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The Relationship Between Self-Efficacy and Informed Decision-Making on Primiparous Women During the Birthing Process

Morgan R. Fillipo
Dominican University of California

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Dominican University of California

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Abstract

Childbirth is a very intense and vulnerable experience, especially for first-time mothers. Across the globe, the prevalence of traumatic and unsatisfying births has become an increasingly troublesome issue for women. There is extensive evidence of maltreatment, and a large portion of the problem has to do with the client's medical team. To combat this dilemma, the best course of action would be to prepare women for this possibility by increasing the client's self-efficacy and decision-making abilities. Self-efficacy, also known as confidence in one's skills, is an important trait to have when it comes to patients being able to advocate for themselves. Since it is most common for first-time mothers to face these problems in the hospital, it would be more beneficial to become more educated in pregnancy, thus creating higher confidence. It will be more likely for clients to have an easier time making choices for themselves and their care due to the development of preparedness through proper education. Education and collaboration are some of the most effective ways to increase self-efficacy. It has been found that there is a gap in the research to support the positive relationship between education implementation and self-efficacy so this will be the focal point.

This thesis will focus on displaying the prevalence of obstetric maltreatment and why it is such an important problem in our society. There will be further divulging into solutions that have been implemented to increase self-efficacy, thus also increasing informed decision-making in primiparous women. Topics will all be analyzed more deeply in a literature review where conclusions will be drawn about the main topic overall. Afterward, a study proposal will be formulated in relation to the literature review that will describe how educational methods can improve self-efficacy and its effectiveness in creating high birth satisfaction rates in first time mothers.

Background

Pregnant people are a highly vulnerable population in the hospital setting. Labor and birth are such intense experiences and yet these patients also happen to be some of the most frequently mistreated populations on the floor. Whether it be a non-consensual vaginal exam or coercing a woman into an unwanted procedure, violence against pregnant patients is becoming a more frequent phenomenon. According to recent reports, “about 1 in 3 women will experience some form of birth trauma.” (Huschke, 2021). To combat this, several resources have been made available for expectant mothers to learn and gain confidence in their abilities to take control of their birth plans. But truly, how effective are these strategies in terms of contributing to higher satisfactory births? This thesis will analyze the relationship between self-efficacy and decision-making to positive birth outcomes. This thesis will investigate some real-life solutions and how real patients felt about their implementation. We will also look further into how this can be improved, making a research proposal so that we can work towards increasing rates of high birth satisfaction. Once answers have been drawn out, conclusions will be presented all with the utilization of several pieces of literature.

Introduction

Imagine, you have just gone into labor and are mere hours away from becoming a new mother. You go to the hospital where you get settled into a room, excitedly awaiting the arrival of your new bundle of joy. Some time has passed, and your cervix has progressed to 5cm of dilation and is effaced at around 70%. Suddenly, your nurse comes into the room with your OBGYN doctor (Obstetrics and Gynecology) stating that your labor has stalled and that you need to have a C-section because things are not advancing quickly enough. This is troubling information, as you have planned to have a medicated vaginal birth and want no major surgical interventions.

You express your wishes to the provider. They double down and insist that you have a C-section asserting that first-time moms have C-sections all the time and it is a perfectly safe procedure. They say that you are overreacting, and it is foolish to be worried. Although you do not want to have this done, the medical team prepares for you to go to the operating room and deliver your baby.

In this situation, healthcare professionals are using tactics such as using biased or insufficient information, as well as emotional blackmail, to coerce the client into getting an unnecessary medical procedure. According to Merriam-Webster, emotional blackmail is also known as an attempt to control someone with whom one has an emotional connection by tactics that make the person feel guilty or upset. This scenario may sound uncommon however, it happens more often than one would think. Over the years, several women have, "[reported] feeling disrespected and ignored during labor and birth in maternity care settings where they are treated as objects rather than active subjects by medical professionals." (Huschke, 2021). This is a serious issue that is continuing to rise across the world, putting numerous mothers, families, and babies at risk for dangerous complications.

To decrease these high rates of birth dissatisfaction and trauma, we must continue to utilize key components including self-efficacy, and properly informed decision-making to be taught to first-time mothers. Promoting self-efficacy can lead to higher confidence and capabilities in the client. At the same time, informed decision-making helps the client to learn and make choices based on accurate information. These factors can help mothers control their birth plans and feel more comfortable with their situation.

Problem Statement

There are large numbers of women who are undergoing obstetric procedures such as c-sections, repeat c-sections, and early elective deliveries when they may not be medically indicated; practices that can result in a higher rate of complications for both women and their babies. This is known as “obstetric violence” where pregnant individuals are subjected to abusive encounters including healthcare professionals, most typically during birth. To fight this, one of the best things that can be done is for patients to advocate for themselves in hospital settings. Labor and childbirth self-efficacy is an essential element that can help to promote these critical components so that higher birth experience satisfaction can be achieved. Patients have the right to put trust in their medical team, but it is ideal to ensure that they are comfortable with themselves, minimizing feelings of fear and uncertainty as much as possible before having healthcare workers handle things.

A woman who has high self-efficacy during labor and birth is more likely to present great confidence in her abilities to complete the birthing process, leading to a higher satisfactory experience. According to the American Psychological Association, self-efficacy reflects confidence in the ability to exert control over one's motivation, behavior, and social environment. Individuals with high-efficacy beliefs tend to exhibit greater situational adaptability and are much more confident in their intuitive decision-making. In contrast, having low confidence and a lack of knowledge can lead to more perceived pain, increased stress, and overall, less fulfillment. Examples include a study from Australia about childbirth self-efficacy that investigated a group of first-time mothers and, “[found that women] who were giving birth for the first time had lower self-efficacy. Fear of childbirth and post-natal depression were highly significantly correlated with childbirth self-efficacy. They concluded that women would benefit from programs which could develop coping skills and confidence in abilities.” (Howarth, 2019, p. 18).

Further implications will be explained throughout the paper, pulling from other sources to show the importance of self-efficacy in primiparous women and steps that can be taken to achieve this.

Purpose Statement

The focus of this investigation is to examine the relationship between the promotion of self-efficacy and informed decision-making for first-time mothers in terms of creating higher birth satisfaction rates. The literature review will concentrate on self advocation in the hospital setting and examining personal encounters with patients and staff. It will also explore resources that have been mentioned or implemented for mothers to help strengthen their sense of confidence and collection of accurate medical information. In addition, we will analyze why these factors are so important for higher rates of safe, satisfactory births. It will also address the harm that emotional blackmail and biased information can have on patients and how nurses can lessen these behaviors on the unit.

Literature Review

This literature review will analyze studies conducted about dissatisfaction with birthing in the hospital setting as well as explain solutions that have already been implemented to increase pregnant women's self-efficacy and decision-making. There will be a total of 6 articles, all retrieved through the Dominican University of California's databases including CINAHL, Iceberg, and PubMed. When searching for articles, some of the key terms that were used included: *self-efficacy in first-time mothers, self-efficacy and childbirth, and birth satisfaction.* These searches yielded a considerable number of results, however, a large portion of them did not relate to the specific issue that was being researched. By narrowing down the results to experiences surrounding childbirth, including the components of self-efficacy, decision-making,

confidence, or satisfaction, there were enough sources to examine relationships between these factors.

The criteria that were required for each article included that they needed to be primary studies or systematic reviews that were conducted within the last 20 years. Additionally, they had to demonstrate one of the following: the prevalence of dissatisfaction with a birth experience in first-time mothers: how or why obstetric maltreatment occurs; effective tools that have been or will be implemented to help first-time moms gain confidence for birth. The articles were split into two categories. The first three works of literature explored the personal experiences of first-time moms giving birth as well as explaining obstetric maltreatment and the last three articles highlighted possible solutions and tools for women to use to gain self-efficacy and become more educated about childbirth. There will be two subheadings, the first one will review the problem, “Giving Birth in the Hospital as a First-Time Mother”, and the second one, “Implementations to Increase Self-Efficacy in First-Time Mothers,” will explore the solutions. See the Literature Review Table in Appendix A for a summary of each study.

Giving Birth in the Hospital as a First-Time Mother

Obstetric maltreatment has become an increasingly concerning issue can throughout the world however, the problem seems to be concentrated within the primiparous population. This will be further discussed in the following section. In the article*, “The System is Not Set up for the Benefit of Women: Women’s Experiences of Decision-Making During Pregnancy and Birth in Ireland,"* (2021) Susann Huschke examines the in-depth interviews that they conducted with about 23 women who gave birth between 2019-2020, focusing on their involvement in decision-making during pregnancy and birth. The qualitative study, as noted by the author, aimed to emphasize the value of patient experiences to speak for how hospitals treat pregnant clients.

Although the small sample size did prove to be an instant limitation, Huschke tried to have as diverse a population as possible. Being based in Ireland, the author explained how even though European law is in favor of having pregnant people be a part of their treatment, it is not always upheld in everyday practice. Women have reported being greatly displeased with their experiences in the hospital, being seen as objects rather than actual patients. The author noted that to ensure women's compliance and discourage autonomous decision-making, "women are frequently only given insufficient or biased information by their health care providers, combined with 'emotional blackmail' used to ensure their 'consent' to the option preferred by the medical professional." (Huschke, 2021). This phenomenon, also known as obstetric violence, is an umbrella term used for treatment measures or procedures that clients do not consent to but ultimately have done anyways.

In these interviews, the author wanted to move beyond "what" was happening in the healthcare system and instead ask "why" it is happening. As a result of all interviews, there was a mixture of both positive and negative encounters, which was to be expected. One account from a Latvian mother of two explains how after a failed home birth, she was sent to the hospital just to be pestered constantly with unwanted hourly vaginal exams and threats of a c-section if things did not progress. When she became fully dilated, she said that she felt pressured to get her baby out and the doctors even used a vacuum on the baby to get them out faster without her consent. Another account explains how at their 38-week check-up, their consultant did a membrane sweep without proper patient education. The sweep broke the client's water and they contracted an infection that ultimately put both her and the child in danger. The client stated that they wished the actual risks were provided to her so she could have the proper chance to give consent to the medical procedure. A benefit of this study is that because the researcher was very passionate

about the topic, they got several in-depth and meaningful interviews that truly gave a perspective of what mothers experienced and felt through the birthing process. Providing a safe space for women to express themselves about their experiences, yielded more promising results. It was able to show just how loosely medical staff can be with their policies and practices, not taking into consideration the people they take care of.

The next article, *"Exploring women's experiences of participation in shared decision-making during childbirth: a qualitative study at a reference hospital in Spain"* (2021), inspects the experiences of women and their participation in shared decision-making with their birth plans in Spain. The study also emphasized analyzing first-time mothers, ages 18 years or older, with a sample size of 23 just like the study examined above. There was also an emphasis on the utilization of the SDM approach which has been proven to be one of the most ideal ways to promote patient involvement in health decisions. SDM, " is a process in which clinicians and patients consider available information about the medical problem and work together to make a decision taking into account the patient's preferences and values…Particularly in maternity care, SDM has been associated with higher satisfaction of childbirth experience among women and increased involvement in decision-making." (López-Toribio, 2021, p. 2). Author María López-Toribio and colleagues took a qualitative approach, similar to the previous study, where women were interviewed in three focused groups. All medical information about their birth was accessible through health records from the same hospital. A total of 10 questions were asked, ranging from how they felt about treatment, whether they attended any antenatal classes, whether the experience was satisfying, and whether there was anything that would be done differently.

One thing to note about this population is that nearly 70% of the participants were identified to have a high-risk pregnancy. This specific population was greatly represented but it

would be less likely to properly represent the entire population. The results from the questionnaires presented three recurring themes; “Women’s low participation in shared decision-making”, “Lack of information provision for shared decision-making”, and “Suggestions to improve women’s participation in shared decision-making.” (López-Toribio, 2021, p. 1). Several women explained that they were very much willing to take part in decision-making but there was a barrier encountered and some women just did not feel prepared enough to participate. The women who were identified to be high-risk seemed to have less confidence to question their clinicians’ decisions and to participate in SDM perhaps because, “they felt that if they made decisions other than those advised by health professionals they would be putting their babies and themselves at risk.” (López-Toribio, 2021, p. 8-9). Birth plans were another important tool that was mentioned during the study because it is one of the clearest ways for patients to communicate with their healthcare provider. In this circumstance, however, many women said that they were not even used during the entire process showing another failed attempt of interacting with medical doctors.

Additionally, women felt that information provided by medical staff was insufficient and not offered promptly or found to be useful at that point so that it could aid in decision-making. One personal account from a participant entails, “[that they] feel that [they didn’t] decide anything. The (healthcare providers) did” as well as this account where a woman, “had the feeling of fighting from the beginning […] with decisions that were being made where there was no other choice, but [they] couldn’t put more energy into imposing [their] will, you know, [they] wore [themselves] out in that.” (López-Toribio, 2021, p. 5). This notion of medical professionals overtaking the clients’ birth plans, and not adhering to their wishes is clearly shown respectively in both articles. A lot of women felt that the environment was hostile, not

providing a sense of safety or tranquility. Women felt very discouraged about their experiences, speaking about all of the same things that were happening to them like the women in the Ireland study. Rates of satisfaction were relatively low, which is associated with low rates of self-efficacy and overall involvement. Being subjected to unwanted episiotomies, cervical checks, and more all stem from the same issue of pregnant women not being treated with the same respect and dignity as other patients in the hospital setting.

In the final article for this section, "*First-Time Mothers' Satisfaction with Their Birth Experience"* (2019), Christel Johansson and associates conducted a cross-sectional study of 584 primiparous women who gave birth in 2017 at a birthing center in Southern Sweden. The purpose of the study was to explore the birth experiences of first-time mothers using a Visual Analog Scale and identify possible risk factors for a negative birth experience. The study looked into several factors that influenced birth satisfaction including the mode of delivery, emotions during labor and birth, and oxytocin augmentation. The results of the study showed that about 10% of the women from the sample reported a negative birthing experience and the most common reasons were either due to a severe injury, oxytocin augmentation, or low birth weights. One thing to note about this article is that it analyzed practices in Sweden, where obstetric care is covered by the government and there are more effective care techniques that are used regularly. This type of accessibility is one thing that can also affect a woman's pregnancy and birthing experience. Circling back to the article, women also stated that, "giving birth vaginally reported statistically significant greater fulfillment and less distress than those who delivered by cesarian section." (Johansson, 2019). The author further goes on to explain that women who did have a c-section reported a less positive experience and felt higher amounts of stress and anxiety due to fearing for their newborn's safety.

Furthermore, women also said that having the ability to make a majority of their healthcare choices directly contributed to their birth satisfaction and feelings of security. Sweden is also a great example of a country that has made conscious efforts to provide all pregnant individuals with antenatal education for the sole purpose of increasing women's self-efficacy and decision-making skills for birth and postpartum. Comparing this to a nation like the United States, healthcare is very hard to access, especially for certain populations. This will be further examined in the research proposal where women in the United States will be the target population. Although outcomes were not as negative as the previously inspected articles, it does reveal how different factors can play into someone's birthing experience and why these components must be upheld to be successful.

Implementations to Increase Self-Efficacy in First-Time Mothers

Seeing that obstetric maltreatment continues to be an ongoing issue, one approach that can be done to take action is to prepare mothers during pregnancy before birth. The will have a better idea of what to expect and how to navigate the types of choices that will have to be made about their medical care. Expanding education for first-time mothers has the chance to increase their self-efficacy and decision-making skills. The following articles provide examples of this idea. A study in New Zealand, conducted by Anne M. Howarth and Nicola R. Swain, examined if the implementation of self-directed educational programs could improve birth satisfaction in first-time moms. Through a randomized control trial, two educational programs for pregnant women were compared in terms of their effectiveness and were rated within the first two days of moms being postpartum. One of the educational groups was known as the "skills group" which provided,"commercially available, self-paced, multi-media, skills-based, childbirth preparation program available on the internet." (Howarth, 2019, p. 16). The program offered four books, two

audio CDs, and a single video DVD. The content included within the reading material included, “breath, language and touch skills; teamwork for managing skills; rationalization for basic skills applicable for every birth; and extra skills for specific situations.” (Howarth, 2019, p. 16). Items included in the videos revolved around skills used to manage the birth process and how to stay relaxed. In total there were about 40 hours of content available and women were recommended to do a 5-15 minute study session every day. As for the other educational group, its main way of educating clients was through the shared experiences of other mothers which were compiled into a 58-page storybook that the mothers of this group could analyze and refer to when learning about childbirth and other things that could occur. The chapters were as follows, “home births, water births at home and hospital, natural births in hospital, hospital births with induction and/or pain management, premature and multiple births, pregnancy, and birth complications, forceps and ventouse births in hospital, and unexpected cesarean births in hospital.” (Howarth, 2019, p. 16). Researchers kept track of participants up until delivery when they were evaluated on the influence of the given material. Both educational groups provided excellent and thorough resources that could properly educate first-time mothers, so they could have a logical foundation and help them solidify their birth plans.

Some criteria for recruitment purposes included the women having to be between the ages of 18-42 years, having to be English-speaking, living in a relationship with the father, and being less than 24 weeks along. After enough people were acquired, approximately 137 women, were split into three groups, the two educational programs and the control group which received routine antenatal care. Questionnaires were utilized to keep track of the progress and how women felt in terms of their preparedness to give birth. In the end, results showed that women who were a part of either educational program had a significantly higher sense of self-efficacy

and satisfaction with their birth. Several women noted that they felt well-equipped and were able to go forward with their plans with little to no obstacles. Some of the most prevalent factors that contributed to the less satisfying births included inductions and c-sections, some being linked to bad experiences with medical doctors and others due to actual emergencies. This article shows a highly positive correlation between self-efficacy and antenatal education for first-time mothers.

In the next article, Heidi Preis and colleagues conducted a longitudinal, qualitative study on 330 Israeli first-time mothers that assessed birth satisfaction within physical, emotional, and cognitive factors. Women completed questionnaires during pregnancy and two months postpartum. The goal of this study was to see how mothers felt about their experiences and if any specific conclusions could help aid medical staff to ensure women feel comfortable and confident about their birth. Women were recruited through random sampling, certain health clinics, or social media boards where those who wanted to participate would fill out a baseline questionnaire. Of the original 1,059 women who completed this initial paper, only 413 were able to move forward. Some factors that caused this major decline were factors such as women being multiparous, losing interest, incompletion of the other following surveys, or unexpected infant mortality. The sample size ended up being 330 however due to the exclusion of women who did not complete the birth satisfaction measurement in the postpartum period. Different populations were represented including distinctions in ethnicity, income, and education level but they were not all exactly equal in terms of their numbers. For the actual measurements of each level in the study, the authors first went to assess the socio-demographics and obstetric history of each participant. They also asked about their planned mode of delivery which yielded several different plans which were beneficial to the study. A total of seven birth variable categories were organized by a panel of obstetricians and midwives ranging from one (most medical) to seven

(most natural). After birth occurred, women were asked to restate the actual modes of delivery, taking into account unplanned birth possibilities.

Next, researchers evaluated perceived self-control through a verified questionnaire that asked women to rate how much control they felt they had on a scale from one (none) to five (a lot). Emotions were also considered, a total of 27 different emotions to be exact. Each emotion that was included had to have already demonstrated strong psychometric properties. There were 16 negative emotions and 11 positive emotions, all being based on other studies that were conducted previously. Women were asked to rate what emotions they experienced and whether or not any emotions were experienced at all. The last two factors that were studied were perceptions of aftercare and overall satisfaction. Certain components that the participants were asked about included perceptions of communication, respect, safety, emotional support, and informed decision-making. After all the data was collected, the results were presented as follows; the most popular mode of delivery was a vaginal birth with an epidural. There was also, "greater perceived control-environment was associated with more positive emotions, less fear, and greater perceptions of care, while greater perceived control-process was associated with more positive emotions, less fear, and less guilt." (Preis, 2018, p. 112). The consistency with first-time mothers and their birth plans showed to have significantly higher satisfaction while greater incongruences with birth plans would lead to more feelings of guilt and stress as well as less perceived control of one's environment. In further discussion, the authors explain the significance of particular factors that have shown to be major predictors in a primiparous women's birthing experience. Mode of delivery is one of these factors, meaning that a change in delivery plans can be detrimental to the mother and baby, especially if they are done against their wishes. The study also revealed that there is a strong relationship between these plans as well as the woman's

expectations for the entire experience. If the birth does not align with the mother's beliefs, there will be a higher chance of dissatisfaction.

It is highlighted that medical staff should always adhere to the patient's decisions and there is a distinct change if they choose not to do this. Giving birth is a unique life experience, "a pivotal event for many women, especially first-time mothers, who may have been thinking about, dreaming, and planning the very birth experience they want to have (Miller & Shriver, 2012). At the same time, birth is highly medicalized and controlled by the medical establishment to which women must adhere as part of their role as "good mothers." Consequently, women's birth preferences, especially non-medical ones, are often not realized (Preis, Eisner, Chen, & Benyamini, in press). (Preis, 2018, p. 113). This problem is further exacerbated by the societal expectation that women need to give birth in a certain way thus making them feel like they need to "perform." By allowing women to have a say in their birth plans, the study shows a striking positive correlation to higher satisfaction and confidence.

For the last article, Samuel Ginja and colleagues discuss the relationship between social support, mental well-being, self-efficacy, and technology use in first-time mothers. Data was collected as part of an ongoing study, the BaBBLeS Study, to explore the effect of a pregnancy and maternity software application on maternal well-being and self-efficacy. The two main factors that were being compared were the implementation of social support and the implementation of technology for first-time mothers. The BaBBLeS Study, as previously mentioned was a part of a longitudinal study that was aimed to assess the impact of the Baby Buddy app, which was an experimental software designed to help women through their pregnancy. The study took place in the United Kingdom, comparing groups of women who used the app and who did not. First-time pregnant women, ages 16 or older were recruited from five

different maternity sights across the country between September 2016 to February 2017. In order to try to better represent the majority population, these sites were all located in different cities across England. They also tried to include other categories of ethnicities, educational levels, employment, and marital status. All baseline data were then taken from each participant, a total of 492 participants, at around 12-16 weeks gestation. The data that was collected with this baseline questionnaire included sociodemographics, social support, self-efficacy, and maternal mental well-being.

Social support was further assessed in a separate questionnaire where women were asked about the support they were receiving from friends, family, and spouses. Separate studies were done on maternal well-being and self-efficacy where women would rate certain statements on a numerical scale. For the rest of the women's pregnancies, researchers routinely checked in on the participants and their progress in terms of how these outside resources were aiding them to have a higher self-efficacy and overall well-being going forward, especially into birth. The results show a clear positive correlation between social support and maternal well-being, meaning that outside support can truly make a woman feel more comfortable and confident throughout her experience. Pregnancy and birth can be challenging times and family, friends, and partners need to show their support for the sake of the mom and her child to have a good and meaningful time. As for technology usage, the results were rather unexpected because the researchers anticipated positive outcomes from the women who were using the app along with having the appropriate support as well. A handful of participants stated that there was little to no change in self-efficacy or satisfaction with the use of the Baby Buddy app.

Although this occurred, there were specific aspects of technology that women did benefit from that may not be directly related to the app. Many women explained that blogging and social

media, taken from a separate study, “was associated with feelings of connection to extended family and friends which then predicted perceptions of social support and, in turn, maternal well-being.” (Ginja, 2018, p. 8). According to the authors, “these results could be related to the nature of activities involved in blogging and social networking: women were able to share successful parenting experiences on blogs, receive feedback and learn from others while reading blogs…In fact, learning through others (vicarious experience) is known to enhance self-efficacy.” (Ginja, 2018, p. 8). Altogether, these findings suggest that the impact of technology use on antenatal well-being is dependent on the type of activity. It is also conceivable that some technologies and online activities yield greater benefits later in pregnancy or postnatally when demands increase. This question compelled the authors to want to further investigate this in future studies. Overall, there is a strong connection between support and maternal self-efficacy and technology as well in respective manners.

Discussion of the Literature

Overall, both sections of the articles demonstrated the argument that they were trying to convey. The first subheading, *Giving Birth in the Hospital as a First-Time Mother*, showed three different works of research that gave a platform for first-time mothers to speak about their birthing experiences and the factors that contributed to their outcomes. A qualitative approach showed to be the most popular form of data collection, which was appropriate seeing that having in-depth interviews was able to get very concrete evidence of ways in which mothers are mistreated in hospitals. A lot of the negative experiences all seemed to revolve around a similar narrative where women in one way or another were experiencing maltreatment by their healthcare team. Most to all women with a negative birth story stated that there was less satisfaction, also pointing out how lost they felt in the entire process. This helps add to the

evidence that there is a relationship linked between birth satisfaction, decision-making, and patient treatment.

In the next subheading, *Implementations to Increase Self-Efficacy in First-Time Mothers*, the last three articles communicated how actual implementations were put in place for women to utilize as well as the results. Whether it be through books, videos, or apps, all articles show at least one of these forms of education when exposed to the primiparous population. Overall, the results did show that education has a positive correlation with higher rates of self-efficacy and decision-making. One gap that was found in the research includes the very last article, the BaBBLeS study (Ginja, 2018), where results warranted a need for further research due to insufficient information that the app had a positive effect on pregnant women. As mentioned previously, the amount of research that was found investigating self-efficacy, decision-making, and birth satisfaction was not plentiful. In the research proposal, there will be a study structured similarly to the implementations above to help provide for material to back up this correlation.

Research Proposal

Research Question

After a thorough review of the relationship between patient experiences and the importance of self-efficacy and decision-making skills, a new research question has arisen: Does the implementation of educational programs help increase self-efficacy and decision-making skills in first-time mothers?

Aim of the Study

With current strategies not yielding consistent positive results, the proposed study will investigate how curated educational practices can benefit first-time mothers by increasing their self-efficacy and decision-making skills. Additionally, there was an insufficient amount of

research material that dealt with the specific topic of interest so it felt necessary to conduct a study that would help contribute to this gap that was created in the literature. The study will be a mixed method design, utilizing both aspects of qualitative and quantitative strategies, that will evaluate the effectiveness of the newly implemented curriculum for first-time mothers compared to those who are not receiving these materials. The assumed results would be that with access to supplemental information, those groups of women will have a higher sense of self-efficacy and decision-making skills going into birth thus creating a higher birth satisfaction rate overall. The goal of this study is to educate and expose women to information about all things related to pregnancy, birth, and postpartum so that they can have more confidence in the choices that they make. It is essential to have first-time moms develop a sense of control, promoting autonomous behaviors so patients will be able to have faith in themselves, their support system, and the medical staff.

Primary Research Aim

Determine whether the implementation of outside educational materials can create a positive outcome for first-time mothers' self-efficacy, decision-making skills, and birth experience.

Research Study Design

As mentioned before, the study will be a mixed-method design, using both qualitative and quantitative strategies, observing the health outcomes of four different groups of first-time mothers. The study will look at the entire United States, looking at two groups of women from four different regions, in total there will be eight groups. One group will be from California, another will be from North Dakota, the third group will be from Alabama, and the last group will be from Pennsylvania. Each group will consist of 80 women, which will then be split in half,

leaving 40 women in two different groups. In total there will be 320 women across all groups. The reason for the placements of each group is to explore different populations from around the country so that there is a better chance for diversification and inclusion.

Population, Sample, and Recruitment

All women must be first-time mothers and there will be a recruiting window of between 20-24 weeks of gestation. Other than the women being ages 18 or older, there are no specific factors that we want to exclude when it comes to the actual recruitment process so all backgrounds will be welcome to be a part of the study. We want to have a range of women from different ethnic backgrounds, socioeconomic statuses, education statuses, and marital statuses. In two of the chosen states, larger, urban hospitals will be examined while in the other two states, smaller and more rural hospitals will be chosen. In terms of obtaining participants, we will utilize Sigma Theta Tao, an international honor society of nursing that is committed to promoting nursing research. I will have my team in California, as that is where I am from, and we will reach out to the organization to recruit nurse collaborators from our selected states to help collect participants within their hospitals. Advertisements for the study will be posted within each facility as well as be sent out via email and text to patients through medical staff. Other ways of recruiting are welcome as long as they are mentioned beforehand. Those who want to join will be subjected to a screening interview, via zoom, just to ensure they fit the criteria and are willing to remain a part of the study for the remainder of their pregnancy. Once potential participants confirm that they meet eligibility. requirements, the women will receive an online link to find further information where women can read more about the structure of the study and also be given consent forms to sign before any next steps. The signature will also be obtained electronically.

Methodology

After consent for participation in the study is obtained, an initial online questionnaire will be provided. The first part of the questionnaire will ask questions related to self-efficacy, decision-making, and more. In this format, they will be given a short list of statements that they will rate on a numerical scale, also referred to as the quantitative aspect.

There also will be a second part of the initial questionnaire in which participants will be asked about their birth plan, and support system, as well as components like emotions about childbirth, which they can open-endedly answer. This will constitute the qualitative portion of the study.

After completing the survey, women will then be randomly assigned to one out of two groups, the experimental group or the control group. For the remaining weeks of pregnancy up to birth, women in the experimental group will have educational content provided to them about pregnancy and birth while women in the control group will not receive any additional materials other than routine care.

The experimental group will be asked to study the given information for about 15-30 minutes a day. The materials that are going to be provided include books, online videos, classes, and counseling. The control group will be doing nothing different in their routines. Once labor and delivery have occurred, all women will then fill out a final questionnaire in a format that is similar to the previous one. In the first quantitative part, women will read statements related to their birth and rate on a numerical scale how they feel about each one. The experimental group's questionnaire will include questions about the usefulness of the educational materials they received. The control group will fill out a similar questionnaire but without any questions about the educational interventions. In the qualitative section, women will be able to write further in

depth about what happened during labor and birth, including interactions with staff and emergencies.

Analysis

Statistical methods will be used to evaluate the quantitative data while content analysis will be used to review all of the qualitative, open-ended responses from the women.

For the first part of the survey, descriptive statistics will be used to determine percentages, mean, median, and mode.

For the interventional portion of the study, answers from all three groups will be compared and contrasted to search for any significant relationships and correlations between them. A paired t-test will be used to evaluate both groups in each state and an analysis of variants, also known as an ANOVA will be used to examine all four states together.

Content analysis will be used to explore the data collected from the open-ended answers that women supply, and gain insight into their perceptions of their experiences. The researchers will meet regularly over several weeks to read and discuss the women's answers, and similar words and phrases will be grouped and categorized. From the determined categories, potential themes will be established.

Ethical Considerations

The pregnant population is considered to be vulnerable in terms of research purposes, so we must keep this in mind going forward. We are also conducting a study that involves medical patients so there will be measures taken to ensure safety and promote confidentiality. Before the initiation of this experiment, an application will be submitted to the Institutional Review Board in each state. The experiment is not invasive in any way, only observations and recording information. The Internal Review Board (IRB) process is essential to guarantee

patients/well-being and privacy throughout the entire study. Once IRB approval is attained, all participants will be required to fill out and electronically sign a consent form to fill out the survey portion of the study.

For the second portion of the study, researchers will explain the intervention and goals of the study. Once a potential participant states that she understands the study and wants to participate, signed consent will be obtained in person. Information explaining the experiment's purpose, the protocol in which it is going to occur, and required baseline details will be noted before they decide if they want to participate. If any participants in the study choose to opt out at any point during the study, they are allowed to as well. All information will be stored on a password-protected secured computer, ensuring that everything will remain confidential for all participants.

Theoretical Framework

After a thorough review of the literature above, the theoretical framework that would best suit this topic of the promotion of self-efficacy and decision-making would be Albert Bandura's theory on self-efficacy. Bandura was well known for his work in behavioral psychology, as he developed this theory, he wanted to focus on factors that could influence one's confidence. He discovered the very factors that contribute to low or high self-efficacy. Those who have high self-efficacy usually have an easier time changing behaviors and facing up to life issues while those with low self-efficacy have a more difficult time with changing behaviors or dealing with life changes. Another thing that was noted was how those with high self-efficacy tend to gravitate towards options that would not even occur to those who have low self-efficacy. There may even be individuals who prevent with high self-esteem but possess low self-efficacy. The healthcare field often involves patients that are to undergo major life changes. Assessing their

self-efficacy levels and other factors is a clear and concrete way for the healthcare team to create a path to help the client where they truly need it. This a method that can prove to help make nursing care more effective, putting the needs of the patient at the forefront so that their stay is as productive as possible. In terms of this thesis, it felt like it aligned with the overall research question that is being asked. Providing educational resources for first-time mothers is a way to help prepare them for their new impending life change so that they can develop new behaviors that can handle it. Developing these new behaviors can also open women up to other possibilities that may not even occur to them before in other aspects of their lives. Focusing on providing optimal nursing care and prioritizing the patient's well-being is exactly what this research is all about.

Conclusion

To reiterate, being a first-time mother can be a very challenging and stressful life adjustment. It can be overwhelming, trying to take in all of the new changes and prepare for events like childbirth which is usually very important to most women. Pregnant women are a vulnerable population, making them a target for medical professionals to take advantage of their possible deficiency in knowledge. It has become a global problem, leading to increased low satisfaction rates among this population. After the issue was presented through several personal accounts from real-life patients, implementations were then rigorously evaluated to show how there is a positive correlation between educational programs and high rates of self-efficacy and decision-making. Some of the articles showed a clear positive relationship between the implementation of educational programs and self-efficacy, which was able to support the stated claim. After everything else was presented, some of the research also showed to not have the

most compelling conclusions, warranting the need for more research. This is where the research question was formulated, asking for more research about said educational programs.

A study design was formulated to create research pertaining to the population in the United States. One thing to note is that almost all of the articles found for the literature review were from different countries around the world. Since maternal care is a very relevant topic in America, it felt proper to study this region due to the lack of research that involved self-efficacy and childbirth. A theoretical framework was also constructed around Albert Barunda's theory of self-efficacy which was able to perfectly capture the essence of what was being researched in this thesis. The research proposal was created to assess how educational materials contributed to the preparation of childbirth compared to those who only had routine care. All parameters were explained and given in a comprehensive manner.

To fully understand the concept of self-efficacy and decision-making and how important it is for first-time mothers, we must remember the reasons why it is needed in the first place. Not only do we as a healthcare team want our patients to thrive and have a satisfactory experience, but we also want to make sure they are equipped with the tools necessary to combat medical professionals and other obstacles that try to interfere with that process. Education, support, and encouragement are all great and regarded strategies to accomplish this goal and it is our job as a society to emphasize the significance it can have in people's lives. Becoming a mother is meant to be a beautiful and heartwarming experience, as healthcare workers, we are here to help guide and support our patients no matter the circumstance. Self-efficacy can completely change the trajectory of major life experiences, so making it a priority to maintain and grow is one of the most important things we can do to support our soon-to-be mothers.

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LITERATURE REVIEW TABLE

Title of your paper: The Relationship Between Self-Efficacy and Informed Decision-Making on First-Time Mothers

Your name: Morgan Fillipo Date: 10/2/22

Authors/Citation	Purpose/Objective of Study	Sample - Population of interest, sample size	Study Design	Study Methods	Major Finding(s)	Strengths	Limitations
Samuel Ginja Jane Coad	This paper presents data on how technology use affects the association between women's social support and, (i) mental wellbeing and, (ii) self-efficacy in the antenatal period.	n= 492	Quantitative study Cross sectional study	Bumps and Babies Longitudinal Study	Social support is associated with mental well-being and self-efficacy in antenatal first-time mothers. This association was not significantly affected by general technology use as measured in our survey. Future work should investigate whether pregnancy-specific technologies yield greater potential to enhance the perceived social support, wellbeing and self-efficacy of antenatal women.	1. Large sample size 2. One of the first studies of its kinds 3. Takes several factors into account to view self efficacy	1. Not as diverse population 2. Needs further investigation to yield more promising results 3. Stuy can only show if an association exists between variables, not a causal relationship
Anne M. Howarth Nicola R. Swain	This research aimed to assess whether either of two self-directed educational programmes could improve birth satisfaction in New Zealand first-time mothers	n= 137	Randomized control trial Qualitative study	Implementation of educational programs (late analyzed)	Increased preparation for childbirth may be important for birth satisfaction; both induction and cesarean section reduce satisfaction; and expectations around birth might be managed to improve satisfaction. This study found evidence that simple low-cost programmes can improve birth satisfaction.	1. Adequate sample size 2. Randomization of the sample 3. Actions taken to minimize biases	1. Population doesn't represent the vast majority of women in the area 2. Costly process 3. time-consuming
Susann Huscke	The aim of this study was to investigate women's subjective experiences of mental health and wellbeing during pregnancy, birth and postpartum.	n= 23	Qualitative study	Interviews	There was a mixture of positive and negative feedback about the mothers' experiences towards their births. Which was to be expected.	1. Diverse group of people (background) 2. Passionate, educated researcher 3. Initial invitation subject was more broad to steer away from biased interviews(emotiona	1. Small sample size 2. Time consuming process

						l-well being vs. decision-making/autonomy)	
Cristel Johansson Hafrun Finnbogadottir	To explore first-time mothers´ satisfaction with their birth experience using Visual Analog Scale and to identify possible risk factors for a negative birth experience.	n= 584	Cross-sectional study Mixed method	Utilization of retrospective data collection from participant's medical files VAS scale (rating birth experience) included in the medical files	Women who had their labours augmented with oxytocin or sustained an anal sphincter injury were statistically significantly more likely to have a negative birth experience. However, it is uncertain whether the women scored pain experience or birth experience when they reported their satisfaction on the Visual Analog Scale; further investigation is required.	1. Large sample size 2. Observes a wide range of components that could affect birth experiences 3. This study fills an important gap in the literature concerning possible obstetric risk factors for a negative birth experience and the use of a VAS instrument to evaluate birth experience.	1. Unclear results requiring further investigation 2. Leaves out certain populations (including those with language barriers) 3. VAS is primarily used for pain experiences, rather than birthing experiences
María López-Toribio Paulina Bravo Anna Llupià	This study aimed to explore women's experiences of participation in SDM during hospital childbirth. Specifically, two research questions were stated: 1) What were the barriers and facilitators to women's involvement in SDM during hospital childbirth? 2) What were the opportunities for improvement regarding participation in SDM?	n= 23	Qualitative study	Interviews Surveys Questionnaires	This study has shown that women who were willing to take an active role in SDM during hospital childbirth faced difficulties in doing so. The information needed to take an active role during childbirth was perceived as missing or given to women at an inappropriate time. Potential improvements identified as enablers of women's participation were having a mutually respectful relationship with their care providers, the support of partners and other members of the family, and receiving continuity of a coordinated and personalized perinatal care. Enhancing women's participation requires the acquisition of skills by health professionals and	1. Qualitative methodology provided a deep and broad insight into women's experiences 2. First study of its kind for the area it's analyzing 3. Utilizes multiple methods for collecting data	1. Small sample size 2. Data may not represent the vast majority of women giving birth in the country 3. Underrepresented populations

					women and the development, implementation, and evaluation of interventions to facilitate women's engagement in SDM.		
Heidi Preis Marci Lobel Yael Benyamini	**We distinguished between physical, emotional, and cognitive factors and used them to assess the underlying mechanism of satisfaction, based on theoretical frameworks of stress and control.**	**n= 330**	**Longitudinal study Qualitative study**	**Questionnaires**	**This investigation unraveled the association between women's lived birth experience and their birth satisfaction. The findings underscore the value of helping women achieve satisfying births by discussing their expectations with them, providing them with experiences that meet their needs, and supporting those with a gap between their expectations and experience**	**1. Adequate sample size 2. First study of its kind 3. Not representative of that country's population**	**1. Study was too tailored to the researcher's preferences 2. Left out some possible predictors of birth satisfaction 3. Validity hindered due to time-frame in which the rate of birth satisfaction was measured**