled "intruding." In this study, the limited data regarding intruding may well be another emergent category. One study participant perceived her privacy and dignity intruded upon by caregivers during childbirth:

> What I didn't like was that I felt like there was so many people...all these different doctors and nurses and everybody in and out of the room and examining me - I felt like I had no privacy at all. I felt like any bit of dignity that I had was taken away from me....It was a really uncomfortable feeling. I am a very private person and I didn't like all these different people seeing me, and it was really uncomfortable for me....When you've got all these

> student doctors and nurses and everybody - it's just too much....It's no big deal to them. I'm sure that they see thousands of women all the time so it's no big deal, but it is a big deal to the woman.

Coercing

Caregivers coerced or subjected labouring women to procedures and/or hospital protocols for which the women were not prepared, nor to which they had agreed. These actions resulted in dissatisfaction with the birth experience. Mrs. K. was coerced into various procedures:

> When I got to the hospital they automatically put the monitors on me and I had to stay in bed and that's when I can't handle the pain. I can't be confined - the pressure of the belts and all that was just too much for me. I just can't take that. I have to be one that can walk around....Right after they broke my water they put a monitor on his [baby's] head - up to that point I was wearing [monitor belts]. I could take them off once in a while so I could walk around but they didn't like that - they wanted me to stay in bed....Can I take these belts off? "No, we [nurses] want them on"....I was in the birthing room, that's why I was really upset. Being moved around when I

didn't want to be moved around.

The baby's head was...caught around the lip of the cervix. So without even telling me she [physician] sticks her hand up me and starts going like this [made circular motions with her hand]....I said "What are you doing? Get your hand out of there!" I don't know what she was doing - just like get away from me. She said "Well - then we'll be here all day." She was very bad, bed - mannered....She was just doing things and not preparing me for them. I didn't know what was going on.

Further coercion for Mrs. K. included:

I knew what was comfortable for me - what wasn't. They were telling me you have to do this, this and that....they were making me do it....I was just disappointed....[with] the way they were with me. I wasn't satisfied with - just the procedures that they were using....I just didn't agree with a lot of things that they were doing.

Ms. V.'s greatest dissatisfaction with coercion included:

> The thing I was dissatisfied with was - when I had to push they [nurses] kept lifting my head up and it was hurting my neck. I kept telling them "It's hurting me", but they wouldn't listen. They'd say "It helps." ...For about two days my neck was hurting real bad...I was telling [the nurse] "Stop!"...They were pushing my neck and pushing me up and telling me when to go and I knew when to go.

One subject, Mrs. W., did not perceive herself coerced into unwanted behaviours, nor perceive the need to be in control, neither did she have complaints about anything. Rather, she flourished under "passive dependence." When asked to explain "the warm cocoon feeling" Mrs. W. commented:

> I was looked after. You know when you have a child you end up doing - in the beginning you give up so much of yourself - what you want and your desire and that. So all of a sudden there was a reversal - I was being taken care of. It was a nice feeling. That was one thing why I had a hard time leaving the hospital. I wanted to stay....I liked that feeling of being looked after....I don't have anything to complain about....I didn't feel any dissatisfaction at all.

In this study, participants identified aspects of controlling that occurred during the childbirth experience. For study participants controlling meant: 1) having their requests denied without being offered reasons; 2) having caregivers intrude on their privacy and dignity; and 3) being coerced into behaviours about which they were not well informed. Regardless of which aspect of controlling subjects' were confronted with, they all contributed to dissatisfaction with the childbirth experience. That is, because subjects were unable to remain in control of the situation.

In summary, the categories "Doing For", "Doing With", and "Doing To" all involved caregiver and subject interaction. Any one of these aspects of "Being There" contributed to postpartum women's satisfaction and/or dissatisfaction with childbirth. That is, whether women were satisfied or dissatisfied was associated with how subjects' perceived their needs and requests were met by significant others and/or caregivers.

CHILDBIRTH EXPECTATION CHANGES

It also became evident from the analysis that most subjects experienced a change in feelings from the prenatal to the postnatal period. These changes were associated with subjects' prenatal expectations and how they were or were not met during the birthing process. Again, satisfaction and/or dissatisfaction with childbirth was determined by subjects' perception of how closely expectations and outcomes matched.

Subjects were asked to describe whether they had experienced any change in their expectations and/or perceptions of the birth experience. Childbearing women in

this study reported prenatally conceived expectations regarding childbirth. From the analysis, it was apparent that subjects' anticipations pertaining to the childbirth experience frequently changed during the course of labour and delivery. Subjects identified three specific changes that occurred: a shift from the negative to the positive and the positive to the negative, and incremental negativism. Two participants reported that they experienced no changes during labour and delivery, rather the outcome matched their antenatal expectations.

Unaltered Perceptions

For two women, existing positive feelings remained unaltered throughout childbirth. These study participants had no surprises, that is, the experience turned out as expected. Childbirth was therefore viewed with satisfaction.

> [I had no feeling change]. No, not really. I was so excited about - finally the baby's going to come.

A second woman described her expectations of childbirth as follows:

> [I had] no change in feelings, because [I] knew what to expect....nothing had changed....For the most part [childbirth was what I expected], except that it took a fair bit longer than I had figured that it would, but for the most part it was good....I knew the whole routine, I knew what the labour room was going to look

> like...so I had no unreal [expectations]....So I went in knowing what the floor [labour unit] looked like - what the whole area looked like.

Negative to Positive

Some study participants went into labour with negative expectations. Two subjects emerged from the birth experience feeling positive. These women also viewed the childbirth experience with satisfaction. Mrs. A. stated that her prenatal perceptions of the childbirth experience changed during the birthing process:

> I guess my feelings changed - they just changed....I went in with horrible feelings....I went with a bad experience the first time and the second time I came out with a better experience....This time they [contractions] weren't that bad....I came out feeling that you can really have a good childbirth. Not every childbirth is as horrible as the first one, I think that is where my attitude changed toward childbirth. The first time it was 15 hours of pure hell and now it was only six [hours].

Mrs. T., like Mrs. A., had a previous negative childbirth experience and therefore went into this birthing process fearing labour and childbirth:

> I went in being very apprehensive and scared about labour and delivery. This was all because of my last experience, which wasn't good at all. I really feared this childbirth.

When Mrs. T. was asked to share what happened during this childbirth that changed her feelings of apprehension and fear to positive ones:

> The nurses that I had were really great. They were helpful and helped me walk through my labour and so I didn't lose control of myself....I had gone in with all these fears and as it turned out, I had my baby before anything got to the stage that I couldn't control. I went in with negative feelings and came out of it feeling so positive.

In summary, these subjects went into labour with negative feelings regarding childbirth, but emerged from their most recent birth experience feeling positive.

Positive to Negative

Other subjects went into labour anticipating a positive experience, yet, emerged feeling negative about the experience. These negative feelings contributed to subjects' dissatisfaction with the birth experience:

I thought it [childbirth] would be just like the first, but easier. I was totally wrong....I thought it would be better. I thought the pain wouldn't be as bad as the first one. The first one though was nothing compared to this one. And I just thought it would go by quickly and I'd be nice and happy.

Another subject stated:

I was always told that your second delivery is... easier, so here I guess I had this illusion in my head that I was going to walk...[into hospital] and that things would just go smoothly....When I went in it was like "Oh, great! I get to see my baby finally." I think I was more disillusioned by everything... During it [childbirth] - it was "Oh, no! All those old memories are coming back to me. Oh, no! I'm going to die."...I was really scared....I expected to have my delivery in half the time - I was in there for eleven and a half hours and I was expecting - no problems, just two pushes and out he comes and I didn't have that....It always felt there was one obstacle, another obstacle and just trying to get through that one....Right at the end my

> feelings were "It's over!"...Finally it was relief
> and satisfaction. I was satisfied that he was here,
> but not with what was going on....I didn't feel like
> anything went smoothly.

Mrs. L. described what her antenatal perceptions of childbirth had been and how she perceived childbirth postnatally:

> Through out the pregnancy I had sort of consoled myself
> of the fact that this [childbirth] was going to be okay
> - especially since I had such a carefree pregnancy in
> terms of any medical problems. So by the time....[the
> baby was due] I had really done a good job of changing
> my attitude - went in very positive, not being worried
> about it [childbirth] and always looking forward to it
> sort of....I had gone in with such a positive attitude
> and sort of been so disappointed in that respect....
> the way things turned out it....[and] Afterward...
> feeling like I don't care about the baby....I didn't
> feel a real connection to him....Initially I don't
> think [I felt] guilty, as much as worried by it [not
> feeling a real connection to baby]....[and] thinking
> this is not a good way to start....It felt like things
> weren't going at all...the right way....I didn't think

it would be such a medical thing - taking pain killers and not being able to get in and off the bed on my own. It became so much more medical than I had anticipated ....It [cesarean section] wasn't expected in any which way....I [also] feel a little bit cheated somehow with the childbirth experience. That I really haven't got it [childbirth experience]. I really haven't had it when you read the books and things - the descriptions of seeing the birth, holding the baby immediately - it all sounds so rewarding and I didn't have any of that. In that respect I feel disappointed.

Another participant described her change of expectations as follows:

When they got the stirrups - yes [I felt] a definite change from the positive to the very negative. Suddenly it was - like you might as well have stepped into a whole 'nother world. It was just something odd....That [immediate awareness of this oddity] made me in the end decide to go without them [stirrups]. I wasn't sure at first what the doctor meant when she said I could have a choice.

In summary, unexpected, unfavorable events during labour and delivery changed

subjects' expectations of childbirth satisfaction to ones of dissatisfaction.

Incremental Negativism

For one woman negative feelings regarding childbirth, became progressively more negative during the course of labour. This participant went into labour expecting dissatisfaction with the childbirth experience, yet, postnatally found herself feeling more dissatisfied than she had anticipated.

> I had this horrible fear of labour....Labour and delivery is something I feared all through my pregnancy....So I went in there expecting the worst and it was even worse than I expected....it was like my worst nightmare coming true. And I thought, this is bad, no wonder I was fearing all the time.

This observation suggests that the events of the labour and delivery experience can also compound existent perceptions - in this case, fear compounded fear.

In summary, analysis of the data showed that childbearing women's perceptions of the birthing process can change or remain unchanged. That is, women can go into labour with positive feelings and emerge from the experience with similar feelings. However, when unexpected events occurred during labour and delivery, three types of perceived changes were observed: 1) positive to negative, 2) negative to positive, and 3) incremental negativism. Two basic types of responses were identified. Firstly, when outcomes did not match women's prenatal expectations, that is, when they were worse

than expected, subjects experienced dissatisfaction with the birth experience. Secondly, when outcomes matched favorable prenatal expectations or were better than expected, childbearing women perceived their childbirth experience with satisfaction.

SUMMARY

Analysis of nine study participants' responses to the childbirth experience led to identification: 1) of an affective meaning of satisfaction with childbirth for three childbearing women, 2) of an overall theme "Being There", 3) of categories and sub-categories "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling), and 4) of the finding that childbearing women have prenatal expectations of labour and delivery and consequently experience feeling changes throughout the birth process.

The final chapter of this thesis includes a summary of the study, a discussion of the findings as they relate to current literature and to the conceptual framework; implications for nursing practice, education, and theory; limitations of the study; recommendations for future research; and conclusions.

Chapter Five

SUMMARY AND DISCUSSION

The final chapter of this thesis includes a summary of the study; a discussion of the findings; implications for nursing practice, education, and theory; limitations of the study; recommendations for future research; and conclusions.

Summary of the Study

The purpose of this study was to explore and describe the meaning of satisfaction in childbirth from the perspective of postpartum women. Three questions guided the study: 1) what does it mean to be satisfied in childbirth; 2) what factors in the birth experience contribute to satisfaction in childbirth, and 3) does a childbearing woman's satisfaction with childbirth change during the course of labour and delivery?

The conceptual framework for the study was based on Symbolic Interactionism, a social theory about human behaviour that focuses on the meaning experiences have for individuals. Chenitz and Swanson (1986) argue that only through interaction with the experience and with self is the experience defined and meaning attached to it. Based on this perspective, the research focused primarily on women's reported interactions with partners, caregivers, and newborn infants during the birthing process.

A review of the literature had shown that little was known about satisfaction in childbirth due to the difficulty of conceptualizing the multidimensional construct of satisfaction and the problems inherent in its operationalization. Qualitative research

methods and designs are used when: 1) the study questions raise queries about people's experiences under natural conditions, 2) the investigation deals with a study question about which very little is known, and 3) where the intent of the study is to gain insight about a particular group of people (Wilson, 1985). Since the purpose of the study was to gain insight into how postpartum women perceive satisfaction in childbirth, a qualitative design was utilized.

Semi-structured interviews with open-ended questions were used so that postpartum women might share information about their childbirth experience and provide the detailed and comprehensive information needed to understand the meaning of satisfaction with childbirth as perceived by childbearing women. A convenience sample of nine postpartum women was recruited through a City Public Health agency. A fairly heterogeneous sample of postpartum women was recruited to the study including: both single and married women; primiparas and multiparas of different ages; women who experienced spontaneous vaginal deliveries or a cesarean section; subjects who delivered in four of the five facilities that attend to deliveries in a major Canadian city, and women who were attended to in delivery by obstetricians, family physicians, residents, and in one instance, by a nurse.

An interview guide and a demographic tool were used to facilitate data collection. The interview guide consisted of several open-ended questions which enabled subjects to describe the childbirth experience from their own perspective. Additionally, interviewing allowed women to clarify their entire range of feelings of satisfaction and/or dissatisfaction with childbirth, rather than agreeing and disagreeing with given statements. The interview questions were directed by the researcher's experience with childbearing women, the purpose of the study, and the literature review. The interview

approach produced a large amount of narrative material. Content analysis provided a systematic procedure for analyzing the unstructured qualitative data obtained from the interviews. In the following section the findings of this study are summarized and discussed.

Discussion of the Findings

The purpose of this study was to determine what postpartum women perceive as the meaning of satisfaction in childbirth. During the interview, study participants were asked to describe what satisfaction with the childbirth experience meant to them.

Meaning of Satisfaction and Dissatisfaction

Data obtained through audio-taped interviews showed that childbearing women had difficulty defining satisfaction with childbirth. Two distinct types of responses were obtained. For three participants, satisfaction meant experiencing an affective response or feeling about childbirth. For these three subjects, the common exemplar for the meaning of satisfaction, was "I'm happy!" Other exemplars included: a state of "feeling content", a goal or point of achievement in life - "fulfillment" - "feeling complete." To define dissatisfaction with childbirth was an equally difficult task for the women. No common exemplar was identified. Dissatisfaction was defined in various ways as: a "negative feeling", "feeling uncomfortable and scared", and "what I wasn't happy or pleased with."

Westbrook and Oliver (1981) argue that "consumer satisfaction refers to an

evaluative response concerning the perceived outcomes of experiences", yet, they perceive "affect as central to the construct of satisfaction" (p. 94). Gutek (1978) argues that happiness may be "more a reflection of mood than is satisfaction" (p. 54). The findings of this study are consistent with earlier findings (Westbrook & Oliver, 1981). That is, study participants evaluated their childbirth experience. How they evaluated childbirth, determined their feelings about the experience. For example, when expectations were met by significant others/caregivers subjects experienced satisfaction with childbirth. Conversely, when expectations were not met women experienced dissatisfaction. Satisfaction with childbirth, therefore, is both an evaluative process of and an affective response to the birth experience.

Factors Contributing to Satisfaction and Dissatisfaction

The six other women in the study described aspects of the birth experience that contributed to their satisfaction or dissatisfaction with childbirth rather than specifically defining what satisfaction meant to them. Analysis of subjects' descriptions of the factors associated with satisfaction and/or dissatisfaction with childbirth led to identification of the theme "Being There", as well as the categories and sub-categories "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling). Although few women provided clear definitions, they clearly identified association factors. No earlier studies were found that had identified the emergent overall theme, categories and sub-categories of this study. These findings will be discussed in relation to information presented in the current literature.

Study participants identified major aspects of the birth experience that contributed to their satisfaction with child- birth. All nine subjects identified caregivers' combined psychological and physical support as contributing to their satisfaction with the birth experience. Additionally, the eight married women identified the presence of the husband as a contributor to satisfaction. When these aspects did not meet women's expectations, they were perceived as contributing to their dissatisfaction. This finding supports Pascoe's (1983) argument that expectations serve as a standard for assessing a commodity or service, including the context, the process, and the outcome. In other words, patient satisfaction resulted from the childbearing woman's evaluation of specific aspects of childbirth (the context), labour and delivery (the process), and a healthy baby (the outcome). For some women, satisfaction and its converse, therefore, were characterized as an evaluation comparing directly received service or outcome to a given subjective standard. Other aspects subjects identified as contributing to dissatisfaction included the use of analgesics (demerol in particular) and the enforced passive role during childbirth. These aspects will be discussed later in this chapter.

For study participants, the husband's "Being There" centered on his presence at childbirth. Women did not want to be left with hospital caregivers, but desired to have someone there whom they knew and loved. Women perceived their husband's physical presence: 1) as the key contributor to satisfaction with childbirth, and 2) as the key source of psychological support, hence both contributing to satisfaction. This supports earlier findings that a husband's emotional support has paramount influence on women's perception of satisfaction with childbirth (Broome & Koehler, 1986; Brown, 1987; Mercer et al., 1983).

Subjects yearned for their spouses' "Being There" during the birthing process

and perceived their presence as contributing to satisfaction with childbirth. Study participants, however, made no reference to the husband's presence as being influential in controlling their perception of pain, or increasing their sense of self-control. This finding is consistent with those of Norr et al. (1977) and Doering et al. (1980), who found that the husband's presence has no significant impact on the labouring woman's pain, but does, however, significantly influence her satisfaction with the birth experience. All three types of social support as identified by House (1981) [physical, psychological and informational], were identified by study participants as aspects of caregivers' support that had a significant impact on their satisfaction with childbirth.

Nurses who provided psychological support were perceived to be: "really nice", "open", "wonderful", "in good spirits", "friendly", "encouraging - positive in reinforcement", "sensitive to me as a person and my needs", "my advocate - communicating between myself and the doctor." These findings are consistent with Roach's (1987) description of a 'caring' nurse. Roach (1987) also suggests that caring is not evidenced in specific acts, but "rather specific manifestations ...represented by behaviours such as taking the time to be with...[and] showing respect" (p. 58). In other words, caring is expressed as a response to something that matters, in this case providing a supportive social environment to childbearing women.

The findings of this study also are consistent with those of earlier studies in which women placed high value on interpersonal support during labour and delivery (Affonso, 1977; Brown, 1987; Collins, 1984; Kintz, 1987). In these studies, investigators found that social support greatly improves women's psychological approach to labour and satisfaction with childbirth. Conversely, subjects perceived nurses' inappropriate comments as a hinderance to psychological support and a

contributor to dissatisfaction with childbirth. These findings are consistent with the findings of a study by Shields (1978), in which a nurse's negative manner ("nasty, short... blase about the pains, bossy, not directive, making fun of another girl who was crying..." [p. 541]) was perceived most contributory to subjects' dissatisfaction with childbirth.

Some subjects perceived physicians as providing psychological support, while others reported not having received any such support. Psychological support was the most frequently identified type of social support received from physicians. Participants also perceived psychological support as the most crucial contributor to satisfaction with childbirth. Despite the fact that physicians (in comparison with husbands and nurses) spend limited amounts of time with labouring women, the physician's presence at childbirth was perceived as highly significant to satisfaction. Study participants also reported that in the absence of their own physician, the older, experienced, "On Call" doctors were more likely to meet their birthing needs and contribute to their satisfaction with childbirth, than younger and/or student doctors.

Shields (1978) found psychological care to be the decisive factor in satisfaction with childbirth when postpartum women evaluated nurses and nursing care. In this study, combined physical and psychological support by nurses contributed most to women's satisfaction with the birth experience. Combined care that study participants perceived as enhancing their satisfaction involved: "hands on" nursing care, for example, "brought warm blankets", "bundled me up", "held my hand", "massaged my back", and "helped with the breathing." Subjects who received physical support without psychological and/or verbal informational support, did not perceive physical support as enhancing childbirth satisfaction. Further, women who received exclusively physical care

described the emotional feelings they experienced as a "Really uncomfortable feeling. You're a statistic to them! I just thought that I was a nobody."

Shields (1978) found that the second most frequently identified nursing measure of supportive care was explanation (verbal informational support). In this study, caregivers lack of verbal informational support regarding procedures was identified as an underlying contributor to dissatisfaction with childbirth. This finding is consistent with those found in a study by Sullivan and Beeman (1982). That is, satisfaction with childbirth was greatly enhanced when the quality of communication improved through explanation of procedures.

Support was found for earlier findings that "childbearing women have a legitimate need to understand all the events that occur to them during birth" (Affonso, 1977, p. 163). Both this study and earlier investigations indicate how essential sharing of information is to childbearing women's satisfaction with childbirth. Communication is a critical element that needs enhancing between caregivers and labouring women, if health care professionals wish to be proponents of a positive childbirth experience. Additionally, if childbearing women are to experience satisfaction in childbirth, it is imperative that caregivers combine physical, psychological, and informational support when attending to labouring women.

Kirke (1980) found that many postpartum women were dissatisfied with how physicians communicate with them during childbirth. The question Kirke (1980) asked:, "Is it likely that communication or the lack of it, is the variable associated with childbirth satisfaction or dissatisfaction?", received some affirmation by the findings of this study. That is, adequate verbal and non-verbal communication, or its converse, respectively contributed to satisfaction and dissatisfaction with childbirth. This also is

consistent with findings of earlier investigations (Kintz, 1980; Mercer, 1985; Sullivan & Beeman, 1982), which indicated that lack of communication was the most likely reason why subjects did not actively participate in labour and delivery decision-making, nor maintain control during the birthing process.

Conversely, these findings do not support the observation by Woolley et al. (1978), that the effectiveness of patient-satisfaction communication may be far less important than the fact that an effort was made. In other words, patients may rate their satisfaction based on the degree to which they perceive the physician or nurse cares about them. Whether it is care women perceive they received from health care professionals or direct communication with them that contributed to their satisfaction with childbirth, it remains imperative that caregivers provide some form of social support.

In summary, the findings of this study confirm that all three types of social support contribute to childbearing women's satisfaction with the birth experience. Despite the significance of the various types of support to satisfaction with childbirth, combined physical and psychological support was identified as the most predictive of satisfaction. Lack of verbal informational support from caregivers was perceived as an underlying cause for inadequate social support and childbirth dissatisfaction. Analysis also showed that women perceived dissatisfaction with childbirth to be increased by a combination of inadequate physical, psychological or informational support. Caregiver support for labouring women therefore, cannot be exclusively that of ensuring a safe delivery, but must also include social support that facilitates satisfaction with the childbirth experience.

Powerlessness

Technological interventions ensure women a safer childbirth, yet, concurrently foster a sense of maternal powerlessness (Willmuth et al., 1978). In contrast to the formerly passive maternal role, many contemporary women are demanding less technology and asking for more active participation and greater control in their childbirth experience (Littlefield & Adams, 1987; Nelson, 1983; Sullivan & Beeman, 1982). The findings of this study, that women want to be involved in making informed decisions and remain in control, are consistent with earlier findings by Nelson (1983), and Sullivan and Beeman (1982). Thus, to facilitate satisfaction in childbirth for present day childbearing women, requires psychological and verbal informational support, as well as competent physical and/or technological care.

For study participants, dissatisfaction with childbirth was perceived as the converse of satisfaction. Subjects also identified two major aspects of labour and delivery that contributed to their dissatisfaction with childbirth: 1) the use of analgesia, and 2) controlling caregivers during childbirth. The first aspect of labour and delivery that subjects perceived as contributing to their dissatisfaction was the use of analgesia, particularly use of demerol. Participants reported "unbearable pain" as the reason why they requested medication. All eight subjects who received analgesia expected to obtain pain relief and consequently, to remain in control of the experience. With the exception of one subject, the unanimous perception of the effect of demerol was that "it did nothing for pain relief!" No study participants, however, reported feeling guilty or being a failure for having accepted analgesia. Today's childbearing women learn about analgesia and its availability in childbirth classes, as well as from their physicians,

family and friends. Also it is offered liberally to labouring women. Use of analgesia has become more accepted as the means of coping with "labour pain" and therefore it is "okay" to use analgesia, even though many women are proponents of natural childbirth.

The majority of the women in this study reported that the ineffectiveness of the medication interfered with maintenance of control and consequently contributed to dissatisfaction with the childbirth experience. Subjects' basic argument against the use of demerol was the effect it had on them. Women stated for example, that "at that point I lost it", "emotionally I was fine until they gave me demerol, that's when I went downhill." One woman perceived accepting demerol as the "biggest mistake" she made during childbirth and indicated that she "would never use it again in labour." Another study participant, however, reported that demerol enabled her to maintain control during labour and delivery. She also identified demerol as an aspect of the experience that contributed to her satisfaction with childbirth. This is consistent with earlier findings that control is an important correlate of satisfaction (Humenick, 1981; Littlefield & Adams, 1987; Willmuth, 1975).

Whether the effects of demerol were what women expected or not, study participants identified remaining in control as underlying contributor to satisfaction with childbirth. These findings are consistent with those of an earlier study by Willmuth (1975), in which subjects perceived decreased pain or increased physical comfort as a key factor associated with maintaining control and consequently contributing to satisfaction with childbirth.

The association between pain relief and control found in this study differs from findings of some earlier studies (Doering et al., 1980; Norr et al., 1977). Doering et

al. (1980), for example, found that remaining in control and receiving less medication were more important to a childbearing woman's satisfaction with childbirth than simply experiencing less pain. Participants in the present study, however, argued that, if they had had less pain, labour and delivery would have been under better control, they would have managed better, consequently, they would have experienced greater satisfaction with childbirth. Taking into account that the majority of subjects perceived the effects of demerol to have negative repercussions, it is imperative that caregivers offer alternatives and/or be more sensitive to maternal needs when offering and/or administering analgesics. As one woman stated: "I did it on my own this time" (meaning without analgesia). The alternative offered her was most effective: "It was the nurse holding my hand, rubbing my back and walking me through it [contractions]" that made it possible for this subject to experience satisfaction with childbirth, without receiving analgesia.

The significance of nurses' social support to satisfaction with childbirth is consistent with the concept that nursing is a caring, helping profession. Roach (1987) states that "Caring is responsivity, a response to someone/something who/which matters" (p. 47). Several subjects reported nurses being very caring and helpful. Being cared for in a caring way was thus an aspect that helped women maintain control during labour and delivery, and consequently contributed to their satisfaction with the childbirth experience.

Caring demands competence, but it also must be provided appropriately, adequately, and "in a manner compatible with the dignity and needs of those we serve" (Roach, 1987, p. 63). Care should never be at the expense of someone else, nor done "within a power struggle which suffocates the very source of caring energy....Being for

other is authentic when it calls the other to freedom, it is inauthentic when characterized by dominance/depersonalization" (Roach, 1987, p. 63). The latter is consistent with what study participants perceived as controlling. That is, subjects perceived themselves subjected to both procedures or aspects of care without their informed consent, or without caregivers heeding the women's requests and wishes.

Participants reported being induced and analgesics administered without informed consent. One subject also perceived herself having an emergency cesarean section, without being informationally prepared for the surgery. Each procedure done without informed consent contributed to subjects' dissatisfaction with childbirth. These findings are inconsistent with the findings of Norr et al. (1977), that the effect of medical factors on satisfaction with childbirth were very insignificant. Norr et al. (1977), however, do not report whether information about these procedures was communicated to subjects prior to actual implementation. This aspect might well have been a critical influencing factor in satisfaction with childbirth.

Denying women their request without giving reasons contributed to their dissatisfaction with childbirth. As a result of being denied requests, participants perceived themselves as "a nobody - a statistic" rather than "active participants" in their labour and delivery experience. This meant subjects were denied dignity and privacy, freedom from restraints, access to vital information, and the choice of pain relief. This finding is consistent with Roach's (1987) argument that "competence without compassion can be brutal and inhuman" (p. 61). Roach (1987) also perceives care with compassion "indispensible to the caring relationship between caregivers and subjects (p. 61). The findings support earlier findings by Willmuth (1975), that negative effects of hospitalization relate to forcing patients to regress to the point where they no longer

are self-sufficient adults. Relationships between childbearing women and caregivers may be a major reason why some childbearing women choose not to deliver in hospital. Hence, to facilitate childbearing women's satisfaction with the birth experience, it is imperative caregivers provide supportive nursing care.

Gratification

Two study participants described satisfaction with childbirth as "feeling fulfilled" or "contentment". Subjects' gratification or sense of "feeling fulfilled" or "contentment" was associated with giving birth. These participants' responses to the birth of their baby seemed to be that of gratification, and a contributor to satisfaction with childbirth. Study participants wanted both a healthy baby (which they identified as the most satisfying aspect of childbirth) and satisfaction with the childbirth experience. Subjects evaluated events, incidents, interactions, and procedures of the labour and delivery experience to rate their childbirth experience with regard to satisfaction or dissatisfaction. As Oakley (1983) pointed out, women want both a healthy baby and a good experience.

Most Satisfying and Dissatisfying Aspects

All subjects when asked what they perceived as the most satisfying aspect of the birth experience, without hesitation identified the baby as the most satisfying aspect of the birth experience. This was an interesting finding, because no women had referred to the outcome of a healthy baby as a determinant of satisfaction with childbirth.

Rather subjects described the congruency between their expectations and outcome of events, and procedures and interactions during labour and delivery as obvious determinants of their satisfaction with childbirth.

No one single aspect of the birth experience was perceived by subjects as the most dissatisfying in childbirth. Eight subjects, however, identified either non-psychological support by caregivers, having a procedure performed without informed consent, or labour pain as the most dissatisfying aspect of the birth experience. The finding that events, procedures and interactions are determinants of satisfaction or its converse, is consistent with findings of earlier studies that also identified a host of variables as determinants of satisfaction (Bennett et al., 1985; Stolte, 1987). None of the earlier studies however, mentioned the baby as a determinant of satisfaction with childbirth.

Sullivan and Beeman (1982) found that a healthy infant tended to cloud negative experiences and that women are less critical of their maternity care if they gave birth to a healthy infant. All study participants gave birth to healthy infants, however, only four of the nine women associated their childbirth experience with satisfaction, the others with dissatisfaction. This finding therefore is inconsistent with earlier findings by Sullivan and Beeman (1982).

Only one subject stated there was nothing about the childbirth experience she would have liked to change. The other eight women had multiple aspects they would have liked changed. The woman who wanted nothing about her childbirth or outcome changed, had her physician with her the "whole time" during her two hours of labour in hospital. The physician ruptured the subject's membranes, examined her, and was constantly in and out of the room. This subject perceived her physician's presence at

childbirth as a determinant of satisfaction.

For another woman, the attending physician's presence contributed to her dissatisfaction. This subject described her experience with the on-call physician as "I was really getting upset about the doctor...if she touches me one more time I'm going to hit her...she was really rude to me." It is understandable that, to have your own physician with you throughout most of labour, would contribute to women's satisfaction with childbirth. While for obstetricians, group practice and its accompanying "On Call" rotation is a useful arrangement, this practice may be in question when subject satisfaction with childbirth is considered.

Gutek (1978) claims a person may be happy, yet, expect changes. Taylor (1977) argues that a satisfied person is one who momentarily cannot think of anything that s(he) would like changed. One study participant reported that she had no aspects of the birth experience that she would have liked to change. In light of Gutek (1978) and Taylor's (1977) views of a satisfied person, it is understandable why so few subjects associated their childbirth experience with satisfaction. Kintz (1986) and Shields (1978) argue that when childbearing women's expectations are met, women reported satisfaction with their experience. The converse is also true. The findings of the present study show that postpartum women based their expressions of satisfaction and dissatisfaction on how labour and delivery events met their expectations or on their psychological feelings about the birth event. It is impossible from the findings of this study to determine why women find it difficult to define the meaning of satisfaction with childbirth. The only likely reason is that everyone has difficulty defining feelings and therefore satisfaction would not be an exception. Further, whenever feelings are defined it is in comparison to something, which in this study was whether there was

congruence between expectations and outcomes.

Changes in Perception and Feelings

The final aspect of the interview was guided by the question: What changes if any occurred in your feelings about the birth experience from the time you went into labour until you delivered? Responses indicated that childbearing women have prenatally conceived expectations regarding childbirth. Previous studies confirm that antenatal women have definite expectations for their labour and delivery (Beaton & Gupton, 1990; Bramadat, 1990; Chute, 1985; Clark, 1975; Kearney & Cronenwett, 1989).

In the present study subjects' feelings about childbirth frequently changed, apparently because their prenatally conceived expectations were not met during the birthing process. This finding is consistent with Blumer's (1969) notion and meaning of fluidity. That is, labour is a developmental process and not structured. Hence, feelings may change during the birthing process. Two participants experienced no change in their feelings toward childbirth from the prenatal to the postnatal period. Both women went into labour with positive feelings and remained positive about the experience postnatally. Other participants identified three specific types of change: 1) a shift from the negative to the positive, 2) a shift from the positive to the negative, and 3) incremental negativism. The latter group of women went into labour not expecting a good delivery. Postnatally they rated their childbirth experience as worse than anticipated. One subject described it as "the worst nightmare come true."

When a birth experience failed to match prenatal expectations, or was even

worse than expected, subjects in this study reported dissatisfaction with the experience. For example, one study participant who had a totally uncomplicated pregnancy expected to have a similar experience in childbirth. Unfortunately, the subject ended up with an emergency cesarean section. Likewise, two multiparas went into labour expecting the second childbirth experience to be much quicker, easier, and better than the first, only to find these expectations were not met. All three subjects associated their childbirth experience with dissatisfaction because expectations and outcomes were incongruent. Subjects had preconceived expectations of childbirth and used these prior expectations as determinants of satisfaction. Thus prenatal women need to be assisted in forming realistic expectations of childbirth.

These findings are consistent with a discrepancy theory of satisfaction. Discrepancy theorists define satisfaction as the "difference between actual outcomes and some other ideal outcome" (Pascoe, 1983, p. 186). These theorists' also argue that deviations from subjects' perceived expectations are assumed to produce dissatisfaction. The findings of this study do not support this argument. That is, two subjects whose outcome was better than expected experienced satisfaction. Conversely, other study findings support this argument, in that subjects whose outcomes were worse than expected experienced dissatisfaction.

Conversely, the findings do not support fulfillment theory, the major alternative to the discrepancy theory of satisfaction. Fulfillment theorists view satisfaction as a function of the amount received from an event, regardless of how much one feels they should and/or want to receive. This approach assumes satisfaction is determined by objective outcomes alone. Hence, when outcomes are evaluated, consideration of the psychological standard involved is neglected (Pascoe, 1983). The findings of this study

are inconsistent with these views. For women in this study, satisfaction with childbirth encompassed far more than giving birth to a healthy child. Had "outcome" been the only factor used to rate the childbirth experience, all nine women would have had a satisfactory childbirth experience, because all gave birth to a healthy term baby. Only four of the nine subjects rated their experience as satisfactory, whereas five did not.

Based on fulfillment theory, this finding is clearly not what one would expect to find when a woman delivers a healthy baby. Women in this study rated their birth experience on the basis of events, incidents and procedures, instead of using outcome as the criterion for classifying their childbirth experience.

In sum, satisfaction with childbirth emerged as a complex, multidimensional construct. As in previous studies (Shaw, 1985; Sullivan & Beeman, 1982), subjects who expressed satisfaction with their birth experience simultaneously identified some labour and delivery aspects as contributing to dissatisfaction. Taking into account subjects' fluctuating perceptions of satisfaction and/or dissatisfaction with aspects of labour and delivery, a single overall rating of satisfaction with the birth experience would not adequately represent the complexity of women's satisfaction with childbirth.

Implications

These various findings have important implications for health care professionals in that it behooves prenatal caregivers and educators to discuss childbirth expectations with childbearing women. That is, if expectations are unrealistic, women should receive help in formulating reasonable expectations. The role of Labour and Delivery staff in promoting realistic expectations is more limited, depending on the stage of labour the

woman is in upon admission. If women are admitted in early labour, however, caregivers can facilitate formation of realistic expectations in view of both the mother's and the baby's condition. Implications of the findings will be discussed as they relate to nursing practice, education, and theory.

Nursing Practice

The major contribution of this study is the objective confirmation of the helpfulness of selected nursing support behaviours for childbearing women. The findings suggest that a more personal and satisfactory course of care depends on increased attention to interpersonal relationships between caregivers and labouring women, that is, to the essence of Symbolic Interactionism. In other words, this finding supports Blumer's (1969) idea of the fitting together of acts. For example, labouring women had certain anticipations of caregivers, as did caregivers of the women in labour. Whenever these anticipated acts between caregivers and labouring women did not fit together, it led to dissatisfaction with childbirth. Conversely, when the caregiver's and the labouring woman's acts fit together, expectations were fulfilled and led to satisfaction.

Additionally, greater flexibility in hospital rules and policies, and women's participation in decision-making regarding clinical procedures were also perceived as determinants of satisfaction with the childbirth experience. These two suggestions are largely reciprocal. That is, if caregivers strive to develop a good rapport or interaction with childbearing women, they are more likely to be patient advocates with regard to subjects' wishes concerning childbirth management. Likewise, if patients have a good rapport with their caregivers, they will more likely understand the desirability of recommended procedures.

The nurse can help reduce a childbearing woman's distress during labour in a variety of ways. She can acknowledge the distress or discomfort the woman is experiencing and engage her in efforts to deal with labour. Techniques, such as relaxation and distraction could be employed, for example, holding her hand, rubbing her back, or talking her through her contractions. The nurse can eliminate distressing environmental factors by confining the patient to bed as little as possible, and by encouraging her to assume the most comfortable sitting or lying position, and/or to ambulate. Not "hooking" women to monitors and intravenous' is another means of reducing environmental stressors. Caregivers also can promote realistic expectations about labour, the nature of labour contractions, and the use of analgesia during labour.

Additionally, the nurse can encourage the support person's participation during labour. Assistance by husbands and/or significant others greatly contributed to the reduction of distress that labouring women experienced in childbirth. In addition, husbands' support had a major impact on women's satisfaction with childbirth. Nurses are a vital element in assisting the childbearing woman's husband and/or significant other to feel more confident in their helping tasks and in providing a supportive environment. Coaches also should be encouraged to be active participants during the birthing process. Inappropriate supportive actions by caregivers, however, only contribute to women's dissatisfaction with childbirth.

A further finding was that psychological support was perceived more of a contributor to childbirth satisfaction than physical support. A combined effect however, had the greatest impact on women's satisfaction with the childbirth experience. Competence alone is not enough. Nurses must show childbearing women the concern, respect, care and acceptance they deserve during the significant life event of childbirth.

All actions, therefore, that support the childbearing woman and reduce her distress during the birthing process must be considered as the legitimate arena of nursing care.

Education

The field of childbirth education is an ever changing and expanding domain. Nurses have contact with childbearing women, their husbands or coaches through childbirth preparation classes or prenatal clinics. These nurses have the opportunity to share accumulated experiences and new knowledge and information. Periodic reassessment of women's expectations for childbirth, in view of the progression of pregnancy, would allow women to make informed decisions and to be in a better position to chose safe yet individualized labour and delivery options. Informed husbands/coaches also will be better prepared to support the labouring woman during childbirth. Being informed also will enhance husbands/coaches feelings about their ability to support the woman during such a stressful time.

Theory

The conceptual framework of this study was based on Symbolic Interactionism, a social theory about human behaviour that focuses on the meaning experiences have for individuals (Chenitz & Swanson, 1986). In this study, childbearing women were asked to share what satisfaction with childbirth meant to them. For three subjects the meaning of satisfaction with childbirth was that of experiencing an affective response or feeling about childbirth, whereas the other six described aspects of the birthing process that they perceived as contributing to their satisfaction. Blumer (1969) argues that individuals point out meaningful things to themselves and transform these meanings

in relation to the experience. Subjects identified aspects of the labour and delivery experience that they perceived as meaningful and then transformed these into determinants of satisfaction with childbirth.

The self-concept is central to Symbolic Interactionism (Blumer, 1969). Because it is only through interaction with the experience and with self that the experience is defined and meaning attached to it (Chenitz & Swanson, 1986), the meaningfulness of events or experiences may vary from one individual to another. Despite commonalities like "labour pain" and a favorable "outcome", each childbirth experience of the women in this study was unique. In other words, each postpartum woman rated her childbirth experience in relation to aspects of the event that had meaning for her. The purpose of this study was to determine the meaning of satisfaction with childbirth for postpartum women. Therefore, by determining the meaning of satisfaction to women themselves, this study began clarification of the construct.

From the literature review it is apparent that the difficulties arising from the use of models of patient and consumer satisfaction are related to both conceptualization and measurement issues. One of the basic problems identified in the review of the literature (Chapter Two), was the need, before operationalization of satisfaction in childbirth is possible, to clearly conceptualize the construct. In other words, the complexities encountered in the conceptualization of satisfaction with childbirth are also reflected in its operationalization. An approach other than the forced-choice method was employed to determine how women perceive childbirth satisfaction (Charles et al., 1978; Gutek, 1978; Kirke, 1980).

Use of a semi-structured, open-ended interview research design facilitated collection of pertinent data. Subjects were able to report, verbalize, and/or clarify the

events, incidents and outcomes of the childbirth experience as they perceived them. In other words, women had an opportunity to explain and expand their perceptions of the meaning of satisfaction with childbirth. Forced-choice questions would not have allowed subjects to clarify their answers in this manner. To simply have answered forced-choice questions with "agree" or "disagree", would have limited subjects in sharing their perceptions about their childbirth experience and/or their meaning of satisfaction in childbirth.

Analysis of subjects' responses provided insight into how women conceptualize the construct satisfaction. Determinants of satisfaction with childbirth did not emerge as unidimensional, but rather as multidimensional. Neither were the determinants of satisfaction based on outcome alone. For example, in this study the outcome of a healthy baby was not identified as the criterion for satisfaction with childbirth. Instead, subjects reported labour and delivery events, incidents and interventions as contributing to satisfaction with childbirth, or to its converse, dissatisfaction. Subjects had varying expectations of their husbands/coaches and caregivers, implying each childbirth experience is unique, as is the childbearing woman. Only the individual woman can highlight those aspects that have meaning for her and contribute to her satisfaction with childbirth.

Analysis of the data further showed that feeling changes toward childbirth took place during labour and delivery, and that unique incidents during varying stages of labour and involving a range of individuals were associated with these changes in feelings about childbirth. The implication of this finding is that no specific time can be used to evaluate the overall childbirth experience in terms either of satisfaction or dissatisfaction. If childbearing women, however, want an overall rating, each woman

must step back and retrospectively assess the whole experience in relation to the events and outcomes as she perceives them.

In summary, analysis of subjects' responses to their meaning of satisfaction with childbirth led to a clearer conceptualization of the construct. Findings indicated that women had difficulty defining satisfaction or giving meaning, but were clear about associative events, procedures and incidences.

The overall theme "Being There" and the categories and sub-categories "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling) describe the birth events and/or interactions that had meaning for the study participants and ultimately contributed to their satisfaction with childbirth. These findings, of what contributes to childbearing women's satisfaction with childbirth, may be useful in helping caregivers provide the type of care that enhances other labouring women's birth experience.

Limitations

A limitation of this study was the criterion that women should be three to four months postpartum. This criterion placed limitations on the number of subjects accessible during the time frame for the data collection. Public Health Nurses, therefore, encountered some difficulties findings women who met the criteria for inclusion of the study. The number of women who declined and reasons for opting not to participate is unknown. Since the characteristics of those who declined are unknown, the study findings may not be representative of women who have experienced childbirth. An additional limitation was that the researcher conducted a single interview

at three to four months following childbirth. Although study participants reported that their perceptions of the childbirth experience had not changed, interviews at varied postpartum stages (several hours after, a couple of weeks after, possibly at a year), might have resulted in different findings.

Since all subjects had healthy infants, a question that must be asked is: How would women perceive their childbirth experience if the outcome had not been favorable? For example, if the baby had been born prematurely; alive, but with obvious anomalies; had died neonatally; or had been stillborn, would any women classify their childbirth experience as satisfactory? In view of the findings of this study and its failure to support fulfillment theory, the tentative answer would be "yes". Further research however, is needed to determine the answer to this question.

Recommendations for Further Research

Several recommendations for further research emerged from the findings of the study.

1. Satisfaction with childbirth should be studied longitudinally with postpartum women. Subjects should be interviewed shortly after childbirth; a couple of weeks later; several months after; at a year, and during a subsequent pregnancy.

2. Using the research design and technique of this study, further comparative group studies should be conducted to determine whether the different socio-economic groups, cultural groups, and rural versus urban residents perceive satisfaction with childbirth differently.

3. To determine whether, in the presence of unfavorable fetal outcome, women

would focus on aspects of the birth experience or fetal outcome to rate their childbirth experience, studies should examine women's satisfaction with the childbirth experience in the presence of such outcomes as live newborns but with anomalies; stillborn baby; premature infants; and neonatal death. Should findings indicate that in the presence of unfavorable outcomes the determinant of satisfaction is the baby, an investigation would be needed to determine how caregivers could enhance satisfaction with childbirth for such women.

4. Study findings indicated excessive use of analgesia during labour. It would therefore be of interest to determine whether there is any relationship between childbirth preparation classes and the use of analgesia. Further, such an investigation should include comparisons between primiparas and multiparas to determine the incidence of use and subjects perceptions of its effectiveness. The prevailing perception among health care professionals is that childbearing women are very satisfied with the effects of demerol. The study findings showed that women generally are dissatisfied with the outcomes of demerol. Therefore, a longitudinal study should be conducted to determine whether women's perceptions regarding the effects of demerol change over time.

Conclusion

Childbirth, an event that millions of women experience daily, is poorly understood by both childbearing women and health care professionals. The findings of this study suggest that postpartum women themselves have difficulty defining satisfaction with childbirth. Further analysis, however, showed women had no apparent

difficulty identifying labour and delivery events that contributed to their satisfaction and/or dissatisfaction with the birth experience.

This study provided a description of a common, yet, highly unique experience from the perspective of nine postpartum women. Findings showed that multiple events occur in childbirth and are perceived as either the source of significant personal satisfaction or dissatisfaction. The theme "Being There" encompasses the categories and sub-categories "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling). The above theme, categories and sub-categories describe the events that created meaning for the study participants and contributed to their satisfaction with childbirth.

The focus of this study was on women's conceptualization of satisfaction with the childbirth experience. The intent of the investigation was to increase knowledge and understanding about the meaning of satisfaction with childbirth from the perspective of postpartum women. The findings may be useful to health care professionals in their preparation of women for childbirth and in their care of labouring women. The overall theme "Being There", the three categories and supportive sub-categories "Doing For" (nurturing, advocating, supporting), "Doing With" (togetherness, sensitivity), and "Doing To" (intervening, controlling) which emerged from analysis of postpartum women's responses, provide a basis for further research and development of nursing theory related to satisfaction with childbirth.

REFERENCES

Affonso, D.D. (1977). "Missing pieces" - A study of postpartum feelings. Birth and the Family Journal, 4(4), 159-164.

Anderson, R.E. (1973). Consumer dissatisfaction: The effect of disconfirmed expectancy on perceived product performance. Journal of Marketing Research, 10(February), 38-44.

Astbury, J. (1980). Labour pain: The role of childbirth education, information and expectation. In Peck, C. & Wallace, M. (Eds.). Problems in pain, (pp. 245-252). Sydney: Pergamon Press.

Austin, S.E. (1986). Childbirth classes for couples desiring VBAC. American Journal of Maternal Child Nursing, 11, 250-255.

Beaton, J. & Gupton, A. (1990). Childbirth expectations: Qualitative analysis. Journal of Midwifery, 6, 133-139.

Bennett, A. (1985). The birth of a first child: Do women's reports change over time? Birth, 12(3), 153-158.

Bennett, A., Hewson, D., Booker, E. & Holliday, S. (1985). Antenatal preparation and labour support in relation to birth outcomes. Birth, 12(1), 9-16.

Blumer, H. (1969). Symbolic interaction: Perspective and method. New Jersey: Prentice-Hall Publishing Co.

Bramadat, I. (1990). Relationships among maternal expectations for childbirth, maternal perceptions of the childbirth experience, and maternal satisfaction with childbirth in women undergoing induction, augmentation and spontaneous labor. Doctoral disseration, University of Texas, Austin.

Broome, M.E. & Koehler, C. (1986). Childbirth education: A review of effects on the woman and her family. Family & Community Health, 9(1), 33-44.

Brown, M.A. (1987). How fathers and mothers perceive prenatal support. American Journal of Maternal Child Nursing, 12, 414-418.

Butani, P. & Hodnett, E. (1980). Mother's perceptions of their labor experiences. Maternal-Child Nursing Journal, 9(2), 73-82.

Carlsmith, J.M. & Aronson, E. (1963). Some hedonic consequences of the confirmation and disconfirmation of expectancies. Journal of Abnormal & Social Psychology, 66(2), 151-156.

Charles, A.G., Norr, K.L., Block, C.R., Meyering, S. & Meyers, E. (1978). Obstetric and psychological effects of psychoprophylactic preparation for childbirth. American Journal of Obstetrics and Gynecology, 131(1), 44-52.

Chenitz, W.C. & Swanson, J.M. (1986). Qualitative research using grounded theory. In W.C. Chenitz & J.M. Swanson (Eds.). From practice to grounded theory Qualitative research in nursing (pp. 3-15). California: Addison-Wesley Publishing Company.

Chute, G.E. (1985). Expectation and experience in alternative and conventional birth. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 14(1), 61-67.

Cirz, D. (1978). Nurses and the future in childbirth. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 7(1), 25-26.

Clark, A.L. (1975). Labor and birth: Expectations and outcomes. Nursing Forum, 14(4), 413-428.

Collins, B.A. (1986). The role of the nurse in labor and delivery as perceived by nurses and patients. Journal of Obstetric, Gynecologic, and Neonatal Nursing,

15(5), 412-418.

Cranley, M.S., Hedahl, K.J. & Pegg, S.H. (1983). Women's perceptions of vaginal and cesarean deliveries. Nursing Research, 32(1), 10-15.

Danziger, S.K. (1979). Treatment of women in childbirth: Implications for family beginnings. American Journal of Public Health, 69(9), 895-901.

Davenport-Slack, B. & Boylan, C.H. (1974). Psychological correlates of childbirth pain. Psychosomatic Medicine, 36(3), 215-223.

Day, R.L. (1976). Toward a process of model consumer satisfaction. In H.K. Hunt (Ed.). Conceptualization & measurement of consumer satisfaction & dissatisfaction (pp. 153-183). Mass.: Marketing Science Institute.

DiMatteo, M.R. & Hays, R. (1980). The significance of patients' perceptions of physician conduct. Journal of Community Health, 6(1), 18-34.

Doering, S.G. & Entwisle, D.R. (1975). Preparation during pregnancy and ability to cope with labor and delivery. American Journal of Orthopsychiatry, 45(5), 825-837.

Doering, S.G., Entwisle, D.R. & Quinlan, D. (1980). Modeling the quality of women's birth experience. Journal of Health and Social Behavior, 21(March), 12-21.

Erb, L., Hill, G. & Houston, D. (1983). A survey of parents attitudes toward their cesarean births in Manitoba hospitals. Birth, 10(2), 85-91.

Fox, J.G. & Storms, D.M. (1981). A different approach to socio-demographic predictor of satisfaction with health care. Social Science & Medicine, 15A(5A), 557-564.

Friedman, H.S. & DiMatteo, M.R. (1979). Health care as an inter-personal process. Journal Of Social Issues, 35(1), 1-11.

Gutek, B.A. (1978). Strategies for studying client satisfaction. Journal Of Social Issues, 34(4), 44-56.

Hodnett, E. (1982). Patient control during labour Effects of two types of fetal monitors. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 11(2), 94-99.

Holsti, O.R. (1969). Content analysis for the social sciences and humanities. London: Addison-Wesley Publishing Company.

House, J.S. (1981). Work stress and social support. Reading, Mass.: Addison-Wesley Publishing Co.

Humenick, S.S. (1981). Mastery: The key to childbirth satisfaction? A review. Birth and the Family Journal, 8(2), 79-83.

Humenick, S.S. & Bugen, L.A. (1981). Mastery: The key to childbirth satisfaction? A study. Birth and the Family Journal, 8(2), 84-90.

Hunt, H.K. (1976). CS/D -- Overview and future research directions. In H.K. Hunt (Ed.). Conceptualization & measurement of consumer satisfaction & dissatisfaction, (pp. 455-488). Mass.: Marketing Science Institute.

Kearney, M. & Cronenwett, L.R. (1989). Perceived perinatal complications and childbirth satisfaction. Applied Nursing Research, 2(3), 140-141.

Kieffer, M.J. (1980). Part II: Consumer satisfaction during one year. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 9(3), 155-159.

Kintz, D.L. (1987). Nursing support in labour. Journal of Obstetric, Gynecologic, and Neonatal, 16(2), 126-130.

Kirke, P.N. (1980). Mothers views of obstetric care. British Journal of Obstetrics & Gynecology, 87(11). 1029-1033.

Kovacs, A.R. (1985). The research process: Essentials of skill development.

Philadelphia: F.A. Davis Company.

Lawler, E.E. (1971). Pay and organizational effectiveness: A psychological view. New York: McGraw-Hill Book Company.

Leifer, M. (1980). Psychological effects of motherhood: A study of first pregnancy. New York: Praeger Publishers.

Levy, J.M. & McGee, R.K. (1975). Childbirth as crisis: A test of Janis's theory of communication and stress resolution. Journal of Personality and Social Psychology, 31(1), 171-179.

Linder-Pelz, S. (1982). Toward a theory of patient satisfaction. Social Science & Medicine, 16(5), 577-582.

Linn, M.W. & Linn, B.S. (1975). Narrowing the gap between medical and mental health evaluation. Medical Care, 13(7), 607-614.

Lipson, J.G. & Peterson Tilden, V. (1980). Psychological integration of the cesarean birth experience. American Journal Orthopsychiatric, 50(4), 598-609.

Littlefield, V.M. & Adams, B.N. (1987). Patient participation in alternative perinatal care: Impact on satisfaction and health locus of control. Research in Nursing & Health, 10(3), 139-148.

Locker, D. & Dunt, D. (1978). Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. Social Science & Medicine, 12(4A), 283-292.

Lomas, J., Dore, S., Enkin, M. & Mitchell, A. (1987). The labor and delivery satisfaction index: The development and evaluation of a soft outcome measure. Birth, 14(3), 125-129.

Lumley, J. (1985). Assessing satisfaction with childbirth. Birth, 12(3), 141-145.

Marut, J. S. (1978). The special needs of the cesarean mother. American Journal of Maternal Child Nursing, 4(3), 202-206.

Marut, J.S. & Mercer, R.T. (1979). Comparison of primiparas perceptions of vaginal and cesarean births. Nursing Research, 28(5), 260-266.

Mercer, R.T. (1985). Relationship of the birth experience to later mothering behaviors. Journal of Nurse-Midwifery, 30(4), 204-211.

Mercer, R.T., Hackley, K.C. & Bostrom, A.G. (1983). Relationship of psychosocial and perinatal variables to perception of childbirth. Nursing Research, 32(4), 202-207.

Miller, J.A. (1976). Studying satisfaction, modifying models, eliciting expectations, posing problems, and making meaningful measurements. In H.K. Hunt (Ed.). Conceptualization and measurement of consumer satisfaction and dissatisfaction (pp. 72-91). Mass.: Marketing Science Institute.

Nelson, M.K. (1983). Working-class women, middle-class women, and models of childbirth. Social Problems, 30(3), 284-297.

Norr, K.L., Block, C.R., Charles, A., Meyering, S. & Meyers, E. (1977). Explaining pain and enjoyment in childbirth. Journal Of Health and Social Behavior, 18 (September), 260-275.

Oakley, A. (1983). Social consequences of obstetric technology: The importance of measuring "soft" outcomes. Birth, 10(2), 100-108.

O'Connell, M.L. (1983). Locus of control specific to pregnancy. Journal of Obstetric, Gynecologic, and Neonatal Nursing Nursing, 12(3), 161-164.

Pascoe, G.C. (1983). Patient satisfaction in primary health care:

A literature review and analysis. Evaluation and Program Planning, 6, 185-210.

Polit, D .F. & Hungler, B.P. (1989). (2nd ed.). Essentials of nursing research methods, appraisal, and utilization. Philadelphia: J.B. Lippencott Company.

Reeder, L.G. (1972). The patient-client as a consumer: Some observations on the changing professional-client relationship. Journal of Health & Social Behaviour, 13(1), 406-412.

Roach, M.S. (1987). The human act of caring. Ottawa, Ontario: Canadian Hospital Associations.

Roberts, C.A. & Burke, S.O. (1989). Nursing research: A quantitative and qualitative approach. Boston: Jones and Bartlett Publishers.

Roberts, J.E. (1983). Factors influencing distress from pain during labour. American Journal of Maternal Child Nursing, 8(January/February), 62-66.

Sandelowski, M. (1984). Expectations for childbirth versus actual experiences: The gap widens. American Journal of Maternal Child Nursing, 9(July/August), 237-239.

Seaman, C.H.C. (1987). (3rd Ed.). Research methods Principles, practice, and theory for nursing. Los Altos, California: Appleton & Lange.

Shaw, I. (1985). Reactions to transfer out of a hospital birth center: A pilot study. Birth, 12(3), 147-150.

Shearer, M. (1983). The difficulty of defining and measuring satisfaction with perinatal care. Birth, 10(2), 77.

Shearer, M.H. (1987). Commentary: How well does the LADSI measure satisfaction with labor and delivery? Birth, 14(3), 130-131.

Sherif, M. & Hovland, C.I. (1961). Social judgments: Assimilation and contrast effects in communications and attitude change. Connecticut: Yale University Press.

Shields, D. (1978). Nursing care in labour and patient satisfaction: A descriptive study. Journal of Advanced Nursing, 3(6), 535-550.

Stamps, P.L. & Finkelstein, J.B. (1981). Statistical analysis of an attitude scale to measure patient

satisfaction with medical care. Medical Care, 19(11), 1108-1135.

Stolte, K. (1987). A comparison of women's expectations of labor with the actual event. Birth, 14(2), 99-103.

Sullivan, D.A. & Beeman, R. (1982). Satisfaction with maternity care: A matter of communication and choice. Medical Care, 20(3), 321-330.

Treece, E.W. & Treece, J.W. Jr. (1986). (4th Ed.). Elements of research in nursing. Toronto: The C.V. Mosby Company.

Weaver, D. & Brickman, P. (1974). Expectancy, feedback, and disconfirmation as independent factors in outcome satisfaction. Journal of Personality and Social Psychology 30(3), 420-428.

Westbrook, R.A. & Oliver, R.L. (1981). Developing better measures of consumer satisfaction: Some preliminary results. Advances in Consumer Research, 8, 94-99.

Willmuth, L.R. (1975). Prepared childbirth and the concept of control. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 4(5), 38-41.

Willmuth, R., Weaver, L. & Borenstein, J. (1978). Satisfaction with prepared childbirth and locus of control. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 7(3), 33-37.

Wilson, H.S. (1985). Research in nursing. Massachusetts: Addison-Wesley Publishing Company.

Woods, N.F. & Catanzaro, M. (1988). Nursing research theory and practice. Toronto: The C.V. Mosby Company.

Woolley, F.R., Kane, R.L., Hughes, C.C. & Wright, D.D. (1978). The effects of doctor-patient communication on satisfaction and outcome of care. Social Science & Medicine, 12, 123-128.

APPENDIX A

INTERVIEW GUIDE

The interview began with a general statement followed by general questions to get the woman talking about her childbirth experience.

_____, as you have already been informed and read about in the different sheets, I am interested in learning from you what for you was satisfying, as well as dissatisfying about your childbirth experience.

To begin, please:

1. Tell me how you felt about your pregnancy.
2. How was your pregnancy?

_____, thank-you for sharing with me about your pregnancy.

Now:

1. Tell me about your childbirth experience, that is, both labour and delivery.
2. Now that you have shared with me about your childbirth experience would you say that you were satisfied with the childbirth experience?
3. Tell me, what was there about the childbirth experience that was satisfying.
4. What would you say were the sources (aspects or things that contributed to) of satisfaction for you in childbirth?

You mentioned (example) was (were) satisfactory (positive, favorable, good) aspects during childbirth.

1. Tell me how did (example) relate to or contribute to satisfaction in your childbirth experience.

In our society words mean different things to different people. Satisfaction is a word that means different things to different people. Therefore, tell me what satisfaction in childbirth means to you.

In summary, what was most satisfying about your childbirth experience for you.

_____, looking at the other side of the experience:

1. Tell me, was there anything about your childbirth experience that was dissatisfying.
2. Tell me how (example) was dissatisfying for you.

Earlier we talked about what satisfaction in childbirth meant to you. Now that we have confirmed that there was (were) also a dissatisfying aspect(s) about your childbirth experience, tell me what dissatisfaction in childbirth means to you.

In summary, tell me, what was most dissatisfying about your childbirth experience for you.

_____, we have discussed both your childbirth satisfaction and dissatisfaction.

1. Tell me, what changes if any occurred in your feelings about the birth experience from the time you went into labour until you delivered.
2. Tell me what happened during the course of labour and delivery that changed your feelings.
3. Tell me, if I had asked you earlier (within 24-48 hours; one or four weeks, after delivery) to share your childbirth experience would your answers have been the same as they are now - three months postpartum.

Succeeding questions to the participants comments re: the above questions depended largely on the woman's childbirth experience. Subsequent interviews had additional and different questions as a consequence of new insight gained from a previous interview(s).

Throughout the interview I probed for more information by asking the woman, for example, to:

1. Tell me more about your feelings regarding _____. (I restated her word(s)).
2. Explain what you mean by _____ (word or comment). (I again restated her words).

APPENDIX B

DEMOGRAPHIC DATA

Please answer the following questions. If you choose not to answer all questions, your preference will be honoured.

1. Age:_____

2. Education:

    1. Highest grade in Grade or High School _____

    2. Vocational/Diploma/Technical School _____

    3. University : diploma _____

        degree _____

3. Occupation:

    1. Specify type _____

    2. Full-time _____ Part-time _____

4. Marital status at time of delivery:

    Single (never married) _____

    Married or common law _____

    Separated _____

    Divorced _____

    Widowed _____

5. Type of delivery: Vaginal _____ Cesarean Section _____

6. Number of: pregnancies _____

    live births _____

    miscarriages _____

    children living with you _____

APPENDIX C

Date

Mary Driedger

Winnipeg, Manitoba

Telephone

Address of City Public Health

Dear (Name of chairperson/group co-ordinator):

Subject: Research Project

I am a Master's of Nursing student at the University of Manitoba. I have completed the required course work for the Master's Program, and am preparing my proposal. Professor Ina Bramadat is the chairperson of my thesis committee.

In my research study, I will explore satisfaction in childbirth from the postpartum woman's perspective. I am interested in learning from postpartum women themselves, how they describe satisfaction in childbirth and what about the birth experience was satisfying or dissatisfying for them. Women who had their baby approximately three to four months ago will be interviewed. The interview will be audio-tape recorded and will describe satisfaction in childbirth. The findings of this study will be used to inform perinatal health care professionals about women's perceptions of the factors that influence satisfaction in childbirth.

I am approaching your agency because you attend to women who have experienced childbirth. With your permission, I would like to attend a board meeting to present my research topic and recruitment approach.

The women volunteering to participate in the study will be provided with written explanation of the study and how it will be conducted. Participation will be voluntary and subjects may withdraw from the study at any time. All information the participants share with me will be kept confidential.

I would welcome the opportunity to meet with your Executive at your earliest convenience to provide you with further information about my study, which I expect will take 6-8 months. I ask you to consider my request and look forward to receiving your response.

Yours truly,

Mary Driedger, R.N.

APPENDIX D

PRESENTATION TO INDIVIDUAL REQUESTING SUBJECTS FOR INDIVIDUAL INTERVIEWS

Hello. My name is Mary Driedger. I am a Master's of Nursing Student at the University of Manitoba. I have had thirteen years of experience working as a Nurse-Midwife in Belize, Central America and two years of maternity nursing in Manitoba. My area of special interest is promoting healthy mother-child relationships.

To complete a Master's of Nursing program, both course work and a thesis project are required. I have completed my course work and am presently working on my thesis. Professor Ina Bramadat is my thesis advisor. My topic is an exploration of satisfaction in childbirth from the postpartum woman's perspective. I am interested in recruiting approximately ten women who delivered three to four months ago.

At this time I want to tell you how the study will be conducted and what you as a volunteer in the study will be asked to do. Please feel free to interrupt me at anytime if you have questions.

Any woman who agrees to participate in the study will be asked to take part in an interview. I expect each interview to take approximately 1 - 1 1/2 hours. The interview will be audio-tape recorded. No names will appear anywhere on the tapes and transcriptions. Only a code number will be used to label the tape recordings and transcripts. All information you share with me will be kept confidential. The tapes and trancriptions will be kept in a locked filing cabinet. Only I and if necessary, my advisor, will have access to the transcribed tape. Any publications arising out of the study would not identify any names. At the end of the study I will erase the tapes.

If you are interested in participating, I would like to arrange for a convenient time and place for the interview. If you want more time to think about this study and whether you want to participate, I have provided my telephone number at the end of this handout. Please telephone me if you decide you want to be involved in the study.

Women volunteering to be in the study must:

1. Have delivered three to four months ago.
2. Be able to read, write and speak English.
3. Live within the perimeter of the city of Winnipeg.
4. Have a telephone - for purposes of arranging the interview.

Your involvement in this study is voluntary. You may withdraw from it anytime you choose to do so.

If you agree to participate you will be asked to sign a consent form. Before you sign the consent form, please read it carefully. If you have any questions, please bring them to my attention. If you would like a summary of the study once it is completed, please fill out the sheet attached to this handout.

Thank-you for your time and attention. If there are any questions, I will gladly do my best to answer them.

Mary Driedger

APPENDIX E

Consent Form

I _____, volunteer to be a participant. I have been provided with and have read a written explanation of the study.

I have been told that:

The purpose of the study is to examine how satisfaction in childbirth is perceived by postpartum women themselves.

Mary Driedger, a Master's of Nursing student at the University of Manitoba is conducting the study. Professor Ina Bramadat, Associate Director for the Undergraduate Program, at the University of Manitoba is her advisor and her office telephone number is 474-6222.

I understand consenting to be a participant in this study includes the following:

My involvement includes an audio-taped interview at a time and location convenient to me. The interview will take about 1-1 1/2 hours.The interview can be done in two sittings if necessary.

I am free to withdraw from this study at anytime. I have the right to refuse to answer specific interview questions, if I choose. I will derive no direct benefit from participating in this study.

All the information I share during my involvement in this study is confidential. Selected, anonymous passages of the audio-tapings, except those I may specify to remain entirely private, may be used in publications or presentations.

The researcher is the only person who will have access to my interview tape and name, and these things will be kept under lock and key. The researcher's advisor will have access only to the coded and transcribed tapes if necessary.

I may telephone Mary Driedger anytime I have questions regarding my participation in her study. Her telephone number is . Her advisor may also be called at her office: 474-6222.

I have received a copy of this consent form for my records. My signature signifies my agreement to participate in this study under the terms stated above.

_____	_____	_____	_____
Date	Participant	Date	Researcher

APPENDIX F

I would like a summary of the results of this study:

No _____

Yes _____

If Yes: Name _____

Address _____

_____

_____

APPENDIX G

Explanation By The Public Health Nurse

Mary Driedger, finishing her Master's of Nursing program, now doing her thesis is trying to find out the satisfaction of childbirth from individuals like you who have a child and now are home. She would like to know if you will help her by participating in her study.

If you are willing can I give her your name, address, and/or telephone number? Mary will contact you and explain the details of the study.

After hearing about the study from Mary, if you do not want to participate you can tell her.

APPENDIX E

Consent Form

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I have been told that:

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_____	_____	_____	_____
Date	Participant	Date	Researcher

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