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Lost wisdom: An exploration of the experiences of women who chose to birth at home

Lee-Anne Raeside
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Lost Wisdom: An Exploration of the Experiences of Women who chose to
Birth at Home

Lee-Anne Raeside

A report submitted in Partial Fulfilment of the Requirements for the Award
of Bachelor of Arts Honours, Faculty of Community Studies, Education and

Social Sciences,

Edith Cowan University

October, 2005

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Table of Contents

Abstract.....	2
Introduction.....	3
Childbirth Practices over the Last Century.....	4
The Meaning of Childbirth Labour and Pain.....	6
<i>Medical Meanings of Childbirth</i>	6
<i>Midwives' Meanings of Childbirth</i>	8
<i>Women's Meanings of Childbirth</i>	12
Women's Choice and Factors that Influence Choice of Options.....	16
<i>Birth Options</i>	16
<i>Hospital Birth</i>	19
<i>Birthing Centre and Home Setting</i>	20
<i>Factors Associated with Loss of Choice</i>	21
Limitations of the Review.....	24
Summary and Conclusions.....	25
References.....	27
Guideline for Authors.....	33
Abstract.....	37
Introduction.....	38
Psychological Outcomes in Response to Care.....	39
Perceived control.....	40
Emotional Support.....	41
The Present Study.....	43
Method.....	44
Research Design.....	44
Participants.....	45
Data collection.....	47
Procedure.....	47
Data Analysis and Research Rigour.....	48
Findings and Interpretations.....	50
Self- Construction.....	51
<i>Self-Efficacy</i>	51
<i>Comparative Descriptions between Homebirth and Previous</i> <i>Hospital Birth</i>	53

Relationships.....	55
<i>Strengthening Family Relationships.....</i>	<i>55</i>
<i>Strengthening Partner Relationship.....</i>	<i>57</i>
Practice Issues Surrounding Birth.....	58
<i>Continuity of Care.....</i>	<i>58</i>
<i>Information/Choices Pertaining to Childbirth.....</i>	<i>59</i>
Conclusions.....	61
Limitations of the Study.....	63
Implications.....	63
Future Research.....	64
References.....	65
Appendix A.....	69
Appendix B.....	70
Appendix C.....	71
Appendix D.....	72
Appendix E.....	73
Appendix F.....	74

Running head: LOST WISDOM

Lost Wisdom: Understanding Women's Perspectives on Childbirth

Lee-Anne Raeside

Lost Wisdom: Understanding Women's Perspectives on Childbirth

Abstract

Childbirth literature was explored firstly to gain a historical understanding of childbirth practices over the last century and secondly to explore the influences that determine a woman's birth choice. A shift from midwife-based care to medical-based care has resulted in the majority of births occurring in hospital. This shift has promoted the perspective that childbirth is a risky pathological event to be feared. However, professional perspectives of childbirth vary from birth being seen as a natural and challenging process to birth as a risky event that requires medical intervention. Women's perspectives are shaped by both professional perspectives and a natural perspective, and may fall somewhere along a continuum between the two. However, with an emphasis placed on medicalisation, women's birthing choices are limited.

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Submitted: August, 2005

Lost Wisdom: Understanding Women's Perspectives on Childbirth

Introduction

There are very few events in the life of a woman that compare to the birth of a child. Some women have described their childbirth experience as a major personal achievement, joyous and empowering (Davies, 1992; Kitzinger, 1991; Parratt & Fahy, 2003), whereas other women have described their childbirth experience as frightening, traumatic and disempowering (Dennis, Janssen & Singer, 2004; MacFarlane, 1977; Willinck & Cotton, 2004). Birth experiences may impact on how well a woman makes the transition to motherhood, on her self-esteem, her physical and mental health, her relationships with the child, and on the well being of the child and on the family (Beech & Phipps, 2004). However, in Western societies, women are expected to be satisfied with the birth of a live baby irrespective of the birth experience (Downe, 2004).

To understand women's perspectives on childbirth this review will explore the social forces implicated in influencing a woman's decision, expectation and perception surrounding childbirth. A historical reflection of the accepted norms and practices of giving birth will assist in providing a retrospective outlook into how women's perspectives have been shaped through the last century to current times. For example, during the past century there has been a movement towards childbirth becoming medicalised and 96% of births occurring in hospitals in Australia, the United Kingdom and the United States of America. This has resulted in a rising number of women electing to have caesarean births (Walker, Turnbull & Wilkinson, 2004), an increase in medical intervention (Cosans, 2004;

Parratt & Fahy, 2003; van der Hulst et al., 2004; Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004), women with lower self-efficacy and fear in regard to childbirth (van der Hulst et al., 2004), dissatisfaction surrounding the birth and negative outcomes for both mother and child (Waldenstrom et al., 2004).

The aim of writing this review is to explore the midwifery and psychological literature pertaining to psychological implications of childbirth for providing explanations of women's perspectives on childbirth and demonstrate how mainstream ideology, particularly as promoted by the medical model, in regard to childbirth may not be an optimal belief system required for the psychological well-being of all birthing women. The net effect is that women's choices surrounding childbirth are limited.

Childbirth Practices over the Last Century

In Western societies, women's experience of birth has been influenced by dramatic changes in the social organisation of birth over the last hundred years. Prior to the twentieth century most births occurred in the home. Childbirth was seen as a natural event in the life of a woman and was attended by female members or midwives (Coyle, 1998). Women delivered in the comfort and familiarity of their own surroundings but endured high rates of infant mortality and maternal deaths, mostly due to poor health and hygiene, and at times poor obstetric practices (Markus, 1997). With the emphasis on safety, a shift occurred at the turn of the twentieth century resulting in the application of medically based care in which childbirth became a medical event and the use of midwives became culturally taboo (Davis, 2001). Urbanisation, centralisation of healthcare, and improved

medical technology provided greater safety for mothers and infants.

However this was accompanied by heavy social and psychological burdens for women as they then delivered among strangers in an unfamiliar setting and were forced into a more passive role in the birth process (Norr, Block, Charles, Meyering & Meyers, 1977).

During the 1970s women became discontent with hospital obstetrics and requested a birth without intervention. In response to this discontent professionals in the U.K. and the U.S.A. formed national organisations that sought to support natural childbirth and challenge the medical model for the care of healthy pregnant women. These movements together with research documenting the harmful effects of excessive medication, promoted a more humanising environment for birthing women, at least in some hospitals (Norr et al., 1977), ultimately leading to the formation of birthing centres, either independent or under the jurisdiction of a hospital (Morison, 1996). Currently, birth place choices in the U.S.A., Canada, U.K. and Australia include hospital, birthing centres and the parent's home. However, only 1% of women birth at home and 3% birth in birthing centres in Australia which is representative of other Western countries (Hildingsson, Waldenstrom & Radestad, 2003). These statistics demonstrate how the medical model of care has permeated women's choice, as it is the predominant method of childbirth delivery.

In addition, psychological approaches have shadowed the medical model of care with an emphasis on pathology and statistically based research. For instance, the prolific psychological literature on the mental health of women rests on the assumption that medicalised childbirth is

normal, even though medical approaches to the management of birth have been implicated in certain circumstances as leading to poor psychological outcomes (Allen, 1998; Campbell & Cohen, 1991; Waldenstrom et al., 2004). Conversely, the midwifery literature on childbirth takes a different approach and focuses on methods to enhance women's self-efficacy and is imbued with respect for women's individual choice in how and where they would like to birth.

The Meaning of Childbirth, Labour and Pain

Two mutually exclusive models of childbirth care were identified by Cunningham (1993); the medical model and the natural model. Both models differ with respect as to how they define normal birth, view safety and how women cope with labour and pain. Obstetricians, hospital trained midwives and nurses tend to adopt the medical model ideology whereas traditional midwives who attend some births in birthing centres or in the woman's home tend to adopt the natural model ideology. These two dichotomous approaches are strong in their perspective and currently remain in debate over best practice for childbirth.

Medical Meanings of Childbirth

The medical model for childbirth is described by Perkins (2004) as an economical model that incorporates efficiency, uniformity, control, market competition for trade with other hospitals ultimately bringing together financial management and medicine. This implies that under the medical paradigm birthing women are customers who are crucial for the survival of the business. It also follows that professionalised medical services are provided in such a manner so that clients fit the needs of the

service rather than the service meeting the needs of the client (McKnight, 1977).

The ideology underpinning the medical model is that childbirth is an illness and therefore requires medical expertise (Perkins, 2004). The emphasis is on pain relief and safety, whereby interventions such as episiotomies, monitoring, analgesia, epidurals and caesarean sections are considered necessary to alleviate pain and to minimise risks (Cunningham, 1993). The medical pain relief paradigm can be characterised as a set of paternalistic attitudes, values and practices with the view that childbirth is a physiological act and practitioners are expected to make full use of the benefits of technology. Under the medical paradigm, a practitioner's role is to inform women of all the options of pain relief regardless of whether she is classified as high or low risk (Leap & Anderson, 2004). However, under this paradigm the spiritual, psychological and emotional aspects of the birth process are often ignored (Markus, 1997).

According to Noble (1983) conventional medical antenatal classes do little to psychologically prepare women for childbirth due to standardised 'one size fits all' service. Rather the conventional antenatal preparation serves hospitals, doctors and instructors better than it serves expectant mothers. More recent evidence for this claim was demonstrated when Renkert and Nutbeam (2001) interviewed five antenatal educators and conducted two focus groups with five pregnant women and seven new mothers to obtain different perspectives on the issues surrounding antenatal classes. Although the study utilised small samples thus limiting the generalisability of the sample to the larger population, the results indicated

that women were dissatisfied with time constraints and the delivery of factual information rather than teaching decision making skills and practical skills to prepare for childbirth and parenting.

A survey conducted by Gilles et al. (1995) for the Western Australian Health Department also provided evidence to support Noble's (1983) claim. The results of the survey indicated that regardless of whether women were multiparous or nulliparous, they were treated the same by the doctor in attendance or nursing staff. Suggestions for improvement of services from the majority of women included a calling for more personalised and respectful service with more time and advice from the doctor and less time in the waiting room. Furthermore, it was noted that whilst most women were satisfied with their antenatal care, some women expressed a desire for a greater focus during antenatal classes on more realistic preparation for lifestyle changes and the emotional demands of motherhood. The findings from the surveys reviewed indicate that the medical perspective suggests that women are homogenous and that technical assistance and medical expertise can provide safe and painless births.

Midwives Meanings of Childbirth

In the Western world, there are two distinct types of practising midwives; hospital trained midwives, whereby nursing is a prerequisite to midwifery training and traditional midwives whereby training is solely focused on pregnancy, childbirth and breastfeeding (Mead, 2004). Traditional midwives are represented more in countries that view birth as a natural physiological process, such as the Netherlands, whereas hospital trained midwives are heavily represented in U.S.A., U.K. and Australia. In a

study conducted in the U.K., Mead (2004) compared the medical intervention rates for women suitable for midwifery-led care (low risk). Questionnaires were completed by 249 midwives who worked either in a district general hospital or a teaching hospital. The results indicated that 69% of the midwives would offer non-pharmacological pain control as a first option, 27% would offer analgesia and 3% would offer epidural analgesia as first option. Analysis of data for 4,090 first time low risk mothers revealed that 46% had epidural analgesia and that mothers were more likely to have birthed in the teaching hospital. Mead concluded that pain relief was too readily available and that women characterised as low risk responded to the cultural definition of normal childbirth that is constructed from a statistical point of view that hospital births are normal because the majority of women (97%) select them.

Traditional midwives tend to advocate the natural model of childbirth which emphasises the woman's right to make informed decisions about her body and self-responsibility for health and acknowledges the spiritual, psychological and emotional aspects of birth (Cunningham, 1993). Kennedy and Shannon (2004) interviewed 14 midwives from hospital, birthing centres and home settings to explore the beliefs that underpin midwifery practices. The findings revealed that the midwives believed that childbirth was natural and many of their actions were specifically aimed toward the support of birth as a physiological, rather than a pathological process. This was achieved through subtle care processes on meeting a woman's individual needs and tapping into her personal strength. The findings also indicated that midwives believed that medical intervention

might be necessary for women classified as high risk, i.e., the mother or baby's life is at risk. However, the survey illustrated that midwives defined high risk differently from medical attendants whereby the risk to baby and mother increases with standard medical intervention, rather than decreases, due to the side affects produced through medical intervention.

Traditional midwives tend to hold the belief that the submission to the overwhelming nature of natural birth and the weathering of the labour pain is an empowering process for a woman. Overcoming and dealing with labour pain is synonymous with achieving great feats such as running a marathon and that it is this major achievement of conquering pain which provides self-knowledge, empowerment and self-efficacy for the new mother (Leap & Anderson, 2004).

According to Parratt and Fahy (2003) women who have birthed without pharmacological pain relief have more positive feelings about themselves compared to women who have birthed with pharmacological pain relief and advocate a women-centred way of practising that involves providing continuity of care and utilising the principles of individual negotiation, informed choice and consent, and shared responsibility. The implication for woman-centred care is that the bond created between midwife and mother assists in preparation for the birth that empowers the woman's self-confidence. According to Parratt and Fahy the woman-centred model of practising recognises that fear and anxiety surrounding birth is a natural response that requires encouragement and support from early pregnancy to birth. This was illustrated in a small qualitative study to explore whether a non-interventionist birth would increase self-confidence,

which would act as a buffer against developing a propensity for postnatal depression. In-depth interviews were conducted with three women who experienced natural birth at home and three women who had medically managed births in hospital.

Although the sample was too small to be generalised to all women, the results illustrated the impact that a woman's childbirth experience might have on her sense of self. Positive factors identified from homebirth mothers included control over her environment, receiving positive affirmations, effective communication with caregivers and experiencing mutually trusting relationships. This enabled mothers to feel safe to attune to their bodies and surrender to the natural force of birth with the outcome of feeling empowered from a sense of accomplishment that resulted in the development of a more positive sense of self.

In contrast, the women who birthed in hospital did not understand the process of surrendering or 'letting go'. Parratt and Fahy (2003) concluded that under the medical model, the women were less likely to be respected or encouraged to continue when they reached the second stage of labour, which may result in making medicalisation necessary. According to Parratt and Fahy, if a woman is not encouraged to continue during her labour and responds with the assistance of analgesia, she risks the loss of her bodily awareness that is her bodily cues and responses. This loss of internal awareness might increase her external awareness, which can result in a loss of focus and an increase in pain perception. Therefore the authors conclude that a non-interventionist birth may increase a woman's confidence specifically related to the birth experience. In contrast, the

experience of intervention childbirth practices such as pharmacological pain relief, forceps and caesarean sections are more likely to lead to a woman's diminished sense of self.

Layne (2003) argued that biomedical obstetrics and the traditional midwives critique of it share the same belief i.e., that to control reproduction is important, as it will lead to a positive outcome. This emphasis on happy endings, whether believed to be a result of medical intervention or women's natural inherent powers to reproduce, exacerbates the experience of those whose pregnancies do not end as they expected or as happy. Layne purports that an emphasis on being in control of their bodies may contribute to self-blame when pregnancies are not perfect or are complicated. This suggests that traditional midwives perspectives alongside the medical perspective, may also view women as a homogenous group.

Women's Meanings of Childbirth

Childbirth for women tends to have emotional and social significance and can be defined as a major transitional period for women with varying meanings attached to the event due to factors such as unplanned pregnancies, age, maternal identity, support and relationships (Cunningham, 1993). Birth has the potential to be life changing and the implication for this is that there is no going back. For instance, in some cultures birth is a rite of passage when a woman moves from one social state to another and/or from one spiritual state to a state of greater awareness. For women with religious beliefs the birth experience may bring them closer to the higher being they believe in or the birth experience may be one of providing the opportunity for personal discovery and growth (Hall &

Taylor, 2004). However, for some women birth may mean the burden of more responsibility, loss of career options and increased financial concerns which may impact on the profundity of birth (Waldenstrom et al., 2004). Consequently, women's perspectives will differ according to many operating factors.

According to Howell-White (1999) women's beliefs and expectations about childbirth are not as polarised as that espoused by the natural or medical model which underpins traditional midwives and medical practitioners ideology. Utilising a longitudinal design with a combined quantitative and qualitative approach, Howell-White employed logistic regression analyses to measure 200 women's beliefs about birth at their first meeting with their chosen provider and then again after each woman gave birth. The data was collected concerning the personal and birth setting characteristics and the factors that affected the woman's satisfaction with her birth provider. The results revealed that women's beliefs fall somewhere along a continuum, from pregnancy being a medical condition with risks that require medically trained attendants, to pregnancy as a natural and normal process that requires attendants who know how to make the process happen more smoothly.

One particular aspect of the birth experience that demonstrates women's different perspectives is the research on pain. Certain studies have demonstrated that in some instances women view pain as a part of the birth process and reflect positively about the pain after childbirth. For example, in a qualitative study that explored the meaning of labour pain, Lundgren and Dahlberg (1998) interviewed four primiparous mothers and five multiparous

mothers who had birthed naturally in a birthing centre in Sweden. The findings revealed that women believed that pain was a natural part of the delivery process and enabled women to blend their mind and body as 'one' in order to attune to the labouring process. The experience of labour pain and the experience of strength during childbirth gave meaning to the transition to motherhood. Lundgren and Dahlberg concluded that the experience of pain appears to have significant meaning for a birthing woman with the outcome of increased self-efficacy that provides a more positive transition to motherhood.

Furthermore, in a review of childbirth pain literature between 1990 and 1999, Niven and Murphy-Black (2000) found that for many women, recall of their labour pain was often associated with largely positive feelings about their ability to cope with severe pain. Labour pain was accompanied by feelings of emotional well being, of being in control, and being nurtured and respected by their loved ones and caregivers. Women's later recall focused on their sense of accomplishment in having dealt with the pain successfully which Niven and Murphy-Black concluded deemphasised the severity of pain.

This positive meaning for pain is described as purposeful which may result in less painful births for women who birth naturally. Evidence which supports this claim was obtained by Morse and Park (1988) who investigated the perceived pain in labour. In this study, 282 women who had birthed at home with no intervention and 191 women who had birthed in hospital were asked to compare and rate their labour pain against 8 other painful events. Utilising the univariate scaling method of paired

comparisons the results revealed that women who had birthed in hospitals reported childbirth more painful than the homebirth women. These findings suggest that the woman's home might provide an environment, which modulates their reports of pain.

In contrast, Waldenstrom et al. (2004) demonstrated that not all women perceived childbirth and pain as an empowering experience. In their study 2,541 women recruited from antenatal clinics in Sweden were required to respond to a series of questionnaires focusing on possible risk factors prior to birth and the global experience of labour and birth. Of these questionnaires one was sent out during early pregnancy, another one month after birth and another one year after birth. Data collected from the early pregnancy questionnaire revealed that 4% of women reported that under no circumstances did they want pharmacological pain relief. Whereas 42% of women reported that they would prefer not to have pharmacological relief but were prepared to take them if needed, and 52% reported that they would not hesitate to take any pharmacological pain relief. However, 41% of women reported positive expectations about the upcoming birth whereas 48% reported mixed feelings and 9% reported negative expectations about the approaching birth.

Women were most fearful about something being wrong with the baby (23%) and giving birth in general (18%). Of the sample, 26% of women also reported that labour pain must be the worst imaginable pain. Data collected after the birth revealed that 7% of women experienced a negative birth and that 53% of the women who had a negative experience responded to the early pregnancy questionnaire that they would not hesitate

to take any pharmacological pain relief and were more likely to believe that labour pain was the worst imaginable pain indicating that their experience met their expectation. A negative birth experience was more common in women who were young, single, unemployed, pregnancy less welcome and were smokers indicating that environmental and developmental factors implicated in the negative birth experience. These results reflect the findings from Slade, MacPherson, Hume and Maresh (1993) who also found from data collected from questionnaires administered to 81 primiparous women prior to birth and after birth, that positive emotional expectations were strong predictors of positive emotional experiences. However, positive expectations about personal control during birth were elevated in relation to experience suggesting that not all women's personal expectations were achieved.

Women's Choice and Factors that Influence Choice of Options

Women's options in relation to childbirth may be determined by their perspectives and beliefs, personal characteristics, previous childbirth experiences, medical complications during delivery and socialisation processes. Furthermore, different systemic influences may shape and impact a woman's choice.

Birth Options

According to van der Hulst et al. (2004) a woman's choice of birth reflects her underlying perception of childbirth. Women opting for a midwife are more likely to consider the birth process as a natural event than women opting for an obstetrician who tend to define childbirth as risky. Women who fully embrace the natural model tend to birth their babies at

home where they feel safe, comfortable and supported by those they love and trust and less threatened by medical intervention. Whereas women who advocate the medical model either due to personal or medical circumstances out of their control tend to birth their babies in a hospital where they feel safe and reassured that the hospital staff will take responsibility for pain relief of the labouring process and the welfare of the baby. Women who fall in between the two distinct ideologies on the continuum tend to choose birthing centres where they feel they have the best of both worlds, the opportunity for a natural birth in a less clinical setting with less intervention and the closeness of medical intervention in the event that risk to both mother and baby is increased (Coyle, 1998).

In order to compare antenatal education levels, reasons for choosing the birthplace, experiences during childbirth, analgesia, satisfaction with birth attendants and the attitudes of Australian women towards birth Cunningham (1993) sent a questionnaire to 239 women who gave birth in a hospital, 35 women who birthed in a birthing suite and 121 who chose to birth at home. The results revealed that women's experience of birth was consistent with their expectations and beliefs they held about childbirth in relation to the ideology they embraced. Hence in general women viewed the birthplace positively whatever their choice and endeavoured to validate their experience in their own and others eyes.

Women who embraced the natural model either birthed at home or in a birthing centre. Women who birthed at home tended to be older than the women who birthed in a birthing centre or hospital, more educated about childbirth, felt more pride, confidence and achievement after birth, believed

the birthplace affected bonding, had an internal locus of control, more likely to be multiparous, in a steady relationship with the father and held more feminist views. The women who birthed in a birthing suite were similar in their characteristics apart from the fact that they were more likely to be primiparous. This suggests that maybe first time mothers who embrace the natural model might require the closeness of a hospital to increase confidence and assuage fear of negative outcomes.

In contrast, women who birthed in a hospital were less likely to be in a steady relationship with the father of the baby, felt that birth is a medical condition, birth is a risky process, had an external locus of control, less educated about childbirth, more likely to be primiparous and felt less pride, confidence and achievement after birth compared to mothers who birthed in birthing centres or at home.

These results were in accordance with Heinze and Sleigh (2003) who investigated the different characteristics between women who had an epidural during childbirth and women who birthed vaginally without an epidural in a hospital setting. A survey that assessed fear of childbirth, locus of control for childbirth, desired participation in the childbirth process and knowledge of epidural risk were given to 46 women 6 months after their childbirth experience. Results revealed that women who chose to deliver with an epidural had a high fear of childbirth, an external locus of control for childbirth and a desire for passive compliance in the childbirth process. Conversely, results also showed that women who laboured without an epidural had low fear of childbirth, an internal locus of control and a desire

to actively participate in the childbirth process. The research indicates that personal characteristics of women may influence birth options.

Hospital Birth

Medical intervention is rising with an increasing number of women electing to have caesarean section. According to Walker, Turnbull and Wilkinson (2004) the proportion of births by caesarean section has increased in Australia by 35%, rising from 17% in 1990 to 23% in 2000. In an effort to understand the increase, Walker et al. (2004) investigated the perceptions of community acceptance of caesarean section. Questionnaires were sent out to 148 women, living in South Australia 7 weeks after delivery. Logistic regression analysis revealed that the majority of women (71%) agreed that caesarean section is seen as easier, convenient and routine. However, 77% of the sample did not agree that the media portrayed caesarean section as an easier way of giving birth. The results also revealed that women who had delivered vaginally tended to agree more than women who had delivered by caesarean section that caesarean section was seen as easier and more convenient. Of the sample, 10 women expressed during pregnancy that they would consider delivering by caesarean section. However, 8 out of the 10 women reported having a previous caesarean section prior to current pregnancy, indicating that they were high-risk women. The results of the study indicate that there is some community acceptance in relation to caesarean section seen as a more convenient and easier method of giving birth. The study also highlighted that high risk women might be more likely than low risk women to elect caesarean section, which is in accordance with other research (Saisto & Halmesmaki,

2003; Geissbuehler & Eberhard, 2002; Wijma, 2003) whereby previous complicated births, daily stressors and general fear of pain were given for reasons to seek a totally free from pain delivery.

Factors that were identified as associated with choosing a hospital birth in the Cunningham (1993) study were safety, the availability of medical facilities and the proximity of the hospital to home. The doctor's suggestion was also a major influence as this usually meant the hospital where the doctor practised. The research reviewed indicates that factors such as high-risk pregnancies, previous birth experiences, concerns about safety, convenience and community acceptance are associated with women choosing a hospital birth.

Birthing Centre and Home Setting

Factors that were identified as associated with choosing to birth at home or in a birthing centre in the Cunningham (1993) study were that some women were born in other English speaking countries such as Britain or the Netherlands where the tradition of homebirth may have influenced their decision. This is in accordance with Monto (1993) who found that women acquire their perspectives on childbirth and make decisions according to their socialisation processes. This was illustrated when Monto interviewed 30 primiparous mothers from two distinct antenatal classes twice prior to birth and once after the birth. Interviews explored the way in which women enrolled in different childbirth curricular and how they came to define and understand childbirth. What emerged from the study was that cultural themes related to childbirth are omnipresent and are very hard to transcend.

Both homebirth and birthing centre mothers in Cunningham's (1993) study nominated the desire to have a natural birth with control and no intervention. Homebirth mothers in particular felt that being able to have family and friends present at the birth was an important factor in their decision. Likewise Coyle (1998) who interviewed 17 women who gave birth in a Western Australian birthing centre also found that having carers who believed birth was a natural process, engaged in sharing care and continuity of care were the most salient considerations for choosing a birthing centre.

Most of the homebirth mothers in Cunningham's (1993) study had experienced a negative hospital birth previous to their homebirth which greatly influenced their decision to birth at home. A survey to Australian women conducted by Choice Magazine (1988) also revealed that previous hospital experiences determined some women's decision to birth at home. The research reviewed indicates that factors such as previous birth experience, desire for a natural birth that does not rely on medical intervention, opportunity for self-control, family attendance at birth and shared continuity of care are associated with women choosing either to birth at home or in a birthing centre.

Factors Associated with Loss of Choice

Cunningham's (1993) study demonstrated that some women have little choice for birthplace. In this study, 12% of the sample were prevented from birthing where they wished due to medical complications. Furthermore, the study also revealed that choice sometimes changes depending on circumstances during birth. For example, the main change that occurs for women is to change from delivery in the birthing centre to labour

ward. Also women may need to deliver in surgical theatre. For birthing centre mothers, 36% ended up in the labour ward or surgical theatre denying them their preference for birthplace and intervention free birth. This was considered a particularly large proportion considering the strict low-risk criteria these mothers fulfilled in selection for the birth centre.

Systemic factors may also influence a woman's choice of birth such as advice from obstetricians and doctors, fear of stigmatisation for choosing homebirth and government policies. For example, a meta-analysis of 10 research articles examining women's preferred mode of birth conducted by Gamble and Creedy (2000) revealed that advice from obstetricians influenced women's decision towards a caesarean section birth. Concerns identified in the studies related to the assumption that if women say they were well informed, they must have access to accurate and unbiased information. However other studies have questioned the notion that women make well informed choices to have a caesarean section. Hillan (1992) reported that 20% of women in the study group either did not know why caesarean section was performed or gave completely mistaken explanations for the operation and a further 16% were only partially correct in their comprehension. Other researchers have reported a poor correlation between the reasons for caesarean section in patients' records and mother's interviews (Hemminki, 1997; Hemminki & Lofgren, 1990; Perez, 1989). In addition, one study conducted by Lescale et al. (1996) reported that obstetricians were likely to disclose only risks with a relatively high probability of occurrence and to provide little information about alternative

treatments. The results of the meta-analysis indicate that women might make decisions based on biased information about childbirth.

Furthermore, women who have inquired into natural birth or have sought advice in relation to homebirth have reported non-supportive responses from their doctor. This was illustrated by Viisainen (2000) who interviewed 21 homebirth women about their perceptions of risks in homebirth. The women reported that they felt shamed for wanting to birth their baby naturally when they discussed the birth options with their doctor or obstetrician. The women reported that they were labelled as irresponsible and the medical staff questioned the safety of the baby. Douglas (1985) purports that medical discourse that refers to alternative birth as risky can be viewed as a social coercion technique to keep women in compliance with the system which leads to the loss of alternative choice of childbirth for women. Particularly when evidence has been found that homebirth for low risk women is safe (Parratt & Johnson, 2002).

Policies and government funding are factors identified as influential for women's decision about childbirth. Australian policy in reference to birthing women does not recognise the heterogeneity of women. There is a lack of government funding for women who decide to birth in different settings other than a hospital. Since 1983 Australia has had a system of free (2% tax levy) healthcare called Medicare however, only doctors and to a lesser extent opticians and dentists have been the only service providers whose patients may claim a Medicare rebate. As a consequence due to this financial support, 97% of women birth in hospital (Harris, 2000).

In Sweden, which is similar to Australia where hospital births are financially supported, Hildingsson, Waldenstrom and Radestad (2003) provided evidence to indicate that if Swedish women were offered a free choice of birth place that the homebirth and birthing centre rate would be higher. This was illustrated when they surveyed 3,283 women during pregnancy, two months after birth and one year after birth to determine interest in homebirth, birthing centres and hospital births. The results revealed that interest in homebirth and birthing centres were ten times higher than actual homebirth and birthing centre birth rates.

In comparison, in the Netherlands homebirth has a central role in maternity care and is medically and culturally regarded as desirable whereby all low risk women have free choice between home or hospital birth regardless of their socioeconomic status or forms of insurance. Consequently homebirth percentages are higher than hospital births in the Netherlands (van der Hulst et al., 2004). The research reviewed indicates that negative medical discourse in relation to childbirth, medical complications during birth and lack of funding for alternative birth options may impact on women's birth choices.

Limitations of the Review

Due to the paucity of research in the psychology literature, the review relied on research from the fields of midwifery. The combination of reviewing literature from the different fields led to further limitations for a number of reasons. Firstly, there are disparate approaches to studying the meaning of childbirth in both the psychology and midwifery fields. The merging of these two approaches is problematic due to the philosophy and

perspectives that underpin them. Secondly, there is limited research in either the field of psychology or midwifery that explores women's meanings of childbirth, the focus is based more on outcomes which impacts on the ability to arrive at a clear understanding of women's perspectives.

Furthermore, the combination of comparing small scale studies with large scale studies has resulted in a lack of standard measures, thereby lacking rigour in the experimentation, which can reduce the validity and reliability of the research reviewed.

The review omitted to explore the perspectives of single women giving birth, teenage pregnancy, unwanted pregnancy and women who have not yet birthed or are not able to birth, due to the paucity of research. This might have provided a more representative sample of women's perspectives on childbirth. Women from cultures other than Western were also omitted from the study due to a lack of ethnographic studies whereby women's perspectives could be gleaned from within their culture.

Summary and Conclusion

The aim of this review was to explore societal beliefs and practices that influence women's perspectives on childbirth. A particular emphasis of the review was how the dominant medical ideology surrounding childbirth, labour and pain can shape a woman's perspective on birth. It leads to the perspective that technology and medical expertise provides the safest, most convenient and pain free method for childbirth. Under this paradigm, women tend to be treated as a homogenous group.

The review began by reflecting on historical childbirth practices that demonstrated how childbirth practices have changed from midwifery based

practices of women caring for women to medically based practices whereby the emphasis is on paternalistic provision of care. The implication for this historical shift in care has resulted in two distinct ideologies about the care of women during childbirth. Firstly, the medical model whereby medical practitioners perceive birth to be risky thereby requiring the assistance of medical expertise to keep her safe and to alleviate labour pain through the utilisation of analgesia to major surgery. Secondly, the natural model whereby traditional midwives perceive birth as a natural physiological process and labour pain as purposeful that may result in increased self-efficacy and feelings of empowerment for the new mother. However, the research indicates that women are not so dichotomous in their perspectives of childbirth but fall along a continuum between these two mutually exclusive perspectives.

The review also highlighted that the place a woman chooses to give birth reflects her underlying perception of childbirth. A woman who births in a home may tend to adopt the natural model whereas a woman who births in a birthing centre may fall somewhere along the continuum and a woman who births in a hospital may tend to adopt the medical perspective. However, research has illustrated how influences such as government funding geared towards hospital births, medical discourse promoting fear and risk and biased information towards hospital births are influences that help shape a woman's choice of birth in hospital.

The review illustrates that women are heterogenous in their perspectives on childbirth. According to the research it would appear that unless a woman possesses characteristics such as strong beliefs in natural

birth, has an internal locus of control and is well educated about childbirth from sources provided by alternative sources, her choices and informed decision making may be limited.

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Running head: LOST WISDOM

Lost Wisdom: An Exploration of the Experiences of Women who chose to

Birth at Home

Lee-Anne Raeside

Lost Wisdom: An Exploration of the Experiences of Women who chose to
Birth at Home

Abstract

Homebirth is perceived as a woman centred practice of care that encompasses choice, continuity and control for women and is associated with improved psychological outcomes for women. In order to provide a more comprehensive understanding of women's psychological needs and values it is important to provide information gained from women who have had no voice in the psychological literature. The present qualitative study involved eight mothers who had chosen to birth in their home. A feminist perspective was utilised to gain insight into the mothers' perspectives. Semi-structured interviews revealed psychological and psychosocial benefits for participants including; increased self-efficacy, perceived control, strengthened familial and spousal relationships. Future directions are discussed including the need for research to compare the psychological and psychosocial outcomes for women who birth in hospitals, birthing centres, and in their homes to examine care issues that are implicated in the psychological well being of birthing women.

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Supervisor: Dr Elizabeth Kaczmarek

Submitted: October, 2005

Introduction

Since the late 1980's women's birthing choice for delivery of their babies have expanded to include hospital, the use of birthing centres, and homebirth. Whilst the majority of Australian women (96%) will birth their babies in a hospital, there has been a very small increase in the incidence of homebirth with approximately 1% of Australian babies being born in the comfort of their home (Morison, 1996).

Homebirth is perceived as a woman centred practice of care that encompasses choice, continuity and control for women and has also been associated with improved physical and psychological outcomes for women who have chosen and are able to birth at home (Baker, Choi, Henshaw & Tree, 2005; Davies, 2001; Kitzinger, 1991; Lundgren & Dahlberg, 1998; Niven & Murphy-Black, 2000; Parratt & Fahy, 2003). The midwifery literature highlights the strengthening of relationships and positive bonding experiences with the new baby for all members of the family who may be present at the birth. (Hoddinott, Simpson & Pill, 2002; Morison, 1996). Furthermore, research has demonstrated that homebirth for those who can deliver this way is safe for both mother and baby (Hodnett, Gates, Hofmeyr & Sakala, 2005; Olsen & Jewell, 2005; Woodcock, Read, Moore, Stanley & Bower, 1990) and has been considered by some as a safer alternative to hospital birth even for women identified as high risk (Tew, 1990).

Despite the heterogenous midwifery literature on childbirth, scant research on homebirth has been conducted by psychologists. Psychology has tended to focus more on women who have birthed their babies in hospital. Therefore the implications for women birthing in their own home

are yet to be explored, including the impact on child development, relationships, personal well being and the transition to motherhood. The present study attempts to address the gap in the psychological literature for women who birth at home through eliciting current first-hand experiences of women who experienced a planned birth in their home. Apart from furthering the understanding of how women experience childbirth in their home, the knowledge gleaned from homebirth mothers may provide a more comprehensive research base on women's perspectives on childbirth that has been seriously neglected in the field of psychology.

Psychological Outcomes in Response to Care

The majority of the midwifery literature pertaining to homebirth has come from a feminist perspective grounded in qualitative research. Feminist critics argue that the concepts of medical power and authority inherent in the medical profession, with its philosophy of pathology and a paternalistic model of care, acts to control, discipline and disempower women during childbirth. This, it is argued has acted to negate women's actual experiences fostering the notion that they have become compliant passengers in the birth process (Baker et al., 2005). The success of childbirth has been judged solely on the basis of physical indicators (e.g., mortality rates), while the experience of labour is considered irrelevant or of minor importance.

In contrast, homebirth midwives are described as professional practitioners who can provide continued care that meets the unique needs and preferences for women throughout the childbearing process (Tew, 1990). According to Tew midwifery practice for homebirth is underpinned

by the understanding of the importance of the psychological and biological processes of birth and as a result women who can birth at home are more satisfied with the care they receive. However, in Australia, the midwifery practice for homebirth care is not offered as a serious and safe method of delivery with government funding geared towards hospital births (Harris, 2000).

Research conducted by Shields et al. (1998) compared women's satisfaction with midwife-managed care, involving continuity of care, and shared care, i.e., the client being shared among the midwifery team. Self-report questionnaires sent to 1,299 women experiencing low risk pregnancies revealed that both groups were satisfied with their care. However, women in the midwife-managed care were more satisfied with respect to the relationship with the carer, transfer of information, choices and decisions, and support. It was also found that women in the midwife care group were more likely to make positive comments about their childbirth experience compared to the shared care group who were more likely to make negative comments.

Perceived Control

There have been several studies, indicating that satisfaction with the experience of childbirth is dependent upon women's perceived control of the process (Coyle, 1998; Green, Coupland, Kitzinger, 1990; Morison, 1996; Slade, MacPherson, Hume & Maresh, 1993; Waldenstrom, Hildingsson, Rubertsson & Radestad, 2004). Control of the process includes feeling in control of; what staff are doing, own behaviour, and during contractions (Green & Baston, 2003). Control of childbirth and continuity of

care were identified by Coyle (1998) as issues for 17 women who had given birth in a birthing centre in Western Australia and had previously birthed in a hospital setting. The women wanted carers who viewed birth as a natural process rather than an illness and who engaged in a sharing, rather than a controlling relationship.

Mothers who birthed at home have cited the desire to have control over their birth as one reason for choosing a homebirth (Cunningham, 1993; Morison, 1996). Morison's study revealed that the abundance of information in respect to childbirth offered by the midwife and the opportunity to make shared decisions with the midwife provided a sense of personal control for mothers. The mothers reported that they felt safe and the labour pain was less intense as a result of their perceived control.

Emotional Support

Emotional support has been identified as a major factor for satisfactory births and to impact on the birthing outcome (Hodnett, et al., 2005; Madi, Sandall, Bennett and MacLeod, 1999; Taylor, 2002). Specifically it has been demonstrated that emotional support during pregnancy, labour and after the birth has been associated with decreased labour pain, shortened labour time, decrease in medical intervention and improved transition to motherhood (Cunningham, 1993; Morison, 1996). For instance Madi et al. (1999) found that having a female relative present during labour was associated with fewer medical interventions and more spontaneous births (91%) compared to women who birthed without a support person present (71%).

Furthermore a meta-analysis on 15 trials involving 12,791 women conducted by Hodnett et al. (2005) found that women who had continuous support during labour were less likely to have operative birth, analgesia or to report dissatisfaction with their childbirth experiences. A review of the Cochrane Library by Taylor (2002) also found that the continuous presence of a support person reduced the likelihood of medical intervention. In addition the review revealed that continuous support was more likely to produce a healthier baby at birth and a reduction in length of labour. According to Parratt and Fahy (2003) an outcome for women who birthed at home who had received continual emotional support was a trusting relationship between mother and carer. This trust relationship resulted in increased self-confidence for the birthing mothers with the outcome of feelings of empowerment in conjunction with no medical intervention, shortened labours and decreased labour pain.

Psychosocial Outcomes for Planned Homebirth

Research has revealed that psychologically homebirth mothers tend to be better prepared, more confident, responsible and efficacious (Cosans, 2004; van der Hulst et al, Teijlingen, Bonsel, Eskes, & Bleker, 2004; Morison, 1996). Positive psychosocial outcomes for mother, father, siblings and the newborn have also been identified (Cunningham, 1993; Fleming, Ruble, Anderson and Flett, 1988; Hoddinott, 1989). For example, in a qualitative study conducted by Morison (1996) who interviewed 10 couples, it was found that the homebirth experience brought couples closer together and fostered a closer bond with the child at birth. The fathers in this study felt involved and very much a part of the birth process and the mothers

expressed a sense of achievement in that they felt capable of fulfilling the mother role after conquering natural childbirth.

Children present at the birth were viewed as an asset who would learn from the experience and furthermore fulfilled a desire to maintain the family unit without the need for childcare or exclusion of family members. The study's findings were in accordance with Mehl, Brendsel and Peterson (1977) who observed and interviewed 20 children who had been present at a birth and 20 children who had not been present. Children present at birth were found to view birth in a positive, happy manner and female children also felt capable of giving birth. In addition, three couples reported less sibling rivalry.

Couples also expressed their delight in giving birth in a quiet, calm and peaceful environment whereby parents were able to spend as much time as they desired with their newborn without interference. All mothers in the study breastfed their newborns immediately after birth. This finding was in agreeance with Hoddinott, et al. (2002) who found that women who birthed at home had the highest percentage for breastfeeding compared to birthing suites and hospital deliveries.

Results from Hoddinott et al.'s (2002) study also revealed that homebirth mothers reported lower levels of anxiety before and after birth. Furthermore, homebirth mothers and their families appeared to be more satisfied with their birth experience and mothers appeared to adapt to the mothering role with more a more positive framework.

The Present Study

As the midwifery literature denotes homebirth as an empowering process for women with the potential to strengthen familial and spousal relationships, and provide a positive framework towards motherhood, it is possible that the information gleaned from homebirth mothers could inform the psychological literature by providing a more comprehensive understanding of women's values and psychological needs with respect to childbirth. This would supplement the perspectives obtained from psychological literature from women who have birthed in hospital.

A feminist perspective to explore the recognition and validation of the woman and her experience utilising women who have had no voice in the psychological literature is paramount to gain insight into women as a heterogeneous group. Whilst homebirth is acknowledged as one choice of birth, the perspectives of women who select this birthing option can be useful as they may provide optimal birthing choices for women by helping educate and empower women to be less fearful, to produce a more satisfied birth experience and a more positive transition to parenthood. Therefore the following research question was: What is the experience of women who make the decision to birth at home?

Method

Research Design

Qualitative methodology was employed to elicit the rich dialogue from the participants. Furthermore this approach is consistent with feminist theory which espouses that a value-free science requires a comprehensive, inclusive and affirmative investigation of human behaviour through

qualitative research, which is a relational process that involves shared stories, present bodies, and real voices (Paludi, 2001). Consequently, the lived experiences and multiple realities of a group of women were explored from their own perspectives, as the focus was on the way participants made sense of their experience (Letherby, 2003).

A semi-structured interview format was formulated utilising questions designed to elicit a rich description of the participant's experience. In addition, a semi structured interview format assisted in confirmability with each participant responding to the same questions whilst simultaneously allowing the conversation to flow and establish rapport (Smith, 1995). Consistent with feminist research the interviews allowed for a collaborative approach between researcher and informant, treating what participants stated as meaningful and informative (Letherby, 2003).

Upon completion of the interviews the data were transcribed from the tape recorded interviews and analysed utilising thematic content analysis by identifying themes and issues as outlined by Miles and Huberman (1994). In accordance with Miles and Huberman systematic data reduction, display and interpretation were followed. Similarities were noted and comparisons drawn between participants' stories, from which the meaning of their experience was derived and then interpreted. Confirmability and transferability were given careful consideration throughout the process, including triangulation and member checking (Miles & Huberman).

Participants

Eight participants who experienced a homebirth during the year 2004 were recruited through the Peel region Community Midwifery

Program in Western Australia. Seven mothers included in this study were multiparous and one mother was primiparous. The average age of the mothers at the time of interview was 31 years with the youngest age at 25 and the oldest age at 40. Of the participants, six mothers were born in Australia, one mother was born in Britain and one mother born in New Zealand. Five mothers were not working at the time of interview while one mother was working fulltime as a registered nurse and two mothers were working part time in non professional jobs. However, prior to motherhood, one mother worked as a veterinary surgeon and one mother worked as a computer analyst. Further demographic data is provided in Table 1. All interviews were conducted in participants’ home. To protect the identity of participants, pseudonyms have been utilised.

Table 1.

Demographic Data Collected from Participants

Participant Pseudonym	Marital status	Number of children	Number of homebirths	Age at time of homebirth
Joanne	Married	3	2	27/29
Cathy	Married	1	1	28
Tanya	Married	4	4	32-40
Gigi	Married	3	1	26
Dianne	Married	2	1	33
Clarice	Married	2	1	31
Katie	Defacto	3	1	25
Annabel	Married	3	2	28/30

Data collection

Four questions were formulated for the semi structured interview (see Appendix A). Initial questions were broad to avoid bias on behalf of the researcher. Further questions funnelled down to more specific areas allowing for more in depth analyses of the topic (Smith, 1995). Although the interviews were guided by the question format, the structure of the interview was deliberately flexible to enable each participant's unique experience to be explored.

The research questions were scrutinised by independent persons to assess face validity and suitability of the interview schedule.

Procedure

Following approval from the ethics committee to conduct the research, copies of an information letter were sent (see Appendix B), to the Peel region Community Midwifery Program to be distributed with their monthly newsletter. This resulted in five participants contacting the researcher. Another three participants were recruited through the technique of snowballing from the Perth Community Midwifery Program also contacted the researcher.

On receipt of an expression of interest an interview time was arranged. Interviews occurred in participants' homes as all participants expressed that their home would be the most convenient place for them. Prior to the interviews, participants were given a consent form (see Appendix C) to sign and a demographic form to complete (see Appendix D). The interviews lasted approximately 45 minutes and were audio taped.

During the interviews, the researcher was aware of the core assumptions of the feminist approach concerning issues of relationship and power (Letherby, 2003). Furthermore, the researcher was aware of her own biases, as like the participants she had experienced a homebirth. It is of the researcher's opinion that rapport was enhanced as participants inquired about researcher's experience. The researcher conducted all eight interviews. It was decided not to take notes during the interview, thus attempting to address the power dynamic by conducting research 'with' the participant rather than 'on' the participant (Letherby, 2003). The reduction of researcher effects by addressing similarity issues, having one researcher to conduct interviews and power dynamics in conjunction with supervisory debriefing after interviews assisted in the confirmability of the interview data (Breakwell, 1995).

At the conclusion of the interview the participant was thanked, and given the opportunity to ask questions about the process of the project. One participant was debriefed after the interview and offered a list of referrals (see Appendix E), to assist in maintaining the well being of the participant. Following each interview the researcher recorded reflections and impressions in a journal to assist in analysis.

Ethical considerations were strictly adhered to throughout the process, including elimination of all identifying names and places in the data. In addition, pseudonyms replaced participants' names.

Data Analysis and Research Rigour

An idiographic approach to the data was adopted and analysis began as data was collected focusing on particulars. This was reduced to the level

of slowly working up to generalisations (Smith, 1995). The recorded interviews were transcribed verbatim. The transcripts were read numerous times to gain an overall impression of the data. Thematic content analysis techniques were employed to analyse the data as outlined by Miles and Huberman (1994). This consisted of data reduction, data display and data conclusion and verification, which involves processes such as coding, clustering and identifying themes in conjunction with the use of a reflective journal to assist verification by means of an audit trail.

During transcription, reflections and themes were recorded utilising a triple column data display. The left hand column was for recording impressions, personal bias and general thoughts on topics discussed; the middle column was the interview transcribed verbatim; and the right column was to record themes and sub themes identified from reading through the text.

A question ordered matrix (see Appendix F) was utilised to assist in data reduction (Miles & Huberman, 1994). The matrix columns were organised so the researcher could view participant responses to the interview questions. The columns were used for participant responses and the rows were used for each individual. The matrix allowed for the researcher to search for recurrent themes and issues. Keywords and quotations were used in reporting in order to illustrate the salience of such themes and to demonstrate how they influence the construction of the participant's experience.

The data was then segmented by means of categorisation of themes and issues. Significant phrases were underlined in the data and colour coded

to form categories of emerging themes. The research journal was consulted to assist in interpretation of meaning. The next process for data reduction involved identifying significant themes and issues by their frequency and clustering issues under significant themes.

To address the question of confirmability and transferability a method of member checking as outlined by Miles and Huberman (1994) was employed to ensure the authenticity of interpretation whereby a sample of participants were contacted for respondent validation of the researchers' interpretation. Credibility of the findings was also enhanced through the employment of triangulation to minimise researcher bias (Letherby, 2003). A colleague of the researcher cross checked the interpretations of the themes and issues to ensure their validity.

Findings and Interpretations

The aim of this study was to explore the experiences of women who had chosen to birth in their home. Inductive data analysis revealed positive experiences on many levels, particularly those that concerned women centred care practices and the participants' feelings of self-empowerment. Three major themes, each incorporating two sub themes were generated from the data. See Table 2.

Table 2

Categories of Emergent Themes and Sub-Themes

Themes	Sub Themes
Self-construction	Self-efficacy
	Comparative descriptions between Homebirth and hospital birth
Relationships	Strengthening family relationships Strengthening partner relationships
Practice issues surrounding birth	Continuity of care Information/choice

Self-Construction

The homebirth experience provided participants with a positive sense of self (Parratt & Fahy, 2003) which was in keeping with their personal beliefs about birth being a natural process and assisting in the formation of their feminine identity (van der Hulst et al., 2004). This was noted through their feelings of empowerment and increased self-efficacy and their descriptions of their homebirth experience in comparison to their previous hospital experience.

Self-Efficacy

The literature suggests that women describe their homebirth experiences as a major personal achievement, joyous and empowering (Davies, 2001; Kitzinger, 1991; Parratt & Fahy, 2003). In addition, this sense of achievement has been implicated to provide a positive transition to motherhood (Morison, 1996). In accordance with the research, all eight participants described feelings of empowerment: “*I feel so much more*

confident, I feel like I've been empowered. Like this empowerment you get after a sense of yeah...I'm capable...I just birthed my child in my own home without anybody telling me what I can and can't do" (Gigi). Also "I felt proud of myself, you know that I had accomplished it in the end without drugs or whatever..." (Katie) and "I came out of that thinking, well I can do anything..." (Joanne). From a first time mother "It empowered me, I can do this! What I have done is what a million women these days are copping out of doing...so yeah...I feel special" (Cathy).

Participants expressed the realisation of an inner strength which was found to be utilised later as a coping strategy. In accordance with Niven and Murphy-Black (2000) the participants' reports of labour pain was often associated with largely positive feelings about their ability to cope with severe pain and accompanied by feelings of emotional well-being and of being in control. Annabel encapsulates for all participants *"I felt really strong, there was a definite sense of strength...I have just jumped through a particular hoop in life, I know that I have the inner strength to trust my body...I trust my own ability to get something done despite working through a lot of pain and also finding the strength within myself to deal with it".*

The experience of labour pain and the experience of strength during childbirth gave meaning to the transition to motherhood with the increased self-efficacy providing a more positive framework towards motherhood (Hoddinott et al., 2002; Lundgren & Dahlberg, 1998). For instance Tanya who has birthed four babies at home stated, *"it gives you great confidence I think in your ability, you know it made me feel a great mother even before I had started mothering...you kinda did a great thing and you did so well...it*

gives you this massive confidence, it empowers so much...I remember thinking that I had done this it was so good it went well there was so much love around...a beautiful baby and nothing could go wrong after that". The participant's reports of empowerment and sense of achievement is suggestive that women who birth without pharmacological pain relief have more positive feelings about themselves with the outcome of increased self-efficacy and sense of self (Parratt & Fahy, 2003) and a smoother transition towards motherhood (Morison, 1996). Furthermore, the participant's reports were consistent with the research that has revealed that homebirth mothers tend to be better prepared, more confident, responsible and efficacious (Cosans, 2004; van der Hulst et al., 2004).

Comparative Descriptions between Homebirth and Previous Hospital Birth

Literature on homebirth suggests that women are more satisfied with their birth compared to women who birth in a hospital or birthing suite (Cunningham, 1993). Interestingly, some participants described birth complications however, all eight participants described their homebirth with positive tones. For example, Gigi, described her previous hospital experience as *"a traumatic event...my aim as a woman was to birth my babies as natural as possible and that was taken away from me...it broke me...I had severe depression"* and then described her homebirth *"it was such an empowering and healing and beautiful experience and even now when I think about it, it makes me want to shed a tear...I was able to enjoy my baby on a different level...the birth was very peaceful"* even though the baby was in an awkward position for birthing, with the cord wrapped around

his neck. Dianne who went into labour three weeks early described the homebirth “*magical...I felt more comfortable with everything...it was peaceful*” compared to her description of her previous hospital birth “*I was out of control totally... I couldn't share all the experience with my husband...*”

Two participants who had experienced more than one homebirth disclosed that the homebirth under study was not as satisfying as the previous homebirth. For instance Joanne expressed “*I was just so tired and it seemed so much more painful*” after her second day of labour and Tanya expressed “*I was really tired and I found that the labour progressed a lot slower than I was expecting...the one before was a two and a half hour labour*”. However, even though this birth was not as satisfying as the previous homebirth, all six participants who had experienced a hospital birth with medical intervention stated that their homebirth was much more satisfactory than the hospital birth. Joanne “*the homebirths were much better just more relaxed at home*”. Clarice stated “*the biggest difference was I was in control...with my first birth it was great until I got to hospital and then the power was taken away from me and I gave up...*” Dianne described her homebirth as “*shorter, it was a little easier and less painful*” when asked how her birth was different to previous birth.

The participant's positive descriptions of homebirth are consistent with the literature which suggests that homebirth mothers provide more positive descriptions of their birth experience compared to hospital mothers (Cunningham, 1993; Hoddinott et al., 2002; Shields et al., 1998). In addition, the findings are supportive of the literature that purports that

perceived control is a critical factor for a satisfactory birth (Green & Baston, 2003).

Relationships

In accordance with the research (Mehl et al., 1977; Morison, 1996), participants unanimously reported that being in their own home provided privacy and intimacy that was conducive to strengthening family bonds.

Strengthening Family Relationships

For some women having close family and friends present during birth is optimal for a satisfactory birth. Research has demonstrated that support is an important factor for the psychological well being of birthing women (Hoddinott et al., 2005; Madi et al., 1999; Taylor, 2002). A woman who chooses to birth at home also has the choice of support she would like around her. For instance, Cathy had her parents, her mother in law and her husband present for the birth. She expressed how wonderful it was to have them present with comments such as *“dad said oh you look so beautiful while I’m in labour”* and *“I said Dad you can come in now you have a grand daughter and he came in in tears and he helped weigh her...yeah...it was good”*. Cathy also expressed that her mother was a great help *“mum cooked breakfast and um the house got cleaned for a week, it was great...I didn’t go near my kitchen for two weeks...it was good”*. Six out of the eight participants invited family to the birth, *“mum was there with hubby and the two girls”* (Katie). Also Tanya *“my husband and I and the children wanted to be involved as well and his mother was here and she wanted to be involved”*. All family members who were going to be present at the birth were included in the birth process from pregnancy onwards. For example,

from Dianne “*my parents, daughter and husband met Louise (pseudonym)(midwife) and she explained how it all worked to them*”.

Clarice also expressed that antenatal appointments were made for the whole family. Gigi mentioned “*Travis (pseudonym) would come home when midwife was coming to feel part of the process. So midwife got to know Travis really well*”. Gigi expressed her husbands satisfaction for level of involvement “*Travis is a very involved dad and he wanted to be involved from the pregnancy, he is very supportive so I am very lucky...so he was devastated to be pushed aside with the other two...it was fantastic that he was included this time*”.

Tanya also highlighted how her other children were included in the process “*Having the midwife come to your home was great because they were able to see her in their own environment...so they got to know her as a friend rather than a practitioner...*” and “*...the midwife had given us books...a great story to read to them which was pitched perfectly towards them...so they read this story about homebirth and it was all done for children’s understanding, so they were prepared for the yelling so there was no concern from them...it was all just a great adventure for them*”. Gigi also expressed how the midwife involved the other children “*she involved the kids, she helped explain to the kids what was going on*”.

The participant’s recount of the family’s involvement of the birth process is consistent with the literature that family relationships are strengthened when all family members are included from pregnancy to postnatally (Morison, 1996). Furthermore, the family inclusive practice

provided better understanding of birth processes for the siblings, allaying any alarm or fears (Hoddinott et al., 2002; Morison, 1996).

Strengthening Partner Relationships

The literature on homebirth suggests that partner relationships are strengthened through experiencing the birth together (Morison, 1996). Data from participants certainly provided support for this. Dianne expressed “...*it (homebirth) certainly brought my husband and I closer together, my mum was just amazed what he was like*”. From Gigi “*it brought Travis and I so much closer*” and from Cathy “*all I wanted to do was tell him how much I loved him and how proud I was of him and everything...everyone usually yells at their husband and tells them they are horrible and I just had this overwhelming love for him...just wanted to give him a big kiss and a cuddle*”.

Participants described their partners as very supportive. When describing her partner Dianne stated “*he was so supportive, he knew what I needed before I did. He put on music, massaged my back, he was doing exactly as I wanted and putting pressure where I needed it*”. From Gigi “*Travis was just there for me*”. Dianne encapsulated what all participants felt “*we felt like we experienced it together rather than being bystanders to the birth*”. An example of the relationship bonding “*when the baby was born we got into bed together that night and had him between us and talked about him and talked about the experience...we were sort of tucked up in bed together our daughter tucked up in her bed and it just felt really comfortable and really family oriented I guess than being in a hospital and separated from everyone especially when they are there to share it with*

you". These findings are consistent with Morison (1996) who noted that relationships between couples were found to be strengthened as a consequence of intimacy and privacy enhanced by being in their own environment.

Practice Issues Surrounding Birth

All participants embraced the women centred model of care adopted by their midwives, thus supporting the literature that women in the midwife-managed care are more satisfied with respect to the relationship with the carer, transfer of information, choices and decisions, and support (Coyle, 1998; Hoddinott et al., 2005; Shields et al., 1998).

Continuity of Care

Participants were unanimous with respect to their care. In accordance with the literature (Coyle, 1998) continuity of care was considered very important to the participants. Joanne expressed *"I got everything! It's not so much the homebirth but the midwifery care"*. Clarice confirmed the continuity of care *"you see the same person every time. She (midwife) was always there at the end of a phone"* In accordance with Morison (1996) all participants stated that their midwife came to their home for visits and provided the opportunity to build a relationship between carer and mother. Annabel expressed *"because I had the two girls, Macy(pseudonym) (midwife) would come to me. Which was really lovely. I didn't have to get babysitters"* to Tanya *"I had home visits through all my pregnancies, I didn't have to pack the children up and go to a clinic...and afterwards she came everyday for the first week and just made it so easy and she was able to answer questions for the children and myself and you*

know you really felt that they become a part of your family for that time”.

Gigi expressed that the relationship between carer and mother is very close
“she was my friend, she was with me from the moment I was pregnant to post natal care had finished and I know to this day that I can phone her and ask her about anything. You develop such a close bond having that continued care”.

The midwifery care was described by Annabel as *“Having Macy was like having your mum around”*. Tanya also described her midwifery care as *“ I think being able to talk to somebody who you felt was really there for you and listen to any kind of query...to be able to have a midwife here with a cup of tea, talk about anything that’s going on, you feel really supported...yeah such great support...you can’t beat that”*. The continuity of care provided to the participants suggests that a trust relationship was formed through the provision of emotional support that acted as a buffer against medical intervention (Fahy & Parratt, 2003; Hoddinott et al., 2005; Madi et al., 1999; Taylor, 2002).

Information/Choices Pertaining to Childbirth

In accordance with the literature (Coyle, 1998; Green & Baston, 2003; Green et al., 1990) the participants were emphatic that the amount of information provided by the midwives allowed for more choice with the outcome of perceived control from pregnancy through to postnatal periods. Dianne epitomised this *“she gave us many choices...this is the program and this is your choice kind of thing...so the whole way through the pregnancy you feel like you’re more in control... I guess you have more knowledge so you feel like you are making choices for you not for going along with what*

everyone else thinks you should do". Participants unanimously reported that they received a lot of information. For example, Gigi expressed *"you are given choices in what to do...she would always do what you wanted, to have this or this and this...so you pretty well make your own choices all the way...so much information"* Participants also acknowledged that the information provided was inclusive of hospital procedures as well as midwifery procedures. For example, Annabel stated *"I remember her discussing medication, procedures, homeopathics that sort of thing with me and having a wide choice of what I don't want to do and what I do want to do"* Participants also expressed choices during birth *"she presented my options, we can carry on, she can break my waters, we can go to a hospital"* (Joanne). Annabel expressed *"having the freedom to choose relaxes your brain, makes you feel safer too and that helps with the progress of labour in that you know that you're the person who is ultimately in control or somebody who knows what you want is in control..."*

In addition the participants expressed that the amount of time spent with the midwife allowed for more information to be passed on *"she was here for an hour and a half at a time, so the information I got from her was amazing!"* (Cathy) to *"you get to spend about an hour and a half with the midwife and get loads of information compared to ten to fifteen minutes with your doctor"* (Dianne) and Clarice *"you can ask loads of questions...she came and had a cup of tea...she had loads of books, videos and time just to sit and chat and it was really lovely just to get to know her...so much more information gets across and then you get to know that person so well that you'll ask anything a couple of times"*.

The findings are consistent with Morison's (1996) study whereby the abundance of information in relation to childbirth offered by the midwife and the opportunity to make shared decisions with the midwife provided a sense of personal control for mothers, which resulted in mothers feeling safe with less intense labour pain.

Conclusions

The aim of the present study was to explore the experiences of women who had chosen to birth in their own home. Utilising a feminist perspective (Letherby, 2003), it was found that the experience of homebirth was extremely positive for this group of women. Much of this satisfaction appeared to result from a high degree of congruence between the development of a sense of self and personal childbirth beliefs that led to feelings of empowerment and a sense of achievement (Parratt & Fahy, 2003). Furthermore, satisfaction also appeared to be the result of a sense of personal control experienced from early pregnancy through to six weeks post natal (Green & Baston, 2003). The majority of participants experienced greater depths of emotionality and connectedness with their family and partners as a consequence of the intimacy and privacy enhanced by being in their own environment (Hoddinott et al., 2002; Morison, 1996).

The most important finding for this study is that for this group of women, the type of midwifery care they received appeared to facilitate the high level of satisfaction they derived from the experience (Baker et al., 2005). Many of the feelings expressed by the participants were compatible with the findings related to women centred midwifery care (Shields et al., 1998). Specifically these feelings related to the relationship with the carer

(Coyle, 1998), the transfer of information, shared decision-making, choice (Cunningham, 1993; Morison, 1996), and provision of emotional support (Hoddinott et al., 2002; Madi et al., 1999; Taylor, 2002).

The current participants' positive descriptions of their midwife are consistent with the research on continued care (Coyle, 1998; Shields et al., 1998). Accordingly, it is reasonable to hypothesise that continuity of care for birthing women promotes a trust relationship between carer and mother (Coyle, 1998) and enables mothers to feel safe and comfortable to birth regardless of the place a woman decides to birth. This close relationship facilitated security for participants who felt relaxed and safe. This resulted in easing anxiety associated with pain relief thus not feeling the need to request medical intervention (Hoddinott et al., 2002; Madi et al., 1999; Taylor, 2002). Conversely the participants' negative narratives about their previous hospital birth specifically related to lack of support and lack of personal control supported the notion that birthing women's psychological needs are not addressed in this setting (Baker et al., 2005; Coyle, 1998).

Furthermore, the provision of information to participants enabled participants to make informed decisions which were conducive to their beliefs and expectations about childbirth thus facilitating perceived control throughout the childbirth process (Green & Baston, 2003). Finally, homebirth mothers appear to become empowered to birth naturally in their home due to the women centred care they receive and the security of being in their own environment.

Limitations of the Study

Although qualitative research is useful for topics that are exploratory in order to avoid inaccurate assumptions, it does limit the generalisability of the sample to the larger population. In addition, there may be sampling bias in the current study due to the non random sampling method of recruiting participants via advertised requests. It is possible that only participants who found the experience positive were inclined to respond. Due to the absence of negative narrative in the present study sampling bias must be considered. However the possibility that birthing a baby at home may impact on the mother's psychological well being can not be ruled out.

Implications

This study contributes towards the understanding practitioners require to effectively engage and empower women during the birthing process by recognising the psychological needs of birthing women and their families. Considering that homebirth mothers who represent 1% of Australian births tend to be more satisfied with their birth compared to hospital birth mothers who represent 96% of Australian births (Cunningham, 1993) suggests that care practices for women who birth in hospitals needs to be addressed. An awareness of the woman centred care provided to homebirth mothers and their families would be especially helpful to clinicians and health professionals working in the area of childbirth; specifically, continued care from early pregnancy to postnatal.

Given that the homebirth experience can be a positive bonding experience that facilitates a smooth transition towards motherhood (Hoddinott, Simpson & Pill, 2002; Morison, 1996), suggests that

practitioners may benefit from the findings of this study. Specifically clinicians and health professional in antenatal training and therapy might find it helpful to provide childbirth information inclusive of homebirth care practices and procedures for women who perhaps desire a natural birth and who are seeking knowledge in relation to childbirth options.

Future Research

The present study has addressed the gap in the psychological literature pertaining to homebirth. The study also provides a conceptual framework to guide a more detailed exploration of women birthing in their home. Future research could employ a blend of qualitative and quantitative methodology in order to allow for generalisation. It would be useful to make comparisons between psychological and psychosocial outcomes for women birthing in hospitals, birthing centres, and at home, addressing care practice issues for birthing women.

In conclusion, the findings illustrated the participants' positive feelings of empowerment and sense of achievement derived from their homebirth experience. The findings are important not only to inform practitioners who work in the area of childbirth but also to inform policy makers in order to provide options for women seeking a natural birth.

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Appendix A

Interview Schedule

1. Can you tell me about your homebirth experience?
Prompt: Has having a homebirth made you think about
yourself in a different way?
Prompt: How was this homebirth different from your other
births?
2. Can you outline the reasons that lead to your decision to have a
home birth?
Prompt: Was there any specific information that assisted in
your decision?
3. Tell me about the ante and postnatal care you received.
4. What do you think other women should know about homebirth?

Appendix B

Information Sheet

Dear Participant,

My name is Lee-Anne Raeside and I am currently studying Psychology at Edith Cowan University. As part of my course requirement for Honours, I am required to undertake a research project in an area where there is a need to expand the existing body of psychological literature.

I have decided to explore the topic of homebirth in Western Australia. The main aim of the project is to find out what your experience of homebirth was like, its meaning for you and whether the experience has changed the way you think about yourself. To be included in this study you will need to have given birth at home during the year of 2004. The project has been approved by the CSESS Faculty Ethics Committee of Edith Cowan University.

I will conduct a face to face, tape-recorded interview that should last approximately 45 minutes. There will be certain questions that I would like to ask you however the format will be more like a conversation than a question and answer session, as I am interested in everything you have to say about your homebirth.

All information given will be held in strict confidence and all identifying information will be omitted from the finished project. Although you may agree to participate in the study, you are free to withdraw from the research project at any time, or refuse to answer any question without reason. After the interview has been transcribed the tape will be erased and the transcription will be deleted from my computer. You will have the opportunity to view the finished project at the end of the year.

If you would like to participate in this project, or wish to discuss any aspect of this study, please contact me on 9276 6610 or 0417 994 558 at your earliest convenience to arrange an interview time that is convenient for you. Alternatively you can complete the consent form attached to this letter and return it to me in the reply-paid envelope supplied. If you wish to speak to someone else connected to the study you may contact my supervisor Dr Elizabeth Kaczmarek on 6304 5193. Alternatively if you wish to speak to someone not connected with the study, please contact Professor Alison Garton on 6304 5110.

Thank you for taking the time to read this information letter and for your participation in this project.

Lee-Anne Raeside

Please keep this information sheet for your reference

Appendix C

Consent Form

Project Title: Exploring the Experiences of women who have Birthed at Home

Please read the following statements and sign below if you agree to participate

I _____ (the participant) have read the information provided with this consent form and any questions I have asked have been answered to my satisfaction.

I agree to participate in the activities associated with this research and understand that I can withdraw consent at any time or refuse to answer any question without offering a reason.

I agree to be audiotape recorded during the interview and understand that the tape will be erased after transcription of the interview.

I understand that any identifying information will be erased from the finished work, that I have the right to view the finished project and that the study may be published.

Participant's Signature _____

Date _____

Participant's First Name _____

Researcher's Signature _____

Date _____

Appendix D

Demographic sheet

First name..... Surname.....

Date of Birth.....Phone number.....

Town or suburb where you live.....

Nationality.....

Marital status (please tick box)

- | | | |
|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> divorced |
| <input type="checkbox"/> De facto | <input type="checkbox"/> Separated | |

How Many children do you have?.....

If more than one, how many were born at home?.....

How old were you when you had your first child?.....

How old were you when you birthed at home?.....

Your Occupation.....

Your partner's occupation.....

Are you currently employed? ☐ Yes ☐ No

☐ Full time

☐ Part time

Appendix E

Support Organisations

Edith Cowan Psychological Services

8 Davidson Terrace
Joondalup 6027
Phone: 9301 0011

Relationships Australia

Phone: 1300 364 277
www.relationships.com.au

Centrecare

Counselling service
Phone: 9325 6644 and 9440 0400

Family Helpline

Confidential counselling and information service
Phone: 9223 1100

Appendix F

Question Ordered Matrix (*Example only*)

Questions Participant Pseudonym	Can you tell me about your homebirth experience?	Can you outline the reasons that lead to your decision to have a homebirth?	Tell me about your antenatal and postnatal care	What do you think other women should know about homebirth?
Gigi	It was such an empowering and healing and beautiful experience & even when I think of it it makes me want to shed a tear...	...its just who I am...childbirth is a natural process women have been doing it for years and years and years...its only been in the last century that it has to be done in a hospital...	I just learned so much from Lois (midwife) we became friends...	...giving birth isn't that hard...its not supposed to be tragic & traumatic...its supposed to be a beautiful experience of bringing this child that you have carried for nine months into this world as peacefully and calmly and give it the best start to life...
Tanya	...I was really tired and I found the labour progressed a lot slower than I was expecting...the one before was 2 ½ hours	I did a prochoice antenatal course...they presented lots of information about labours, births from hospital and homebirth sides...ended up feeling that being able to birth in your own home in your own environment with the support of a midwife without fearing the intervention was definitely the right place	I had home visits all through my pregnancies...I didn't have to pack the children up and go to a clinic...	Women need to make the decision for themselves about homebirth...I found the decision easy once I had the information...
Dianne	...I remember saying to my husband "this is perfect, it is just the way I wanted it"...I had music playing candles on and it was really peaceful	I wanted continuity with the midwife...also I don't like being away from my daughter so I thought it would be really nice to be here with her rather than in hospital...	Lois (midwife) was just amazing! Every time she came and every question I asked she was here for an hour and a half...	The biggest thing I had is that the body is able to do it naturally...in a homebirth you get the chance to follow your intuition within yourself and do what your body wants to do and is capable of doing