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Childbirth and Control Behind Bars: A Descriptive Qualitative Analysis of the Maternal Perception of Control in Women Who Have Given Birth While Incarcerated

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CHILDBIRTH AND CONTROL BEHIND BARS: A DESCRIPTIVE QUALITATIVE ANALYSIS OF THE MATERNAL PERCEPTION OF CONTROL IN WOMEN WHO HAVE GIVEN BIRTH WHILE INCARCERATED

by

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ABSTRACT

The perception of control during childbirth has been widely studied in various setting and groups. Many factors have been found to aid or impede the perception of control for birthing women. Significance of that perception of control during childbirth has also been measured in past studies. This descriptive qualitative study advances the knowledge of the perception of control during childbirth and examines a population that has thus far been excluded. Four previously incarcerated women participated in semi-structured interviews about their experience of giving birth while incarcerated and their perception of control during that time. The women were from diverse backgrounds and varying gravidity and parity. Each woman delivered a viable infant while incarcerated. This research examined the perception of control for incarcerated women during their childbirth experience. Factors associated with control for non-incarcerated women from prior research were discussed during the interviews. Significance of these factors was also questioned during the interviews. The two major themes derived from the research were Being Controlled and Compulsory Support/Attended Solitude. With the development of federal policies for incarcerated women during pregnancy and childbirth, research that includes the perspective of those who the policies will affect the most is vital. While further research is needed on the perception of control during childbirth for incarcerated women, this study is a valuable foundation. Including previously incarcerated and currently incarcerated women in childbirth experience research will reveal ways to improve the carceral system and the healthcare system.

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DEDICATION

Upon completing this dissertation, I realized that I have been working on this for about a fourth of my life. That is a lot of time to have something on your mind. All the while, I completely regretted my decision to start this program and definitely did not think I would ever finish. But here I am: finished, graduating, and feeling a sense of relief like I have never felt before. I wish I could say that I knew I would make it with my own personal drive keeping me going. I cannot. Through it all, the only things getting me through was the support of my family, friends, and mentors.

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LIST OF ABBREVIATIONS

APHA	American Public Health Association
CEQ	The Childbirth Experience Questionnaire
CHCUW	Committee on Health Care for Underserved Women
DHHS	Department of Health and Human Services
GRADE-CERQual	Grading of Recommendations, Assessment, Development, and Evaluation- Confidence in the Evidence from Reviews of Qualitative Research
IRB	Institutional Review Board
LAS	Labour Agentry Scale
MCSRS	The Mackey Childbirth Satisfaction Rating Scale
NCCHC	National Commission on Correctional Health Care
NICU	Neonatal Intensive Care Unit
PPD	Postpartum Depression
PPTSD	Postpartum Post-traumatic Stress Disorder
U.S.	United States

CHAPTER I - INTRODUCTION

Background

One of the most incredible and complex human relationships is between a mother and her child. This relationship has inspired a myriad of research on fetal development (Godfrey et al., 2011); the psychology of the birthing woman (Beck, 2004; Berg et al., 2010; Blanch et al., 1998; Butoni & Hodnett, 1980; Ford & Ayers, 2009; Goodman et al., 2004; Hallgren et al., 1995; Hodnett & Simmons-Tropea, 1987; Lavender et al., 1999; Lowe, 2009; Waldenström, 1999;); the connection between a mother and her newborn (Barker et al., 2017; Bornstein et al., 2012; Winston & Chicot, 2016); and the perceptions and feelings of a mother before and during birth and how those impact her birthing experience, motherhood, and life after for mother and child (Cook & Loomis, 2012; Crowe & von Baeyer, 1989; McCrea et al., 2000; Melender, 2006; Namey & Lyerly, 2010; Sjögren, 1997). Childbirth is a significant point in the lifetime of mothers. New life can bring with it new perspectives, hopefulness, fears, doubts, dreams, and excitement. When childbirth is out of a mother's control and filled with uncertainties, this incredible life event can lead to feelings of despair that are difficult, if not impossible, to overcome (Ayers & Pickering, 2001; Ballard et al., 1995; Ford & Ayers, 2009). Without control, childbirth can lead to feelings of anxiety or trauma, causing postpartum depression (PPD) or postpartum post-traumatic stress disorder (PTSD) (Ayers & Ford, 2009; Ayers & Pickering, 2001; Ballard et al., 1995).

Incarcerated women potentially enter childbirth with less exposure to pregnancy and childbirth education due to: vulnerability, being from low socioeconomic positions, and marginalization (Alemango, 2001; Dumant et al., 2012; Greenfield & Snell, 1999;

Harlow, 1998; Henderson, 1998). Given the inconsistencies in facilities across the United States (U.S.) adopting the national pregnancy-related healthcare standard created by the National Commission on Correctional Health Care (NCCHC) and the American Public Health Association (APHA) (NCCHC, 2018), incarcerated women are susceptible to negative experiences during childbirth.

Perceived control, or a lack of perceived control, during childbirth is a significant factor in birthing women (Cook & Loomis, 2012; McCrea et al, 1999; Melender, 2006; Namey & Lyerly, 2010; Sjögren, 1997). Researchers have surveyed and interviewed women to identify factors that contributed to feelings of control during childbirth, and a perception of control was determined to contribute to a positive birth experience (Crowe & von Baeyer, 1989; Hardin & Buckner, 2004; Waldenström, 1999). This study explored such matters and developed that research further by adding the perspectives of the experiences of women who gave birth while incarcerated. Ongoing research on the topic of childbirth and the perception of control will only help to create more positive outcomes and a fuller understanding of what it means to have a positive birth story.

Problem Statement

From 1980 to 2014, the number of incarcerated women in the U.S. grew by 700% (Carson, 2015). This number is at a historic high and accounts for more than 30% of the world's incarcerated women (Kajstura, 2018). Incarcerated women have healthcare concerns, including women-specific and pregnancy-related healthcare concerns. America's prison systems often provide the only health care that many prisoners ever receive (Sufrin, 2017). "Although standards for pregnancy-related health care have been established by the NCCHC and the APHA, there is no mandatory accreditation that

requires adherence to these standards" (Clarke & Ferszt, 2012, p. 558). The standards that exist for health care in correctional facilities and laws in place to protect prisoners from neglect or undue harm are open to interpretation (Sufrin, 2017).

The First Step Act (2018) includes federal level protection against shackling for pregnant, laboring, and postpartum female inmates. However, this bill does not protect women in state or county facilities in many states that allow shackling of incarcerated pregnant females. The overwhelming reproductive health disparities (Sufrin et al., 2015), lack of education or counseling, history of abuse (Harlow, 1999), mental health disorders (Dumant et al., 2012), shackling, and racial discrimination (Freudenberg, 2002), are all issues of carceral health care that must be addressed in order to achieve better healthcare outcomes for incarcerated women. Achieving better healthcare outcomes for incarcerated women improves the public health for the communities to which they return. A lack of female-specific research and pregnancy-related research on health care in incarcerated women exists, despite the rise in female incarceration (Sufrin et al., 2019). One way to improve the healthcare outcomes of incarcerated women is to understand what is important, significant, and meaningful to incarcerated women, and this study focused on the perception of control for incarcerated women during labor and childbirth, providing a greater understanding of the topic.

Purpose

The purpose of this qualitative study was to examine the maternal perception of control during childbirth of women who have given birth while incarcerated. Data were obtained through semi-structured interviews with four, previously incarcerated women, over the age of 18, who delivered a viable newborn while incarcerated. The lack of

research on the health care of incarcerated women during pregnancy (Sufrin et al., 2019) and, specifically, the perception of control for incarcerated women during childbirth motivated this study. Control and the perception of control is a common thread throughout research on childbirth with various populations and settings (Butani & Hodnett, 1980; Christiaens & Bracke, 2007; Cook & Loomis, 2012; Crowe & von Baeyer, 1989; Downe et al., 2018 Ford & Ayers, 2009; Goodman et al., 2004; Hardin & Bucker, 2004; Hodnett, 2002; Karlström et al., 2015; Lavender et al., 1999). Including as many populations and groups as possible in research is important. Incarceration is often temporary, but the health care of incarcerated people leaves lasting effects that continue beyond incarceration. If the health care in prison can be improved, the potential for public health improvement in the communities those populations reenter can also be improved (Greifinger, 2007).

According to Cohen et al. (2005), qualitative research is useful when little research exists on a topic; when no reliable or valid instrument exists for that specific group; or when language to use, concepts, or questions to ask for that group are unclear. The maternal perception of control in childbirth experiences has been explored and found to be an important part of many women's birth stories, and researchers continue to search for a deeper understanding. Many researchers have created instruments to measure satisfaction during childbirth (Mackey, 2004) and explored factors related to childbirth satisfaction (Hodnett & Simmons-Tropea, 1987). Instruments have also been created and used to find correlations between factors related to childbirth satisfaction and the significance assigned to those factors (Christiaens & Bracke, 2007; Jafari et al., 2017; Kabakian-Khasholian et al., 2017). Research includes the experiences of women who

have given birth during imprisonment (Sufrin, 2017). Research on the perception of control of incarcerated women during childbirth has not been done. Without including incarcerated women and analyzing the policies and constraints surrounding their experiences, the care provided cannot be improved.

Research Questions

This study was guided by the following research questions:

1. Do incarcerated women feel a perception of control during childbirth?
2. Is a perception of control important to incarcerated women during childbirth?
3. What does the perception of control for incarcerated birthing women mean?
4. Is the perception of control for incarcerated women during childbirth different from non-incarcerated women?
5. Does a perception of control have an influence on the evaluation of a negative or positive birth experience for incarcerated women?

Conceptual Framework

This research was guided by the concept of self-efficacy from the social cognitive theory (Bandura, 1977). A fundamental part of self-efficacy is the idea that the more a person believes he or she is capable of a task, the more successful he or she will be in achieving goals. To Bandura (1994), "Self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" (p. 2). Bandura states that there are four main sources of influence on an individual's beliefs about their efficacy and how they can develop and change during an event. The four sources of influence are: through mastery of one's experiences, vicarious experiences of social models, social persuasion, and their somatic

and emotional states (Bandura, 1977). The two major components of self-efficacy are self-efficacy expectations and self-efficacy outcome expectations (Resnick, 2018).

> An outcome expectancy is defined as a person's estimate that a given behavior will lead to certain outcomes. An efficacy expectation is the conviction that one can successfully execute the behavior required to produce the outcomes. Outcome and efficacy expectations are differentiated, because individuals can believe that a particular course of action will produce certain outcomes, but if they entertain serious doubts about whether they can perform the necessary activities such information does not influence their behavior. (Bandura, 1977, p. 193)

In this study, self-efficacy is defined as having perceived control during childbirth. Based on Badura's research on self-efficacy, external and intrinsic factors will affect the perception of control and the ability for incarcerated women to achieve a perception of control.

In a study completed on self-efficacy during the third trimester of pregnancy in preparedness for childbirth, self-efficacy expectancies were significantly correlated with childbirth fears. One of the most common fears found in the high fear group was losing control during delivery. The women studied in this research were predominantly white, middle class, well-educated women (Lowe, 2009). A sample of women with such a description had doubts about their abilities and a fear of losing control. One assumption is that a group of women generally classified as minorities, under-educated, and with low socioeconomic status will experience an even greater loss of control, fear and lack of self-efficacy expectations or outcomes. While not the only factor to consider when determining a mother's perception of control or success of a birth, self-efficacy is one

that may influence the outcome greatly. A lack of physical freedom, little to no support from loved ones, and emotional stress from incarceration influence the self-efficacy and perception of control for incarcerated women.

Significance

In their study on pregnancy outcomes in U.S. prisons from 2016-2017, Sufrin et al. found that there were 753 live births among the participants. This study is the first known to collect systematic pregnancy outcome data among incarcerated pregnant women. That study is incredibly recent, indicating a substantial neglect and disregard for pregnancy outcomes of incarcerated women (Sufrin et al., 2019). Collecting data on pregnancy outcomes for incarcerated women will now be a requirement of the Bureau of Justice per the First Step Act (2018). Data for the calendar year 2019 is not available as of conducting and writing this study. Not only is the statistical data limited, but research on accounts from incarcerated women in the U.S. from childbirth are minimal.

This study is significant because first-hand information from women who have given birth in prison in scholarly research is limited. Scholarly research that focuses on the perception of control for birthing incarcerated women is even more limited. Semi-structured interviews with women from this population will add to the body of knowledge on the maternal perception of control during childbirth and either support current research or provide a new perspective to consider. Perception of control during childbirth has been immensely studied (Cook & Loomis, 2012; Crowe & von Baeyer, 1989; McCrea et al, 2000; Melender, 2006; Namey & Lyerly, 2010; Sjögren, 1997), but these studies do not include populations such as those who are currently or previously incarcerated.

A concept analysis of control as it relates to childbirth revealed four attributes associated with the perception of control during childbirth. These attributes include decision-making, access to information, personal security, and physical functioning (Meyer, 2013). All of these factors are limited and sometimes impossible for incarcerated women. Women in a prison system must wait for physicians they may not choose; appointment times and location out of their control; and education provided to them through the prison, jail, or volunteers. Support systems, such as families and significant others, usually live a considerable distance, especially since most women's facilities are few and far between. Family members cannot be as involved as some may like, and the fathers of these infants may have little or no input. Many incarcerated women do not have the ability to create a birth plan and may not have access to the information to allow them to try. Without the information or support readily available to these women, it is unlikely that incarcerated women would consider their birth experiences positive or in their control.

Delimitations

Women chosen to participate were included regardless of the crime or crimes that resulted in their incarceration. Limiting the population to only women who have committed non-violent crimes may have restricted this research even further. Including women without considering the severity of their crimes allowed for the inclusion of more perspectives to be explored. However, this information may have significance. Prisoners may have been treated differently during their labor and delivery process based on their level of security and classification. Their potential lengths of sentencing at the time of labor and delivery may contribute to their feelings of self-efficacy, despair, or

indifference relating to childbirth. Limiting the research participants to only those who have committed non-violent crimes would decrease the number of allowable participants, as well as potentially create an even more niche perspective than that of incarcerated women. Race was not a factor in the inclusion criteria of women who were chosen to participate. Including only one race had the potential to distract from the aim of the study. While race could have been addressed by the participants during the interviews and discussions, participants' races were not specifically asked, and none of the participants included their race or racial biases in their responses. Treatment based on race and health disparities between different races may greatly influence personal perception of control during childbirth.

This research did not include women who were incarcerated at the time of participation. In order to create a feasible study with minimal barriers, the population of inmates was not sought after or included in the research. Previously incarcerated women were included because they are not considered a vulnerable population as defined by the Office for Human Research Protections of the U.S. Department of Health and Human Services (DHHS). Previously incarcerated women may have the benefit of time to reflect on their experience, deepening their understanding of their own feelings. Time and freedom can also provide the opportunity for a different perspective to emerge. Women under the age of 18 were not asked to participate, avoiding a vulnerable population of adolescents. Including adolescents had the potential to change the direction of the study. Aside from being a vulnerable population, being a juvenile mother in the carceral system could have many more challenges and considerations which may detract from the purpose of this study.

Men were not asked to participate in this study. The experiences and reactions of a father at the birth of his child may contribute to the overall maternal perception of the event but were not be the focus of the study. Paternal involvement was included if it was a significant factor for the birthing mother for support. Relationship status at the time of incarceration was not specified for participants' inclusion. Sexuality and gender-identities were also not specified for participants' inclusion. The researcher understands that all of this information is important and contributes to each individual's story and perception of events but would detract from the focus of the study.

Limitations

This researcher chose to conduct research on a non-vulnerable population. Identifying and recruiting participants was one of the most challenging aspects of this study. A myriad of factors contributed to the low recruitment number. Women may have been embarrassed to admit to giving birth while incarcerated. Many of the planned avenues the researcher took, such as emailing parole offices and support groups, failed due to lack of responses. The privacy of individuals who were once incarcerated is protected. Some participants were unable to complete the research due to erratic behavior or lack of understanding of the project. Conducting research with a vulnerable population of currently incarcerated women may have generated a larger sample size, because all participants would be in central locations. However, saturation was reached, as all of the participants gave similar answers to crucial research questions.

A goal of the researcher was to ensure that all participants felt a sense of safety and trust, and the researcher was careful not to coerce participants to ensure beneficence and justice. One limitation of this goal was that all interviews were conducted over the

phone. Without the personal, face-to-face interaction, sincerity and trust were built on prompt responses to phone calls and text messages, full disclosure of the research, and sending the $25 gift card immediately after the interview was completed.

A significant challenge of this research is how past experiences and meaning and interpretation of those experiences affected each individual. The researcher kept in mind personal biases when conducting, interpreting, and coding the interviews. The researcher remained a calm listener without being argumentative or judgmental. Securing the trust of the participants was vital. The research participants were encouraged to tell their own stories without the researcher guiding their answers due to biases and previous research findings. Studying this group of women and hearing their stories provides the research community with new perspectives and knowledge and maybe be a small part in creating positive changes for society. “It benefits society as a whole to promote and support the relationship between mother and child rather than devastate that relationship before it even has a chance to grow” (Johannaber, 2006, p. 10).

Qualitative research can be time consuming, especially with interviews. Scheduling and location of participants was a limitation. Distractions to some participants were excessive. Ambiguities in speech or anecdotes could have been interpreted in the analysis as something other than what was meant. Some phrases and colloquialisms may have been misunderstood by the researcher.

Summary

The number of women incarcerated in the U.S. has increased astronomically in the last few decades. With this influx comes women-centric health concerns and an increasing number of incarcerated women giving birth. The legality and ethicality of

shackling female inmates during labor and delivery is inconsistent across the nation. Shackling in this research refers to any form of restraint used to bind, restrict movement of any part of the body, or detain an inmate. Descriptive qualitative analysis was used to explore the perceptions of control of women who have given birth while incarcerated and compared to the literature to find similarities, nuances, and new themes. The self-efficacy theory, which suggests that the readiness of a person to accomplish a task relates to the level of success, provided the conceptual framework for this research. Control was measured with the four attributes found by Meyer (2013) to relate to the perception of control: decision-making, access to information, personal security, and physical functioning. Personal biases of the researcher must be recognized and to the best of the researcher's abilities, removed from the exploration.

CHAPTER II – LITERATURE REVIEW

Introduction

The practices and cultural norms of the birthing process have evolved and advanced throughout history (Kaplan, 2012). Similarly, the way women and the healthcare system view this life event has shifted and invoked questions and conversations about what is appropriate, safe, and meaningful. Once considered a social event in Western civilization including past generations for encouragement and teaching, childbirth has shifted to hospitalization being the norm (Kaplan, 2012). Medical advancements, women's rights, feminism, technology, policy changes, court cases, and economics have all influenced the progression of health care and what is considered normal for women giving birth. One area of interest for the research community that has persisted over many years is the perception of control for women during childbirth. Control and the perceived control women feel during their childbirth experience has been explored and studied in a variety of countries and birth settings and many contributing factors have been identified as aiding or inhibiting perception of control. The relationship between control and satisfaction in birth experience has been examined as well as the relationship of control to a positive or negative birth experience. The research published on control in childbirth has helped define control to childbearing women, explored the importance of control for women in labor, and has helped clinicians understand their roles in childbirth by helping create a positive experience for birthing mothers.

While control has been found to be a significant aspect of childbirth, research has been somewhat limited, excluding populations such as incarcerated women and other vulnerable populations. Not only will understanding this concept of control for birthing

women and continuing research on the subject promote patient satisfaction, but this understanding will help the future of policy formation and standardize practices to promote outstanding health care. The purpose of this study was to create a greater understanding of the concept of control as it relates to all birthing women, specifically those in the carceral system. This literature review recalls the research done on the perception of control during childbirth thus far.

A comprehensive literature review was completed using mainly online research databases including EBSCOHost through The University of Southern Mississippi's libraries. Mendeley, a reference manager, was used to search and save potential research articles and various sources of information. Internet searches were performed on the concept of control, control and its relationship to childbirth, the significance of control to childbearing women, important attributes for a positive childbirth, perception of control and relationship to pain during childbirth, patient-centered care, postpartum depression, and postpartum post-traumatic stress disorder. A review was also completed on shackling during childbirth for incarcerated women. Nursing research books were used for reference, as well as books written on the experiences of childbirth for incarcerated women. Though the following factors are important to the overall health outcomes of incarcerated women, for the purposes of this research and creating a feasible study on the perception of control, the following were not included in the literature review: healthcare cost, healthcare insufficiencies, statistics on race and birth outcomes of incarceration, health disparities among varying races of incarcerated women, lasting effects of incarceration, drug use prior to and after incarceration, and socioeconomic status among incarcerated women.

Control During Childbirth

Literature reveals an abundance of evidence indicating that perceived control, or a lack of control, during childbirth is a significant factor to birthing women (Cook & Loomis, 2012; Crowe & von Baeyer, 1989; McCrea et al, 1999; Melender, 2006; Namey & Lyerly, 2010; Sjögren, 1997). A risk factor noted as a cause of postpartum PTSD in mothers after childbirth is feeling a loss of control over the birth (Beck, 2004; Olde et al., 2006). In addition, a feeling of being in control may be a factor contributing to a positive birthing experience, better perceived care in first-time mothers, and less fear and guilt (Preis et al., 2019). This literature review discusses the studies relating to control during childbirth, patient-centered care, and shackling of incarcerated women during childbirth.

Control Associated with a Positive Birth Experience

Understanding why women define their birth experience as positive and the factors associated with a positive birth experience is fundamental. Despite the cultural differences, one study found that throughout the world, what mattered most to women during childbirth was universal (Downe et al., 2018). This study was conducted by searching for qualitative data on women's childbirth beliefs, expectations, and values. Themes were derived and findings were assessed using GRADE-CERQual (Grading of Recommendations Assessment, Development, and Evaluation- Confidence in the Evidence from Reviews of Qualitative Research). The findings revealed:

> What mattered to most women was a positive experience that fulfilled or exceeded their prior personal and socio-cultural beliefs and expectations. This included giving birth to a healthy infant in a clinically and psychologically safe environment with practical and emotional support from birth companions, and

> competent, reassuring, kind clinical staff. Most wanted a physiological labor and birth, while acknowledging that birth can be unpredictable and frightening, and that they may need to 'go with the flow'. If intervention was needed or wanted, women wanted to retain a sense of personal achievement and control through active decision-making… Most healthy childbearing women want a positive birth experience. Safety and psychosocial wellbeing are equally valued (Downe et al, 2012, Results section).

In 1999, a quantitative study was conducted including 111 women who filled out a survey early in their pregnancies regarding information about background, personality, expectations, and parity. Hospital records were obtained as well as a survey 2 months after giving birth about the actual birth. Using logistics regression, five variables accounted for the birth experience. Involvement in the birth process, or perceived control, and midwife support were associated with a positive birth experience, while variables associated with a negative birth experience were anxiety, pain, and having a first child (Waldenström, 1999).

Melender (2006) explored what Finnish women perceived as a good childbirth by conducting 24 interviews. The participating women were aged 19 to 45, and interviews were conducted in a clinic or hospital setting post childbirth. Five main variables were revealed as important during childbirth to this group of women. These variables were: an unhurried atmosphere, normality, reasonable duration of labor, security, and control. These factors were found through identifying recurrent words and themes used by the women in the various interviews. In a pseudo-quantitative study conducted in England, 412 women answered an open-ended question following a questionnaire on the second

day post-delivery. These responses were reviewed to reveal recurrent themes. Control was found as one of the main themes women identified as relating to a positive birthing experience (Lavender et al., 1999). Butani and Hodnett (1980) conducted a study in which they asked women open-ended questions prompting them to explain what contributed to a positive birthing experience. Out of 50 women, 39 indicated that personal control was important to them during labor.

Possible predictors of a positive childbirth experience with less pain were found in one study to be knowledge, confidence, and anxiety. Thirty primiparous (first time pregnant) women were asked to attend prenatal classes and self-report three separate times throughout pregnancy and postpartum using multiple instruments. Two components from childbirth classes that were identified as predicting a positive birth experience were knowledge of childbirth and confidence in ability to control pain (Crowe & von Baeyer, 1989). A qualitative study was used to find themes from interviews from a group of women in Sweden who characterized their birth experiences as positive. These themes were experiencing own ability and strength and having trustful and supportive relationships. A subtheme of experiencing own ability and strength was “control gives ability to relax and let go” (Karlström et al., 2015, Results section). A takeaway of this research was recognizing that a positive birth experience is somewhat reliant on care given rather than just personal experience.

Loss of Control Associated with a Negative Birth Experience

The Childbirth Experience Questionnaire (CEQ) was developed to identify why first-time laboring women have negative experiences to help aid in future pregnancies and if further support and counseling may be needed. This questionnaire can also be used

to identify areas of caregiving that may need improvement. The pilot study of this questionnaire yielded four major dimensions of the childbirth experience: own capacity, perceived safety, professional support, and participation.

> The dimension that explained most of the variance, own capacity, included items regarding experienced emotions and sense of control, together with experienced labour pain… Labour pain is considered to be a very significant part of childbirth and experienced pain is likely to be strongly associated with the mother's sense of control in childbirth. *Own capacity* also has a component of self-efficacy (*I felt capable*) and coping (*I felt that I handled the situation well*) and thus likens the domain-specific Childbirth Self-efficacy Inventory scale (Berg et al., 2010, Discussion section).

This questionnaire aids in assessing childbirth from a multidimensional viewpoint, in order to better understand the complex experience of childbirth and in turn, improve next outcomes.

The prevalence and risk factors for a negative birth experienced were studied by a group of researchers in Sweden. Of the 2,541 women recruited for participation, 7% had a negative birth experience as defined by the researchers' questionnaires. The following risk factors were found to yield a negative birth experience: factors that could be remedied by caregivers (analgesia, time given to a woman's questions, and support during labor), factors related to the woman's social life (unwanted pregnancy and insufficient support from partner), unexpected medical problems (emergencies or operative deliveries and the infant being transferred to neonatal intensive care or

nursery), and factors related to the woman's feelings during labor (pain and lack of control) (Waldenström et al., 2004).

In Norway, a sample of 1,352 women were studied using a mixed methods design to describe their childbirth experience as entirely positive, entirely negative, entirely positive with negative elements, or entirely negative with positive elements. In this group, 21% rated a previous childbirth experience as negative. Among these women, three main themes were extracted from the qualitative portion of the study: complications for mother, child, or both; not being seen or heard; and an experience of pain or lack of control (Henrikson et al., 2017). In addition to contributing to a negative birth experience, loss of control during childbirth can lead to anxiety, even more so than the fear of pain (Sjögren, 1997). A perceived lack of control during childbirth to birthing women has also been noted as a significant risk factor in the development of postpartum PTSD (Beck, 2004; Olde et al., 2006).

Control Defined During Childbirth

Control is an important factor taken to account by women when labeling their birth experience as positive or negative. Additionally, control in childbirth must be defined by the women who deem it important. Through a concept analysis of control during childbirth, four attributes were found to be associated with the perception of control during childbirth. These attributes include decision-making, access to information, personal security, and physical functioning (Meyer, 2013). The researcher used Walker and Avant's (2019) method of concept analysis to do a comprehensive search of the literature on control in childbirth, narrow down the results to include only women's perceptions of control, exclude healthcare providers' perceptions of control, and

focus on the timeframe of labor and birth. After reviewing the collected data, 34 studies met inclusion criteria and used for the concept analysis (Meyer, 2013).

Namey and Lyerly (2010) attempted to analyze the meaning of control in the context of childbirth by interviewing 101 women who had previously given birth in the United States. The authors coded the interviews independently and qualitative coding software was used to analyze the transcriptions of the interviews. Control was mentioned spontaneously by 46% of the women. When not explicitly mentioned, the definition of control was solicited from the participants. Control for these women was found in five categories: self-determination, respect, personal security, attachment, and knowledge. The researchers noted that more important than control being narrowly defined, is the need to understand what control means for each individual woman.

Control and Pain During Childbirth

Natural childbirth is likely to be one of the most painful events in a woman's life (Brownridge, 1995). When ranked using the McGill Pain Questionnaire, childbirth was rated as one of the most intense pains out of those recorded with the questionnaire (Melzack et al., 1981). A research exploration was completed in Ireland to determine which variables were most influential on control of pain relief during labor. Of the 146 women who met criteria to participate (planned to not receive an epidural and expected to have a vaginal delivery), 100 women participated in the study to completion. The women were given a questionnaire rating their expectations of labor pain, anxiety caused by thinking about labor pain, and their anticipation of the severity of the labor pain. After analyzing the data, the most critical finding was a significant relationship between personal control variables and satisfaction with pain relief. This result indicates that being

in control and having the ability to participate in decision-making influence the satisfaction with pain relief during childbirth (McCrea & Wright, 1999). During this same study, the researchers conducted a separate analysis. The same women were given a questionnaire that had them rate constructs of personal control and pain relief, including control of information, control of decision-making, control of emotions, planning for control and compliance with professional care. Statistical analysis of multiple datasets was completed, and this retrospective study found that antenatal training for childbirth can affect how women govern their control in pain relief as well as pain intensity (McCrea et al., 2000). None of these 100 women received an epidural, and most had a partner for support.

Control and Childbirth Satisfaction

Control has been found to be an important aspect of measuring the quality of the birth from a mother's perspective, as well as the satisfaction with childbirth. Instruments in the form of questionnaires and surveys have been developed in order to put that information in a measurable format. The Labour Agentry Scale (LAS) was created in its earliest form to measure expectancies and experiences of control during childbirth and the influence of those expectations on physiological and psychological outcomes of birth (Hodnett & Simmons-Tropea, 1987). This instrument has been revised and verified in multiple languages and various formats to suit when the survey is distributed (during pregnancy, immediately following birth, weeks after birth, etc.) (Redman, 2003). The LAS only focuses on control during the childbirth experience and has been used in conjunction with other instruments to reveal the relationship of control and other factors during childbirth. Several thousand participants have been tested with the LAS; however,

the score associated with control and its relevance to women is uncertain (Blanch et al., 1998). A limitation of using instruments such as the LAS is that they may not translate the importance of control during childbirth to each individual woman, instead simply scoring the level of control felt.

The Mackey Childbirth Satisfaction Rating Scale (MCSRS) was developed by Marlene Mackey as a way to measure the satisfaction of childbirth. This 34-item scale measures childbirth satisfaction. The MCSRS has been used and tested for reliability and validity in the U.S. and other countries (Mas-Pons et al., 2011; Moudi & Tavousi, 2016). Mackey (2004) used this instrument, along with the LAS and the McGill Pain Questionnaire to reveal factors related to childbirth satisfaction in 60 women. Personal control was found to be statistically significant as a predictor of total childbirth satisfaction. In a study completed in Western Asia, 2,620 women were given the MCSRS and the LAS during their hospital stay. The women surveyed in this research were given a questionnaire about demographics, the MCSRS, the LAS, and a questionnaire about satisfaction with the birth room setting. Statistical analysis of the results indicated that perceived control during labor was a significant factor in satisfaction levels among the women (Kabakian-Khasholian et al., 2017). The MCSRS was used as the tool to measure satisfaction in an exploration on Belgian and Dutch women. To examine association of certain factors to childbirth satisfaction, the following instruments were used together: the MCSRS, Visual Analogue Scales, the Wijma Delivery Expectancy/Experience Questionnaire, and Pearlin and Schooler's mastery scale. Statistical analysis indicated that personal control improved satisfaction and lowered the scale at which pain affected the women's overall satisfaction score (Christiaens & Bracke, 2007). Control was found

again to ensure childbirth satisfaction in natural childbirth for women in Iran (Jafari et al., 2017).

A study completed by Humenick and Bugen (1981) indicated that the key to childbirth satisfaction was mastery. Thirty-seven primigravid women who were attending Lamaze classes with their husbands completed the Prenatal Attitude Towards Childbirth Participation Scale, scoring the degree to which they have perceived control over her childbirth and life in general. Participants also completed a Labor/Delivery Evaluation Scale, a Personal Attributes Questionnaire, a Childbirth Experience Rating scale, and the LAS. The results revealed that the scores on the Personal Attributes Questionnaire increased after childbirth and that the increase was associated with an increased perception of active participation and control based on the LAS (Humenick & Bugen, 1981).

The Perceived Control in Childbirth Scale and the Satisfaction with Childbirth Scale (Stevens et al., 2012) were developed to measure the correlation between perceived control during childbirth and satisfaction with childbirth. These two instruments were used in a recent study to examine the association between perceived control, satisfaction during childbirth, and postnatal phycological health. Control during childbirth was a significant factor influencing childbirth satisfaction and decreasing postnatal depressive symptoms (Townsend et al., 2020).

Control and Knowledge During Childbirth

Jane Savage conducted a phenomenological exploration of knowing in childbirth. Savage found that power (control during childbirth/knowledge control) emerged as a theme from the interviews. Of the nine women interviewed for this phenomenological

study, eight recounted dilemmas they encountered as a result of their knowledge. The expectant mothers explained how throughout their lives, from adolescence through adulthood, the amount of information given to them was controlled by others. When the mothers had information causing concerns in the care they were given, most were passive. Savage (2006) concluded that though past and current knowledge are empowering, they are not in cases where the environment is not viewed as receptive by the mother.

A study focused on childbirth education prior to birth noted that nearly half of the nulligravida (never having been pregnant) participants reported a lack of confidence in their own knowledge about pregnancy and childbirth. The researchers recommended that education on childbirth should happen long before first pregnancies, as knowledge and confidence in abilities aids in informed decision making (Clarke & Ferszt, 2012; Edmonds et al., 2015).

Patient Satisfaction and Patient-Centered Care

Patient satisfaction has become a priority in health care. Patient satisfaction guides practices, standards, and even affects profitability in healthcare settings (Richter & Muhlestein, 2017). Today in the U.S., patient-centered care receives a great amount of attention and is integrated into many healthcare systems, practices, and approaches to patient interactions. “Patient-centered care focuses on the patient and the individual’s particular healthcare needs. The goal of patient-centered health care is to empower patients to become active participants in their care” (Reynolds, 2009, p. 133). Patient-centered care goes beyond providing a patient with a positive experience in a time of health crisis to include prevention and follow-up through education as well as providing

resources that allow the patient to succeed in their healthcare goals. Unlike what we have seen in health care of the past, patients are expected and encouraged to participate in their care and make decisions based on what they feel is best for their expected outcomes. Additionally, patient-centered care takes into account the person as a whole, rather than simply a focus on the disease, problem, or a healthcare crisis (Reynolds, 2009). A patient's emotional well-being and satisfaction with the care received are of great importance in patient-centered care. This inclusion of patients in decision-making means the patient will have some control over their care and outcomes.

Another qualitative study was conducted with 15 Canadian women. The study explored how women created their birth plans and how any changes made to those plans impacted the experience of childbirth. In this study, specificities of the birth itself did not affect the experience as much as the women feeling in control and able to be part of the decision-making (Cook & Loomis, 2012).

Inmate Health Care and Shackling

Women who are pregnant and give birth while incarcerated are a part of the healthcare system. Incarcerated women are already susceptible to more health disparities simply because of their socioeconomic status prior to incarceration (Alemango, 2001; Dumant et al., 2012; Greenfield & Snell, 1999; Harlow, 1998; Henderson, 1998). Among the patient population of incarcerated women and their healthcare needs are specific pregnancy related issues that must be addressed. One of those specific pregnancy-related issues is shackling of pregnant, laboring, and postpartum women while incarcerated. While federal legislation has been passed limiting or prohibiting the use completely, shackling during childbirth is still a common practice in many states, and no standard is

in place to protect incarcerated women during this time (Sufrin et al., 2019). Shackling has been found to increase the risk of injury to childbearing women and their unborn children as well as detrimental to the mental health of incarcerated women (Committee on Health Care for Underserved Women [CHCUW], 2011). Many policies are up to interpretation and based on a woman's behavior, danger, and flight risk, which are evaluated and determined by the prisons and guards housing and transporting them.

The prison ethos follows these incarcerated women to the hospital. Use of shackling during childbirth has been implied as a way for these women to be dehumanized and further controlled by guards and prisons (Ocen, 2012). In the American medical society, patients have the right to the least restrictive form of restraint use and constant reevaluation of the need. However, the restraining of prisoners in a hospital setting, especially birthing women, are not awarded nearly as much attention, protection, or advocacy. Reevaluation of the need for handcuffs and shackles in a hospital is not reevaluated, as is required of any medical or physical restraint in a hospital setting ("Condition of Participation," 2006). The First Step Act (2018) was made law and includes prevention of shackling (e.g., handcuffs, restraints, straitjackets) pregnant incarcerated women during any point of their pregnancies and includes many other ways to better the life for incarcerated women. As the number of incarcerated women continues to increase, policies will also need continual changing. Until recently, incarcerated people were predominantly male. Because most incarcerated people were predominantly male, most current laws were created with a male population in mind (Sufrin, 2017).

Despite introduction of the First Step Act (2018), shackling of pregnant women during pregnancy, childbirth, and the postpartum period is still a common practice, and

research has noted the danger of doing so (Adashi & Dignam, 2014; Ocen, 2012). Though a federal law, many states still allow pregnant, laboring, and birthing women to be shackled. Some policies and state laws include specifying the use of waist shackles versus arm or leg shackling and how the arms may be shackled (e.g., behind the back or in front of the body). Some policies designate that the use is prohibited during labor, but these policies fail to clarify how the beginning of labor is defined. Without clarifications, incarcerated women are subject to actions being taken based on discretion rather than policy. Research on shackling has indicated that shackling can hinder the birthing process, but many incarcerated women are still subjected to these conditions.

Conclusion

Preferred childbirth methods vary greatly between families, cultures (Namujju et al., 2018), individuals (Fairbrother et al., 2012), and socioeconomic status (Milcent & Zbiri, 2018). Despite these differences, the literature review reveals that the perception of control during childbirth is significant and may influence the experience for a woman giving birth. Incarcerated women were not included in any of the literature on the perception of control during childbirth. Because incarcerated women have been excluded from statistical data (Sufrin et al., 2019), they have also not had a significant voice in the research completed on childbirth. No results of the perception of control or the meaning assigned to that perception from incarcerated women during childbirth were found in the literature review. The definition and significance of control may not be the same for incarcerated women as it is for non-incarcerated women. A more complete understanding of the subject will come from including incarcerated women. This study adds to the

existing body of knowledge on the perception of control during childbirth and aids in bettering the care provided to incarcerated women during childbirth.

CHAPTER III - METHODOLOGY

Introduction

Common in every pregnant woman is the expectation of control (Rich, 1973). Control has been proven to play a significant role in the satisfaction of childbirth to birthing women and a factor associated with a positive birth experience (Cook & Loomis, 2012; Crowe & von Baeyer, 1989; McCrea, et al., 1999; Melender, 2006; Namey & Lyerly, 2010; Sjögren, 1997). Qualitative research is a method that can be used to explore individual circumstances and factors contributing to a sense of perceived control and should include minority and vulnerable populations. A qualitative design was used for this study, utilizing semi-structured interviews with a convenience sample of previously incarcerated women over the age of 18 who delivered a viable infant while incarcerated. A descriptive qualitative design was utilized to identify recurrent themes in the interviews.

Design

A qualitative descriptive design was used in this research to illustrate women's experiences of childbirth and the perceived control, or lack thereof, they felt during their childbirth while incarcerated.

> The goal of qualitative descriptive studies is a comprehensive summarization, in everyday terms, of specific events experienced by individuals or groups of individuals. To some researchers, such a qualitative design category does not exist. Unfortunately, this has forced other researchers, especially novices to the methods of qualitative research to feel they have to defend their research approach by giving it 'epistemological credibility.' This has led to the labeling of many

> research studies as phenomenological, grounded theory, or ethnography, when in fact these studies failed to meet the requirements of such qualitative approaches (Lambert & Lambert, 2012, p. 255).

This research was not conducted to explain phenomena, but rather to gather information on an understudied group, using knowledge from heavily researched groups. The hope was that gathering this data will direct future research and continue improve childbirth outcomes during incarceration. The researcher questioned if participants felt they had a positive or negative birth experience, and if perceived control was important. Prior research has revealed that for non-incarcerated women in most groups studied, control and the perception of control are significant and important for a birthing woman. Control is also a significant factor in if the birth is perceived as negative or positive by the birthing woman.

Data Collection

Prior to any research conduction, Institutional Review Board (IRB) approval was obtained through submission of the proposed study with all details, including the planned interview questions and consent form (Protocol number: IRB-18-95; see Appendix D). Once approval was obtained, the researcher initiated the process of recruiting participants. Social media, email, and word of mouth were used to gather participants. The researcher reached out to multiple government organizations as well as rehabilitation facilities and residential housing for previously incarcerated women including: Alabama Prison Birth Project, Alabama Bureau of Pardon and Paroles, Florida Department of Corrections Probation Services, Escambia County Health Department, Louisiana Parole Office, Escambia County Parole Office, Slidell Louisiana City Court Parole Office,

Mississippi Department of Corrections, The Friendship Connection, and Crossroads Ministries. None of these organizations responded to emails and could not give information when contacted by telephone. An email address and phone number were included on social media posts for participants to contact the researcher. When a potential participant was suggested through word of mouth, the researcher had the person of contact ask if the researcher could connect with the candidate through an email, social media message, letter, or telephone number. With permission, the researcher then sent a message to that individual asking if they would be interested in participating. An email address specifically for this study was created and used for correspondence with potential research participants. The researcher's personal cell phone as well as personal computer were used. All devices and the email address are locked, requiring a password for use and to access participants' information.

The information sent to potential participants included an explanation of the study. Willing participants were asked if they would prefer to participate using a recorded telephone call or a face-to-face interview. All participants chose a recorded telephone call. Interviews were recorded using the voice/telephone recording feature on a private, password-protected Zoom account. Each participant was given a pseudonym for documentation chosen at random by the researcher. Research participants were all read the informed consent prior to the recorded interview and gave verbal consent before beginning the interview process and before recording. Semi-structured, reflective interviews were conducted individually to explore in a more in-depth manner the realities and experiences of women who have given birth while imprisoned and to explore personal perception and significance of control. An interview guide (see Appendix C)

was used to lead the conversation with allowance for discussion and deviation. The interview questions were created by the researcher based on available research and factors identified as significant to birthing women such as: safety, support, choice, and control. The researcher encouraged participants to elaborate whenever they desired and contribute information they deemed relevant. The researcher bracketed preconceived notions or assumptions for the participants to reveal their own truths and realities. Personal biases of the researcher include being a labor and delivery nurse, not having any children or pregnancies, and being a Caucasian female with no history of incarceration. When asked by the participant, the researcher answered honestly about these biases.

Sample

A convenience sample of 6 free (non-incarcerated) women in the U.S. who have given birth while incarcerated agreed to participate in this research. Criteria for participation included women previously held in a federal or state facility, over 18 years of age who delivered a viable child while incarcerated in the U.S. Participants were all English-speaking, and none of the participants were pregnant or incarcerated at the time of the interviews. Men were excluded from this study. Participants who did not verbalize understanding of the study were removed.

Rigor and Validity

Reliability, replication, and validity are tenants associated with rigor in quantitative studies (Maher, et al., 2018). Unlike the ways in which validity are recognized in quantitative studies, rigor and trustworthiness constitutes validity for qualitative research (Munhall, 2012). In order to ensure trustworthiness, the research should satisfy four criteria: credibility, transferability, dependability, and confirmability

(Guba & Lincoln, 1989). Creswell (2007), built on this criterion by identifying eight strategies for confirming rigor, stating that at least two of these strategies should be met: prolonged engagement, persistent observation, triangulation, peer-review or debriefing, negative case analysis, reflexivity, member-checking, thick description, and external audits.

The researcher ensured credibility using the strategies described by Guba and Lincoln (1989). The researcher utilized various institutional advisors for peer debriefing to establish the best research path for the intended study. This debriefing was done continually throughout the research process. Persistent observation of childbirth also helped the researcher understand the limitations and power of women giving birth. The researcher is a labor and delivery nurse and has spent several years assisting various populations in childbirth. Triangulation was performed through an iterative process by the researcher taking notes during interviews, reviewing transcriptions, and relistening to the interviews multiple times.

The researcher ensured transferability by keeping all documents and reasons for inclusion saved on the researcher's personal locked computer. Each interview guide, consent form, peer-reviewed document, and transcriptions could be used by other researchers to replicate this research. To practice confirmability, this research has an audit trail and all decisions related to the research development and analysis are documented on the researchers personal locked computer and notebooks. Member-checking was offered to the participants. Participants were asked if they would like to review the transcriptions or data gathered from the research. All participants declined the offer.

Data Analysis

According to Braun and Clarke (2006), thematic analysis can be a foundational method for qualitative analysis and is argued to be a method in its own right, rather than an assistance to other analysis (Braun and Clarke, 2006; Thorne, 2000). During interview sessions, each was recorded using a meeting and recording website called Zoom. The researcher created a personal, password protected Zoom account on which each interview was recorded separately. The researcher made notes while conducting the interview and immediately following, noting reactions or hesitations. The total amount of time allotted for each interview depended on participants' available time, verboseness of participants, and unforeseen events that arose during the interview. Each interview was transcribed verbatim. When all were transcribed and reviewed to ensure accurate transcription, hand coding and multiple readings and evaluations were performed to find significant and recurring themes (Creswell, 2014).

Each interview was transcribed verbatim by the researcher and listened to multiple times to verify accurate transcription. The interviews were then coded for similarities and themes. The researcher was careful not to make inferences about the population as a whole from any similarities found in the cases studied. After the researcher performed initial coding, a peer reviewer, an experienced qualitative researcher, reviewed the transcriptions and verified or added to the coding process by providing their own coding and insight. These themes were reviewed in depth through an iterative process. Similar codes were found between the researcher and peer-reviewer. Codes that were found to be demographic information were removed. Similar codes were

discovered and from the coding, two major themes were derived: Being Controlled and Compulsory Support/Attended Solitude.

Limitations and Ethical Considerations

Prior to conducting any research, the IRB granted approval for the study (IRB-18-95). After approval was granted and changes made based on the suggestions of the review board, the researcher recruited participants. One significant challenge this research faced was finding participants. Difficulty in locating women who have given birth while in prison and who were also willing to tell their story was a challenge. Potential participants were few and far between, limiting the sample size. Despite the small sample size, data saturation was reached, and participants gave important information.

The researcher ensured that the women did not feel coerced and were able to withdraw from the research at any point. Participants needed to have the opportunity to make an autonomous decision and not be pregnant at the time of the interview. Participants remained confidential on all documents associated with the research except for informed consent documentation. Childbirth is an extremely personal and sensitive topic that may bring about discomfort to participants. Participants were informed that they did not have to answer any question that generated discomfort or distress, and the participants could withdraw from the research study at any time. The researcher was responsible for presenting the subjects' stories truthfully, accurately, and respectfully. Participants received a $25 gift card for completion of participation.

Summary

Research on the perception of control in women during childbirth that includes all populations will broaden the understanding and ability to provide excellent care. While research exists on the perception of control to child-birthing women, this study adds to the body of knowledge and support research that has already been conducted on this topic, including a population that has mostly been excluded. Control has been found in many studies to be significant to birthing women. Including the population of incarcerated women in this research revealed significance in various settings. Policy changes are under consideration now to completely eliminate shackling of pregnant women while incarcerated, which may later create an overall better experience for childbirth from the perspective of incarcerated women. This research revealed the stories of women who have experienced childbirth as incarcerated individuals. The findings may contribute to policy change in the future, or at the very least, aid and give better care to incarcerated individuals.

A descriptive qualitative approach was used for this research to describe the experience as it was perceived by the women who experienced it. Discussion and research on the laws in place to protect incarcerated women are a positive first step, but going directly to the women who have experience with current policies will help make changes that will benefit these populations and those to come. This study was completed to add to the body of knowledge on the subject of control as it relates to childbirth. This study also proposes policy changes to improve the way incarcerated women give birth and improve their lives, their family's lives, and the lives of the infants born to incarcerated women.

CHAPTER IV – FINDINGS

Introduction

The purpose of this study was to examine the maternal perception of control during childbirth of women who have given birth while incarcerated. A sample of four, previously incarcerated women aged 26 to 59, who gave birth while incarcerated participated in this research. Participants were asked a series of questions in an open-ended form to describe their journey of giving birth while incarcerated and their feelings and significance assigned to the word control during that experience. They were allowed to provide as much information as they wanted, and the interview guide served as more of a discussion template for the interview, rather than a strict questionnaire.

Control for childbearing women who are incarcerated has a vastly different meaning from those who are giving birth outside of incarceration. Research has revealed that non-incarcerated women who have given birth generally found an important factor for birth or a factor associated with a successful birth to be control (Butani & Hodnett, 1980; Humenick & Bugen, 1981). These women wanted a sense of being in control of the situation and decision making. Control was important and meaningful to these women and associated with success. To incarcerated women, control is meaningful in a much different way. Participants described control from a perspective of captivity, rather than authority.

Sample

Six women, aged 26 to 59, agreed to participate in this study. All of the participants were obtained through word of mouth and social media. Inclusion criteria included: being English-speaking, being over the age of 18, not being pregnant at the

time of the interview, not being incarcerated at the time of the interview, and having given birth to a viable infant while incarcerated. Two of the women did not complete the study, leaving the convenience sample size at four women. One potential participant never responded after the initial agreement to participate and multiple attempts to reach her. Another potential participant agreed to participate in person and was contacted by telephone; however, her behavior was erratic, and her understanding of the research and participation was questionable. These participants were excluded from the research.

This study included women with various backgrounds. Many factors were not discussed in the research or results, such as: race, sentence, severity of the crime, year in which the crime was committed, socioeconomic status, gravidity of the mother, location in which the mother gave birth, state laws where each mother gave birth, prior medical conditions of the women, and sexual orientation. These factors all had the potential to impact the participants' experiences. For example, a certain gravidity was not part of the inclusion criteria, but viability of the newborn was required. Gravidity at the time of childbirth while incarcerated will affect the perception of events, but undoubtedly, delivering a non-viable newborn would drastically change the direction of the study.

Analysis of Data

Each interview was reviewed and analyzed multiple times. The recorded interview was transcribed and reviewed for accuracy. After each interview, the researcher reviewed notes taken during the interview and more notes were added after about anything relevant the researcher remembered. Codes were identified by the researcher and put in categories. Categories were labeled as: demographic data, gravidity and parity, support, shackling, control, importance, and control meaning. A peer reviewer was asked

to analyze the transcripts and coding comments were made in the margins of each transcript. The peer-reviewed codes were compared to the researcher's codes and combined into a separate document. Similarities were found for some codes and categories. Demographic data was put into a separate category. Each category was reviewed for repetitive words and phrases. The categories were narrowed down to the most prevalent and themes were derived. The themes were reviewed multiple times through an iterative process and themes relevant to the perception of control were named: Being Controlled and Compulsory Support/Attended Solitude.

Being Controlled

The participants were asked a series of questions about their pregnancy and childbirth journeys while incarcerated. The interviews opened by allowing the participant to describe their story in their own words and tell the researcher about themselves. They were then asked questions about the details of their childbirth experience such as if they were allowed to have a support person, or were they shackled at any point during their labor and delivery. All participants were incredibly open about their experiences and willing to answer any question they were asked. Throughout each interview, when asked what control meant to them, the participants defined control in a similar manner. The participants defined the word control as being controlled.

These interviews were performed through the lenses of incarceration, as that is what most of the questions were about. Unsurprisingly, the participants answered the questions about control in that manner. Most of the participants described control as being told what to do or how and when to do it, rather than using statements of authority or statements of ownership over their actions and decisions. The participants described

being controlled themselves, rather than controlling their circumstances or outcomes. One participant described control in these words:

> When you're told when you get up. When somebody has say over everything that you do. They can never have control over what you think or what you feel. They have control over when you're going to get up, when you can go to the bathroom, when you go to bed. You know, when you have to do 'this,' when you have to do 'that.' I mean, that's control. When you have no free will of your own except your own thoughts.

Another participant said, "When somebody's telling you what to do constantly and somebody wants you to do it right then and now; then and there." Similarly, what control meant for one woman was, "Jail. Control? Just somebody trying to tell you what to do or make you do something you don't want to do." The last participant simply said she could not tell me what control meant to her, as she did not feel like she had control over anything. All of the women answered what control meant to them as if they were still imprisoned. Not one woman described control as being in control of their situations. This study may have had different answers had the researcher asked the women to define control first, prior to any questions about incarceration.

When the participants were asked if they felt like they were in control at any point during their labor or delivery, 3 of the 4 women answered immediately with, "no." One participant responded with, "No, not at all. I was on the complete control of what the hospital said, number one…They were being cool with it. I mean, they didn't judge at all, whatsoever. But I was simply under the control of what the procedures were for (the prison)." Another participant responded with, "No. No, I couldn't even get my son

circumcised, because I wasn't at the hospital, because they released me back to the jail." Almost all decision-making, access to information, and physical functioning was unavailable to the participants, leaving their ability to feel any semblance of being in control, obliterated.

Compulsory Support/Attended Solitude

Many jail and prison facilities are located far from the families of incarcerated women. Even when they are close, visitation is rarely allowed during childbirth. None of the women were able to have family or have any support system of their choosing in attendance of the birth or after. The fathers of the infants were not present for any of the four women during birth. Three of the four women were explicitly banned from contacting family or any support person when they were transferred to the hospital for the delivery of their infants. One participant was too far from family, despite being allowed to contact them, so they were unable to be with her. Two of the four women described incidents of finding ways around the rules about not contacting family for the delivery of their infants. The two women set up a daily phone call with a family member for the same time each day. The family member would know when the inmate was possibly in the hospital when there was no phone call.

Despite not having family in attendance, the women were never alone. A guard was in each woman's room at all times, even for the delivery of the infants. Some of the women found comfort in certain guards or some of the hospital staff, but comfort was dependent on the shift and the circumstance. Mostly, the women felt supported by the guards or nurses when they were breaking the rules or violating policy. One participant recounted the following event when asked if she felt supported:

> The only time I felt supported, besides the other women that I was incarcerated with in my dorm, ones that I got to know, you know, because you live with them every day, was one guard, Mrs. Jamie, who was on third shift. Because she would always hold the baby and, you know, just do anything and everything. You know, there's just one or two motherly types. Other than that, no…She brought me to the desk to look at the flowers; against protocol, I'm sure.

While some of the guards and nurses were comforting and supportive, they were assigned, not chosen by the participant.

When one participant was asked if she felt supported, she responded with the following: "No, I was by myself. I felt like I was alone. My first child was way down here in Miami. I don't know anybody, and I just felt like I was by myself." When asked if she had a positive or negative birth experience, she said, "I would say both positive because I had someone there. I could have really been by myself. Negative because I got myself into this situation and it was just something I had to go through."

One woman, who's infant went to the neonatal intensive care unit (NICU) after a cesarean section, was shackled less than 24 hours after her surgery. She received general anesthesia for the procedure due to an emergency situation requiring quick action. She was unable to witness her infant being born. Per her prison facility's policy, she was not allowed to see or have pictures of her newborn. The guard with her that day made her own rules. "The officer I had that day, she was very sweet. When you're incarcerated, you're not allowed to have pictures of the baby. The officers aren't allowed to take pictures for you. The officer I had with me took pictures for me." Because the infant went to the NICU, the participant was unable to spend her already limited time with him. She

was required to be in her room for two hours while the guards did their change of shifts. With the already limited time, two hours each shift was substantial. This participant described an experience with one of her nurses.

> But because I had a c-section, I was in my own room and he was in the NICU. So, whenever I was in his room, I don't think they were supposed to do it, but the hospital allowed me to have visitors up there with him. So my aunt was able to see him and she was able to bring up his first outfit for me to put him in. But at first, he had a breathing tube; he had a feeding tube. But I was able to put his first outfit on him. I was in the room with the baby and one of the officers and I just thought it was a nurse coming in, and the officer was like, 'And who are you?' And I turned around and my aunt was standing in the door and I'm like, 'Oh my god…You're about to go to jail." But Megan (NICU nurse) like let her sneak in on purpose."

These small acts of defiance by the nurses and the guards left lasting impressions on the participants and were some of the only ways participants felt supported during such a tumultuous time.

Summary

The concept analysis of control as it relates to childbirth revealed four attributes associated with the perception of control during childbirth. These attributes include decision-making, access to information, personal security, and physical functioning (Meyer, 2013). The women interviewed for this study had limited decision-making ability, little access to information, security in the form of guards, and physical functioning restricted by shackles and freedom. This research was guided by the concept

of self-efficacy from Bandura's (1977) social cognitive theory. The four main sources of influence of self-efficacy are through mastery of one's experiences, vicarious experiences of social models, social persuasion, and their somatic and emotional states. If these sources of influence are the criterion for self-efficacy of women giving birth while incarcerated, it is no surprise that the women felt a lack of control or power over their childbirth.

CHAPTER V – CONCLUSIONS

Introduction

The purpose of this descriptive qualitative study was to examine the maternal perception of control during childbirth of women who have given birth while incarcerated. Data were obtained through semi-structured interviews with four, previously incarcerated women, over the age of 18, who delivered a viable newborn while incarcerated. The focus was on analyzing the perception of control to individual women who have given birth while incarcerated. Four women participated in the study to completion. Analysis of the transcribed interviews revealed two major themes: Being Controlled and Compulsory Support/Attended Solitude.

Limitations

Several limitations existed for this study. Finding participants who met the inclusion criteria proved difficult. A lower response rate than desired was obtained. The researcher expected a small number of participants given the population that was studied. Many reasons accounted for this difficulty. First, many agencies that the researcher asked for assistance were not allowed to give information about people in their programs. These agencies included parole officers and offices, rehabilitation facilities, health departments, charitable organizations, and outreach programs. Some of these organizations and institutions include the Alabama Prison Birth Project, parole and probation offices for the state of and cities in Louisiana, Florida, Mississippi, and Alabama, The Friendship Connection, Crossroads Ministries, and health departments in Alabama and Florida. When contacted by phone, no one was able to provide any information for potential participants. When contacted by email, no one responded. Similarly, the jail and prison

facilities were unable to provide the researcher with specific numbers of previously incarcerated pregnant women for any given timeframe.

Another limitation was that some potential participants had difficulty focusing on conversations and erratic behavior deemed the interview process too difficult and incoherent. Those participants were removed from the study, decreasing the sample size. All participants gave birth while incarcerated in different facilities in Florida, Kentucky, and Louisiana. Each state has varying laws in place, and each facility has different guidelines and policies that may or may not align with the standards developed by the NCCHC (NCCHC, 2018). Additionally, all participants delivered in different hospitals with different policies and procedures.

A perception of control for women giving birth has been found to be associated with a positive birth experience and is important for patient satisfaction and success after birth. Pregnant women in prison have the same desires and needs, if not more, than any woman before, during, and after childbirth. Incarcerated women may have some voice in their care but not nearly to the extent that is expected and encouraged by the rest of society.

The U.S. Constitutional Amendment VIII expresses that prisoners have a constitutional right to adequate health care, prohibiting cruel and unusual punishment, including neglecting healthcare needs and concerns. Despite prisoners having the right to health care, there is no true standardization. Health care is a requirement, but the quality health care varies across the U.S., and some are receiving care that greatly exceeds others (Sufrin, 2017).

Women giving birth while incarcerated have to consider situations that the majority of the population may never encounter. With little control over their actions in daily life, they could feel an even greater lack of control in their health care. Many incarcerated women are not provided the same educational opportunities as the free population. For the most part, the free population has a choice in when, where, and by whom they are seen and cared for. Similarly, planning birth scenarios have become a norm, and many factors are considered while a woman is pregnant and planning the birth of a child. Women can now choose to have a home birth with a midwife, hospital birth with or without pain medicine, scheduled births, inductions, or any number of options. Being able to plan parts of labor and delivery may help women feel prepared and less fearful. Incarcerated women may not have these options.

Results and Theoretical Framework

The theoretical framework guiding this research was the concept of self-efficacy from the social cognitive theory. According to Bandura, there are four main sources of influence on an individual's beliefs about their efficacy. These four sources of influence are: through mastery of one's experiences, vicarious experiences of social models, social persuasion, and their somatic and emotional states (Bandura, 1977). In this study, self-efficacy is having perceived control during childbirth. Badura's research on self-efficacy implies that external and intrinsic factors will affect the perception of control. The ability for incarcerated women to achieve a perception of control will be affected by external and intrinsic factors. Previous research has revealed that self-efficacy expectancies were significantly correlated with childbirth fears. The high fear group in this research found losing control to be one of the most common fears. The women studied in this research

were predominantly white, middle class, well-educated women (Lowe, 2009). Incarcerated women are a minority group, generally under-educated, and usually have a low socioeconomic status. The participants in this study had little to no support of their choosing, emotional stress from giving birth while incarcerated, and limited physical freedom.

Implications for Nursing

Nurses are the liaisons between patients and care teams. Nurses not only carry out orders, but also coordinate care and provide individualized considerations to treatment plans. Because of the close observation of nurses to their patients, nurses are often consulted about the best decisions for each patient. Incarcerated women who are pregnant and giving birth will be cared for by nurses. Increasing knowledge about the needs of incarcerated women will broaden nurses' competency. Every woman deserves a birth experience with informed and compassionate caregivers. Nurses are taught to treat all patients with respect and provide the best care, despite differences. Nursing programs often incorporate education about treating people from varying cultures and backgrounds. Incarcerated women have their own unique culture, and if nurses understand that caring for this particular culture will need special care, they will be able to provide more personalized and better care.

Knowing current healthcare policies will allow nurses to confidently address issues that arise with patients' rights. With understanding current policies, it is also important that nurses understand how incarcerated women feel about childbirth and the power dynamics that exist. Having a better understanding of the perception of control during childbirth for incarcerated women will provide nurses with a more dynamic

skillset. Nurses will be able to address the needs of incarcerated women better and improve outcomes and experiences. Nursing is always evolving, and patient satisfaction has become the forefront in that evolution (Richter & Muhlestein, 2017). Nurses will be aware that their presence in a delivery room may be one of the few comforts and supports they have during that time, which can make a huge impact on the experience of the patient.

Implications for Research

The purpose of this qualitative study was to examine the maternal perception of control during childbirth of women who have given birth while incarcerated. Further research on the perception of control for incarcerated women during childbirth is warranted. Expanding the interview to include specific population groups and in various settings would add value. Race, socioeconomic status prior to incarceration, abuse prior to incarceration, age, facilities where women give birth, birth outcomes, and recidivism after childbirth during incarceration are all important aspects that influence a perception of control. The multifaceted nature of circumstances contribute to incarceration and the perception of control. Future research will be able to use public data gathered from the Bureau of Justice on pregnancy outcomes of incarcerated women that was not available at this time of this study. Knowing what is important during childbirth for incarcerated women will allow researchers to create population-specific instruments to put a value on significance of factors related to childbirth.

Implications for Policy

This research can influence existing systems by offering insight into the perceptions of control for incarcerated women giving birth. Further research is needed

about the lasting effects of the perception of control for incarcerated women. Childbirth while incarcerated can leave a long-term impression on the lives of the mother, child, and family members. To better the outcomes of those lives, policies need to change for the better. Certain federal policies on women's health during incarceration, including pregnancy, are changing. Studying the perspectives and needs of incarcerated women will ensure the changes that are being made are the best for the population.

Criticism may arise from those who believe that incarcerated individuals have lost their rights to certain choices. Childbirth is a life-altering experience that has lasting impacts on individuals and society as a whole. It is not an experience that someone can redo. Basic health care rights are guaranteed to prisoners, but a positive or healthy emotional experience is not guaranteed. This research adds to the existing knowledge on the perception of control and needs of women during childbirth.

Summary

This study provides strong evidence that the perception of control for women who have given birth while incarcerated is different than non-incarcerated women. Not only is the perception different, but the meaning assigned to that perception varies. Using semi-structured interviews of four women, this descriptive qualitative analysis found differences from research that has previously been done. The major themes found in this study were Being Controlled and Compulsory Support/Attended Solitude. Future research can use these themes and perspectives to further knowledge on control during childbirth and improve health care.

APPENDIX A – Informed Consent

Informed Consent

Thank you for considering joining this research project. The purpose of this study is to explore the experiences and feelings of control of women during childbirth while incarcerated. These interviews will take a varying amount of time and will be recorded using a computerized or handheld recording device with no video. You must be 18 years of age or older to participate and have delivered a baby while in jail or prison. Participation is completely voluntary and at any point during this research, you may withdraw and your information will be destroyed immediately. If you decide to withdraw from this research, there are no consequences and the researcher will understand and appreciate the time you have taken. Participation will remain confidential and only the researcher completing the study will have access to your name.

There are no known risks for participating in this research other than possible discomfort answering some questions.

A few questions before we begin the interview:

- What is your current age? If 18 years of age or older, this interview may continue.
- Did you give birth while in jail or prison? If yes, this interview may continue.
- Are you currently pregnant? If no, this interview may continue.
- Do you understand your right to withdraw at any point during this research? If yes, this interview may continue.
- Do you consent to participate in this research at this time? If yes, this interview may continue.

Signature of Participant Date and Time

_____ _____

Signature of Researcher Date and Time

_____ _____

APPENDIX B – Interview Guide

At this time we will begin the interview. Please feel free to elaborate and add information where you see necessary.

- Let's begin by you telling me about yourself and a little bit about your background and your story
- Did you know you were pregnant before you were incarcerated? If not, were you able to contact a doctor immediately after suspecting you were pregnant?
- Was this your first pregnancy?
- Did you receive any education or counseling about pregnancy and birth while in prison?
- Was a doctor assigned to you or did you have the ability to choose a doctor?
- How often did you see the doctor?
- Were you able to see him/her more often if you requested?
- Did you have a birth plan or know what to expect when you went into labor?
- When you went into labor, were you immediately taken to a hospital, were you seen by a doctor at your facility, or did you have to wait?
- Were you shackled at any point during your labor or delivery?
- Where did you give birth?
- If you wanted to, were you able to contact any family when you went into labor?
- Did you feel supported?
- Were you allowed to make any decisions during your labor and delivery?
- Can you tell me what the word "control" means to you?
- Did you feel like you were in control during your labor or delivery?
- Do you think being in control was important to you at the time?
- Did you feel safe during your labor and delivery, physically and emotionally?
- Who was with you in the delivery and were you able to have family with you if you requested?

- How long did you get to spend with your baby?
- Who took care of your baby when you went back?
- Do you feel like you had a positive or negative birth experience? Why?
- Do you have anything you would like to tell me more about?

APPENDIX C – IRB Approval Letters

Office *of*
Research Integrity

THE UNIVERSITY OF SOUTHERN MISSISSIPPI

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NOTICE OF RENEWAL

The University of Southern Mississippi's Office of Research Integrity has received the notice of renewal for your submission:

PROTOCOL NUMBER: IRB-18-95
PROJECT TITLE: Childbirth Behind Bars: A Deductive Content Analysis of the Maternal Perception of Control in Women Who Have Given Birth While Incarcerated
SCHOOL/PROGRAM: School of LANP, Leadership & Advanced Nursing
RESEARCHER(S): Lorin Scroggs, Jennifer Story

IRB COMMITTEE ACTION: Approved

In accordance with Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy your prior reviewed submission has been renewed. From this time of this renewal your study is approved for twelve months.

PERIOD OF APPROVAL: March 3, 2020 - March 3, 2021

Sincerely,
Office of Research Integrity

Office *of*
Research Integrity

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NOTICE OF INSTITUTIONAL REVIEW BOARD ACTION

The project below has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services regulations (45 CFR Part 46), and University Policy to ensure:

- The risks to subjects are minimized and reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered involving risks to subjects must be reported immediately. Problems should be reported to ORI via the Incident template on Cayuse IRB.
- The period of approval is twelve months. An application for renewal must be submitted for projects exceeding twelve months.

PROTOCOL NUMBER: IRB-18-95
PROJECT TITLE: Childbirth Behind Bars: A Deductive Content Analysis of the Maternal Perception of Control in Women Who Have Given Birth While Incarcerated
SCHOOL/PROGRAM: School of LANP, Leadership & Advanced Nursing
RESEARCHER(S): Lorin Scroggs, Jennifer Story

IRB COMMITTEE ACTION: Approved
CATEGORY: Expedited
6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

PERIOD OF APPROVAL: March 7, 2019 to March 6, 2020

Donald Sacco Jr.

Donald Sacco, Ph.D.
Institutional Review Board Chairperson

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