CHARACTERISTICS OF WOMEN HAVING HOMEBIRTHS VERSUS WOMEN HAVING HOSPITAL BIRTHS

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

BY

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DALLAS, TEXAS

MAY 1978

The Graduate School

Texas Woman's University

Denton, Texas

December 6 19 77

We hereby recommend that the Thesis prepared under our supervision by Jean Tillman entitled "Characteristics of Women Having Homebirths Versus Women Having Hospital Births"

be accepted as fulfilling this part of the requirements for the Degree of Master of Science.

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ACKNOWLEDGEMENTS

The author wishes to express appreciation to Peggy Chinn and Marilyn Chassie for initially encouraging the exploration of homebirth as a nursing issue; Helen Jolly for providing insight into the role of the lay midwife, opportunities to attend homebirths, and friendship; Betty Clarke (HOMEBIRTH, INC.), Linda Andre and Convy Stahl (CEA), and the CEA instructors for their cooperation which made this study possible; Connie Goldberg for providing initial support and references; and Dave Hosmer for giving freely of his time when statistical help was needed.

Appreciation is also extended to Janet Vadnais, Edith Reinisch, and Phillip Campbell for providing the time to accomplish this endeavor; twelve NUR 104 students for their interest and high level of competence which enabled me to direct my energies toward this study; David Sigelman for his participation in the review and examination of the manuscript; and Michele Edukas for her contributions in accomplishing all the last-minute tasks.

Gratitude is expressed to Tommie Wallace--an excellent role model--for her patience and sense of humor when teaching physical assessment, and to Donna Kem for promoting self-direction and independence within her courses

and for her encouragement, advice, and guidance in the organization of this study.

Finally, appreciation to my parents for instilling the value of education, and most importantly to my husband for all the supportive hugs and kisses.

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CHAPTER I

INTRODUCTION

Recently in the United States a small percentage of births have been occurring at home and the number appears to be increasing. The trend towards homebirth seems to have started in the Northern California area, spreading to the Northeast, South, and Midwest. General reasons given for the increase include the trend towards naturalness and the natural life style, a desire for greater participation by the father in the birth process, and greater mother-infant contact. Many couples wish to have family and friend support during birth and to avoid what seems to be a mechanized, cold, and dehumanizing hospital. While finances may play a part in the decision to bear children at home, the knowledge that 90 to 96 percent of all births are spontaneous and without complications is also an influencing factor. Other couples believe that gaining personal control; for example, having freedom of choice during the experience, is reason enough to avoid the hospital. This desire for control during childbirth has been expressed by many but researched by few.

The public's interest in childbirth at home appears to have coincided with two larger social trends. The desire fostered by the woman's movement to gain control over one's life and body has naturally extended to this uniquely feminine experience. At the same time, a general movement towards distrust of technology, authority, and government has led to a desire for individual expertise in every phase of life, from home repairs to food production.

Observations and research findings have indicated that childbirth is an extremely important event in the life of a woman and that the nature or quality of this experience can have major implications in her personality, marital relationship, and perceptions of and interactions with offspring. By selecting her home as the environment in which to experience this important life event, is a woman indicating that health professionals and their institutions have failed to care about women? Is there a cultural lag between what is being provided and what the woman wants? Or is it possible that the consumer is simply asking for a critical examination of techniques and routines that are part of institutionalized maternity care, along with an increased sensitivity and awareness toward human feeling and need?

Health care workers are only beginning to respond in the professional journals to the issues surrounding homebirth within the United States. Progress in understanding and dealing with this phenomenon will be delayed until the possible underlying causes for rejection of hospital-based obstetrics are examined. "Homebirth is not a fad. It is an irreversible and inexorable trend. Refusal to recognize this as a trend on the part of some health professionals will not make it go away" (Epstein 1976, p. 193).

Statement of Problem

The central problem formulated for this investigation was to examine select differences in those women preparing for and having had uncomplicated homebirths as opposed to those women preparing for and having had uncomplicated hospital births.

Statement of Purposes

The purposes of this investigation were to:

1. Identify the subjects' general perceptions of health care received during their lives

2. Compare the perceptions of health care received in the population having had homebirths with the perceptions

of health care received in the population having had hospital births

3. Determine whether feelings about the woman's movement differed between the population having had home-births and the population having had hospital births

4. Compare the perceptions of the last birth experience in the population having had homebirths with the perceptions of the last birth experience in the population having had hospital births

5. Identify factors contributing to the decision to have a homebirth or a hospital birth

6. Compare the health locus of control in those women preparing for and having had homebirths as opposed to those women preparing for and having had hospital births

7. Compare the value subjects place on freedom and health as guiding principles in their lives.

Background and Significance

Prior to the 1900s almost all women delivered their babies at home. The latter part of the nineteenth century brought the Industrial Revolution with its social and economic alterations, which, by the turn of the century, influenced changes in maternal and infant care (Clark and Affonso 1976). Though concern over maternal and infant

mortality rates grew and hospitalization for childbirth became the trend, several sections of the country offered homebirth services through established maternity centers. These centers were in cities such as Chicago and New York, as well as in the rural settings of Kentucky.

Births took place at home in settings that offered less than ideal conditions but favorable outcomes statistically (Ward and Ward 1976). As time went on, fewer and fewer women requested home confinements, and the formal homebirth services were gradually discontinued. However, there remained a small number of women who chose to have their babies at home. In Seattle, Washington, the number of home deliveries in 1966 was 1.5 per 1,000 births. In 1969 the rate had risen to 2.0 per 1,000 births. In 1971 the rate of reported home deliveries was 5.8 per 1,000, and in 1973 it had increased to 12.4 per 1,000 births (Clausen, Flook, and Ford 1977).

During the first few months of 1975 the metropolitan Chicago area reported fifty-six home births (Ettner 1976), and in the San Francisco Bay area there were 1,010 homebirths during the five years preceding April 1975 (Mehl 1976). In the United States in 1974 the number of reported live births occurring outside the hospital was 26,161. How accurate a picture this is of the total number of infants born at

home is not known, because there is evidence that some who have delivered at home without medical supervision have not registered their births (Clausen, Flook, and Ford 1977). Though the woman who decides to deliver at home has difficulty finding someone to attend her (Clark and Affonso 1976), it is evident that the choice of home delivery is an increasingly frequent phenomenon.

This phenomenon can be viewed as an outgrowth of the women's movement. Women have become increasingly vocal about their dissatisfaction with health care during the past few years. Some feminists have decried a focus on women's bodies, especially their reproductive organs and functions, and have tended to minimize the differences between sexes; but many women in the health movement have sought to identify more fully with and become more knowledgeable about their bodies. They have sought to discover and share with each other their sense of "feminine self" and to view their bodies as their "primary, essential selves." In this way, gaining control over their bodies is seen as a crucial first step in gaining control over their lives. Ruzek (1975) stated that in the women's movement there is a unique conceptualization and integration of mind, body, social, and political self. Rage and anger are directed against individuals and institutions which separate,

divide or alienate women from their whole selves or restrict women from controlling their bodies, and thereby their lives.

Women health consumers have been encouraged to work for woman-controlled, woman-oriented health care and to pressure medical institutions to respond more flexibly to their needs. A recent best-seller states "If we as consumers of health care do not want the medical industry to control our childbirth experience, now is the time to make our ideas heard" (Boston Women's Health Book Collective 1976, p. 269).

Dissatisfaction with antepartum and hospital care has led many disenchanted mothers to request home deliveries with both first and subsequent pregnancies. Homebirth groups have been formed to meet or provide a service not sufficiently met by existing health professionals or facilities.

> Most important, by preparing ourselves for childbirth we will be giving ourselves more control over the experience. We will be able to make educated choices about the way we want to deliver our babies. We will understand why and how labor is progressing, and we will be able to experience the full excitement and joy that are part of the birth of a baby (Boston Women's Health Book Collective 1976, p. 269).

Consumers are making decisions about childbirth with or without the advice and consent of the health

profession. There appears to be a desire to allow the family to participate in and control one of the most important events of their lives. Consumers ". . . want to control and determine the natural course of parturition, so they give birth at home" (Ritchie and Swanson 1976, p. 375).

Davis (1976) stated that the issue of control is central to the homebirth movement. Since childbirth is not an illness, many women feel they should be in control of the event. The hospital is seen as an overwhelming environment, where women have little to say about what happens to them and their babies. Koons shared her thoughts:

> one thing I wanted very much was to be in control of the birthing energy that was around me, and I couldn't feel that once I went into that big institution that I would have control (Koons and Koons 1976, p. 145).

In her experience, Heroux (1977) found the issue of control over the birth experience to be one of the main reasons given by women for choosing homebirth. Longbrake and Longbrake described control as the key in their decision to birth at home:

> Foremost, and underlying our whole enthusiasm for homebirth, was our desire to be in control of the situation. We could arrange it to suite our needs. Instead of being "intruders" into the medical personnels' world, the midwife and the doctor were

> visitors. We were freed from having to respond to new and unfamiliar hospital routines and to adjust ourselves to conform to the behavioral expectation of others. Rules for institutional convenience were unnecessary. At home we were together to share the total experience . pleasant as well as unpleasant (1976, p. 158).

The literature reviewed in this chapter indicates that the experience of control is strongly enhanced by experiencing birth at home. The dimension of control as a personality trait is a very popular aspect of Julian Rotter's Social Learning Theory (Rotter 1954, Rotter, Seeman, and Liverant 1962). This personality trait is manifested by a consistent attitude toward either an internal or external locus as the source of reinforcement (Rotter 1966).

Social learning theory stresses that reinforcement is crucial to the acquisition of skills and knowledge (Rotter 1954). It is known, however, that an event regarded as a reward (reinforcement) by one person may be regarded differently by another.

> One of the determinants of this reaction is the degree to which the individual perceives that the reward follows from, or is contingent upon, his own behavior or attributes versus the degree to which he feels the reward is controlled by forces outside himself and may occur independently of his own actions. The effect of a reinforcement following some behavior on the part of a human subject, in other words, is not a simple stamping-in process but depends upon whether or not the person perceives a causal relationship between his own behavior and the reward. A perception of causal relationship need not be all or none but can vary in degree. When

> a reinforcement is perceived by the subject as following some action of his own but not entirely contingent upon his action, then, in our culture, it is typically perceived as the result of luck, chance, fate, or under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him (Rotter 1966, p. 1).

Thus it can be assumed that a woman would choose to avoid a hospital environment if she believed this action would effect the outcome of her overall childbearing experience.

Locus of control, as an individual difference variable, has been related to a wide variety of behaviors which have been documented in various reviews (Lefcourt 1966, 1972; Joe 1971; Strickland 1973; Phares 1973, 1976; Hill, Chapman, and Wuertzer 1974). Strickland (1973) identified the relationship between a belief in internal control and physical health or well-being as an important emergent area. Wallston and Wallston (1973) discussed the difficulty of predicting behavior in a specific area such as health when using measures of generalized expectancies such as Rotter's (1966) Internal-External Locus of Control Scale (I-E Scale). Rotter (1975) stated that research whose aim is the prediction of behavior in specific situations could profit from the use of more specific expectancy measures.

Wallston, et al. (1976a) demonstrated the functional utility of an area specific measure of locus of control over

the more generalized I-E Scale. In this study the authors found not only a relationship between internality and health behaviors but also between the value placed on health and a person's locus of control beliefs, thereby suggesting that behavior is a joint function of expectancy and the value of the outcomes (Wallston 1977). Subjects who were internal and valued health highly exhibited more information-seeking behavior regarding preventive health care than subjects who were internal with low health values, or who were external regardless of health value. This is in accordance with Rotter's social learning theory; a person will engage in goal-directed behavior if he values the particular reinforcement available and if he believes that his action will lead to these reinforcers in a particular situation (Wallston, et al. 1976b).

Relating this work to the proposed study, it seems reasonable to assume that women who choose homebirth will not only score numerically lower in the direction of internality on the Health Locus of Control Scale (HLC) but will also place a higher value on freedom of choice than women who choose to give birth in a hospital.

Hazell and Mehl are the only researchers who have provided information about homebirth participants. Hazell

(1974) collected data about the type of people choosing homebirth in the San Francisco Bay area. This study revealed that:

> 90% lived in typical American fashion, with the father gainfully employed, in a single family dwelling with one or two cars, were not members of an ethnic minority, not on welfare, and without household servants. A general characteristic of the group was described as self-awareness shown in concern for nutrition, health foods, ecology, humanistic psychology, and a strong feeling for a natural birth process. Typically, the mother and father had both attended college, but neither had graduated. The fathers' occupations were noted to vary through the range of occupations present in the Bay area, from auto mechanic to physician to homesteader. Only one tenth were classified as "hip" in rebellion to "normal American values," living in a variety of alternative styles (Mehl 1976, p. 77).

Mehl (1975) did not state that home delivery is safer than hospital delivery but showed that complications of home delivery were not higher than those from the general population.

The dearth of information relating to homebirth in the professional literature is striking. Though nurses are increasingly attending to social and political issues which have an influence on the quality of health care for people, Reeder et al. (1976) pointed out they have been reluctant to address the issue of homebirths, even though those involved in prepared childbirth programs receive numerous questions from interested parents.

Perinelli (1977) stated that if we are to deliver superior health care by implementing "the highest standard of obstetrical practice" we can only do so if we know the reasons which lead couples to choose the types of deliveries they do. If these reasons are important to health care providers, then investigation seems warranted; and if nursing exists to meet patient needs, then, to be responsive, we must truly listen to what patients have to say. Honest evaluation of success and failure can assist in the identification of health care services which need to be provided (Clausen, Flook, and Ford 1977).

The Standards of Maternal and Child Nursing Practice as set forth by the American Nurses' Association in 1973 provides excellent guidelines for evaluation. Standard XIII states:

> Maternal and Child Health nursing practice evidences active participation with others in evaluating the availability of services for parents and children and cooperating and/or taking leadership in extending and developing needed services in the community (Clark and Affonso 1976, p. 17).

Nurses can provide the necessary initiative and leadership to change the character of care available to childbearing families (Ritchie and Swanson 1976). They can begin this endeavor by collecting scientific data on homebirths and the women who choose this childbearing environment.

Delivering a baby at home appears to be a growing phenomenon which may be influenced by many different sociologic and psychologic factors. Information regarding characteristics of women seeking this alternative birth environment is lacking, and, therefore, needs to be obtained and understood by professionals serving this segment of the childbearing population.

Definition of Terms

For the purpose of this investigation, the ensuing terms were given the following specific definitions:

Homebirth--giving birth in one's place of residence.

Hospital birth--giving birth in an institution classified as a hospital according to the requirements of the American Hospital Association; for example, "an institution whose primary function is to provide patient services, diagnostic and therapeutic, for a variety of medical conditions, both surgical and nonsurgical" (American Hospital Association 1976).

Uncomplicated birth--a birth in which none of the following conditions are known to exist: history of repeated abortions, premature infants, pre-eclampsia-eclampsia, postpartum hemorrhage, cesarean birth, diabetes, kidney disease, thyroid disease, sickle cell disease, heart disease,

chronic high blood pressure, Rh sensitization, severe infection, viral illness, anemia, maternal age less than sixteen or more than forty, parity over five, inadequate pelvis, multiple births, hydramnios, postmaturity, vaginal bleeding, drug addiction, lack of prenatal care, malpresentation of baby, or fetal distress (adapted from "Contraindications for Childbirth at Home," Reprint #101, Homebirth Inc., 1976).

Delivery attendant--the person who took charge of, looked after, cared for the woman/baby during the delivery process; for example, general practitioner, obstetrician, nurse-midwife, lay midwife, father.

CEA classes--a series of classes given by the Childbirth Education Association designed to educate the woman about the childbearing process; CEA is a member of the International Childbirth Education Association.

Prepared birth--a birth which was preceded by some active process taken on by the woman to educate herself about labor and delivery.

Control during childbirth--". to influence the decisions made during the period of labor and delivery" (Willmuth 1975, p. 39).

Medical care--health services, such as diagnosis and treatment of disease and services for disease prevention,

rendered by a licensed physician. These services are most often performed in the office of the physician or in agencies such as hospitals or clinics (Goldberg 1977).

Nursing care--health services rendered by a registered nurse, or a practical nurse who is licensed to practice the profession in the United States (Goldberg 1977).

Personality--". . . the aspect of a unified, complexly organized person that has to do with his characteristic modes of behaving or interpreting the world in which he lives" (Rotter 1954, p. 82).

Social theory of learning--a system of constructs hypothesized by Rotter to provide maximum predictions and behavior control. The theory states that major or basic ways of behaving are inseparable from needs requiring for their fulfillment the intervention of other people. A basic tenet of this theory is that the role of reinforcement is crucial to the acquisition of skills and knowledge (Rotter 1954, p. 84).

Reinforcement--". any action, condition, or state that effects movement towards a goal." Those that facilitate movement toward a goal would be considered positive reinforcement. Those that impede movement toward

a goal would be considered negative reinforcement (Rotter 1954, p. 98).

Value--to regard highly; the quality of being desirable; ". . . a belief upon which a man acts by preference" (Allport 1961, p. 454).

Locus of control--". . . the degree to which the individual perceives that the reward follows from, or is contingent upon, his own behavior or attributes versus the degree to which he feels the reward is controlled by forces outside of himself and may occur independently of his own actions" (Rotter 1966, p. 1).

Internal control--an individual's perception that an event is contingent upon his own behavior or his own relatively permanent characteristics (Rotter 1966, p. 1).

External control--an individual's perception that an event follows some action of his own but is not entirely contingent upon his actions. In our culture the reinforcement is then perceived as the result of luck, chance, powerful others, or due to the great complexity of the forces surrounding him (Rotter 1966, p. 1).

Internal-external control scale--I-E Scale; a twenty-nine-item forced-choice test including six filler items, which measure a subject's generalized expectancy of control reinforcement (Rotter 1966, p. 10).

Health Locus of Control Scale--HLC Scale; a fifteen-item multidimensional Likert-type test, which measures area specific expectancies regarding locus of control; developed for prediction of health related behavior (Wallston, et al. 1976a, p. 580).

Limitations

The limitations of this investigation were as follows:

1. The sample population of subjects having had homebirths included only those women who had registered their births with HOMEBIRTH, INC., and therefore did not allow for generalization to population groups not registering their births or registering their births with other organizations.

2. The sample population of subjects having had hospital births was drawn from one geographical area. This limited generalization to other population groups

3. The sample population of subjects having had homebirths was drawn from one geographical area. This limited generalization to other population groups

4. The subject sample was not randomly selected from the total population. Subjects only included those choosing to complete and return the questionnaire and was

further reduced to include only those having had prepared, uncomplicated birth experiences

5. The parity of the subjects was limited to five, but was not controlled or matched for comparison between the sample populations. Parity may have effected one's response to health-related issues and questions

6. The number of homebirths a woman had had was not limited. Numerous experiences with homebirth may have effected one's response to health-related issues and questions

7. The subjects were relied upon to know the conditions surrounding or effecting their birth experiences. These data were not verified

8. There were recognized problems inherent in the use of a questionnaire

9. The HLC Scale, in its present form, was but an initial attempt to operationalize health-related locus of control beliefs. It was a generalized measure of expectancy in that it was not a measure of beliefs specific to childbirth

Delimitations

Delimitations of this investigation were as follows. The sample population included only women having had the following:

1. Birth at home or in a hospital

2. Prepared, uncomplicated birth within the past year

3. Their homebirth registered with HOMEBIRTH, INC. or Childbirth Education Association classes taken as preparation for their hospital birth

4. Homebirth in the New England region or hospital birth in Massachusetts

Assumptions

Assumptions basic to the pursuit of this study were as follows:

1. Childbirth is an important event in the life of a woman

2. "All men everywhere possess the same values to different degrees" (Rokeach 1973, p. 3)

3. "What a person is led to believe about the locus of control of reinforcement has a definite impact on his behavior" (Strickland 1973, p. 2).

Summary

Women have been having babies at home long before surgical operations in hospitals were standard procedure. Although the hospital is now generally accepted as the safest place for birth, mothers testify to the joys as

well as the safety of homebirth. Childbirth is a unique emotional as well as physical experience. It is also a family event, and a minority of women still see their home as the place for it. These views and those of professionals who support homebirth cannot, therefore, be lightly brushed aside.

Chapter II presents a survey of the literature relating to the homebirth phenomenon as well as the personality trait of control perception. Chapter III discusses the methodology utilized to investigate select differences in those women preparing for and having had uncomplicated homebirths as opposed to those women preparing for and having had uncomplicated hospital births. Chapter IV presents the results and interpretations of the statistical methods employed in analyzing the assembled data. Finally, a disclosure of all the possibilities that can be derived from this study are discussed, and implications and recommendations for the nursing profession are identified in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

History of Homebirth

Since time immemorial women have carried and delivered their babies in the same physiological manner. Childbearing in primitive times was a relatively simple event. The woman sequestered herself with a female friend in a place away from the tribe and there gave birth without difficulty (Reeder, et al. 1976).

As time progressed and people became more urbanized, industrialized, and given to a more intellectual rather than instinctive existence, medical and surgical advances were made which directly affected childbearing. Positions, techniques, and attendants present at a delivery changed (Lang 1972, Reeder, et al. 1976, Thoms 1960). By the eighteenth century, some women were giving birth in hospitals, though their numbers were small and usually reserved only for those who had had some physical impairment that was at variance with normal delivery. "The vast majority delivered at home in their own beds, surrounded by their families, midwives and obstetricians" (Chabon 1966, p. 58).

Through the nineteenth century this trend continued, and most American deliveries were conducted at home. Home could have been a fort, a flat boat, a covered wagon, train, log cabin, or a two-story abode. There was generally much support and seasoned advice available to the mother, but the greater the distance from civilization, the fewer doctors, knowledge and equipment were available; thereby creating some feared and dangerous conditions (Clausen, Flook, and Ford 1977; Hazell 1976; Ward and Ward 1976). The Industrial Revolution and the turn of the century brought many changes in childbirth practices.

Homebirth: 1900-1960

In the early 1900s most Americans lived in rural areas and hospital maternity care was generally regarded as a last resort, though there is evidence that hospitalization was becoming the trend due to increasing concern over infant and maternal mortality (Clausen, Flook, and Ford 1977). By 1940 half the deliveries in the United States were still carried out at home, and many of these were through home-birth services at established maternity centers (Pearse 1976).

Chicago Maternity Center

In 1885 Dr. Joseph B. DeLee founded the Maxwell Street Dispensary, later known as the Chicago Maternity Center, and by 1932 this center was delivering 3,600 babies a year. Throughout the years of its existence many agencies participated in the Center's city-wide service, using home-births as a training ground for members of the health team. After eighty years of service, the Chicago Maternity Center had delivered 150,000 babies, approximately 90 percent of them at home. By 1973 requests for homebirths decreased from 300 to 30 a month, rendering the service unprofitable. All Chicago Maternity Center births now take place in a hospital (Ward and Ward 1976).

Maternity Center Association

Three antepartal centers sponsored by the Women's City Club of New York City and the New York Milk Committee were opened in 1917. The one sponsored by the Women's City Club was organized as the Maternity Service Association and a year later incorporated as the Maternity Center Association. This Association began to organize and operate a network of prenatal clinics, emphasizing intensive education and good maternity service. The reward for this approach was a 50 percent decrease in maternal mortality accompanied

by 60 percent reduction in infant mortality. These dramatic declines increased public and professional interest in the care of mothers and infants, and other agencies then joined the educational and service arena. At this point in time, the Association was ready to concentrate its efforts on women who were not seeking or receiving adequate maternity care. In 1932 a school for nurse-midwifery was established and the Maternity Center Association began to offer a program for home delivery (Reeder, et al. 1976).

Their system worked well. In the period from 1932 to 1957, 88 percent of the 7,000 women who delivered through their program had had homebirths. In their publication, Twenty Years of Nurse-Midwifery: 1933-1953, the Association made the following statement:

> In the home delivery service associated with the school, it was shown that children could be born safely at home if the mothers and homes were carefully chosen, and that the resultant satisfactions contributed to greater relaxation and comfort during labor, greater security for mothers and children, and better family living (Ward and Ward 1976, p. 127).

In the years following this report, requests for home confinements decreased yearly, and the Maternity Center Association discontinued its homebirth program in 1958 (Ward and Ward 1976). During the past five years the interest in homebirth has seen a revival, and the Association

responded in the fall of 1975 with the establishment of a "home-like" Childbearing Center (ICEA News 1975).

Frontier Nursing Service

In 1925 Mary Breckenridge, a nurse midwife, organized the Frontier Nursing Service. Her goal was to decrease the isolation of the inhabitants of Leslie County in eastern Kentucky. By 1939 the Service had amply grown to a point where more nurses were needed to carry on family nursing; therefore, the Frontier Nursing Service School of Midwifery was established. Through the years the nurse-midwives and their trainees gave consistent and quality maternity care to the eastern Kentucky residents. They delivered almost 20,000 babies with three-fourths of them delivered at home. During the last twenty-five years there have been no maternal deaths (Reeder, et al. 1976). Even though the Frontier Nursing Service has always been willing to offer the homebirth service, by 1974 only one or two mothers were choosing to have their babies at home (Arms 1975).

Homebirth: 1960-1977

Ashley Montagu's article, "Babies Should Be Born at Home" (1955) marked the beginning of opposition to the hospitalization of birth. Vocal organized opposition, however, did not appear until the late 1960s. At the

Annual Meeting of the American College of Obstetricians and Gynecologists in 1970, J. S. Miller, M.D., estimated that about 100 babies a month were being born at home by choice in the greater San Francisco Bay area (Hazell 1974). Six years later on the East Coast it was estimated that 400 homebirths were occurring annually in the greater Boston area (Span 1976). In that span of time the homebirth phenomenon had not only grown in numbers and moved East, but had had an impact on professional and lay literature.

Professional literature

A search of the literature in the decade prior to 1970 revealed an absence of professional writing pertaining to homebirth in the United States. British and Canadian medical and nursing journals published several articles concerned primarily with the pros and cons of domiciliary confinement (Alment 1967; Barber, et al. 1967; Galloway 1968; Law 1968; Dicker 1969; and Fraser 1969), and editorials in the Lancet concerning the "Safety of Domiciliary Midwifery" (Baird 1968, Coates 1968, and Sheldon 1968) were common. The fact that the debate continued was evident in the editorials of the British Medical Journal in 1970 (Park 1970).

It was not until May 1970 that a medical professional from the United States gave recognition to the

homebirth phenomenon. At the International Childbirth Education Association (ICEA) Conference, Miller stated

> I was willing to run the same risk in my refusal to go to their homes to deliver them. We all say we are interested in perinatal mortality, but only on our conditions. In sum, I think that if we suspend our judgment of patients who scorn our services, if we become interested in providing relevant perinatal care instead of judging them, then we must either go to them or make it more satisfying for them to come to us (Miller 1970, p. 6).

The first evidence in nursing literature of the existence of homebirth appeared in 1973. At that time the American Journal of Nursing published an article describing the role of one childbirth educator in helping couples who had chosen unattended homebirth (Edwards 1973). At about the same time the American College of Nurse-Midwives adopted the following statement on homebirths:

> Where homebirths are a necessity, it is essential that the obstetric authorities for that area develop criteria for the practitioners to ensure the safety of the mother and infant. ACNM considers the hospital or officially approved maternity home as the site for childbirth because of the distinct advantage to the welfare of mother and child. We encourage the members of the obstetric team in hospital or maternity home settings to meet the personal needs of child-bearing families by combining a family-centered atmosphere with the safety of full environment resources and a readily available obstetric team including the physician (Journal of Nurse Midwifery 1975, p. 15).

Within the next year the issue of lay-midwifery and homebirths was studied and disucussed in the article "Role of Lay Midwifery in Maternity Care in a Large Metropolitan

Area" (Lee and Glasser 1974). The authors concluded that some women preferred home deliveries with lay midwives, and that more studies were needed to determine what the role of lay midwifery should be.

During the same period of time, the British medical profession was still publishing studies on home confinement (Sides 1973, Goldthorp and Richmond 1974), and the Dutch were also debating and describing the issue (Lapre 1974, Edgar 1975). Birth and the Family Journal, which describes itself as an "interdisciplinary journal for the specialist in obstetrics, maternal-child health and parent education," published two papers in a small but definite attempt to explore the facts of homebirth (Hazell 1975, Mehl 1975). Though the journal claims to serve the medical profession, for example, obstetricians, it is in fact not widely read or accepted by them. Therefore, until this time there was no recognition of homebirth in the standard literature, yet the American College of Obstetricians and Gynecologists (ACOG), felt a need to adopt a statement on home deliveries in May 1975:

> Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation. We recognize, however, the legitimacy of the concern of many that the events surrounding birth be an emotionally satisfying experience for the family. The College supports those actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety

> available only in the hospital (Journal of Nurse-Midwifery 1975, p. 16).

During 1976, two well-known medical researchers, Klaus and Kennell, stated in Maternal-Infant Bonding (1976) that they had ". . . recently begun to study homebirth" (p. 46), but two other authorities in the field, Pritchard and MacDonald, made no reference to homebirth in their respected textbook Williams Obstetrics (1976). Three American medical journals acknowledged the homebirth movement and supported ACOG's position (Contemporary OB/GYN 1976, Mahan 1976, Medical World News (1976); however, these journals are not respected medical publications. It can, therefore, be stated that, in general, the medical profession continued to deny recognition of the homebirth movement.

However, nursing did recognize the movement. Clark and Affonso (1976) questioned whether the hospital was the most conducive environment for childbirth in their chapter on Legal, Moral, and Ethical Considerations, and Reeder, et al. (1976) devoted an entire chapter to home delivery. The Journal of Obstetric, Gynecologic and Neonatal Nursing (March-April 1976) gave space to Meyer who shared the experience and feelings associated with her planned home delivery, and the Journal of Nurse Midwifery (Cassidy 1976) published a two-page editorial, "We Have Major Decisions to Make," concerning the role of the nurse-midwife in maternity care

and alternate ways of serving the consumer population. Prior to publication of this editorial, Hosford (1976) explored the homebirth movement in relation to its significance to national health, maternity care, and individual families.

While researching their article, Ritchie and Swanson (1976) found a paucity of information in the professional literature about childbirth outside the hospital. Non-hospital birth studies were scarce, yet some obstetricians believed too much attention was given to them. The authors concluded that ". . . data must be compiled to identify and describe the effects of home/clinic birth" (p. 377). In the following year, Epstein and McCartney (1977), who are Certified Nurse Midwives, described how their homebirth service worked in Bethesda, Maryland. These authors stated that the needs of those seeking alternative birth environments were successfully and safely being met.

Medical literature has not come forth with facts, information, studies, or a recognition of the homebirth phenomenon during 1977, but two more nursing textbooks (Clausen, Flook, and Ford 1977; Jensen, Benson, and Bobak 1977) do devote time and space to the homebirth movement. Though coverage of this movement has increased significantly in the professional literature in the United States when comparing the seventies to the sixties, it has not paralleled that of the consumer groups.

Lay literature

As in the American professional literature, lay literature does not begin to give evidence of a homebirth movement until the seventies. Newsweek (May 10, 1971) reported in its Life and Leisure section that ". . . home birth advocates among doctors think that the trend is now running their way" (p. 104). Publications such as Vogue (January 1972), Mademoiselle (May 1972), MS (January 1973, October 1973, May 1975), Woman's Day (May 1976, June 1977), East-West Journal (August 1974, August 1975), and Time (August 29, 1977) have all given recognition to the home-birth movement during the last five years. Newspapers, both large (Boston Globe, February 17, 1973; Dallas Times Herald, March 13, 1977) and small (Times Leader, Record, November 27, 1975, Valley Advocate, May 28, 1975) have explored the issue for their readers.

Between 1972 and 1974 two popular books were published which dealt with homebirth in whole (Lang 1972) or part (Milinaire 1974). At least nine such books reached the consumer market in 1975 and 1976 (Arms 1975; Bell 1975; May 1975; Hazell 1976; Fitzgerald, et al. 1976; Boston Women's Health Book Collective 1976; Sousa 1976; Stewart and Stewart 1976; Ward and Ward 1976). At the same time,

homebirth organizations were formed, directories of services and information were distributed, and national conferences were held.

Homebirth organizations, directories, and conferences

There are now at least six nationally known organizations of lay and professional people who support homebirth. Each has its own unique history as well as purposes, goals, and policies; and most distribute newsletters.

The Association for Childbirth at Home, International (ACAH) was founded by Tonya Brooks in 1972. In a 1972 handout describing its functions, ACAH listed its purposes and goals as follows:

> Purposes:
> 1. To give support and encouragement to those planning to have their babies at home.
> 2. To educate through parent-oriented discussion groups, classes, films, and books, and by making people aware that they can take responsibility for their own bodies and, in particular, when and how they will give birth. To demystify obstetrics.
> 3. To disseminate information. Getting people (parents, midwives, doctors, nurses, interested individuals) together for discussion, exchange of ideas and services, books and research dealing with the psychological, physiological, and sociological aspects of childbearing and home delivery.
>
> Goals:
> 1. To give women a choice on where they want to have their babies, and make childbirth at home a physically safe and medically viable alternative for most women.

2. To promote home deliveries in the U.S.A., Europe, and Japan.
3. To get legislation legalizing midwifery.
4. To work for mobile home delivery units.

Home Oriented Maternity Experience (H.O.M.E.) was founded in April 1974 by five women concerned with the return, support, and encouragement of homebirth. It has published its own handbook and regularly sends out a newsletter to all its members.

The American College of Home Obstetrics (ACHO) is another organization geared toward providing support and encouragement for homebirth. It exists to serve the physician who is interested in this alternative birth environment. ACHO is comprised of a small number of physicians and was co-founded by Drs. Gregory White, Robert S. Mendelsohn, Mayer Eisenstein, and Herbert Ratner.

HOMEBIRTH, INC. is a nonprofit organization of parents interested in reclaiming control over the birth experience of their children. They provide guidelines and information for home delivery. Within a brochure distributed by the organization in 1975, the following purposes were set forth:

> establishing an educational and informational group to provide instruction and promote childbirth at home; to research and compile statistics on childbirth at home and make this research available to all members of the community; to provide educational and informational instruction to parents desiring

childbirth at home; to train and instruct individuals in the birth experience; and to provide this information to the broadest spectrum of people of varied experiences, economical and cultural backgrounds.

The National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC) is dedicated to exploring, examining, implementing, and establishing Family-Centered Childbirth Programs; ". . . programs that meet the needs of families as well as provide the safe aspects of medical science." Their goals, as described in the Spring 1976 NAPSAC NEWS, consists of the following:

To promote education about the principle of Natural Childbirth.
To act as a forum facilitating communication and cooperation among Parents, Medical Professional, and Childbirth Educators.
To encourage and aid in the implementation of Family-Centered Maternity Care in Hospitals.
To assist in the establishment of Maternity and Childbearing Centers.
To help establish Safe Home Birth Programs.
To provide educational opportunities to parents and parents-to-be that will enable them to assume more personal responsibility for Pregnancy, Childbirth, Infant Care, and Child Rearing.

The newest organization is the National Midwives Association. Within the Summer 1977 NAPSAC NEWS, this organization stated that the following specific areas needed its immediate attention:

1) the move toward national licensing
2) the need for safe birth alternatives
3) the professional needs of midwives
4) the need for balance and criticism
5) legal and social recognition of midwives

6) the need for a national clearing house for information on midwifery services.

The latest directory of out-of-hospital services published by NAPSAC (NAPSAC NEWS, Summer 1977) listed ninety-five resources in thirty states including the District of Columbia. This is a sharp increase from the initial directory (NAPSAC NEWS, Summer 1976) of nineteen resources in nine states including the District of Columbia. This indicates an obvious increase in interest and involvement on the part of consumers in the homebirth movement.

NAPSAC has sponsored two national conferences. The 1976 conference, "Sale Alternatives in Childbirth," was attended by over 500 persons from 20 states, Canada and Australia. Groups represented included nurses, lay midwives, nurse midwives, obstetricians, pediatricians, family practitioners, chiropractors, osteopaths, lawyers, authors, newswriters, La Leche League leaders, childbirth educators, public health officials, social workers, psychologists, fathers, and mothers. The 1977 conference, "21st Century Obstetrics NOW!", accommodated almost 900 people from 36 states, Canada, and Mexico. Expected attendance at the 1978 national conference in Atlanta, Georgia is 1,500.

The consumers of maternity services give evidence through their literature, organizations, and conferences that they are dissatisfied with the way their babies are being delivered and are willing to assume responsibility for change. They no longer intend to rely solely upon professionals to provide the services they want.

The Women's Health Movement

During the past few years women have been increasingly vocal about their dissatisfaction with the medical care they receive. They are outraged by the demeaning manner of treatment and are critical of the quality of care available irregardless of how much they pay (Rusek 1975). They have begun to explore their common plight and to search out new ways to receive the kind of health care they want. The impetus for the health movement has come from the larger women's movement.

> In the area of health care, there is a need to bring in the theoretical constructs underlying the Women's Movement: the facts and figures speak for themselves. Ninety-three percent of all doctors are male (the figure increases to 97 percent in gynecology)--which is why I used the masculine pronoun throughout when referring to a doctor. But while the providers of health care are predominantly male, the consumers are predominantly females. Women make, on the average, 25 percent more visits to doctors than men and over 100 percent more if pediatric visits are included. They consumer 50 percent more prescription drugs than men and are admitted to the hospital much more frequently.

> Although 75 percent of all hospital workers are female--doctors, medical school deans, hospital directors and trustees and drug and insurance executives (in other words, those in policymaking positions) are almost always men (Frankford 1972, p. xxviii).

Women in the health movement are struggling to become knowledgeable about and intimately involved with their bodies. Common interests are bringing different groups of women into contact with one another to share perspectives on health and health care. The emphasis on discovery and sharing can be seen in the preface to the Boston Health Book Collective's landmark work, Our Bodies, Ourselves (1976). The authors initially titled their health course and book "Women and Their Bodies," then changed it to "Women and Our Bodies," and finally used the title "Our Bodies, Ourselves."

The origins of the health movement can be traced back to the Feminist Women's Health Center in Los Angeles, California in 1971. This nonprofit corporation grew out of the original Los Angeles self-help group, developed into a women's health center offering a variety of services, and has served as an impetus for numerous health groups across the country. The original center grew to include two others in Santa Anna and Oakland, California. These centers offer an opportunity for women in groups to learn

self-examination and, in general, find out about their bodies. The credo of the Feminist Women's Health Center has been expressed in a newsletter, the Self Help Clinic in this way:

> The concept of self help stresses sisterhood that makes possible the benefits from collective knowledge, collective experiences, collective training and especially the sisterly concern for one another. The self help concept emphasizes competent medical back-up and the use of safe equipment at all times (Self Help Clinic 1971, part 1.

Women's health, in an extensive sense, involves all the information that women acquire from their experiences with various medical professionals, facilities, and treatments, including the skills they need to develop in order to care for their own bodies. The role of the health movement as stated in A Vancouver Women's Health Booklet (1972) is as follows:

1. to share information
2. to create alternatives
3. to make specific institutional demands
4. to expose the nature of the health system

As a step toward changing health care and fostering optimum services, a New York City group called the Woman's Medical Center rated doctors and hospitals in their area after utilizing their services. They believed that doctors and institutions that did not give women what they wanted

would start to lose "business," and therefore would have to change (Haggerty, 1973). Golden stated:

> Some feminists insist on teaching themselves how to perform their own gynecological examinations in order to regain control, as they put it, of their own bodies from the male-dominated medical profession (1977, p. 54).

Male-Dominance

Feminist writers, arguing that health care services were not always male-dominated, have traced the history of the women's role in the health care system. Ehrenreich and English (1972) argued that health care is largely in the hands of male professionals, not because of their superior scientific or technological skills, but as a result of an active takeover on their part. From this position the authors examined the suppression of witches in medieval Europe and described the rise of the male medical profession in nineteenth-century America. They pointed out that both of these events involved the overthrow of lay female healers by male professionals. These takeovers were political struggles, they believe, and were part of the general history of sex struggle and class struggle. They portrayed women healers as "people's doctors" while male professionals served the interests of the ruling class.

> Women as health consumers are oppressed by the same male supremacist attitudes and institutionalized

> practices which oppress women as health workers. When they enter a hospital or a doctor's office, women encounter a hierarchy dominated by men, in which, they see women playing only subservient roles. Then as patients, they encounter all the male supremacist superstitions which characterize American society in general. Women are assumed to be incapable of understanding complex technological explanations, so they are not given any. Women are assumed to be emotional and "difficult," so they are often classified as "neurotic" well before physical illness has been ruled out. . . . The sick person who enters the gynecology clinic is the same sex as the sexual object who sells cars in the magazine ads. When it comes to dealing with women's bodies, physicians are no less likely to be hung-up than other American men (The Malefeasance of Health 1970, p. 2).

An editorial in The New England Journal of Medicine ("What Medical Schools Teach About Women," 1974) pointed out the low regard of the medical profession toward women as shown by the following:

1. Little study has been done to determine the relation between trauma and breast disease, a common problem and very susceptible to study

2. Women are subject to a high rate of hysterectomies, sometimes without proper indications

3. There has been a lack of concern for the known side effects, many quite hazardous, of birth control pills

4. Women, far more than men, have their depressions and anxieties treated by drugs rather than an attempt being made to determine and overcome the causes

5. Symptoms of physical illness reported in women are often assumed to be psychological in origin and are so treated

6. Physicians routlinely listen to the heart and lung of all patients yet few routlinely perform breast examinations. Breast cancer is the major cause of death among women. Cardiovascular disease is the primary cause of death for middle-aged adults of both sexes

7. Pelvic examinations are not routinely done unless a woman consults a gynecologist. Even when a "complete" examination is mandated by the hospital on admission, the pelvic examination is often omitted or deferred indefinitely

The article pointed out that, as with segregation in the South, changes in behavior can precede changes in attitude. Similarly, it is possible to discourage behavior harmful to women by diminishing their self-esteem, or by effecting less-than-optimal health care, without waiting for changes in underlying attitudes. The conclusion reached was that information shared between patients and health professionals, concerning attitudes taught about women and the acknowledged consequences of these attitudes for health care, was an important part of the Women's Health Movement. Kaiser and Kaiser stated that:

> . . . it is those attitudes brought into the practice of medicine from the broader context of the general social and economic relations between the sexes, and exacerbated by the position of control and dominance occupied by the doctor over the patient, to which the women's movement today addresses its challenge (1974, p. 654).

The belief that socially prescribed differences between the sexes are inherent and biologically based, and that one sex is inferior has been termed "sexism." Medicine has reflected these beliefs through its ideologies of health and illness with consequences for women. Broverman, et al. (1970) conducted a study in which seventy-nine clinicians (psychiatrists, psychologists, and social workers) were asked to rate 122 personality and behavioral attributes on a scale indicating degree of health for males and females. Qualities described which were traditionally associated with maleness such as aggression and dominance were said to reflect "health" when associated with a male but not when associated with a female. Female-stereotyped attributes such as passivity and dependence were rated as reflective of a healthy female but when associated with a male, reflected pathology.

Similarly Lennane and Lennane (1973), found that dysmenorrhea, nausea of pregnancy, pain in labor and infantile behavioral disturbances present in females were commonly considered to be caused or aggravated by

psychogenic factors. The authors stated that although scientific evidence exists which clearly implicates organic causes for these problems, acceptance of a psychogenic origin has led to an irrational and ineffective approach to their management.

Willson, in his inaugural address to The American College of Obstetricians and Gynecologists said

> I should now like to direct your attention to what I consider the most pressing and important responsibility of the Fellows of the college during the next few years: improving methods for delivering health care to women. "The best medical care in the world is available in the United States." This chauvinistic statement may be true but it is difficult to defend when one considers the results of care presently being provided for women (1970, p. 178).

The author pointed out that the present system of health care for women does not provide adequate care and that less highly trained paraprofessionals can be taught to do many functions doctors are now doing. He further stated that properly trained "non-physicians associates" can perform periodic breast and pelvic examinations, fit diaphragms, insert intrauterine contraceptive devices, and execute many other procedures which principally require the development of manual skills. Willson called for "non-physician associates" to be integrated into the health care system to provide for the health care needs of women that have not

been met and to relieve the physician from many of the routine services he performs. The use of non-physician associates (consistently "he") would seem, however, to keep the control of women's health care in the hands of the male medical profession. It is obvious from the address that although the author recognized the deficiences in the health care system facing women, he exemplified the rigid control of health care by male physicians that women as consumers face. A viable alternative to Willson's proposal of male paraprofessionals under direct physician control is one presented by Ostergard (1971) of California. He was medical director of a program providing theory and clinical training for women with non-medical backgrounds. His findings indicated that non-medical personnel can recognize deviations from normal with a high degree of accuracy. These findings coincided with the belief of advocates of the women's health movement that women with sufficient training opportunities for examining well women can effectively recognize abnormal conditions.

Authoritarianism

Another area of dissatisfaction experienced by women is the authoritarianism of the present health care system. Women have faced this in many areas, ranging from

government control of abortions to the day-to-day relationships women have with their doctors. The Women's Health Movement seeks a redistribution of power between the doctor and the patient. Robinson (1973), writing on the doctor-patient relationship, raised the question of whether expertise is in danger of being used as a mask of privilege and power rather than as a way of advancing public interest. The professional practitioner characteristically claims that his skills are so esoteric that the client is in no position to evaluate them. Therefore, he accepts the evaluation of colleagues rather than clients.

Although the power of the physician, in general, has been challenged, women have turned their resentment more conspicuously towards the obstetrician/gynecologist (Kaiser and Kaiser 1974). As specialists presiding over the mysteries of reproduction and paturition, they have extraordinary control over the events of woman's present and future life. Furthermore, the authors indicated that in this society the phrase "biology is destiny" still has a strong unspoken promise for much behavior and many assumptions concerning the role of women. They explained:

> In this context, "biology" is nothing more or less than the woman's reproductive organs, which--rightly or wrongly--are inextricably associated with the qualities that make her distinctively a woman, and the absence of which robs her of her feminine

> value. . . . Gynecologists are the medicine-men who have women's femininity in their keeping. Women have realized that the doctors on occasion abuse their power and exploit their patients' ignorance and helplessness (1974, pp. 653-654).

In a review of twenty-seven gynecology texts written from 1943 to 1972, Scully and Bart (1973) found that many were written from a male viewpoint. Traditional views of female sexuality and personality were presented and generally unchallenged by the findings of Kinsey (1953) and Masters and Johnson (1966). The authors found that, in the last two decades, at least one-half of the texts that indexed sexuality, stated that the male sex drive was stronger than the females' and that the female was interested in sex for procreation more than recreation. Some texts still considered the vaginal orgasm the "mature" sexual response.

It is sadly ironic to feminists that men make decisions for women health consumers on some of the most important and personal issues of their lives such as what methods of birth control are available to them, whether they can have an abortion, and what method of childbirth they should use. Furthermore, they are not always adequately informed of all possible risks and options (The Malefeasance of Health 1970, p. 4).

Despite the billions of dollars spent annually on health care, women continue to face serious health

problems. Issues of women's health care with which the health movement has been concerned have been in the areas of contraception, abortion, sterilization, pregnancy and childbirth, menstruation, menopause, surgery (especially hysterectomy and mastectomy), drugs, nutrition, rape, sexuality, psychotherapy, and consumerism. The various medical needs associated with a woman's reproductive system make her more dependent on the health care system than men. Breast cancer, which is the major cause of death due to cancer among women in the United States, and cervical cancer, which claims the lives of 12,000 women yearly, are both curable if found and treated in time. These, as well as unplanned pregnancies, side effects of birth control pills, intrauterine devices, and the controversy surrounding use of estrogen replacement therapy during menopause, are unresolved health issues which face women. It is not within the scope of this study to review the available literature on all these topics, but the reader is referred to two sources which offer comprehensive bibliographies on these subjects (see Cowen 1975 and Ruzek 1975).

A group of Canadian women has published a booklet similar in content to Our Bodies, Ourselves (1976). However, in addition to providing articles on health care, these women included the results of a study done in British

Columbia. A Vancouver Women's Health Booklet (1972) reported the results of their survey of women's experiences with doctors and hospitals, women's knowledge of common health problems, and women's experiences in dealing with health problems. Women in the study were questioned about three broad areas: gynecological problems, expectations, and satisfactions with childbirth facilities, and abortion availability. An additional purpose of the survey was to discover what facilities were available in Vancouver to meet the expressed needs of women. Ninety-eight respondents were randomly chosen from residents of Vancouver, and an additional 150 were interviewed on a non-random, voluntary basis. Out of the eighty-four randomly sampled women who recommended their doctors, thirty-three (or 39 percent) did so despite negative experiences they had had with the doctors in some aspect of their medical care. This indicates that 39 percent of the recommendations were based on factors other than the doctor-patient relationship. The authors admit that their questions did not effectively isolate judging doctor-patient communications from other variables such as convenience and trust in the doctor's professional skill.

The authors of this survey are critical of the term "statistically significant" as a basis for decisions or evaluations of health survey results. They consider it a

misleading and unjust perspective from which to judge good health care. They ask ". . . if only one woman in 1,000 suffers emotional or physical humiliation or 'actual' harm in her dealings with the health system, is it not critical?" (A Vancouver Women's Health Booklet 1972, p. 9).

Availabile Literature

Printed information on feminine health care is not widely available. Much of the literature concerning women's health and the Women's Health Movement originates from the Feminist Women's Health Centers in California, the Feminist Press in Westbury, New York, and the New Moon Communications Network in Stamford, Connecticut.

A widely circulated source of information on health centers for women is The New Woman's Survival Catalog (1973). This offers a cursory review of the origin and purpose of these groups and gives listings of Women's Health Centers across the United States.

New Moon Communications located in Stamford, Connecticut, is a press which publishes material from the original women's health movement in conjunction with the Feminist Women's Health Center in Los Angeles. The publishers are a mother-daughter team promoting gynecological self-examination and the right of women to control their bodies.

Our Bodies, Ourselves (1976), published by the Boston Women's Health Collective, has been called "the most important work to come out of the women's movement." It has been acclaimed as the single best source of information on women's health care and the health movement. The authors reviewed topics such as women's feelings about their bodies, anatomy, homosexuality, sexuality, rape, self-defense, venereal disease, birth control, abortion, childbearing, and menopause. In addition, the politics and economics of the American health care system are considered as well as advice about how to choose a doctor and obtain the best possible care from the existing health care system. The outlook of this book is holistic in contrast to the health care system which tends to fragment health care and divide women into isolated organs in her body.

The Health Policy Advisory Center in New York publishes monthly bulletins concerning specific aspects of health care. They are written from a strong feminist and radical political viewpoint. The bulletins examine such topics as women as patients and health workers, the health care hierarchy, the politics of birth control and medical experimentation, medical advertising, and the consumer movement in health care. In addition, articles in these

bulletins deal with topics such as abortion, childbirth, birth control, and the influence of drug companies.

Vaginal Politics (1972) has been criticized by some feminists in the health movement as being unjustifiably harsh and as doing the movement a disservice (Ruzek 1975). Nonetheless, Frankfort, its author, is given credit for bringing public attention to women's health problems in a dramatic fashion. She critically examines women's complaints about health care and "vaginal politics," a term generally referring to the structure and organization of women's health care in American society from a societal level down to the level of face-to-face interaction between an individual woman and an individual health care professional. Frankfort criticized the structure of the medical profession, its inherent sexism, its vested interest in retaining the medical mystique, and its lack of public accountability. Examples are given of poor treatment when women have sought abortions, birth control and gynecological care, and psychotherapy. The economics of medical care and the relationship between profits, unnecessary surgery, and drug experimentation are also explored.

Another source of information on women's health is a periodical, The Monthly Extract, which is a publication of the feminist gynecological self-help clinics of America.

It reports events of importance concerning feminist health. Connecticut's first International Childbirth Conference was one such event.

Childbirth: A Health Movement Issue

For women only, the International Childbirth Conference drew twenty-nine speakers from twelve states and four countries, and attracted a diverse audience of young and old; married and single; pregnant and childless; black, white, and Spanish women. This open forum on the subject of childbirth was another feminist step in an attempt to help women communicate with each other, with the main objective of ". . . demanding changes in standard childbirth techniques and practices" (Tennov and Hirsch 1973, p. 103). The participants in the eight-hour, non-stop marathon of papers and films on childbirth were serious and determined. They emphasized the need for change in obstetrical care. The women were unanimous in their belief that women should be in control of their bodies at all times, especially in the emotionally satisfying process of giving birth. Their emphasis on this process, which leads to motherhood, seemed to reflect Kitzinger's (1972) views:

> The emphasis upon motherhood, and preparation for just one role among the variety available to women today, may also seem to run counter to women's liberation and the movement to free women from the

> shackles of domesticity. But this is not the case: rather, the reverse. I should like to see women able to choose freely whether or not to use their fertility, to have control over their own bodies, and to decide how many children they wish to have, when and under what conditions; and, having decided, to enter on the process with understanding, free of the fears and ignorance of the past, and able to participate in and enjoy childbearing as much--even if in a different way--as they now feel they have the right to enjoy sex (1972, p. 13).

Swenson (BRIEFS, November 1975) echoing this view, described the homebirth movement as representing fusion with these very aspects of feminism. The desire among women to shape their own experiences, to control what happens to their bodies, and to secure their right to good health care prevails throughout the homebirth movement. Ritchie and Swanson (1976) stated that a decision for birth outside the hospital was influenced by the women's movement ". . . which emphasizes equality and sharing between man and woman" (p. 275). However, Gant, an obstetrician at a Southwestern medical school, looked upon the homebirth movement ". . . as an over-reaction to the women's movement, something which often happens when there is social suppression" (Kennedy 1977). Pizer (1976), another obstetrician, from the East, took a different stand when he explained that changes in childbearing had largely been initiated by the new feminist consciousness of women. He predicted that many more changes in birthing would be seen in the future as more

women became aware, and felt more able to criticize the medical profession.

Reasons Underlying the Preference for Homebirth

It is during pregnancy and before labor begins that a couple must explore and define childbirth in their own terms. They must decide how they will participate in the event, and for many, it is through joint effort in labor and delivery that the birth of their child becomes meaningful.

Birth has the potential of being the most joyful event in a woman's life. Or it can be a nightmare of pain and fear. Many believe the choice lies with the parents, and parents favoring homebirth have very definite convictions as to what makes a birth a joyous, meaningful event (Maynard 1977).

Kitzinger (1972) viewed the security of an environment with which a woman is familiar and which she likes as perhaps the most important reason for having a baby at home. In the intimate atmosphere of her home a woman can relax. The labor proceeds in its own rhythm, and the birth occurs in the warmth and love of those attending. This scenerio conveys a sense of being in harmony with one's own body and "with the natural order of the world" (Ritchie and Swanson 1976, p. 375).

For those who select homebirth, their baby's birth is a very special and intensely personal achievement. Some treasure the experience for its warm, human closeness; others infuse it with spiritual overtones. May (1975) stressed the spiritual aspects of birth at home through utilization of first person accounts of experiences; Lang (1972) also used this method to portray the uniqueness of childbirth at home.

Arms (1975) justified homebirth through a critical analysis and negative presentation of hospital births. Avoidance of hospital procedures which tend to be routine; such a lithotomy position, episiotomy, medication, lack of nourishment during labor, and separation of mother and infant after delivery, were seen as an advantage of homebirth by Fitzgerald, et al. (1976) rather than the reason to justify a homebirth experience. When utilizing a guidance association interview with twenty subjects with whom she had not had prior conact, Hazell (1974) was able to establish avoidance of a routine episiotomy as a major reason for having a homebirth. Whether hospitals are cast in a negative light or homebirth is viewed positively, rejection of the present delivery system is evident (Lang 1972; Sander 1972; Stewart and Stewart 1976; Reeder, et al.

1976; Clark and Affonso 1976; Sousa 1976; Davis 1976; Ward and Ward 1976).

The nature of service provided by our health system requiring rules and regulations, conveys a paternalistic approach which places patients in dependent-child positions. Within the hospital delivery system, Sousa (1976) described this approach as depriving parents of control during the birth of their babies; and to have personal control of the labor and delivery is a theme which is found in nearly every article or book on homebirth. Salk (1977), though not an advocate of home delivery, recognized that many couples choose ". . . home delivery in the belief that through this means they can somehow have more control over their own birth experience" (p. 111).

Longbrake and Longbrake (1976) chose the title "Control in the Key" for a presentation about their birth experience at the first NAPSAC conference. They ended their discussion by stating:

> Yes, we may be unusual, even peculiar. We needed to be in control of, wanted to assume responsibility for, and chose to participate together in the births of our children. To do this in an atmosphere of familiarity and peacefulness, we chose to have homebirths. Childbirth is a "natural" event for families--something to be enjoyed. We, as responsible, informed adults decided it should happen and be shared in our home (1976, p. 159).

Ritchie and Swanson (1976) found similar reasoning for seeking alternative birth environments. They explained that couples ". . . want to control and determine the natural course of parturition so they give birth at home" (p. 375). Hazell found the following to be a typical response in her study: "I wanted to have some control over what happened to me and my baby, not simply submit to some assembly-line-like routine and hope for the best" (1975, p. 10).

The decision to give birth at home is not a random choice. It is a far-reaching commitment made by those who recognize that as mature, capable adults they are responsible for planning the actual birth and for creating the environment for it. They become conscious, active, and critical participants in the childbearing experience. They assume individual responsibility for their own health. Stewart and Stewart viewed this assumption of responsibility as a progressive trend:

> In our experience, it is usually the parents who are the most informed and who care the most for the safety of their baby who choose a homebirth. Those parents who are least informed usually relinquish themselves to doctors and hospitals without question, thus abdicating their responsibility and, unknown to them, also giving up their divine birthright to one of life's most potentially uplifting experiences (1976, p. 3).

As pointed out by Hosford this trend typifies Dr. John Knowles' prediction in a recent Time essay:

> The next major advances in the health of the American people will result from the assumption of individual responsibility for one's own health--one that requires a change in life style for the majority of Americans (Knowles 1976, p. 60).

Hazell's (1974) subjects had complete unanimity of opinion that the primary responsibility for birth lies ". . . in the province of the parents, and maybe God, but not with the doctor or the hospital" (p. 24).

Some parents consider hospital treatment degrading and dehumanizing when control and responsibility are denied (Reeder, et al. 1976; BRIEFS, November, 1975; Stewart and Stewart 1976). Ashley Montagu, a Princeton psychologist, expressed agreement with this view (Ward and Ward 1976, Introduction). He declared progress in the name of mechanization has taken control out of human hands and especially out of the human heart.

Other reasons for deliveries outside of the hospital stated by Ritchie and Swanson (1976); Reeder, et al. (1976); Clark and Affonso (1976); and Jensen, Benson, and Bobak (1977) are (1) nostalgia, (2) continuity with a natural life style, (3) desire to save on hospital bills, (4) participation of mate and others, and (5) germ-free environment, for example, less cross infection. Fitzgerald,

et al. (1976) added the lack of family separation as a popular and important reason for staying at home to give birth. At home the needs and rights of the parents and child are of a paramount concern to all present. The laboring woman is ministered to by loved ones and friends, not by strangers.

Another little-discussed reason for childbirth at home is best expressed by Sousa:

> If the baby is born at home, its parents can share in making decisions about its resuscitation, should it be badly malformed. In hospitals, on the other hand, the staff who attend the delivery may be trained to make the baby start breathing before evaluating its condition or forming a prognosis (1976, p. 89).
>
> Increasing numbers of young people today don't want to allow hospitals to force life into their defective babies and then drop the problem of sustaining that life in the parents' laps. Many couples feel that since they wouldn't want to prolong life artificially when they are ready to die, they would not want a doctor to induce life artifically if their baby does not respond to normal measures (1976, p. 91).

People choose homebirth for a variety of reasons, making it apparent that childbirth sociologically has many individual meanings. The interpersonal, social, and psychological rewards gained can often override the judgment of medical expertise. The effects of these unmeasurable, complex explanations should not be underestimated.

Internal-External Control of Reinforcement

Thus far the review of literature has focused on the social forces which have contributed to, and the reasons behind the increased desire on the part of some consumers to have a homebirth. What remains to be investigated are personality characteristics of women who choose homebirth. This researcher chose one variable of fate control, or internal-external control of reinforcement, as a personality characteristic likely to differ between women who choose homebirth and women who choose the hospital as the environment in which to give birth.

Feminist leaders (Blackwell 1930, Leitz 1959, Wise 1960, Stanton and Blatch 1922, Friedan 1963, Millet 1970, Morgan 1970, Thompson 1970) appeared to express a fervent faith in their ability to achieve feminist goals. They stressed the notion that society, through discriminatory attitudes and laws, oppresses women. The Health Movement, as an outgrowth of these feminist beliefs, offers women an opportunity to achieve their goals by gaining greater control over their health care and, therefore, their lives. On the surface it would appear that the homebirth movement is comprised of women who are seeking control and, therefore, are willing to assume personal responsibility for obtaining a service not readily available to them. Assuming this to

be true, it would be reasonable to presume that women in the homebirth movement have a greater tendency to view themselves as having control over their lives.

Internal-external (I-E) control of reinforcement or locus of control is a relatively new psychological concept, having its origin in Rotter's social learning theory of personality (Rotter 1954). The dimension of control is a very popular aspect of the theory. Rotter maintained that the potential for any behavior to occur in a given situation is a function of the person's expectancy that the particular behavior will secure the available reinforcement and the value to the person of that available reinforcement. Furthermore, in any specific situation a person may perceive that the attainment of some desired positive or negative effect or goal is either contingent upon his own behavior and, therefore, subject to his personal control, or unrelated to his own behavior and, therefore, beyond his personal control. The former generalized expectancy is referred to as internal locus of control (of reinforcement), and the latter generalized expectancy is referred to an external locus of control (of reinforcement).

Rotter's locus of control construct seems to have more heuristic value than any other aspect of his social learning theory; over 400 published and unpublished papers

have involved it. Researchers have devised experimental situations in which tasks are so manipulated that expectancies for internal or external locus of control are involved. Measures of internal versus external control control as a personality variable have also been devised and used to make differential predictions of locus-of-control related behaviors. That it is a useful variable has been amply proven. In his review of research in this area, Lefcourt concluded, "The success of a variety of techniques in measuring the control dimension provides support for the construct validity of that dimension . (1966, p. 217).

Rotter's (1966) review of the literature on the I-E Scale (Internal-External Control Scale) provided impressive evidence pertaining to its reliability and discriminant validity and presents the results of numerous studies employing the Scale. Rotter stated the following:

> A series of studies provides strong support for the hypothesis that the individual who has a strong belief that he can control his own destiny is likely to (a) be more alert to those aspects of the environment which provide useful information for his future behavior; (b) take steps to improve his environmental condition; (c) place greater value on skill or achievement reinforcements and be generally more concerned with his ability, particularly his failures; and (d) be resistive to subtle attempts to influence him (1966, p. 25).

Other researchers have reported psychological variables which appear to be related to the concept of fate control. Alienation, a sociological concept, seems related to the variables of internal-external control in that the alienated individual feels unable to control his own destiny (Rotter 1966, p. 3). Seeman (1959) found that alienation (a sense of powerlessness or meaninglessness) was more apt to be found in the externally-oriented person. Abramowitz (1969) found support for the hypothesis that depression and belief in external control were related.

McClelland, et al. (1953) studied need for achievement and found that people who were high on need for achievement seemed to have a belief in their own skill or ability to determine the outcome of their efforts. Rotter (1966) pointed out, however, that the relationship between need for achievement and locus of control was probably not linear since the person high on motivation might not be equally high on a belief in internal control of reinforcement. Furthermore, there may be people with a low need for achievement who persist in their belief that their own behavior determines the kinds of reinforcement they obtain.

Hersch and Scheibe (1967) studied the relationship of I-E scores to personality characteristics by correlating the I-E scale with the California Psychological Inventory

(CPI) and the Adjective Check List (ACL). They found that internally-oriented persons were higher than externally-oriented persons in Dominance, Tolerance, Good Impression, Sociability, Intellectual, Efficiency, Achievement via Conformance and Well-being scales on the CPI. On the ACL, internally-oriented subjects were more likely to describe themselves as assertive, achieving, powerful, independent, effective, and industrious.

Joe (1971), in an extensive review of the I-E control construct as a personality variable, found that the hypothesis that internals not only show more initiative and effort in controlling their environment but could control their own impulses better than externals was supported. He concluded that internals, in contrast to externals, show a greater tendency to seek information and adopt behavior patterns which facilitate personal control over their environment.

Locus of Control and Health-related Behavior

While not surprising in view of the positive attributes usually related to a belief in internal locus of control, an interesting theme running through locus of control research was the extent to which internals as opposed to externals appear to have more interest in and perhaps be

more responsible for their physical health (Strickland 1973). Seeman and Evans (1962) reported internal tubercular patients to know more about tuberculosis and to ask more health-related questions than external patients. In terms of prevention of disease or accident, it appears that internals were more likely to engage in activities that facilitate physical well-being. James, Woodruff, and Werner (1965) replicated a finding by Straits and Sechrest (1963) that nonsmokers were significantly more likely to be internal than smokers. They also found that following the Surgeon General's report on the dangers of smoking, smokers who were convinced by the evidence in the report were more internal than smokers who were not convinced, and internal males were more likely than externals to quit smoking. Platt (1969) also found internals able to change smoking behavior to a greater extent than externals. In a study of inoculations against influenza, Dabbs and Kirscht (1971) reported that college subjects who were internal, according to eight selected "motivational" variables, were more likely than externals to have been inoculated although internals on eight selected "expectancy" items were more likely not to have taken the shots. These results were somewhat confusing in regard to the relationship between motivation to exert control and expectancy of

control but did suggest that the locus of control variable was operating as one took precautions against influenza.

MacDonald and Hall (1971) questioned healthy college students as to how they would respond to various physical handicaps regarding social relationships and feelings about themselves. Internals anticipated less severe consequences of handicaps than did externals, perhaps reflecting the internal's belief that he can adapt to adverse life situations. Dinardo (1972), investigating patients with spinal cord injury, found that internals had higher self-concepts and considered themselves less depressed than externals.

The research cited thus far seems to indicate that women who choose homebirth should be more likely than women who choose a hospital birth to rate themselves as possessing a belief in an internal locus of control. However, a study by Oliver (1972) disputes this indication. Based on studies of eighty-eight women taking Lamaze training and fifty-nine not taking Lamaze training, he concluded that generalized expectancies for internal versus external locus of control, as measured by Rotter's I-E Scale, did not predict expectations for and recalled experiences, as measured by the Labor and Delivery Scales, of control, during specific events of childbirth. Although Rotter's

I-E Scale has been demonstrated to have construct, concurrent, and predictive validity in many contexts, it has not been shown to be consistently related to measures of expected or experienced control in specific situations (Wallston and Wallston 1976a).

Multidimensional Locus of Control

It has been stated that an internal person is one who believes that his behavior influences what happens to him. To be classified as external, however, a person can either believe that his reinforcements are determined by the actions of other people or believe that outcomes are largely a matter of chance occurrences. A number of locus of control investigators (Berzins 1973, Collins 1974, Reed and Ware 1973) have recently argued for a multidimensional concept of externality. In particular, Levenson (1972, 1973) has developed a set of scales which separates externality into two distinct types: a belief that outcomes are determined by powerful others and a belief that chance controls what happens to us. The rationale stemmed from the reasoning that people who believe the world is unordered (chance) would behave and think differently from people who believe the world is ordered, but that the powerful others are in control. In the latter case, a potential for control exists.

Health Locus of Control

Development of the Health Locus of Control Scale was based on the assumption that a health-related locus of control scale would provide more sensitive predictions of the relationship between internality and health behavior. Rotter (1966, 1975) believed it would be worth developing a specific measure of locus of control if one's interest was in a limited area. However, since little scale construction of this type has taken place, it is not surprising that there is a relative dearth of positive relationships of this nature in the literature (Wallston and Wallston 1973).

Wallston, et al. (1976a) cited two studies to establish discriminant validity of the Health Locus of Control (HLC) Scale in contrast with Rotter's I-E Locus of Control Scale. The authors reported an original Kuder-Richardson reliability of .72 on the eleven-item HLC test. In addition, the HLC did not reflect a social desirability bias as evidenced by a -.01 correlation with the Marlowe-Crowne Social Desirability Scale.

Concurrent validity of the HLC was evidenced by a .33 correlation ($p < .01$) with Rotter's I-E Scale for the original sample. The new scale, therefore, shared a 10 percent common variance with the more established measure

of locus of control, thus meeting the requirement that a new test not correlate too highly with measures from which it is supposed to differ. Test-retest reliability of the HLC over an eight-week interval was .71.

Value Reinforcements

In order to translate social learning theory to health behaviors, it can be stated that the potentiality of an individual engaging in behaviors that are recognized as health enhancing can be seen as a function of (1) the individual's expectations that these behaviors will ultimately lead to or enhance health and (2) the value which the individual places on health in relation to all other values he or she possesses. In short, a person must want to be both healthy and believe that certain actions will meet that desire before he will engage in health-related behavior (Wallston and Wallston 1976b). In the same manner, if a high importance is placed on freedom relative to other values and one believes he has control over freedom begetting actions he will behave accordingly (Wallston 1977). The values attached to specific reinforcements are obviously important and probably more crucial determinants of behavior than other personality variables (Rotter 1975).

Summary

There is evidence throughout the literature that homebirth is a growing phenomenon. People involved with the homebirth movement are attempting to fill a need they believe is not met by professionals.

Homebirth appears to be a blend of feminism and consumerism and, as such, seeks to end male dominance over women's health care. Women, involved in the movement, learn skills and gain knowledge which enable them to exercise greater control over their lives by exerting more control over their birth experiences.

Although information about homebirth is available, little is known about the personality characteristics of the women who make this choice. Since feminist philosophy advocates that women exercise greater personal control over their lives, it was assumed that those choosing homebirth would score more internally than those choosing hospital birth on the HLC Scale. In addition, those who choose homebirth would rate their value of freedom of choice and health higher than hospital subjects.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

A non-experimental descriptive design was employed to collect data for analysis of select differences in those women preparing for and having had uncomplicated homebirths as opposed to those women preparing for and having had uncomplicated hospital births. This design yielded demographic data and information about perceptions, feelings, Health Locus of Control, and values of the population sample. Information was gathered to identify reasons underlying the preference for home or hospital birth. Data were collected through administration of a questionnaire distributed to the population groups. Subjects who did not meet the stated criteria were not included in the analysis of data.

Setting

Subjects having had prepared, uncomplicated homebirths were drawn from five states in the New England region (Maine, New Hampshire, Massachusetts, Connecticut, and Rhode Island). Subjects having had prepared,

uncomplicated hospital births were drawn from one section of one state in the New England region--western Massachusetts.

Population

Ninety-five subjects from the homebirth category were selected from a list of 144 names provided by HOMEBIRTH, INC. The 144 names represented a population having registered their births with HOMEBIRTH, INC. The forty-nine subjects not selected from the list represented those having incomplete addresses, residing outside New England and/or indicating complicated birth experiences.

One-hundred and fifty subjects from the hospital birth category were selected by Childbirth Education Association (CEA) instructors. These subjects were those who had participated in CEA classes within the past year. They represented participants in the last class in a series of six, or attendants at a postpartum reunion class offered after all members of an original series of six had delivered.

Subjects selected from the total population were those choosing to complete and return the questionnaire and were further reduced to include only those having had prepared, uncomplicated birth experiences within the past

year. The number of returned questionnaires which met the stated criteria was seventeen in both the homebirth and the hospital population.

Tool

To obtain information about women having had prepared, uncomplicated birth experiences, two separate questionnaires were constructed; one for women having had homebirths (Appendix A), and one for women having had hospital births (Appendix B). The questionnaires were devised from information accumulated through discussions with childbirth educators, attendance at homebirth classes and CEA classes, extensive reading on the homebirth movement, and in-depth conversations with a psychiatric nurse clinician. The questionnaires were reviewed by the Board of Directors of two local Childbirth Education Associations, the Board of Directors of HOMEBIRTH, INC., a biostatistician on the faculty of the University of Massachusetts, and a psychiatric nurse clinician. They were pretested on nine women who had had hospital births and seven women who had had homebirths. The questionnaire posed no problems in relation to clarity or anticipated response. Twenty minutes was the average time for completion.

Homebirth-Hospital Birth Questionnaire

Questions 1 through 6 on both questionnaires served to collect demographic information. Variables examined were age, marital status, education, occupation of the woman and her husband/mate, and annual income.

Questions 7 through 14 and 20 through 22 in both questionnaires served to collect data about the childbearing experiences. Questions 7, 8, 9, 13, 14, and 22 on the homebirth questionnaire were utilized to eliminate those subjects not having had prepared, uncomplicated homebirths. Questions 7, 8, 9, 12, 13, 14, and 22 on the hospital birth questionnaire were employed to eliminate those subjects not having had prepared, uncomplicated hospital births. Questions 10, 11, and 12 on the homebirth questionnaire and question 11 on the hospital questionnaire were utilized to gather information about attendants at the subject's birth and the attendant's degree of training or experience. Question 9 in both questionnaires and question 10 on the hsopital questionnaire served to evaluate the subject's perception of choice in deciding on a birth environment. Questions 20 and 21 on both questionnaires served to evaluate the subject's satisfaction with her birth experience whether at home or in a hospital.

Questions 15 through 18 on each questionnaire yielded data about the general perception of health care received during the subject's life (Goldberg 1977). A scale of poor to excellent was devised to denote satisfaction, and the questions explored both medical and nursing care.

Question 19 on each questionnaire served to identify feelings toward the women's movement (Goldberg 1977). A scale of unfavorable to very favorable was devised to describe feelings.

Question 23 served to determine reasons underlying the preference for a home or hospital birth. Subjects were given space to list or explain these reasons in order of importance.

The homebirth questionnaire was mailed to homebirth subjects. Hospital birth subjects were given the hospital birth questionnaire at Childbirth Education Association classes. These questionnaires were distributed by the CEA instructors.

Health Locus of Control Scale

To obtain data for analysis of Health Locus of Control, each subject was instructed to complete the Wallston Health Locus of Control Scale (HLC Scale,

Appendix C), a fifteen-item multidimensional Likert-type test.

The fifteen-item test, an expanded version of the original eleven-item test, allowed for computation of the total HLC Score (based on questions 1, 2, 4, 5, 6, 8, 9, 10, 11, 13, and 14) and three five-item subscores (internal beliefs, external powerful others, and external chance). Internal belief questions were 1, 6, 8, 11, and 14. External powerful other questions included 3, 5, 7, 12, and 15. External chance questions were 2, 4, 9, 10, and 13.

Wallston, et al. (1976a) reported an original Kuder-Richardson reliability of .72 on the eleven-item HLC test. In addition, the original HLC did not reflect a social desirability bias as evidenced by a -.01 correlation with the Marlowe-Crowne Social Desirability Scale.

Concurrent validity of the HLC was manifested by a .33 correlation ($p < .01$) with Rotter's I-E Scale for the original sample. The new scale, therefore, shared a 10 percent common variance with the more established measure of locus of control, thus meeting the requirement that a new test not correlate too highly with measures from which it is supposed to differ. Test-retest reliability of the HLC over an eight-week interval was .71.

Value Survey

To compare the value subjects placed on freedom and health as guiding principles in their lives, each subject was instructed to complete a Value Survey (Appendix D), listing ten values in alphabetical order with the task of arranging them in order of importance. The Value Survey was modeled after Rokeach's 1973 Value Survey

> . which was designed to serve as an all-purpose instrument for research on human values. Even though it is ordinal and ipsative, it is in many other respects an ideal instrument. It is simple in design and economical to administer. It provides reasonably reliable and reasonably valid measures of variables that are of central importance to the individual and society (Rokeach 1973, p. 51).

Data Collection

Each homebirth subject was sent a letter requesting participation in the study (Appendix E) with a consent form to act as a subject for research and investigation (Appendix G). The appropriate questionnaire, homebirth, was enclosed along with the HLC Scale and Value Survey. A stamped addressed envelope was provided for respondents to return the completed questionnaire. A smaller envelope was provided for respondents to return written consent to act as a subject for research and investigation. To guarantee anonymity, these signed consent forms were separated from

the questionnaires as they were returned. A response rate of 60 percent was received--fifty-seven questionnaires were returned. Thirteen (22.8 percent) indicated a complicated birth experience. Eleven (19.3 percent) did not complete the questionnaire properly, and sixteen (28.1 percent) had births which did not occur within the last year. Seventeen (29.8 percent) met the stated criteria.

Each hospital subject was given a letter requesting participation in the study (Appendix F) with a consent form to act as a subject for research and investigation (Appendix G). The appropriate questionnaire, hospital birth, was given out with the HLC Scale and Value Survey. A stamped addressed envelope was provided for respondents to return the completed questionnaire. A smaller envelope was provided for respondents to return written consent to act as a subject for research and investigation. To guarantee anonymity, these signed consent forms were separated from the questionnaires as they were returned. A response rate of 48.6 percent was received--seventy-three questionnaires were returned. Nineteen (26 percent) indicated a complicated birth experience. Ten (13.7 percent) were pregnant and had never had a birth experience. Ten (13.7 percent) did not complete the questionnaire properly,

and seventeen (23.3 percent) had births which did not occur within the last year. Seventeen (23.3 percent) met the stated criteria. Twenty subjects (8 percent) from the total research population of 245 requested to be informed of the results of the study.

Treatment of Data

On both questionnaires frequency distributions and percentages were utilized to present the data obtained in questions 1 through 6, 9 through 13, and 21 and 23 in order that it would be comprehensible and meaningful and would highlight similarities, differences, and trends. The chi-square was used to determine whether significant differences in total number of pregnancies experienced existed between the two samples (question 7). Due to small sample size, a t-test was utilized to analyze significant difference in question 14 pertaining to the number of prenatal visits that subjects in each sample had.

The data gathered from questions 15 through 20 on each questionnaire were tested for homogeneity of proportion through application of a chi-square test. Wilcoxon's Rank Sum was used to test for significant difference on the HLC Scale, as it is a nonparametric test appropriate when few qualifications and assumptions about the shape of a study

population can be made. A two-sample z-test for difference in proportion was applied to test the difference between the value population samples placed on freedom and health as guiding principles in their lives. Finally, subjects were classified in the following manner, and a chi-square test for homogeneity was applied to the data to test for significant difference--internal with low freedom value, internal with high freedom value, external with low freedom value and external with high freedom value, as well as internal with low health value, internal with high health value, external with low health value, and external with high health value. A high value of freedom or health was a ranking of one through four on a scale of one through ten.

Summary

During this investigation data were collected to identify characteristics of women having had prepared, uncomplicated homebirths with the hope of furthering the understanding of the homebirth phenomenon. Women having had prepared, uncomplicated homebirths were compared with women having prepared, uncomplicated hospital births. Subjects were residents of the New England region and had had their births within the past year.

Questionnaires, designed to yield demographic data, information about perceptions, feelings, values, and factors contributing to the decision to have a homebirth or hospital birth, were distributed to the population sample. In addition, Wallston's HLC Scale was utilized to gather data concerning subjects' health locus of control.

A variety of statistical methods was employed to analyze the compiled data. Choice of methodology was based on the specific type of question and sample size. Methodology ranged from simple frequency distribution and percentages to Wilcoxon's Rank Sum for test of association. Analysis of data is presented in Chapter IV.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this study was to gather and compare data on two groups of women who selected different environments in which to give birth. The total population was comprised of thirty-four women; seventeen of whom prepared for and had uncomplicated homebirths and seventeen of whom prepared for and had uncomplicated hospital births. The study compared demographic and descriptive data and tested the relationship between the following variables: total number of pregnancies experienced, total number of prenatal visits, perceived satisfaction with health care, feelings toward the women's movement, satisfaction with the last birth experience, Health Locus of Control, and value placed on freedom and health as guiding principles in life.

Results and Interpretation of Findings

Tables 1 through 5 present frequency distributions of demographic data which include age, education, occupation of the women and their husbands, and annual income of the thirty-four respondents. As a group, the homebirth sample tended to be older (table 1), as evidenced by the 1.7 year difference in mean ages. The majority of the homebirth

sample (76.5 percent) were twenty-six to thirty years old, while the majority of the hospital sample (88.2 percent) were twenty to thirty years of age; with 47 percent twenty to twenty-five, and 41.2 percent twenty-six to thirty.

TABLE 1

DISTRIBUTION OF AGES WITHIN BIRTH GROUPS (N = 34)

Age Range	Hospital	Home
20 - 25	8 (47.0%)	2 (11.7%)
26 - 30	7 (41.2%)	13 (76.5%)
31 - 35	1 (5.9%)	1 (5.9%)
36 - 40	1 (5.9%)	1 (5.9%)
Total	17 (100.0%)	17 (100.0%)

Hospital: Range: 20 Mean: 26.6 Standard Deviation: 4.611

Home: Range: 17 Mean: 28.3 Standard Deviation: 3.587

All thirty-four sample subjects were married. Within the hospital sample, 41.2 percent had only completed high school, whereas in the homebirth sample, only 17.7 percent indicated that high school was their highest level of education completed (table 2). This tendency on the part of the homebirth group to possess a higher level of education is also manifested at the college and graduate school level. College and graduate school completion was accomplished by

58.8 percent of the homebirth sample, and only 29.4 percent of the hospital sample.

TABLE 2

DISTRIBUTION OF EDUCATIONAL LEVELS WITHIN BIRTH GROUPS (N = 34)

Highest Educational Level Completed	Hospital	Home
Some high school	0 (0.0%)	1 (5.9%)
High school graduate	7 (41.2%)	2 (11.8%)
Some college	5 (29.4%)	4 (23.5%)
College graduate	5 (29.4%)	5 (29.4%)
Graduate school	0 (0.0%)	5 (29.4%)
Total	17 (100.0%)	17 (100.0%)

Table 3 denotes the homebirth subjects as having more careers classified as professional, technical, and managerial occupations (47 percent) than the hospital birth subjects (29.4 percent). The homebirth subjects also classified themselves as "housewife/homemaker" more frequently than did the hospital subjects--41.2 percent versus 23.5 percent, respectively. When rating occupation, two women in the homebirth group differentiated between mother and housewife; they described themselves as having

both occupations. One other woman in this same group indicated she had two occupations, teacher and homemaker.

TABLE 3

DISTRIBUTION OF OCCUPATIONAL CATEGORIES WITHIN BIRTH GROUPS (N = 34)

Occupational Category	Hospital	Home
Professional, technical, and managerial*	5 (29.4%)	8 (47.0%)
Clerical and sales*	4 (23.5%)	1 (5.9%)
Miscellaneous*	1 (5.9%)	0 (0.0%)
Graduate student	0 (0.0%)	1 (5.9%)
Mother	0 (0.0%)	2 (11.8%)
Housewife/homemaker	4 (23.5%)	7 (41.2%)
"At home"	2 (11.8%)	0 (0.0%)
"None"	1 (5.9%)	1 (5.9%)

*Classification according to Dictionary of Occupational Titles: II Occupational & Industry Index. 3rd edition. Washington, D.C.: U.S. Government Printing Office, 1965.

Table 4 displays the thirty-four subjects' husbands occupational categories. The majority (76.4 percent) of husbands whose wives gave birth at home indicated involvement in professional, technical, and managerial occupations. The majority (70.5 percent) of husbands whose wives gave birth

in a hospital were involved in occupations classified as professional, technical, and managerial (41.1 percent) or clerical and sales (29.4 percent).

TABLE 4

DISTRIBUTION OF HUSBANDS' OCCUPATIONAL CATEGORIES WITHIN BIRTH GROUPS (N = 34)

Occupational Category	Hospital	Home
Professional, technical, and managerial*	7 (41.1%)	13 (76.4%)
Clerical and sales*	5 (29.4%)	0 (0.0%)
Structural work*	1 (5.9%)	1 (5.9%)
Bench work*	2 (11.8%)	2 (11.8%)
Service*	0 (0.0%)	1 (5.9%)
Machine trade*	1 (5.9%)	0 (0.0%)
Miscellaneous*	1 (5.9%)	0 (0.0%)

*Classification according to Dictionary of Occupational Titles: II, Occupational & Industry Index. 3rd edition. Washington, D.C., U.S. Government Printing Office, 1965.

Annual income, as displayed in table 5, was similar within the two groups of subjects. Twelve (70.6 percent) of the hospital sample had annual incomes between $10,000 and $25,000 as did eleven (64.7 percent) of the homebirth sample. Distribution in the $5,000 to $9,999 range was

equal (23.5 percent), while distribution in the more than $25,000 category was larger by one (5.9 percent) in the homebirth group.

TABLE 5

DISTRIBUTION OF ANNUAL INCOME WITHIN BIRTH GROUPS (N = 34)

Annual Income	Hospital	Home
$5,000 - $9,999	4 (23.5%)	4 (23.5%)
$10,000 - $14,000	8 (47.1%)	6 (35.3%)
$15,000 - $25,000	4 (23.5%)	5 (29.4%)
more than $25,000	1 (5.9%)	2 (11.8%)
Total	17 (100.0%)	17 (100.0%)

Table 6 indicates that as a group the homebirth sample has experienced significantly more pregnancies than the hospital sample. A chi-square was computed on the data, and it was found that the number of pregnancies was significant at the .05 level, indicating that there is a relationship between number of pregnancies and place of birth.

Thirty-six of the thirty-nine pregnancies experienced by the homebirth sample were viable term births. Twenty-three of the twenty-six pregnancies experienced by the

hospital sample were viable term births. Termination of pregnancy was numerically equal with the two groups.

TABLE 6

NUMBER OF PREGNANCIES EXPERIENCED WITHIN EACH BIRTH GROUP (N = 34)

Number of Pregnancies	Hospital f	Hospital F	Home f	Home F	Total
1	9	(6.5)	4	(6.5)	13
2	7	(6.0)	5	(6.0)	12
3 or 4	1	(4.5)	8	(4.5)	9
Total	17		17		34

df = 2 $\quad x^2 = 7.70 \quad$ $p < .05$

Shown in table 7 is information that no woman in the hospital group had ever had a homebirth, but eleven women (64.7 percent) in the home group had at some time in their lives delivered one or two children in a hospital. Six women (35.3 percent) in the homebirth sample had never delivered a child in a hospital.

All the women in the hospital group stated that the choice to deliver their children in a hospital was theirs (table 8), yet seven of them (41.2 percent) indicated they did not believe they actually had a choice as to where to deliver a baby. The reasons given were (1) doctors refuse

to deliver a baby at home (N = 5), and (2) safety is found only in a hospital (N = 2).

TABLE 7

DISTRIBUTION OF NUMBER OF HOSPITAL DELIVERIES EXPERIENCED BY EACH BIRTH GROUP (N = 34)

Number of Hospital Deliveries	Hospital	Home
None	0 (0.0%)	6 (35.3%)
One	11 (64.7%)	5 (29.4%)
Two	6 (35.3%)	6 (35.3%)
Total	17 (100.0%)	17 (100.0%)

TABLE 8

DISTRIBUTION OF SAMPLES ACCORDING TO CHOICE OF BIRTH ENVIRONMENT (N = 34)

Question: Was this YOUR choice?	Hospital	Home
Yes	17 (100.0%)	15 (88.2%)
No	0 (0.0%)	2 (11.8%)
Total	17 (100.0%)	17 (100.0%)

Fifteen women (88.2 percent) in the homebirth sample implied that they had given birth in an envirnoment of thier choice; whether this was in the hospital with previous

pregnancies or at home with the latest pregnancies (table 8). Two women (11.8 percent) stated they did not deliver in an environment of their choice when they gave birth to their first child. These women wrote the following:

> We tried to find someone to deliver our 1st child at home but were unable to find a suitable situation . . . one doctor refused on the grounds that he didn't know me & had run into legal problems. Another retired . . . & a midwife was only available at certain times.
>
> I would have had 1st at home but at the time in South Dakota it was unheard of & I couldn't find anyone to do it.

As indicated in table 9, when subjects gave birth in a hospital, they were usually attended by an obstetrician. The seventeen women in the hospital sample had an obstetrician at all their births, and in some instances (23.6 percent) other professionals were also there. Of the eleven women in the homebirth sample who had had a hospital delivery at some time in their life, ten (90.9 percent) had an obstetrician in attendance and one (9.1 percent) had a general practitioner. Clearly, all hospital births were attended by professionals.

Table 10 displays statistics which reveal that homebirths are more frequently attended by non-professionals--lay-midwives, birth attendants, and friends or family members, alone or in combination. Besides indicating who

TABLE 9

DISTRIBUTION OF HOSPITAL BIRTH ATTENDANTS WITHIN BIRTH GROUPS (N = 28)

Attendant	Hospital	Home
Obstetrician	17 (100.0%)	10 (90.9%)
General practitioner	1 (5.9%)	1 (9.1%)
Nurse-midwife	1 (5.9%)	0 (0.0%)
Other*	2 (11.8%)	0 (0.0%)

*Medical/nursing students.

TABLE 10

DISTRIBUTION OF ATTENDANTS AT HOMEBIRTHS (N = 17)

Attendant	Frequency Distribution
Obstetrician	4 (23.5%)
General Practitioner	1 (5.9%)
Nurse-midwife	4 (23.5%)
Lay-midwife	8 (47.0%)
Birth attendant	7 (41.2%)
Friend	6 (35.3%)
Other*	5 (29.4%)

*Husband, mother, sister.

attended their home delivery, the seventeen homebirth subjects were also asked to describe the degree of training or

experience with home delivery their attendants had. The following responses were given at least once:

over 30% of his deliveries are @ home
30 homebirths
several homebirths a month
has delivered over 3400 babies
2 homebirths
experienced
extensive
1 homebirth per week
has delivered more than a few babies

Table 11 reveals that all hospital subjects attended childbirth education classes, and all homebirth subjects attended classes specifically for homebirth; in addition, nine homebirth subjects (52.9 percent) also attended childbirth education classes. The majority (94.1 percent) of both samples read books as a means of preparation for their birth experience, and most talked to their doctors, friends, and family members about it. It is apparent that all subjects actively prepared for their birth.

Hospital birth subjects were asked to designate the reason they chose to attend childbirth education classes (table 12). Four (23.5 percent) identified their desire to attend classes as the only reason for doing so. Although all other women (76.5 percent) listed multiple reasons for class attendance, they did include their own personal desire as one of them. Ten women (58.8 percent) identified their husband's desire to attend childbirth classes as one reason

TABLE 11

DISTIRBUTION OF BIRTH PREPARATION WITHIN BIRTH GROUPS (N = 34)

Birth Preparation	Hospital	Home
Attended childbirth education classes	17 (100.0%)	9 (52.9%)
Attended classes specifically for homebirth	0 (0.0%)	17 (100.0%)
Read books	16 (94.1%)	16 (94.1%)
Talked to my doctor about it	10 (58.8%)	11 (64.7%)
Talked to my friends about it	11 (64.7%)	15 (88.2%)
Discussed it with family members	8 (47.1%)	10 (58.8%)
Other (films, pamphlets, exercises)	6 (35.3%)	0 (0.0%)
Nothing special	1 (5.9%)	0 (0.0%)

for doing so, but doctors, nurses, friends, and relatives appeared to have had little influence on the decision.

As table 13 indicates, some degree of prenatal care was received by both samples. Subjecting the data to a t-test revealed no significant difference in the number of prenatal visits members of both sample groups had during their most recent pregnancy. Although the mean number of visits is equal, the range of visits within the homebirth sample is greater than the range of visits within the

hospital birth sample--two through sixteen versus seven through fourteen, respectively.

TABLE 12

DISTRIBUTION OF REASONS FOR ATTENDING CHILDBIRTH EDUCATION CLASSES--HOSPITAL BIRTH SAMPLE (N = 17)

Reason for Attending	Frequency Distribution
My doctor told me to	2 (11.8%)
The office nurse told me to.	1 (5.9%)
My friends did	4 (23.5%)
My sister/sister-in-law did.	1 (5.9%)
My husband wanted to	10 (58.8%)
I wanted to.	17 (100.0%)
Other reasons.	0 (0.0%)

The analysis of general perceived satisfaction toward health care, specifically in regard to nurses and doctors, is presented in tables 14 through 17. Utilizing a chi-square for homogeneity of proportions, significant differences at the .05 level existed between the sample groups. The data indicate that a significant difference in perceived satisfaction existed when rating the doctors' ability to meet psychological needs. The majority of the hospital sample (fifteen subjects) rated this ability as

TABLE 13

DISTRIBUTION OF PRENATAL VISITS WITHIN BIRTH GROUPS (N = 34)

Number of Visits	Hospital	Home
2	0 (0.0%)	1 (5.9%)
5	0 (0.0%)	1 (5.9%)
7	1 (5.9%)	0 (0.0%)
8	3 (17.6%)	4 (23.4%)
9	3 (17.6%)	1 (5.9%)
10	2 (11.8%)	2 (11.8%)
11	1 (5.9%)	0 (0.0%)
12	5 (29.4%)	3 (17.6%)
13	0 (0.0%)	1 (5.9%)
14	2 (11.8%)	1 (5.9%)
15	0 (0.0%)	2 (11.8%)
16	0 (0.0%)	1 (5.9%)
Total	17 (100.0%)	17 (100.0%)

Hospital: Range: 7 Mean: 10.41 Standard Deviation: 2.15

Home: Range: 17 Mean: 10.41 Standard Deviation: 3.75

df = 11 t = 0 not significant

good or excellent, while the majority of the homebirth sample (eleven subjects) rated this ability as fair or poor (table 14).

TABLE 14

A COMPARISON OF PERCEIVED SATISFACTION REGARDING DOCTORS' ABILITY TO MEET PSYCHOLOGICAL NEEDS (N = 34)

Rating	Hospital f F	Home f F	Total
Excellent	7 (4.5)	2 (4.5)	9
Good	8 (6.0)	4 (6.0)	12
Fair	2 (4.5)	7 (4.5)	9
Poor	0 (2.0)	4 (2.0)	4
Total	17	17	34

df = 3 $x^2 = 10.88$ $p < .05$

Table 15 indicates that there was no significant difference in ratings given by the subjects in relation to the doctors' level of competence. The majority, seventeen hospital subjects and fourteen homebirth subjects, gave a rating of good or excellent in this area.

As indicated by the data in table 16, significant differences occurred at the .05 level in perceived satisfaction with nursing care. The majority of the hospital birth sample (fifteen subjects) rated the nurses' ability to

TABLE 15

A COMPARISON OF PERCEIVED SATISFACTION REGARDING DOCTORS' COMPETENCE (N = 34)

Rating	Hospital f	Hospital F	Home f	Home F	Total
Good to excellent	17	(15.5)	14	(15.5)	31
Poor to fair	0	(1.4)	3	(1.4)	3
Total	17		17		34

df = 1 $x^2 = 3.518$ not significant

TABLE 16

A COMPARISON OF PERCEIVED SATISFACTION REGARDING NURSES' ABILITY TO MEET PSYCHOLOGICAL NEEDS (N = 34)

Rating	Hospital f	Hospital F	Home f	Home F	Total
Excellent	10	(7.0)	4	(7.0)	14
Good	5	(3.5)	2	(3.5)	7
Fair	2	(4.0)	6	(4.0)	8
Poor	0	(2.5)	5	(2.5)	5
Total	17		17		34

df = 3 $x^2 = 10.85$ $p < .05$

meet psychological needs as good or excellent. In contrast, more than half, eleven, of the homebirth sample rated the nurses' ability to meet psychological needs as fair or poor.

Exhibited in table 17 are data to show significant differences at the .05 level in relation to perceived satisfaction regarding nurses' competence. The majority of the hospital birth sample (thirteen) rated nursing competence as excellent, while slightly more than half of the homebirth sample, nine, rated nursing competence as fair or poor.

TABLE 17

A COMPARISON OF PERCEIVED SATISFACTION REGARDING NURSES' COMPETENCE (N = 34)

Rating	Hospital f F	Home f F	Total
Excellent	13 (9.0)	5 (9.0)	18
Good	4 (3.5)	3 (3.5)	7
Fair	0 (2.5)	5 (2.5)	5
Poor	0 (2.0)	4 (2.0)	4
Total	17	17	34

df = 3 x^2 = 12.69 $p < .05$

Feelings about the Women's Liberation Movement were almost identical within the two groups (table 18). Testing at the .05 level with a chi-square for homogeneity of proportions did not reveal any significant difference. The majority of both samples (eleven subjects) rated their feelings about the movement as very favorable or moderately favorable.

TABLE 18

A COMPARISON OF FEELINGS ABOUT THE WOMEN'S LIBERATION MOVEMENT (N = 34)

Rating	Hospital f F	Home f F	Total
Very favorable	7 (7.0)	7 (7.0)	14
Moderately favorable	4 (4.0)	4 (4.0)	8
Slightly favorable	5 (4.5)	4 (4.5)	9
Unfavorable	1 (1.5)	2 (1.5)	3
Total	17	17	34

df = 3 $x^2 = 0.44$ not significant

Whether the subjects most recent pregnancy ended with a home delivery or a hospital delivery, the majority, thirteen and twelve, respectively, felt the birth experience was an excellent one (table 19). Only one woman in each

group described her birth experience as only fair, and four hospital subjects and three homebirth subjects described it as good.

TABLE 19

A COMPARISON OF DESCRIPTIONS OF THE LAST BIRTH EXPERIENCE (N = 34)

Description	Hospital f (F)	Home f (F)	Total
Excellent	12 (12.5)	13 (12.5)	25
Good	4 (3.5)	3 (3.5)	7
Fair	1 (1.0)	1 (1.0)	2
Total	17	17	34

df = 2 $x^2 = 1.587$ not significant

All subjects were asked if they became pregnant again where would they deliver their child. All implied satisfaction with their last choice, whether at home or in a hospital, and would again deliver in that same environment if they became pregnant again; as evidenced in table 20.

Table 21 gives frequency distributions for reasons listed by subjects for delivering a baby at home. A reason cited by all the homebirth subjects was the desire not to be separated from family members. Family members included the newly-born infant, husbands, and other children. Sixteen

TABLE 20

DISTRIBUTION OF PLACE OF NEXT DELIVERY ACCORDING TO BIRTH GROUP (N = 34)

Place of Next Delivery	Hospital	Home
At home	0 (0.0%)	17 (100.0%)
At hospital	17 (100.0%)	0 (0.0%)
Total	17 (100.0%)	17 (100.0%)

TABLE 21

DISTRIBUTION OF REASONS FOR HAVING A HOMEBIRTH (N = 17)

Reason for Homebirth	Frequency Distribution
No family separation	17 (100.0%)
Control over experience	16 (94.1%)
Natural, comfortable, loving environment	13 (76.5%)
Dislike, distrust hospitals/doctors	5 (29.4%)
No interfering hospital routines	4 (23.5%)
Birth is a normal process	3 (17.6%)
Can share experience with family/ friends	2 (11.8%)
Safer	2 (11.8%)
Convenience	1 (5.9%)
No episiotomy	1 (5.9%)
Psychological effects on baby	1 (5.9%)
Decreased cost	1 (5.9%)
Nursing on demand	1 (5.9%)

women (94.1 percent) designated maintaining control over the experience as a reason for homebirth. A natural, comfortable, loving environment was the third most frequently cited reason (76.5 percent) for delivering a baby at home.

Reasons for having a baby in the hospital were entirely different than those cited for having a baby at home (table 22). The hospital sample did not cite any one overwhelming reason for their choice, but the top four, and possibly five reasons, could all be classified in relation to the safety or security the subjects assumed was provided by the hospital environment.

Table 23 summarizes scores obtained from Wallston's Health Locus of Control (HLC) Scale. Results of the Wilcoxon Rank Sum test are shown, indicating no significant differences in health locus of control scores or in the multidimensional subscores--internal, powerful others, and chance. The mean HLC score for hospital subjects was 27.118, indicating those who had a total score below the mean would be classified as internals, while those with a total score above the mean would be classified as externals (see appendix H for scoring instructions). The mean HLC score for homebirth subjects was 25.765, slightly lower than the hospital group but not significantly different. Those homebirth subjects who had total HLC scores below the 25.765

TABLE 22

DISTRIBUTION OF REASONS FOR HAVING A HOSPITAL BIRTH (N = 17)

Reason for Hospital Birth	Frequency Distribution
Safer for mother	6 (35.3%)
Equipment for emergencies and coping with complications	6 (35.3%)
Professional and technical help available	5 (29.4%)
Security/Peace of mind	4 (23.5%)
Proper care	3 (17.6%)
Rest	3 (17.6%)
In case baby is sick	1 (5.9%)
Medication	1 (5.9%)
Convenience	1 (5.9%)
Clean, comfortable environment	1 (5.9%)

mean would be classified as internals, while those with a total score above the mean would be classified as externals. The means on the multidimensional subscores were very similar. The lower the numerical score was below the mean, the lesser a belief the subject was said to have had in internal control, or control by powerful others and chance factors. The higher the numerical score was above the mean, the greater a belief the subject was said to have had in

internal control, or control by poweful others and chance factors.

TABLE 23

A COMPARISON OF HEALTH LOCUS OF CONTROL SCORES AND MULTIDIMENSIONAL SUBSCORES (N = 34)

	Mean	Median	Range	Standard Deviation	P Value
HLC					
Hospital	27.118	28	22	5.946	0.328
Home	25.765	27	17	4.829	
Internal					
Hospital	12.765	13	13	4.236	0.445
Home	12.706	14	14	3.424	
Powerful Others					
Hospital	13.647	14	16	4.873	0.079
Home	11.353	11	16	4.471	
Chance					
Hospital	12.412	11	18	5.568	0.398
Home	11.471	11	11	3.064	

HLC:	W = 366.0	W* = 0.449	not significant
Internal:	W = 301.5	W* = 0.138	not significant
Powerful others:	W = 338.0	W* = 1.409	not significant
Chance	W = 305.0	W* = 0.259	not significant

Application of a z-test, for difference between two proportions, to the data in table 24 indicates a significant difference at the .05 level between the sample groups when

ranking freedom on a scale of one through ten on the Value Survey. A significantly greater number of homebirth subjects (52.9 percent) than hospital birth subjects (23.5 percent) ranked freedom highly, one through four on the survey.

TABLE 24

DISTRIBUTION OF VALUE PLACED ON FREEDOM WITHIN BIRTH GROUPS (N = 34)

Value Ranking	Hospital	Home
One through four--high	4 (23.5%)	9 (52.9%)
Five through ten--low	13 (76.5%)	8 (47.1%)
Total	17 (100.0%)	17 (100.0%)
	z = 1.85	p < .05

In relation to ranking health on the Value Survey, table 24 indicates no significant difference between the two groups. Sixteen (94.1 percent) of the hospital subjects ranked health highly, one through four on the survey. Fifteen (88.2 percent) of the homebirth subjects ranked health highly on the same survey. The majority of both samples placed a high value on health as a guiding principle in their life.

TABLE 25

DISTRIBUTION OF VALUE PLACED ON HEALTH WITHIN BIRTH GROUPS (N = 35)

Value Ranking	Hospital	Home
One through four--high	16 (94.1%)	15 (88.2%)
Five through ten--low	1 (5.9%)	2 (11.8%)
Total	17 (100.0%)	17 (100.0%)

z = 0.598 not significant

Utilizing a mean split on the HLC Scale (see table 23), subjects were again classified as either internal or external--those below the mean were internal and those above the mean were external. Further division of the internal and external subjects was made based on the value they placed on freedom, high or low. Table 26 summarizes the samples distribution with this classification and indicates no significant difference between the groups when tested at the .05 level utilizing a chi-square for homogeneity of proportions. This lack of significance implies that there is no relationship between choice of birth environment and combined health locus of control and freedom value.

The classification method just described was also utilized in regard to dividing subjects based on health locus of control and health value. Table 27 summarizes the

TABLE 26

DISTRIBUTION OF INTERNAL-EXTERNAL CLASSIFICATION AND FREEDOM VALUE ACCORDING TO BIRTH GROUP (N = 34)

Classification	Hospital f	Hospital F	Home f	Home F	Total
Internal with low value freedom	6	(5.0)	4	(5.0)	10
Internal with high value freedom	2	(3.0)	4	(3.0)	6
External with low value freedom	7	(5.5)	4	(5.5)	11
External with high value freedom	2	(3.5)	5	(3.5)	7
Total	17		17		34

df = 3 $x^2 = 3.17$ not significant

samples distribution with this classification and, utilizing a chi-square for homogeneity of proportions at the .05 level, indicates no significant difference between the groups. This lack of significance implies that there is no relationship between choice of birth environment and combined health locus of control and health value.

Summary

Data were gathered and compared on two groups of women, each choosing different environments in which to give birth. The seventeen subjects who prepared for and had

TABLE 27

DISTRIBUTION OF INTERNAL-EXTERNAL CLASSIFICATION AND HEALTH VALUE ACCORDING TO BIRTH GROUP (N = 34)

Classification	Hospital f	Hospital F	Home f	Home F	Total
Internal with high value health	8	(8.0)	8	(8.0)	16
External with low value health	1	(1.5)	2	(1.5)	3
External with high value health	8	(7.5)	7	(7.5)	15
Total	17		17		34

df = 2 $x^2 = 0.40$ not significant

uncomplicated homebirths had a mean age of 28.3 while the seventeen subjects who prepared for and had uncomplicated hospital births had a mean age of 26.6. All subjects were married. The homebirth sample tended to possess a higher level of education and had more careers classified as professional, technical, and managerial occupations. The majority of their husbands also had more careers classified as professional, technical, and managerial occupations. The majority of both groups had annual incomes within the $10,000 to $25,000 range. The seventeen homebirth subjects had experienced significantly more pregnancies (thirty-nine as opposed to twenty-six) than the hospital sample. At

some time in their life most homebirth subjects had had a hospital birth, usually attended by a professional. When choosing to deliver at home, this same group appeared to have most births attended by non-professionals. In preparing for their births, the homebirth subjects chose the same means of preparation as the hospital birth subjects--formal classes, reading books, and talking to doctors, family, and friends. The mean number of prenatal visits was the same for both groups (10.41). Those choosing homebirth usually rated doctors' competence as excellent or good, as did the hospital group, but gave doctors' a fair or poor rating on ability to meet their psychological needs. This differed significantly from the hospital sample. The homebirth subjects' ratings of nursing competence and the nurses' ability to meet psychological needs were both significantly different when compared with the hospital sample. Again, the homebirth sample indicated more fair and poor ratings. Their feelings about the Women's Liberation Movement did not differ significantly from the hospital samples' feelings. The majority of both samples described their last birth experience as excellent and would choose the same environment to deliver their next baby. The homebirth sample listed no family separation, control over the experience, and a natural, comfortable, loving environment as the most

important reasons for staying home to give birth. Safety and security appeared to be the main reasons cited for giving birth in a hospital by the hospital sample.

The seventeen homebirth subjects did not differ significantly from the seventeen hospital subjects on the HLC scores or the multidimensional subscores. Though significantly more homebirth subjects placed a higher value on freedom, their placement of health on the Value Survey did not differ; it was high for the majority of subjects in both groups. Correlations with internality, externality, freedom, and health were not significantly different. The conclusions and implications which can be drawn from these observations are presented in Chapter V.

CHAPTER V

SUMMARY, CONCLUSION, IMPLICATIONS, AND RECOMMENDATIONS

The results of this research having been presented, major findings which pertain to the problem, and purposes set forth in Chapter I will now be discussed. Some implications concerning the findings as a whole and recommendations for further research will also be revealed.

Summary

Childbirth is an important event in the life of a woman. The problem formulated for this non-experimental descriptive study was examination of select differences between two groups of women--those preparing for and having had uncomplicated homebirths and those preparing for and having had uncomplicated hospital births. The purposes were to:

1. Identify the subjects' general perceptions of health care received during their lives

2. Compare the perceptions of health care received in the population having had homebirths with the perceptions of health care received in the population having had hospital births

3. Determine whether feelings about the woman's movement differed between the population having had homebirths and the population having had hospital births

4. Compare the perceptions of the last birth experience in the population having had homebirths with the perceptions of the last birth experience in the population having had hospital births

5. Identify factors contributing to the decision to have a homebirth or a hospital birth

6. Compare the health locus of control in those women preparing for and having had homebirths as opposed to those women preparing for and having had hospital births

7. Compare the value subjects place on freedom and health as guiding principles in their lives

The review of literature provided evidence that some consumers are dissatisfied with traditional hospital birth. These consumers appear willing to assume responsibility for change and no longer intend to rely solely upon professionals to provide the services for which they have a preference. The act of taking more control over such a unique feminine experience as childbirth represents to many an embodiment of the women's movement. Control over one's life is basic to the movement, and specifically to the

women's health movement; the aspect of control also appears to be basic to homebirth. The ability to control the birth experience in the home environment is a habitually cited reason for choosing homebirth.

Locus of control is a personality variable that indicates one's perception of responsibility for the outcome of events; the internal extreme indicates a belief that one is totally in control of outcomes, whereas the external extreme indicates a belief that powerful others and chance factors control outcome. A relationship between locus of control and health-related behavior appears to exist (Strickland 1973), and recommendations in the literature strongly suggest the need for a tool to test this relationship. Wallston's Health Locus of Control Scale was devised for this purpose and in this investigation was distributed, along with a value survey, to women preparing for and having had uncomplicated homebirths or hospital births. Questionnaires designed to yield demographic data, information about perceptions, and feelings and factors contributing to the decision to have a homebirth or hospital birth, were also distributed to the population sample.

A variety of statistical methods was employed to analyze the compiled data. Appropriate methodology was

determined by the specific type of question and sample size. The conclusions based on this statistical analysis follow.

Conclusion

The general analysis of data appears to reveal that women who choose homebirth are not very different demographically from those who choose a hospital birth. They are married, middle-class women--women in families with annual incomes of $10,000 to $25,000--twenty-six to twenty-eight years of age. They possess approximately the same educational levels and have actively prepared for childbirth and sought prenatal care. Though many people have tended to classify those who have home deliveries as "kooks" or irresponsible people who are unprepared for what they are doing, neither this limited investigation nor Hazell's (1974) supports this stereotype.

The significant difference in the number of pregnancies experienced by the two groups of women raises several questions. After experiencing one or more pregnancies, does a woman's confidence in her ability to give birth successfully increase? Does the increased confidence lead to a decision to bear children outside the confines of a hosptial? Can successive pregnancies lead to cumulative dissatisfaction with an environment perceived

as demeaning or dehumanizing? Is it possible that with each pregnancy a woman becomes more knowledgeable about alternatives or more assertive and demanding? Possibly, the woman choosing homebirth is a person who simply enjoys pregnancy and/or motherhood and regards these experiences as enhancing self-esteem. Perhaps she may place a high value on the relationship she has with her children and strongly believes in the concept of maternal-infant bonding (Klaus and Kennell 1976); therefore, she chooses to stay at home to prevent separation from her newborn infant as well as the other children in her life. The importance of preventing family separation was given by all homebirth subjects as a reason for choosing a homebirth. Support for this possibility can be found in the homebirth literature (Arms 1975, Fitzgerald, et al. 1976, Lang 1972, May 1975). It is also possible that after having had one baby and attending the Childbirth Education Association classes in preparation for the hospital birth, women having second, third, or fourth babies choose not to attend the six-week series of classes again, therefore, were not seen in this investigation.

The contradiction implied by those women stating the choice of a hospital birth was theirs yet indicating they did not believe they had a choice, may possibly be

explained by Lee Stewart's opening statement at the 1977 NAPSAC Conference:

> Even though most women today think that they are choosing to give birth in the hospital--and that is where they want to give birth and that is where they think it is safer--women have been forced to give birth in the hospital. They indeed have not chosen hospital over home--it has been chosen for them by the professionals who have assumed the leadership and are making the decisions about birth--and women themselves don't even realize it because it has happened so gradually (Stewart 1977, p. 11).

On the basis of findings in this study, the fact that consumers no longer intend to rely solely upon professionals for the type of services they desire is supported. Women having babies at home were frequently attended by non-professionals--lay midwives, birth attendants, friends, and family. As Lubic stated, it seems apparent that

> . options in maternity care are not ours as professionals. Ultimately, they rest with the public. If families choose to bear children outside the confines of the system, they will (BRIEFS, November 1975, p. 101).

Analysis of responses from the sample indicated that women choosing hospital birth had more favorable perceptions about medical and nursing care received during their lives than the homebirth group. It appears that the decision to birth at home is not based on a lack of confidence in the competence of medical profession but rather on the general feeling of doubt in relation to the

ability of doctors to meet psychological needs. In the minds of those choosing homebirth, both nursing competence and nursings' ability to meet psychological needs lacked excellence. A homebirth appears to be perceived by homebirth subjects as having socio-psychological advantages over a hospital birth. The old-fashioned phrase "tender, loving care" appears to play an important part in obstetrics, and it is in this area that hospital births may fall short. Considerations other than technical skills can often override the decision of where to give birth. Childbirth has many individual meanings, and the effect of interpersonal, social, and psychological rewards appears to be significant to those choosing homebirth. Hazell's (1974) interviews found all fourteen homebirth subjects to have negative feelings about the medical profession, and in this present investigation there is indication that women do believe that health professionals and their institutions have failed to care about them.

Control over one's body and, therefore, one's life is a primary goal of the women's health movement. Education is viewed as a means of obtaining this control (Boston Women's Health Book Collective 1976). All the women in this study actively prepared themselves for childbirth through educational processes; therefore, it is possible

to assume that all subjects subscribe to the primary goal of the women's health movement, though not necessarily to the women's movement in general.

The primary reasons found in this study for choosing homebirth--no family separation and control over the experience--support the literature previously reviewed (Arms 1975; Clark and Affonso 1976; Clausen, Flook, and Ford 1977; Davis 1976; Heroux 1977). The experience of control in the environment of the home is clearly important to the nature of childbirth for many women, regardless of the fact that the HLC Scale failed to support the assumption of differences between the homebirth group and the hospital birth group. The lack of significant differences on the HLC Scale suggests that women involved in the homebirth movement do not have a greater tendency to perceive themselves as having control over their lives when compared with women choosing traditional hospital births. However, as previously stated, the HLC Scale is a generalized measure of expectancy and is not a measure of beliefs specific to childbirth; therefore, it may not have been a valid tool for this research.

If the validity of this tool for the present research is suspect, then correlating the Value Survey with the HLC Scale may also be questioned. However, if

values are more crucial determinants of behavior than other personality variables (Rotter 1975), then the significant difference in the ranking of freedom on the value survey may be an important factor influencing the decision to have a homebirth. Freedom of choice in relation to accepting or rejecting traditional hospital routines may be the key factor for professionals to consider when planning options in maternity care.

Though sample size was significantly reduced through application of specific criteria, important variables pertaining to the choice of a birth environment appear to be the following: (1) perception of medical and nursing care, especially as it relates to the psychological needs of the consumer, (2) number of pregnancies experienced, (3) expressed desire for control, and (4) the value placed on freedom as a guiding principle in life.

Implications

If nurses, involved in maternity care, are to understand the homebirth movement, they must first be willing to listen to those expressing a desire to reject hospital-based maternity care. The fact that women considering this alternative may not be considerably different from those women seen in the hospital maternity

units, will hopefully lend credence to their statements of need. If the desire not to be separated from family members during the birth experience is important to women, then making this option a reality for them would appear to improve the hospital maternity environment. And if women desire more control over the birth experience, it would seem reasonable to assume that the maternity nurse is in an ideal position to fulfill this desire. The amount of contact the nurse has with a laboring family and the leadership she can initiate places her in a position to execute and/or influence change.

It appears that women have some very definite perceptions about nursing care. These perceptions appear to be influential when making the decision to have a homebirth. If perceptions of nursing care have such a strong influence on health-related decisions, then perhaps nurses should stop and assess just how serious their responsibilities are. With an increased awareness of and sensitivity to patients' needs, the nurse may be able to have a more positive influence over future health-related behaviors and decisions. Nursing education could contribute to this goal by stressing the seriousness of nursing responsibility and the impact of their image upon future members of the profession.

Recommendations

Based on the results of this study, the researcher would make several recommendations. First, a larger and more geographically-scattered sample from each group, homebirth and hospital birth, should be studied. This would provide more data to compare and contrast and would allow greater generalization of the results.

Second, in keeping with recommendations suggested by Rotter (1975) and Wallston, et al. (1976a), a scale which is more sensitive to childbearing experiences could be developed to study the variable of fate control for these groups. Such a scale would be specific for attitudes of fate control regarding childbearing behavior. The results would be a more appropriate assessment of belief in fate control of people who choose various forms of maternity care services.

Last, a separate more specific study on perceptions of those choosing homebirth toward nursing care could be valuable to assess the impact nursing has on health-related decisions. This would provide insight into the problems nursing must overcome to improve its provision of maternity care for the consumer.

APPENDIX A

QUESTIONNAIRE

This is a questionnaire designed to collect information about women who have had babies at home. Please answer each question as honestly and completely as you can. It is important that you do not leave any questions unanswered. All answers are confidential. You need not sign your name. If you need more space than what is allotted to answer a question, you may write on the back of the paper.

1. Age_____

2. Marital status: single___ married___living with mate__

   separated__ divorced__ widow__

3. Highest level of education completed:

   1 2 3 4 5 6 7 8 9 10 11 12 (circle number)

   college: 1 year__ 2 years__ 3 years__ 4 years__

   graduate school: master's__ Ph.D.__

4. Your occupation:_____

5. Husband's mate's occupation:_____

6. Approximate annual income of your family:

   less than $5,000_____ $15,000 - $25,000_____

   $5,000 - $9,999 _____ more than $25,000_____

   $10,000 - $14,999_____

7. Number of pregnancies you have had_____

   Number of living children_____

   Number of abortions_____ Date of last birth_____

8. Have you had any complications/medical problems with your pregnancies? YES___ NO___
   if YES, please describe:

9. How many of your children were born at home?_____
   In a hospital?_____Was this YOUR choice? YES__ NO___
   Explain:

10. Who attended your hospital deliveries? obstetrician___
    general practitioner___ nurse midwife___
    not applicable___

11. Who attended your home deliveries? obstetrician___
    general practitioner___ nurse midwife___ lay midwife___
    birth attendant___ friend___ other_____

12. What was their degree of training/experience with home birth?_____
    _____

13. How did you prepare for your home birth?
    attended childbirth education classes___ read books___
    attended classes specifically for home birth___
    talked to my doctor about it___ talked to friends___
    discussed it with family members___ nothing special___
    other_____

14. Approximately how many prenatal visits with a physician did you have during your last pregnancy?_____

15. In general, when thinking about medical care you have received, how would you rate the doctors' bedside manner (the doctors' ability to meet your psychological needs)? excellent___ good___ fair___ poor___

16. In general, when thinking about medical care you have received, how would you rate the doctors' level of medical competence or skill (the doctors' ability to meet your physical needs)? excellent___ good___ fair___ poor___

17. In general, when thinking about nursing care you have received, how would you rate the nurses' bedside manner (the nurses' ability to meet your psychological needs)? excellent___ good___ fair___ poor___

18. In general, when thinking about nursing care you have received, how would you rate the nurses' level of nursing competence or skill (the nurses' ability to meet your physical needs)? excellent___ good___ fair___ poor___

19. In general, how would you describe your feelings about the Women's Liberation Movement? very favorable___ moderately favorable___ slightly favorable___ unfavorable___

20. How would you describe your last birth experience? excellent___ good___ fair___ poor___

21. If you were pregnant again where would you plan to delivery your baby? at home___ in the hospital___

22. Are you presently pregnant? YES___ NO___

If YES, when are you due?_____

23. List or briefly explain in order of importance to you reasons for having a baby at home:

APPENDIX B

QUESTIONNAIRE

This is a questionnaire designed to collect information about women who have had babies in a hospital. Please answer each question as honestly and completely as you can. It is important that you do not leave any questions unanswered. All answers are confidential. You need not sign your name. If you need more space than what is allotted to answer a question, you may write on the back of the paper.

1. Age:_____

2. Marital status: single___ married___ living with mate__

   separated___ divorced___ widow___

3. Highest level of education completed:

   1 2 3 4 5 6 7 8 9 10 11 12 (circle number)

   college: 1 year___ 2 years___ 3 years___ 4 years___

   graduate school: master's___ Ph.D.___

4. Your occupation:_____

5. Husband's Mate's occupation:_____

6. Approximate annual income of your family:

   less than $5,000_____ $15,000 - $25,000_____

   $5,000 - $9,999_____ more than $25,000_____

   $10,000 - $14,999_____

7. Number of pregnancies you have had___

   Number of living children_____

   Number of abortions_____ Date of last birth_____

8. Have you had any complications/medical problems with your pregnancies? YES NO
   If YES, please describe:

9. How many of your children were born at home?
   In a hospital? Was this YOUR choice? YES NO
   Explain:

10. Do you believe you have a choice as to where to deliver a baby? YES NO
    Explain:

11. Who attended your deliveries? obstetrician
    general practitioner__ nurse midwife other_____

12. Why did you attend CEA classes?
    my doctor told me to___ my friends did
    the office nurse suggested it
    my husband/mate wanted to___ I wanted to
    my sister/sister-in-law did
    other reasons:_____

13. Besides attending CEA classes, what else did you do to prepare for your birth: read books
    talked to friends talked to my doctor about it___
    discussed it with family members nothing special___
    other:_____

14. Approximately how many prenatal visits with a physician did you have during your last pregnancy?_____

15. In general, when thinking about medical care you have received, how would you rate the doctors' bedside manner (the doctors' ability to meet your psychological needs)? excellent good___ fair poor___

16. In general, when thinking about medical care you have received, how would you rate the doctors' level of medical competence or skill (the doctors' ability to meet your physical needs)? excellent good___ fair poor___

17. In general, when thinking about nursing care you have received, how would you rate the nurses' bedside manner (the nurses' ability to meet your psychological needs)? excellent good___ fair poor___

18. In general, when thinking about nursing care you have received, how would you rate the nurses' level of nursing competence or skill (the nurses' ability to meet your physical needs)? excellent good___ fair poor___

19. In general, how would you describe your feelings about the Women's Liberation Movement? very favorable___ moderately favorable___ slightly favorable___ unfavorable

20. How would you describe your last birth experience?

excellent___ good___ fair___ poor___

21. If you were pregnant again where would you plan to deliver your baby? at home___ in the hospital___

22. Are you presently pregnant? YES___ NO___

If YES, when are you due?_____

23. List or briefly explain in order of importance to you reasons for having a baby in the hospital:

APPENDIX C

QUESTIONNAIRE

This is a questionnaire designed to determine the way in which different people view certain important health related issues. Each item is a belief statement with which you may agree or disagree. Beside each statement is a scale which ranges from strongly disagree (1) to strongly agree (6). For each item I would like you to circle the number that represents the extent to which you disagree or agree with the statement. The more strongly you agree with a statement, then the higher will be the number you circle. The more strongly you disagree with a statement, then the lower will be the number you circle. Please make sure that you answer every item that you circle only one number per item. This is a measure of your personal beliefs; obviously, there are no right or wrong answers.

Please answer these items carefully, but do not spend too much time on any one item. As much as you can, try to respond to each item independently when making your choice; do not be influenced by your previous choices. It is important that you respond according to your actual beliefs and not according to how you feel you should believe or how you think I want you to believe.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1.	If I take care of myself, I can avoid illness.	1	2	3	4	5	6
2.	Good health is largely a matter of good fortune.	1	2	3	4	5	6
3.	My family has a lot to do with my becoming sick or staying healthy.	1	2	3	4	5	6
4.	People who are never sick are just plain lucky.	1	2	3	4	5	6
5.	I can only do what my doctor tells me to do.	1	2	3	4	5	6
6.	Whenever I get sick it is because of something I've done or not done.	1	2	3	4	5	6
7.	Having regular contact with my physician is the best way for me to avoid illness.	1	2	3	4	5	6
8.	People's ill health results from their own carelessness.	1	2	3	4	5	6
9.	No matter what I do, if I am going to get sick I will get sick.	1	2	3	4	5	6
10.	Most people do not realize the extent to which their illnesses are controlled by accidental happenings.	1	2	3	4	5	6
11.	When I feel ill, I know it is because I have not been getting the proper exercise or eating right.	1	2	3	4	5	6

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
12.	My health is dependent on how others treat me.	1	2	3	4	5	6
13.	There are so many strange diseases around that you can never know how or when you might pick one up.	1	2	3	4	5	6
14.	I am directly responsible for my health.	1	2	3	4	5	6
15.	When I recover from an illness, it's usually because other people (for example, doctors, nurses, family, friends) have been taking good care of me.	1	2	3	4	5	6

APPENDIX D

VALUE SURVEY

Below you will find a list of ten values listed in alphabetical order. Your task is to arrange them in order of their importance to YOU, as guiding principles in YOUR life.

Study the list carefully and pick out the one value which is the most important for you. Write the number "1" in the space to the left of the most important value.

Then pick out the value which is second most important for you. Write the number "2" in the space to the left. Then continue in the same manner for the remaining values.

Some people find it difficult to distinguish the importance of some of these values. Do the best that you can, but please rank all ten of them. The end result should truly show how YOU really feel.

_____A COMFORTABLE LIFE (a prosperous life)

_____AN EXCITING LIFE (a stimulating, active life)

_____A SENSE OF ACCOMPLISHMENT (lasting contribution)

_____FREEDOM (independence, free choice)

_____HAPPINESS (contentedness)

_____HEALTH (physical and mental well-being)

_____INNER HARMONY (freedom from inner conflict)

_____PLEASURE (an enjoyable, leisurely life)

_____SELF-RESPECT (self-esteem)

SOCIAL RECOGNITION (respect, admiration)

APPENDIX E

HOMEBIRTH SURVEY

I have received your name from HOMEBIRTH, INC. and am writing this letter to request your participation in a research study.

I am a graduate student in nursing at Texas Woman's University in Dallas and am conducting research for a thesis. The questionnaire which accompanies this letter is for the purpose of gathering data about homebirths and the women involved in this movement. You can be assured that your response on the questionnaire will be confidential and you need not sign your name. A stamped addressed envelope is enclosed for returning your completed questionnaire. A prompt return would be appreciated.

In addition, for protection of your rights, the enclosed consent form needs to be signed in order for me to include your questionnaire in the study. If you will please sign the form, place it within the small envelope, seal it and then return it with the questionnaire, I will be able to keep it separated from the completed questionnaire, thereby protecting your anonymity.

If you wish to be informed of the results of the study, please send me your name and address on a separate postcard.

Thank you for participating in this study.

Sincerely,

Jean Tillman

APPENDIX F

CHILDBIRTH SURVEY

The Childbirth Education Association has granted permission for the distribution of the enclosed questionnaire. I am not affiliated with the Childbirth Education Association and the research is not being conducted or sponsored by the Association. All participation is voluntary and sincerely appreciated.

I am a graduate student in nursing at Texas Woman's University in Dallas and am conducting research for a thesis. The questionnaire which accompanies this letter is for the purpose of gathering data about women who have had prepared hospital births. You can be assured that your response on the questionnaire will be confidential and you need not sign your name. A stamped addressed envelope is enclosed for returning your completed questionnaire. A prompt return would be appreciated.

In addition, for protection of your rights, the enclosed consent form needs to be signed in order for me to include your questionnaire in the study. If you will please sign the form, place it within the small envelope, seal it and then return it with the questionnaire, I will be able to keep it separated from the completed questionnaire, thereby protecting your anonymity.

If you wish to be informed of the results of the study, please send me your name and address on a separate postcard.

Thank you for participating in this study.

Sincerely,

Jean Tillman

CONSENT TO ACT AS A SUBJECT FOR RESEARCH

AND INVESTIGATION

Texas Woman's University

I hereby authorize JEAN TILLMAN to perform the following investigation through the administration of the enclosed questionnaire:

to examine differences in those women preparing for and having homebirths as opposed to those women preparing for and having hospital births

I understand that the investigation involves the following potential risks:

--personal feelings of anxiety, anger or internal conflict may surface in response to completing the questionnaire

--anonymity may not be maintained unless this form is returned sealed within the small separate envelope which has been provided

I understand that contribution of information via the questionnaire may further the understanding of the issues surrounding the homebirth movement and prepared childbirth.

I understand that once my questionnaire is received by the researcher, willingness to participate in the study is assumed.

_____

Signature

_____

Date

APPENDIX H

HLC SCORING INSTRUCTIONS

Original eleven-item HLC Scale: Items numbers 1, 2, 4, 5, 6, 8, 9, 10, 11, 13, and 14

For externally worded items (2, 4, 5, 9, 10, and 13): Score as the number circled by the subjects; i.e., 1 to 6.

For internally worded items (1, 6, 8, 11, and 14): Reverse score; i.e., subtract the circled number from seven so that 1's become 6's, 2's become 5's, and so on.

Total HLC Score consists of the sum of the eleven items as scored above. A high score reflects external Health Locus of Control. A low score reflects internal Health Locus of Control. Divide the subjects utilizing a mean split.

Multidimensional subscores:

Internal subscale (1, 6, 8, 11, and 14): Score as the number circled by the subjects; i.e., 1 to 6.

External-powerful others subscale (3, 5, 7, 12, and 15): Score as the number circled by the subjects; i.e., 1 to 6.

External-chance subscale (2, 4, 9, 10, and 13): Score as the number circled by the subjects; i.e., 1 to 6.

Subscore totals consist of the sum of the five items scored as above. The higher the score the greater the degree of reflected belief in internal control, powerful others control, or chance control.

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